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EUROPEAN COMMISSION - DIRECTORATE GENERAL JUSTICE AND CONSUMERS
Programme and Financial management
Grant Agreement number: 881677 — I.N.T.I.T. — REC-AG-2019 / REC-RDAP-GBV-AG-2019

The Meaning of Trauma Informed Care Today

Position Paper

INTIT

INtegrated Trauma Informed Therapy for Child Victims of Violence

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1. Introduction

Childhood exposure to interpersonal violence and related developmental trauma has been identified as a silent epidemic and as a major public health challenge.[1] Over the past years the relationship between experiences of trauma and both physical and behavioral health disorders has increasingly been acknowledged. The need to address trauma is therefore considered a fundamental obligation for service providers and policy makers.[2] The potential for exposure to trauma is manifold ranging from trauma due to war, natural disasters and accidents to trauma resulting from interpersonal violence and abuse. The transnational project I.N.T.I.T. co-funded by the European Union focuses on these latter types of trauma with a particular emphasis on trauma experienced by children and youth due to maltreatment.

Violence against children affects millions of children throughout Europe and internationally. Worldwide, approximately one third of children are estimated to experience physical abuse and approximately one in four girls and one in five boys experience sexual victimization.[3] While official statistics are limited, a 2014 European Parliament report estimates that "around 18 million children in Europe suffer sexual abuse, 44 million suffer physical abuse and 55 million suffer psychological abuse resulting each year in the deaths of at least 850 children under the age of 15."[4]

Children and youth that have experienced violence pass through multiple systems including mental health services, medical services, welfare services, the educational system and, in some cases, the criminal justice system as part of the investigation and prosecution of the offender(s). While individuals react differently to violence and abuse based on varying degrees of resilience and support, it can be assumed that trauma frequently emerges as a consequence of these experiences. The failure to recognize and understand trauma by relevant services providers can magnify harmful and costly health implications.[5]

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[1] Kaffman, A. (2009): The silent epidemic of neurodevelopmental injuries, in: *Biological Psychiatry*, 66, p. 624-626.

[2] Substance Abuse and Mental Health Services Administration (2014): SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach. HHS Publication No. (SMA). Rockville, MD.

[3] D' Andrea, Wendy et al. (2012): Understanding Interpersonal Trauma in Children: Why we Need a Developmentally Appropriate Trauma Diagnosis, in: *American Journal of Orthopsychiatry*, Vol. 82, No. 2, p. 187-200.

[4] Dimitrova-Stull, Anna (2014): Violence Towards Children in the EU. *European Parliamentary Research Service*. p. 14.

[5] Levy-Carrick, Nomi C. et al. (2019) : Promoting Health Equity through Trauma-Informed Care, in*: Family and Community Health*, April-June, Vol. 42, No.2.

The "trauma-informed-care" approach has emerged over the last few years as a response to better addressing trauma with early research and development financed by the US based Substance Abuse and Mental Health Services Administration (SAMHSA). Subsequently, a "plethora of theories, models, articles and training providers"[6] has emerged constituting a challenge for practitioners to identify an appropriate approach for their respective setting and translating theory into practical implementation. This position paper intends to highlight the core principles and underlying assumptions of a trauma *informed* approach as opposed to a trauma *specific* approach. It also reviews the prevalence of trauma informed care in Europe and with particular focus on the utilization of trauma informed approaches in partner countries of the I.N.T.I.T. project – Italy, Spain, Estonia, Cyprus, and Germany.

2. Defining Trauma

Before focusing on the trauma-informed approach one needs to come to an understanding of trauma itself. The definitions are manifold and will not be discussed at length in this paper, but a common understanding is nonetheless essential. The above-mentioned SAMHSA defines trauma as follows:

> *"Individual trauma results from an **event**, series of events, or set of circumstances that is **experienced** by an individual as physically or emotionally harmful or life threatening and that has lasting adverse **effects** on the individual's functioning and mental, physical, social, emotional, or spiritual well-being."*[7]

According to DeCandia and Guarino "an event becomes traumatic when it overwhelms the neurophysiological system for coping with stress and leaves people feeling unsafe, vulnerable, and out of control."[8] Bessel van der Kolk has described complex trauma as "the experience of multiple, chronic and prolonged, developmentally adverse traumatic events, most often of an interpersonal nature (e.g. sexual or physical abuse, war, community violence) and early-life onset".[9] These exposures to violence often occur in a child's care giving system with long-term (behavioral) health implications. Potential consequences of childhood trauma include the disruption of affect regulation, disturbed attachment patterns, rapid behavioral regressions, aggressive behavior towards self and others, as well as self-hatred and self-blame.[10] In his book *The Body Keeps the Score* van der Kolk emphasizes that trauma is stored in the body and for therapy to be effective it needs to take the physiological changes that occur into account.[11] This view is underlined by the landmark Adverse Childhood Experiences (ACEs) study conducted by the Center for Disease Control and Prevention (CDC) in the United States

[6] Johnson, Dan (2017): Tangible Trauma Informed Care, in: *Scottish Journal of Residential Care*, Vol. 16, p. 1-21.
[7] SAMHSA, p. 7
[8] DeCandia, Camelia and Kathleen Guarino (2015): Trauma-Informed Care: an Ecological Response, in: *Journal of Child and Youth Care Work*, p. 7-32.
[9] Van der Kolk, Bessel (2005): Developmental Trauma Disorder: Towards a rational diagnosis for children with complex trauma histories, in: *Psychiatric Annals*, 33(5), 401-408.
[10] Ibid.
[11] Van der Kolk, Bessel (2015): The Body Keeps the Score. Brain, Mind, and Body in the Healing of Trauma. Published by Viking.

demonstrating that violence in childhood results in a significant increase of health risks for alcoholism, drug abuse, depression, and suicide attempts in addition to an elevated risk of heart disease, cancer, chronic lung disease, skeletal fractures, and liver disease.[12] Ultimately these health implications can lead to the early death of those who have experienced violence during childhood.[13]

SAMHSA further points out that trauma has no boundaries with respect to age, gender, socioeconomic status, race, ethnicity, geography or sexual orientation.[14] Traumatic experiences can be pervasive across life cycles. Additionally, trauma does not occur in a vacuum, but within contexts characterized by socioeconomic disparity, historical injustice, and cultural complexity.[15] According to Levi-Carrick et al. equitable opportunities for optimal health require deliberate attention to these dimensions realizing that individual trauma occurs in the context of a community. In fact, communities as a whole could also experience trauma[16] such as the structural racism and police brutality facing the African-American community in the U.S. Although incidence and prevalence of trauma exposure vary widely in the population, a recent global general population survey revealed traumatic exposure proportions exceeding 70%, with 30.5% reporting exposure to four or more such events. Trauma and adversity are therefore among the critical social determinants of health that affect not just individuals, but also families, communities, and society.[17] [18]

3. The Concept of "Trauma-Informed Care"

The "trauma-informed care" (TIC) approach has received increasing attention in recent years due to the above-mentioned pervasiveness of trauma and its (mental) health implications. The groundwork for defining and conceptualizing this approach was laid out in partnership with SAMHSA (as a funding body), which developed its framework based on academic research, expertise by practitioners as well as survivors' knowledge.[19] SAMHSA defines a trauma-informed entity as follows:

> *"A program, organization, or system that is trauma-informed **realizes** the widespread impact of trauma and understands potential paths for recovery; **recognizes** the signs and symptoms of trauma in clients, families, staff, and others involved with the system; and **responds** by fully*

[12] Felitti, Vincent et al. (1998): Relationship of Childhood Abuse and Household Dysfunction to Many of the Leading Causes of Death in Adults, in: *American Journal of Preventive Medicine*, 14 (4), p. 245; https://www.cdc.gov/violenceprevention/childabuseandneglect/acestudy/index.html
[13] Felitti et al., p. 256
[14] SAMHSA, p. 2
[15] Levy-Carrick, p. 104.
[16] SAMHSA, p. 17
[17] Levy-Carrick, p. 104
[18] For a more comprehensive review of the meaning and impact of trauma in childhood, please refer to the I.N.T.I.T. position paper by IPRS "Trauma and Minors".
[19] Also view https://pubmed.ncbi.nlm.nih.gov/15780539/ for the U.S. federal *Women Co-Occurring Disorder and Violence Study*, setting the groundwork for the federal direction around trauma-informed care.

*integrating knowledge about trauma into policies, procedures, and practices, and seeks to actively **resist re- traumatization**."*[20]

A trauma-*informed* approach is distinct from trauma-*specific* services. While it is inclusive of trauma-specific interventions such as assessment, treatment or recovery support, it also incorporates key trauma principles into the organizational culture.[21] A trauma-informed approach as defined above therefore can be implemented in a wide range of services including but not limited to: behavioral and mental health, education, children and family welfare, criminal and juvenile justice, primary health care, homeless shelters, and the military.

The TIC approach stems from the realization that public institutions and service systems themselves are often trauma-inducing causing "unintended" re-traumatization by treating a patient or client for behavioral issues (e.g. substance abuse, diagnosis of "conflict disorder" in children) in a vacuum without taking into account the impact of trauma.[22] Recognizing and understanding trauma on the other hand could prevent misdiagnoses that are focused on treating symptoms alone while failing to address the underlying cause of a "mental injury".[23] Children and youth are frequently labeled as "oppositional" and misdiagnosed with ADHD or a bipolar disorder.[24] Adoption of a trauma informed approach reflects the recognition that many individuals experience trauma that in turn influences their behavior and may be exacerbated by an inappropriate response by a service or caregiver.

To comply with a TIC approach, organizations should adhere to the following **four key assumptions**[25]:

- All people within an organization or system have a **basic realization of trauma** and how it affects families, groups, organizations, communities and individuals. There should be an awareness that trauma should be systematically addressed in prevention, treatment and recovery settings.

- All people within an organization or system **recognize the signs of trauma**.

- The program, organization or **system responds by applying the principles of a trauma-informed approach** to all areas of functioning including staff, leadership, policies, manuals and organizational culture.

- A trauma-informed care approach **seeks to resist re-traumatization** of clients as well as staff.

[20] SAMHSA p. 9
[21] SAMHSA, p. 9
[22] http://www.traumainformedcareproject.org; DeCandia, Camelia and Kathleen Guarino (2015)
[23] Stenius, Vanja and Bonita Veysey (2005): It's the Little Things. Women, Trauma, and Strategies for Healing, in: *Journal of Interpersonal Violence*, p.2; An example of the failure to recognized the signs of mental injury and misdiagnosis and medication is portrayed in the documentary "Cracked Up: the Darrell Hammond Story" (2018).
[24] DeCandia, p. 15
[25] SAMHSA p. 9-10

Given the assumptions outlined above, TIC can be viewed as a "universal design for serving trauma survivors"[26] with the entire system being used as a vehicle for intervention. These assumptions imply a significant paradigm shift involving whole support systems that need to broaden their scope of intervention from asking "how can I fix you" to "what do you need to support your development and recovery?"[27]

Related to the above-mentioned assumptions SAMHSA developed **six core principles** for TIC requiring an organization-wide commitment for putting these principles into practice. It should be noted that these principles are equally important and no priority is assumed in their listing below:[28]

- **Safety**: staff and the people they serve feel physically and psychologically safe.
- **Trustworthiness and Transparency:** organizational operations are geared towards building trust amongst clients, family members and staff.
- **Peer Support:** "Peers" or "trauma survivors" are considered key elements in fostering healing and recovery. In the case of children, peers could be family members who themselves have experienced trauma during childhood.
- **Collaboration and Mutuality**: Everyone in an organization has a role to play in a trauma-informed approach. Power differences between staff and clients and amongst staff are leveled as opposed to replicating a hierarchy of expert knowledge and client compliance.
- **Empowerment, Voice and Choice:** Organizations believe in resilience and the ability of individuals and communities to heal and recover from trauma. Self-advocacy skills are promoted and staff members are considered facilitators of recovery rather than controllers of recovery.
- **Cultural, Historical and Gender Issues[29]:** Organizations are responsive to cultural needs, recognize historical trauma, and are aware of gender-specific needs.

4. Becoming Trauma-Informed

The above-mentioned assumptions and principles provide a roadmap for an organization or service to become trauma-informed. However, for the approach to be implemented it needs to be fully endorsed and reflected in all areas of operation.

[26] DeCandia, p. 8
[27] Ibid. p. 13
[28] SAMHSA, p.11
[29] According to Stenius and Veysey (2005) there is an acute lack of trauma-informed gender specific care for women, p. 2

An integral role in this process is that of leadership which needs to demonstrate its commitment and define clear expectations. Staff training and workforce development are equally important. Given their frequent exposure to complex mental health issues and emotional needs, professional caregivers often suffer from high levels of stress, burnout, compassion fatigue, and vicarious trauma.[30] In a recent study Schmid et al. found that the exposure to TIC practices and training in an organization has a positive influence on reducing the emotional burden of both staff and clients.[31] Staff experience a higher level of fulfillment through improved client engagement and benefit from a higher level of awareness of the risks of (unintentional) re-traumatization and retriggering of clients and patients.[32]

Another cornerstone and key value of TIC is the involvement of trauma survivors, people receiving services, and family members[33] in all aspects of the organization including program design, service delivery, quality assurance, staff training, cultural competence and evaluation.[34] With this focus, affected individuals are given a voice in how services are delivered. This constitutes a power shift from a focus on professional "experts" to valuing and incorporating the experiences of those who can relate and identify. Ultimately, this means a restitution of dignity for service recipients.[35]

An important prerequisite for the successful implementation of a TIC approach is the inter-disciplinary and cross sector collaboration between service providers and amongst systems of care. The lack of inter-agency cooperation could lead to misdiagnosis, false medication, and re-traumatization.[36] However, systemic barriers are often constituted through different jurisdictions and legal requirements, through strict health insurance parameters, financial concerns and data protection. These barriers force clients to repeatedly outline their issues to a multitude of stakeholders, prevent cross-training and lead to interruptions in service delivery due to insurance constraints. As with the implementation of a TIC approach the commitment towards multi-agency cooperation needs to be endorsed by the leadership. Once the notion of multi-agency cooperation is established staff – and clients – benefit from the added values of a common case analysis and from a sense of shared responsibility.[37] [38]

[30] Levy-Carrick

[31] Schmid, Marc et al (2020): Effect of trauma-informed care on hair cortisol concentration in youth welfare staff and client physical aggression towards staff: results of a longitudinal study, in: *BMC Public Health*,p. 1-11

[32] Levy-Carrick, Nomi C. et al. (2019)

[33] In the case of services for children, this role could be taken by adults with previous experiences of trauma. Save the Children in Sweden has adopted this approach in their hiring process. https://www.raddabarnen.se/rad-och-kunskap/arbetar-med-barn/tmo/

[34] SAMHSA, p.13

[35] Stenius and Veysey, 2005, p.16

[36] Ibid, p. 2

[37] Heinrich, Svenja and Galina Missel (2018): Jung, delinquent und psychisch auffällig. Ein multidisziplinärer Lösungsansatz der Hilfekoordinierung und der Versorgung, in: *ZJJ* 2/2018, p. 119-125. Article on the challenges of multi-agency cooperation for European Union funded project *Fact for Minors*.

[38] For a more comprehensive review on the merit of inter-agency cooperation please refer to the I.N.T.I.T. position paper prepared by Consensus „Multi-agency Approach".

Implementing these core values is an ongoing process due to resistance to change by staff and leadership, high staff turnover within the organization, inadequate training opportunities, and limited financial resources.[39]

5. Prevalence of Trauma-Informed Approaches in Europe

The majority of references around TIC mentioned above derives from U.S. based research.[40] The following chapter discusses the prevalence of TIC in Europe and potential lessons learnt from US practice. Given the scope of the project, this paper will focus on the participating project partners of Italy, Spain, Cyprus, Estonia and Germany and making reference to Sweden as an early implementer of the Barnahus model and country with a high level of TIC implementation.

As noted above, interpersonal violence and neglect are widespread phenomena faced by children in the US and Europe alike.[41] However, with its differences in socio-economic development, its respective political histories and variety of demographics, Europe is also characterized by its diversity in the development of trauma treatment.[42] Although there is growing acknowledgment of the impact of trauma and the relevance of trauma-focused treatments, there is a lack of Europe-wide policies to ensure the availability of treatment to trauma-survivors. Explicit reference to TIC is only made occasionally for individual member states whereas trauma-informed care policies on a European-level have yet to emerge.[43] A step towards a transnational exploration of TIC has been made with the CarePath project focusing on the benefits of TIC for young care leavers in 8 European countries.[44] In addition, the Barnahus Model – a multidisciplinary and interagency model responding to child victims and witnesses of violence or sexual abuse in the context of court proceedings – has been implemented in a growing number of European countries.[45] [46]

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[39] De Candia, p. 16

[40] https://www.nctsn.org/trauma-informed-care National Child Traumatic Stress Network; https://tfcbt.org/

[41] https://ec.europa.eu/home-affairs/what-we-do/policies/organized-crime-and-human-trafficking/child-sexual-abuse_en, Studies suggest that a significant minority of children in Europe, between 10% and 20%, are sexually assaulted during childhood. This phenomenon is not decreasing and certain forms of sexual violence (like child pornography) are becoming a matter of growing concern.
WHO. *European Status Report on Preventing Child Maltreatment.* 2018.
https://www.euro.who.int/__data/assets/pdf_file/0017/381140/wh12-ecm-rep-eng.pdf

[42] Kazlauskas, Evaldas et al. (2016): Trauma treatment across Europe: where do we stand now from a perspective of seven countries, in: *European Journal of Psychotraumatology*, 7:1, DOI: 10.3402/ejpt.v7.29450

[43] Schäfer, I. et al. (2018). Trauma and trauma care in Europe, in: *European journal of psychotraumatology*, *9*(1), 1556553.

[44] https://carepath-project.eu/site/en/news/view.html?id=8

[45] https://www.childrenatrisk.eu/promise/wp-content/uploads/PROMISE-Enabling-Child-Sensitive-Justice.pdf

[46] For a more comprehensive review of the Barnahus Model please refer to the I.N.T.I.T. position paper prepared by the University of Cyprus "The Barnahus Model Across the Broader European Context".

Italy

Data on the incidence of child maltreatment in Italy are generally lacking with data largely limited to a study conducted by Terre des Hommes and CISMAI, based on a national sample of social service provision in Italian cities, in which about 1 in 10 children were identified as being victims of maltreatment. Of these, 52.7% were due to neglect (basic needs and/or emotional), 16.6% witnessing violence, 12.8% psychological abuse, 6.7% sexual abuse, 6.1% excessive medical care, and 4.8% physical abuse[47]. These data need to be interpreted with caution as they are subject to a number of methodological caveats, but are – to date – the only data that include a national sample.

Italy has not adopted the language of trauma informed care and trauma treatment remains largely in the domain of psychiatrists and psychologists[48] as opposed to adopting a more multidisciplinary approach to care. Much of the work on trauma has focused on trauma caused by natural disasters (e.g., earthquakes) with the establishment of the Italian National Trauma Center[49], which has taken some steps towards promoting a trauma sensitive approach adopting well-established diagnostic tools for identifying trauma in partnership with Harvard University. This work, however, has not focused specifically on children.

There remains a general lack of preventive initiatives and early detection assessment tools for post-traumatic syndromes. For this reason, the system tends to respond with delay and mainly to traumatization that became complex as a result of missed accurate diagnoses. To proceed with this vision Kazlauskas et al. suggest for the Italian Society of Traumatic Stress Studies (SISST) to adapt the following strategic steps: promote the synergy between clinical work and research to adapt service models accordingly, provide epidemiological studies to determine the actual prevalence and incidence of traumatic events in Italian society and to further expand possibilities of training in psychotraumatology.[50] Amongst the priority target groups in need of care are highly traumatized refugees and unaccompanied minors that entered Italy particularly over the past 5-10 years.

A systemic vision for care for traumatized populations, with shared policies and protocols has not yet emerged although a plan for general prevention was provided by the Ministry of Health in 2019 focusing on the "first 1000 days" beginning with conception[51]. This represents a broad recognition of the importance of early intervention and long-term impact of abuse and maltreatment during childhood as well as prenatal issues on child development.

Local focus on trauma can be found in some areas such as the Region of Puglia, which has developed an extensive system for identifying complex trauma and providing treatment

[47] Bollini, Andrea, Federica Gianotta, and Antonello Angeli. "Maltrattamento sui bambini: quante le vittime in Italia? Prima Indagine nazionale quali-quantitativa sul maltrattamento a danno di bambini." https://www.garanteinfanzia.org/sites/default/files/documenti/dossier-bambini-maltrattati-tdh-cismai.pdf

[48] Schäfer, I., (2018) https://doi.org/10.1080/20008198.2018.1556553

[49] https://www.intraumacenter.com/index.php

[50] Kazlauskas et al.

[51] http://www.salute.gov.it/imgs/C_17_pubblicazioni_2837_allegato.pdf

within a multi-disciplinary framework. The GIADA project[52] represents a significant advancement in the identification and treatment of trauma that includes some elements of trauma informed care and efforts to reduce re-victimization as part of criminal investigations. GIADA, while providing trauma-specific care to children, is not based on TIC and does not explicitly incorporate the TIC principles.

Germany

In 2019, the German child and youth welfare offices reported 55.500 cases of endangerment of the well-being of a child, which constitutes a 10% increase from 2018. This 10% increase for a second consecutive year led to an unprecedented level of child endangerment cases.[53] While overall numbers of child abuse increased the number of custodial cases involving unaccompanied young refugees has decreased since 2018.[54] Amongst this latter target group between 17-62% of boys and up to 71% of girls are estimated to have evolved some symptoms of post-traumatic stress disorder (PTSD). Between 20-30% of unaccompanied minors are estimated to have developed comprehensive signs of PTSD.[55] While custodial cases for unaccompanied minors have decreased there has been a higher prevalence of child victims of physical and psychological abuse. In 2019, the police crime statistics reported 3.430 cases of child abuse affecting 4.100 victims, 56,9 % of them being male, 43,1 % being female.[56] As for sexual abuse during childhood, there were 15.701 cases officially reported in 2019. The so-called "darkfield" of unreported cases for (sexual) abuse is expected to be much larger.[57]

The prevention and treatment of trauma in different care settings remains a challenge in Germany.[58] According to Fegert stress related disorders in children and youth often remain hidden as children adapt to their respective environment. Consequently, trauma frequently remains unidentified and trauma specific care is only sought after in cases of high latency. The health system has not paid sufficient attention to potential histories of trauma leading to symptom-focused as opposed to trauma-focused approaches to treatment.[59] Amongst the target groups that are particularly vulnerable to becoming exposed to interpersonal violence are children in foster care, children in government custody and residential facilities, children with disabilities, children of parents suffering from mental illness, and unaccompanied minors.

[52] http://www.giadainfanzia.it/
[53] https://www.destatis.de/DE/Presse/Pressemitteilungen/2020/08/PD20_328_225.html
[54] https://www.destatis.de/DE/Presse/Pressemitteilungen/2019/08/PD19_308_225.html;jsessionid=5A2E1B7EFAEEA70E9D8D9B6B568726D9.internet8722 (Statistisches Bundesamt 2018)
[55] Sukale, T., Hertel, C., Möhler, E. et al. (2017): Diagnostik und Ersteinschätzung bei minderjährigen Flüchtlingen. *Nervenarzt* 88, 3–9. https://doi.org/10.1007/s00115-016-0244-4
[56] https://www.polizei-beratung.de/themen-und-tipps/gewalt/kindesmisshandlung/fakten/
[57] https://de.statista.com/statistik/daten/studie/38415/umfrage/sexueller-missbrauch-von-kindern-seit-1999/#professional
[58] Kazlauskas et al. (2016)
[59] Fegert, J. (2016): Folgekosten von Vernachlässigung und Misshandlung in der Kindheit: Verbesserung im Kinderschutz als gesellschaftliche Herausforderung. *Tagung Traumapädagogik überwindet Grenzen*, 19.11.2016 in Dornbirn

Following the comprehensive disclosure of sexual abuse in religious and youth care institutions, in 2010 the German government established an independent commissioner to address child sexual abuse.[60] In addition, substantial funding was provided for research and preventive activities in this domain. However, the introduction of designated trauma-informed practices in the realm of youth welfare or residential care has been limited. The term "trauma-informed care" is rarely used in Germany to date, instead practitioners speak of "trauma-sensitivity" and "trauma pedagogy".[61] Although these concepts acknowledge the importance of addressing trauma, they do not entirely reflect the holistic, systemic approach of TIC and its related means of intervention.

In 2018, Germany opened its first childhood house (Barnahus) in Leipzig. Two more centers followed in 2019 in Heidelberg and 2020 in Berlin. Both childhood houses are affiliated with children and youth medicine divisions of university hospitals and are funded by the World Childhood Foundation. Additional childhood houses are in a planning stage in multiple German states. The concerted objective is to join police investigators, prosecutors, social services, child and adolescent psychiatrists, and child health and medical care/forensic medicine services to avoid re-traumatization through repeated interrogations by multiple stakeholders.[62]

Spain

For 2018 the Spanish Ministry of Health's Children's Observatory reports 1.209 cases of sexual violence, 4.758 cases of emotional violence, 3.894 cases of physical violence and 12.679 cases of neglect of children and youth under 18. [63]

The concept of trauma-informed care is familiar to some professionals and organizations however there is no widespread knowledge. The Barnahus model is just emerging in Spain. Some Autonomous Communities are studying the implementation and there is a pilot Project in Cataluña to be carried out for a year in Tarragona.

Estonia

[60] https://beauftragter-missbrauch.de/, Unabhängiger Beauftragter für Fragen des Sexuellen Kindesmissbrauchs UBSKM

[61] https://ecqat.elearning-kinderschutz.de/, online training on the concept of trauma therapy and trauma pedagogy

[62] https://childhood.org/childhood-opens-germanys-first-barnahus-childhood-haus/

[63] Boletín nº 21 de datos estadísticos de medidas de protección a la infancia. Datos 2018. pp. 107 y ss. Secretaría de Estado de Derechos Sociales Dirección General de Derechos de la Infancia y de la Adolescencia - Observatorio de la Infancia.
https://observatoriodelainfancia.vpsocial.gob.es/estadisticas/estadisticas/home.htm

The most recent research in Estonia on sexual abuse of minors and young people (16 to 26 years old) was conducted in 2019-2020.[64] According to the results of the study 18% of youth age 16 to 19, have experienced some form of sexual violence during their life.

Of those young people, who have experienced sexual violence, nearly half have told someone about the incidence. Young people usually turn for support to their friend (34%), boyfriend or girlfriend (12%), or mother (9%). Only 2% have reported the case to police. The primary reasons for not reporting the case to anyone was that the young person thought the case was not serious enough (1/2 of all victims) or s/he felt ashamed (1/3 of the victims). Only one in ten said they did not know who they can talk to.[65]

In Estonia, the general quality of the services provided for children improved with the adoption of the amendments to the Victim Support Act (which entered into force on 1 January 2017).[66] A pilot project of Children's House (Lastemaja) was started in Tallinn was also started in January 2017. This was done as part of the PROMISE project and the model of Lastemaja is based on the Barnahus model. In 2018 the second Children's House was opened in Tartu, and the opening of the third Children's House is planned in Jõhvi in 2020.

Cyprus

Cyprus police statistics indicate that during 2014-2018 151 cases of child sexual abuse, 2737 cases of child physical abuse and 1475 cases of child psychological abuse were reported. In addition, the Home of the Child (Barnahus) received a total of 368 cases of child sexual abuse from January 2018 to October 2019[67]. The Police Electronic Crime Squad investigated a total of 649 cases of child pornography during the period 2014-2018[68]. This data applies to an estimated population of the Republic of Cyprus at the end of 2020 of 1.207.359 based on projections of the latest United Nations data[69].

In Cyprus the relevant service entities are familiar with the concept of ''trauma informed care''. The notion of trauma informed service delivery has been implemented through the introduction of the Home of the Child (Barnahus) in 2016 in Cyprus.[70]

Sweden

[64] Pärnamets, R., Hillep, P. A Study of Attitudes and Experiences of Sexual Abuse of Children and Young People. Available: https://www.kriminaalpoliitika.ee/et/study-attitudes-and-experiences-sexual-abuse-children-and-young-people

[65] Ibid., 63-69

[66] Victims Support Act (Ohvriabi seadus). Available: https://www.riigiteataja.ee/akt/106052020022?leiaKehtiv

[67] http://www.cna.org.cy/webnews.aspx?a=3cb239305a214e568870aa290d69aef2

[68] Personal communication with and info provided by Mr Kakas, Police officer in charge of the Cyprus Police Electronic Crime Office.

[69] https://www.bing.com/search?q=cyprus+current+population+2020&qs=RI&pq=cyprus+population+2020&sk=EP1SC1&sc=5-22&cvid=FB4FA7056857466F86DEB52B5585711A&FORM=QBRE&sp=3

[70] For a more in-depth review of the Cyprus Barnahus see the I.N.T.I.T. position paper "The Barnahus Model Across the Broader European Context".

Data from Sweden indicates recent increases in the number of maltreatment cases reported to the police with a 6% increase between 2018 and 2019 with 25.500 reported cases in 2019. The capacity to investigate and prosecute, however, remains problematic. While 93% of cases for children between ages 0 and 6, and 70% of cases for children ages 7 to 14 were investigated, the perpetrator was only identified in 5% of cases for children under age 6 and in 10% of cases with children between ages 7 and 14[71]. There is a general recognition by the national crime statistics agency – BRÅ – that much violence and maltreatment of children remains undetected despite. At the same time, the severity of the violence has decreased following the 1979 law criminalizing the use of corporal punishment for children[72] [73].

Sweden, as one of the main actors in the development of Barnahus after their initial development in Iceland, has adopted a trauma informed care, translated as "traumamedveten omsorg" or TMO, thanks to work done by the Swedish branch of Save the Children, which has made TIC central to its work.[74] [75] TIC is now a part of services provision[76] and schools[77] [78] [79] with an array of courses available to professionals and caregivers. Schools in particular are seen as a key contact point for working with traumatized children. Sweden was one of the first European countries to open a Childhood House – today the country has established around 30 Barnahus children houses.[80] Some Barnahus centers have also explicitly adopted TIC within their work with children.[81]

6. Ways Ahead: Benefits and Challenges of Trauma – Informed Care

The above chapter suggests that the approach of TIC is not yet as prevalent in European health and social services as it is in the U.S. However, recognition of and interest in the approach are growing in Europe as well. In closing, this paper will therefore summarize some of the benefits and challenges that could inform possible adaptations to a European context taking into consideration the recent "hype" that has developed around TIC.[82]

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[71] https://www.bra.se/statistik/statistik-utifran-brottstyper/barnmisshandel.html
[72] https://www.bra.se/statistik/statistik-utifran-brottstyper/barnmisshandel.html
[73] https://www.barnombudsmannen.se/barnombudsmannen/i-fokus-just-nu/en-samlad-handlingsplan-for-att-motverka-vald-mot-barn/vald-mor-barn-i-familjen/
[74] https://www.raddabarnen.se/rad-och-kunskap/arbetar-med-barn/tmo/
[75] https://resourcecentre.savethechildren.net/library/one-year-transforming-care-annual-report-about-save-childrens-trauma-informed-care-programme
[76] https://www.uppdragpsykiskhalsa.se/asylsokande-och-nyanlanda/om-vara-utbildningar/utbildning-i-traumamedveten-omsorg-tmo/
[77] https://www.skolverket.se/skolutveckling/kurser-och-utbildningar/tmo-utbildning-i-traumamedveten-omsorg
[78] http://pedagogiskpsykologi.se/tag/traumamedveten-omsorg/
[79] https://www.vanersborg.se/utbildning--barnomsorg/nyheter-utbildning--barnomsorg/nyheter-grundskola-barnomsorg/2018-09-06-traumamedveten-omsorg---utbildning-for-skolpersonal.html
[80] https://childhood.org/childhood-opens-germanys-first-barnahus-childhood-haus/
[81] Barnafrid. 2019. *Slutrapport Utvärdering av Barnahus.* S2018/00212/FST.
[82] Becker-Blease, Kathryn (2017): As the world becomes trauma-informed. Work to do, in: *Journal of Trauma and Dissociation* 18:2, p. 131-138. The author traced google entries on the subject and has found a substantial increase in recent years.

The benefits of TIC are manifold. The approach constitutes a relatively low cost and high yield investment to address the needs of clients and patients who have experienced trauma.[83] By recognizing the implications of trauma, misdiagnoses are reduced and mislead medication can be avoided. In addition, the participatory approach of involving trauma victims themselves has the potential to better tailor services towards clients' needs and improve program retention rates. An increase in inter-agency cooperation in TIC can enhance early identification of trauma while reducing re-traumatization through repeated questioning and interaction with multiple stakeholders. The TIC approach also has the potential to alleviate emotional stress and vicarious traumatization of staff through training and through conveying the notion of shared responsibility between colleagues and systems.[84]

On the other hand, TIC is not a "panacea" to the difficulties facing children who have experienced trauma. Amongst the key criticisms of the approach is the limited amount of evaluation that has been conducted so far to demonstrate the effectiveness of TIC. In addition there are concerns about how to translate the theory of TIC into practice.[85] As stated by Becker-Blease "even the most experienced clinician or researcher cannot rely on intuition alone to create trauma-informed care."[86] Although a wide range of cost-intensive TIC trainings is currently emerging there is hardly any research on the quality of these trainings and participants' ability to translate the training into their respective work environment. In fact, some providers have voiced fears of opening Pandora's box by addressing trauma and consequently creating needs that cannot be met by their existing services.[87]

Another area of criticism revolves around the focus on trauma itself and individual trauma in particular. Critics have argued that TIC bears the risk of being deficit-oriented and focusing on treating individual pathologies rather than fostering possibilities of well-being.[88] While this is a valid concern, it should be noted that one of the core elements of TIC is the focus on healing and recovery from trauma.[89] Becker-Blease stresses the importance of critical engagement with the systems behind the trauma-informed movement to avoid "perpetuating the same victim-blaming, silencing, shaming, and retraumatizing" practices of the past.[90] Therefore, the above mentioned key principle of understanding trauma in its broader societal context of social inequality and oppression needs to be recognized as an integral part of delivering services in the TIC framework.

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[83] DeCandida (2015)
[84] Levy-Carrick, Nomi C. et al, p.105
[85] Johnson, Dan (2017): *Tangible trauma-informed care*, in: Scottish Journal of Residential Child Care, No.16, No. 1, 1-22; Berliner, Lucy and David Kolko (2016): *Trauma-Informed Care: A Commentary and Critique*, in: Child Maltreatment, Vol. 21 (2), 168-172. Hanson RF, Lang, J. (2016): *A Critical Look At Trauma-Informed Care Among Agencies and Systems Serving Maltreated Youth and Their Families*. Child Maltreatment;21(2):95-100.
[86] Becker-Blease, Kathryn (2017) p. 135
[87] DeCandida (2015)
[88] Berliner and Kolko (2016)
[89] SAMHSA (2014): p. 11
[90] Becker-Blease, Kathryn (2017) p. 132

The above-mentioned criticisms of the TIC approach can be summarized along the following lines: the lack of evidence-based evaluation to date, misunderstandings around the core principles of the approach and the challenges of putting it into practice. In an attempt to adopt the approach of TIC in Europe stakeholders need to be aware of these challenges and need to carefully customize TIC to their particular setting since a “one-size-fits all” template will not do justice to the sensitivity of trauma. Once these notions are kept in mind the creative and empowering approach of TIC could provide considerable opportunities for both victims of trauma as well as for professional care takers.

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