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TRAUMA PSYCHOLOGY

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NEWS

PRESIDENTIAL VOICE

Trauma Psychology: Getting the Word Out

By: Joan Cook, PhD

We have accomplished so much in a relatively short period of time. In 2006, the Division of Trauma Psychology was started with 901 members. Since then, we have grown as well as deepened and broadened our roots. At our 10th year anniversary, we are one of only five divisions to increase membership in the last year, and we are still growing. We are indeed among the most vibrant of all divisions although we are the youngest.

Joan Cook, PhD

In just under 10 years, we have created a dynamic and flourishing permanent home within the American Psychological Association (APA) for scientific research, professional and public education, and the exchange of support for activities related to trauma. We have a strong track record of high quality programming at the APA Annual Convention, our journal *Psychological Trauma, Theory, Research, Practice and Policy* has a strong impact factor, our newsletter and recently revised website continue to provide helpful resources, and we held a consensus conference on competencies for working with trauma survivors which were approved by the APA Council of Representatives in August 2015 and are now become official APA policy (http://www.apa.org/ed/resources).

Our members, with their rich and diverse collection of knowledge and interests across the domain of psychological trauma, have helped us to accomplish this and so much more. Besides an incredible membership that forms the base of our Division, we have had wonderful leadership. I particularly want to thank all

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Task Forces

Turn to p. 16 to meet the chairs of new task forces.

Wang, C., & Burris, M. A. (1994). Empowerment through photo novella: Portraits of participation. *Health Education & Behavior*, *21*(2), 171–186.

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Bekh Bradley, PhD *received his BA in psychology from Wesleyan University in 1993 and his PhD in Clinical Community Psychology from the University of South Carolina in 2000. Dr. Bradley is an Associate Professor in the Department of Psychiatry and Behavioral Sciences at Emory University. Dr. Bradley has significant experience in clinically and empirically grounded research on PTSD and trauma. Though his clinical work, research, teaching and leadership responsibilities, Dr. Bradley is dedicated to providing outstanding clinical care and to increasing knowledge of factors contributing to risk and resilience following trauma exposure.*

Measuring Trauma-Informed Care: The Attitudes Related to Trauma-Informed Care (ARTIC) Scale

By: Steven M. Brown, PsyD and Courtney N. Baker, PhD

In recent years, the push to implement trauma-informed care (TIC) has increased dramatically across a wide variety of sectors including mental health, substance abuse, child welfare, education, corrections, primary care, and youth development. In addition, whole cities are implementing TIC (e.g., http://www.peace4tarpon.org/). TIC is defined as service delivery that recognizes the profound biological, psychological, and social sequelae of trauma with the goal of amerliorating, rather than excerbating, its impact (Harris & Fallot, 2001). Entire systems of care are now working to become trauma-informed, grant applications are requiring organizations to address how they will provide services in a trauma-informed manner, state legislation is being considered to mandate TIC in schools, and there are calls to rigorously evaluate TIC as part of implementation monitoring, quality assurance, and research. The ultimate goal is to gather and use empirical data on TIC to promote widespread and sustainable adoption (Cole et al., 2013; Ko et al., 2008; SAMHSA 2014).

Steven M. Brown, PsyD

This growing interest in TIC has led to a upsurge in implementation and practice models. However, practice is far ahead of science with respect to defining and operationalizing TIC phenomena, identifying critical elements of the trauma-informed change process, and rigorously evaluating TIC efficacy and effectiveness. Unfortunately, numerous barriers exist to research on TIC, including the description of TIC varying widely across the emerging literature, resulting in an operational definition that is unclear. For example, a recent literature review revealed 19 recent publications articulating TIC frameworks, most being literature syntheses, white papers, or theoretical writing (Baker, Brown, Wilcox, Overstreet, & Arora, 2015). On the implementation front, systems are hungry not only for clear implementation blueprints, but also for the evidence that supports them. In short, the TIC field is primed to move from fruitful theoretical and conceptual thinking to data-driven analysis.

One major impediment to forward movement is the absence of psychometrically robust instruments to evaluate TIC. The empirical work on TIC, while limited, generally measures the impact of implementation through client-reported outcomes (Morrissey et al., 2005); program level data such as restraints and seclusions (Azeem, Aujla, Rammerth, Binsfeld, & Jones, 2011); and organizational-level features such as treatment environment (Rivard, Bloom, McCorkle, & Abramovitz 2005). While these are vital outcomes, they are costly and time-consuming to collect and evaluate. Because so many factors can influence these distal metrics, it is difficult to know whether TIC implementation was the factor related to the change. Organizations often report anecdotal evidence of change, but they struggle to find practical tools to capture this change quantitatively. In response to this need, we developed and evaluated the Attitudes Related to Trauma-Informed Care (ARTIC) Scale.

Development and Psychometric Support of the ARTIC

The ARTIC was based on an earlier 19-item measure developed for program evaluation of the Risking Connection® (RC) staff trauma training model (Brown, Baker, & Wilcox, 2012; Saakvitne, Gamble, Pearlman, & Tabor Lev, 2001). The ARTIC evaluates attitudes, which are understood as a primary driver of the moment-to-moment, day-to-day behavior of its personnel and thus foundational to any trauma-informed system (Ajzen, 1991; Fixsen, Blase, Naoom, & Wallace, 2009; Kirkpatrick, 1967; Metz, Blase, & Bowie, 2007). The original instrument was limited in that it included only one general factor. To address the limitation, we embarked on an extensive mixed methods process to revise the measure, involving a review of the theoretical, empirical, and measurement literatures relevant to TIC and utilizing a community-based participatory research approach (Hausman et al., 2013).

Courtney N. Baker, PhD

Items were written to characterize a TIC-favorable attitude and were then paired with the opposite attitude. For example, the item "the clients I work with are doing the best they can with the skills they have" (favorable) is paired with "the clients I work with could act better if the really want to" (unfavorable). All items use a seven-point bipolar Likert scale. ARTIC items were evaluated using a sample of 760 service providers, including 595 who worked in human services, community-based mental health, or health care and 165 who worked in schools. A little over half of participants reported having previously participated in formal TIC training (e.g., Risking Connection, Advocates for Children, Sanctuary).

Item analysis and confirmatory factor analysis supported three ARTIC versions: the ARTIC-45, ARTIC-35, and ARTIC-10. The ARTIC-45 is a 45-item measure with seven total subscales, including five core subscales (i.e., underlying causes of problem behavior and symptoms, responses to problem behavior and symptoms, on-the-job behavior, self-efficacy at work, and reactions to the work) and two supplementary subscales (i.e., personal support of TIC and system-wide support for TIC) and an overall score. The ARTIC-35 excludes the supplementary subscales for those systems that have not yet implemented TIC. The ten-item short form, called the ARTIC-10, provides one overall score derived from the five core subscales. Internal consistency reliability was good to excellent (αs = .82-.93) for the three ARTIC versions, and subscale alphas ranged from respectable to very good (DeVellis, 2012). Temporal consistency was strong, with correlations of r = .84 at ≤ 120 days, r = .80 at ≤ 121-150 days, and r = .76 at 151-180 days for the ARTIC-45. Associations among ARTIC subscales and numerous validity indicators suggest construct and criterion-related validity. Several investigations to further support validity are now underway. For more information about the study method and findings, please see the full article (Baker et. al., 2015).

Study Implications

Stakeholders in the burgeoning TIC movement have started to ask what concretely trauma-informed care means, how one operationalizes it, and how one knows TIC is truly being practiced. For example, some organizations offer periodic trainings or evidence-based trauma treatments for individual clients and understand that as meaning they are "trauma-informed." However, the field lacks an objective way to determine the extent to which an individual or system is trauma-informed. The ARTIC was developed to address this gap by measuring one important element of TIC – service providers' attitudes related to TIC. We anticipate that the use of the ARTIC will also spur the field to identify what is and is not trauma-informed and to progress beyond what are currently important but vague principles underlying the movement.

Because of the widespread applicability of TIC to educational, human service, corrections, and medical settings, the ARTIC has many possible uses. Organizations that have never implemented TIC could use the ARTIC to assess their "readiness" to embrace innovation (Weiner, 2009). They can also use it as a baseline measure to determine the extent to which their culture is trauma-informed, and how it changes as result of intervention. For organizations that have implemented TIC, the ARTIC can provide a way to engage in ongoing evaluation of system-wide TIC practices that are hypothesized to be associated with better outcomes.

Experts in trauma-informed system change argue that, while TIC is difficult to implement, it can be even harder to sustain due to pressures that act as a "gravitational pull toward the punitive" (Baker et. al., 2015; Morgan, Salomon, Plotkin, & Cohen, 2014). The ARTIC can be used both to monitor and resist such deterioration. For schools or organizations that have already implemented TIC, the ARTIC can be used to determine which personnel need additional training and supervision to practice in a more trauma-informed manner. In short, the ARTIC provides the first psychometrically reliable and valid tool to help researchers, practitioners, policymakers, and consumers assess TIC and its effects.

To learn more about the ARTIC Scale including how to obtain it, visit www.traumaticstressinstitute.org.

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Courtney N. Baker, Ph.D., *is an Assistant Professor in the Department of Psychology at Tulane University. Her career is committed to bridging the gap between research and practice, with a particular focus on facilitating the translation of evidence-based programs into under-resourced school and community settings. Dr. Baker's research is guided by the fields of dissemination and implementation research and prevention science, and it is distinguished by its interdisciplinary nature. She is the recipient of state and federal grants, including serving as co-PI on a National Institute of Justice-funded grant on trauma-informed schools.*

International Psychologists

Division 56 is seeking international psychologists to write articles for upcoming editions of *Trauma Psychology News*. Please contact Elizabeth Carll at ecarll@optonline.net for more information or to submit an article.