



## Childhood Trauma and Its Effects: Implications for Police

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### Executive Session on Policing and Public Safety

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Repeated exposure to traumatic events during childhood can have dramatic and long-lasting effects. During the past 20 years, there has been an enormous increase in our understanding of how being repeatedly traumatized by violence affects the growth and development of preadolescent children, especially when such traumatized children lack a nurturing and protective parental figure that might mitigate the impact of the trauma. In this paper, I summarize the current understanding of the effects of ongoing trauma on young children, how these effects impair adolescent and young adult functioning, and the possible implications of this for policing.

To demonstrate this, I describe the case of a 17-year-old African American male who was charged with attempted murder. I was asked to perform a psychiatric evaluation because (1) everyone who knew him was shocked about what happened because, before the crime, he had never been in trouble and he had always appeared to be functioning well; and (2) he appeared to be extremely unemotional about what happened, which his attorney viewed as either a lack of remorse or a failure to appreciate how much trouble he was in.

Although this young man had always lived in an extremely violent and drug-infested neighborhood, he was neither a drug dealer nor a gang member. Instead, he had shown such promise that his single mother had gotten him a scholarship to a private school. He was performing well in school despite the problems in his neighborhood and his home, including his mother's involvement in a series of relationships in which she had been physically abused. When I asked him about the multiple homemade tattoos on his body, he told me that each represented a family member or friend who had been killed. He cried as he described the first in this series of deaths, including the death of his best friend, which occurred when they were 8 years old and walking home from school. He also noted that the most recent death, that of his brother, occurred about a year ago. As he spoke of these deaths, that first one, which occurred about 9 years ago, seemed just as fresh to him as the recent death of his brother. In addition, I was struck by the fact that this young man had never been given any parental support that might have helped him begin to cope with these losses. When he was only 8 years old, instead of helping her young son cope with his trauma, his mother yelled at him for being on a street that she had told him not to go on.

During his psychiatric evaluation, it became clear that the young man's initial unemotional

presentation was a psychological defense against his enormous fear that he would be killed. He had been carrying a gun since his brother was killed; the shooting incident for which he was charged was the first time he had used the gun. Furthermore, the fear for his life, coupled with his almost taking another's life, made the incident yet another traumatic experience for him.

It also became clear that his history of trauma influenced his interaction with the police at the time of his arrest. The police had shown no sensitivity to him when he was 8 years old, found holding and crying over his dead friend's body. Instead, they simply pulled him away from his friend, pushed him into the background, and never attempted to assess his physical or emotional status or make sure that someone else did so. During his early adolescent years, he had seen police officers mistreat others, which made it harder for him to trust or feel comfortable with police officers. His interaction with the police was further complicated by their initial presumption that he, like the victim, was a gang member and that the attempted murder was gang-related, which influenced not only perceptions of him but also how they treated him, even though he presented no physical threat to them. As a result, the police were physically aggressive with him. Being roughed up made him fearful of the police, and his attempts to manage that high level of anxiety and fear with an unemotional and cold presentation caused the police to be suspicious that he would suddenly act out, which in turn caused them to be even more confrontational and physical with him.

Police officers may also suffer from trauma-related difficulties that impair their ability to do their work. These may be long-standing difficulties stemming from their own childhood that were never identified or adequately addressed, or they may stem from traumatic experiences that occurred while working as a police officer. However, a fuller discussion of that is beyond the scope of this paper.

### **Stress, Trauma and Parental Protection**

Understanding the stress response in children requires consideration of both the persistence and the severity of the stressor — which can range from those experienced by all children to the most severe traumatic events — and the availability of parental nurture, support and protection.

All children have stressful experiences, such as the anxiety associated with the first day of school, being frustrated by a friend's behavior, or being frightened by a big dog. Stresses such as these can be positive experiences when a nurturing adult helps the child learn healthy ways to manage anxiety, frustration and fear (Briere and Lanktree, 2008; Gunnar and Quevedo, 2008; Tarullo and Gunnar, 2006). Some children are also exposed to far more stressful experiences, such as the death of a parent or other close family member, their own childhood illness, or exposure to an isolated incident of violence. Here, too, a nurturing, protective adult can help the child overcome the distress associated with the event and thereby help the child not only tolerate the stressor but also grow from the event (Goslin et al., 2013; Maschi, 2006).

Some children are exposed to events that are exceptionally stressful. The impact of such traumatic events is more severe when they occur repeatedly (Breslau et al., 1999). Various types of violence can traumatize children, including sexual abuse and nonsexual physical abuse (Beitchman et al., 1992; Saywitz et al., 2000). Trauma can also result if a child witnesses acts of violence, including domestic violence and street violence (Berton and Stabb, 1996; Fitzpatrick and Boldizar, 1993). Additionally, psychological abuse that threatens violence, especially when the child has seen the perpetrator become violent, can traumatize children (Levendosky et al., 2002).

Although parental support can attenuate the effects of repeated exposure to extremely traumatic events, this support tends not to be available to these children, who need it the most (Green et al., 1991; Terr, 1991). In the vast majority of these cases, the parents of these children are either abusive (i.e., perpetrators of the abuse) or neglectful (i.e., they have failed to protect the child from exposure to the violence) or both, instead of nurturing and protecting the child. This repeated violent traumatization in the absence of parental nurture and protection is toxic to developing children. The group of children who suffer from this harmful combination are the focus of this paper. The resulting psychiatric impairments and associated dysfunction they exhibit as children and adolescents significantly increase their risk of coming into contact with police officers and present a significant challenge to police officers when such contact occurs.

Parents who fail to adequately nurture and protect their children usually have problems of their own (Green et al., 1991), including their own history of abuse or neglect; serious mental health problems, including intellectual deficits and substance abuse; and situational difficulties that have so overwhelmed them that they cannot parent, such as poverty or their own victimization by a partner (Gewirtz and Edleson, 2007; Lieberman, Van Horn and Ippen, 2005). Therefore, in addition to having to cope with repeated trauma without parental nurture and support, often these children also have to cope with a range of other problems related to the difficulties that their parents might be having. For example, in addition to not adequately protecting his or her child, a parent might be so depressed, drug addicted or cognitively impaired that he or she fails to meet the child's most basic needs.

For example, I was involved in a case where a woman had become involved with a man who seemed to be a "good man" until he moved in with her, when he began to psychologically control and severely physically abuse her and her 6-year-old son. Due to her own history and associated psychiatric difficulties, she was so overwhelmed by the psychological domination and physical abuse that she could not protect herself or extricate herself from the situation. She was also repeatedly abused in front of her son, thereby repeatedly exposing him to violence. She was so overwhelmed by her predicament that she could not protect her son from the abuse that he was enduring. As a result, her son felt constantly at risk of harm, constantly feared that his mother

would be harmed or killed, felt there was no place where he would be safe, and saw no reason why things would or even might soon be better. Not surprisingly, the boy developed multiple trauma-related symptoms, such as extreme hypervigilance and overreactivity, that were never identified and treated (these symptoms are described in more detail later). Therefore, as he got older, he repeatedly overreacted violently to perceived threats of harm in all sorts of interactions, including his interactions with police officers.

### **The Child's Response to Repeated Trauma and Its Implications in Later Life**

The combination of repeated childhood trauma and the absence of parental nurture, support and protection can result in the development of multiple psychiatric and neuropsychiatric disorders. For the purposes of this paper, it is more meaningful to talk in terms of symptoms instead of psychiatric disorders because discussing symptoms will help readers better appreciate the severity of the distress and the magnitude of the dysfunction seen in persons with such a childhood history.

I will discuss four categories of symptoms: (1) trauma-related neurological symptoms, (2) trauma-related psychological symptoms, (3) developmental difficulties brought on by poor parenting, and (4) other associated difficulties. Each of these categories or clusters of symptoms cause children considerable emotional distress and impair their ability to function, and the distress and dysfunction are even more severe

when they are combined. Although these four sets of difficulties are hard to “cure,” appropriate mental health treatment can act as a buffer against them and their effects, especially when such treatment is initiated during childhood (Cicchetti and Toth, 1995; Toth and Cicchetti, 1993). In the absence of treatment, however, trauma-related difficulties and their effects tend to persist into adolescence and adulthood and become difficult to reverse (Perry et al., 1995; Schore, 2001).

### **Trauma-Related Neurological Symptoms**

In the past two decades, a greater understanding of the effects of stress on the human brain has bolstered our understanding of the dynamics of childhood exposure to traumatic stress. Research has demonstrated that repeated violent traumatization of children in the absence of parental protection can permanently rewire their brains, which do not become fully developed until early adulthood. This influences the structure and the functioning of the brain so as to create symptoms that were previously thought to be purely psychological (Van der Kolk, 1994).

The human body’s physiological response to stress is well-documented. When one encounters a stressor and becomes frightened, the body produces stress hormones; this has been called the “fight or flight response” (Kearney et al., 2010; Van der Kolk, 2005). This is a transient hormonal response, which healthy individuals experience and manage with little long-term effect on their functional capacities (Gunnar and Quevedo, 2008; Tarullo and Gunnar, 2006). However, in

children, excessive stimulation of this hormonal response for prolonged periods of time — due to the combination of repeated trauma and the absence of parental intervention that helps the child manage or calm the response — eventually impairs regulation of the response (Handwerker, 2009; Van Voorhees and Scarpa, 2004). That is when the “fight or flight response” ceases to become a useful transient response to danger that the individual can regulate; instead, it becomes a constant, uncontrollable physiological warning of danger that persists even when no danger is present. Over the past 20 years, research has shown that this impaired regulation results from the effects of the toxic stress-hormonal load on the structure and functioning of the still-developing child brain (Lupien et al., 2009; Teicher et al., 2003).

Studies have shown that, when children are repeatedly exposed to trauma, the amygdala — the area of the brain known to activate the physiological stress response — overdevelops. This overdevelopment increases the fear and anxiety these children experience and causes them to be hyperresponsive to frightening situations in both their physiology and their observable behavior (Pollak, 2008; Shin, Rauch and Pitman, 2006). At the same time, the development of the hippocampus — the area of the brain known to turn off the stress response — is inhibited, decreasing its capacity to control the response (Bremner et al., 2003). Impairment of the hippocampus also results in difficulties in memory, mood regulation and contextual learning, which includes learning to differentiate

dangerous situations from safe ones (Pugh et al., 1997; Rudy, Kuwagama and Pugh, 1999). In addition, high levels of stress hormones impair the development of the connections to and within the prefrontal cortex of the brain (Elzinga and Bremner, 2002; Richert et al., 2006). The prefrontal cortex plays a role in modulating the physiological stress response and is responsible for decision-making, which includes assessing a perceived threat and responding appropriately (Lee and Seo, 2007; Morgan and LeDoux, 1995; Morgan, Romanski and LeDoux, 1993; Robbins, 2000).

### **Trauma-Related Psychological Symptoms**

In addition to neurological impairments, many trauma-exposed children also develop psychological trauma-related symptoms similar to those seen in adults with posttraumatic stress disorder (PTSD). These children tend to be anxious (Copeland et al., 2007). They are hypervigilant, meaning that they are always expecting something bad to happen to them and they often perceive danger where none exists (Briere and Lanktree, 2008; Terr, 1991; Van Zomeren-Dohm et al., 2013). They also tend to be hyperreactive to perceived threats of danger (Terr, 1991). These children try not to think about their traumatic experiences and they become distressed when those experiences come to mind (Terr, 1991). New experiences that remind them of their past traumatic experiences, or symbolize those experiences, exacerbate these and other trauma-related symptoms that they may have acquired (Ehlers and Clark, 2000; Terr, 1991). Children also have difficulty calming down

once hyperreactivity has been triggered (Van der Kolk, 1994). Although these difficulties might be apparent to others who know them, the author believes such affected children are far too young to appreciate the fact that they are suffering from psychiatric difficulties. Trauma-related neurological and psychological difficulties interact so as to exacerbate each other.

I evaluated a young man who was born when his mother was still a young adolescent. For some years, he and his mother lived with his maternal grandmother. His grandmother repeatedly physically abused both him and his mother, which so overwhelmed his young mother that she was of little help to him. As a result of the combined effect of his psychological and physiological response to the trauma, he was always extremely nervous and fearful. Although, finally, the young man's mother took him and ran away from his grandmother's home, the neighborhood that she ended up in was extremely dangerous and he was constantly exposed to violence that neither he nor his mother knew how to cope with. This new danger only served to exacerbate the difficulties he had already developed. The young man became even more hypervigilant: He was in constant fear for his life and, by the time he was a pre-adolescent, he carried a gun with him all of the time. He never shot or even brandished the gun. However, as part of a police initiative to stop and search adolescents in his neighborhood for drugs and weapons, he was repeatedly stopped by the police. When stopped, he was always found to have a gun; as a result, he developed a juvenile record of repeated arrests

for gun possession. I present this case because it demonstrates the effects of trauma and because no one ever seemed to wonder why this young man was being repeatedly arrested for the same thing. Regrettably, he was never evaluated by a mental health professional and never received the treatment he so desperately needed.

### **Other Developmental Difficulties Resulting From Trauma and Lack of Parental Nurture**

Individuals whose childhood traumatization is left unchecked may also experience developmental symptoms such as instability in their sense of self (Van der Kolk, 2005). Without parental nurture and support, this shifting sense of self can be so extreme that sometimes the individual feels empty. These feelings of emptiness can be associated with cutting (i.e., repeatedly cutting oneself to feel pain and see the bleeding) or similar behavior in an attempt to feel something and know that one is alive (Briere and Gil, 1998; Landecker, 1992; Van der Kolk, 2005). These individuals also experience relational difficulties characterized by intense but unstable relationships. These relational difficulties are due, at least in part, to a frantic need for attachments to feel whole, accompanied by fears of abandonment. Such difficulties are also due to rapidly alternating perceptions of important others, which shift from idealizing them to devaluing them because of feelings that the other person does not care about the traumatized individual (Gunderson and Sabo, 1993; Herman, 1992). Afflicted individuals also experience difficulty in regulating mood because of intense depressive, irritable or

anxious reactions to nontraumatic situations. This mood instability can result in suicidal behavior, inappropriate and intense outbursts of anger, or difficulty in controlling anger. In addition, traumatized individuals may exhibit impulsive, potentially self-damaging behavior such as reckless sex and substance abuse (Van der Kolk, 2005). When under extreme stress, such individuals can briefly become paranoid and they may experience dissociative symptoms such as not feeling in control of their own body or actions (Steiner, Garcia and Matthews, 1997; Van Der Kolk et al., 2009).

Such broad-based instability in so many important areas results in considerable emotional distress and dysfunction. “Trust issues” are a part of this constellation of developmental difficulties that result from inadequate parenting; these trust issues exacerbate the anxiety, fear and hypervigilance that are part of the trauma response. Many adolescents will attempt to block out or mask that intense anxiety and fear with a tough, “I don’t care about anything” façade. When this façade is coupled with the difficulty in managing anger and impulsivity that are part of this constellation of developmental difficulties, these adolescents can appear hostile and threatening. When police officers come upon such adolescents, they have to instill safety and order quickly. However, when the officers’ use of increasingly more forceful language and more aggressive behavior starts to result in increasingly paranoid and defiant behavior on the part of the adolescent, this might indicate that the adolescent is suffering from trauma-related

difficulties and that de-escalating the situation will require a more calming intervention on the officers' part.

### **Other Associated Difficulties**

Most children who develop the above three types of disorders eventually also suffer from one or more commonly associated difficulties: depression, aggressive acting out (in an effort to “never be a victim again”), substance abuse, which often starts as an attempt to self-medicate overwhelming anxiety (Heffernan et al., 2000; Van der Kolk, 2005). Each of these associated difficulties can, by itself, impair judgment and decision-making. When superimposed upon the psychiatric and neuropsychiatric difficulties that result from early exposure to repeated trauma in the absence of parental nurture and support, they can render someone extremely dysfunctional.

Some severely physically abused children sustain serious injuries to their developing brain that result in cognitive deficits. For example, serious injury to the front of the brain might result in severely impaired decision-making capacity. In addition, in a home where domestic violence occurs, a child with existing intellectual or other cognitive deficits is often at greatest risk of being physically abused, at least in part because the abusive parent views that child as more difficult to manage. Therefore, intellectual or other cognitive deficits should be included in the list of other associated difficulties that might be seen in these children. Such neuropsychiatric difficulties further impair functioning on their own, but they also interact with and exacerbate many

of the other psychiatric and neuropsychiatric difficulties. They may also impair insight and judgment so as to severely compromise the individual's capacity to recognize a need for mental health treatment, access treatment, and benefit from treatment.

Although these four discrete sets of disorders — neurological, psychological, developmental and other associated difficulties — can be described separately, they often occur simultaneously in the same person. When they occur together, these disorders tend to exacerbate one another, in part because their symptoms, such as hypervigilance and hyperresponsiveness, overlap. Therefore, instead of being simply cumulative in contributing to the expression of these symptoms, each disorder increases the intensity of the symptoms exponentially.

For example, both depression and substance abuse further impair the decision-making mechanisms that exposure to trauma has already compromised. The slowed thinking associated with depression impairs decision-making. Certain drugs can exacerbate depression, making its impact on decision-making more severe (Cornelius et al., 1998; Kelly, Daley and Douaihy, 2012). In addition, some drugs impair one's ability to monitor one's environment, which can increase feelings of fear in an already fearful individual. Additionally, the hypervigilance or heightened sense of danger, among the cluster of trauma-related symptoms such individuals may experience, can exacerbate their existing relational difficulties (Ehlers and Clark, 2000; Rich and Grey, 2005).



We now understand that children who are repeatedly exposed to violent, traumatic events in the absence of parental nurture and support develop a number of discrete difficulties that are already challenging to cope with on their own but then interact with and intensify one another in a way that renders normal functioning still more difficult. Even during childhood, traumatized individuals may exhibit clinically significant symptoms that impair their ability to function. Left untreated, their problems persist and intensify into their adolescence and adulthood and become irreversible (Perry et al., 1995; Schore, 2001).

### **Prevalence of Trauma-Related Difficulties Among Persons Exposed to Violence**

The number of individuals who, as children, were repeatedly exposed to violent trauma in the absence of parental protection, and then went on to develop the cluster of psychiatric and neuropsychiatric difficulties, is difficult to determine. This is because there are no studies that have attempted to determine the overall prevalence of children exposed to one or more of the various types of violent trauma known to cause such psychiatric or neuropsychiatric difficulties. Nor are there any studies that followed the traumatized children to see what percentage actually develop such psychiatric or neuropsychiatric difficulties. However, studies that have tried to look at prevalence in subsets of these children suggest that the rate is alarmingly high.

For example, it is estimated that 35 percent of children exposed to domestic violence will develop trauma-related difficulties (Moretti et al., 2006). A recent estimate puts the number of children exposed to domestic violence during 2012 at 266,110 (U.S. Department of Health and Human Services, 2013) — meaning that approximately 93,139 children will develop trauma-related difficulties as a result of exposure to domestic violence during that year.

Similarly, it is estimated that between 42 percent and 90 percent of child victims of sexual abuse will develop trauma-related difficulties (De Bellis, Spratt and Hooper, 2011). During 2012, an estimated 62,936 children were victims of sexual abuse (U.S. Department of Health and Human Services, 2013) — meaning that between 26,433 and 56,642 of those children will likely develop trauma-related difficulties as a result of being sexually abused.

Although these data give some indication of the scope of exposure to domestic violence and childhood sexual abuse, statistics related to both these issues are thought to be underestimates (Leventhal, 1998; Wilt and Olson, 1996). It is therefore likely that the actual prevalence of PTSD stemming from both childhood sexual abuse and exposure to domestic violence is greater than stated above.

More difficult to estimate is the number of children repeatedly exposed to or even directly threatened by various forms of neighborhood violence. We know that, although domestic violence and child sexual abuse occur in all

neighborhoods, children who are raised in poor, drug-infested, violent neighborhoods are at increased risk of exposure to street violence, increasing their risk of developing trauma-related difficulties (Buka et al., 2001; Stein et al., 2003). In addition, because these children are much less likely to be identified as needing treatment and have less access to medical care, their difficulties are more likely to continue unabated into adolescence and adulthood (Cooper, Masi and Vick, 2009).

### **Implications for Policing**

In the course of their duties, police officers often encounter individuals who have suffered repeated exposure to traumatic events during their childhood. Understanding the effects of such childhood trauma, and the behaviors that these individuals are likely to exhibit as a result, has practical implications for police operations in three areas: first, where police deal with violence and children are victims or witnesses; second, where police encounter individuals already affected by childhood trauma who exhibit behaviors often attributed to aggressiveness and callousness; and, third, when a suspect in police custody or under interrogation manifests behaviors symptomatic of a history of trauma, case officers need to recognize those symptoms and make appropriate referrals, as they would for any other mental disorder.

### **Police Challenges in Encounters With Traumatized Individuals**

Because of their tendency to violent and erratic behavior, these sizable numbers of individuals

who experience trauma-related difficulties are at an increased risk of coming into contact with police officers. The likelihood of police contact is even greater if these traumatized individuals live in violent neighborhoods. This is for two reasons. First, violent neighborhoods tend to have a large police presence, meaning that all residents of these neighborhoods come into contact with police more frequently (Hangartner, 1994). Second, if an individual already suffers from trauma-related difficulties, a new traumatic experience will exacerbate those difficulties. This combination of past trauma and subsequent exposure to violence increases the likelihood that an individual will have violent reactions of the type that would bring them into contact with police officers and complicate that contact (Donley et al., 2012).

Without training focused on issues related to childhood trauma, it is unlikely that police officers will recognize that individuals may be acting out due to difficulties stemming from past traumatic experiences. Although anxiety, fear and impaired regulation of the brain's stress response drive the behavior of traumatized individuals, their visible symptoms are more obvious. Attention to these visible symptoms at the expense of their underlying causes results in police misperceiving these children, adolescents and young adults. Traumatized individuals tend to be hypervigilant and hypersensitive to perceived threats, and they tend to overreact to such threats, often violently. This extreme reaction becomes the focus of police attention. For example, a traumatized person may mask

anxiety with an extreme bravado, which police view as arrogance or a lack of caring instead of the psychological defense mechanism that it is (Arroyo, 2001). Also, the brain's impaired regulation of the stress response makes it difficult, if not impossible, for traumatized individuals to calm themselves down, even when it would be in their best interest to do so, which makes them seem more aggressive (Van der Kolk et al., 2009). In addition, associated difficulties such as substance abuse can also become a focus of police attention, with no thought about whether underlying psychiatric difficulties might have contributed to such substance abuse.

Factors other than the absence of police training on childhood trauma contribute to a misunderstanding of individuals with a history of such trauma, especially when the individual is a young man of color. Many believe that children and adolescents who have been exposed to violence — a sizable portion of whom are African American children — have become immune to violence (Gottlieb, 2004). In my experience, this notion is readily expanded into a belief that such children and adolescents have become hardened to violence and its effects and that they virtually embrace violence instead of being frightened by it. However, for most children repeatedly exposed to violence, this is not the case (Thomas et al., 2012; Cooley-Strickland et al., 2011). Furthermore, recent studies have begun to confirm the common anecdotal observation that African American boys are viewed as older, less childlike and less innocent than white same-age peers (Goff et al., 2014). Because they are viewed

as more like adults, African American boys are seen as more responsible for their behavior and, as a result, they are at risk of being treated more harshly than their white counterparts by police and other components of the criminal justice system (Goff et al., 2014). Therefore, any training on childhood trauma and its effects must address how race frames one's understanding of behavior and how, for many, such race-based beliefs overshadow other well-established factors in their perception of the behavior of young men of color. In other words, if a goal of this training is to influence the thinking and alter the behavior of police officers toward traumatized young men of color, the training must first undo the false belief that such young men may have never been that traumatized and instead became immune to violence.

An increased awareness of the high prevalence of severe childhood trauma and an increased appreciation of its effects on both the developing child and later adolescent and adult functioning might impact the thinking and behavior of police officers in several ways as they go about the work of policing.

### **Considerations for Dealing With Traumatized Individuals**

First, with regard to prevention, or at least early intervention, in the development of trauma-related disorders, police officers can learn more about traumatized children when regularly called to investigate alleged cases of domestic violence (Butzer, Bronfman and Stipak, 1996). An increased appreciation for the impact of exposure

to domestic violence on developing children might lead police to develop better mechanisms for reporting domestic violence to their local child protective services and to better advocate for the development of mental health services to address the needs of children so exposed. Furthermore, because a significant subset of children living in homes where there is domestic violence are victims of child abuse and neglect, those children will also need services to address these issues.

Police officers already recognize that one of their roles is to enhance a sense of safety in the communities they serve (Plant and Scott, 2009). However, recognizing that this effort also helps decrease the prevalence of childhood trauma-related difficulties — and guard against the exacerbation of symptoms in those who already suffer from such difficulties — might help police understand how important this aspect of their work is, and how central it is to decreasing crime. Ideally, this would also prompt police to explore whether certain police practices that seem to undercut this goal might be altered without impeding police work.

One police chief, with whom I spoke in connection with writing this article and who wished to be unnamed, noticed that many violent crime scenes were left undisturbed far longer than was required for officers to do their work. In his view, having to constantly see these crime scenes — with blood and police tape or evidence markers and medical refuse — made citizens more fearful and caused them to be all the more traumatized by the crimes that had occurred. The

police chief instituted an effort to clean up crime scenes as quickly as possible, which significantly reduced citizens' exposure to reminders of neighborhood violence. Recognizing that this decreased exposure was particularly critical to the well-being of children, this chief also began a practice where his department notified local schools when there were violent crimes in the neighborhood. Such notifications allowed school personnel to keep an eye out for students with any trauma-related difficulties.

In addition, the list of possible causes of any behavior that the police are called upon to investigate and address could be broadened to include the cluster of psychiatric and neuropsychiatric difficulties that result from childhood trauma. This might change how police officers view and treat alleged perpetrators.

Armed with such knowledge, possibly from internal databases and made available at dispatch or, in smaller departments, common knowledge about an individual, police officers would come to understand that, when managing individuals with a childhood trauma history, certain interventions may escalate rather than control difficulties. For example, interventions involving displays of aggression such as yelling, rough physical contact and intense eye contact (“the stare”), though meant to curb aggressive behavior, may provoke aggression. This understanding reinforces the notion that police need not behave in an overly aggressive manner, except when officers deem it necessary to ensure the safety of themselves or those around them. It

may also prompt police organizations to develop new interventions that might help manage individuals whom the police already know to suffer from trauma-related difficulties.

### **Recommendations for Dealing With Traumatized Individuals**

With regard to developing trauma-specific interventions, much can be learned from many police organizations' efforts to develop alternative interventions to manage individuals who suffer from a range of psychiatric and neuropsychiatric issues. For example, many police organizations have developed units of officers who understand and appreciate the impact of paranoid delusions. They also learned (a) how to respond to individuals suffering from such delusions in a way that helps calm them instead of making them more paranoid, and (b) what to do if attempts to calm individuals suffering from delusions fail. Although the fears of traumatized individuals are not delusional, neither are they rational — their fears are greater than the situation merits. Furthermore, as with persons suffering from paranoid delusions, the fears of persons suffering from trauma-related difficulties can be exacerbated by the behavior of those they come in contact with. Therefore, it is reasonable for police organizations to develop a protocol for trauma-specific interventions, with goals and objectives similar to those developed to manage other mentally ill individuals.

Moving beyond on-street dealings with traumatized individuals, once a suspect is taken into custody and is being questioned and a

full investigation is under way, understanding childhood trauma and its effects might inform next steps. At this point, trained officers can recognize, better than they can during on-street encounters, that they are dealing with a person with a trauma history, and they can use the knowledge, understanding and associated skills that they have developed to deal with such a person. This knowledge and these skills may help officers obtain the cooperation of a suspect instead of making the suspect so much more fearful that he or she shuts down and refuses to cooperate or even speak. This knowledge may also help officers better understand the suspect's responses to questioning and determine the best approach to further questioning. In addition, this new awareness may help officers understand more accurately what happened during the course of the alleged crime.

When individuals suffering from the psychiatric and neuropsychiatric effects of childhood trauma are victimized again as adolescents or young adults, or when someone close to them is victimized, this can significantly exacerbate their symptoms. Unfortunately, this problem is far too common in poor communities of color, and there are virtually no victim services, mental health treatment or social services programs specifically designed for young men of color who are revictimized (Bell and Jenkins, 1991; Edwards and Foley, 1997; Snowden, 2001). Because leaving their difficulties unaddressed causes them additional pain, suffering and dysfunction and further increases their risk of coming into contact with the police, an awareness of these issues

## Child Development — Community Policing

In Child Development — Community Policing (CD-CP) service areas, mental health professionals are on call 24 hours a day, seven days a week, to respond immediately to police calls involving child victims or witnesses to violence or other trauma. Working together, police, mental health professionals, child protective services and other providers coordinate multisystem interventions that re-establish safety, security and well-being in the immediate wake of violent events. CD-CP has served as a model for law enforcement–mental health partnerships around the country.

The goals of the CD-CP program are to:

- Increase officer awareness and identification of children exposed to violence and other trauma.
- Increase clinical assessment and coordinated services to targeted children and families.

The Office of Juvenile Justice and Delinquency Prevention recognizes the program as a successful model and has designated the Childhood Violent Trauma Center, a component of the Yale Child Study Center at Yale University School of Medicine, as the National Center for Children Exposed to Violence (NCCEV), with Charlotte-Mecklenburg as the NCCEV Southeast Regional Training Center. The Charlotte-Mecklenburg CD-CP replicates the parent program between the Yale Child Study Center and the New Haven Department of Police Service. For more information about the program at Yale, see <http://www.nccev.org>. For more information about the program in Charlotte-Mecklenburg, see <http://charmec.org/Mecklenburg/county/PSO/CJS/Pages/CD-CP.aspx>.

See also the International Association of Chiefs of Police website, [www.theiacp.org](http://www.theiacp.org), for additional resources about the program, including an article from *Police Chief Magazine*, [http://www.policechiefmagazine.org/magazine/index.cfm?fuseaction=display\\_archandarticle\\_id=2882andissue\\_id=32013](http://www.policechiefmagazine.org/magazine/index.cfm?fuseaction=display_archandarticle_id=2882andissue_id=32013).

might help police become important advocates for the development of treatment and service programs for these victims.

As police and police organizations increase their understanding of childhood trauma and its effects, they will be more invested in and better able to develop and institute police practices that take this serious mental health problem into consideration. In addition, if this training is integrated with training on how race frames our understanding of human behavior, then the relationships that the police have with communities of color could be significantly enhanced.

## Summary and Conclusion

For children, repeated exposure to violent trauma, particularly in the absence of parental nurture, support and protection that might mitigate the impact of such trauma, can have devastating effects on their psychiatric and neuropsychiatric development. These include the development of mutually exacerbating disorders: neurological difficulties, trauma-specific psychological difficulties, developmental difficulties and other associated functional difficulties.

These psychiatric and neuropsychiatric difficulties become evident when traumatized

children are still children, long before they understand what is happening to them or can assume responsibility for addressing what is happening to them. Early therapeutic intervention can help enormously. However, when such early therapeutic intervention does not occur, many of these difficulties become irreversible. Individuals continue to suffer from these difficulties during their adolescent and adult years, and they are vulnerable to exacerbation of their symptoms by subsequent traumatic events as well as events that remind them of or symbolize the childhood traumas that they endured.

Although children from any neighborhood can be exposed to the type of trauma described here, children from poor communities of color are particularly at risk for such exposure. Because these communities are often the focus of police attention, it is important that police be aware of the high prevalence of severe childhood trauma in such communities, appreciate its effects on the developing child, and understand its impact on adolescent and adult functioning. With this knowledge, police officers will have a greater capacity to help decrease the prevalence of this major public mental health problem and will be able to better manage those they come in contact with who suffer from trauma-related psychiatric and neuropsychiatric difficulties.

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## Acknowledgments

Dr. Dudley would like to especially thank Anthony Bator for his research assistance, without which the completion of this paper wouldn't have been possible. Dr. Dudley would also like to thank the members of the Harvard Executive Session on Policing and Public Safety for their helpful comments on earlier versions of this paper, especially those from police organizations who suggested the ways in which the information summarized in this paper could be utilized by individual police officers and police organizations.

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