

**Expert Opinion - 1**  
**Gauri Goel, Psy.D.**  
**August 3, 2018**

**Summary**

Issue: Whether Clarinda Academy is providing investigation participants appropriate treatment and behavior supports?

Answer: Upon reviewing case specific documents and engaging in either phone interview (one youth) or face-to-face interview (two youth), there is clear indication that each of the three youth are complexly traumatized and the implications of complex trauma were not adequately attended to by their current provider.

Defined by the American Psychological Association, trauma is “the emotional response someone has to an extremely negative event. While trauma is a normal reaction to a horrible event, the effects can be so severe that they can interfere with an individual's ability to live a normal life”. Complex trauma, on the other hand, refers to the dual occurrence of exposure and adaptation to experiences of prolonged, multiple, and chronic events of trauma endured during childhood (Cook et al., 2007). As a result of a youth's exposure to chronic and prolonged forms of trauma, a youth may have significant impairments (adaptations) in various multifaceted dimensions of functionality. Most significant symptoms of complex trauma include impairments in affect self-regulation that often lead to various forms of maladaptive behavioral expressions, impairments in cognitive functioning which may be evidenced in difficulty with attention and/or concentration and may impact educational endeavors, impairments in neurobiological functioning which may impact a youth's ability with to create new neural pathways that are not focused on surviving trauma, impairments in attachments which may impact a youth's ability to create and maintain healthy and appropriate relationships, and impairments in self-concept which may exacerbate negative perceptions a youth may have about themselves and their place in the world.

Additionally, research (Green et al., 2000) confirms that youth who have experienced multiple traumatic experiences are at a significantly higher risk of experiencing detrimental psychological impairments when compared to youth who have endured single-incident trauma. Often the diagnostic structure of Post Traumatic Stress Disorder (PTSD) is insufficient in capturing the functional impairments and symptoms associated with chronic forms of extreme stress through exposure to continuous traumatic events. There is a large body of evidence-based psychological research suggesting that youth who have endured complex trauma, are often diagnosed with various psychiatric diagnoses and symptoms including behavioral diagnoses such as conduct disorder or oppositional disorder rather than PTSD as PTSD does not always capture the intensity and severity of symptoms experienced as a result of complex trauma exposure (Kisiel et al., 2013). Other youth are diagnosed with major depression, anxiety spectrum disorders, personality disorders, attention deficit hyperactivity disorder, substance abuse disorders, bipolar disorder, in addition to various diagnoses given the substantial symptom manifestation associated with a youth's adaptation to complex trauma exposure (Luxenburg et al., 2001). Studies indicate that when youth are diagnosed with various mental health disorders that are regarded as behavioral and not trauma-related diagnostic

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structures, the devastating reality is that their treatment is geared away from developmental responses of trauma “which is not only less effective but can be potentially harmful to the child over time” (Kisiel et al., 2013).

It is therefore necessary that youth that have endured multiple forms of trauma be assessed for symptoms of trauma based on complex trauma research. Furthermore, given the variability in each individual’s adaptation to complex trauma symptomology, it is essential that an individualized assessment and treatment model be adapted to meet each youth’s diverse set of complex trauma symptoms/needs. It is necessary that complex trauma exposure is explored in order to decipher the types of interpersonal trauma exposure endured (violent or nonviolent), length of exposure, along with corresponding developmental adaptation to the trauma exposure. When comorbid diagnoses are attended to, there a strong focus on attending to maladaptive behavioral patterns rather than exploring behaviors in relation to endured trauma that might yield treatment progress on domains such as attachment, self-concept, affect self-regulation, cognition, and consequently behavior. When assessed and treated through the complex trauma lens, behaviors are seen as an adaptation to complex trauma exposure rather than behavioral dysfunctions that are rooted in various other psychiatric conditions. When the basis of behavior is explored and attended through as a manifestation of complex trauma exposure, symptoms of trauma (including behavior) can be attended to more effectively. When behavior alone is addressed without consideration of a youth’s trauma history, the behavior may be reinforced as trauma triggers may inadvertently occur through the behavior modification process.

In the case of the 3 youth currently being treated by Clarinda, it is unclear if there is any acknowledgement of how or if their experience of complex trauma relates to their maladaptive behavior. There is clear documentation in the Clarinda Academy records, interviews with all three youth, and a document review to suggest that each youth is complexly traumatized. In each case, youth are documented to have exposure to prolonged, multiple and chronic occurrences of trauma. Additionally, each youth has reportedly exhibited individual adaptations to their complex trauma exposure in various domains including the ability to form and maintain adaptive relationships, impairments in affect self-regulation displayed through maladaptive behaviors, cognition impacting academic endeavors, and a self-concept that is impacted by their trauma exposure. If for example, there is no evidence of exploration by treatment providers to consider specific chronic trauma exposure, it is unclear how they might be able to fully comprehend the youth’s adaptation to various forms of trauma, and consequently how their adaptation to chronic trauma and chronic stress is expressed behaviorally. Even more, without the exploration of chronic trauma exposure, there is no evidence suggesting how providers can identify or support youth identifying potential trauma triggers in their environment that might increase dangerous behavioral expressions when their internal resources are overwhelmed. Without identification of trauma triggers, there does not seem to be a viable source of therapeutically attending to potential trauma triggers or aiding youth to identify warning signs and methods of adaptively attending to trauma triggers. Without fully assessing for complex trauma symptoms/adaptations unique to each individual and

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their experience, it is unclear how they might be able to treat manifestations of that complex trauma adaptation.

For example, if a youth's trauma is triggered by either an environmental and/or internal stressor and he/she begins to clench his jaw and/or pace, staff might be able to intervene in a therapeutic manner that the youth has helped design in order to avoid a potentially dangerous behavioral outburst. Often youth are able to identify which specific interventions/supports might help them de-escalate while being able to verbalize which interventions might further escalate them. If a youth initially lacks insights and/or ability to verbalize his/her trauma triggers and/or coping strategies, a therapeutic debriefing focused on better understanding the youth's trauma, trauma triggers, and ability to cope might be employed following an incident in order to help youth avoid potentially dangerous behavioral outbursts and consequences such as physical interventions that may be re-traumatizing. The trauma-focused debriefing might help define a plan that enables a youth to avoid engaging in a potentially dangerous behavioral expression that might lead to and/or warrant physical intervention. By attempting to understand and attend to trauma symptomology unique to each youth, programs have the capability to aid youth in increasing their awareness of their own symptomology while working alongside them in creating individualized strategies that help them succeed both within their current placement and in the community. For one youth, taking time away from a potentially triggering climate might be the most effective strategy, whereas another youth might identify that he/she might be most supported with a trusted staff sitting quietly next to them for a few minutes. There are countless intervention strategies that can be employed at any given time. One intervention that works well for a particular youth might further escalate his/her peer. It is therefore imperative to make the effort in attending to each youth individually. This requires that youth's trauma needs/symptomology be assessed, reassessed, and treatment plans be tailored to each youth. Even more, when working with a survivor of complex trauma, it is imperative to take the time in understanding their trauma triggers. One youth might be extremely triggered by a certain loud or authoritarian tone of voice based on their history of trauma exposure so when a staff attempts to redirect or offer intervention, having some information regarding the youths trigger(s) would allow the staff to employ a different tone of voice or suggest a different staff attempt to intervene. Most significantly, the use of a trauma-informed approach allows for youth to avoid being engaged in physically restrictive interventions, which have the potential to further escalate their trauma symptomology and re-traumatize youth. If a youth has a history of being physically dominated and perpetrated against, he/she may experience significant psychological distress when being physically restrained.

Additionally, as youth are being treated outside of their home state, it is unclear how they might have the opportunity to create and maintain meaningful relationships with caretakers to whom they will be released. Even more, a substantial number of potentially already existing support systems are removed from youth who are placed out of state for treatment, which has the potential to further exacerbate their distress. Although youth may have the opportunity to engage in therapeutically structured phone conversations with family members, they are being distanced from those who may be able to provide

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them with a sense of safety and security both within the here-and-now and as potential future caretakers. Moreover, each of the youth interviewed strongly proclaimed their ultimate goal to be returned to their home state in order to engage with healthy relationships they have created there (potential discharge locations), engage in treatment programming that addresses their specific trauma needs, and be in a physically safe environment. Each youth emphatically reported that their specific trauma needs were not being addressed and that they did not feel either physically or emotionally safe within the current treatment facility due to ongoing experiences of physical and emotional trauma being endured by a treatment model that they described as unpredictable and oppressive. Even more, they discussed the psychological distress associated with being separated from caregivers, distanced the familiarity of their home, distanced from friends, and the unpredictability of their potential return back to their home state.

Upon completing a documentation review of 3 specific youth's complex trauma history and corresponding trauma-related needs, engaging in a face-to-face interview with 2/3 youth, a phone interview with 1/3 youth, phone interview with the clinical director at Clarinda Academy, and reviewing information regarding the Clarinda Academy program structure, it is evident that the 3 youth's trauma treatment needs are not being adequately assessed and/or attended to at Clarinda Academy. Each youth's treatment plan and corresponding therapy record at Clarinda Academy suggests that their behavior is being treated without the consideration of how complex trauma exposure might have an impact on their individual affect self-regulation skills and thus their behavior. Given each youth's expression of distress associated with the current behavior modification strategy employed by the Clarinda Academy program structure, reports that their trauma needs are not being addressed in individual therapy, and provided records that do not reflect a treatment plan and individual therapy that seek to explore the impact of and adaptation to trauma exposure specific to each youth, the treatment they are receiving is likely to be ineffective and potentially counterproductive in attending to their trauma-related needs.

Additionally, there is no evidence to support that the youth being treated are engaged in the process of creating a safety plan based on identifying their trauma triggers and corresponding strategies that they can employ with the aid of providers. Moreover, each youth has stated that they were not comfortable in their individual therapy sessions. Two of the youth reported that their therapist "does not like talking about feelings". Provided documents do not indicate that each youth's trauma experience or adaptation to trauma exposure was explored as it relates to their behavior and may be a vulnerability to a behavioral outburst. Furthermore, each youth has individually described a significant amount of distress and fear related to their current treatment at Clarinda Academy in addition to being placed out-of-state and away from established support systems. Lastly, each youth has individually discussed significant distress related to physical interventions employed at Clarinda Academy which they perceive to be punitive in nature, excessive in force, and employed with the intent to harm and control rather than support youth in maintaining/regaining a sense of safety. Each youth has described his/her engagement in physical intervention as painful and unjust. All three youth have reported a significant amount of distress experienced both physically and emotionally due to their involvement

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in physical interventions at Clarinda Academy. Two of the three youth have likened physical interventions at Clarinda Academy to their histories of being perpetrated against, thus reporting the endurance of traumatic stress during and after restraints. It is likely that their described experiences of physical restraints that were unjustly employed and painfully executed exacerbated the level of internal distress already experienced. Physical restraints have the capacity to be re-traumatizing and harmful specifically for youth that are complexly traumatized (Zelechowski et. al, 2013).

It is recommended that each youth be treated in Washington State and in a trauma-informed system dedicated to assessing and addressing individual complex trauma needs collaboratively with each youth. The following report will address specific implications of complex trauma including attachment related impairments, affect self-regulation, and sense of self that are impacted by exposure to complex trauma. This is not an exhaustive list of complex trauma implications, however, each domain is relevant to the youth being reviewed. Additionally, the report will seek to provide a more thorough summary of each youth in addition to their specific complex trauma exposure and potential adaptations to their experiences. Youth summaries will provide recommendations for each specific youth. Lastly, this report will provide more abstract trauma-informed recommendations for receiving systems in Washington State aiming to treat complexly traumatized youth.

### **Analysis**

Acknowledging various symptoms/impairments that are associated with complex trauma exposure allows caregivers/providers with the ability to better understand how to assess and treat individuals who have a unique set of symptoms that may have a significant role in their behavioral expression. The listed domains of impairment resulting from complex trauma exposure is not exhaustive, however, is relevant to the three youth being reviewed. Additionally, it is imperative to consider the impact that these domains have on each youth's vulnerability to be re-traumatized. As youth grapple with and adapt to their symptoms of trauma exposure, they are substantially more vulnerable to increased occurrences of trauma exposure. For example, in the instance that youth have significant impairments in affect self-regulation, they may be more inclined to engage in substance abuse in order to manage their internal distress states which may increase their vulnerability to make poorer decisions, engage with individuals that are dangerous, and ultimately increase their risk of being traumatized again. In another example, youth struggling with creating and maintaining appropriate relationships may be at a higher risk of seeking out relationships with dangerous others who might seek to involve them in dangerous activities such as sexual exploitation. Poly-victimization is a term that refers to this scenario and defines the occurrence of successive victimization (Finkelhor et al., 2009).

### Neurobiological Implications of Complex Trauma:

Adolescence is perhaps one of the most significant stages in human development impacting the growth of major areas of the brain. For example, it is during adolescence

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that an individual begins to form his/her prefrontal cortex (the structure of the brain that is best known for executive functioning, judgment, and insight). In the instance that a youth has experienced trauma and/or ongoing forms of trauma for a prolonged period of time, an individual's brain structure is strongly reliant on areas of the brain that are focused solely on their survival rather than the development of the prefrontal cortex. A youth's brain becomes heavily reliant on survival rather than being able to discern an appropriate response to a potential threat. There is research suggesting that neurobiological implications of complex trauma include the diminished capacity for the prefrontal region of the brain to develop in a normative manner (Gabowitz et al., 2008).

Specifically, adolescence is a period of human development in which there is a significant biological expansiveness in which youth are exploring sexual behavior, experiencing puberty, engage in impulsivity, and are striving toward a sense of independence. Adolescents are on a journey moving from more primitive levels of processing to more sophisticated methods of processing complex information related to their experiences and the world around them. Essentially a normative adolescent brain is moving from limbic system functioning to prefrontal functioning (van der Kolk, 2003). Normative development suggests that an adolescent will be able to integrate thoughts, emotions and past experience in order to manage and control behavior with comprehension of how ones behavior might impact the environment. Normative brain development allows for an integrated process in which an adolescent is able to use their thoughts, emotions, and past experiences to respond to their environment in an integrated fashion. They are typically in the process of learning how to navigate the external through internal resources (Kolassa & Elbert, 2007). Youth are essentially moving from mindless emotional responses to their environment to a more integrated fashion of attending to their environment. Often, there is marked periods of chaotic behavior that indicate how a normative adolescent developing may move from emotional (limbic) responses to their environment to more integrated (prefrontal) responses to their environment.

Exposure to chronic stress states due to a youth's endurance of prolonged trauma exposure changes biological systems and normative adolescent development. As normative development seeks to strengthen the prefrontal cortex and thus an individual's ability to attend to complex internal structures (emotions, thoughts, and past experiences) as it relates to the environment, events of trauma disrupt the prefrontal cortex's ability to attend. During experience of trauma, the brain relies on the structures of the brain that are dedicated to attending to danger. When an alarm in the brain is sounded due to trauma, blood flow to the frontal cortex is rerouted to the limbic system. The occurrence of trauma or potential trauma activity is redirected from the prefrontal cortex to the primitive brain (limbic system) in order to fight off perceived environmental danger. The limbic system does not seek to integrate thought, emotions, and past experience into action, rather it seeks to survive by directing activity to regions of the brain and body to fight off the threat. Moreover, the same process of disinhibiting prefrontal activity and relying on the limbic system for survival is activated in instances where a youth's trauma is triggered by either an internal experience and/or external stimuli. Trauma triggers

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activate the same alarm in the brain signaling the need for survival in the same way an actual trauma event does

Additionally, youth who have endured intense traumatic experiences consistent with complex trauma exposure, often engage in physical actions to nonthreatening sensory reminders of their trauma experiences (van der Kolk, 2006). Examples of these include physical reactions an individual might display to hearing loud noises. Although the loud noise may be a seemingly nonthreatening environmental condition to most individuals, an individual with a history trauma exposure may react with an extreme physical reaction. Similarly, youth who experience anxiety and/or mood disorders are found to have enlarged amygdala activation as a response to traumatic incidents (van der Kolk, 2003). Traumatized youth are likely to interpret diverse sets of external stimuli as dangerous and threatening while engaging with others and their environment with a substantial amount of mistrust. As the amygdala is on consistent high alert for potential dangers in the environment and from others, there is a decrease in activity within a youth's prefrontal region (impacting decision making). In instances that youth continue to have elevated levels of trauma exposure and/or perceived trauma exposure, they remain reliant on neural pathways that are reinforced (reacting to trauma) and less able to build strong neural pathways for areas of the brain like the prefrontal region that are not reinforced. Furthermore, when youth are experiencing potential threats in their environment consistently, their trauma response might be reinforced. For example, if youth are being consistently exposed to extreme adverse events in their environment that infringe on their emotional and/or physical safety, they will continue to rely heavily on attending to threats or potential threats through the lens of survival. As adolescent survivors are presented with external environmental stressors, extreme stress reactions are generally heightened (Ford et al., 2005). It is imperative to support youth in being able to identify when their brain interprets likely benign sensory experiences as traumatic events based on their previous experiences.

Affect Self-Regulation Impairments of Complex Trauma:

The biological and behavioral deficits resulting from complex trauma exposure are undeniable. What endures in the environment inevitably impacts an individual's biological process. In understanding neurobiological impairments, it is evident that youth may thus experience affect self-regulation difficulties. As their brain structure is reliant on surviving trauma and potential trauma threats in the environment, their behavioral expression will correspond strongly to the functionality of their brain structure. As neurobiology is impacted by exposure to complex trauma, an individual begins to develop a method of attending to his/her environment with a bank of emotional experiences rooted in trauma. Affect self-regulation requires that individuals be able to recognize and identify their emotional experience prior to being able to find an appropriate method of expressing that emotional experience into the environment. Youth with a history of traumatic experience "may lack the awareness of body states or the connection of those states to specific experiences and emotions" (Kinniburgh et al., 2005). Even more, as youth have a history of complex trauma experiences, they may be

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more predisposed at experiencing negative affect states as a result of their internalization of traumatic experiences. Youth may feel a sense of responsibility for their traumatic experiences and thus inadvertently adopt internal states of shame, self-blame, and isolation as a basis for receiving all other environmental stimuli. As a result, they may view all environmental and/or relational cues as dangerous or through the lens of anger and blame. As youth may have difficulties in receiving relational and environmental cues based on their history of trauma exposure, they may also have difficulty in expressing their emotional experiences. Most often, youth may be likely to be “constricted (shut down) or labile (explosive)” (Kinniburgh et al., 2005) when experiencing intense emotions. Even more, when intense emotions are experienced, they may have difficulty regulating or calming form their internal experience thus relying on maladaptive methods of coping such as using substances and/or engaging in self-injurious behaviors in order to modulate their emotional experiences.

As individuals with a history of complex trauma experience the environment, they are required to engage in a process of interacting with external world through their internal navigation system. For many youth, their response to external stimulus has been primed to detect danger and threat in order to survive that threat thus relying heavily on their fight/flight/freeze response (survival mode). When youth rely on the survival mode to respond to their environment, they often lose the ability to engage in the process of having thoughts about their experiences or their mood. When their bodies and minds are focused on surviving the detected danger, their brain does not allow for the process of having thoughts about their emotions, rather, it is focused entirely on finding a way of surviving the experience. Additionally, individuals who have experienced any incident of trauma (single-incident or continuous and prolonged trauma exposure) are constantly defending against the threat of flashback. Some researchers suggest “flashbacks and reliving are some ways worse than the trauma itself. A traumatic event has a beginning and an end- at some point its over” (van der Kolk, 2014). People with symptoms of trauma (PTSD or complex trauma), flashbacks can occur at any time (sleeping or awake) as there is no way of knowing when it might occur. As a result, many seek to survive the trauma by organizing their lives in order to avoid experiences and/or situations in which they are reliving the horrors of trauma. Some may rely on substances, some may seek solace in self-harming, some may seek salvation in cultivating another form of control over their potential of reliving the past. Significantly, the more an individual experiences flashbacks and is required to relive their trauma, the more likely that those memories are “engraved ever more deeply in the mind” (van der Kolk, 2014).

When environmental cues trigger a youth’s historical trauma, there is a substantial process within the body that seeks to fight of the danger. Youth may respond as if they are re-experiencing the trauma and become enraged. Some might become numb. As each youth experiences the trauma trigger, he/she may respond entirely differently. Youth at this point do not have control over the way in which they are responding despite the potential irrational response. A youth may, for example, react with rage when asked to discuss his/her history of trauma whereas another youth may experience a migraine or feel numb during the discussion. Essentially, the body seeks to survive the environmental

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cue that has ignited a flashback of his/her trauma experience in any way it possibly can. Even more, youth with complex trauma exposure are at an elevated risk of displaying attentional and behavioral impairments than youth with exposure to single incident trauma exposure. Even more, youth with exposure to both violent and nonviolent trauma exposure are at the highest level of impairment across every impairment type including anger control, affect dysregulation, numbing, eating disturbances, self mutilation, danger to others, avoidance, regulatory problems, and sexually reactive behavior (Kisiel et al., 2013). Without exploring how complex trauma exposure impairs various domains of functionality and behavior through diminished affect self-regulation, it is unclear how providers can begin to attend to the magnitude of symptoms in a meaningful manner.

The observable elements of complex trauma are the behavioral choices endorsed by survivors as a direct reaction to internal states of extreme stress. Furthermore, as the brain begins to adapt to trauma response systems, neural pathways are reinforced and thus become less regulated (van der Kolk, 2003). Essentially, individuals begin to respond to daily stressors with heightened biological trauma systems that were once adaptive survival mechanisms (van der Kolk, 2001). The culmination of impairments undoubtedly results in difficulties with affect regulation, neurobiology, cognition, self-concept, and relational patterns (Luxenburg et al., 2001). Although distinct in their trajectory, these specific domains of impairment can be observed behaviorally as trauma overwhelms an individual's capacity to cope with environmental interactions adaptively. As individuals are tremendously influenced by their subjective interpretation of vulnerability and risk, observable behavior becomes a gateway into comprehending coping behaviors related to victimization (Knight, 2006). Some typical behavioral mechanisms include dependence on substances, homelessness, and other high-risk behavior leading to poly-victimization or continued exposure to trauma (Finkelhor et al., 2009). Substance abusing and homeless adolescents are among the most susceptible for poly-victimization (Kilpatrick et al., 2003).

Poly-victimization is a term used to describe the phenomenon of multiple events of victimization due to a diverse set of factors. Poly-victimization includes various types and contexts of trauma in addition to differing perpetrators offending any single survivor (Finkelhor et al., 2009). Substance abuse is a variable that increases the likelihood of an individual survivor of trauma to be victimized again. Turner et al. (2010a) illustrate that pathways to poly-victimization are generally mediated by risk-taking behavior during adolescence.

Finkelhor et al. (2009) found a diverse set of factors that lead to poly-victimization, including: living in a dangerous community, parent and family distress, interpersonal victimization, and childhood psychological distress leading to maladaptive and high-risk behavioral patterns. Additional research has formulated that poly-victimization is tied to a history of sexual abuse (Elwood et al., 2011), PTSD symptoms (Risser et al., 2006) and psychological disorders (Cuevas et al., 2009). Essentially, trauma can be a significant risk factor for poly-victimization due to the extreme stress reactions and symptoms leading to maladaptive high-risk behaviors used to self-medicate and attend to overwhelming

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trauma states (Luxenburg et al., 2001). Unfortunately, re-victimization is a pandemic among trauma survivors, requiring direct attention, because child trauma survivors are susceptible to lifelong incidents of tragic victimization in their struggle to recover from early experiences. Indeed, trauma predisposes one to more traumas (Finkelhor et al., 2009).

Risser et al. (2006) suggest that specific trauma and PTSD symptoms largely account for increased probabilities for poly-victimization. Largely, symptoms such as re-experiencing, avoidance, and hyperarousal symptoms are the most suggestive traits of PTSD that lead to psychological distress and high-risk behaviors resulting in poly-victimization. Specifically, Risser et al. found evidence to substantiate that childhood sexual abuse leads to profound PTSD symptoms, resulting in an elevated potential for poly-victimization, as childhood survivors of sexual abuse are twice as likely to experience adult sexual abuse. Adolescent populations with a history of interpersonal trauma are also at elevated risk due to their wide-ranging symptomatic domains.

Adolescent survivors use a diverse set of behavioral strategies to reduce tension and respond to overwhelming internal states. Specifically, Cook et al. (2005) indicate that adolescents lack behavioral control and are likely to: act impulsively, participate in self-destructive behaviors such as self-mutilation, act aggressively toward others, use substances, suffer from eating disorders, rebel against authority figures and rules, and reenact trauma, such as sexual reenactments. Cook et al. propose that adolescent survivors are either attempting to cope with the debilitating symptoms of extreme traumatic stress or are attempting to simultaneously gain mastery and control over the trauma they endured. High-risk behavior associated with trauma symptomology is a condition of complex trauma that inevitably places survivors at high risk for poly-victimization during their adolescent and adulthood years (Turner et al., 2010a). Research by Finkelhor et al. (2009) found that in a national sample of 2 to 17-year-old children who were labeled as poly-victims, 7% had seven or more kinds of victimization by different offenders within a single year, and 20% of this sample had been victimized 5 or more times by different offenders. Turner et al. (2010a) found that the most salient factor in poly-victimization is linked to high-risk behavioral choices made by young survivors of abuse. After a child has been exposed to any single trauma experience of interpersonal victimization, there is a continuous level of elevated risk of vulnerability and victimization across multiple contexts of abuse and trauma (Finkelhor et al., 2009).

The negative impact of complex trauma on an individual's ability to interpersonally relate is undeniable (Knight, 2006). Adolescent survivors of interpersonal victimization are at a substantial risk for internalizing the offenses against them. By internalizing the abuses to which they have been subjected, adolescents are likely to perceive themselves, others, and the world around them as untrustworthy, dangerous, and unpredictable (Mendelsohn, Zachary, & Harney, 2007). Moreover, exposure to complex trauma is linked to the process of traumatic loss, which often relates to a survivor's loss of identity and sense of self that is exacerbated in interpersonal relationships (Knight, 2006). Complex trauma exposure positively correlates with an individual's inability to securely attach and relate to others (Markin & Marmarosh, 2010).

### Cognitive impairments of complex trauma

Youth with a history of complex trauma exposure are also likely to have significant impairments in attention, concentration, and lower overall scores on standardized measures, lower academic achievement and performance, and higher rates of grade repetition (Cook et al, 2007). Youth who have been exposed to complex trauma are more likely to drop out of school prematurely which in turn may heighten corresponding perceptions of failure and compounding feelings of unworthiness. Even more, youth exposed to multiple types of maltreatment experiences (violent and nonviolent) are at a substantially higher risk of increased functional impairments in school behavior, school achievement, school attendance, along with various other forms impairment (Keisel et al., 2013).

### Attachment Impairments

Childhood interpersonal victimization and complex trauma are associated with severe detriments to an individual's capacity to build and maintain healthy interpersonal relationships (Cook et al., 2005). Often, survivors of complex trauma are perpetrated against by those individuals who they have an existing relationship with and/or by those that are regarded as their caretakers. Interpersonal victimization refers to the exposure of trauma perpetrated by a caretaker or an individual who has/had an existing interpersonal relationship with the youth prior to the trauma exposure. As a result of interpersonal victimization during childhood, adolescent survivors have strong relational difficulties.

Early caregiving relationships are associated as the foundation for which individuals build a diverse set of skills including developmental competencies such as "distress tolerance, curiosity, a sense of agency and communication" (Cook et al., 2005). Significantly, research as also evidenced that adolescents who have received inadequate nurturance from their caregiver(s) showed increased impairment in relational competencies in addition to increased levels of psychopathology (Kinniburgh et al., 2005). It is likely that survivors of complex trauma and interpersonal maltreatment come from homes in which caretaking systems are impaired, inconsistent and unpredictable in their parenting styles (Jones et al., 2006). It is therefore likely that youth with a history of complex trauma and interpersonal victimization exposure are likely to respond to their environment with maladaptive coping skills such as aggression, dissociation, and avoidance (Kinniburgh et al., 2005). In their approach to their environment and relationships, it is also more likely that adolescence with a history of complex trauma have an increased propensity to build a sense of self-based on rejection, abandonment, neglect and abuse experiences. The way in which an adolescent views the world and interacts with the world is connected strongly to the way in which he/she is treated by caretakers. When caretakers violate and perpetrate against children, they not only view themselves through the lenses of their trauma, but they also interact with others and the world around them through maladaptive approaches. It is within the maladaptive approaches to others and their environment that they are also now more likely to have

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their sense of self reinforced. When a youth views herself/himself as rejected (for example), she/he interacts with others with trepidation and potentially through aggression in order to avoid being maltreated or rejected again, the environment and others then also react by either distancing, withdrawing, or with aggression. This cyclical pattern essentially reinforces the youths original thought process that she/he is unlovable and unworthy of healthy relationships and likely reinforces both their approach to relationships and their environment in addition to their view of themselves based on their history of trauma exposure.

The interplay between complex trauma exposure and a youth's ability to create and maintain positive, healthy, and adaptive interpersonal relationships is perhaps one of the most detrimental aspects of complex trauma exposure as it distances youth from one of the most rewarding and nurturing experiences; healthy caring relationships with others. It is within these caretaking relationships that they have the opportunity to challenge their originally held views about their worth and their place in the world. They are able to challenge the experience of being an extension of another's deviant needs through different types of relationships that offer safety and care. The ability to engage in healthy caretaking relationships provides youth with the ability to create a sense of resiliency within themselves while also protecting against ongoing internal distress, poly-victimization (the propensity to be exposed to ongoing trauma as a result of symptomatic behaviors associated with complex trauma exposure), and decreased psychopathology. Even more, new neurobiological pathways informing relationships can be created and reinforced through healthy relationships (Kinniburgh et al., 2006). Treatment models that emphasize attachment processes and provide youth with the opportunities to build on relational competencies while receiving the inherent rewards of adaptive caretaking relationships are likely to best serve youth who have histories of complex trauma exposure and interpersonal maltreatment histories.

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### EDUCATION

#### Alliant International University

##### California School of Professional Psychology

*Date Entered:* September 2008

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*Program:* Clinical Psychology; Emphasis in Family, Adolescence and Couples Therapy

*Degree received:* **Masters in Clinical Psychology (M.A., 2010)**

**Doctor of Clinical Psychology (Psy.D., 2012)**

#### Pepperdine University

*Date Entered:* September 2006

*Date of Graduation:* December 2007

*Major:* Psychology

*Degree received:* **Masters in Psychology (M.A.)**

#### Vanguard University of Southern California

*Date Entered:* January 2004

*Date of Graduation:* June 2006

*Major:* Psychology

*Degree received:* **Bachelors in Psychology (B.A.)**

### CLINICAL EXPERIENCE

#### **CLINICAL DISSERTATION:**

##### ***ARC-Based Group Psychotherapy with Adolescent Survivors of Complex Trauma***

- Presentation Sites
  - Gateways Hospital and Mental Health Center
  - Children's Hospital Los Angeles
  - YWCA Mohawk Valley

#### **OFFICE WITH PEOPLE WITH DEVELOPMENTAL DISABILITIES**

##### ***Central New York DDSO***

Taberg, NY

##### Associate Psychologist (3/17-Present)

- Writing Functional Behavior Assessments and corresponding Behavior Support Plans for individuals with complex challenging behaviors based on intellectual disability in addition to psychiatric disorders.
- Writing Medication Monitoring Plans for individuals diagnosed with an intellectual disability and severe psychiatric condition.
- Creating, implementing, and interpreting various data collection forms based on each individual's unique behavioral and psychiatric composition.
- Training direct care staff and members of an interdisciplinary team on each individual's functional behavior assessment and corresponding behavior support plan.
- Training "Dual Diagnosis" for all new employee's to OPWDD during a 6-week orientation course.
- Co-facilitating psychoeducational and process oriented group for individuals with a developmental disability and a history of sexual offense.
- Providing individual psychotherapy for individuals requiring and capable of engaging in treatment.
- Creating, coordinating, and implementing electronic record sharing applications for an interdisciplinary team.
- Completing intake, progress, and discharge paperwork based on each individual's data collection system.

## **YWCA of MOHAWK VALLEY**

Utica, NY

### Consultant and Therapist (4/17-Present)

- Providing monthly two hour trainings to a diverse Crisis Management Team on intricate dynamics of trauma informed care including neurocognitive implications of trauma, diagnostic features of trauma, distinctions between single-incident trauma and complex trauma, engagement strategies for working with survivors of complex trauma, role of substance abuse with survivors of complex trauma, impacts of organizational trauma and the role of parallel process in treatment delivery, in addition to case-specific training on conceptualization and treatment.
- Providing trainings for judges, court advocates, district attorneys and law enforcement leadership on the implications and manifestation of complex trauma symptomology while interacting with and navigating through the legal system.
- Assessment of individual, group, and organizational dynamics specifically decreasing overall employee performance and appropriate delivery of trauma informed care.
- Worked with agency administration to develop policies, procedures and corresponding programs based on trauma informed care and culture in order to create an organizational structure and culture grounded in trauma informed framework while increase employee effectiveness of trauma informed interventions and overall care.
- Created, trained and implemented trauma-informed vocational program for women currently residing at domestic violence shelters.
- Created and facilitated substance abuse training for staff working directly with survivors of domestic violence.
- Implementing enhanced trauma-informed programs into various shelters by providing ongoing personalized assessment and training during shelter visits.
- Providing individualized trauma-informed psychotherapy with individuals with a significant history of complex trauma and corresponding symptoms.

## **OFFICE OF CHILDREN AND FAMILY SERVICES**

*Taberg Residential Center for Girls*

Taberg, NY

### Acting Assistant Director for Treatment (6/1/15-7/1/16)

- Developed and implemented procedures such as suicide watch protocols in order to increase trauma-informed interventions and supervision for youth exhibiting increased mental health symptoms leading to suicidality.
- Implementing enhanced trauma-informed programs into the milieu setting by supervising and training clinical team and direct care staff.
- Created and implemented advanced clinical training programs for direct care and management centered on attachment, self-regulation, and competency while emphasizing interventions to increase efficacy and productivity for organizational advancement.
- Worked closely with the Office of Ombudsman in order to review and discuss current policy and procedures to ensure youth rights were adequately addressed.
- Facilitated individual and group supervision for middle management and clinicians in order to work through individual, programmatic, and clinical concerns.
- Created and facilitated programs and procedures adhering to existing OCFS policies for regular the Department of Justice monitoring visits to ensure that protection from harm and mental health compliance standards were adhered to.
- Worked with advanced leadership team in OCFS to increase contracts with agencies to ensure youth had optimal levels of care when transitioned to community providers.
- Supervision of all mental health, psychiatric, and intervention strategies related to care for youth.
- Conducted ongoing DBT, Sanctuary, NY Model and ARC training sessions for staff and clinical teams.
- Created and facilitated in-depth presentation on clinical and programmatic advancements based on enhanced attention toward organizational practices for the Department of Justice.

## **OFFICE OF CHILDREN AND FAMILY SERVICES**

*Taberg Residential Center for Girls*

Taberg, NY

Associate Psychologist (4/24/14-6/1/15)

- Facilitating DBT skills group psychotherapy providing youth with adaptive interpersonal and distress tolerance skills to utilize during experienced internal distress.
- Trauma focused individual therapy for youth with a history of complex trauma and substance abuse issues.
- Facilitating family therapy sessions with families of youth suffering with trauma related issues in order to aid youth and their families in transitioning back into the community.
- Utilizing components of New York Model in order skillfully integrate DBT and Sanctuary models during group and individual therapy.
- Establishing therapeutic goals, objectives, and interventions with youth for Support Team Meetings aiding in youth's progress in treatment.
- Responsible for initial treatment reports assessing diagnosis, history of trauma, expression of present behaviors, substance abuse history, and evaluating treatment progress to date.
- Attend and participate in multidisciplinary treatment team meetings focusing on youths' treatment, emotional, behavioral, medical, and psychological strength and risk factors for successful treatment engagement and progress into the community.
- Working with and collaborating with multidisciplinary team in order to modify youth's maladaptive negative and violent behaviors while increasing the level of environmental safety.
- Trained clinical and direct care staff on 7 Challenges harm reduction model and facilitated implementation of 7 Challenges model into program structure.

**NEW YORK STATE OFFICE OF MENTAL HEALTH**

***Central New York Psychiatric Center; Sex Offender Treatment Program***

Marcy, NY

Associate Psychologist (10/20/13-4/23/14)

- Facilitating didactic and process group psychotherapy exploring and addressing residents' criminogenic needs and psychopathic traits related to their history of sexually deviant behaviors.
- Facilitating specialized Arousal Reconditioning groups aimed at aiding residents become aware of, process, and decrease arousal to sexually deviant thoughts, urges, and fantasies.
- Participate in co-facilitating, interpreting, and clinically addressing Penile Plethysmograph (PPG) assessments.
- Facilitating, scoring, and interpreting individual PCL-R scores to assess for psychopathy levels in order to inform treatment and annual psychological reports.
- Administer and interpret specialized forensic psychological assessments and research resident records in order to inform, appropriately diagnose and create each individualized clinical treatment plans.
- Responsible for annual treatment reports assessing diagnosis, history of offenses, expression of present criminogenic needs, psychopathic traits/behaviors, and evaluating treatment progress to date.
- Attend and participate in multidisciplinary treatment team meetings focusing on residents' treatment, emotional, behavioral, medical, and psychological risk factors for re-offending and engaging in criminality.
- Working with and collaborating with multidisciplinary team in order to modify resident maladaptive negative and violent behaviors while increasing the level of environmental safety.

**GATEWAYS HOSPITAL AND MENTAL HEALTH CENTER**

***Adolescent and Adult Inpatient Services***

Los Angeles, CA

Supervised Internship (8/2011-9/2012)

- Short-term and crisis based individual psychotherapy with patients admitted for acute psychiatric services.
- Facilitated didactic and discussion based group psychotherapy with adult and adolescent patients.
- Individual and group psychotherapy with Restore to Competency and AB-109 patients.
- Administered, scored, interpreted, and wrote-up cognitive, personality and projective psychological testing batteries for adult and adolescent patients.
- Participated in multidisciplinary case meetings in order to conceptualize treatment planning for patients.
- Participated in intake evaluations for adult and adolescent patients newly admitted to hospital.

- Participated in a weekly assessment lab in order to learn, discuss, and present psychometric assessment findings as applied to individual treatment planning.
  - Mini Mental Status Exam, MMPI-2, MMPI-A, Rorschach, TAT, WAIS-3, WISC-4, Bender-Gestalt, Rey-O, TRAILS, Wisconsin Card Sort, VMI, BDI, BAI, Sentence Completion, and HTP.

## **CHILDRENS HOSPITAL LOS ANGELES, DIVISION OF ADOLESCENT MEDICINE**

### ***Division of Adolescent Medicine and High Risk Youth***

Hollywood, CA

#### Supervised Internship (8/2010-9/2011)

- Provided short-term, long-term, substance abuse and crisis intervention individual therapy.
- Facilitated psychoeducation and process-oriented group psychotherapy focusing on stress awareness and management. Specifically using the evidence-based SPARC and ARC curriculum in order to provide members with information and tools for managing complex trauma symptoms.
- Prepared and delivered PowerPoint presentations focusing on a number of issues related to high-risk youth mental health needs such as: Child Abuse Reporting and Treatment, Trauma-Informed CBT Basics, Complex Trauma affecting Adolescent and Caregiver Relationships, and ongoing case conceptualizations of active patients.
- Administered, scored, interpreted, and wrote-up cognitive testing batteries for youth residing in emergency homeless shelters, group homes, and transitional living programs.
- Facilitated multiple intake evaluations for new clients at a number of facilities including: The Saban Free Clinic, Los Angeles Youth Network, Jeff Griffith Youth Center, and My Friends Place
- Attended continuing education didactic lectures twice a week focusing on medical and mental health issues pertaining to homeless youth suffering from complex trauma symptomology.
- Participated in street outreach services providing clothes, food, condoms, blankets, hygiene items, and other necessary resources for homeless youth residing on the streets.

## **HARBOR UCLA MEDICAL CENTER**

### ***Adult Dual Diagnosis Outpatient Treatment Program***

Torrance, CA.

#### Supervised Practicum (9/2009-7/2010)

- Long-term and short-term individual therapy under the supervision of Director of Psychiatry.
- Facilitated psychoeducation and process-oriented group psychotherapy focusing on: stress, anger management, boundary setting, interpersonal relationships/communication, relapse-prevention, 12-step study and medical consequences of various diseases.
- Attended weekly Psychiatric Emergency Room training rounds with attending Psychiatrists in order to increase clinical interviewing and diagnostic assessments skills through the medical and psychological model.
- Attended a yearlong continuing education program on Cognitive Behavioral and Dialectical Behavioral Therapy provided by Harbor UCLA and the Los Angeles County Department of Mental Health.
- Participated in case management multidisciplinary team meetings in order to case conceptualize and treatment plan for individual clients.
- Facilitated intake evaluations for prospective new clients.

## **CHILDREN, YOUTH, & FAMILY SERVICES CONSORTIUM**

### ***School-Based Program***

Alhambra, CA.

#### Supervised Clerkship (10/2008-7/2009)

- Provided individual therapy for adolescent clients in the school setting.
- Conducted intake evaluations.
- Consultation with school personnel and staff from various community organizations.

- Developed skills in working in a multidisciplinary team focused on treatment processes.
- Prepared documentation for each client (intake, progress notes, preliminary reports, crisis consultation notes, termination summary).

## **AEGIS MEDICAL SYSTEMS**

### ***Outpatient Methadone Clinic***

West Los Angeles, CA

Case Manager (8/2005-2/2006)

- Carried caseload of 60 adult clients suffering from heroine addiction in addition to various psychological disorders (mood disorders, coexisting substance abuse, eating disorders, and schizophrenia).
- Provided individual counseling and case management.
- Attended weekly and monthly team meetings, working closely with medical and psychological staff.
- Monitored each client's methadone dosage while working directly with M.D. in order to educate clients.
- Facilitated intake process, orientated clients to program, created treatment plan, documentation.
- Incorporated use of several referral services for homeless and mentally unstable clients.

## **CENTER FOR DISCOVERY AND ADOLESCENT CHANGE**

### ***Residential Inpatient Dual-Diagnosis***

Long Beach, CA

Counselor (4/2003-10/2004)

- Provided individual counseling for adolescent clients suffering from mood disorders, substance abuse, self-mutilation, and eating disorders.
- Conducted biopsychosocial interviews in addition to preparing documentation.
- Involved in composing each clients comprehensive treatment plan.
- Facilitated psycho-educational, discussion, and multifamily group sessions on addiction, self-esteem, communication, physical education, nutrition, and anger management.
- Involved in creating educational goals for each client while communicating daily with teachers.
- Administered psychotropic medications on a daily basis while communicating with therapists and psychiatrists.

## **RELATED VOLUNTEER EXPERIENCE**

### **PALOS VERDES VILLA**

Palos Verdes, CA

Student Volunteer (6/2002-7/2003)

- Created and maintained relationships with patients while learning elderly cognitive and emotional concerns.
- Assisted nurses with weekly weighing, feeding and social activities for patients.
- Assisted the Activities Director with clerical and organizational tasks.

### **REGENCY HOSPITAL**

Dar Es Salam, Tanzania

Volunteer (6/2002-7/2003)

- Worked with patients attending medical treatment services providing some individual counseling.
- Interacted with medical personnel to relay information and perform various task throughout the hospital.
- Maintained the delivery of exceptional patient hospitality.

## **ORGANIZATIONAL EXPERIENCE**

### **ARUN ENTERPRISES INC.; GAURI CORP.**

*8 Subway Sandwich Franchises in the greater Los Angeles area*

Huntington Park, CA; Montebello, CA

Chief Operating Officer (June 2005-August 2013)

- Developed and implementation of operational standards to increase productivity, efficacy, and efficiency.
- Ongoing team meetings with managerial and direct staff to establish and maintain organizational culture valuing team cohesion while addressing any major concerns impacting the overall culture of and organizational value of providing optimal service.
- Involved in recruitment, hiring, training, and creating promotional items for development of organization size.
- Increased sales production by 9% (above Los Angeles market trends) by implementing ongoing compliance training systems for new hires, existing staff, and management teams.
- Decreased inventory and overtime costs by 17% by working closely with management teams to increase supervision and training practices.
- Creating policies and procedures to decrease theft, absenteeism, and overall counterproductive work behaviors.