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## Traumatic Stress/ Child Welfare



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# Traumatic Stress and the Child Welfare System

Traumatic events cause overwhelming feelings of terror, horror, or hopelessness. These kinds of feelings often occur when a person experiences or witnesses a serious injury, or witnesses a death. A person may also be traumatized by threats of injury or death, or by experiencing other forms of attack or violation. Child traumatic stress occurs when exposure to traumatic events overwhelms the child's ability to cope.



This issue of *Focal Point* focuses on child traumatic stress, particularly the kinds of stress most commonly found among children and adolescents who are involved with the child welfare system. We (the RTC on Family Support and Children's Mental Health at Portland State University) and the National Child Traumatic Stress Network (NCTSN) have worked together to provide this summary of what is currently known about the effects of child traumatic stress and the most effective treatments.

Traumatic stress can arise in the context of war, endemic community violence, or natural disaster. In this issue, however, we focus on traumatic stress that arises in the context of families and within the systems that are designed to protect children when their families cannot. Children who enter the child welfare system are typically affected by abuse, neglect, and/or domestic violence. If they are removed from their homes, they often face further traumas that are caused by efforts to remedy the situation. Children's relationships with caregivers and other family members are ruptured, they are uprooted from friendships and familiar surroundings, and their daily routines are destroyed. Often, children face ongoing uncertainty and instability that can

continue for years.

We know that a strong relationship with a caregiver is by far the most potent buffer against child traumatic stress. This is precisely the asset that children involved with child welfare typically lack. When children lack a secure bond with a caregiver, they are highly vulnerable to the immediate effects of trauma. Additionally, when traumatic stress is left untreated—or when it is compounded by ongoing experiences of instability and uncertainty in the absence of a strong attachment to a caregiver—problems begin to multiply and can impact every area of a child's functioning. Cognitive, attentional, and emotional resources that are normally devoted to learning, exploring, and developing are instead devoted to coping and survival strategies. While these strategies may work to protect the child in the short run, they are often maladaptive in the long run, resulting in problems with forming healthy attachments, regulating attention and emotion, and learning. In turn, these cascading problems leave children vulnerable to further traumas and victimization, and increase the likelihood of school failure, substance abuse, and involvement in antisocial activity.

Later on in their lives, we may encounter these young people as “multi-system kids”: runaways, delinquents,

substance abusers, and dropouts, often carrying labels like “oppositional defiant” or “conduct disordered.” We also encounter other youth with similar problems, many of whom experienced abuse, neglect, domestic violence, or other traumatic stressors but who did not come to the attention of child protective services. As adolescents, these young people may appear undeserving of sympathy. It is easy to

see them as willfully “bad” kids, and often they are not particularly receptive to our efforts to help.

Intervening early and effectively can help traumatized children recover. Even severely traumatized children like Aaron Weaver (page 9 in this issue) can thrive when they find safety and love, and when they have opportunities to learn how to manage the enduring aftereffects of trauma. Understanding the ways that traumatic experiences impact young people can make us more alert to possible traumas that lurk in the life histories of “bad” and highly troubled adolescents we encounter in human service settings. Being knowledgeable about child traumatic stress can help us respond more sympathetically and responsively to their needs. The goal of this *Focal Point* issue is to help build the knowledge and understanding that supports effective efforts to help young people recover from the effects of trauma.

*By Janet S. Walker and Aaron Weaver*

*Special thanks to Susan Ko of the NCTSN for helping make this issue possible.*

# Complex Trauma in Children and Adolescents

The term *complex trauma* describes the dual problem of children's exposure to multiple traumatic events and the impact of this exposure on immediate and long-term outcomes. Typically, complex trauma exposure results when a child is abused or neglected, but it can also be caused by other kinds of events such as witnessing domestic violence, ethnic cleansing, or war. Many children involved in the child welfare system have experienced complex trauma.

Often, the consequences of complex trauma exposure are devastating for a child. This is because complex trauma exposure typically interferes with the formation of a secure attachment bond between a child and her caregiver. Normally, the attachment between a child and caregiver is the primary source of safety and stability in a child's life. Lack of a secure attachment can result in a loss of core capacities for self-regulation and interpersonal relatedness. Children exposed to complex trauma often experience lifelong problems that place them at risk for additional trauma exposure and other difficulties, including psychiatric and addictive disorders, chronic medical illness, and legal, vocational, and family problems. These difficulties may extend from childhood through adolescence and into adulthood.

The diagnosis of posttraumatic stress disorder (PTSD) does not cap-



ture the full range of developmental difficulties that traumatized children experience. Children exposed to maltreatment, family violence, or loss of their caregivers often meet diagnostic criteria for depression, attention-deficit/hyperactivity disorder (ADHD), oppositional defiant disorder (ODD), conduct disorder, anxiety disorders, eating disorders, sleep disorders, communication disorders, separation anxiety disorder, and/or reactive attachment disorder. Yet each of these diagnoses captures only a limited aspect of the traumatized child's complex self-regulatory and relational difficulties. A more comprehensive view of the impact of complex trauma

can be gained by examining trauma's impact on a child's growth and development.

## Impact on Development

A comprehensive review of the literature suggests seven primary domains of impairment observed in children exposed to complex trauma. Each of the seven domains is discussed below.

### *Attachment*

Complex trauma is most likely to develop if an infant or child is exposed to danger that is unpredictable or uncontrollable, because the child's body must devote resources that are normally dedicated to growth and development instead to survival. The greatest source of danger and unpredictability is the absence of a caregiver who reliably and responsively protects and nurtures the child. The early caregiving relationship provides the primary context within which children learn about themselves, their emotions, and their relationships with others. A secure attachment supports a child's development in many essential areas, including his capacity for regulating physical and emotional states, his sense of safety (without which he will be reluctant to explore his environment), his early knowledge of how to exert an influence on the world, and his early capacity for communication.

When the child-caregiver relationship is the source of trauma, the at-

tachment relationship is severely compromised. Caregiving that is erratic, rejecting, hostile, or abusive leaves a child feeling helpless and abandoned. In order to cope, the child attempts to exert some control, often by disconnecting from social relationships or by acting coercively towards others. Children exposed to unpredictable violence or repeated abandonment often learn to cope with threatening events and emotions by restricting their processing of what is happening around them. As a result, when they confront challenging situations, they cannot formulate a coherent, organized response. These children often have great difficulty regulating their emotions, managing stress, developing concern for others, and using language to solve problems. Over the long term, the child is placed at high risk for ongoing physical and social difficulties due to:

1. Increased susceptibility to stress (e.g., difficulty focusing attention and controlling arousal),
2. Inability to regulate emotions without outside help or support (e.g., feeling and acting overwhelmed by intense emotions), and
3. Inappropriate help-seeking (e.g., excessive help-seeking and dependency or social isolation and disengagement).

### *Biology*

Toddlers or preschool-aged children with complex trauma histories are at risk for failing to develop brain capacities necessary for regulating emotions in response to stress. Trauma interferes with the integration of left and right hemisphere brain functioning, such that a child cannot access rational thought in the face of overwhelming emotion. Abused and neglected children are then prone to react with extreme helplessness, confusion, withdrawal, or rage when stressed.

In middle childhood and adolescence, the most rapidly developing brain areas are those that are crucial for success in forming interpersonal relationships and solving problems. Traumatic stressors or deficits in self-regulatory abilities impede this development, and can lead to difficulties in

emotional regulation, behavior, consciousness, cognition, and identity formation.

It is important to note that supportive and sustaining relationships with adults—or, for adolescents, with peers—can protect children and adolescents from many of the consequences of traumatic stress. When interpersonal support is available, and when stressors are predictable, escapable, or controllable, children and adolescents can become highly resilient in the face of stress.

### *Affect Regulation*

Exposure to complex trauma can lead to severe problems with affect regulation. Affect regulation begins with the accurate identification of internal emotional experiences. This requires the ability to differentiate among states of arousal, interpret these states, and apply appropriate labels (e.g. “happy,” “frightened”). When children are provided with inconsistent models of affect and behavior (e.g., a smiling expression paired with rejecting behavior) or with inconsistent responses to affective display (e.g., child distress is met inconsistently with anger, rejection, nurturance, or neutrality), no coherent framework is provided through which to interpret experience.

Following the identification of an

abuse).

The existence of a strong relationship between early childhood trauma and subsequent depression is well-established. Recent twin studies, considered one of the highest forms of clinical scientific evidence because they can control for genetic and family factors, have conclusively documented that early childhood trauma, especially sexual abuse, dramatically increases risk for major depression, as well as many other negative outcomes. Not only does childhood trauma appear to increase the risk for major depression, it also appears to predispose toward earlier onset of depression, as well as longer duration, and poorer response to standard treatments.

### *Dissociation*

Dissociation is one of the key features of complex trauma in children. In essence, dissociation is the failure to take in or integrate information and experiences. Thus, thoughts and emotions are disconnected, physical sensations are outside conscious awareness, and repetitive behavior takes place without conscious choice, planning, or self-awareness. Although dissociation begins as a protective mechanism in the face of overwhelming trauma, it can develop into a problematic disorder. Chronic trauma exposure may

*The early caregiving relationship provides the primary context within which children learn about themselves, their emotions, and their relationships with others.*

emotional state, a child must be able to express emotions safely and to adjust or regulate internal experience. Complexly traumatized children show impairment in both of these skills. Because they have difficulty in both self-regulating and self-soothing, these children may display dissociation, chronic numbing of emotional experience, dysphoria and avoidance of emotional situations (including positive experiences), and maladaptive coping strategies (e.g., substance

lead to an over-reliance on dissociation as a coping mechanism that, in turn, can exacerbate difficulties with behavioral management, affect regulation, and self-concept.

### *Behavioral Regulation*

Complex childhood trauma is associated with both under-controlled and over-controlled behavior patterns. As early as the second year of life, abused children may demonstrate rig-

idly controlled behavior patterns, including compulsive compliance with adult requests, resistance to changes in routine, inflexible bathroom rituals, and rigid control of food intake. Childhood victimization also has been shown to be associated with the development of aggressive behavior and oppositional defiant disorder.

An alternative way of understanding the behavioral patterns of chronically traumatized children is that they represent children's defensive adaptations to overwhelming stress. Children may reenact behavioral aspects of their trauma (e.g., through aggression, or self-injurious or sexualized behaviors) as automatic behavioral reactions to trauma reminders or as attempts to gain mastery or control over their experiences. In the absence of more advanced coping strategies, traumatized children may use drugs or alcohol in order to avoid experiencing intolerable levels of emotional arousal. Similarly, in the absence of knowledge of how to form healthy interpersonal relationships, sexually abused children may engage in sexual behaviors in order to achieve acceptance and intimacy.

### *Cognition*

Prospective studies have shown that children of abusive and neglectful parents demonstrate impaired cognitive functioning by late infancy when compared with nonabused children. The sensory and emotional deprivation associated with neglect appears to be particularly detrimental to cognitive development; neglected infants and toddlers demonstrate delays in expressive and receptive language development, as well as deficits in overall IQ. By early childhood, maltreated children demonstrate less flexibility and creativity in problem-solving tasks than same-age peers. Children and adolescents with a diagnosis of PTSD secondary to abuse or witnessing violence demonstrate deficits in attention, abstract reasoning, and problem solving.

By early elementary school, maltreated children are more frequently referred for special education services. A history of maltreatment is asso-

ciated with lower grades and poorer scores on standardized tests and other indices of academic achievement. Maltreated children have three times the dropout rate of the general population. These findings have been demonstrated across a variety of trauma exposures (e.g., physical abuse, sexual abuse, neglect, and exposure to domestic violence) and cannot be accounted for by the effects of other psychosocial stressors such as poverty.



### *Self-Concept*

The early caregiver relationship has a profound effect on a child's development of a coherent sense of self. Responsive, sensitive caretaking and positive early life experiences allow a child to develop a model of self as generally worthy and competent. In contrast, repetitive experiences of harm and/or rejection by significant others and the associated failure to develop age-appropriate competencies are likely to lead to a sense of self as ineffective, helpless, deficient, and unlovable. Children who perceive themselves as powerless or incompetent and who expect others to reject and despise them are more likely to blame themselves for negative experiences and have problems eliciting and responding to social support.

By 18 months, maltreated toddlers already are more likely to respond to self-recognition with neutral or

negative affect than nontraumatized children. In preschool, traumatized children are more resistant to talking about internal states, particularly those they perceive as negative. Traumatized children have problems estimating their own competence. Early exaggerations of competence in preschool shift to significantly lowered estimates of self-competence by late elementary school. By adulthood, they tend to suffer from a high degree of self-blame.

### *Family Context*

The family, particularly the child's mother, plays a crucial role in determining how the child adapts to experiencing trauma. In the aftermath of trauma, family support and parents' emotional functioning strongly mitigate the development of PTSD symptoms and enhance a child's capacity to resolve the symptoms.

There are three main elements in caregivers' supportive responses to their children's trauma:

1. Believing and validating the child's experience,
2. Tolerating the child's affect, and
3. Managing the caregiver's own emotional response.

When a caregiver denies the child's experiences, the child is forced to act as if the trauma did not occur. The child also learns she cannot trust the primary caregiver and does not learn to use language to deal with adversity. It is important to note that it is not caregiver distress per se that is necessarily detrimental to the child. Instead, when the caregiver's distress overrides or diverts attention away from the needs of the child, the child may be adversely affected. Children may respond to their caregiver's distress by avoiding or suppressing their own feelings or behaviors, by avoiding the caregiver altogether, or by becoming "parentified" and attempting to reduce the distress of the caregiver.

Caregivers who have had impaired relationships with attachment figures in their own lives are especially vulnerable to problems in raising their own children. Caregivers with histories of childhood complex trauma

may avoid experiencing their own emotions, which may make it difficult for them to respond appropriately to their child's emotional state. Parents and guardians may see a child's behavioral responses to trauma as a personal threat or provocation, rather than as a reenactment of what happened to the child or a behavioral representation of what the child cannot express verbally. The victimized child's simultaneous need for and fear of closeness also can trigger a caregiver's own memories of loss, rejection, or abuse, and thus diminish parenting abilities.

### Ethnocultural Issues

Children's risk of exposure to complex trauma, as well as child and family responses to exposure, can also be affected by where they live and by their ethnocultural heritage and traditions. For example, war and genocide are prevalent in some parts of the world, and inner cities are frequently plagued with high levels of violence and racial tension. Children, parents, teachers, religious leaders, and the media from different cultural, national, linguistic, spiritual, and ethnic backgrounds define key trauma-related constructs in many different ways and with different expressions. For example, flashbacks may be "visions," hyperarousal may be "un ataque de nervios," and dissociation may be "spirit possession." These factors become important when considering how to treat the child.

### Resilience Factors

While exposure to complex trauma has a potentially devastating impact on the developing child, there is also the possibility that a victimized child may function well in certain domains while exhibiting distress in others. Areas of competence also can shift as children are faced with new stressors and developmental challenges. Several factors have been shown to be linked to children's resilience in the face of stress: positive attachment and connections to emotionally supportive and competent adults within the family or community, development of cognitive and self-regulation abilities, and positive beliefs about oneself and

motivation to act effectively in one's environment. Additional individual factors associated with resilience include an easygoing disposition, positive temperament, and sociable demeanor; internal locus of control and external attributions for blame; effective coping strategies; a high degree of mastery and autonomy; special talents; creativity; and spirituality.

The greatest threats to resilience appear to follow the breakdown of protective systems. This results in damage to brain development and associated cognitive and self-regulatory capacities, compromised caregiver-child relationships, and loss of motivation to interact with one's environment.

### Assessment and Treatment

Regardless of the type of trauma that leads to a referral for services, the first step in care is a comprehensive assessment. A comprehensive assessment of complex trauma includes information from a number of sources, including the child's or adolescent's own disclosures, collateral reports from caregivers and other providers, the therapist's observations, and standardized assessment measures that have been completed by the child, caregiver, and, if possible, by the child's teacher. Assessments should be culturally sensitive and language-appropriate. Court evaluations, where required, must be conducted in a forensically sound and clinically rigorous manner.

The National Child Traumatic Stress Network is a partnership of organizations and individuals committed to raising the standard of care for traumatized children nationwide. The Complex Trauma Workgroup of the National Child Traumatic Stress Network has identified six core components of complex trauma intervention:

1. *Safety*: Creating a home, school, and community environment in which the child feels safe and cared for.

2. *Self-regulation*: Enhancing a child's capacity to modulate arousal and restore equilibrium following dysregulation of affect, behavior, physiology, cognition, interpersonal relatedness and self-attribution.

3. *Self-reflective information processing*: Helping the child construct self-narratives, reflect on past and present experience, and develop skills in planning and decision making.

4. *Traumatic experiences integration*: Enabling the child to transform or resolve traumatic reminders and memories using such therapeutic strategies as meaning-making, traumatic memory containment or processing, remembrance and mourning of the traumatic loss, symptom management and development of coping skills, and cultivation of present-oriented thinking and behavior.

5. *Relational engagement*: Teaching the child to form appropriate attachments and to apply this knowledge to current interpersonal relationships, including the therapeutic alliance, with emphasis on development of such critical interpersonal skills as assertiveness, cooperation, perspective-taking, boundaries and limit-setting, reciprocity, social em-



pathy, and the capacity for physical and emotional intimacy.

6. *Positive affect enhancement*: Enhancing a child's sense of self-worth, esteem and positive self-appraisal through the cultivation of personal creativity, imagination, future orientation, achievement, competence, mastery-seeking, community-building and the capacity to experience pleasure.

In light of the many individual and contextual differences in the lives of children and adolescents affected by complex trauma, good treatment requires the flexible adaptation of treatment strategies in response to such factors as patient age and developmental stage, gender, culture and ethnicity, socioeconomic status, and religious or community affiliation. However, in general, it is recommended that treatment proceed through a series of phases that focus on different goals. This can help avoid overloading children—who may well already have cognitive difficulties—with too much information at one time. A phase-based approach begins with a focus on providing safety, typically followed by teaching self-regulation. As children's capacity to identify, modulate and express their emotions stabilizes, treatment focus increasingly incorporates self-reflective information processing, relational engagement, and positive affect enhancement. These addition-

al components play a critical role in helping children to develop in positive, healthy ways, and to avoid future trauma and victimization.

While it may be beneficial for some children affected by complex trauma to process their traumatic memories, this typically can only be successfully undertaken after a substantial period of stabilization in which internal and external resources have been established. Notably, several of the leading interventions for child complex trauma do not include revisiting traumatic memories but instead foster integration of traumatic experiences through a focus on recognizing and coping with present triggers within a trauma framework.

Best practice with this population typically involves adoption of a systems approach to intervention, which might involve working with child protective services, the court system, the schools, and social service agencies. Finally, there is a consensus that interventions should build strengths as well as reduce symptoms. In this way, treatment for children and adolescents also serves to protect against poor outcomes in adulthood.

#### References

This article has been adapted from the following sources:  
Cook, A., Spinazzola, J., Ford, J.,

Lanktree, C., Blaustein, M.; Cloitre, M., DeRosa, R., Hubbard, R., Kagan, R., Liataud, J., Mallah, K., Olafson, E., & van der Kolk, B. (2005). Complex trauma in children and adolescents. *Psychiatric Annals*, 35, 390-398.

Cook, A., Blaustein, M., Spinazzola, J., & van der Kolk, B. (Eds.). *Complex trauma in children and adolescents*. National Child Traumatic Stress Network. [www.nctsnct.org/nav.do?pid=typ\\_ct](http://www.nctsnct.org/nav.do?pid=typ_ct)

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## A Real Mother's Embrace: Reflections on Abuse and Recovery

A warm breeze gently blew across my face as I was swinging on my porch, thinking of the visit I was about to endure. I had to face the same uncomfortable wait for my caseworker every Tuesday. Just thinking about what was to come made my eyes feel fuzzy and my head spin as fast as a tornado. I closed my eyes and tried to make that feeling go away, but fear of my biological mother just made the spinning faster. At that moment the front door swung open and my foster mom appeared. She gave me a toothy grin as she walked towards me and asked if the spot next to me on the swing was taken.

"No."

"Well, I think I'll sit down next to ya', good lookin'." With these words she sat down beside me, swinging her arm around my shoulder. We sat there in silence together for about five minutes, although a day's worth of thoughts passed through my mind. Why did I have to go see the person who had made me fear almost all women for the first six years of my life?

I saw the car coming from about a block away. The sun was shining brightly off the silver paint. In my mind the car was coming towards us very slowly, like a hearse carrying someone's remembered relative and friend. I felt very alone, and very much like I might soon be the person in the back of the hearse.

The car finally arrived, pulling up into the long drive and honking while the driver waved enthusiastically at us through the window. I gave a fake smile and waved back, slowly getting up. I liked my caseworker, who



by then I simply called Aunt K, but I would be lying if I said that I enjoyed seeing her on those terrible Tuesdays. She opened her car door, and walked up the six concrete steps before stepping onto the light blue wood of the porch that creaked and moaned even under the petite frame of Aunt K.

"Hello sweetheart, how are you doing today? Are you a little uneasy about having to see Mama Cathie for the last time?" I was excited that this would be the last time I would ever see my bio-mom Mama Cathie, but very nervous about having to see her at all.

"Yes, but I don't want to go." I said this in a very meek voice, and then looked down as I smoothed my blonde hair out with my left hand. As I stood there, water began to swell in my eyes.

My foster mom brought her mouth close to my ear, and said, "Sweetie, I will be right here waiting for you when you get back." She accompanied these calming words with an embrace that was bursting with love. After my foster mom released me, Aunt K took hold of my hand and led me from the porch, away from my soon-to-be-legal family, and to the passen-

ger side of her car.

"I love you Aaron. I will be standing right here when you get back." My foster mother said these words as I lowered myself into the form-fitting seat. As we began to back out of the driveway I gave my soon-to-be adopted mom a last glance, and an emotion swelled inside of me the likes of which I had never before known. I did not want to leave my foster mom. I pushed the foreign feeling to the back of my thoughts, focusing instead on rolling the window up and

down as many times as were possible in one minute. A block away from the only true home I had ever known, I quickly looked out the back window hoping I would get to see my foster mom just one last time.

The ride to my biological mother's apartment was quiet. I stared non-stop out the window at nothing in particular. Honestly, I only remember seeing one sight, and that is a little boy about two or three riding his tricycle while his mother stood watching and smiling. I felt anger towards the little boy that he had a mom and I might never know what having a real mom would feel like.

I do not really remember the car pulling into the building parking lot, or the walk into the building, up the stairs and to the door with the number five hanging from a nail. What I do remember is the look on the face of my bio-mom as she gazed through me.

Her exceptionally plump face was framed with her stringy strawberry blonde hair. Her already tight mouth was now a hardly visible line above her four chins. Her usually very pale complexion was a beautiful shade of

scarlet, and her eyes scanned me with a lack of interest.

“How many times have I told you to call me before you come!?! You know I never remember these visits, and I just called your aunt to come take me to get some fast food. Now I have to call her back and tell her to forget about picking me up for an hour!” My bio-mom roared these words at Aunt K, who kept a pleasant smile on her face until Mama Cathie was done with her tantrum.

“Cathie, we have these visits the same time every Tuesday, and the fact that you can never remember is exactly why this is the last time you will ever have with your son.” Aunt K was a woman with a big and very powerful heart, which oftentimes made her forget about what she should and should not say.

“I am sorry Cathie, but you should know better than to say something like that in front of Aaron.” For the first time my bio-mom actually looked at me.

“That is right, this is the last time I will get to see him, isn’t it? Well, might as well get this going.” She said this in a very different tone from her previous comment, a tone lacking any emotion.

Mama Cathie stepped aside and allowed us to come into her very untidy apartment. There were boxes everywhere. This apartment was her fifth in about a year, and quite noticeably she was about to make the change to number six. The odor of cleaning solutions and air freshener made this more obvious, since Mama Cathie’s apartment usually smelled musty with a lingering trace of french-fries.

Mama Cathie planted herself on her stained loveseat. Aunt K took her usual spot in an antique rocking chair positioned in a corner so that she was out of sight but not out of ear-shot. I sat myself on the floor in front of the loveseat and began playing with a frayed string of carpeting.

“I think the reason I forget about these visits is because they are so boring. I need to call my sister. Aaron, bring me the phone!” I slumped myself onto my feet, and retrieved and handed the phone to Mama Cathie.

“May I please use the bathroom?”

Mama Cathie huffed as she said, “I suppose, but don’ make a mess,

I just got the thing clean.” I quickly walked to the bathroom, and shutting the door behind me allowed my six year-old heart to release the emotions that had been swelling inside of me. The tears streaked down my face, some going down my nose, others dripping into my silently sobbing mouth. I stood there quietly, with the only sound to be heard the constant running of water in the broken sink. My face was burning, especially the scar on the bridge of my nose where Mama Cathie had once hammered in a nail as a punishment. I had similar

greeted by my mom and dad. My dad put his hand on my head, and messed up my hair. I gave my mom a hug, and she held me tight. As we stood there, the unknown emotion finally gave me a name—love. In that split second, my young heart began to let go of the pain. I now allowed myself to feel what a real family felt like. I finally allowed myself to let in the love they had been trying to give me. My mom squeezed me harder as the tears poured down my face and my body trembled. In that embrace, I let myself have my real mom.

*I wanted my bio-mom to love me, but I also wanted her to never want to see me again.*

scars all over my body, but this one was different. This scar becomes deep red whenever I am very sad or angry. At that moment I had no idea of what I felt. I wanted my bio-mom to love me, but I also wanted her to never want to see me again. I sat down on the toilet lid, and tried to make the drops stop from streaming over my face. At last, I dried my face with the newly washed but vomit-stained yellow hand towel. I flushed the toilet, walked out of the bathroom and down the sparsely lit hallway, and found myself again face to face with Mama Cathie.

Mama Cathie stayed on the couch as Aunt K and I walked out the door. We said goodbye the way two people do who have just met, but will never see one another again. I was finally free of those terrible Tuesdays.

The ride to my foster home was a long one. I was anxious to see my only real family. The emotion that I had felt before leaving my home was very strong now. My heart was beating a little faster than usual, and all I could think of was needing someone to squeeze.

We finally pulled up into my driveway and there she was, exactly where she said she would be standing. Next to my mother was my father, both smiling at me as I emerged from the car. My two brothers came running from around the house, and greeted me with an atomic wedgie. I walked up the six concrete steps, and was

Tragedy and trauma walk hand-in-hand in the lives of so many youth today, particularly those who are involved in the child welfare system. A pressing question is how to help a young person overcome that trauma and lead a successful and happy life. That answer is as varied as the forms of trauma the youth must face. All people have some form of trauma in their lives: No single person is immune to tragedy. The challenge in life is overcoming the tragedy and facing the trauma in a way that allows us to resolve the conflict within ourselves. Here are some of the ways that I was able to overcome the tragedy that I faced so early in my life, and more importantly, the ways that other people helped me to face and overcome the trauma.

The first event that allowed me to have a chance was when my biological mother saved me from an even more abusive situation than I had to endure when living with her. After I was removed from my mother’s care, I was sent to stay with her parents in Montana. That soon escalated into a very volatile placement. I was beaten every day in addition to being sexually molested by my grandfather. My biological sisters learned these behaviors and soon started to physically abuse me as well. My biological mother came to visit and, realizing the severity of the situation, had my sisters and me removed. The woman who tormented me in one form or an-

other for much of my childhood was also the woman who gave me my first real chance at hope.

The second string of events that helped me have a fighting chance was being accepted into a very loving family, and the court's decision to look for adoption to be my permanency rather than reunification. The story above details my internal struggle to find a real mom and family, but the true reason I was able to let in my new family's love was the support that they had set up around me. Having a stable and reliable support system is absolutely a necessity for any child and especially for a child with a traumatic history.

The first of those supports was simple but very effective. I always got into trouble when I had the time to think of a way to cause mischief, so my parents got me heavily involved in sports and other activities. I played soccer, football, baseball, basketball; I wrestled, and was in Cub Scouts. When I became a little older I realized the importance of staying busy and with the backing of my parents I began to volunteer and try to give back to the system that had given me a second chance.

Another support that my parents found for me was a therapist. Carol was her name, and she was one of the biggest influences in my life. She was the one who started having me write down or draw my feelings. I had a terrible temper as a child, and I would fight for no reason in school. Carol helped me not only to recognize what made me angry, but also to identify why I was angry. She was one of the first to make me face my past trauma and realize that the pain did not define me. I saw Carol for several periods over the years. At first, she helped me deal with the adoption and the feelings that those terrible Tuesdays would stir. Then she helped me to overcome my anger and violent outbursts. The last times I saw Carol were when I was fourteen and fifteen. I started to have flashbacks of the abuse and neglect I endured as a toddler. Even before the flashbacks I remembered events from when I was just barely two. I would always have the memory of making my grandfather angry, but the memory always stopped when he would grab me.

When the flashbacks started they were more like continuations of those memories. I started to remember the room my grandfather would use to beat me; to remember my sisters spinning me by my hair until chunks would rip out. When I went to live with my parents at the age of three, I had several bald spots on my head, and my hair was partially stained red from all the blood. Carol gave me the insight into my own emotions that allowed me to break down the feelings



and deal with the specific emotions associated with the memories. This skill is one that I use today.

Possibly the most important aspect of what made my situation a success was the fact that my adopted parents were so supportive and consistent in my life. Rick and Cheryl Weaver did not back down from any challenge I would throw their way. I tested those expectations every day and in the most extreme ways I could think up. They were consistent with what the expectations they had of me were and even more consistent with the punishments when I did not follow those expectations.

My parents also pushed me every day to be a better person, whether by signing me up for sports at an early age or making me sit down and fill out applications for volunteer and leadership positions when I would have rather been out playing football. They always had my best intentions in mind. They were great models for me to learn from about being a responsible and caring adult. I am the

person I am today because of their guidance, acceptance, and love.

None of these traits my parents instilled in me would have been helpful had my parents ever given up on me. One of the most detrimental parts of foster care is the way that children are passed around. A young person does not know where they fit in or who they are, and without a stable home this often leads to more serious problems. My parents made a commitment to me the minute I became their foster child to provide for me what every young person deserves.

Another part of the healing process for me was being allowed to just be a kid. I knew abuse and hate when I was placed into foster care and had no idea that a hug could feel so right. In my grandparents' home I would be beaten for being too loud or for not sitting completely still. The first time I played with my adopted brothers they screamed and yelled and fell down all over. I expected at any minute someone would come running in and beat them severely. The longer that did not happen the more fun I started to have and before I knew what I was doing I was also screaming and jumping around.

The most important factor that I have detailed about how to overcome trauma is that I had help. I would not have been able to do any healing on my own and thus I would have become a negative statistic about foster care and adoption. The more supports we have around youth and the more outlets the youth have, the better their chances for being successful. Internally I had to make the decision to let people help me, and that decision took time and patience on everyone's part. Looking at my life now I understand the worth every child has and the potential that could be unlocked just with a little understanding and patience, and a whole lot of caring. I now try to make a difference every day in a life, and I would not have that opportunity had I not had the support and love I needed.

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*Aaron Weaver* is guest editor of this issue of *Focal Point*.

# Evidence-Based Treatment for Children in Child Welfare

Many children in the child welfare system exhibit behaviors or social competency problems warranting mental health care. Studies of children in foster care suggest at least 50% meet criteria for a mental health diagnosis. Often, these difficulties are related to trauma they have experienced. This paper presents a review of the research evidence for trauma-focused interventions for children and adolescents. The goal is to provide guidance about effective strategies for addressing emotional and behavioral problems associated with trauma.

Children with posttraumatic stress disorder (PTSD) or symptoms related to trauma often exhibit other mental health disorders as well. Although interventions for these other disorders are not addressed in this review, trauma-affected children and adolescents may also need diagnosis-specific treatment for co-occurring conditions such as attention deficit hyperactivity disorder (ADHD) and depression. They may also require intensive home- and community-based services (e.g., wraparound, therapeutic foster care, Multisystemic Therapy) for persisting difficulties.

## Evidence-Based Treatments for Child Trauma

In the last decade, a number of organizations have created lists of “evidence-based” practices for treating children and youth who experience emotional and behavioral difficulties.



However, the standards required for a treatment to be “evidence-based” vary from list to list. This proliferation of standards and lists of evidence-based practices may have created confusion around how to determine what is effective for children and youth with emotional and behavioral problems. For this review, our goal was to highlight treatments that have been evaluated according to the criteria proposed by the Division of Clinical Psychology of the American Psychological Association.<sup>12,4</sup>

Four reviews of treatment for child abuse and neglect, completed in the last three years, provide the basis for this paper.<sup>13,10,2,3</sup> These reviews rated the extent to which interventions meet criteria that have been deemed essential for a treatment to be labelled as an “evidence based practice.” Essential criteria include use of a treatment manual, positive findings from at least two rigorous studies, evidence of long-term outcomes beyond treatment termination, and use of standardized therapist training and adherence monitoring.

Two of the four reviews aimed

to identify the leading treatment candidates with the most controlled research, while the other two aimed to review the evidence for some of the most commonly provided treatments for child trauma. Our goal was to determine where these reviews converged to identify some exemplary candidates for treatment dissemination. Seven treatment models

emerged as the most-supported interventions for children with histories of trauma. All are evidence-based, meeting criteria for either “well-established” or “probably efficacious” (see Table 1). Each treatment model is described briefly below.

### *Trauma Focused Cognitive Behavior Therapy (TF-CBT)*

TF-CBT<sup>5</sup> addresses behavioral and emotional symptoms as well as the negative thought patterns associated with childhood trauma. Treatment is targeted at both the parent and the child. For example, the therapist teaches the child how to regulate his or her emotions stemming from the trauma, and how to cope when experiencing reminders of the trauma. Parents are taught how to encourage these skills in the child. In joint sessions, parents and their children practice these skills with live feedback from the therapist. A PTSD diagnosis is not necessary; TF-CBT treatment is appropriate for any child who exhibits behavioral or emotional problems related to past trauma, such as nightmares, clinging

to caregivers, or an increased startle response to loud or unusual noises. The model is clinic-based and short-term (12-16 weeks). In randomized trials TF-CBT has been linked to improvements in PTSD symptoms, depression, anxiety, behavioral problems, and feelings of shame and mistrust. Moreover, these improvements have been maintained for a year following treatment completion. When parents are also involved in TF-CBT, the positive effects for children increase. This occurs through improvement of parental depression, increased support of the child, decreased emotional distress about the child's abuse, and more effective parenting practices.

### *TF-CBT for Childhood Traumatic Grief*

TF-CBT for Childhood Traumatic Grief,<sup>1</sup> a revised form of TF-CBT, is designed specifically to help children suffering from traumatic grief after experiencing the loss of a loved one in traumatic circumstances. These children often have PTSD symptoms that prevent them from successfully grieving their loss. The therapy model is calibrated for two age groups: children up to six years old, and children and adolescents over age six. Treatment is provided to both child and caregiver (together and alone) over 12-16 sessions, focused at first on trauma and then on grief. The treatment pays special attention to cognitive, behavioral, and physiological reactions to the combination of trauma and bereavement, most notably sadness and fear. The components of the model are similar to those for TF-CBT, but with added focus on fear and sadness resulting from bereavement. The evidence base for TF-CBT for Childhood Traumatic Grief is emerging because the treatment is relatively new. Two studies have linked specific components of treatment to targeted changes in symptoms over time.

### *Abuse-Focused Cognitive Behavior Therapy (AF-CBT)*

AF-CBT<sup>10</sup> is delivered in an outpatient

setting to physically abusive parents and their school-age children. Treatment is brief (12-18 hours) and can be applied in the clinic or the home. The model incorporates aspects of learning/behavioral theory, family systems, and cognitive therapy. Individual child and parent characteristics, as well as the larger family context, are targeted. AF-CBT addressed both the risks for abuse in the parent and the consequences of abuse in the child. For example, the therapist may work with the parent on relaxation training and anger management, while discouraging aggressive behavior in the child and teaching positive social



### *Cognitive Behavioral Intervention for Trauma in Schools (CBITS)*

CBITS<sup>9</sup> is a group intervention intended to build coping skills for children suffering from symptoms of PTSD, depression, and anxiety related to trauma. CBITS is commonly used for children ages 10 to 15 that have experienced or directly witnessed a traumatic event, including violence. Briefly, during group sessions, children express their

interaction skills. Experimental studies suggest that AF-CBT can decrease parental anger and use of physical discipline and force.

### *Parent Child Interaction Therapy (PCIT)*

PCIT<sup>8</sup> is a highly structured treatment model involving both parent and child. Originally developed by Eyberg in the 1970s for children with behavioral problems, PCIT has been adapted for physically abusive parents with children ages 4 to 12. The overarching goal of PCIT is to change negative parent-child interaction patterns. Treatment is brief (12-20 sessions) and involves live-coached sessions where the parent/caregiver learns skills while engaging in specific play with the child. The time in each session is usually divided among enhancing the relationship between the parent and child, teaching the parent how to use positive discipline tech-

niques, and working with the child to improve his or her compliance with parent directions. Specific parent and child behaviors are tracked and charted on a graph during each session, and the therapist provides feedback to the parent on his/her mastery of skills. Parents and children are given daily homework assignments to reinforce the skills learned in therapy. Experimental and quasi-experimental findings have shown that abusive parents and their children participating in PCIT reported declines in physical abuse, child behavior problems, and parental stress, as well as increased positive parent-child interactions.

feelings through drawings and group discussion. This serves as the context for building skills with guidance from the therapist. Some of the skills taught include relaxation, social problem solving, challenging upsetting thoughts, and processing traumatic memories and grief. Children are then given homework assignments to practice the skills learned in each session. Research shows that CBITS is effective, particularly in cases where trauma was more recent. Emerging findings also suggest that CBITS is effective for Latino immigrant children.

### *Child-Parent Psychotherapy for Family Violence (CPP-FV)*

CPP-FV<sup>11</sup> is an individual psychotherapy model for infants, toddlers, and preschoolers who have witnessed domestic violence or display symptoms of violence-related trauma such as PTSD, defiance, aggression, mul-

TABLE 1. WELL-ESTABLISHED\* AND PROBABLY EFFICACIOUS\*\* INTERVENTIONS FOR CHILD TRAUMA

Intervention	Age Group	Research Design	Main Findings
<i>Adapted CBT models for physical and sexual abuse (TF-CBT, AF-CBT, CBT for child traumatic grief)*</i>	4-18 years	10 randomized trials 4 quasi-experimental	<ul style="list-style-type: none"> <li>• Improvement in child PTSD, depression, anxiety, behavior problems, sexualized behaviors, and feelings of shame &amp; mistrust</li> <li>• Decreased parental PTSD, depression and emotional distress about the child's abuse</li> <li>• Decreased parent use of physical discipline and parent anger problems</li> <li>• Decreased family conflict</li> </ul>
<i>Parent-Child Interaction Therapy (PCIT)*</i>	4-12 years	1 randomized trial 4 quasi-experimental	<ul style="list-style-type: none"> <li>• Decreased parent physical abuse</li> <li>• Reduced negative parent-child interactions</li> <li>• Maintained effects at long term follow-up (3-6 years after treatment)</li> </ul>
<i>Child-Parent Psychotherapy for Family Violence*</i>	Up to 5 years	4 randomized trials	<ul style="list-style-type: none"> <li>• Decreased PTSD symptoms and behavior problems</li> <li>• Decreased maternal avoidance</li> </ul>
<i>Cognitive Behavioral Intervention for Trauma in Schools**</i>	10-15 years	1 randomized trial 1 quasi-experimental	<ul style="list-style-type: none"> <li>• Improvement in PTSD and depressive symptoms</li> <li>• Maintained improvements at 6-month follow up</li> </ul>
<i>Project 12-Ways/Safe Care for Child Neglect**</i>	Young children	4 quasi-experimental	<ul style="list-style-type: none"> <li>• Improved skills in assertiveness and home management</li> <li>• Improved job skills</li> </ul>

\*Meets criteria for "well-established" as defined by Lonigan, Elbert & Johnson, 1998. Efficacy results from at least two group-design studies in which the intervention was either superior to another intervention or equivalent to another evidence-based treatment; Treatment manuals preferred; Sample characteristics clearly specified.  
\*\*Meets criteria for "probably efficacious" as defined by Lonigan, Elbert & Johnson, 1998. Two studies showing superior results when compared to no-treatment control, or two group-design studies conducted by the same investigator; Treatment manuals preferred; Sample characteristics clearly specified.

multiple fears, and/or difficulty sleeping. The treatment incorporates aspects of psychodynamic, attachment, trauma, cognitive-behavioral, and social-learning theories. The parent and child attend therapy sessions together. The therapist targets the child-parent relationship and the individual child's functioning, helping the child to gain a sense of security and self-esteem. Typically, treatment is delivered for one hour per week for approximately 12 months. Randomized trials have shown better outcomes in areas including behavior problems, symptoms of traumatic stress, and maternal avoidance of the child for children who received CPP-FV compared to children receiving other control or comparison treatments.

#### *Project 12-Ways/Safe Care for Child Neglect*

Project 12-Ways/Safe Care<sup>6</sup> is focused on child neglect and is included in this review because neglect is a form of maltreatment that places children at risk for mental health problems. The intervention targets the various

contexts in which the child and family live, and is based on behavioral principles. Parents are taught skills in safety, bonding, and health care. The intervention often incorporates video modeling, and is used for both prevention and treatment. The evidence consists of as many as 60 program evaluations and quasi-experimental studies, showing improvement in both interpersonal (social interactions, assertion skills) and functional (job training, home management skills) domains for parents.

#### Disseminating Evidence-Based Practice

Many efforts are underway to spread evidence-based practice across the country. Some of these initiatives are being undertaken directly within child welfare/foster care service settings and therefore provide a direct application to a foster care population.

The State of Oklahoma has partnered with Mark Chaffin and his colleagues at the University of Oklahoma School of Medicine to test and

disseminate evidence-based interventions in child welfare populations and foster care settings. Their work to date has included initiatives with a strong federally-funded research component that seek to implement PCIT and Project Safe Care across the state.

The State of California recently funded the development of a clearinghouse for evidence-based practice in child welfare that is being implemented under contract by the Chadwick Center for Children and Families at Children's Hospital, San Diego. This initiative will post reviews of the evidence for interventions in numerous areas, including mental health treatment for children and adolescents involved with child welfare.

The Oregon Social Learning Center in Eugene, Oregon has recently partnered with the County of San Diego child welfare system and the Child and Adolescent Services Research Center at Children's Hospital to test a parent management training intervention for foster parents that is modeled on the principles of Multidimensional Treatment Foster Care. With funding from

the National Institutes of Mental Health, the partnership has recently completed a two-phase study of the model's effectiveness with promising results for children in foster care.

The National Child Traumatic Stress Network, supported by the Substance Abuse and Mental Health Services Administration, is currently disseminating TF-CBT to several sites around the country. The network provides training, subsequent consultation/supervision, and manual development. As the intervention developers train local clinicians who will then become trainers, a cascading effect should be seen through greater availability of expert treatment. Use of the internet for training in areas of the country where face-to-face training is not available (or in concert with in-person training where trainers are available) will further increase access to TF-CBT.

Finally, resources are available to provide conceptual and empirical guidance about factors that require attention prior to and during dissemination initiatives. An example of one guide is *Implementation research: A synthesis of the literature*.<sup>7</sup>

## Conclusions

This article has described exemplary trauma-focused treatments, focusing on how these treatments are useful for treating the mental health difficulties typically experienced by children who are involved in child welfare systems. Research on these interventions has revealed some common characteristics of effective treatments for children who have experienced trauma. Specifically, treatment is more effective when it is brief and when parents are involved. Overall, the findings presented here are promising and give hope that children who receive evidence-based treatment for trauma can have significantly improved lives.

## References

- 1 Brown, E. J., Pearlman, M. Y., & Goodman, R. F. (2004). Facing fears and sadness: Cognitive-Behavioral Therapy for Childhood Traumatic Grief. *Harvard Review of Psychiatry*, 12, 187-197.
- 2 Chadwick Center for Children and Families. (2004). *Closing the quality chasm in child abuse treatment: Identifying and disseminating best practices*. San Diego, CA: Author. [www.chadwick-center.org/kauffman.htm](http://www.chadwick-center.org/kauffman.htm).
- 3 Chaffin, M., & Friedrich, B. (2004). Evidence-based treatments in child abuse and neglect. *Children and Youth Services Review*, 26, 1097-1113.
- 4 Chambless, D. L., & Hollon, S. D. (1998). Defining empirically supported therapies. *Journal of Consulting and Clinical Psychology*, 66, 7-18.
- 5 Cohen, J. A., Mannarino, A. P., & Deblinger, E. (2006). *Treating trauma and traumatic grief in children and adolescents*. New York: The Guilford Press.
- 6 Dubowitz, H. (1999). *Neglected children: Research, practice, and policy*. Thousand Oaks, CA: Sage.
- 7 Fixsen, D. L., Naoom, S. F., Blase, K. A., Friedman, R. M., & Wallace, F. (2005). *Implementation research: A synthesis of the literature*. Tampa, FL: The University of South Florida, National Implementation Research Network. <http://nirn.fmhi.usf.edu/resources/publications/Monograph/>.
- 8 Herschell, A., Calzada, E., Eyberg, S. M., & McNeil, C. B. (2002). Parent-Child Interaction Therapy: New directions in research. *Cognitive and Behavioral Practice*, 9, 9-16. <http://pcit.org>.
- 9 Jaycox, L. (2003). *Cognitive Behavioral Intervention for Trauma in Schools*. Sopris West Education Services, [www.sopriswest.com](http://www.sopriswest.com).
- 10 Kolko, D. J., & Swenson, C. C. (2002). *Assessing and treating physically abused children and their families: A cognitive behavioral approach*. Thousand Oaks, CA: Sage.
- 11 Lieberman, A. F., & Van Horn, P. (2004). *Don't hit my mommy! A manual for child-parent psychotherapy for young witnesses of family violence*. Washington, DC: Zero to Three Press.
- 12 Lonigan, C. J., Elbert, J. C., & Johnson, S. B. (1998). Empirically supported psychosocial interventions for children: An overview. *Journal of Clinical Child Psychology*, 27, 138-145.
- 13 Saunders, B. E., Berliner, L., & Hanson, R. F. (2002). *Child physical and sexual abuse: Guidelines for treatment*. Charleston, SC: Office for Victims of Crime.



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# Early Intervention as Prevention: Addressing Trauma in Young Children

**T**wo and one-half-year-old David was in his mother's arms as his father stabbed her. David was not injured physically, but he saw the entire event. After David's mother was stabbed, she ran into the street and hailed a passerby, who called the police. As his mother collapsed, the passerby picked up David and held him. When the police arrived, his mother was taken to the hospital. David was taken to a neighbor's home where he stayed for three hours until his grandmother could pick him up. He did not see his mother for 5 days, until she returned home from the hospital.

According to his mother, David seemed subdued when she returned home. He refused to go to his daycare program. He had trouble sleeping at night. He asked repeatedly about his mother's "boo-boos." His mother worried about the changes in his behavior, and wondered if what he saw could have a lasting effect on David. She decided to call her pediatrician, who suggested that she might talk to a therapist about her concerns. She was referred to a program that offered specialized services to preschoolers.

The story of David raises important questions about the impact of trauma on very young children. How does David understand what happened? How do we make sense of David's response to this event? How might this event affect his behavior and his relationship with his mother? How do we effectively help this mother and child? For the past five years, the Early Trauma Treatment Network, a consortium of four specialized early



childhood mental health programs around the country, has provided counseling and support to parents and children affected by domestic violence who are similar to David and his mother. This article will present an overview of the research on early childhood trauma, and what we have learned about effective intervention.

## Babies, Toddlers, and Trauma

Young children bear a disproportionate share of violence and abuse in the home. Infants and toddlers experience the highest rates of child maltreatment of any age group. Of the 1400 children who died from child abuse in 2004, 76% were under the age of four.<sup>9</sup> Domestic violence (defined here as abuse or threats of

abuse between adult partners in the home) also affects many young children. A survey of American households revealed that nearly 30% of children in this country live in homes where there is some form of intimate partner violence.<sup>7</sup> A study on police responses to domestic violence calls in five large metropolitan areas found that children under the age of six were disproportionately represented in the homes that police responded to.<sup>2</sup> Some were directly injured; others, like David, were the helpless bystanders to the violence.

## Young Age and Vulnerability

In the past 15 years, tremendous strides have been made in recognizing the vulnerability of our youngest children to trauma in the environment. Previously, it was commonly thought that young age somehow protected children: they were too young to understand, and therefore, they could not be seriously affected. However, research has shown that babies take in much more of their world than we previously thought, and the developing brain is highly responsive to the caregiving environment. This knowledge of the sensitivity of very young children to their environment and the malleability of the developing brain in the neonatal and early childhood developmental periods has increased the importance of early identification of significant childhood stressors.

The meaning of a traumatic event in the life of a child is based on the child's stage of cognitive and emo-



tional development. Two-year-old David may witness his mother being battered, and construct a meaning of the event that will be quite different from the explanation that a five- or eleven-year-old would develop. In one study of young victims of child abuse, researchers found that the most powerful predictor of the development of traumatic symptoms was not the direct abuse, but the child's perceptions of the physical safety of a caregiver.<sup>10</sup> Given this finding, David's reactions to his mother's abuse become more comprehensible. In general, young children lack the cognitive capacities to understand cause and effect; they are less able to anticipate danger or to know how to keep themselves safe, thus being particularly vulnerable to the effects of violence exposure.

A study by Davidson and Smith<sup>1</sup> reported results consistent with this view, finding that traumatic events experienced prior to age twelve are three times more likely to result in Post Traumatic Stress Disorder than such events experienced after age twelve.

### Young Children and Exposure to Violence

Child stressors fall on a continuum, ranging from short-term, tolerable or even beneficial stress, to prolonged, uncontrollable stress that is traumatic or toxic to child development. Chronic exposure to traumatic stress can produce dramatic changes in the stress response system and in extreme cases may result in the development of a smaller brain.<sup>8</sup>

In our work with young children and families, we have learned that when children are exposed to family violence, their expectations for a safe and predictable world are shattered.<sup>3</sup> Young children depend on the attachment relationship with the primary caregiver to organize what is safe and

dangerous in the environment, and when this fails, children lose their basic trust that a parent can emotionally and physically protect them. This disruption of the attachment relationship is at the core of risk for children. The strains on the attachment relationship are further exacerbated if the



parent is also traumatized. Consider David and his mother: she is a victim of abuse. Her ability to be physically and emotionally available to David may be compromised. For example, she was physically separated from him immediately after the traumatic experience, at the time when he most needed the comfort and security of his mother.

Children respond to trauma-related feelings of fear and vulnerability in a variety of ways. Often, the child is aggressive. In fact, the most frequent referral complaint voiced by parents is concern about their child's aggression, short temper, or impulsive behavior. Other children respond with increased anxiety about any separation from a parent, and with irregular sleeping and eating patterns. Children also learn early and powerful lessons about the use of violence in interpersonal relationships. Violence is an acceptable way to relieve stress and exert one's will. It can also be confused with expressions of love and intimacy.

### Interventions with Children and Parents

The Early Trauma Treatment Network uses a model of intervention, Child-Parent Psychotherapy.<sup>5</sup> Child-Parent Psychotherapy (CPP) is based on the premise that trauma-related problems in young children should be addressed within the context of the child's primary attachment relationships. For many children, this relationship is with their mothers or mothers and fathers. However, for children in foster or kinship care, there are other possibilities for an attachment relationship. The essential premise of this treatment is that the caregiver-child relationship is targeted and strengthened, thus enhancing supportive, protective and responsive parenting, and restoring the child's sense

of safety and trust in adult caretakers. CPP interventions revolve around free play with the parent and child and the therapeutic use of developmental guidance and information. The intervention also guides the caretaker and child to create a joint narrative of the traumatic experience, so that each person has a greater understanding of the experience of the other, and what was unspeakable becomes tolerable to talk about. An evaluation of this intervention has substantiated CPP's effectiveness in decreasing children's behavior problems and trauma-related symptoms. The intervention also decreased mothers' trauma-related symptoms.<sup>6</sup>

### Intervention with David and his Mother

David and his mother were seen together by a mental health clinician for 6 months. In the beginning, his mother had difficulty talking about what had happened. David also avoided all talk or reminders about what he had seen. The issue came up when David saw his mother's scars, and asked

about the “boo-boos.” The therapist had several sessions with David’s mother, alone, to talk about what she observed with her son, to discuss her own trauma, and to inquire about the possibility of talking about what had happened with David. His mother felt uncomfortable with this idea. As the therapist explored her resistance, David’s mother spoke of her remorse about what her son had witnessed. Once she explored these feelings with the therapist, she felt more able to talk about the incident with her son. The therapist facilitated this discussion with the use of puppets and dolls to act out what David had seen. As David played out his memories of the incident, it became clear that the most upsetting aspect of this event for him was the disappearance of his mother when she was taken to the hospital. David’s mother learned important information about how he had perceived the event and she was able to speak directly to him about his fear and anger at her for leaving him. At the conclusion of this intervention, David’s symptoms had decreased. Both mother and son had a deeper understanding of how this trauma affected them, and the mother was able to support David in sorting out his confused and frightened feelings.

This case provides an example of the impact of traumatic events for very young children and of the power of developmentally informed interventions that support both children and parents. With support, David’s mother was able to respond to David’s worries and fears, thereby helping him to feel protected. Both mother and child benefited from this treatment.

### Identifying Young Children Affected by Trauma

Perhaps the greatest challenge that lies ahead is to develop systems that can provide early identification of children such as David and link them with appropriate intervention. The research on the adverse effects of early child exposure to violence creates a compelling case for developing more effective identification strategies. There are a variety of screening tools, both formal and informal, to assess for child abuse. However, tools for assessing exposure to domestic violence have not been as well developed, and

screening for this type of exposure is not universally done.

Healthcare, early care/education settings, and Head Start are examples of agencies that see large numbers of young children and parents, and they offer important opportunities to screen for early trauma as well as other early childhood mental health risks. Some of these institutions have created tools for screening. For example, as part of the intake assessment at Head Start, families are asked about domestic violence and safety in the home. In pediatric and family healthcare settings, there is also a growing awareness of the importance of early identification of mental health issues in pre-schoolers. Recommendations for inquiring about family violence in pediatric and family health settings have been developed and are widely distributed.<sup>4</sup>

A greater capacity to identify young children who are affected by trauma must be met with greater resources for intervention. The first step toward increasing programmatic resources is to raise public awareness of the risks of trauma exposure for young children and the importance of investing in their early lives. We owe our youngest children this effort.

### References

- 1 Davidson, J., & Smith, R. (1990). Traumatic experiences in psychiatric outpatients. *Journal of Traumatic Stress Studies*, 3, 459-475.
- 2 Fantuzzo, J., Boruch, R., & Berriama, C. (1997). Domestic violence and children: Prevalence and risk in five major U.S. cities. *Journal of the American Academy of Child and Adolescent Psychiatry*, 36, 116-122.
- 3 Groves, B. (2002). *Children who see too much: Lessons from the Child Witness to Violence Project*. Boston: Beacon Press.
- 4 Groves, B., Augustyn, M., Lee, D., & Sawires, P. (2002). *Consensus recommendations for pediatric and adolescent health settings*. San Francisco: Family Violence Prevention Fund.
- 5 Lieberman, A., & Van Horn, P. (2005). *Don't hit my mommy! A manual for child-parent psychotherapy with young*

*witnesses of family violence*. Washington, DC: Zero to Three Press.

6 Lieberman, A. F., Van Horn, P., & Ghosh-Ippen, C. (2005). Toward evidence-based treatment: Child-parent psychotherapy with preschoolers exposed to marital violence. *Journal of the American Academy of Child and Adolescent Psychiatry*, 44, 1241-1248.

7 McDonald, R., Jouriles, E., Ramisetty-Mikler, S., Caetano, R., & Green, C. (2006). Estimating the number of American children living in partner violent households. *Journal of Family Psychology*, 30, 137-142.

8 National Scientific Council on the Developing Child. (2005). *Excessive stress disrupts the architecture of the brain*. Working Paper #3. www.developingchild.net/reports.shtml.

9 Palusci, V. J., Smith, E. G., & Panneth, N. (2005). Predicting and responding to physical abuse in young children using NCANDS. *Children and Youth Services Review*, 27, 667-682.

10 Scheeringa, M. S., & Zeanah, C. H. (1995). Symptom expression and trauma variables in children under 48 months of age. *Infant Mental Health Journal*, 16, 259-269.

### Author

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## Adapting Evidence-Based Treatments for Use with American Indian and Native Alaskan Children and Youth

It is impossible to capture or explain the nature and extent of assaults experienced by American Indians and Alaskan Native (AI/AN) families. AI/AN communities experience a disproportionate number of events that put them at risk for trauma reactions. Often, these contemporary disruptions have roots in the historical past.

According to the National Childhood Traumatic Stress Network (NCTSN), trauma is a unique individual experience associated with a traumatic event or enduring conditions.<sup>7</sup> This definition is of limited usefulness within the AI/AN communities, however, since it does not take into account the cultural trauma, historical trauma, and intergenerational trauma that has accumulated in AI/AN communities through centuries of exposure to racism, warfare, violence, and catastrophic disease. Cultural trauma is an attack on the fabric of a society, affecting the essence of the community and its members. Attacks on AI/AN communities have included prohibiting the use of traditional languages, banning spiritual/healing practices, removing or relocating individuals or whole communities, and restricting access to public or sacred spaces. Historical

trauma is the cumulative exposure of traumatic events that affects an individual and continues to affect subsequent generations. Intergenerational trauma occurs when the trauma of an event is not resolved and is subsequently internalized and passed from one generation to the next through impaired parenting and lack of support in the community. These types of traumas increase individuals' risks of experiencing traumatic stressors while also decreasing their opportunities to draw on the strengths of their culture, family, or community for social and emotional support.

### Service Needs

Currently, the majority of Native people live in urban areas. Although many move from isolated and economically deprived settings to seek better living conditions, they often times have difficulty securing stable employment. Many Native people are employed in low-wage, unskilled positions and they may require assistance such as food stamps, reduced-price school lunches, and/or subsidized housing. Heads of households for the majority of Native families are women, who are not only poorly paid, but also often engaged in a

constant struggle to provide support to immediate and extended family members. The bitter reality is that a large proportion of the Native population experiences severe financial hardship, which increases stress and compounds the risk of exposure to crime and violence.

AI/AN families are also at risk for violence due to political, economic, and social inequalities. According to the Department of Justice,<sup>9</sup> the average annual violent crime rate among AI/AN people over 12 years of age is approximately 2.5 times the national rate. There is approximately one substantiated report of violent crime per year for every 30 Native children.<sup>10</sup>

Average life expectancy among AI/AN people is lower than in the non-Indian population. Given the shorter life expectancy and population growth of AI/AN persons, nearly half the AI/AN population is comprised of minors who need care, guidance, and support. The community's ability to provide these resources is compromised as the challenges of maintaining a livelihood, combating cultural genocide, coping with violence, and rebounding against emotional and spiritual bankruptcy tear at the integrity of home and culture.

Given the multiple risks present in

AI/AN communities, it is not surprising that the prevalence of post-traumatic stress disorder (PTSD) is substantially higher among AI/AN persons than in the general community (22% vs. 8%).<sup>5</sup> It is likely that higher rates of exposure to traumatic events coupled with the overarching cultural, historical, and intergenerational traumas make this population

remarkable resilience. Communities have retained cultural strength in kinship networks, language, stories, songs, ceremonies, and spiritual beliefs. However, to survive, many individuals have developed coping strategies that leave them ill-equipped to deal with the ongoing trauma, stress, and hardship they endure. Because of past experiences with misguided

censed professionals may be few.

The process of adaptation began with identifying the core concepts within existing EBTs. At the same time, the ICCTC worked to identify Native traditional teachings and concepts that would be relevant for trauma therapy in Indian Country. Particular focus was placed on traditions related to parenting, nurturing, and therapeutic practice. Attention was also paid to traditional ways of teaching and learning, and to cultural worldviews that are used to explain individual behavior. Using a process

*Because of past experiences with misguided programs offered by the government and social service organizations, many AI/AN people are distrustful and reluctant to consider professional mental health services.*

of ongoing and open dialogue, the ICCTC worked with EBT developers and a diverse group of Native cultural consultants to create intervention and training materials as well as implementation support strategies and protocols.

more vulnerable to PTSD. In addition, people who have traumatic experiences and develop PTSD are also at risk for several other negative mental health outcomes. Rates of substance abuse disorders and other mental health disorders, particularly depression, are also elevated among AI/AN peoples.<sup>1</sup> In short, the AI/AN population is especially susceptible to mental health difficulties.

### Honoring Children: EBT for Indian Country

Despite the hardships outlined above, Native people have shown



### *Honoring Children, Making Relatives*

An existing EBT called Parent-Child Interaction Therapy (PCIT)<sup>4</sup> was adapted into Honoring Children, Making Relatives. This intervention maintains the guiding principles and theory of PCIT while incorporating AI/AN practices, rituals, traditions, and other cultural elements.

One Native method of teaching typically moves from observation to teaching others: "Watch. Listen, as I tell you what to do. Do it this way. Now go teach your little sister." This same series of steps is a central feature in Honoring Children, Making Relatives: instruct the parents, model the behavior, let the parent practice, have the parent work directly with the child, and be sure the parent praises the child. For example, when a child demonstrates disruptive behaviors or is difficult to control, some parents may punish the child. The traditional Native concept of respect and honor, however, would dictate that the adult be patient, be instructive, not embarrass, and use the opportunity to teach. During PCIT, the parent engages the child in positive interactions, attends

to the child, lets the child know what the child is doing right, and eventually instructs the child in good behavior. Honoring Children, Making Relatives is the clinical application of parenting techniques in a traditional framework that supports the emphasis that AI/



AN culture places on honor, respect, extended family, instruction, modeling, and teachings.

### *Honoring Children, Respectful Ways*

Native youth confront many challenges that negatively impact their sense of self, their interactions with others, and their connection to their culture. Traumas of sexual abuse, physical abuse, and violence, overlaid with historical and cultural trauma, can lead young people to disregard or devalue modesty and to develop inappropriate sexual behavior. Inappropriate sexual behaviors can have wide-ranging impact on the children themselves, and can also significantly affect the family, the extended family, and the community. Ultimately, inappropriate behavior can result in serious negative social or legal consequences. Honoring Children, Respectful Ways<sup>8</sup> is designed to honor AI/AN children and promote their self-respect while also promoting respect for others, elders, and all living things.

The Honoring Children, Respectful Ways curriculum teaches young

people culturally congruent ways to honor themselves. The use of traditional healing and cultural practices encourages young people to identify with their AI/AN heritage. This treatment approach is congruent with an evidenced-based group treatment program for children with sexual behavior problems.<sup>3</sup> In addition, Honoring Children, Respectful Ways is an approach that can be implemented as a prevention or intervention treatment program that helps AI/AN children and their families to connect with their traditional values, ways, and practices, and to develop positive beliefs about themselves and healthy values and behaviors in their relationships with others.

### *Honoring Children, Honoring the Future*

The impact of youth suicide in Indian country cannot be underestimated. The resultant loss of family members reverberates throughout the community, putting other family members at risk for depression, grief reactions, poor work performance, drug and alcohol use, and domestic violence, as well as for contemplations of suicide. The American Indian Life Skills Development Curriculum (AILSDC),<sup>6</sup> the only evidence-based suicide prevention program in Indian country recognized by SAMHSA and the National Registry of Effective Programs, is the clinical component of Honoring Children, Honoring the Future. The larger intervention includes supports for case consultation, program development, and training in risk.

The AILSDC uses risk and protective factors specific to AI/AN youth as the basis for its prevention strategies. The curriculum, designed for middle- and high-school students, teaches such life skills as communication, problem solving, depression and stress management, anger regulation, and goal setting. Problem solving and suicide intervention skills are taught through activities that encourage students to seek out cultural knowledge in their communities. AILSDC curriculum is specifically tailored to be compatible with the norms, values, beliefs, and attitudes of Native communities. Special attention is paid to worldviews, communication styles,

and forms of recognition.

### *Honoring Children, Mending the Circle*

Trauma-Focused Cognitive-Behavioral Therapy (TF-CBT) is an evidence-based application of cognitive behavioral techniques to support the healing process of trauma in children. Honoring Children, Mending the Circle<sup>2</sup> is grounded in a traditional framework that supports the AI/AN traditional belief in spiritual renewal leading to healing and recovery.

The TF-CBT adaptation is based on traditional AI/AN beliefs and practices about behavior, health, healing, humor, and children. The premise is the belief that AI/AN cultures have current healing practices, activities, and ceremonies that, like cognitive-behavioral therapy, instruct individuals about how to manage thoughts, emotions, and physical reactions. For example, with trauma-exposed children, a common symptom is intrusive thoughts that create anxiety and inability to concentrate. During many traditional ceremonies and activities traditional healers instruct participants to "leave bad thoughts at the door" or "come in with good thoughts." A similar technique used in TF-CBT is the "stop sign." A child is instructed to use a stop sign image when intrusive thoughts begin.

Common reactions to trauma include physical sensations of rapid heartbeat and breathing that result in distress or discomfort. Relevant tradi-

**T**here are currently over 550 federally recognized tribes in the United States. There are 33 states with reservations nationwide. Twenty-one of the 24 states located west of the Mississippi River have at least one Indian reservation within their borders. Tribes range from two to three members in several California tribes to the Western Band of the Cherokee Nation, headquartered in Oklahoma, with over 300,000 members. Navajo Nation, located at the Four Corners region connecting Utah, Arizona, Colorado and New Mexico, has over 200,000 members.

tional instructions during ceremonial or related activities might be to "Bring yourself to this place, think about this place, close your eyes, breathe in, think about where your body is, your spirit, your connection with Mother

these sacred teachings. With Honoring Children, this prophecy has been partially fulfilled. Respect for American Indian and Alaskan Native ways of healing is being upheld.



Earth, you being okay with who you are." This kind of instruction is similar to the relaxation techniques of TF-CBT.

### Summary

The Indian Country Child Trauma Center is providing important resources to American Indian and Alaskan Native communities. Beyond the culturally-based therapeutic approaches, the Center offers training and implementation support that is also culturally based. The guiding vision is that Native children who are experiencing trauma will be able to access treatment that is structured and systematic, but also culturally responsive, promoting connection with their community, their culture, and their heritage.

There is a prophecy held sacred by Native people which foretold the coming of a different people who would bring disease and sickness to the Great Turtle Island (America). The story tells that it would be the ancient traditions and teachings of past generations that would help Native people climb up and regain their heritage as proud and rightful Nations. The Native people hold to the promise of

### References

- 1 Beals, J., Manson, S. M., Whitsell, N. R., Spicer, P., Novins, D. K., & Mitchell, C. M. (2005). Prevalence of DSM-IV disorders and attendant help-seeking in two American Indian reservation populations. *Archives of General Psychiatry* 62, 99-108.
- 2 BigFoot, D. S., & Schmidt, S. (2006). *Honoring Children, Mending the Circle (Trauma-Focused Cognitive Behavior Therapy): A training and treatment manual*. Oklahoma City, OK: University of Oklahoma Health Sciences Center, Indian Country Child Trauma Center.
- 3 Chaffin, M., Berliner, L., Block, R., Johnson, T. C., Friedrich, W., Louis, D., Lyon, T. D., Page, J., Prescott, D., & Silovsky, J. F. (2006). *Report of the ATSA Task Force on Children with Sexual Behavior Problems*. Beaverton, OR: ATSA.
- 4 Herschell, A., Calzada, E., Eyberg, S.M., & McNeil, C.B. (2002). Parent-Child Interaction Therapy: New directions in research. *Cognitive and Behavioral Practice*, 9, 9-16.

5 Kessler, R. C., Sonnega, A., Bromet, E., Hughes, M., & Nelson, C. B. (1995). Posttraumatic stress disorder in the National Comorbidity Survey. *Archives of General Psychiatry*, 52, 1048-1060.

6 LaFromboise, T. D. (1995). *American Indian Life Skills Development Curriculum*. Madison, WI: University of Wisconsin Press.

7 National Child Traumatic Stress Network. *Defining trauma and child traumatic stress*. [www.nctsnet.org/ncts/nav.do?pid=faq\\_def](http://www.nctsnet.org/ncts/nav.do?pid=faq_def).

8 Silovsky, J. F., Burris, L. J., McElroy, E., BigFoot, D. S., & Bonner, B. L. (2005). *Honoring Children, Respectful Ways (Treatment for Children with Sexual Behavior Problems): A training and treatment manual*. Oklahoma City, OK: University of Oklahoma Health Sciences Center, Indian Country Child Trauma Center.

9 U.S. Bureau of Justice Statistics. (2004). *American Indians and crime*. Washington, DC: U.S. Government Printing Office.

10 U.S. Department of Health and Human Services, Administration on Children, Youth, and Families. (2006). *Child maltreatment 2004*. Washington, DC: U.S. Government Printing Office.

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# Creating a Trauma-Informed Child Welfare System

This issue of *Focal Point* presents the story of Aaron (page 9), whose life was deeply influenced by childhood experiences of severe physical abuse, sexual abuse, and systems-induced trauma. Unfortunately, Aaron's story is typical of many abused and neglected children and adolescents who become involved with the child welfare system. Each year, there are more than 500,000 children living in out-of-home child welfare placements.<sup>6</sup> It is well established that abused and neglected children suffer from short- and long-term psychological and behavioral difficulties. Among youth in the foster care system, it is estimated that more than half experience at least one significant psychological disorder, including depression, posttraumatic stress disorder (PTSD), social phobia, panic syndrome, or drug dependence.<sup>2</sup>

The most common sources of traumatic experiences for children who become involved in the child welfare system are abuse, neglect, and domestic violence. Like Aaron, many children in the child welfare system are exposed to multiple or complex traumas. What is more, children are often further traumatized by their involvement with the child welfare



system itself. Common causes of such system-induced trauma include repeated, insensitive, or humiliating interviews; unnecessary ruptures of family, extended family, and community relationships; repeated changes of placement; confrontations with abusers; and court testimony. There is growing attention to the need to create trauma-informed child welfare systems that are more aware of and responsive to the needs of vulnerable and traumatized children.<sup>8</sup> Most recently, the National Child Traumatic Stress Network (NCTSN) has described services that are designed to

reduce the impact of trauma on the child and family as trauma-informed services.<sup>4</sup>

Many child welfare systems around the country lack the ability to respond sensitively to the specific needs of children with complex trauma issues. This article explores challenges to creating trauma-informed child welfare systems and provides recommendations for future directions in the field.

## Eight Essential Elements

As a first step in helping to create child welfare systems that are more trauma informed, the NCTSN has identified eight essential elements of trauma-informed child welfare practice.<sup>5</sup> The eight essential elements are as follows:

1. Maximize the child's sense of safety.
2. Connect children with professionals who can assist them in reducing overwhelming emotions.
3. Connect children with professionals who can help them develop a coherent understanding of their traumatic experiences.
4. Connect children with profession-

- als who can help them integrate traumatic experiences and gain mastery over their experiences.
5. Address ripple effects in the child's behavior, development, relationships, and survival strategies following a trauma.
  6. Provide support and guidance to the child's family.
  7. Coordinate services with other agencies.
  8. Ensure that caseworkers manage their own professional and personal stress.

Achieving these eight essential elements requires work at the level of individual children, the children's immediate families (including both foster parents and biological parents), and the child welfare system.

At the individual level, children's safety must be ensured, and children must be connected with services that will help them process and integrate traumatic experiences. At the family level, both foster parents and biological parents need to learn about trauma and its effects, as well as how to provide a safe and supportive environment for a traumatized child. Often, biological and foster parents also need information about what resources the system can offer to support them, including resources for increasing parenting competency.



Providing training for the biological parents is particularly important, given the focus on reunification in the child welfare system.

On a systemic level, the creation of a more trauma-informed system requires educating all child welfare staff (direct service providers, management, and foster parents) about the impact of childhood traumatic experiences and about how systems can traumatically impact a child. Training on these topics should include basic definitions of trauma, information about how children vary in their experiences of and reactions to trauma, and a discussion of cultural interpretations of traumatic events. Training should emphasize that different forms of maltreatment impact children differently and cause different symptoms. The short- and long-term impact of trauma, and the development of maladaptive coping strategies as a response to trauma, should also be discussed. Training should also emphasize the importance of performing a thorough assessment, including taking a detailed trauma history, identifying salient symptoms, and discovering trauma triggers. Child welfare workers and administrators should receive training in effectively communicating a child or family's trauma history to other professionals, foster parents, or biological parents; and in developing an intervention plan that is consistent across child-serving systems. Only after child welfare staff, foster parents, and biological parents have been trained in this manner can appropriate placements and intervention decisions be made.

Building awareness about trauma is necessary, but not sufficient, in the creation and implementation of a trauma-informed system. Caseworkers must also change their practice. They should be supported in seeking out trauma-informed mental health providers. These providers are trained to deliver established trauma treatments that are consistent with the eight essential elements in that they focus on maximizing interpersonal safety, reducing negative emotions, and helping a child integrate traumatic experiences and achieve mastery over the traumatic experience. These interventions teach children practical ways to identify and control the

## CHILD WELFARE SYSTEM TRAINING TOPICS

- *How children experience trauma*
  - *Maltreatment issues*
  - *System-induced trauma*
- *Immediate and long term impact of trauma*
- *Understanding and adequately assessing the unique trauma experience of the child*
  - *Using assessment tools*
  - *Using the trauma history*
- *Identifying trauma triggers*
- *Communicating trauma history to other professionals, including foster parents and law enforcement*
- *Continuity of Care: Developing an intervention plan that is consistent across systems*
- *Foster parent competencies*
- *Skills training for biological parents*

emotions associated with traumatic memories, typically using relaxation techniques (e.g., focused breathing or progressive muscle relaxation), techniques for controlling intrusive thoughts (e.g., "thought stopping"), and positive self-soothing activities (e.g., visualization).

Treatment strategies that address the individual child's trauma experience and incorporate evidence-based, practical interventions show promise for the future of treatment for traumatized children. For example, the Assessment-Based Treatment for Traumatized Children: A Trauma Assessment Pathway<sup>7</sup> model uses an individualized assessment process as a basis for selecting an appropriate evidence-based intervention for a child with trauma symptoms. In some cases of complex trauma, an evidence-based treatment may not be the best choice. In these cases, an individualized treatment approach should be



employed to address the most prevalent symptoms, while work continues within the larger system to meet the child's particular needs.

More generally, trauma-informed child welfare systems work to ensure that trauma-affected children and families are appropriately linked to services and resources in the community. One challenge is ensuring that trauma-affected children are appropriately identified. Child-serving agencies (including the courts, child welfare, and juvenile justice) should be made aware of their options for making referrals and be informed about how to assess whether or not a child needs a referral for trauma-specific or general mental health services. Use of a trauma assessment tool (e.g., the Child Welfare Trauma Referral Tool)<sup>3</sup> provides a structured way for caseworkers to assess a child's trauma history, the severity of the child's reactions to the trauma, and any developmental concerns. A further challenge is identifying providers who are qualified to deliver the best evidence-based services available. A coordinated response between referring agencies and treatment providers helps ensure that children and families receive the best promising and/or evidence-based treatments available. Although challenging, it is essential that child-serving agencies are informed about best practices and know who in their community provides such services. Child welfare staff can obtain a list of qualified providers by directly contacting the developers of an evidence-based practice.

### A Community Protocol

Involvement in the child welfare system can further traumatize an already vulnerable child. In this issue, Aaron's story illustrates how something as simple as asking a child to visit with his abusive mother can result in a lifetime of traumatic memories. Achieving a coordinated child welfare system response that serves to heal, rather than re-traumatize a child, requires creating a community

protocol that focuses on addressing the complex and varying needs of the individual children served. Open communication among agencies is essential. Agencies can share information and coordinate their responses for individual children via an interdisciplinary child protection team that includes representatives from a variety of child-serving agencies and meets regularly to focus on a specific child's case. Child protection teams often include social workers, law enforcement agents, district attorneys, medical doctors, and mental health counselors. The child's attorney or advocate can join these meetings to



provide a voice for the child. Working together, team members can share their various perspectives to create a plan for the child that considers his unique trauma experiences and needs.

Former foster youth, foster parents, and biological parents also have valuable perspectives to contribute to community efforts to create a child welfare system that heals rather than re-traumatizes. These consumers of child welfare services have important

information about ways to improve child welfare treatment, case management, and services. Creating opportunities and incentives to air and act upon these perspectives is a key element in creating a child welfare system that avoids further traumatization, and promotes healing for the children and families served.

Another way systems can avoid further traumatizing children is through the use of forensic interviewing, in which a child can tell her story to a trained interviewer who is experienced in sensitively obtaining the details of the abuse in a manner that is defensible in court. Other agencies can then use the forensic interview and transcripts to review the abuse details, eliminating the need for the child or parents to retell the story.

Finally, it is important to recognize the impact on a child and family if the child has to testify in court. Coordination between the agencies involved serves to minimize the stress children experience when they are called into court and helps prevent re-traumatization. The Kids and Teens in Court program in San Diego, California, brings the components of trauma-focused cognitive-behavioral therapy into a real courtroom.<sup>1</sup> Prior to appearing in court, children visit the courtroom and learn what to expect when they testify. They are also coached in anxiety reduction, cognitive coping, and relaxation techniques. The use of this practice in court preparation provides children with skills that will enhance their ability to understand the interplay of their feelings, thoughts, and behaviors; help them regulate their emotions; and increase their ability to keep themselves safe both in the courtroom and in other areas of their lives.

### Policies and Procedures

The core of trauma-informed child welfare practices is knowledge. In this type of child welfare system, staff are encouraged to stay up-to-date on current knowledge in the field of child trauma. Effective trauma-informed

policies guide the care of vulnerable and traumatized children. These policies should clearly state how the eight essential elements of a trauma-informed child welfare system are to be implemented.

Policies can be structured to ensure that traumatized children in the child welfare system are served by staff who understand their special needs. Policies should be individualized depending upon the specific clientele of the agency and available community resources. Examples of trauma-informed child welfare policies include the following:

- Immediately after entering the system, children will be assessed for the existence of trauma-related symptoms and specific interventions that would be most beneficial.
- To the extent that it is developmentally appropriate, children and adolescents will be involved in developing their case plans.
- All child welfare system staff, as well as foster and biological parents, will be trained to recognize behavioral indicators of trauma.
- Foster and biological parents will be provided with ongoing support by child welfare staff to manage children's trauma-related behaviors, thus reducing the risk of systemic trauma through disrupted placements.

### Conclusion

While it has long been clear that virtually all of the children involved in the child welfare system have suffered from one or multiple traumatic experiences, systems continue to struggle to offer an appropriate healing response. The eight essential elements provide a framework for creating a responsive, healing system. Within this framework, the perspectives of children, adolescents, and biological and foster parents can be integrated with provider and

system perspectives to identify and address the individual and systemic needs of traumatized children. The use of assessment-focused products, such as the Trauma Assessment Pathway and the Child Welfare Trauma Referral Tool, hold promise for helping to ensure that trauma-affected children are identified, and that they receive appropriate and effective trauma-informed interventions. Finally, strategies are being developed to ensure that system involvement serves to heal, rather than re-traumatize children and families. Further exploration and discussion in each of these areas is a necessary step in continuing efforts to create child welfare systems that are truly trauma-informed.

### References

1 Cohen, J. A., Mannarino, A. P., & Deblinger, E. (2006). *Treating trauma and traumatic grief in children and adolescents*. New York: Guilford Press.

2 Garland, A. F., Hough, R. L., McCabe, K., Yeh, M., Wood, P. A., & Aarons, G. A. (2001). Prevalence of

psychiatric disorders in youths across five sectors of care. *Journal of the American Academy of Child & Adolescent Psychiatry*, 40, 409-418.

3 NCTSN. (2005). *Child Welfare Trauma Referral Tool (CWT)*. National Child Traumatic Stress Network. Unpublished assessment tool.

4 NCTSN. (2006a). *Creating trauma-informed child-serving systems*. National Child Traumatic Stress Network. Unpublished manuscript.

5 NCTSN. (2006b). *Comprehensive guide: Child trauma and the child welfare system*. National Child Traumatic Stress Network. Unpublished manuscript.

6 NDAS. (2006). *National Data Analysis System*. Child Welfare League of America. <http://ndas.cwla.org>.

7 Taylor, N., Gilbert, A., Mann, G., & Ryan, B. E. (2006). *Assessment-based treatment for traumatized children: A Trauma Assessment Pathway (TAP) Model*. [www.chadwickcenter.org](http://www.chadwickcenter.org).

8 Taylor, N., Wilson, C., & Igelman, R. (2006). In pursuit of a more trauma-informed child welfare system. *APSAC Advisor*, 18, 4-9.

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## Child Trauma: The Role of Public Policy

**P**ublic policy decisions play a pivotal role in prevention, service, and treatment efforts for children who have been affected by traumatic events. An understanding of this role is a critical part of well-informed discussion of the impact of traumatic events on the health and well-being of children and families. Well-informed policy decisions can lead to better prevention efforts, more appropriate services, more effective treatments, and sufficient funding for these activities, but poor decisions can fail to help or make a bad situation worse. Ideally, policymakers are informed by a comprehensive understanding of how traumatic events impact children and families. In reality, policymakers may not have the information they need.

Child traumatic stress occurs when children are exposed to traumatic events, and when this exposure overwhelms their ability to cope with what they have experienced. Policies cannot prevent all bad things from happening to children, but they can help prevent some traumatizing events from occurring and help ensure that the necessary infrastructure is in place when events do occur and support is needed.

Good public policies must address the complexities of child trauma directly. Child trauma comes in many forms, including abuse, disaster, bereavement, violence, or war, and affects all ages, genders, cultures, and communities. Child trauma occurs, is diagnosed, and is treated in a variety of settings, including hospitals, schools, surrogate care, or family homes. Funding for services comes from multiple sources, including federal health care, private health insurance, state block grants, federal discretionary programs, and personal income. Creating effective policy in such complex contexts requires strong collaborative relationships among policy leaders, affected families, and all those who work with traumatized children.

### Policy Interventions at Multiple Levels

Repeated exposure to traumatic events can affect a child's development and greatly increase the risk of future serious health problems, even death.<sup>4</sup> Left untreated, problems can worsen, negatively affecting a child's educational, social, and mental health outcomes. Fortunately, knowledge about

how best to identify and treat traumatized children is increasing. Policy interventions can help ensure that this knowledge continues to expand, and that what is learned is mobilized effectively to improve the lives of traumatized children. Such interventions are needed at the federal, state, local community, and program/treatment level.

### *Federal*

Federal policies do address some forms of child trauma, but these efforts are piecemeal and uncoordinated. In contrast, a coordinated public health approach would work to reduce the impact of trauma across the population as a whole.<sup>6</sup> This kind of approach targets different segments of the population with different kinds of efforts focusing on prevention programs for the general public, early detection and intervention for populations at risk (including children), and treatment for those who need it. Public health programs can provide psychoeducational information to the public about what child trauma is, what signs of trouble to watch for, and where help can be sought. Such campaigns have been launched

around acute events, such as the September 11, 2001 terrorist attacks and the 2005 Gulf Coast hurricanes. Incorporating trauma information into standard public health and mental health campaigns could provide a psychoeducational “vaccine,” helping families and others to understand,

### *Local Community*

Policy efforts at the local level can support collaborative partnerships among agencies whose missions overlap in the service of children’s needs. This kind of collaboration generally requires policy changes at the institu-

of mental health services into schools was shown to be effective in addressing the chronic exposure to violence experienced by many children in the Los Angeles Unified School District.<sup>10</sup>

Ideally, all child-serving systems will someday have an understanding about the impact of trauma and how to collaborate to provide support for children and families. Such community partnerships are not yet the standard of care, as noted in a recent survey by the National Child Traumatic Stress Network (NCTSN).<sup>11</sup> The survey revealed major shortcomings in the ways in which trauma issues were addressed. Regardless of the type of service system, agencies rarely received in-depth information about a child’s trauma history when a child was first referred to them. Collecting and sharing such information is critical to the development of an effective case management and treatment plan.

### *Program/Treatment*

Policy changes within programs and agencies can directly affect indi-

*Incorporating trauma information into standard public health and mental health campaigns could provide a psychoeducational “vaccine.”*

prepare for, and support children when they are exposed to traumatic events of all kinds.

Federal policies should also support evaluation of prevention and intervention efforts, as well as coordinated studies of prevalence and incidence across all trauma types. Large gaps exist in available information, and the information that currently exists in federal studies and reports has not been synthesized or comprehensively analyzed.<sup>3</sup> A thorough synthesis could provide important guidance about how to create and implement effective prevention and intervention programs.

### *State*

State policies can directly affect the ways in which child trauma services are integrated into child-serving state systems, including child welfare, mental health and addiction services, juvenile justice, and schools. Several states (Ohio, Oklahoma, and New Mexico) are currently addressing the impact of trauma through state infrastructure grants, funded by the Substance Abuse and Mental Health Services Administration to help states transform their mental health systems. In the state of Massachusetts, policymakers are fully involved in a coalition of concerned advocates that is addressing trauma in the public school system. This partnership led to specific legislative changes and funding for schools to remove trauma as a barrier to learning.<sup>1</sup>

tional or agency level. Creating effective collaboration also requires building trust among diverse professional groups, and between families and the organizations who are offering services to them.

Several programs have been successful in building such partnerships.<sup>8</sup> In one case, a prevention effort, a partnership between a local substance abuse program and a pediatric primary care clinic helped mothers obtain the addiction treatment they needed and get pediatric care for their children at the same location. Because this program succeeded, literacy programs and early childhood education services were added. In a second case, a community child development clinic joined with a police department to create a child development/community policing program to help children and families who were affected by domestic and community violence. This program expanded to offer “24/7” on-call services for child clinicians to work with first responders in cases of domestic violence, and to offer training in this model to police and other clinicians. In a third case, the integration



vidual treatment and services. In this issue, the report by Ingelman and colleagues (pages 23-26) describes an approach that can help guide caseworkers to make more trauma-informed decisions. This approach is founded on eight essential elements; for example, "Maximize the child's sense of safety," and "Address ripple effects in the child's behavior, development, relationships, and survival strategies following a trauma." Policies that promote the inclusion of families as treatment partners are also critical for providing high quality care.

### A Broad View of Child Trauma

The complexity of the child trauma issue underscores the responsibility of the public health system to move beyond a narrow focus on medical issues.<sup>7</sup> Understanding public health as closely aligned with social justice leads to greater clarity about how policy directives affect children exposed to trauma. Taking this broader view highlights key policy imperatives such as improving the public health system, reducing socioeconomic disparities, addressing health determinants (such as poverty, pollution, unemployment, or hunger), and planning for health emergencies with a focus on the needs of the most vulnerable, including children. The chronic underfunding of the public health system, with mental health and trauma needs often particularly neglected, results in an unfortunate over-emphasis on intervention only after problems have become severe (and possibly less amenable to treatment), and a corresponding under-emphasis on prevention and early intervention. Emergency response plans often fail to consider the vulnerabilities of those without resources, or the impact that chronic exposure to trauma and the lack of access to health care may have on chances for future recovery. A broad public health perspective would take into account the multiple ways that social justice issues, such as poverty, racism, and violence, affect the health and safety of children.

Policymakers generally rely heavily on science-based evidence when making decisions.<sup>5</sup> This can work well when the science base is adequate.

When it is not, then society has a responsibility to fund research that moves beyond biological- or individual-level causes and cures to a larger psychosocial, public health perspective. To enhance the research base, research funding priorities should expand to include qualitative information, economic evaluations of the total impact of interventions and policy changes, systematic research of actual demonstrations of techniques, and the full participation of survivors in the identification of research needs.<sup>2</sup>

### Current Policy Issues

In 2006-2007, many federal and state policy-related challenges illustrate the tensions imposed by the chronic underfunding of public health and social services related to child trauma. Examples of successful recent efforts, initiatives that are in progress, and some notable setbacks include:

- Head Start Federal legislation for programs to serve children at risk of abuse addressed support for home-based services, training of parents in child development, promotion of collaborations between Head Start and child welfare agencies, and training of Head Start staff regarding children exposed to trauma.
- Federal legislation enacted in the Violence Against Women Act extended services to children exposed to domestic violence.
- The State Child Welfare Legislation Report<sup>9</sup> highlighted key state-level child welfare issues, including some which involve children exposed to trauma:
  - Adoption, including adoption of children with abuse histories;
  - Parent and child involvement in case planning to ensure a comprehensive understanding of the child's history;
  - Social worker loan forgiveness programs to attract and keep a workforce in place and reduce turnover; and
  - Strengthening of behavioral health care for children in the child welfare system, so that training in trauma-informed care



can be integrated into child services through these service structures.

- The Deficit Reduction Act made several highly significant changes to Medicaid that have the potential for reducing services for traumatized children. Such changes include reductions in reimbursement for Medicaid rehabilitation and school-based services, and the addition of restrictions to the scope of Medicaid rehabilitation services.
- Following a Government Accounting Office report which documented at least 12,700 children placed in child welfare and juvenile justice systems solely to access mental health services, new policies have been recommended. Efforts around custody (e.g., Keeping Families Together Act, HR 5803) establish state family support grants to help ensure that families do not have to give up custody of their children solely to obtain mental health services. The traumatic impact of losing one's child, or one's family, in order to obtain health care is an example of the secondary traumatization that can be caused by the very system that is supposed to help. This Act is intended to prevent these losses from occurring.

The integration of high quality, trauma-informed services into all child-serving systems is a more efficient way to allocate scarce resources to ensure that traumatized children and families obtain appropriate care regardless of the service system that helps them. The National Child Traumatic Stress Network and its national and local partners are working in multiple ways to raise the standard of care for traumatized children in all service systems, including developing and supporting policies that help this integration of services and system transformation to occur.

## References

- 1 Cole, S. F., O'Brien, J. G., Gadd, M. G., Ristuccia, J., Wallace, D. L., & Gregory, M. (2005). *Helping traumatized children learn: Supportive school environments for children traumatized by family violence*. Boston, MA: Massachusetts Advocates for Children.
- 2 Crossbear, S. (Ed.) (Fall, 2003). *Claiming children: Joint NCTSN trauma edition newsletter of the Federation of Families for Children's Mental Health*. Alexandria, VA: Federation of Families for Children's Mental Health.
- 3 Fairbank, J. A., Putnam, F. W., & Harris, W. W. (In press). The prevalence and impact of child traumatic stress. In M. J. Friedman, T. M. Keane, & P. A. Resick (Eds.), *PTSD: Science and practice—A comprehensive handbook*. NY: Guilford Publications.
- 4 Felitti, V., Anda, R., Nordenberg, D., Williamson, D. F., Spitz, A. M., Edwards, V. J., Koss, M. P., & Marks, J. S. (1998). Relationship of child abuse and household dysfunction to many of the leading causes of death in adults. *American Journal of Preventive Medicine*, 14, 245-258.
- 5 Fielding, J. E. & Briss, P. A. (2006). Promoting evidence-based public health policy: Can we have better evidence and more action? *Health Affairs*, 25, 969-978.
- 6 Friedman, M. J. (in press). Towards a public mental health approach for survivors of terrorism. In Y. Danieli & D. Brom (Eds.), *The trauma of terror: Sharing knowledge and shared care*. NY: Guilford Publications.
- 7 Gostin, L. O., & Powers, M. (2006). What does social justice require for the public's health? Public health ethics and policy imperatives. *Health Affairs*, 25, 1053-1060.
- 8 Harris, W. W., Putnam, F. W., & Fairbank, J. A. (2006). Mobilizing trauma resources for children. In A. F. Lieberman & R. DeMartino (Eds.), *Interventions for children exposed to violence*. Johnson & Johnson Pediatric Institute, 311-339.
- 9 National Conference of State Legislatures (2006). *State child welfare legislation 2005*. [www.ncsl.org/programs/cyf/cwlegislation05.htm](http://www.ncsl.org/programs/cyf/cwlegislation05.htm).
- 10 Stein, B. D., Jaycox, L. H., Kataoka, S. H., Wong, M., Tu, W., Elliott, M. N., & Fink, A. (2003). A mental health intervention for schoolchildren exposed to violence. *Journal of the American Medical Association*, 290, 603-611.
- 11 Taylor, N., & Siegfried, C. B. (2005). *Helping children in the child welfare system heal from trauma: A systems integration approach*. Report by the National Child Traumatic Stress Network. [www.nctsn.org](http://www.nctsn.org).

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