

**RESPONDING TO CHILDHOOD TRAUMA:
THE PROMISE AND PRACTICE OF TRAUMA INFORMED
CARE**

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INTRODUCTION

From the level of the individual child and family to specific child-serving programs to the broader arena of policy, the recognition of the pervasiveness of trauma and the consequent provision of what is known as “trauma informed care” will need to significantly influence our work in mental health and related fields in the future (Harris and Fallot, 2001, and National Executive Training Institute [NETI], 2003). Trauma is not a new concept. However, until recently, it has largely been viewed to be applicable to only a select group of individuals, under extraordinary circumstances – for example, survivors of catastrophic events such as war, earthquakes, and abduction. With notable exceptions, trauma has not been recognized as a part of the daily, regular, experience of many individuals, including children and adolescents. Nor has the profound linkage between trauma and child development and the disruption of physical and emotional health been fully recognized.

The goal of this paper is to build on comprehensive efforts by the National Technical Assistance Center for Mental Health Planning (NTAC), the National Association of State Mental Health Program Directors (NASMHPD) and others, to increase appreciation of the relevance of trauma in understanding children and in planning to meet their needs. NTAC and NASMHPD have assumed substantial leadership in encouraging states, agencies, and providers across the country to recognize the pervasiveness of trauma in the lives of consumers of all ages and to meet the needs of individuals in treatment facilities without re-traumatizing them through coercive and restrictive interventions such as restraint and seclusion. While the principles disseminated by NTAC and NASMHPD in comprehensive training modules are relevant to children, there is need for elaboration of the special circumstances relating to child maltreatment – particularly the impact on children of physical and sexual abuse and neglect, and the potential for traumatization through use of restraint and seclusion. Children are not “little adults,” and it becomes clear, once the process of development is understood, that they are more vulnerable than adults to trauma – whether such trauma occurs in the community or, unfortunately, even in the name of “treatment.”

Depending on the type, severity, duration, and chronicity of trauma – in association with the child’s age, prior vulnerability, and the response of primary caregivers – child maltreatment and traumatic exposure may result in vastly different outcomes. These outcomes potentially affect every aspect of the child’s development and functioning, including brain development, neurochemical pathways, psychosocial adaptation, and preferential responses to subsequent stress and other life experiences. Early identification, intervention and support, and at times formal mental health treatment may be indicated for those children subjected to maltreatment and other trauma that disrupts their functioning and threatens their development. Attention is also needed to ensure that trauma, when still occurring, is interrupted, and that the child can gain a sense of physical and emotional safety.

The provision of “trauma informed care” is a seminal concept in emerging efforts to address trauma in the lives of children, as well as adults. Trauma informed care has many facets. It refers to recognition of the pervasiveness of trauma and a commitment to identify and address it early, whenever possible. Trauma informed care also involves seeking to understand the connection between presenting symptoms and behaviors and the individual’s past trauma history.

As a practice and set of interventions, trauma informed care involves professional relationships and interventions that take into account the individual's trauma history as part of efforts to promote healing and growth.

At the most basic level, trauma informed care involves the provision of services and interventions that do no harm – e.g., that do not inflict further trauma on the individual or reactivate past traumatic experiences. Beyond this, trauma informed care helps the individual to heal. The concept is not limited to Mental Health, and in fact applies to multiple systems and settings. Thus, for children, trauma informed care is applicable to a range of residential settings, whether psychiatric inpatient or residential treatment (Mental Health), detention or secure treatment (Juvenile Justice), shelter or group homes (Child Protection), or residentially based schools (Education). Beyond residential settings, trauma informed care is relevant to ambulatory care and to community programs. Since children with serious emotional disturbance (SED) and significant trauma histories typically are involved in multiple systems, trauma informed care also entails cross-system coordination that incorporates consideration of trauma into comprehensive service planning.

Predicated on an individualized understanding of each child, trauma informed care promotes healing and growth by addressing the fundamental needs of persons subjected to significant trauma. Trauma informed care should be distinguished from trauma-specific treatment. The latter involves specialized treatments that some individuals also may need, to address complex trauma-related consequences. Trauma informed care, in contrast, is not highly specialized and can be provided in multiple settings by committed professionals who understand trauma without the expertise to offer trauma-specific treatment, which can be offered as needed by designated staff or through referral.

Given that a significant goal of this paper is to support current efforts to reduce seclusion and restraint with children, its scope and focus will reflect this orientation. Thus, after consideration of the pervasiveness and potential consequences of childhood trauma, the focus becomes trauma informed care, with particular attention to how to prevent the need for restrictive procedures such as seclusion and restraint and how to create compassionate, non-coercive settings. It should be appreciated that the underlying principles and practices are applicable to ambulatory settings, but the reference point here are institutional settings where a distinct subset of children subjected to trauma end up. Such children may be admitted to psychiatric hospitals and residential treatment facilities as a result of trauma-related, mental health and substance-related disorders. They may end up being placed in shelters or group homes as a result of abuse or neglect related issues. Unfortunately, since these children are also at high risk for conduct disorders, many enter detention and long-term secure treatment facilities within the juvenile system. The discussion to follow is relevant to all of these children.

The paper is organized into two main parts, followed by Discussion, Conclusion, and Suggested Reading. Part I delineates “The Challenge of Childhood Trauma.” Part II then addresses, “Meeting the Challenge – Trauma Informed Care.”

PART I: THE CHALLENGE OF CHILDHOOD TRAUMA

WHAT IS TRAUMA?

Although not the most helpful source in gaining a full understanding of trauma, the DSM IV (1994) provides a useful starting point. It defines a “traumatic event” as one in which “the person experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the integrity of self or others.” The second critical component of a traumatic event is that “the person’s response involved intense fear, helplessness, or horror.” The DSM IV states that children may express fear, helplessness, and horror as disorganized or agitated behavior. Trauma may have many sources, including neglect, physical abuse, psychological abuse, sexual abuse, witnessing of domestic abuse and other violence, community violence, school violence, traumatic loss, medical trauma, natural disasters, war, terrorism, refugee trauma, and others (National Child Traumatic Stress Network, 2005). Within the DSM IV, trauma is tied to two specific trauma-related diagnoses (Acute Stress Disorder, ASD, and Posttraumatic Stress Disorder, PTSD), but the definition of trauma is also free standing.

According to the DSM IV, both ASD and PTSD share in common a specific symptom constellation involving exposure to a traumatic event as described above, with the presence of 3 categories of symptoms – re-experiencing, persistent avoidance and numbing of general responsiveness, and increased arousal – which cause “clinically significant distress or impairment in social, occupational, or other important areas of functioning” (1994). In ASD, the presence of dissociative symptoms is separated out as a separate criterion, while in PTSD dissociative symptoms are combined with avoidance of stimuli as a joint criterion. The major distinction between the two diagnoses is one of onset and duration. ASD, by definition, occurs within 4 weeks of the traumatic event, and can last no longer than 4 weeks. A requirement for the designation of PTSD is that the disturbance has lasted more than 1 month. Actual onset of the disturbance may have occurred at the time of the traumatic event or shortly thereafter (as an Acute Stress Disorder), or onset may occur 6 months or more after the traumatic event (delayed onset PTSD).

Studies have tended to validate the predictive value of ASD, primarily with adults, as a precursor to the development of PTSD in untreated individuals (Cahill and Pontoski, 2005, pp. 14-25). For example, in a study of 92 consecutive motor vehicle accident victim admissions (ages 16-65) to a major trauma hospital for ASD symptomatology, 77.8% of individuals meeting full criteria for ASD developed chronic PTSD at follow-up assessment. Among individuals who did not meet criteria for even subclinical ASD (e.g., meeting criteria for 4 of the 5 ASD symptom clusters), 87.2% did not meet criteria for PTSD or subclinical PTSD (e.g., subclinical PTSD satisfies criteria for only 2 of the 3 PTSD symptom clusters) at the follow-up assessment. Only 4.3% of the individuals who did not meet criteria for even subclinical ASD at time of initial assessment subsequently met full criteria for PTSD, when assessed later.

From this writer’s perspective, there are significant limitations to the DSM IV constructs of ASD and PTSD as the only diagnosable manifestations of traumatic exposure. For example, in reality a child can show significant evidence of traumatic maladaptation and yet not meet the

full criteria of PTSD. In addition, some adaptations by children to chronic maltreatment, as discussed later, are not captured at all by the DSM IV, even though these children manifest significant impairment in both functioning and development. PTSD, in particular, as the diagnosis that corresponds to severe and chronic trauma, should be seen as only partially reflective of the range of potential clinical responses to traumatic exposure. Others also concur with this perspective (Perry et al, 1995). As will become evident, traumatic exposure can result in a myriad of consequences for children, only a few of which are formally identified by the PTSD diagnosis.

A SYNOPSIS OF CHILD DEVELOPMENT AND DIFFERENTIAL RESPONSES TO TRAUMATIC EXPOSURE

Children experience rapid changes in development, making childhood a time of both great opportunity and extreme vulnerability. Multiple factors influence the short- and long-term impact of trauma on a child. Given the complexity of interacting factors and the uniqueness of every child, it is not possible to precisely delineate the relative contributions of each factor, just as it is not possible to predict the eventual outcomes for a child with certainty. Nevertheless, it is important that both parents and professionals understand some of the variables that influence the child's response to traumatic exposure. Consistent with a framework offered in an NIMH Fact Sheet (NIMH, 2001) we consider below 3 sets of factors: 1) Characteristics related to the individual child, 2) Characteristics related to the trauma exposure, and 3) Post-trauma factors.

Characteristics of the Individual Child

Age of the Child

An important variable involves the age of the child. In contrast to earlier belief that early trauma had little impact on the child, it is now recognized that early trauma has the greatest potential impact, by altering fundamental neurochemical processes, which in turn can affect the growth, structure, and functioning of the brain (Schwartz and Perry, 1994). Whereas trauma during adulthood tends to be more circumscribed (although still significant) and is activated by exposure to cues associated with the traumatic event, early childhood trauma tends to have more global and pervasive consequences for the child, affecting the basic template for development (Perry, 2004).

-Children ages 5 years and younger tend to show the greatest reactivity, in general, to the impact of the traumatic event on the mother or other primary caregiver, rather than to the trauma per se. In the aftermath of a traumatic event, children in this youngest age group show combinations of the following responses to trauma, which combine both internalizing symptoms and externalizing behaviors (NIMH, 2001, pp. 2-3). [This latter source is the basis for the information offered below on the differential influence of various ages on child reactivity to trauma]:

-Fear of being separated from the mother or primary caretaker, and excessive clinging.

-Crying, whimpering, screaming, trembling and frightened facial expressions.

-Immobility or aimless motion.

-Regressive behaviors, such as thumb sucking, bedwetting, and fear of darkness.

-Children ages 6 to 11 years may show combinations of the following responses:

-*Internalizing symptoms*: Extreme withdrawal; emotional numbing or “flatness”; irrational fears; somatic complaints; depression; anxiety; guilt; inability to pay attention; other regressive behaviors, including sleep problems and nightmares.

-*Externalizing behaviors*: Irritability; outbursts of anger and fighting; school refusal.

-Adolescents ages 12-17 years, in general, may exhibit responses similar to those of adults, which include:

-*Internalizing symptoms*: Emotional numbing; avoidance of stimuli; flashbacks and nightmares; confusion; depression; withdrawal and isolation; somatic complaints; sleep disturbances, academic or vocational decline; suicidal thoughts; guilt; revenge fantasies.

-*Externalizing behaviors*: Interpersonal conflicts; aggressive responses; school refusal or avoidance; substance abuse; antisocial behavior.

Past Exposure to Trauma

Since the effects of trauma are understood as being cumulative, the child who has had prior – or chronic – trauma exposure is at greatest risk of developing symptoms and of having the normative developmental progression disrupted. The more the child’s neurobiological system needs to make adaptations to traumatic situations, the greater the chance that these adaptations will become enduring. Repeated exposure to trauma therefore may result in a situation-specific “state” becoming a more permanent “trait” (Perry et al, 1995) – e.g., an ongoing neurobiological adaptation, rather than an acute, adaptive response specific.

Presence of a Pre-Existing Mental Health Problem

The child who is already compromised in coping and overall development by a pre-existing mental health problem is at greater risk to respond negatively to traumatic exposure, especially trauma of a chronic nature. At times, the pre-existing mental health problem is known and being addressed. Unfortunately, this may not be the case, and the underlying mental health problem may not be recognized until the child is assessed following the trauma incident. Even then, assessment will not lead to identification of pre-existing mental health problems unless it is comprehensive and broad-based.

Nature of Pre-Trauma Social Support

A child who has received, prior to a trauma incident, strong social and familial support has likely benefited from significant protective factors that promote healthy development. Thus, such a child may be better able to show resilience in response to trauma. On the other hand, when the neighborhood is dangerous, the family experiences poverty, or there is impaired functioning on the part of adult family members, the child's development may be compromised. Inner city children, for example, experience the greatest exposure to community violence. One study found that children exposed to community violence were more likely to exhibit aggressive behavior or depression within the following year than non-exposed children (NIMH, 2001, p. 6).

Other Circumstances Compromising Development

Additional circumstances compromising a child's typical development might include the presence of a disability that affects cognition, such as a processing problem, or Mental Retardation, which globally delays development relative to a child's chronological age. Other examples involve situations in which the child has experienced significant loss, particularly loss of a parent or other caregiver. Children with significant physical health problems may experience trauma as a result of their medical condition, along with treatments to address it. Finally, preliminary genetic studies suggest the possibility of inheritance and genetic constitution as potentially relevant factors that may predispose to the development of PTSD as an aftermath of trauma exposure (Yehuda and Davidson, 2000).

Characteristics of the Trauma Exposure

Proximity to the Trauma

Although some children may react negatively even when not directly involved, in general proximity to trauma is a significant exacerbating variable. Thus, the child who is directly victimized by maltreatment is usually more vulnerable than a child who witnesses the event. Similarly, direct victimization and witnessing usually have greater impact than hearing about the trauma indirectly, for example by children in the community or a school. Yet the latter may at times lead to panic and contagion, with significantly negative consequences for specific children and the community.

Specific Type of Trauma

Researchers are interested in distinguishing between types of trauma and their subsequent short- and long-term impact on children. However, this process is complicated by the frequent coexistence of many types of trauma in the lives of children, and the potential secondary effects of trauma, regardless of the initial type (Caporino et al, 2003). Secondary effects of trauma involve those changes that occur in the aftermath of trauma, and may include alteration of core relationships, separation of the child from home or from a particular family member, change in the family's socioeconomic status, and involvement of legal or police systems.

A helpful review article considers the relationship between different types of trauma and the child's responses (Caporino et al, 2003). Specific traumas considered are: physical abuse, sexual abuse, domestic violence, community violence, and disasters. It becomes clear that children may respond to any of these traumatic events with both internalizing symptoms and externalizing behaviors, either at different times or at the same time. In addition, the child's response to maltreatment – past and present – may change over time, as the child becomes older and both cognitions and reactivity change. Given the presence of multiple pathways, specific causality between traumatic exposure, on the one hand, and symptoms and behaviors, on the other, is difficult to establish. It is likely that both set of factors operates in a circular, reciprocal manner (e.g., significant trauma exposure may give rise to symptoms and behaviors, and symptoms and behaviors may predispose to additional trauma).

Despite many confounding variables, the evidence points to a few generalizations regarding the specific type of trauma and the subsequent responses by the child (Caporino et al, 2003, p. 73). These include the following:

- Physical abuse tends to be linked most commonly to externalizing behaviors, although there is increased risk for anxiety and depression as well.
- Sexual abuse tends to be linked most commonly to internalizing symptoms, although externalizing behaviors may also occur, particularly with older children and adolescents.
- Severe physical abuse during the preschool period tends to predict externalizing behavior and aggression.
- Severe neglect during this same period has been associated with internalizing symptoms and withdrawal.

Gender

It is recognized that females tend to develop internalizing symptoms and become passive, while males tend to externalize and turn to activity and aggression (Schwartz and Perry, 1994). At the physiological level, females tend to use dissociation and the surrender response pattern as their primary defense, while males tend to use an active emergency response (the flight-and-fight response) and become hyper-aroused (Perry et al, 1996).

Nevertheless, there are exceptions to the above generalization. For example, young children, including males, subjected to maltreatment may preferentially use dissociation, which is adaptive given their relative powerlessness in the presence of an offending adult. In addition, females may develop externalizing behaviors in addition to their internalizing symptoms. The increasing number of females with a history of trauma who are arrested and enter the juvenile justice system (in 1997, 26% of juvenile arrests were females) reflects the vulnerability of many females to develop externalizing behaviors, including drug and alcohol abuse, as they get older (Hennessey, 2004).

Relationship to the Perpetrator

A child's response to maltreatment may be influenced by the nature of the child's relationship to the perpetrator. In general, maltreatment by a stranger is less devastating to a child than similar maltreatment by a family member or other trusted adult. In the latter case, the child not only incurs the direct trauma, but also experiences confusion and a possible sense of betrayal with loss of trust. In addition, the familiar adult may make threats to the child to prevent disclosure of the incident(s) to others, and he remains a continuing presence in the life of the child, creating chronic stress and uncertainty. The child may harbor ongoing fear of being alone with that person, and fear of displeasing him.

If, for whatever reason, the abuse becomes known, then the child faces the possible loss of the adult – physically and emotionally. This is difficult because, typically, the child has positive as well as negative feelings toward the perpetrator, and may even identify with this individual. An unfortunate aftermath of disclosure, even if the child did not initiate it, may be blaming or even rejection of the child, by the other parent or other family members.

Severity, Duration, and Frequency Of Trauma

Although children may have different levels of vulnerability, the more severe the traumatic event, the longer it lasts, and the more frequent the episodes, the greater the potential impact on the victimized child (NIMH, 2001, Schwartz and Perry, 1994). Such considerations pertain to physical abuse, sexual abuse, and neglect. In addition, the chronicity of trauma – especially child maltreatment – is of particular relevance.

Chronicity of Trauma

The chronicity of traumatic exposure is regarded as extremely significant, in terms of its impact on the child over time. Since the brain adapts to the requirements of the environment, the child's metabolism and blood flow, and subsequent brain development and functioning, can be significantly altered in response to ongoing trauma (NIMH, 2001). In like manner, the child's behavioral patterns are influenced by the need to maintain safety and survival. The child's development in effect becomes skewed by a state of chronic helplessness and hyperarousal, with the resultant development of what is referred to as "malignant memories" (Schwartz and Perry, 1994), which predispose the child to re-experiencing and other symptoms of PTSD.

Post-Trauma Factors

Early Intervention

There is evidence that "counseling children very soon after a catastrophic event may reduce some of the symptoms of PTSD" (NIMH, 2001, p. 5). Ideally, this would include intervention "during the early hours and days" after the traumatic exposure (Schwartz and Perry, 1994,). Animal studies have suggest that there may be a critical period before which a "fear memory" is transferred from temporary storage in the brain to permanent storage, so early intervention with children might interrupt the development of subsequent permanent, malignant

memories (Schwartz and Perry, 1994). Early intervention with children, by ameliorating the intensity and severity of the child's response to trauma, can "decrease the probability of developing...sensitized neural systems" that lead to persistence of trauma symptoms and defenses (Perry et al, 1995).

Early intervention in response to traumatic exposure requires early detection and recognition of such events. This, unfortunately, is easier to achieve following a single disaster or other discrete event than with chronic child maltreatment. Nevertheless, routine trauma assessments of children increase the likelihood of greater and earlier recognition. Effective intervention for childhood trauma may or may not require formal, long-term mental health treatment. Essential short-term goals are to help child and family understand what has occurred and the natural history of the trauma response, and to help them to take steps that restore a sense of control and safety for the child, with resumption of normal routines as soon as appropriate (Schwartz and Perry, 1994).

Social Support and Social Responses

The family can help the child substantially, when the adults remain calm, ensure the safety of the child, and provide appropriate structure, limits, routines, and nurturance. The family needs to understand that short-term regression by the child is normal and should not be subject to disapproval or discipline. After the acute period, the child should be encouraged to resume typical functioning, including social interactions and community involvement. It is important that neither peers nor family members stigmatize the child victimized by trauma.

When the family as a whole has been significantly affected by a traumatic event, the ability of the parents to help the child may be undermined, but they still need information and encouragement to do so. When there is ongoing parental impairment, or when an adult family member perpetrated abuse of the child, the degree of family support available to the child will be correspondingly diminished.

Response to Interventions and Degree of Symptom Resolution

When the child receives early intervention, with appropriate social support and social responses, "most children and adolescents...will recover almost completely from the fear and anxiety caused by a traumatic experience within a few weeks" (NIMH, 2001). Grief over loss of a loved one or the loss of other special relationships, in contrast, takes longer to resolve, but not all trauma involves such loss. Under certain circumstances, the child – ideally, the child and family – will need to pursue formal mental health treatment, since severe symptomatology in the child following trauma exposure may be a precursor to the development of PTSD or other significant post-trauma impairments. Significant delay in recovery from trauma, and the development of symptoms consistent with Acute Stress Disorder (in complete or subclinical form), may signal the need for mental health treatment, or for intensification of prior mental health interventions. In addition to efforts to address the disabling symptoms of hyperarousal, numbing, and avoidance, there is need to be alert to the possibility of coexisting depression, which also requires treatment. If other psychiatric disorders are identified, these too need to be addressed.

The nature of specific interventions for trauma-related impairments is influenced by the age and developmental level of the child, with preferential use of non-verbal techniques for younger children and verbal techniques, or combined modalities, for older children. A persistent focus, especially with younger children, should involve the assurance of safety and/or consideration of ways to re-establish safety. It is important that the child's cognitive distortions, when present, be understood and clarified (Perry, 2004). Such distortions may relate to causality and inappropriate attribution of personal responsibility by the child for the event. More broadly, another critical task involves "careful attempts to weave the traumatic experiences and walled off memories into (a) personal narrative" (Schwartz and Perry, 1994). Developing a personal narrative involves helping the child to understand the traumatic experience within a frame of reference that makes sense and offers a sense of mastery and hopefulness.

RISK AND PROTECTIVE FACTORS RELATED TO CHILD MALTREATMENT

"Child maltreatment," the type of trauma of primary interest in this paper, refers to a child being exposed to neglect and/or abuse (physical, sexual, and/or emotional abuse) by a caregiver. Child maltreatment may be a one-time event, an ongoing and continuing pattern, or somewhere in between. In general, according to the National Center for Injury Prevention and Control within the Centers for Disease Control and Prevention (2005), children under the age of 4 years are at greatest risk of severe injury or death. In 2003, children under age 4 accounted for 79% of child maltreatment fatalities, with infants under 1 year accounting for 44% of the deaths (2005). Consistent with a public health approach, the National Center for Injury Prevention and Control has identified risk and protective factors related to childhood maltreatment. Both risk and protective factors exist at individual, relational, community, and societal levels.

Examples of risk factors for child maltreatment, as identified by the National Center for Injury Prevention and Control (2005), include the following:

- Disabilities or mental retardation in children, which may increase caregiver burden.
- Social isolation of families.
- Lack of caregiver understanding of the child's needs and child development.
- Caregiver history of domestic abuse.
- Poverty and other socioeconomic disadvantage.
- Family dissolution, violence (including domestic abuse), lack of cohesion, and ineffective organization.
- Substance abuse in the family.
- Caregiver stress and distress, including depression and other mental health conditions.

- Young, single, non-biological parents.
- Negative caregiver-child interactions.
- Caregiver beliefs and emotions that support maltreatment.
- Community violence.

Protective factors that protect against child maltreatment, in contrast, include the following (2005):

- A supportive family environment.
- Nurturing caregiver skills.
- Stable family relationships.
- Consistent household rules and monitoring of the child.
- Adequate housing.
- Parental employment.
- Access to healthcare and social services.
- Caring adults outside the family who serve as role models or mentors.
- Communities that support caregivers and help prevent abuse.

In general, prevention strategies, at both the individual and the community level, seek to promote protective factors and to ameliorate risk factors.

THE MAGNITUDE OF THE PROBLEM OF CHILDHOOD TRAUMA

One of the reasons for increased attention to the problem of trauma involves increased recognition of its pervasiveness. For example, in 2004, the National Association of State Mental Health Program Directors (NASMHPD) and the National Technical Assistance Center for State Mental Health Planning (NTAC) published a report, *The Damaging Consequences of Violence and Trauma: Facts, Discussion Points, and Recommendations for the Behavioral Health System*. This report offers a range of disturbing information about childhood trauma, in particular child maltreatment and violence.

The consequences of severe childhood maltreatment can be viewed from the vantage point of immediate and persisting effects on the child during childhood – including disruption of the normal developmental process – and longer-term outcomes on the child once grown up as an

adult. Both perspectives are important, and are related. The NASMHP/NTAC report is informed, in part, by significant longitudinal outcomes obtained through the Adverse Child Experiences (ACE) Study (Felliti et al, 1998, Centers for Disease Control and Prevention, 2005). The ACE Study was initiated at Kaiser Permanente in California from 1995 to 1997, to determine the relationship between childhood maltreatment and family stress (referred to as “adverse childhood experiences”) and later outcomes in adulthood. Voluntary adult participants, while undergoing a standardized physical examination, completed a confidential survey inquiring about childhood maltreatment and family stressors, as well as current health status and current behaviors. With this information providing a baseline, the study is continuing to follow participants over time, in order to determine the relationship between childhood maltreatment and stressors, on the one hand, and subsequent high-risk behaviors and health outcomes, on the other. Three sets of outcomes are particularly noteworthy:

1. A high percentage of the adult participants reported adverse childhood experiences. For example, more than 50% reported at least one, and 25% reported two or more childhood exposures.
2. There was a graded relationship between number of exposures (the ACE Score) and negative outcomes. Thus, the greater the number of exposures, the greater was the likelihood of the individual having significant health risk behaviors, poor health status, and disease. In addition, individuals with multiple categories of childhood exposure were likely to have multiple health risk factors later in life.
3. The ACE Score also showed a strong, graded relationship between adverse childhood experiences and subsequent health-related behaviors and outcomes *during childhood and adolescence* (2005). These outcomes included early initiation of smoking, sexual activity, illicit drug use, adolescent pregnancies, and suicide attempts (2005).

The ACE Study thus demonstrates a clear relationship between adverse childhood events and a range of poor individual outcomes. These negative outcomes can be further classified and broken down. The discussion that follows builds upon outcome information contained in the NASMHPD/ NTAC Report, with additional sources identified for augmentation. Relevant epidemiological and outcome issues include the following: 1) the prevalence and frequency of trauma, 2) medical and physical health consequences (immediate and long-term), 3) specific consequences related to adult psychiatric disorders, 4) consequences related to juvenile and criminal justice, 5) other social consequences for women, 6) under-diagnosis, misdiagnosis, and inappropriate interventions, and 7) subtle psychological effects of trauma on youth.

Prevalence and Frequency of Trauma

The statistics offered below, taken as a whole, indicate the pervasiveness of various forms of abuse and other forms of trauma, among children and adolescents in real time and among adults with prior trauma exposure during their childhood:

-Up to 81% of men and women in psychiatric hospitals diagnosed with major mental illnesses have experienced physical and/or sexual abuse. Of note, 67% of these individuals experienced their abuse as children (NASMHPD/NTAC Report, p. 41).

- In Maine's Mental Health Institute in Augusta, 74% of adult consumers reported histories of sexual and physical abuse (p. 41).

-Each year, between 3.5-10 million children witness the abuse of their mother. Up to half of these children are also abused themselves (p. 72).

-In Massachusetts, a point in time medical review of the continuing care adolescent Inpatient programs revealed that 84% of this population had a history of trauma. In another study of adolescent inpatients, 93% reported a history of trauma (NETI, 2003).

-Infants are commonly subjected to hitting: 25% of infants 1-6 months are hit, and 50% of infants from 6 months-1 year are also hit (p. 72).

-Estimates of childhood abuse increased significantly from 1986-1993: neglect by 102%, physical abuse by 42%, sexual abuse by 83%, and emotional neglect by 333% (p. 72).

-A history of trauma is pervasive among youth (especially minority youth) in the juvenile justice system:

-In one study of juvenile detainees, 93.2% of males and 84% of females reported a traumatic experience, with 18% of females and 11% of males meeting full criteria for PTSD (Hennessey et al, 2004. p. 3).

-Among incarcerated youth, gender differences regarding type of trauma most commonly experienced among incarcerated youth: males were most likely to report witnessing violence, while females were most likely to report being victimized by violence (p. 3).

-Further evidence of the need to consider the needs of females separately from males: In a sample of incarcerated female juvenile offenders, 74% reported having been hurt or in danger of being hurt, 60% being raped or in danger of being raped, and 76% witnessing someone being severely injured or killed (p. 3).

Medical and Physical Health Consequences

Childhood trauma is associated with medical and physical health consequences in two primary ways: 1) as a direct physical consequence of the abuse or trauma, and 2) as a longer-term influence on coping, adaptation, and habits and routines that may increase the eventual risk of undesired medical and physical health consequences. Thus, some of the medical and physical health consequences occur immediately (or shortly after) the trauma, while others represent longer-term outcomes. Consequences of concern include the following:

-Between 20-50% of abused children will have some degree of permanent disability as a result of abuse (NASMHPD/NTAC, p. 46).

-Childhood violence is a significant causal factor in 10-25% of all developmental disabilities (p. 43).

-Medical impacts of childhood abuse may involve any of the following:

Head trauma, brain injury, sexually transmitted diseases, unwanted pregnancy, HIV infection, physical disabilities, chronic pelvic pain, headaches, stomach pain, nausea, sleep disturbance, eating disorder, asthma, shortness of breath, chronic muscle tension, muscle spasms, and elevated blood pressure (p. 45).

-Childhood trauma is linked to the following physical health problems in adulthood:

Adult smoking, multiple sexual partners and sexually transmitted diseases, physical inactivity, severe obesity, and other adult diseases such as ischemic heart disease, cancer, chronic lung disease, skeletal fractures, and liver disease (p. 45). Another medical consequence may involve autoimmune disorders (p. 63).

-Sexual abuse predisposes to: drug and alcohol addiction, unprotected sex, increased sexual partners, prostitution, and HIV/AIDS (p. 45).

-Severe and prolonged childhood sexual abuse causes damage to the child's brain structure (p. 45). In fact, all forms of abuse can cause what appears to be permanent damage to the developing brain (p. 21, 22).

One study of 44 maltreated children and adolescents diagnosed with PTSD using magnetic imaging brain scans found that, compared to the matched controls, maltreated subjects had 7% smaller intracranial volumes and 8% smaller cerebral volumes. In addition, the total midsagittal area – the interconnection between the two hemispheres that is believed to facilitate intercortical communication – and the middle and poster portions of the corpus callosum, were all smaller in abused subjects (DeBellis, p. 2).

The fact that, by age 2 years, 75% of adult brain weight has been gained, with near completion of adult intracranial volume by age 5, reflects the importance of recognizing and addressing traumatic exposure in young children (DeBellis, p. 3). This typical growth pattern may help explain why severely traumatized children have smaller brains than children unaffected by serious trauma.

-Significant hormonal changes also occur, and may be irreversible (NASMHPD/NTAC Report, pp. 21, 22).

A study of stress-related metabolites in 18 prepubertal maltreated children with PTSD reflected this change in hormonal activity. In comparison with the

controls, the maltreated children excreted significantly greater amounts, upon 24-hour urine collection, of urinary-free cortisol and urinary catecholamines (DeBellis, p. 2).

-Adults rate their own health as poor at a frequency that is 2-4 times greater than adults not subjected to trauma in childhood or adolescence (NASMHPD/NTAC Report, p. 45).

-Dual diagnosis (MH and D&A) occurs in many adults with childhood history of trauma. Many also have PTSD.

Consequences Related to Child Psychiatric Disorders

We have seen that children subjected to a discrete traumatic episode, when offered appropriate early intervention and support, typically respond favorably and return to their baseline state within several weeks. Children who have severe symptoms – as identified in DSM IV – that arise within 4 weeks of a traumatic event, significantly impair their functioning, and persist for a period of 2 days up to 4 weeks, may be diagnosed with Acute Stress Disorder (ASD). If symptoms continue beyond 4 weeks or arise later on, then the diagnosis of Posttraumatic Stress Disorder (PTSD) may apply.

Children subjected to severe, chronic maltreatment may experience multiple symptoms as well as alterations in neurobiology that affect their developmental process. Many, but not all, of these children eventually meet the criteria for PTSD, yet even when this is not the case, their impairments are significant. They may also experience additional symptoms and develop cognitions and beliefs that the DSM IV does not address, as discussed at length below. Children subjected to severe maltreatment frequently present with other psychiatric disorders, such as depression and anxiety, and may at times manifest symptoms consistent with others, including ADHD and Pediatric Bipolar Disorder (NASMHPD/NTC, 2004). During adolescence, it is not uncommon for children who have experienced severe maltreatment to develop substance abuse problems. Diagnostically, it can be a challenge for clinicians at times to determine when the child's symptoms and behaviors are a consequence of the trauma, and when they reflect the presence of independent psychiatric disorders.

Although neglect is the most common form of child maltreatment, constituting over 50% of substantiated cases of abuse in 1994, it is often the least discussed and least effectively addressed. Therefore, this aspect of child maltreatment is considered briefly now (Perry et al, 2002). Physical and emotional neglect are the most damaging types of neglect, especially when occurring in a sustained manner early in the life of a child. Infants require a certain amount of emotional and physical stimulation in order to have normal patterns of neuroendocrine activity and growth (p. 4). In the absence of such stimulation, the infant may fail to thrive, and even die. Neglect of all types (physical, emotional, medical, and educational) is actually responsible for the majority of abuse-related deaths in children each year. The child under age 3, subjected to chronic neglect, is at high risk of developing problems with attachment and relationships, as well as difficulty in establishing and maintaining appropriate self-regulation (p. 3). Over time, there is "increased likelihood for hyperactivity, aggression, and disciplinary problems, (which) places neglected children at a much greater risk for criminal behavior later in life" (p. 4). The most

effective approaches to child neglect involve prevention and early intervention. The latter requires early identification, followed by comprehensive, collaborative, system-based interventions. Beyond provision of services and interventions, professionals need to appreciate the importance of developing a positive alliance with the child's caregivers.

Consequences Related to Adult Psychiatric Disorders

The issue here involves the increased frequency of formal psychiatric disorders that are associated with various forms of trauma in childhood. The discussion is confined to specific DSM IV diagnoses, not more subtle effects on cognition, beliefs, and values, which are discussed later. Adults exposed to abuse and trauma during childhood are:

- Almost 3 times more likely than non-abused adults to have an affective disorder (NASMHPD/NTAC, pp. 41-42 for this and other items to follow).
 - Almost 3 times as likely to have an anxiety disorder.
 - Almost 2½ times as likely to have phobia.
 - More than 10 times as likely to have a panic disorder.
 - Almost 4 times as likely to have antisocial personality disorder.
 - More likely to engage in self-harm -- suicide attempts, cutting, self-starving.
 - More prone to experience auditory hallucinations and develop Schizophrenia.
 - Much more likely to be homeless and mentally ill as adult women (97% of homeless, mentally ill women experienced severe physical and/or sexual abuse)
 - At risk of developing PTSD or PTSD-related symptoms.
 - Other psychological and behavioral consequences of childhood trauma may involve:
 - Hyperactivity, inattention, impulsivity, extreme anger, paranoia, aggression, substance abuse, antisocial behavior, and attachment problems (pp. 27-28).
- The above symptoms may give rise to a variety of diagnoses, often without recognition of the underlying trauma (further discussed below).

Consequences Related to Juvenile and Criminal Justice

Not unexpectedly, children who have experienced trauma with subsequent maladaptation and disruption of typical development are at increased risk of behaviors that may lead to legal problems, with increased entry into the juvenile and criminal justice systems. The following facts show this increased association:

-Childhood abuse is correlated with increased truancy, running away, and homelessness (NASMHPD/NTAC, p. 55).

-Childhood abuse or neglect increases the likelihood of arrest as a juvenile by 53% and as a young adult by 38%. The likelihood of arrest for a violent crime also increases by 38% (p. 49).

-Boys who experience or witness violence are substantially more likely to commit violence than those who do not. Reenactment of victimization is a major cause of societal violence (p. 49).

-More than 75% of adolescent females adjudicated delinquent by one court system had been sexually abused (p. 55).

-In 1998, 92% of incarcerated females reported sexual, physical or severe emotional abuse in childhood (p. 49).

-The majority of men and women in the criminal justice system, including sex offenders and murderers, were abused as children (p. 49).

-While estimates of the prevalence of PTSD in the juvenile justice population vary widely (from 3% to 50%), the overall rates are 8 times as high as community samples of similar-age peers (Wolpaw and Ford, 2004).

-A notable study (Flannery et al., 2001) involved assessment of dangerously violent adolescents (male and female) in grades 9-12, through anonymous self-report questionnaires administered in school, and comparison of this group with a community sample of nonviolent adolescents. While none of the students were studied as a consequence of apprehension for violent acts, it is clear that most of the involved aggressive behaviors would have led to arrest, if detected. Pertinent findings from the male and female study groups are summarized below:

Male study group:

-Dangerously violent males were 3-6 times more likely than the male controls to have been witnesses and victims of high levels of violence in the home, neighborhood, and community.

-Males were significantly more likely to exhibit clinical levels of anger, dissociation, and PTSD than the male controls.

Female study group:

-Dangerously violent females were significantly more likely to score in the clinical range for *all* trauma symptoms, compared to both the female controls and the dangerously violent males.

-Dangerously violent females were 2-7 times more likely than female controls to have been exposed to violence, 159% more likely than study males to experience clinical levels of anger, and 152% more likely than study males to experience clinical levels of depression.

-There was an increased likelihood of suicide by the female study group – almost 1 in 5 were at risk, compared to significantly lower percentages in all other comparison groups (p. 441).

Other Social Consequences for Women

The social consequences of trauma typically increase as abused, symptomatic individuals, particularly women, enter adulthood. This exacerbation of symptoms and maladjustment potentially affect the quality of life of these women as well as that of their own children. It is the latter reality that perpetuates poor quality of life for females and inter-generational cycles of trauma:

-Females sexually abused during childhood are 2.4 times more likely than non-abused females to be re-victimized sexually as adults (NASMHDP/NTAC, p. 55).

-Females who experience violence during childhood are 3-4 times more likely to be raped (p, 56).

-Females subject to incest in childhood are twice as likely to become victims of domestic violence (p. 56).

-Females abused in childhood are at greater risk of suicidal and self-mutilating behavior (Herman, 1992).

-Females subject to childhood trauma are at increased risk to have a lack of empathy (NASMHPD/NTAC, pp. 27-28).

-Approximately 33% of individuals abused in childhood may neglect or abuse their own children (p. 49), reflective of problems in parenting (pp. 27, 28).

Under-Diagnosis, Misdiagnosis, and Inappropriate Interventions

Since the DSM IV has rigid criteria for the diagnosis of ASD and PTSD and does not address the recognition of other manifestations of chronic trauma exposure, it is easy for symptoms related to traumatic exposure to be overlooked. Screening for and thinking about trauma has been relatively uncommon in many mental health and other child-serving settings, although this is now changing. Problems may involve under-diagnosis, and lack of recognition, of trauma as the core basis for maladaptation. There is also misdiagnosis, which occurs when other psychiatric disorders are inaccurately diagnosed, based on overlapping symptoms and the lack of trauma as a diagnostic reference point. The following generalizations are made in the joint NASMHPD-NTAC Report:

-Trauma is frequently not asked about and is under-reported (pp 6-7).

-The role of trauma frequently goes unrecognized (pp. 6-7). One example involves the child whose depression is missed, due to the prominence of trauma-related externalizing behaviors.

-Further evidence of under-diagnosis: Treating mental health staff in one Inpatient unit identified just 2% of consumers as having PTSD. On independent assessment, however, 43% of the group was found to have PTSD (p. 6).

-Many adolescents with drug and alcohol problems also experienced childhood and/or adolescent trauma, but this often goes undetected. Adolescents with alcohol dependence are 18-21% more likely than adolescents not dependent on alcohol to have experienced sexual abuse, and 6-12% more likely to have a childhood history of physical abuse (p. 25). Similar considerations apply to individuals with drug problems, who also have a high incidence of past abuse.

-Misdiagnosis, as reflected in the following examples:

-Children exposed to trauma may be incorrectly diagnosed with ADHD (Glod and Teicher, 1996), due to the possible presence of inattention, hyperactivity, and impulsivity (also potential trauma symptoms).

Misdiagnosis of ADHD is of concern because psychostimulant medication is not the pharmacological treatment of choice for children with trauma symptoms who do not have true ADHD. [When a child has both trauma-related symptoms and ADHD, an individualized approach is then followed].

-The child with trauma-related symptoms, who is diagnosed with Oppositional Defiant Disorder (ODD) and/or Conduct Disorder (CD). Even if behaviors consistent with these diagnoses are present, recognition of underlying trauma as the potential driver of these behaviors typically does not occur.

-The child with moodiness, temper tantrums, and low frustration tolerance, who may be diagnosed as having Juvenile Bipolar Disorder.

-The child with dissociative features, including self-injurious and aggressive behaviors and substance abuse, who may be diagnosed as having Borderline Personality Disorder (Perrin et al, 2000).

-As a result of lack of identification and diagnosis of trauma – as well as a lack of understanding of what the trauma represents – children with symptomatic responses to trauma may be subject to inappropriate interventions:

-It is a central thesis of this paper that adults often misread such children by presuming that negative behaviors are intentional and willful, when in fact such

behaviors are often a consequence of neurobiological factors and prior adaptation to dangerous circumstances.

-Punitive and shaming interventions – to be distinguished from respectful adult redirection and the maintaining of accountability – typically exacerbate behaviors of concern and alienate children from helpers and help.

-In addition, at times adults mistakenly believe that helping the child decrease or eliminate negative behaviors is sufficient, when in fact such behaviors typically reflect or mask underlying trauma-related issues that need to be addressed, and the observed behaviors may even be adaptive for the child in some contexts.

-Thus, with justification the NASMHDP/NTAC Report concludes by pointing out that the centrality of abuse and trauma within mental health and substance abuse treatment often goes unappreciated:

Many mental health and substance abuse providers may be under the impression that abuse experiences are an additional problem for their clients, rather than the central problem (underlining added)...every major diagnostic category in the...DSM-IV can sometimes be related to trauma (p. 5).

-For similar reasons, Schwartz and Perry caution that it is “important to maintain a high level of suspicion regarding the post-traumatic etiology of any presenting symptoms and include the possibility of trauma in differential diagnoses of most childhood symptoms” (p. 9).

Subtle Psychological Effects of Trauma on Children

In addition to the above consequences of trauma, children and adolescents who are required to adapt to dangerous and frightening circumstances, especially within the context of poverty, tend to develop subtle changes in their thinking, beliefs, and values. Such changes lead to attitudes and behaviors that are seen by adults as pathological, even though they may have been adaptive in the past, or in some cases continue being adaptive in the community environment. The subtle psychological effects of trauma on children represent yet another manifestation of the pervasive impact of trauma, and its importance requires its own discussion below.

A CLOSER LOOK AT SUBTLE PSYCHOLOGICAL EFFECTS OF TRAUMA ON CHILDREN

Behaviors of Concern That Have Been Adaptive for Survival

As alarming as the above description of the effects of trauma on children may be, there are additional subtle internal changes that the child makes in response to the trauma experience that need to be understood. These internal changes and consequent behavioral manifestations,

while appearing maladaptive to mainstream adults and child-serving professionals, actually have often been of adaptive benefit to the child, given the need for survival.

Professionals working with children who have been exposed to trauma often encounter highly guarded individuals, who appear unresponsive to adult efforts to help. Not uncommonly, the trauma goes unrecognized and the child enters, or is at risk of entry into, the juvenile justice system. Many similar children are in Special Education as well. In addition to aggressive behaviors, these children are also at risk of self-injurious behaviors and suicide attempts (Flannery et al, 2001).

Potential Reality-Based Factors Maintaining Maladaptive Responses

Beyond the *past* adaptive functions of the seemingly negative behaviors of children exposed to trauma, there is the additional possibility that such behaviors *continue* to be adaptive due to ongoing trauma. One cannot automatically assume that all childhood trauma is in the past. Continued reality-based factors may reinforce earlier abuse-based beliefs and behaviors that are facilitative of the child's survival. Such reality-based factors might include any of the following:

- Continuing trauma and abuse, whether related to bullying, gangs, or intra-familial violence.
- Lack of safety at home and in the neighborhood and community, giving rise to lack of security and consequent hypervigilance.
- A range of additional external stressors, such as poverty, unstable housing or overcrowding, over-responsibility, problems in the home, etc.
- Continuing experiences of shaming and humiliation.

The implications of the above should be clear. Adults working with children are justifiably concerned about the child's symptoms, behaviors, skills, and relationships. As important as these are, however, it is also essential that adults be informed about the safety of the child's environment and the extent to which basic prerequisites for stable community living are present. When community safety – for the child alone or for the child and family – is absent, helping adults need to offer information, applicable referrals, and advocacy in support of the child's wellbeing.

Common Observations by Adults of Children Who Have Experienced Maltreatment

A casual adult observer, unfamiliar with maltreatment and its potential effects, might obtain a highly skewed impression of a child so affected. Many of the following characteristics apply to both males and females, but tend to be more extreme in males:

- The child often appears guarded, defensive, and angry.

- The child can be difficult to redirect, and dismisses support.
- The child manifests great reactivity. The reactivity is more frequent, more intense, and lasts longer than with unaffected children. Emotional outbursts often appear to be in response to seemingly unimportant events, and may have no immediately identifiable antecedent.
- When the child actually “loses it” and has a temper outburst or meltdown, behaviors may be extremely inappropriate and offensive, and include hurtful sexual comments, racial slurs, other personal comments, threats of harm, and actual physical aggression.
- The child has difficulty settling afterwards (e.g., has a slow recovery).
- The child tends to hold on to perceived grievances for a long period of time (e.g., holds grudges).
- The child typically does not take responsibility for his behavior, instead blaming others or minimizing the event. He thus appears to lack insight and remorse.
- The child often appears to be oppositional and disruptive “on purpose.” He/she may thus be perceived as “trying to get over” on staff and as “manipulative.” [This is an inference we will examine and challenge later].
- Especially in females, there may be overly sexualized behaviors and a lack of interpersonal and physical boundaries. Alternatively (or in addition), there may be great sensitivity to boundary violations. There may also be extreme attempts to control others.
- Internalized responses by females may involve social withdrawal and lack of response to adult efforts at engagement. More severe responses include depression, dissociative reactions, self-injurious behaviors, and suicidality.
- Males also withdraw and become depressed, but rarely will acknowledge depression.
- The child seems to make the same mistakes over and over, and does not appear to learn from experience.

Common Cognitions and Beliefs of Children Who Have Experienced Trauma

While some, but not all, of the above descriptions may accurately describe challenging children subjected to maltreatment, they represent only part of the information needed for a full understanding. Rather than being malicious and “manipulative,” such behaviors and responses may have been highly adaptive in the past, in response to danger. In addition, they may reflect physical consequences of trauma exposure, and changes in cognitive beliefs triggered by such experiences.

An individual's cognitive beliefs not only create the basis for interpersonal responses to others, but also influence one's values and morality. In turn, it is one's values and morality that provide justification for one's behavior. One study of adolescents exposed to different degrees of earthquake-related trauma in Armenia in 1988 found that trauma resulting from a severe disaster created "a psychopathological interference" with conscience functioning among adolescents who had the most severe trauma exposure (Goenjian et al, 1999). While this report is significant in demonstrating that a disaster can influence a child's moral development and interfere with the functioning of one's conscience, there remains a need for research regarding the cognitive and conscience-related outcomes in children subjected to severe, chronic maltreatment, especially those subjected to poverty and other reality-based hardships most of their lives.

Repeated clinical observations of, and conversations with, maltreated children suggest that most maintain at least some of the following beliefs:

- “The world is threatening and bewildering.”
- “The world is punitive, judgmental, humiliating, and blaming.”
- “Control is external, not internal.” Therefore, “I don't have control over my life.”
- “People are unpredictable. Very few are to be trusted.”
- “When challenged, I must defend myself – my honor, and my self-respect. Above all else, I must defend my honor – at any price.”
- “If I admit a mistake, things will be worse than if I don't.”

Potential Physically- and Developmentally-Based Factors Maintaining Maladaptation

This section considers some of the possible mediating factors that may underlie the youth's limitations and maladaptive responses. These may be substantially – although not necessarily entirely – due to the developmental and physical consequences of trauma. The child's eruptions, reactivity, and difficulty with flexibility could be a consequence of a combination of many elements. Some are associated with the traumatic exposure and its physical consequences, while others may be a consequence of unrecognized psychiatric comorbidity and learning problems. Thus, many of the mediating factors identified below may be a consequence of alterations of hormonal balance and/or interruptions in brain growth and development that may follow severe trauma exposure. From a practical point of view, each of these elements may greatly interfere with adult efforts to soothe and de-escalate a child, since the child who is upset may no longer be able to *hear* and *process*:

- Hyperarousal, predisposing to misperception and eruption. Early abuse is believed to create a particular vulnerability to hyperarousal and explosiveness, often referred to as “kindling” (Donnelly, 2003).

- Numbing and depersonalization, common sequelae to trauma.
- Lack of impulse control.
- Lack of a sense of safety and security.
- Misperceptions.
- A specific processing problem, or specific learning disability.
- The effects of any additional psychiatric disorder(s) present – e.g. depression, Bipolar Disorder, ADHD, etc.
- Limited “executive skills.” These involve the ability to analyze, consider alternatives, problem-solve, maintain self-control, and compromise.
- Limited social skills and other developmentally based delays in the acquisition of “emotional competence,” which has also been called “emotional intelligence” (Goleman, 1995). Emotional intelligence includes self-awareness, listening, relating effectively to others, and managing negative affect.

Underlying Neurobiological Processes

The neurobiological processes involved in trauma and an individual’s responses to trauma represent an area of considerable interest. Research is incomplete and ongoing, and there are important areas in need of clarification. Acute trauma constitutes a shock to a person’s system, and creates a fear response. It is known that the response to trauma events, acutely and over time, involves complex physiological systems and multiple structures within the brain, which are affected through a series of chemical activations and feedback loops.

The two chief responses to fear involve an active response, known as the “fight-or-flight” or hyperarousal response, and a passive response, known as the surrender response, which involves varying degrees of dissociation – “disengaging from stimuli in the external world and attending to an ‘internal’ world” (Perry et al, 1995). Both of these are of adaptive benefit to the organism and promote human survival. Fight or flight tends to be a male response, while dissociation tends to be a female response. However, if an initial active response characterized by crying is unsuccessful, infants and young children of both genders tend to use dissociative responses. This tends to protect the young child, who is incapable of effective fighting and effective flight. As the male child grows older, in conjunction with other variables also, he may shift from dissociation to fight or flight, and it is not uncommon for children to use a combination of both types of defensive responses (Perry et al, 1995).

Specific brain pathways and affected structures in the response to trauma include the hypothalamic-pituitary axis (HPA axis), the brain stem, the right amygdala of the limbic system, the left hippocampus, the prefrontal cortex, the vermis of the cerebellum, the corpus collosum, and the cerebral cortex, with left cortex underdevelopment (referred to as hemispheric

lateralization) (van der Kolk, pp. 300-311). It is presumed that structural changes in the brain are intimately linked to biochemical processes that occur, and that brain structure and function are altered as a result of trauma exposure, especially of a chronic nature. Practically, the affected parts of the brain are linked to critical functions for each individual. These include recognition and response to danger, interpretation of stimuli, self-regulation, memory formation, attention and ability to acquire information, processing of emotional information, control of impulses, planning, and learning from experience.

Especially prominent at a biochemical level in the brain's fight or flight response to trauma is the release of chemicals known as catecholamines, which include adrenaline and noradrenaline. Catecholamines are responsible for a variety of emergency bodily responses, including highly focused attention, increased heart rate and blood pressure, sweating, and increased energy availability in skeletal muscles. These responses create a state of hyperarousal and enable the person to focus on the danger and react actively, either in self-defense ("fight") or by removing oneself from the danger ("flight").

The immediate catecholamine release in the fight or flight response is adaptive, and promotes survival of the individual and the species. For most people, this emergency response shuts down shortly after the danger has passed. The person once again calms down and is able to attend to the wide range of events occurring at the time and afterwards. In contrast, people exposed to severe and chronic trauma often are unable to "shut down" their emergency response system (Yehuda and Davidson, pp. 16-18). As a result, they remain in a hyperaroused state, which interferes with their internal comfort level, their ability to complete daily tasks, and their capacity to listen, reason, take in information, and learn new skills.

A variation of chronic hyperarousal involves the person able to shut down, while remaining highly vulnerable to reactivation of the internal emergency system – even in response to stimuli that others would not experience as threatening. In effect, an exceedingly low stress threshold can now trigger hyperarousal. Elevated levels of catecholamines may also contribute to the over-consolidation of memories that underpins the persistent re-experiencing found in the trauma response and in PTSD (Bryant, 2003, p. 671). Thus, a common consequence of severe fight or flight reactions to trauma, in both children and adults, is that a short-term, protective response (release of catecholamines) becomes chronic and, even in the absence of objective danger, a barrier to effective functioning.

The dissociation responses form a continuum, depending on the severity of the trauma and the circumstances of the child. Initially, there is release of catecholamines as with the fight or flight response, but then a different neurobiological process occurs. With dissociation, there is an increase in vagal tone, which decreases blood pressure and heart rate despite the increased catecholamines (Perry et al, 1995). As other neurobiological processes are activated, the manifestations of early dissociation occur – for example, decreased movement, compliance, avoidance, numbing, and restrictive affect. It has been proposed that these responses may help "camouflage" the child and enable the child to organize and figure out how to respond, thereby promoting survival (Perry et al, 1995).

The role of cortisol in trauma responsiveness is not at present entirely clear. Cortisol, a glucocorticoid produced by the adrenal gland in response to stimulation by the pituitary gland, is critical to the adaptation of the organism to stress and serves to activate the emergency response. Later on, it also is involved in “turning off” the acute physiological response. Some studies have shown low cortisol levels in adults with PTSD (Donnelly, p. 251). It is hypothesized that the low level of cortisol might be associated with the impaired shut down. In contrast, some studies of traumatized children have shown elevated cortisol levels (van der Kolk, p. 304). These seemingly conflicting findings will eventually be explained and reconciled. It is likely that some people may be at greater risk than others due in part to their biological profile prior to trauma exposure (Bryant, pp. 670-672). In addition, the biological processes that occur after trauma exposure follow a changing course (Bryant, p. 672).

Regardless of the details of the neurobiological processes, it is essential that clinicians, educators, and other child-serving professionals appreciate that the symptoms and behaviors demonstrated by traumatized children, for the most part, reflect physiological and experiential responses that are not *intentional* in nature. This is of considerable practical relevance, because those working with these children “have a tendency to deal with their frustration by retaliating in ways that often uncannily repeat the child’s earlier trauma” (van der Kolk, p. 310).

The Contribution of James Garbarino – “Lost Boys”

James Garbarino, who has studied youth violence and adaptation to maltreatment for many years, addresses some of the consequences of trauma, particularly for males, not reflected in the diagnostic nomenclature but of extreme importance in understanding and working effectively with these youth (1995). In *Lost Boys: How Our Sons Turn Violent and How We Can Save Them*, he refers to what he calls the ten “facts of life” for violent males subjected to trauma (pp. 215-232). In what follows, Garbarino’s “facts” are listed and underlined, followed by brief editorial comment or elaboration underneath:

1. Survival strategies often involve antisocial and/or self-destructive responses.

Part of the problem is often denial of prior experiences and feelings.

2. Child becomes hypersensitive to arousal in the face of a (perceived) threat, with response to threat involving emotional disconnection or aggressive acting out.

Apparent disinterest can be misleading: The child may appear emotionless, “when in fact (he is) actually filled with intense emotions,” and may explode, “when pushed too far.”

3. Traumatized kids need a calming and soothing environment to increase the level at which they are functioning.

Adults “should provide an environment that encourages calmness and reflection.”

4. Traumatized youth are likely to lack a future orientation.

Without a future orientation, there is little motivation to try, and a tendency to take unnecessary risks and place oneself and others in harm's way.

5. Traumatized youth tend to develop "juvenile vigilantism," lacking trust in the adult's ability to ensure safety and feeling the need to "take matters into their own hands,"

They can only let go of this when they feel safe and protected, and experience adults as fair and trustworthy.

6. Some youth are likely to have distorted materialistic values.

Material objects are used to fill a void. This orientation is difficult to change, and requires the promotion of spiritual values and a positive identity.

7. Traumatized youth are likely to view life as meaningless.

When life is meaningless, the child lacks a sense of identity and purpose. Since "feeling like a nobody is intolerable," it follows that "even a negative definition of self is better than nothing at all."

8. Issues of shame are paramount.

Therefore, there is need for respect and saving face, to avoid humiliation and additional shame.

9. Violence can be seen as an attempt to achieve justice, as the child's sees it.

Thus, it is important to understand and begin from the point of view of the child, in non-judgmental manner, as "the first step in moral reeducation."

10. Such children often cannot afford empathy.

With needs so great and overwhelming, many of these children also have not *developed* empathy. Without empathy, they tend to depersonalize others, who are viewed as objects, not real people. Violence more easily occurs, when individuals are objectified.

Taken as a whole, Garbarino's findings further substantiate the important concept that children and youth subjected to severe maltreatment adapt in ways that promote their physical and emotional survival, even though these adaptations are often do not facilitate effective functioning in mainstream society. These children seek not to control others per se, but are trying to maintain some semblance of control in their own lives.

The Great Danger – Adults Stigmatizing Children:

We have seen that childhood trauma – particularly trauma resulting from maltreatment – represents a significant public health problem in our society. Children and adolescents who have experienced severe, chronic maltreatment are at risk of global consequences that, in combination, negatively impact normative development at many levels. Specific consequences may involve alterations of neurophysiology, brain morphology, and brain function; persistent hyper-reactivity and impulsivity; negative beliefs about the world at large and people in general; limited social skills and capacity for problem solving; multiple externalizing behaviors, often in association with substance abuse; problems with authority, which may result in eventual entry into the legal system; the development, or mimicking, of other psychiatric disorders; and a preoccupation with physical and emotional survival, associated with exquisite sensitivity to shaming, which may trigger explosive violence.

The problems of such children are significant enough, but for many reasons, adult stigmatization is often superimposed. Such stigmatization involves the inaccurate attribution of intentionality to these children, whereby they are viewed as being “manipulative” and seeking to create havoc “on purpose.” They may also be seen as “bad kids” who need to be “put in their place” and punished rather than helped. Adults need to appreciate that, even though such children may present unsympathetically, wary if not outright rejecting of adult attention in the beginning, they are manifesting behavior that has been adaptive to their survival.

There is thus a two-fold task for human service professionals, as well as for adults in the community involved with children and adolescents: The first involves the avoidance of stigmatization, which makes an already difficult situation worse. The second involves addressing the continuing impact of trauma, so that the child can feel safer and gain a better chance to live a meaningful life. It is through trauma informed care that both of these challenges can be met.

PART II: MEETING THE CHALLENGE – TRAUMA INFORMED CARE

INTRODUCTION

The term, trauma informed care, conveys a purposeful, therapeutic approach to individuals exposed to trauma, and can operate on many levels. “Trauma informed care” involves the provision of care that, borrowing from the field of cultural competence, is “trauma competent.” Trauma informed care must begin with the provision of safety, both physical and emotional, by adult caregivers to the traumatized child. In the absence of safety, the child will be unable and often unwilling to alter behavior, consider new ideas, or accept help. Children concerned about their survival cannot broaden their focus, engage in self-reflection, or allow themselves to be emotionally vulnerable. In general, trauma informed care can be provided to a child within any level of care – Inpatient, RTF, Partial Hospital, community based residences, foster care, shelters, detention, secure juvenile treatment facilities, schools, and home and community. As discussed below, trauma informed care is based on public health concepts of

prevention. Trauma informed care can be implemented as part of group interventions, and also as part of individualized responses to specific children.

Effective interventions for children with trauma-related symptoms and behaviors ultimately operate at two broad levels: 1) the level of individual physiology, with particular attention to issues of arousal and self-regulation, and 2) the larger social-environmental level, so that conditions that produce or sustain maladaptive traumatic reactions are mitigated (NETI, 2003, Module IV, “The Neurobiological and Psychological Effects of Trauma”). At both levels, the goal is to create the conditions for successful adaptation by the child. In this way, the child is able to change in a variety of synergistic ways. These include the following: the child’s baseline physiological state and degree of reactivity; the repertoire of available skills; specific behavioral responses and patterns; capacities for relating and problem solving; and changes in beliefs and values.

KEY COMPONENTS OF TRAUMA INFORMED CARE

Trauma informed care involves the closely interrelated triad of understanding, commitment, and practices, organized around the goal of successfully addressing the trauma-based needs of those receiving services. Harris and Falot discuss trauma informed *service systems*, not just trauma informed services within a specific service or level of care (2001). Within this broad conceptualization, it becomes possible to think about a trauma informed approach to multiple services, including: screening and assessment, inpatient services, case management, addiction services, and housing. For children, we can also add the category of trauma informed residential services. The authors believe that trauma informed care and creation of a trauma informed service system requires “a vital paradigm shift.”

Areas in Need of Understanding

In their discussion of the principles and philosophy of a trauma informed system, the authors identify four areas in need of understanding. These areas of understanding, with a concomitant commitment to implement the core components into practice, involve: 1) understanding trauma, understanding the consumer-survivor (the child), 3) understanding services, and 4) understanding the service relationship. These are each discussed below:

Understanding Trauma

Understanding trauma includes appreciating its prevalence and common consequences. The experience of trauma “changes the rules of the game,” with the person’s functioning and development typically skewed and now organized around “the horrific event or events” (p.12). Trauma is thus “a defining and organizing experience that forms the core of an individual’s identity,” creating a new meaning system for the child. That meaning system “then informs other life choices and guides the development of particular coping strategies,” many of which are maladaptive for the child in the larger world (pp. 11-12). There is thus need to develop a plan of care that incorporates the child’s trauma history, and that seeks to address the relationship between the trauma and current symptoms and behaviors.

Understanding the Consumer-Survivor (the Child)

Service providers need to understand the whole child, not just focus on problems and concerns. Understanding a child also involves understanding the child's familial, social, and community contexts. It is also important to try to understand the problem from the child's perspective, while also appreciating – and eventually helping the child to appreciate – that symptoms arise “as attempts to cope with intolerable circumstances” (p. 14). For recovery to occur, the child cannot remain passive or be a victim, but rather must be active in the change process and work collaboratively with those chosen to serve as “collaborators in...recovery” (p. 13).

Understanding Services

Services represent more than a mechanism to address symptoms and behaviors. In a broader sense, services need to promote understanding, self-control, and skill building. There is proactive focusing on prevention and preparing for the future. The goal of services is “to return a sense of control and autonomy” to the child (p. 16). To be effective, services must be strengths based. The latter concept is considered at length below. There is also need for staff to understand the nature of the service relationship with the child.

Understanding the Service Relationship

Service provision is not impersonal process. On the contrary, “Human services are delivered in the context of a relationship” (p. 18). Therefore, there is appreciation by staff that “trust and safety, rather than being assumed from the beginning, must be earned and demonstrated over time” (p. 20). Progress is best achieved through collaboration and a sense of partnership, which includes sharing information and acknowledging one another's strengths and areas of expertise. Decisions are the result of discussion and compromise, not unilateral action on the part of the professional, however well intentioned.

Values that Differentiate Trauma Informed Services from Traditional Services:

In a separate chapter in the same monograph, Freeman amplifies the above discussion, and identifies 4 clusters of values that differentiate trauma informed services from traditional ones (Harris and Fallot, 2001). These involve: 1) power and control, 2) authority and responsibility, 3) goals, and 4) language. These are discussed below:

Power and Control

The focus of services is on empowerment, not management and control. As a result, power and control are “vested in the consumer,” and staff willingly cede some control to the consumer (p. 76).

Authority and Responsibility

There is responsibility for staff to offer psychoeducation to the consumer, not just expert interventions. Psychoeducation is seen as essential because it “introduces consumers to the explanatory power of a trauma-informed clinical conceptualization,” linking past abuse to current coping and reframing current symptoms as attempts to cope with past abuses (p. 78).

Goals

Consistent with the provision of psychoeducation to promote understanding and coping, the goal of trauma informed services involves growth and change – the promotion of a “safer environment and better life” – not just stabilization of symptoms (p. 78). There is therefore support for the development of self-advocacy skills, and staff accept protest and intense affect by a consumer without regarding it as pathological.

Language

Language is a significant – although not the only – means of communication with consumers, and the choice of language conveys many messages to them, whether intentional or not. Choice of language should convey that staff view consumers as human beings, not as impaired cases. This means that specific terms and phrases to be avoided (some of which may need to be identified by a specific consumer). It also entails the use of everyday language and the avoidance of clinical jargon. To be sure, non-verbal communication with consumers also needs to be respectful and welcoming.

Prerequisites for Trauma Informed Services

Achieving a trauma informed system of care requires sustained effort. Harris and Fallot identify 5 prerequisites for achieving a trauma informed system of care (2001). These involve: 1) administrative commitment to change, 2) universal screening, 3) staff training and education, 4) hiring practices, and 5) review of policies and procedures. These are discussed below:

Administrative Commitment to Change

Administrative commitment in support of trauma informed care – by “those who control the allocation of resources within an organization” – is essential and must come first. The authors suggest that the commitment to trauma informed services become part of an organization’s mission statement. A defining element of a trauma informed system is that an understanding of trauma is integrated into how staff understand and respond to those being served. It is not necessary for an agency to deliver trauma-specific treatment, but this also may be offered.

Universal Screening

Screening should occur routinely, as soon after admission as possible. The authors point out that the screening process need not be complex or threatening. In fact, beyond providing

clinically relevant information about violence and trauma in the lives of consumers, use of screening conveys to them that “histories of violence and victimization matter” (p. 7).

Staff Training and Education

Since all staff interact with consumers in some manner, it is important that all receive introductory information on the impact of trauma. Provision of such introductory information to all staff is seen as more meaningful than having an intensive training for a cadre of special staff, although an agency can, over time, do both. Once staff learn about basic trauma dynamics, their view of consumers, and their responses to them, may change significantly. Externally developed curricula addressing trauma are available (Nunno and Holden, 1998), or the agency can develop its own and add it to pre-existing internal curricula. There is additional benefit in having trauma survivors speak.

Hiring practices

It is important for an agency to actively hire and designate a few staff who can serve as “trauma champions” (p. 8). These individuals can then influence treatment teams and guide specific interventions, in part by helping others to consider how behaviors or symptoms of concern may be related to abuse and violence. Hodas (2005) proposes that hiring practices, as well as training, supervision, and staff performance evaluation, incorporate 3 sets of broadly based standards that incorporate the principles and practices of trauma informed care. These standards involve: values and beliefs; job-specific expectations and competencies, including relationship building and de-escalation skills; and professional self-awareness and self-control (2005).

Review of Policies and Procedures

It should not be assumed that current policies and procedures, however carefully drafted at an earlier time, are consistent with trauma informed care. At least one staff person with a strong understanding of trauma and trauma dynamics should be part of the review group. There is need to determine if any policies or procedures are damaging and replicate past abusive practices. There is special need for alertness to “traumatic reenactments masquerading as benign practice,” and policies and procedures that may inadvertently permit and rationalize abusive responses and relationships (p. 9). Such practices are damaging at the moment, and also activate past experiences of abuse.

In what follows, we consider the important concept of strengths based treatment, with particular attention to children subjected to trauma. Next we amplify the public health model of prevention, first in general terms and then specifically related to trauma informed care. Then, following a brief consideration of trauma-specific treatment approaches, we consider broadly based programmatic approaches to trauma informed care.

STRENGTHS BASED APPROACHES AND PROMOTION OF RESILIENCE

Identifying and Recognizing Child Strengths

Effective trauma informed care is predicated on strengths based beliefs and practices. Strengths based beliefs include the presumption that the child is doing the best that he/she can, and wants to do well. Possible barriers to the child's more effective functioning may involve limitations in any of four areas – lack of support, stability, knowledge, and/or skills – and often all four. Regardless how challenging a child's behavior might be, the helper strives to gain an individualized understanding of the child's strengths and needs, and then proceeds with the belief that – once understood and supported – the child's strengths can be used to effectively address the child's limitations. Strengths based practice involves building on the strengths of the child and family, and also those in the community. Progressive, meaningful change can be achieved over time by “presuming the positive” about child and family (Hodas, 2001a), and through engagement, listening, partnering, and mutual learning.

In order to help any individual in need, one should begin by identifying and recognizing strengths and competencies, since these ultimately become the foundation for positive change (Hodas, 2001a). It is especially important to identify strengths when working with children who are challenging (Hodas, 2001b), since this promotes development of a constructive relationship and also offers tangible starting points for treatment planning.

Promoting Resilience in Children

Fortunately, not all children exposed to trauma develop serious or chronic trauma-related symptoms. This may be due to the phenomenon of “resilience.” Resilience is a term used to describe an individual's ability to withstand adversity and hardship – often but not always including exposure to trauma – and move forward with life tasks and quality of life, despite the negative circumstances (Coatsworth and Duncan, 2003, p. 2). Resilience is frequently used in relation to children and adolescents, even though the concept is applicable to individuals of all ages. A resilient child exposed to trauma may present no differently than a typical child with no such exposure.

Initially considered to be an innate characteristic of certain fortunate children, resilience is now understood to be a result of the balance of protective and risk factors affecting a child (above, pp. 2, 3). Protective factors include constitutional and psychological elements within the child, positive family factors (positive relationships, optimistic beliefs and values, sense of purpose, open communication, etc.) and community factors (social cohesion, available resources, opportunities for youth, etc.) (above, p. 4). One implication of the above, from a public health perspective, is that, under the right circumstances, resiliency can be promoted in *all children*. Another is that professionals need to identify each child's unique set of risk and protective factors, which include the child's strengths, so that risk factors can be reduced and protective factors promoted.

Common Strengths of Maltreated Youth

Unfortunately, many children exposed to trauma develop symptoms or adapt in ways that do not constitute a good fit with success in society at large. It is easy for adults to become organized by the limitations of these children, so it is essential that their strengths be recognized. While in no way inclusive, some of the strengths of challenging youth who have been maltreated include the following:

- They are very aware of how they are treated.
- They are typically responsive to respectful adults – if not immediately, then after a trust and comfort level has been reached.
- They typically recognize sincerity, and can tell when someone cares as opposed to one who is “faking it.”
- They have concern about the concepts of fairness and justice.
- They are capable of loyalty – often, great loyalty.
- They actively seek personal control and mastery.
- They have developed strong survival skills.
- They may be open to change, so long as they are offered a path that does not threaten their survival or subject them to shame and humiliation.

Identifying and Recognizing Family Strengths

In like manner, it is important that the strengths of families of children with trauma-related symptoms be identified and supported. This begins by identifying the current family caregivers/support persons and their strengths. Then, with the help of the child and immediate family, extended kin and potential community resource persons are identified and engaged. The professional then inquires about past family successes, since these serve as the basis for overcoming current challenges. The professional also asks family members to describe their goals and aspirations, in relation to both the child and the family as a whole. These goals can inform service and treatment plans, and serve as a source of ongoing motivation for the family. In addition, four assumptions, known as the “Four C’s,” can guide professionals in their work with families.

The Four C’s (*caring, competent, caught, changing*) posit that families are fundamentally *caring* and *competent* in many respects – in fact, families are often heroic in their efforts to protect their child from unsafe, traumatic situations. Nevertheless, at present the family is *caught* and uncertain regarding how to best help the child. By forming a connection with professionals and resource persons, the family can *change* in desired ways, because the development of a therapeutic alliance and the formation of a child and family team create energy

that supports new discoveries and progress. It is important for professionals to remember that parenting under the best of circumstances is a challenging endeavor. With a child experiencing a psychiatric disorder or subjected to trauma, and when the larger context is not facilitative, parenting becomes that much more difficult. Often, parents benefit from information and the acquisition of additional skills to support their parenting efforts. It is essential that professionals offer information and assistance to parents in a respectful and collegial way, building upon their pre-existing knowledge, past accomplishments, and desire to help their child.

Useful Strengths Based Assumptions

Given the challenges presented by many children subjected to trauma, professionals need strengths based assumptions in order to respond constructively to an angry, hyper-reactive child. In fact, use of pragmatically oriented, strengths based assumptions is an essential part of a therapeutic response to children and adolescents who have experienced trauma. The following are some valuable inferences and assumptions for adults, consistent with our current knowledge base and understanding of children subjected to trauma:

1. Most of the time, the “manipulative child” is feeling very *out* of control, not in charge.
2. Behavior that may appear to be *intentional* usually is not – it is more likely reactive, impulsive, or the result of limited social skills and emotional competence, emotional delay, and/or neurobiological factors.
3. The child therefore needs developmental support – support of the child’s personal psychosocial development, to help reverse negative prior learning – and help in acquisition of new skills.
4. The key determinant of the adult’s ability to help the child with emotional and behavioral problems is the ability of that adult to form a therapeutic relationship with the child. A therapeutic relationship is one that is: supportive, respectful, friendly, consistent, non-threatening, strengths-based, consistent with the child’s developmental abilities and individualized needs, and based on clear expectations and standards.
5. A relationship that is “therapeutic” does not imply that the adult engages in psychotherapy with the child, but that the adult responds in ways *of therapeutic benefit* – developmentally, behaviorally, socially, and emotionally – to the child. This includes expressions of caring and support, managing one’s own frustrations, and opportunities for the child to express oneself, be listened to, and save face. In such a relationship, the child trusts the adult.
6. The core consideration in interacting with children who are challenging involves helping them avoid shame and humiliation. Gilligan, in his work in prisons, has identified shame and humiliation as the core element that triggers most violence:

...the basic psychological motive, or cause, of violent behavior is the wish to ward off or eliminate the feeling of shame and humiliation – a feeling that is painful

and can even be intolerable and overwhelming – and replace it with...a feeling of pride (p. 29).

It should be understood that the need to avoid shaming and humiliation of a child does not in any way preclude efforts to educate and redirect the child. In fact, it is essential that adults do this. A respectful approach to a child increases that child's sense of safety and security and thereby increases the likelihood of openness to input and subsequent internal reflection. Shaming the child, in contrast, solidifies the child's defensiveness and externalizes the issue into an interpersonal conflict.

7. Finally, given the pervasiveness of trauma in childhood and adolescence, it is appropriate to borrow a concept from physical medicine – that of *universal precautions* – as a prudent way to avoid preventable negative outcomes (in medicine, this involves prevention of exposure to contaminated blood).

As part of trauma informed care, what is proposed here is that each adult working with any child or adolescent *presume* that the child has been trauma exposed. With this presumption in place, the use of universal precautions in support of trauma informed care involves providing unconditional respect to the child and being careful not to challenge him/her in ways that produce shame and humiliation. Such an approach has no down side, since children who have been exposed to trauma require it, and other, more fortunate children deserve and can also benefit from this fundamentally humanistic commitment.

USE OF THE PUBLIC HEALTH MODEL OF PREVENTION

Introduction

In public health, prevention is paramount, and there is recognition of three different levels of prevention -- *primary*, *secondary*, and *tertiary prevention*. These prevention concepts are also now being referred to as *universal*, *selective*, and *indicated* interventions, respectively. Due to the benefits accruing from the explicit use of “prevention,” so relevant here, the language of prevention (primary, secondary, and tertiary) will be maintained in the discussion that follows.

In general, *primary prevention* involves creating circumstances that prevent the onset of problems for an entire population. This may be achieved through programming that all involved children receive (universal programming). It also occurs through screening procedures that include an entire group. Primary prevention occurs when the structure and climate of a setting – whether a classroom, a neighborhood, or community – are organized so as to meet the needs of the population and to create a sense of wellbeing, respect, and trust. In this way, there is prevention of potential re-traumatization, since there is reduced likelihood that involved children will re-experience trauma in such a setting.

Secondary prevention involves responding to at-risk individuals within a group or population, prior to the onset of serious problems. Following a screening process, for example,

those individuals identified as being at risk can receive an assessment. Assessing children whose screens raise concerns about possible diagnosable disorders constitutes secondary prevention, and the goals are to prevent serious problems from developing and to make a referral, if indicated. Another example of secondary prevention involves linking an at-risk child with a mentor in a Big Brothers Big Sisters of America Program. This volunteer, community based program has been shown to be evidence-based (Elliot, 1998, see also Blueprint website). A core element of successful outcomes in this program involves the presence of a strong mentoring relationship, so that “participating youth come to...experience their mentors as significant adults in their lives” (DuBois et al. 2002. p. 54). The importance here of the relationship between child and adult volunteer underscores the importance of relationships at all levels of helping, whether in prevention or in treatment. In treatment settings, it is early response by staff to the distressed child that often determines the success of secondary prevention efforts.

Tertiary prevention involves addressing the needs of those individuals with known severe emotional disturbance (SED). Tertiary prevention actually constitutes what we regard as “treatment” of identified psychiatric disorders, but such treatment is also preventive in terms of containing the problem, preventing comorbidity, and improving the child’s functioning and adaptive capacity.

At all of the above levels, prevention is based on an ecological model that includes the child, family, community, and a variety of other contextual elements that vary from child to child. The goal is to understand as much about each of these variables as possible, so that prevention (and intervention also) can reduce risk factors and promote protective factors (Greenberg et al, 2000, p. 3). The biopsychosocial perspective as a frame of reference for understanding the child is also relevant here, since risk and protective factors encompass *biological factors* affecting the child, the child’s unique *psychology* (including emotional strengths, needs, history, beliefs, and values), and the broader *social* environment (the child’s context or ecology). Both competence and disorder in children are determined in multiple ways, so effective prevention programs can have direct effects “on diverse outcomes” – for example, by decreasing the incidence of many negative outcomes and increasing the incidence of many positive ones, thereby promoting the child’s healthy development (Greenberg et al, pp. 3, 4).

Assessment and Identification of Childhood Trauma

The identification of trauma exposure in children is consistent with a public health focus on prevention. While it is beneficial to use “universal precautions” for trauma and children – by making the operational assumption that every child has been exposed to trauma and therefore should receive trauma informed care – it is also an important part of individualized care to obtain a specific trauma history for each child. A “thorough trauma assessment with children and adolescents is a prerequisite to preventing the potentially chronic and severe problems in biopsychosocial functioning that can occur when PTSD and associated or comorbid behavioral health disorders go undiagnosed and untreated” (Wolpaw and Ford, 2004, p. 3). Therefore, assessment and identification of trauma – along with identification of other mental health and/or drug and alcohol disorders – are important precursors to trauma informed care.

Questions about trauma should be part of the routine mental health intake of children, with parallel questions posed to the child's parent or legal guardian. Screening and assessment for trauma should occur not only in mental health settings, but also in juvenile justice and child protection settings as well. Assessment for trauma exposure and impact should be a routine part of psychiatric and psychological evaluations, and of all assessments that are face-to-face.

Wolpov and Ford indicate that there are three basic approaches to the assessment of trauma and post-traumatic sequelae in children through tools and instruments. First are those instruments that directly measure traumatic experiences or reactions. Second are broadly based diagnostic instruments that include PTSD subscales. Third, there are instruments that assess symptoms that are not trauma specific but commonly associated symptoms of trauma. Examples of such symptoms include anxiety, depression, and dissociation (p. 6).

The use of de-escalation preference surveys/safety plans, a secondary prevention intervention, represents an indirect method of finding out about trauma exposure (NETI, 2003). For example, in indicating a desire not to be touched, a child may be reflecting past negative experiences in which trauma was inflicted and personal boundaries violated. Similarly, in institutional settings, use of a risk assessment tool to determine potential contraindications to the use of restraint requires that information on past abuse be obtained.

A useful screening tool for traumatic exposure that can be completed directly by a youth or older school-age child is the "Traumatic Events Screening Instrument – Self Report Revised," which is available at the website of the National Child Traumatic Stress Network (TESI-C/Self Report Revised, www.NCTSNet.org). The TESI systematically asks about the full range of traumatic experiences, including the severity and consequences of the trauma in question. The range of traumas include the following:

- Direct involvement or witnessing a bad accident involving serious injury or death.
- Being involved in a natural disaster.
- Serious illness or death of someone close to the child.
- Other unnatural death of someone close to the child.
- Direct experience of serious physical symptoms or illness.
- Significant separation from caregivers.
- Knowledge of suicide attempt or completed suicide by someone close to the child.
- Physical abuse, or serious threat of violence from anyone.
- Being jumped or mugged.
- Being kidnapped, or knowing someone who was.

- Being attacked by a dog or other animal.
- Witnessing domestic violence, or experiencing the threat of violence in the family.
- Use of a weapon in the family.
- Arrest or incarceration of a family member.
- Exposure to community violence.
- Direct involvement in war or a terrorist attack, or watching these on TV.
- Experience of neglect and not having “the right care.”
- Experience of sexual abuse or sexual exploitation, or observing forced sex acts.
- Experience of emotional abuse or threats of permanent rejection.
- Observing drug use by others.

Other important considerations regarding trauma assessment include the following (Wolpow and Ford, 2004):

- It is essential to determine if the child is still living in a dangerous environment, since this needs to be addressed and the child’s symptoms and behaviors in the face of real danger may actually promote survival.
- While being asked about trauma exposure and its consequences, the child needs to be provided a genuinely safe setting, and needs to be informed about the nature – and limitations – of confidentiality.
- Multiple perspectives about trauma help broaden the information base. Thus, parents and legal guardians should be asked questions or asked to complete relevant questionnaires, not just the child. In addition, with the child a combination of self-report and assessor-directed questions is especially beneficial.
- It is important to recognize the potential impact of both culture and developmental level, while obtaining trauma information from children. Some children may not be able to understand certain questions. Others may tend to withhold information due to culturally based constraints.

Finally, since questions about trauma may be de-stabilizing for some children, it is important that some responsible clinician or case manager monitor the response of the child, so that the assessment process can be modified or interrupted, when indicated. This monitoring of the child during assessment reflects the responsibility of the professional to appreciate that

assessment impacts the child emotionally and, in essence, constitutes a therapeutic intervention, not solely an information-gathering activity.

Addressing Reality-Based Trauma, When It Persists

A clear priority for professionals in contact with children who have been exposed to trauma involves assessing the child's current community reality – in particular, trying to ascertain whether or not trauma is ongoing or confined to the past. When trauma is ongoing or at risk of re-occurrence, multi-system intervention is needed. When a child's ongoing trauma is related to socioeconomic issues, community based interventions and referrals, and short-term economic and practical support, may be of particular benefit to child and family. Children and Youth involvement may become necessary in response to child protection concerns in the home.

Even when a child protection issue is present, it is important to presume that most parents and other caregivers want to promote the wellbeing of the child. Consistent with this perspective, Family Group Decision Making (FGDM) is a strengths based approach to child protection in which the dignity of the parents is maintained, such that they and members of their extended network are afforded the opportunity to develop a safety plan for the child and partner with the involved professionals (American Humane Association, 2000, Harper et al, 2002, and Pennell and Burford, 1995).

Variability of Outcomes for Children Subjected to Trauma

We have seen that trauma exposure does not result in serious negative consequences for every exposed child. Variables that determine the outcome of trauma include the nature of the trauma, the characteristics of the child, the nature of the pre-existing support system, and the events that follow the trauma. "Resilience" is the term that helps explain the positive outcomes of many children, and it is essential that resilience not be viewed as representing solely the intrinsic characteristics of a child. Reality-based, extrinsic factors influence the outcome as well. Ultimately, it is the net balance of protective factors in relation to risk factors that determines outcome (Coatsworth and Duncan, 2003). Safe, stable, enduring relationships are particularly important protective factors for a child.

Children and adolescents who have been exposed to trauma need holistic, integrated interventions. This is especially the case in instances of co-occurring disorders involving serious trauma-related symptoms and substance abuse. As described in the NASMHPD Report (2004) cited earlier, "Without trauma informed interventions, there can exist a self-perpetuating cycle involving PTSD and substance abuse." The cycle can be described as follows: Trauma leads to PTSD, which in turn leads to substance use. Substance use creates a greater likelihood of retraumatization and PTSD. As the individual experiences renewed trauma and symptoms of PTSD, there is further likelihood of substance use (p. 6). In addition, it needs to be recognized that, without attention to trauma, PTSD symptoms often worsen during the initial stages of abstinence, leading to a high probability of drug or alcohol relapse (p. 6). For such reasons, there is a growing consensus that the successful treatment of dual diagnosis (also referred to as co-occurring disorders) requires that trauma sequelae be addressed concurrently with substance abuse (p. 7).

Children with severe traumatic reactions who do not receive appropriate interventions will likely experience interruption of the normal developmental process, with devastating outcomes as have been described. It has been estimated that “at least half of all children exposed (to trauma) may be expected to develop significant neuropsychiatric symptomatology” (Perry et al, 1995). Furthermore, more than 30% of children living through traumatic stress develop some form of PTSD (Perry, 2004). Children with significant trauma reactions will benefit from trauma informed care. Some of these children, however, may also need even more intensive and specialized interventions. These are known as trauma-specific treatments.

Trauma-Specific Treatment – Supplemental Interventions for Those Most Affected

There are trauma-specific treatments for those who have experienced acute trauma that does not resolve with supportive interventions and trauma informed care, and for those dealing with severe, chronic, unremitting trauma-related symptoms. While these treatments will be considered briefly, it is not the intent of this paper to review them in great detail, since our focus is primarily on trauma informed care, not trauma-specific treatment. The general concept is that trauma-specific treatment is typically reserved for the most severe and chronic traumatic stress reactions. Fortunately, the great majority of children exposed to trauma respond favorably to acute crisis intervention soon after trauma exposure, and to social support. Other children, for example those in institutional settings, gain considerable benefit from programmatically based trauma informed care within these settings. At the same time, for some children supportive approaches and even trauma informed care are insufficient. These are the children in need of trauma-specific treatment, which may be provided by the primary provider agency or obtained through outside consultation or referral.

Adult survivors of abuse, especially women who experienced child sexual abuse, have for many years offered self-help perspectives on healing (Bass and Davis, 1988), which involve addressing the abuse per se and gaining a broader perspective on the experience and on oneself as an integrated person. Professional psychotherapy for trauma and the promotion of recovery were greatly influenced by Herman (*Trauma and Recovery*, 1992), who centers her treatment on “the empowerment of the survivor, (who) must be the author and arbiter of her own recovery.” (p. 133). Herman’s core treatment themes involve a healing relationship, safety, remembrance and mourning, reconnection, and commonality. These same ideas are often used, appropriately tailored to the child’s age and developmental level, in the therapy of children who have experienced sexual abuse and other trauma.

Although not specific to children, the Practice Guidelines of the American Psychiatric Association for the Treatment of Patients with Acute Stress Disorder and Posttraumatic Stress Disorder (2004), comprehensively identify the goals of a treatment intended to address trauma: reduction of the severity of trauma-related symptoms; prevention or treatment of trauma-related co-morbid conditions; improving adaptive functioning; restoring a psychological sense of safety and trust; limiting the generalization of the danger; and protecting against relapse. If a trauma-specific treatment achieves all of these, it is likely that the disruption to the child’s overall development will be diminished.

In generalizing about the core elements of most treatments that address trauma, Mahoney et al (2004) identify a shared emphasis on teaching key skills that include the following components: 1) emotion identification, processing and regulation; 2) anxiety management; 3) identification and alteration of maladaptive cognitions; and 4) interpersonal communication and social problem solving.

Trauma treatment for children needs to be tailored to the age and developmental level of the child. As in the approach to the child in the aftermath of an acute traumatic event, the treatment of severe and chronic trauma responses needs to be flexible and compassionate, with primary reliance on non-verbal approaches for very young children and combinations of verbal and non-verbal interventions for older children. Specialized techniques may include play therapy, art, storytelling, and role-playing (Schwartz and Perry, 1994). Individual trauma-specific therapy can be provided in the home, school, office, or residential setting. When the child is living at home, clinical treatment can at times be supported in the school and community, with such efforts most effective when coordinated. As with all interventions with children, trauma treatment needs to incorporate understanding of the child and family culture, so that it is culturally competent (Benjamin and Isaacs-Shockley, 1996).

A limitation of current research is that more trauma-specific treatments have been studied systematically with adults than with children. Nevertheless, there is an increasing evidence base related to trauma-specific treatment for children. Notably, Cognitive Behavior Therapy (CBT) in various forms is regarded as either “promising” or “evidence-based” for children in the treatment of PTSD and PTSD with substance abuse (Mahoney et al, 2004). Perrin et al state that there is “general consensus among trauma experts” that CBT for children and adolescents constitutes “the ‘first-line’ treatment for PTSD” (2000, p. 286). They identify four critical components of CBT for childhood PTSD: 1) education and goal-setting, with both child and parents involved; 2) coping skill development, which can be varied and includes recognition of “triggers” for anxiety, with the child learning to quantify anxiety; 3) exposure, which involves the use of imaginative or in vivo exposure “to facilitate emotional processing of traumatic memories” (p. 285); and 4) termination and relapse prevention, sometimes followed up with one or two booster sessions.

Other specialized approaches to trauma have also been used with children and adolescents. These include Dialectical Behavior Therapy (DBT) (Linehan, 1993) and other behavioral approaches. There has been use of eye movement desensitization and reprocessing (EMDR), but there are no controlled studies of this approach with children, and many regard it as controversial (Perrin et al, p. 284).

There is only limited controlled evidence on the effectiveness of individual and family psychosocial approaches, but this is changing. For example, a recent randomized, controlled clinical trial for children with sexual abuse-related PTSD symptoms demonstrated the effectiveness of both established treatment models studied (Child Centered Therapy, CCT, and Trauma Focused-Cognitive Behavioral Therapy, TF-CBT), each of which work with the parent and child together, not solely the child alone. TF-CBT, which is the more active treatment model, had better outcomes on measures related to PTSD, depression, total behavior problems, and interpersonal trust, and parents assigned to TF-CBT reported greater improvement in their

own depression, abuse-related distress, parental support, and parenting practices (Cohen et al, 2004a).

Other evidence-based approaches have also been developed. For example, Lieberman has shown positive outcomes involving the use of Parent-Child Psychotherapy with young children exposed to violence (2005). Cohen et al have described the use of Trauma Focused-Cognitive Behavior Therapy (TF-CBT) in the treatment of childhood traumatic grief (2004b). Stein has provided data on the effectiveness of the CBITS program – Cognitive-Behavioral Intervention for Trauma in Schools (2003). Saxe et al have described the Trauma Systems Therapy approach and have offered preliminary data as well (2005). There are other treatments to child trauma and maltreatment that also have evidence (see www.NCTSNet.org).

Many of the above treatments address the concern identified in the NASMHPD Report on trauma, that there be greater use of “trauma-focused relational psychotherapy” in addressing the consequences of trauma (NASMHPD/NTAC Report, p. 59).

The issue of psychotropic medication for children can be controversial, and clearly medication is not the first-line response in most situations, especially for younger children. However, when trauma symptoms are severe and incapacitating, and when comorbid psychiatric disorders are present that would typically be treated, one has to weigh the risk of using medication with the risk of *not* using medication. Many trauma experts agree that there may be a role for psychotropic medication in the individual treatment of trauma-based symptoms, particularly in the presence of extreme hyperarousal and emotional reactivity (Donnelly, 2003, pp. 257-258). DeBellis states, “Pharmacological treatments for PTSD that dampen the activity of the major biological stress systems...in conjunction with psychotherapy and social skills training, may provide an effective treatment strategy for maltreated children who suffer from PTSD.” Pharmacological intervention, he adds, “may prevent the secondary long-term adverse psychobiological consequences of traumatic stress in these patients” (p. 3).

Thus, children with PTSD or other serious trauma symptoms, and those with comorbid psychiatric disorders known to be medication-responsive, may be good candidates for psychotropic medication. Unfortunately, there are few randomized, controlled studies involving use of psychotropic medication for trauma symptoms in children, but such studies are currently being pursued in many research centers. Some medications used in treating PTSD are not FDA approved for this purpose, either in general or for children. However, the off-label use of medication is a common practice that is often clinically justified, so long as child and family are informed of this and are educated regarding expected therapeutic effects and possible side effects. Additional ethical considerations involve ensuring that medication is being given to address specific target symptoms that are monitored over time, and that medication is not used to sedate or incapacitate the child. Appropriate use of psychotropic medication, by addressing symptoms that interfere with self-regulation and daily functioning, can promote the child’s capacity to make use of psychotherapy and other treatments. Psychotropic medication should typically not constitute the only intervention for children with significant trauma based impairments.

First-line medications for trauma symptoms include the selective serotonin reuptake inhibitor (SSRI) antidepressants, which also have anti-anxiety properties. Medications that specifically target hyper-arousal and hyperactivity include the adrenergic agents, clonidine or guanfacine. In cases of extreme mood lability and anger dyscontrol (p. 263), there may be a role for mood stabilizers (lithium, valproic acid, and carbamazepine). An atypical neuroleptic medication (risperidone, olanzapine, quetiapine, aripiprazole, etc.), often in low doses, can also be helpful in addressing hyperarousal and symptoms of anger and mood lability.

The following generalizations are offered regarding the use of psychotropic medication for children with trauma symptoms: 1) Medication can play a meaningful role in the individual treatment of some children, and in fact can help them improve their overall function and quality of life and benefit more fully from other interventions. 2) There is no universal medication protocol or algorithm at present, since symptom complexes vary and children also vary in their responses and sensitivity to different classes of medication. 3) Medication alone is rarely if ever adequate in addressing significant trauma symptoms. 4) In treatment trials for PTSD, it has become “state of the art (practice)...to define optimal outcomes in terms of reduced severity of anxiety and depression in addition to PTSD per se and global improvement scales, which may include measurement of general function and quality of life” (Donnelly, p. 264). Thus, use of medication, always an individualized decision, can potentially improve the child’s functioning and overall sense of wellbeing, not just trauma-related symptoms per se.

Overall, it can be stated that the evidence base present for most trauma-specific treatments for children, regardless of type, is limited but growing. There is therefore need for continued clinical research and for additional support for such research. Since relatively few clinicians have been trained in trauma-specific treatments, it is often difficult for children and families to obtain this kind of assistance, so there are clear training and access needs as well. It is also important to appreciate that, in order to be effective, specialized interventions need to be based on trusting therapeutic relationships in which the therapist works to help the child regain a sense of hopefulness, what Frank refers to as “remoralization” (1991). Technical expertise in the absence of a therapeutic relationship will likely be of little benefit to the child. The therapist, within the context of a trusting relationship, seeks to create and maintain a calm, nurturing environment for the child (NASMHPD, 2004) and support the child’s active coping, thereby preventing loss of control. Ultimately, trauma-specific treatments need to restore a sense of mastery to the child and transform previous experiences of terror and uncertainty into some kind of reassuring, age-appropriate, explanatory framework. In this way, the child’s “sense of having been damaged, demoralized, and made different in a negative and shameful way” due to the trauma can be mollified and (hopefully) eliminated (Kluft et al, 2000, p. 88).

Finally, consistent with the design of the most holistic evidence based approaches to childhood trauma, it is always important to work with the child within the context of the family and community, not in isolation. Families in particular remain the single most important resource for a child dealing with trauma exposure and trauma-related symptoms. As such, families should be supported by professionals and actively included in all aspects of the treatment process. Communities can also support the safety of children, and the role of community mentors should not be under-estimated (Canada, 1998, and Anderson, 1999).

PROGRAMMATIC APPROACHES TO TRAUMA INFORMED CARE

Key Goals and Application of Prevention Concepts to the Program Level

A great deal can be done at the programmatic level to provide trauma informed care and to create a trauma informed therapeutic community (NETI, 2003, and Bloom, 2003). At this level, key goals include promoting wellness and a therapeutic experience for the child, preventing crisis, and intervening at the early signs of a problem. A key principle involves the avoidance of coercion – both verbal and physical – in favor of approaches that promote partnership with the child and build on comprehensive knowledge by staff of the child’s individualized strengths, needs, and treatment plan. The avoidance of coercion includes a strong commitment to do everything possible to prevent use of seclusion and restraint, except as a last resort in situations involving imminently lethal behavior. Programs are encouraged to actively monitor the use of seclusion and restraint and to work toward their reduction and eventual elimination, through system-wide efforts that begin with administrative and clinical leadership and incorporate staff at all levels together with children and families.

There are many reasons for the increasing focus in human services on the prevention of seclusion and restraint. First is the recognition that seclusion and restraint are not treatment but instead constitute emergency interventions that reflect an overall failure of the treatment system to meet the needs of the child (Hardenstine, 2001, Hodas, 2004a). Second, there is considerable risk associated with their use, particularly use of restraint. Serious injuries and even deaths have occurred during restraint administration, and this remains an ongoing concern each time a restraint is applied (Allen, 1998). Third, individuals being restrained almost invariably experience this as psychologically stressful and even terrifying, and staff applying a restraint may have similar reactions. Restraint is thus traumatizing and – for those previously traumatized – potentially re-traumatizing (NETI, 2003). Finally, more and more, consumers, families, and oversight bodies view a program’s use of restrictive procedures as reflecting an underlying deficit based treatment philosophy and the limitations of its clinical practices.

Within the context of treatment programs, public health prevention concepts can be slightly modified, so that they address the following:

1. *Primary prevention* – Creating culture, climate, clinical knowledge base, and therapeutic relationships in order to prevent crises, meet the needs of the child proactively, and avoid the need for coercion and restrictive procedures. Primary prevention at the program level also includes wellness approaches, both individual and group-based.
2. *Secondary prevention* – Responding to crisis or imminent crisis through use of relationships and de-escalation approaches, in order to prevent escalation and need for restrictive procedures, including physical restraint. Early intervention by alert staff is especially important.
3. *Tertiary prevention* – Terminating a restrictive procedure – when it has become necessary as a last resort to preserve safety – as soon as feasible, and learning from the

incident, to benefit the child, staff, other children, and program. Prevention comes through the learning and debriefment processes that follow discontinuation of the restrictive procedure. Prevention also involves the use of continuous quality improvement, to benefit the individual child and the overall program.

Important Programmatic Elements that Promote Trauma Informed Care

Programs can effectively create and maintain a non-coercive, trauma informed environment to address underlying trauma-related needs by using the public health model of prevention. The discussion that follows considers prevention in terms of each of the three levels of primary, secondary, and tertiary prevention, with appropriate references for each.

Primary Prevention

Primary prevention involves interventions intended to prevent crises, so that children benefit from the program and are unlikely to experience trauma and be retraumatized. Primary prevention involves creating an environment where children are treated as individuals, rules are minimized, shaming does not occur, staff listen and do not need to “win,” and there are many choices available. Such an environment is safe and builds hope and resilience. Primary prevention is applicable to the entire population of children being served. All of the following constitute primary prevention steps that can be undertaken at the program and/or larger agency level:

- A clear statement from administrative and clinical program leadership that identifies the program as committed to providing a trauma informed, non-violent, healing therapeutic community. Such a statement should specifically identify a commitment to reduce, and work toward elimination of, the use of seclusion and restraint. A statement incorporating the above commitments can be added to the organization’s mission or philosophy statement. In the absence of this, there should at least be a clearly articulated commitment at the program level.

- A willingness on the part of leadership to examine and, as needed, change program culture and practices, so that the latter are consistent with strengths based, trauma informed treatment.

- A commitment to maintain a setting that is individualized to the unique needs of each child, with the capacity to prioritize and be flexible. Greene refers to this as a “user-friendly environment” (1998).

- A practical plan by leadership to educate and supervise staff in such key areas as normal development, psychiatric and substance use disorders, the pervasiveness and impact of trauma, the dynamics of trauma for each individual child, strengths based treatment, the maintenance of user-friendly environments, and use of a broad range of de-escalation approaches. Goals of such training include the avoidance of restrictive procedures and the need for collaboration with child, family, and other involved professionals.

-Efforts to make the physical treatment environment appealing, age-appropriate, and culturally competent. Similar efforts should be undertaken with schedules and programming for the children – e.g. they need to engage the child, so that participation is active and not coerced.

-Ongoing efforts to maintain contact, and actively collaborate, with the child's family. The family is seen as a partner with staff in efforts to prevent crises and help the child benefit from interventions and treatment.

-Use of screening and de-escalation tools upon (or shortly after) admission based on information from child and family, in order to gain a comprehensive understanding of each child being served. Such tools include a trauma history survey, a risk assessment for violence and aggression, and a systematic assessment of contraindications to the use of seclusion and restraint. With this information available, staff can then work collaboratively with the child to complete a client de-escalation preference survey/safety plan, which identifies optimal ways to help the child maintain self-control when provoked or upset and offers guidance to intervening staff. These documents can both inform and complement the child's individualized treatment plan. It is essential that such information then be shared among staff and followed, not just filed in the child's chart.

-Sound understanding by staff of the population being served. This includes an appreciation of the culture, race, religion, and ethnicity of children and their families and of variations within larger groups. It also includes understanding the role of gender in the genesis of trauma and possible gender-related differences to trauma and treatment, including the increased vulnerability of females to internalizing responses and self-injurious behaviors. Understanding of child development involves recognizing age-related capabilities and developmental tasks, and the process of child development from a neurobiological perspective.

-Active efforts to help each child develop effective social and coping skills. Over time, the development and eventual generalization of such skills provides the child greater mastery in relationships and in the community. With skill development, the child becomes more resilient and better able to self-regulate and self-advocate. The likelihood of a meltdown decreases when a child has alternative ways to deal with frustration and resolve issues. Commercially available curricula address child coping and skill development. As an alternative, programs may research and develop their own curriculum. Either way, all staff within a program need to understand and implement the same approach.

-Helping *the child* understand the dynamics of trauma in general, and the specific dynamics as they apply to his/her life and adaptation efforts to date.

-Formal adoption and implementation of a trauma program by the agency. Creation of a Task Force or workgroup is an important initial step. The agency can implement its own program, or implement a specific model already available within the field. An example of the latter is the Sanctuary Model, as developed by Bloom (2003a and 2003b, Rivard,

2004 and 2005). The success of the initiative, regardless of its source, will depend substantially on the degree of ongoing commitment by program leadership and staff.

-In schools and other community based settings, adoption of primary prevention programs that reduce the likelihood of violence and violence exposure. These can be implemented in educational and community settings, not just in residential programs. An example of a school-based program for students from kindergarten through 5th grade is the evidence-based PATHS Program (Promoting Alternative THinking Strategies, see Blueprints website). The classroom teacher presents the curriculum 3 times per week, for a minimum of 20-30 minutes each time. This universal curriculum has been implemented for students in both regular and special education settings. There have been many positive, demonstrated outcomes from the PATHS Program, including improved self-control, better understanding and recognition of emotions, improved frustration tolerance, effective conflict resolution, improved thinking and planning, and decreases in anxiety, depression, and conduct problems (see Blueprints website).

Secondary Prevention

Secondary prevention involves attending to those children who are at risk of entering crisis or who are already provoked and upset, with the goal of resolving the situation calmly and therapeutically, without need for coercion or restrictive procedures. Effective secondary prevention becomes less necessary in those settings where there is ongoing commitment to primary prevention, as discussed above. The following responses and interventions constitute selective examples of secondary prevention:

-The provision of unconditional respect to each child, which is offered even when respect is not returned or reciprocal. It should be appreciated that the provision of unconditional respect in no way interferes with maintaining accountability. Respect reaffirms the basic humanity of the individual being addressed, and also avoids the toxic effect of shaming. In addition, "it is because of the central role of shame in instigating and sustaining violence that we must communicate respect...as a precondition for transformation of troubled and violent (youth) (Garbarino, 1999, p. 229).

-Maintaining a soothing environment, with avoidance of yelling and rebuke.

-Responding immediately to any signs of conflict, disruption of the milieu, or changes in behavior indicating distress.

-A focus on strengths and positive intentions, maintaining the assumption that the child wants to do well. The direct care worker and/or therapist must believe that, given sufficient knowledge, support, stability, and skills, the child would do well.

-Using information from the child's de-escalation preference survey/safety plan, trauma history, treatment plan, and other information previously provided by the child.

-Obtaining individualized information from the present, to guide the child's efforts at self-control as well as staff interventions. Staff should modify pre-existing information, based upon the immediate response of the child to de-escalation efforts.

-Continual efforts at engagement and affirmation. This process should be continuous and unrelenting. In so doing, the staff person "...convey(s) acceptance as an antidote to shame" (Garbarino, 1999, p. 299).

-Concern with the child's perceptions, not just one's own. Staff tries to understand the situation from the child's point of view, not just their own. This means that, even if a child's statement does not appear to be accurate ("My counselor, Sam, hates me"), there still is need to explore further, in order to identify and address a possible conflict or unmet need.

-Avoidance of power struggles and coercive responses. The goal is to maintain safety, de-escalate, and then learn from the experience jointly afterwards. Youth, in part due to the legacy of past trauma and in part due to their developmental stage, tend to escalate blindly when engaged in a power struggle. As stated by Garbarino:

Adults dealing with these kids should avoid power assertion whenever possible to reduce the experience of threat and thus maintain the youth in an emotionally engaged and nonaggressive state. 'Gentle but firm, always kind' should be the watchword (Lost Boys, p. 220).

-Maintaining awareness of issues of personal space. Staff, through information provided in the client de-escalation preference survey/safety plan, should be clear which children welcome hugs and touch and which regard such proximity as threatening. In addition, staff should determine the most appropriate degree of physical proximity at each moment in responding to the child in crisis.

-Avoiding the temptation to compare one child with another. This process, rather than motivating, tends to enrage and shame children. It is far better to regard each child as his/her own control by monitoring progress over time, and to encourage the child to remember an earlier time when he/she was able to deal with frustration effectively.

-Continual efforts to educate, confirm, redirect, and process with the child. Educational input can involve any aspect of the information learned about and from the child. It should also include reviewing the dynamics of trauma with the child, so that the child can begin understanding the course of anger and rage, and encouraging the child to use coping skills to gain personal control.

-Adults, acting as mentors, modeling flexibility and compassion.

-Adults managing their own internal reactions and subsequent external responses, when interacting with children who are challenging. The words and behaviors of children who are angry and distressed can at times be hurtful to helpers. Staff need to be centered and

supported so that they neither burn out nor act out, in response to genuine provocation. Avoiding potentially aggressive responses (counter-aggression) and/or internal numbing requires training, supervision, and support, begun for staff as part of primary prevention and continued as part of secondary and tertiary prevention.

Tertiary Prevention

Tertiary prevention becomes applicable when a crisis has occurred requiring use of seclusion, restraint, or other coercive interventions. Under such circumstances, there is need for termination of the crisis and the restrictive procedure, plus a subsequent process of debriefing and learning from the incident. In situations where a restrictive procedure is implemented, the need for tertiary prevention reflects a failure of primary and secondary prevention to meet the needs of the child in question. This in turn constitutes a failure in treatment, which should serve as an impetus for program improvement. Specific examples of tertiary prevention include the following:

- The restrictive procedure is implemented for the shortest necessary interval. The child is clearly informed of the criteria for its discontinuation.
- The physical and emotional needs of the child are addressed continuously, as identified by federal and state regulations and other relevant authorities, such as the Joint Commission on Accreditation on Healthcare Organizations (JCAHO, 2003) and the Child Welfare League of America (2004).
- Involved staff continue efforts at engaging the child, using relationships constructively, in support of de-escalation. Every effort is made to avoid provoking the child or turning the incident into a personal power struggle.
- Upon discontinuation of the restrictive procedure and resolution of the crisis, the child is examined by a nurse, to determine if there are injuries in need of documentation and attention. As needed, involved staff also see the nurse and receive necessary medical attention.
- Upon discontinuation of the restrictive procedure, staff determine if there is need to attend to other children who witnessed the incident (contagion), or to the milieu as a whole.
- A short de-briefing occurs, involving the child and involved staff or other staff (e.g. the supervisor), if this appears more appropriate.
- A formal debriefing occurs the next workday, involving administrative and program leadership with the child, who is encouraged to attend. In addition, parents/guardians and an advocate should be invited. The goal is to learn more about how to prevent future crises and avoid the need for restrictive procedures. Possible outcomes of such a meeting include changes to the child's treatment plan, modification of program policies or procedures, and/or additional training and supervision for direct care or other staff.

Need for Prevention Efforts to Be Integrated

Finally, in considering the role of prevention in supporting trauma informed care, it is important to recognize the importance of integration of efforts. Integration is important among the three prevention levels within a program, so that they are congruent and build on each other. In addition, integration is also important between prevention efforts and treatment efforts within a program. Finally, integration is needed between a specific program or agency and other involved agencies and systems. Integration has many benefits in terms of cohesiveness and continuity of care: Through integration, “communities can develop common conceptual models, common language, and procedures that maximize the effectiveness of programs at each level of need” (Greenberg et al, p. 6). Indeed, when such integration occurs, the result is likely to be synergy and sustainability over time.

An Overview of Core Interventions for Reduction of Seclusion and Restraint

Given the importance of reducing seclusion and restraint in institutional and other settings serving children, a brief overview is now offered of the core interventions that promote successful reduction. In reality, all of the elements identified in the foregoing discussion of primary, secondary, and tertiary prevention are relevant. At the same time, it is helpful for programs to have a snapshot and ready checklist of core interventions, which can become the focus of a concerted programmatic effort to reduce restrictive procedures.

As identified by Huckshorn (2004), six core interventions for reducing seclusion and restraint are: 1) leadership toward organizational change, 2) use of data to inform practice, 3) workforce development, 4) use of seclusion and restraint prevention tools (including de-escalation preference surveys and safety contracts), 5) broadly based consumer roles in inpatient and residential settings, and 6) debriefing activities to improve the quality of care and prevent future need for restrictive procedures. These interventions are elaborated upon in a related discussion of Core Intervention Fidelity Measures (NETI, Draft 2004).

The initial demonstration that the use of restraint and seclusion could be dramatically reduced and even eliminated through intensive planning, training and monitoring occurred in the Pennsylvania State Hospital System, as described by Hardenstine (2001) and more recently by Smith et al (2005), under the leadership of Charles Curie, now administrator of the Substance Abuse and Mental Health Services Administration (SAMHSA). This statewide experience helped move the national initiative, as well as the identification of core interventions, forward. As a result of the outcomes, which have been maintained up to the present, the Ford Foundation, in conjunction with Harvard University’s John F. Kennedy School of Government, awarded Pennsylvania the Innovations in American Government Award in 2000.

Additional evidence of the effectiveness of restraint and seclusion reduction initiatives comes from the outcomes of the NETI trainings, as conducted by the National Technical Assistance Center (NTAC). Initial data from the states that received the NETI training, analyzed as of May 2004, demonstrated significant reductions in multiple parameters of restraint and seclusion use (Conley and Huckshorn, 2004). While this data does not reflect just child-specific reductions, the trends and methodologies are nevertheless highly relevant. Similar outcomes

have also been shown by the NASMHPD Research Institute, Inc., up to December 2004 (Glover, 2005).

Implementation of the core interventions as part of a concerted, organized effort to reduce use of restraint and seclusion with children can also be successful. This has been impressively demonstrated at the state level by the outcomes achieved in Massachusetts by the State Mental Health Authority, which focused on the use of restraint and seclusion in psychiatric inpatient units (LeBel et al, 2004). Dramatic reductions were achieved in child units, adolescent units, and mixed child/adolescent units. There was also significant cost savings for facilities, as well as decreased injuries to both children and staff, and lower staff turnover (LeBel and Goldstein, 2005). There are now plans to expand the initiative to residential settings (LeBel et al, 2004).

Finally, the implementation of a specific trauma informed care model, the Sanctuary Model, in residential treatment for children has recently been analyzed, leading to positive, preliminary data outcomes (Rivard et al, 2005). In comparison to units where standard residential care was provided, the Sanctuary units showed significantly higher scores in relevant areas. For example, the Sanctuary program promoted the physical, social, and psychological safety of staff and clients more effectively. It also more effectively encouraged the open expression of feelings by clients, and promoted client self-sufficiency and independence in decision making. In addition, community members were found to help and support each other more than in the standard care units. They also sought greater understanding of their feelings and personal problems, decreased their antagonistic coping mechanisms, and developed a greater sense of internal control (p. 10). All of these outcomes are consistent with creating and maintaining a therapeutic environment for healing.

Potential Barriers to a Trauma Informed Program

The question then arises, what can undermine the creation and maintenance of a trauma informed, therapeutic community? Given the degree of commitment and effort required to establish and maintain a trauma informed program, barriers may often be unintentional, although it is not uncommon for a few individuals to actively oppose this challenging shift in paradigm. Among many possible barriers are the following:

-Lack of attention to organizational culture and the need for organizational change:

Organizational culture exists whether recognized or not, and it profoundly affects every aspect of an institution's functioning. Acknowledging a need to change organizational culture constitutes a strengths based commitment to collective growth and quality care.

-Lack of recognition of the nature of the population served and their collective and individualized needs:

Children require individualized care, and cannot be treated in aggregate. An organization needs to understand its population and also its own capabilities and limitations, so that services can be effectively matched to both child and program.

-Lack of adequate skill sets for direct care staff, based on insufficient training, supervision, and oversight:

Even well intentioned individuals require orientation, training, supervision, and oversight. An organization needs to prioritize staff training and staff development, if it expects to genuinely help children and families.

-Lack of adequate response to the trauma histories and experiences of the children being served:

Since trauma exposure is pervasive and often associated with significant negative consequences, programs that do not ask about trauma and design services and interventions that are trauma informed will be limited in scope, and may misconstrue surface behaviors to be “the problem,” rather than the manifestation of a larger problem.

-Lack of awareness of the potential impact of each helping adult – positive and negative:

One study of the use of coercion in an acute state hospital setting in South Carolina found that more than half of the crises were precipitated by overly controlling, unnecessary behavior of staff – i.e., crises were iatrogenic (Hughes, 2002). Staff need to appreciate the degree of impact they have on the children they serve.

-Mistakenly attributing *intentionality* to the child’s behavior:

This perception is perhaps the most significant barrier at the clinical level to trauma informed care. One’s beliefs profoundly influence one’s practices. If the child is seen as “manipulative,” the staff person’s agenda will be to expose and control him, interventions likely to precipitate meltdowns and loss of trust.

-Equating trauma informed care and being therapeutic with “being soft”:

Being “therapeutic” does not mean abandoning accountability. In fact, being truly therapeutic presupposes that accountability is maintained (Hodas, 2001b).

-Lack of understanding by staff that the behavior of children and stressful work-related events can create problematic internal reactions (“counter-transference”):

With supervisory support, direct care staff can be helped to recognize, understand, and constructively process the negative internal reactions that are an inevitable part of working in treatment settings. In this way, they can remain helpful and therapeutic (Hodas, 2003).

-A program overly concerned with rules and procedures:

Most of the time, rules and procedures were developed with a meaningful goal in mind. Over time, the initial purpose of the rules – and the need for exceptions – may be forgotten.

-A prevailing belief that “we are doing this already”:

This attitude saps motivation and creates a disincentive for staff to advocate for change, think creatively, or dialogue openly about problems.

Implications of Current Knowledge for Programming for Females

Most programmatic recommendations for children and adolescents in care have been developed with males in mind. This represents a problem, since females respond differently than males in some important respects, and individualized programming for them should incorporate gender-based considerations. Females experience rape and sexual abuse more commonly than their male counterparts, and a higher percentage of them develop PTSD (Hennessey et al, 2004). Like males, females also frequently witness violence. We have seen that females tend to respond to maltreatment in a passive manner via the surrender response, which predisposes them to dissociative reactions of varying severity, as well as to internalizing responses in general (Perry et al, 1996). Internalizing responses include depression, anxiety, withdrawal, emotional inflexibility and low frustration tolerance, self-injurious behaviors, suicidal ideation, and overt suicide attempts. Use of substances also may occur, and there may be inappropriate sexual activity. While adolescent females may also show aggressive responses and manifest anger and even rage, these behaviors do not typically ameliorate the tendency toward internalized responses as well.

Thus, there is need for additional thinking – and for pilot projects as part of clinically based research – to determine how to best meet the needs of females subjected to maltreatment, so that they can receive gender competent, trauma informed care. The following represent some considerations regarding potentially gender competent practices:

- Providing periodic screening or assessments, avoiding sole reliance on one-time screens and assessments.
- Referring the individual to a psychiatrist for evaluation, based on apparent signs of PTSD, depression, suicidality, psychosis, or other serious symptomatology.
- Maintaining a high index of suspicion and concern regarding depression and potential suicidality.
- Developing safety contracts and using one-to-one staffing, if concerns about suicidality arise.
- Ensuring physical safety for the female at the setting in question.

- Ensuring that interpersonal responses by staff, especially males, are not threatening or demeaning (this concept applies to both genders).
- Ensuring that male staff members appreciate the dynamics of trauma as it relates to the female and are clear regarding their own professional boundaries, so that inappropriate sexual innuendo or exploitation does not occur.
- Providing age-appropriate information on wellness, appropriate personal habits, and sexuality.
- Helping the female understand, in age-appropriate manner, the link between trauma, gender, and her current challenges.
- Offering an opportunity for females who have been sexually abused and/or raped to process these experiences therapeutically, when they are ready.
- Helping the female maintain contact with family members and other resource persons whom she trusts.
- Addressing alcohol and drug-related problems, as indicated.
- Treating co-occurring psychiatric disorders, through use of therapy and medication as indicated.
- Building on the capacity of many females to affiliate and network constructively with female peers.
- Teaching skills that support healthy, non-exploitative relationships with males.
- Focusing particularly on the needs of minority females, since they are over-represented in the juvenile justice system and issues of both cultural competence and gender competence apply.

PUBLIC POLICY AT FEDERAL, STATE AND LOCAL LEVELS

The Federal Level

The federal government has taken a leadership role in supporting programs that address youth violence. During the Clinton Administration, Surgeon General David Satcher, MD, PhD, released *The Surgeon General's Report on Children's Mental Health* (1999), which discusses a range of risk factors for the mental disorders of childhood, including stressful life events and childhood maltreatment (pp. 131, 132). The Report identifies prevention as a core approach to helping at-risk children. In 2001, *Youth Violence: A Report of the Surgeon General* addressed violence perpetuated by youth against one another. This report is also prevention oriented, and identifies effective research-based preventive strategies.

In 1999, the Safe Schools Healthy Students Initiative began, under the joint sponsorship of the Substance Abuse and Mental Health Services Administration (SAMHSA) – in particular, SAMHSA’s Center for Mental Health Services (CMHS) – along with the Department of Justice’s Office of Juvenile Justice and Delinquency Prevention and the Department of Education’s Safe and Drug-Free Schools Program. The goal of the Safe Schools Healthy Students Initiative is to prevent school violence by promoting healthy development. Another program funded by CMHS, with additional funding from SAMHSA’s Center for Substance Abuse Treatment, involves the Cooperative Agreements for Comprehensive Community Actions To Promote Youth Violence Prevention, Suicide Prevention, and Resiliency Enhancement.

A related initiative involves SAMHSA’s Cooperative Agreement to Study Children of Women with Alcohol, Drug Abuse, and Mental Health Disorders Who Have Histories of Violence, funded by the Center for Substance Abuse Treatment (CSAT). Goals here include eliminating or reducing intergenerational cycles and also reducing the impact of violence for children whose mothers have co-occurring mental health and substance abuse problems plus histories of trauma. In 2001, CMHS funded the National Child Traumatic Stress (NCTS) Initiative as part of a national effort to improve services and treatment for children and adolescents exposed to traumatic stress. Part of the initiative involved the establishment of a National Center for Child Traumatic Stress. At state and local levels, SAMHSA and CMHS has supported efforts by various members of the National Child Traumatic Stress Network (NCTSN) to effect change through policymaking. The NCTSN Policy Core provides coordination of these policy efforts.

The sweeping report of the President’s New Freedom Commission on Mental Health (2003) identified the impact of trauma as one of four areas “that have not been studied enough” (Goal 5, p. 5). The Report states, “The mental health field lacks sufficient information about dealing with trauma and its effects on different populations,” including children and adolescents. (p. 6). The Commission therefore recommends that the knowledge base be developed regarding how to reduce the impact of trauma (p. 11).

Recognizing the importance of public and professional education, SAMHSA, through the Center for Substance Abuse Prevention (CSAP), has developed violence-related resource guides. Examples include *Violence: An Overview of its Relationship to Substance Abuse*, and *Children Witnessing Violence and Substance Abuse*. Other educational publications are also available. A useful website is www.mentalhealth.samhsa.gov/child/childhealth.asp, then clicking on “The National Child Traumatic Stress Network (NCTSN) and other sites. The NCTSN website can also be accessed directly: www.NCTSN.org.

In 1997, the National Institute on Drug Abuse (NIDA), identified Prevention Principles for Children and Adolescents that, due to their comprehensiveness, are applicable to prevention of mental health as well as drug and alcohol problems. In abstracted form, these Principles involve the following: enhancing protective factors and reducing risk factors; targeting the entire range of identified problems; teaching skills and increasing social competency; using interactive methods as part of education; including a parent/caregiver component to interventions; maintaining a long-term outlook and scope; being family-focused rather than addressing child and parents by themselves; working with community programs; including opportunities for

children at school; incorporating prevention efforts, based on specific needs; promoting age-specific, developmentally appropriate, and culturally competent interventions; and being cost-effective, by recognizing the cost-savings that effective prevention creates (1997).

In addition to the above, there are other ongoing initiatives started or supported by the federal government. An important example involves the effort to reduce and eliminate the use of seclusion and restraint in hospitals and residential facilities. Consistent with a SAMHSA priority identified by SAMHSA Administrator Charles Curie, the National Technical Assistance Center for State Mental Health Planning (NTAC) and the National Association of State Mental Health Program Directors (NASMHPD) have used SAMHSA funding to provide comprehensive training to states on effective ways to reduce and eliminate the use of seclusion and restraint in their facilities (NTAC, 2003). Mr. Curie, who spearheaded similar reduction within the state hospital system in Pennsylvania prior to going to SAMHSA, notes that “the use of this practice (seclusion or restraint) represents a failure of our treatment system” (*SAMHSA News*, Winter 2002, p. 22).

The State Level

State government can also take a lead in moving trauma informed care forward, and Pennsylvania, among other states, is committed to doing so. As mentioned above, Pennsylvania became the national leader in the reduction of seclusion and restraint in the state hospital system (Hardenstine, 2001), and these impressive outcomes continue. The newly reinstated Bureau of Children’s Services within OMHSAS, and indeed Pennsylvania’s Department of Public Welfare in general, are committed to reducing the use of seclusion and restraint in psychiatric hospitals, RTFs, and other group residential programs for children and adolescents across multiple systems. Increasing efforts at cross-system collaboration and movement toward integration at the county level can help with the broad based recognition of trauma as a pervasive reality for many children and their families, and the need to address it, consistent with available resources, through integrated, cross-systems efforts.

The County and Other Local Levels

Opportunities for addressing trauma are not restricted to the federal and state government. There is need for counties and behavioral health managed care organizations as well as providers to take up the challenge. At all levels, successful efforts require an understanding of normal child development and the potential effects of trauma on the developmental process, plus a commitment to treat the whole child, work actively with the family, and offer family choice. There is need for ongoing commitment to joint planning among systems, through workgroups and policy groups at the systems level, and through child and family teams at the clinical level. To achieve genuine trauma informed care, prevention, not just intervention, needs to be seen as crucial and supported as a priority.

DISCUSSION

It is an unfortunate irony that, within our highly prosperous society, childhood trauma remains so ubiquitous. Yet this is the reality, now reinforced by concerns about terrorism as well, necessitating that parents, child-serving professionals, policy makers, and community leaders be familiar with the pervasiveness and consequences of trauma. Thankfully, single exposures to trauma often do not result in significant negative consequences, but they may. In like manner, some children experience severe, ongoing trauma yet escape relatively unscathed, and some even become leaders themselves.

We have seen how trauma can potentially affect every aspect of child development, both in ways not typically reflected in the formal diagnostic nomenclature and in ways reflected through multiple psychiatric disorders and substance abuse problems. Trauma is often overlooked and may be masked by externalizing behaviors that orient staff in the direction of Conduct Disorders. Trauma may also present with symptoms suggestive of other psychiatric disorders.

Appropriate responses to childhood trauma can be considered at both a societal and a clinical level. The societal level equates with prevention. Ultimately, it is insufficient to address the child-specific manifestations of trauma when the root causes and social imbalances remain unaddressed. Prevention efforts, however, are difficult to fund within a capitated public mental health system, where each expenditure must satisfy medical necessity criteria for a particular individual. County mental health reinvestment funds offer one pathway, but this will likely remain at limited scale. There is promise in the coming county integration process – whereby planning and funding of children’s services will need to include multiple child-serving systems – since some of the restrictions on mental health dollars are not applicable to county funds and to some federal funds available to other systems. As money for prevention becomes available, there will be need for increased exploration of evidence based prevention interventions and programs, so that efforts can be preferentially directed to where there is actual benefit to children, their families, and communities.

In addition, there is clear need for universal screening and mental health check-ups for children, with follow up assessment of those with a history of trauma and those identified as being at risk for other psychiatric disorders and substance abuse. High risk and symptomatic children should receive secondary prevention and be referred for treatment, as indicated.

Looking at the broader ecology that promotes coping and maintains risk, we need to recognize the need for clinical services to partner with the community. For example, both wraparound as a process (as opposed to just the provision of “wraparound services”) (Stroul, 1996) and Family Group Decision Making (FGDM), when implemented consistent with theory, engage in a careful assessment and engagement of the community (Pennell and Burford, 1995, (American Humane Association, 2000, and Harper et al, 2002). Family Based Mental Health Services (FBMHS, Lindblad-Goldberg et al, 1998) and Multisystemic Therapy (MST, Henggeler et al. 1998) regard the identification and use of natural supports to be part of their role as child and family catalyst. As an evidence-based, non-professional resource, the Big Brother Big Sister

Program offers mentoring for individual children and is by its nature a community resource that can readily complement formal services (Elliot, 1998, and see Blueprint website).

Another evidence-based approach involves home visitation by public health nurses through the Nurse-Family Partnership (NFP). NFP is a non-mental health service for high-risk pregnant mothers during pregnancy and the first 2 years of the child's life, which is a valuable tool for early intervention and prevention (Elliot, 1998, and see Blueprint website). Goals of the program involve improved prenatal care and outcomes of pregnancy, improved care provided to infants and toddlers, and attention to the woman's own personal development. A 15 year follow-up in one community (Elmira, New York) as compared to a control group, showed impressive and enduring outcomes, including: 79% fewer verified reports of child abuse or neglect, 69% fewer maternal arrests, 44% fewer maternal behavioral problems due to substance abuse, and better adaptation on the part of the now 15 year old children (including 56% fewer arrests and 60% fewer instances of running away). There have been similar outcomes, encompassing multiple cultural and ethnic constituencies, in subsequent pilots.

The broadest level of community partnership goes beyond child-focused services that incorporate the community and community resources, to programs that are directly community centered and community driven. Such programs, more utopian than real as of this writing, attempt to prevent trauma to individual children by empowering the entire community to take care of its own. By being inclusive and comprehensive, these types of programs have the greatest prevention potential. One model that already exists is known as "Neighborhood Solutions," developed under the auspices of the Family Services Research Center (FSRC) at the Medical School of South Carolina (Randall et al. 1999), which also provides research resources for Multisystemic Therapy (MST).

Neighborhood Solutions was implemented in an economically disadvantaged neighborhood in Charleston (Union Heights). This program is based on the concept of creating and maintaining a partnership between stakeholders within the chosen neighborhood and the involved professionals. Neighborhood stakeholders guide the professionals and identify priority needs. In the case of Union Heights, the priorities were to address the following: 1) the intensive clinical needs of all youth engaging in antisocial behaviors and their families; 2) the school-related needs of at-risk youth; and 3) the recreational, educational, and vocational needs of neighborhood youth during after-school hours and summer months. These identified priorities encompassed all levels of prevention – primary prevention (all youth, by addressing their recreational, educational, and vocational needs), secondary prevention (at-risk youth, to be addressed in the schools), and tertiary prevention (direct treatment needs for youth in need of treatment, through use of MST). A variety of formal and informal programs and interventions were developed in partnership with the neighborhood, to help the community, youth, and families in ways that could be sustainable. Outcomes were positive (Randall et al). Within the context of trauma prevention, this work is extremely promising, and replication efforts will be followed with great interest.

At the clinical level involving individual children, there is need to support evidence based (and promising) practices for children who have been affected by trauma. At the same time, evidence based programs and protocols cannot be effective unless we maintain "clinical common

sense” to ensure that there is sufficient time for professionals working with children and families to build trust and provide quality care. Clinical common sense also involves all helping adults consistently offering kindness, patience, and unconditional respect to children and families. A humanistic approach is appropriate for all children, and is especially important for children who have been traumatized, even if they present with challenging behaviors. To possible skeptics concerned that the above approach may be “soft,” we offer the reminder that positive change nearly always occurs within the context of respectful, trusting relationships. In addition, genuine respect inherently presupposes that the child is held responsible and accountable (Hodas, 2001b). A child who feels respected is more likely to be receptive to expectations and to being held accountable. Geoffrey Canada, in *Reaching Up for Manhood* (1995), cautions against giving up on youth or trying to bully them to change. He advises “...we always give (youth) the message of salvation and forgiveness with our chastisements. It is important...even when we are at our wits’ end...to say...‘I know you can change’” (p. 103).

As help-givers, we can engage in self-assessment to determine if we have a positive relationship with each child by asking ourselves what I refer to as “The Cardinal Question” (Hodas 2003 and 2004b):

Given the totality of my relationship with the child, is it likely that he/she sees me as “being on his/her side?”

If the answer is affirmative, then the helper is on the right track. If it is not, then there is need for the helper to consider ways of strengthening the relationship. It can also be useful to pose the Cardinal Question, from time to time, directly to children being served: “Do you see me as being on your side?”

The recognition of trauma as both a central and a mediating force in the development of serious emotional disturbances, maladaptive coping, and deviations of psychosocial development is relatively new. Similarly, the study and implementation of trauma informed care is in its early stages as well. Previous mention has been made to the parallel between trauma-based care and the incorporation of cultural factors in caregiving, in that each of these areas seeks to achieve a level of competence in practice. It might be beneficial to take the parallel further, and to use “the cultural competence continuum” (Isaacs-Shockley et al, 1996) as the basis for a similar typology for trauma informed care. As with the cultural competence continuum, the typology has 6 components. Moving from least to most desirable, the components involve: 1) trauma destructiveness, 2) trauma incapacity, 3) trauma blindness, 4) trauma pre-competence (trauma sensitivity), 5) basic trauma competence (trauma informed care), and 6) advanced trauma competence or trauma proficiency:

1) Trauma destructiveness:

This is the most negative end of the continuum, and involves extremely negative attitudes, policies, and practices destructive to children who have been adversely affected by trauma. Such children are dehumanized and viewed as objects to be controlled and “put in their place,” rather than as children in need of help. It is assumed that the child acts this way “on purpose,” and that he/she has neither desire nor capacity

to be prosocial and change for the better. Program practices tend to be rigid, punitive, and shaming/humiliating. Such children are given little if any “slack,” and at times are discharged early and without warning. At the extreme, the child receives threats or is subject to overt staff aggression, either in retaliation for past behaviors or as part of a “tough love” approach.

2) *Trauma incapacity:*

There is no conscious desire to be trauma destructive, but the program lacks the capacity to help symptomatic and behaviorally challenged children who have been trauma exposed. Consideration of the possible role of trauma, if it occurs at all, may be seen as an attempt to “excuse” the child for his/her behavior and let the child “off the hook.” Children with externalizing behaviors in particular are seen as acting intentionally and trying to “sabotage treatment.” As a result, such children may be discriminated against, and intake procedures may attempt to restrict their access to the program.

3) *Trauma blindness:*

Trauma blindness is midway in the continuum. The program is well intentioned and tries to be therapeutic, but does not recognize the central role of trauma as both an independent variable and a contributing (and, at times, confounding) variable in relation to psychiatric and substance abuse disorders. Due to limited information and a limited conceptual scheme, children may still be blamed for their behaviors and labeled as “manipulative” and/or “attention-seeking,” but there is no effort to deny care to them.

4) *Trauma pre-competence (trauma sensitivity):*

There is significant understanding of the role of trauma in the lives of children, as well as a desire to address it. Efforts have begun but remain limited. There may be either a false sense of accomplishment, or a false sense of failure that prevents further progress along the continuum. There is also a danger of token change, as occurs when there is insufficient awareness of unfinished business.

5) *Basic trauma competence (trauma informed care):*

There is genuine commitment to provide trauma informed care, offer individualized interventions, and make the necessary organizational and cultural changes. Many of these commitments have already been put into practice, and the effort remains ongoing. Children and families are empowered to participate in care and in program-wide decisions. They are given information that helps them understand the child’s problems from a broader developmental perspective. Staff members, in turn, are encouraged to discuss program goals, practices, progress and remaining needs, and their input is valued.

6) *Advanced trauma competence, or trauma proficiency:*

Trauma informed care is consistent, with continuous quality improvement. There is continuous expansion of the knowledge base, with possible pilot/demonstration projects and other research. Trauma specialists are present, and seek to raise the proficiency of all staff. New models or programs have a built-in evaluation component. Program leaders serve as advocates for trauma informed care throughout all child-serving systems and in Education (Isaacs-Shockley et al, pp. 28-30).

CONCLUSION

It is possible that, in a future that truly embraces the public health perspective, the expenditure of enormous amounts of money on tertiary interventions, after problems have developed and become serious, will be seen as an anachronism. While clinical treatment will always be necessary, perhaps the field, and our larger society, will recognize the inherent limitations of a “catcher in the rye” approach to mental health and human services – an approach that Holden Caulfield describes as involving the need “to catch everybody if they start to go over the cliff...” (*The Catcher in the Rye*, p. 173). How much more effective, and ultimately more economical, would it be to keep children from falling in the first place!

In responding to children who have been exposed to trauma and its negative consequences, we can offer trauma informed care and continue building the evidence base for both specialized treatment and trauma informed treatment programs. We can also work to ensure that systems of care at all levels recognize the pervasive role of trauma in the lives of children and families and the need to incorporate trauma informed care as a priority into systems planning and program implementation. Addressing underlying trauma-related issues increases the likelihood that evidence based practices will prove effective in the real world, and that benefits will be sustainable.

The provision of trauma informed care also promotes resilience for children and recovery for children and their families (Herman, 1992, Monahan, 1993). Since child maltreatment and other forms of trauma unfortunately often have long-term effects – and since many of the conditions that we refer to as “SED” for children and adolescents do not resolve completely and in fact are often early manifestations of adult psychiatric disorders – the concept of recovery becomes highly relevant. During childhood, children and their families need to gain an understanding and sense of perspective regarding the child’s SED, so that development can move forward constructively and a sense of hopefulness maintained. There is even greater challenge when the child reaches Transition age and is on the verge of adulthood, since there is need to acknowledge limitations and the need for services and support at the same time that there is an overriding desire to be as autonomous and typical as possible. The concept of recovery offers the individual an opportunity to accept personal needs and limitations, by also developing a sense of understanding and personal meaning in life. Trauma informed care, by promoting emotional healing and offering the individual a personalized understanding of their life history, creates an opportunity for skill-building, constructive change, and remoralization. All of these are cornerstones of the recovery process (Torrey et al, 2005).

It is important that administrators, programs, and others not respond to the call for trauma informed care in unrealistic extremes. One extreme involves viewing the necessary transformation to establish trauma informed care as unrealistically daunting, as exemplified in the statement, “These are nice ideas, but we are just in no position to make this happen.” In reality, the shift to trauma informed services, as pointed out by many sources cited in this paper, is essentially a worker-like process, where an organized, persistent effort can lead the way. To be sure, creativity and flexibility are quite helpful, but the basic process involves accumulating information and knowledge, embracing the values and making the commitment, and then following this up with systematic training of all staff, systems of accountability, ongoing supervision and monitoring, and use of the basic principles of quality improvement.

The other extreme is perhaps more worrisome, and involves those who claim that they are “already providing trauma informed care,” even though in reality this is not the case. Certainly, since nearly all programs have benevolent intentions, there may be some elements of trauma informed care – and strengths based treatment – already in place, but this does not mean that these concepts have been fully implemented. It should be clear that trauma informed care is a package that includes many components, and that – perhaps most importantly – these components are cohesive and consistently applied. A program aspiring to be trauma informed can ask itself the following 4 questions, which represent just a fraction of the critical elements of trauma informed services:

- 1. Do we view the child’s negative behaviors primarily as “damage,” “pathology” and “manipulation,” or as active efforts to cope with challenging circumstances?*
- 2. Are we so focused on compliance with rules that there is minimal flexibility and creativity, when these would benefit the child and not jeopardize the safety of anyone?*
- 3. Do we seek to understand, and help the child understand, the likely connection between past traumatic experiences and current behaviors?*
- 4. Are we so concerned with managing the child’s behavior that it interferes with our helping the child develop needed psychosocial skills and greater personal mastery?*

In a truly trauma informed program, the child is seen as doing the best he can – responding to threats to integrity and survival by developing adaptations that serve, or at one time served, a meaningful purpose. The goal of services is not just to contain negative behavior or even reward positive behavior, but also to help the child acquire prosocial skills and a sense of mastery and hopefulness. While adherence to program rules is important, the larger goal involves helping the child to learn more about traumatic life forces that may have been unknowingly driving his behavior. When the child starts to grasp the likely connection between past trauma and current behavior, a sense of empowerment can begin to replace the long-standing sense of helplessness, and the child is better able to become an active change agent.

At the systems level, then, we need to support the creation of *trauma informed systems of care*. This, in turn, involves bringing together those involved in the initiative to reduce restraint

and other coercive practices with those involved in promoting systems of care for children and their families. There is much that these two groups can learn from each other.

At the level of practice, we also need to ensure there is sufficient time for therapists and other professionals to spend with children and families, since no intervention – regardless how efficacious in research – will prove effective in practice in the absence of trust, engagement, and hope on the part of child and family. Similarly, while we uphold the importance of evidence, given the current limitations of clinical research, we need to be flexible enough to accept the validity of “practice based evidence” and not just “evidence based practice.” Especially when we find clinical progress slow, we need to remember that resiliency can be promoted in *all* children, not just a select few, if we are strengths based and are guided by public health prevention principles. We can help *all* children by understanding trauma and practicing trauma-based universal precautions, since any given child may have been trauma exposed. Finally, in supporting the wellbeing of all children, we are obliged to address the root causes of trauma through parent-professional partnerships and sustained prevention efforts that involve professionals, communities, the private sector, government, children and families, and other stakeholders committed to supporting and preserving childhood. Ultimately, the attainment of successful outcomes requires that we all act as advocates for our children, and that we encourage them to do the same.

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