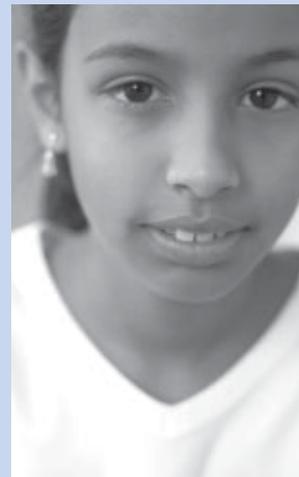
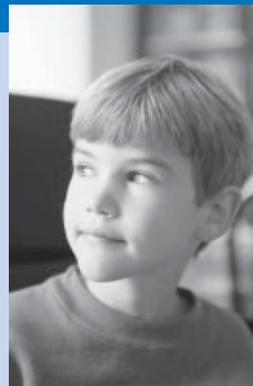


Children

Children and Trauma in America

A Progress Report of the
National Child Traumatic Stress Network



NCTSN

The National Child
Traumatic Stress Network

This project was funded by the Substance Abuse and Mental Health Services Administration (SAMHSA), US Department of Health and Human Services (HHS). The views, policies, and opinions expressed are those of the authors' and do not necessarily reflect those of SAMSHA or HHS.

National Child Traumatic Stress Network 2004

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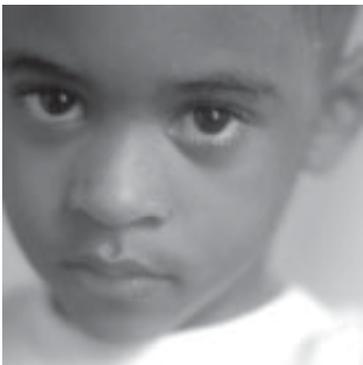
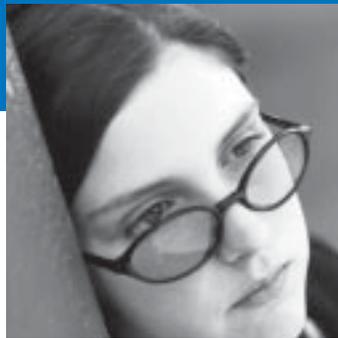
The National Child Traumatic Stress Network is coordinated by the National Center for Child Traumatic Stress, located at the University of California at Los Angeles and Duke University.

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From the NCCTS Co-Directors



The National Child Traumatic Stress Network has undergone considerable growth since its inception in 2001. In partnership with CMHS/SAMHSA, the Network has grown from 17 centers to its current 54 centers in 32 states and the District of Columbia. We have all been working together to enhance public awareness of the scope and impact of child traumatic stress and to bring about fundamental improvements in the standard of care and access to services for traumatized children and their families across our nation. We are proud to provide leadership through the UCLA/Duke University National Center for Child Traumatic Stress to this unique national collaborative initiative.

With all of our Network partners, we have built a dynamic organization that can support and sustain the many varied activities needed to meet our national mission. Day by day, we are learning how to integrate advances in science, clinical care, and service delivery to help in our nation's efforts to transform mental health care in America. This report highlights many of the major accomplishments of the Network since its inception, with an emphasis on events and achievements in 2002-03. The vitality and commitment of our Network partners, coupled with their humanity and scientific rigor, provide a strong foundation for continued progress over the years ahead.

Robert S. Pynoos
John A. Fairbank

Robert S. Pynoos and John A. Fairbank
Co-Directors, UCLA/Duke University
National Center for Child Traumatic Stress

Foreword

Laura is a 3-year-old girl from San Francisco who developed severe anxiety and nightmares after seeing her father beat her mother. Maria is a 10-year-old girl from Colorado who developed disabling guilt and shame after being sexually assaulted. Carlos is a 12-year-old boy from Boston who was hospitalized after hitting his head repeatedly against the wall at his new school. He was growing up in constant fear of assault from his father. Kevin is a 16-year-old boy who was shot while caught in the crossfire between two gangs and was unable to concentrate in school and lost interest in pursuing higher education. Mark is a 17-year-old boy from New York who became isolated from his peers and grew anxious and depressed after the 9/11 terrorism attack. In the year before the attack, he was almost killed in a car crash. Laura, Maria, Carlos, Kevin, and Mark have important things in common: they have each experienced a traumatic event. They are each also receiving help through the National Child Traumatic Stress Network (NCTSN).

The NCTSN was established in 2001 when Congress passed the Donald J. Cohen National Child Traumatic Stress Initiative. It's a unique collaborative effort of more than 50 research and clinical centers across the United States, all working to raise the standard of care and improve access to services for traumatized children, their families, and communities. The Network is organized under the auspices of the Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, US Department of Health and Human Services. As you will read in this report, the NCTSN has helped children like Laura, Maria, Carlos, Kevin, Mark, and many, many more.

Trauma is a serious, widespread problem. The report of the President's New Freedom Commission on Mental Health identifies it as one of the four main areas for the nation to address. A. Kathryn Power, MEd, the director of the Center for Mental Health Services, the primary federal agency addressing mental health, has said, "Trauma is pervasive, it is damaging, and it is an extremely serious threat to our public health." *Mental Health: A Report of the*



Surgeon General, published in 1999, cites child abuse and neglect as one of the primary risk factors for mental disorders.

Why are so many people concerned about trauma in American children? Because the facts are staggering: 25 percent of children surveyed in one major study had experienced a traumatic event by the age of 16. Another study found that 64 percent of New York City schoolchildren had experienced at least one significant traumatic event *before* 9/11. An estimated 4 million children and youth have experienced a serious physical assault, and 9 million have witnessed serious violence. Estimates of the number of children abused, neglected, or exposed to domestic violence exceed 3 million cases annually.

What do these numbers mean? Acts of violence, terrorism, physical or sexual abuse, or life-threatening natural disasters can result in long-term disturbances that may affect all the facets of a child's life. Some children and youth experience chronic trauma in unstable, dangerous environments. They may be exposed repeatedly to acts of violence, as either witnesses or victims. Some experience the loss of the "protective shield," which parents or caregivers traditionally provide, when adults are the perpetrators of abuse.

Trauma can interfere with a child's ability to think and learn and disrupt the path of healthy physical, emotional, and intellectual development. Recent studies have even documented how exposure to

trauma can interfere with the healthy development of the brain. The long-term consequences may include substance abuse, poor school performance, mental health disorders, and physical health conditions. Traumatized children and youth may lose much of their capacity to manage and control their emotions and may suffer from trauma-induced mood changes, irritability, depression, and anger that not only are disabling for them but are profound challenges for families and communities. Their capacity to form healthy emotional relationships may be severely diminished, and tragically, the consequences of trauma may affect future generations as traumatized children and youth grow to adulthood and become parents.

With the numbers of children exposed to trauma, it is so important that we augment our nation's efforts at prevention by doing everything we can to address trauma's harmful consequences. Efforts to address these profound developmental consequences are critical if we are to achieve our nation's goals for mental health, education, and good citizenship. A major national response of the US government has been the creation of the NCTSN. In the pages that follow, you will read about the Network—what it does, how it works, and the children it treats. There is no doubt that Laura, Maria, Carlos, Kevin, and Mark have experienced tragedy. They are also fortunate to have the Network, and the hundreds of dedicated staff associated with it, to help move them toward recovery and a restored sense of personal future.

The mission of the National Child Traumatic Stress Network is to raise the standard of care and improve access to services for traumatized children, their families, and communities throughout the United States.

To meet this mission, the NCTSN has brought together the academic community's specialized knowledge and experience in developing evidence-based treatments with the wisdom of frontline, community-based service providers. Together, they meet the challenges of treating diverse children in a variety of real-world child-service settings. The NCTSN also reaches beyond traditional mental health-care settings to schools, the juvenile justice system, child protective services, police and other first

responders, foster care programs, and many other organizations that serve children.

The NCTSN is committed to advancing the knowledge of the full spectrum of childhood trauma, from a developmental and family-centered perspective, and to helping children from every ethnic, sociocultural, and economic background.

The NCTSN's uniquely multilayered and flexible structure facilitates innovative and productive collaborations. This structure accelerates the development of new knowledge and its widespread dissemination. Continuous feedback among the Network's sites ensures that advances in interventions fill the needs of children and families, providers, and service settings. The Network's 38 Community Treatment and Services Centers provide critical input about client and service-provider needs for the development of interventions at the Network's 15 Intervention Development and Evaluation Centers.

The final report of the New Freedom Commission decries the length of time that it takes for mental health research to influence practice. The NCTSN is intentionally structured to address this problem; its close collaborations ensure that evidence-based interventions reach practice sooner, and that they are informed by the needs of community-based providers.

Every day, the NCTSN is working to enhance the standard of care for America's traumatized children. Every month, more than 3,600 children are treated within the Network and 5,400 professionals are trained. More than 25 interventions are being developed, tested, and disseminated by the Network, and numerous scientific, policy, and other publications have been disseminated on the nature and treatment of childhood traumatic stress. The Network has aimed to increase the availability of and access to services, improve the standard of care, train and educate those who help children, raise public and professional awareness, and enhance our national capacity to plan and respond to terrorism and disaster. This report documents the Network's activities in achieving these aims.

Children like Laura, Maria, Carlos, Kevin, and Mark require our attention and our help. The National Child Traumatic Stress Network is here to respond.

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National Child Traumatic Stress Network Centers

National Center for Child Traumatic Stress

University of California at Los Angeles
Duke University

Alabama

National Children's Advocacy Center

California

Chadwick Center for Children and Families
Trauma Counseling Program
Children's Institute International
Early Trauma Treatment Network
L.A. Unified School District Community Practice Center
Miller Children's Abuse and Violence Intervention
Center

Colorado

Aurora Mental Health Center
Mental Health Center of Denver

Connecticut

Childhood Violent Trauma Center, Yale University Child
Study Center

District of Columbia

La Clinica del Pueblo, Inc.
Wendt Center for Loss and Healing

Florida

Healing the Hurt, Directions for Mental Health, Inc.

Georgia

Open Arms, Inc.

Idaho

Center for Rural, Frontier, and Tribal Child Traumatic
Stress Intervention

Illinois

Heartland International FACES

Louisiana

Louisiana Rural Trauma Services Center

Maine

Mid-Maine Child Trauma Network

Maryland

Kennedy Krieger Family Center Trauma Intervention
Program

Massachusetts

Center for Adolescent Traumatic Stress and Substance
Abuse Treatment
Center for Medical and Refugee Trauma, Boston University
Medical Center
National Collaborative for Homeless Children and Trauma
The Trauma Center, Massachusetts Mental Health Institute

Michigan

Southwest Michigan Children's Trauma Assessment Center

Mississippi

TRY: Trauma Recovery for Youth

Missouri

Kansas City Metropolitan Child Traumatic
Stress Program
The Greater St. Louis Child Traumatic Stress Program

Montana

The Montana Center for the Investigation and Treatment
of Childhood Trauma

New Jersey

Center for Children's Support

New Mexico

New Mexico Alliance for Children with Traumatic Stress

New York

Children's Trauma Consortium of Westchester
Mount Sinai Adolescent Health Center
North Shore University Hospital Adolescent Trauma
Treatment Development Center
Parsons Child and Family Center
Safe Horizon - Saint Vincent's Child Trauma Care
Initiative
The Institute for Trauma and Stress, New York
University Child Study Center
The Jewish Board of Family and Children's Services -
Center for Trauma Program Innovation

North Carolina

Center for Child and Family Health - NC

Ohio

Cullen Center for Children, Adolescents, and Families
The Children Who Witness Violence Program
Trauma Treatment Replication Center

Oklahoma

Indian Country Child Trauma Center
The Oklahoma Child Traumatic Stress Treatment
Collaborative

Oregon

Intercultural Child Traumatic Stress Center of Oregon

Pennsylvania

Allegheny General Hospital Center for Traumatic
Stress in Children and Adolescents
Center for Pediatric Traumatic Stress
Children's Crisis Treatment Center's Project Tamaa

South Carolina

National Crime Victims Research and Treatment Center

Tennessee

Childhood Trauma Intervention Center

Texas

DePelchin Children's Center Child Traumatic Stress
Program

Utah

Child Trauma Treatment Network-Intermountain West

Virginia

International C.H.I.L.D. Center for Multicultural
Human Services

Washington

Harborview Center for Sexual Assault and Traumatic Stress

Wisconsin

Mental Health Center of Dane County, Inc., Adolescent
Trauma Treatment Project



Introduction: Building a Network to Serve Traumatized Children, Adolescents, and Their Families

Documenting and Addressing the Need

Why a Network?

In 2001, in recognition of the national impact of traumatic events on the nation's children and youth, the US Congress passed the Donald J. Cohen National Child Traumatic Stress Initiative establishing the National Child Traumatic Stress Network (NCTSN). Under the auspices of the US Department of Health and Human Services, Substance Abuse and Mental Health Services Administration (SAMHSA), the NCTSN now encompasses 54 centers around the United States, overseen by the National Center for Child Traumatic Stress (NCCTS) at UCLA and Duke University. The NCTSN mission is to raise the standard of care and improve access to services for traumatized children, their families, and communities throughout the United States.

Untreated traumatic stress in childhood and adolescence has serious consequences, not only for individuals and their families, but for all of society. As A. Kathryn Power, MEd, director of the Center for Mental Health Services of SAMHSA, recently stated, "Our streets and our shelters are filled with the victims

of trauma—70 percent of women who are homeless were abused as children" (National Association of State Mental Health Program Directors, 2004 Summer Commissioners Meeting, Plenary on Trauma-Informed Systems of Care).

In early childhood, trauma can adversely affect the developing brain and impair cognitive and emotional functioning, with devastating consequences for academic performance, emotional adjustment, and future capacity to endure adversity. In adolescence, untreated traumatic stress can impede academic performance and motivation and derail the trajectory of future development. The impact of traumatic events in childhood and adolescence can continue to resonate in adult life, affecting physical and mental health, citizenship and community involvement, relationships, parenting, and family stability.

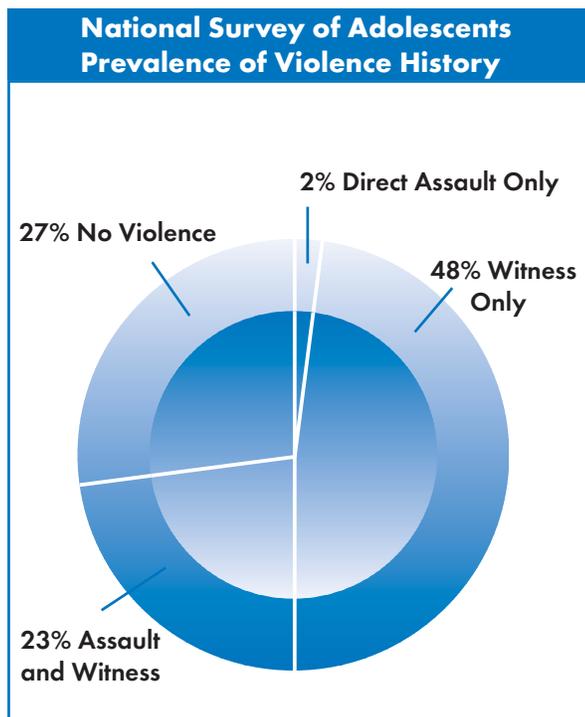
Given trauma's far-reaching and long-lasting effects, the NCTSN mission dovetails with a number of other national priorities, such as the mandate to improve overall academic performance and the call of the President's New Freedom Commission on Mental Health to "fundamentally transform the nation's approach to mental health care." In its 2003 report, *Achieving the Promise: Transforming Mental Health Care in America*, the commission singles out trauma as an understudied area and recommends that the knowledge base for the trauma field be expanded as a critical step in transforming the mental health system.

Trauma Is Common in Young Lives

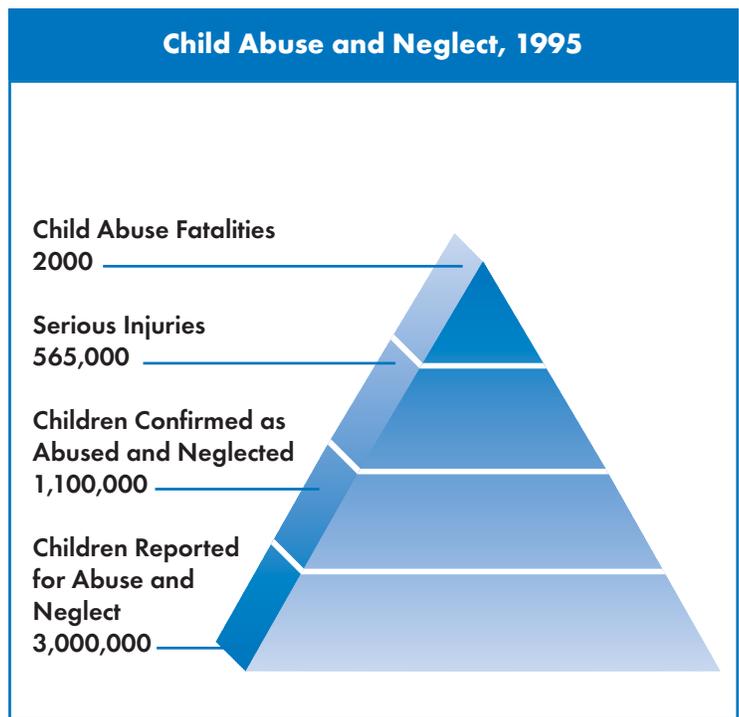
Trauma is more common in the lives of American children and adolescents than is generally understood. Children and adolescents experience trauma in many forms. Millions endure the profound betrayal of physical and sexual abuse, often from trusted caregivers. Ms. Power of CMHS has stated that “a child is reported abused or neglected every 10 seconds in the United States.” Some children and adolescents are victims of and witnesses to crime as well as community and school violence. A survey of American youth between the ages of 12 and 17 conducted by Dean Kilpatrick, PhD, estimates that 1.9 million adolescents have been victims of sexual assault, 3.9 million have been victims of physical assault, and 8.8 million have witnessed violence. In addition, thousands of children and adolescents each year endure natural and manmade disasters, automobile and other accidents, animal attacks and near-drownings, life-threatening illnesses, and invasive medical treatments. Many American youths’ lives are marked by multiple and repeated traumas and the secondary adversities that may follow or accompany trauma.

Children Are Vulnerable to Traumatic Stress Reactions

A significant body of scientific research shows that even the youngest children are affected by traumatic events. Children and adolescents are vulnerable to post-traumatic stress reactions that vary according to developmental level and may be cumulative in their effects. In early childhood, traumatic stress can interfere with a child’s acquisition of basic emotional skills, disrupt bodily functions, and introduce lifelong insecurities about safety and protection. School-age children may become anxious and hypervigilant, startle easily, and experience serious problems with sleep. Recurrent, disturbing images of traumatic events may intrude on their mental lives, interfering with their ability to concentrate and learn. In the aftermath of trauma, adolescents may withdraw from activities and relationships or become irritable and aggressive. They may engage in high-risk or self-destructive behaviors, including drug use, and may lose the will to plan for their futures.



DG Kilpatrick et al., "Violence, PTSD, and Substance Abuse: National Survey of Adolescents Results." Poster session presented at the conference "Traumatic Stress Studies," Boston, Mass., October 1995.



Child Welfare League of America, Stat Book 1997

Effective Treatments Can Help

Effective, evidence-based assessment tools and treatments for childhood traumatic stress have been developed. Early intervention with systematic, trauma-focused treatment can foster natural resiliency and coping skills, enabling most young people to recover significantly. Treatment can also help children and adolescents put traumatic events into a new context and forge constructive, prosocial responses, such as advocating to improve the safety of a community's buildings after an apartment building fire. The National Child Traumatic Stress Network works to develop evidence-based assessment tools and treatments and to disseminate them to the mental health professionals who serve traumatized children, their families, and their communities.

Building a New Model for Collaboration

The President's New Freedom Commission report urges the development of new integrative models to remedy the fragmentation and inadequacy of the current mental health system. The NCTSN strives to create new models of institutional integration, coordination, and spirited collaboration.

To meet its mission, the NCTSN brings together academic institutions with specialized knowledge and

experience in developing evidence-based treatments with community-based service providers whose wisdom has been won on the front lines. The Network's 38 Category III Community Treatment and Services Centers collaborate closely with the Network's 15 Category II Intervention Development and Evaluation Centers. Category II centers provide critical input about client and service-provider needs and serve as sites for the development of new assessment instruments and treatments. The NCTSN centers work together to develop, disseminate, and implement interventions that will serve the nation's diverse populations of children and adolescents in the full gamut of real-world service settings.

Because trauma affects all aspects of families' and communities' lives, the NCTSN extends its reach beyond traditional mental health care settings to schools, medical settings, the juvenile justice system, child protective services, police and other first responders, foster care programs, and many other organizations that interact with children. The NCTSN is committed to advancing the knowledge of trauma's impact, using a developmental and family-centered perspective, and to helping children from every ethnic, sociocultural, and economic background.



Organizational Structure of the NCTSN

The Network encompasses three levels of member centers:

The National Center for Child Traumatic Stress (NCCTS—Category I site)

The National Center for Child Traumatic Stress, based jointly at UCLA and at Duke University, coordinates the activities of the NCTSN. It facilitates collaborations among sites and promotes the rapid sharing of information. It forges new integrative models to challenge the fragmentation of the existing mental health care and child service systems. A major goal of the NCCTS and the Network is to reduce the time it takes for scientific research to influence clinical practice by promoting rapid development, adoption, and adaptation of evidence-based assessments and treatments.

Intervention, Development, and Evaluation Centers (Category II sites)

The 15 Category II sites in the Network are dedicated to identifying, developing, supporting, and improving trauma-focused, developmentally appropriate treatments and services for children and adolescents. Category II sites also partner with Category III sites to offer trainings to providers within and outside the Network, and to identify, assess, and provide treatment for children in child service programs such as schools, the juvenile justice system, the refugee service system, and the child welfare and protective service systems.

Community Treatment and Services Centers (Category III sites)

There are 38 Category III Child Treatment and Services Sites. These community-based programs work with Category II sites to implement and evaluate treatments and services in community settings and gather clinical information about traumatized children receiving treatment. These centers also provide expertise related to effective practices, financing, and other service issues and offer leadership and training on child trauma for service providers in a range of child service systems within and outside the NCTSN.

The Benefits of a Unique Structure

The NCTSN's uniquely multilayered and flexible structure counteracts the current fragmentation of the mental health system and facilitates innovative and productive collaborations. It accelerates the development of new knowledge and its widespread dissemination. The President's New Freedom Commission on Mental Health decries the length of time it takes for mental health research to influence practice. The NCTSN's structure directly addresses this problem; its feedback mechanisms and collaborations ensure that evidence-based practices reach practice sooner and that they are informed, from their inception, by the needs of community-based providers.

The NCTSN advances knowledge of trauma's impact by countering the fragmentation that has existed even within the trauma field. It brings together the full spectrum of people working in the field of child and adolescent trauma so that they can share perspectives. As a result, the Network's overall understanding of trauma's impact broadens and deepens. For example, those who have studied and treated children who have survived life-threatening cancers can learn from and teach those experienced in treating refugees of war. Clinicians who have dedicated themselves to developing effective interventions for sexual abuse may find that these interventions work equally well for other forms of trauma, if adapted inventively by clinicians expert in those areas. Those who have developed effective outreach programs for one underserved population can help those trying to bring services to another.

Collaborative Structures

The NCTSN's organization is designed to foster innovative and effective collaborations among its sites, and beyond its sites to the larger community. It accomplishes this task through a number of organizational structures clustered around content areas.

The Cores

Five functional cores generate and coordinate ongoing efforts vital to the Network's mission:

The Data Core is responsible for expertise, support, and leadership on data collection, analysis, and dissemination across the Network. The Data Core is currently working with the entire Network to implement the Core Data Set—a common set of assessments that will be used to evaluate who the Network is serving, what interventions they're receiving, and how these services are helping the children being served. To strengthen the significance of this data set, the Data Core works with many groups to collect information about current practices across sites, gaps and needs within the Network, and the effectiveness of specific intervention programs.

The Learning from Research and Clinical Practice Core (LRCP) works to ensure that the most effective, evidence-based practices reach the children, families, and communities who need them. It supports researchers and clinicians as they develop and disseminate sound knowledge and proven interventions, and it assists providers as they adopt and adapt these

practices for their own, diverse populations. The LRCP serves as a coordinating hub for Network members and working groups who are creating treatment manuals, treatment guidelines, implementation materials, and other tools for clinicians and clinics.

The Policy Core works with Network members to identify policies within the private and public sectors that affect the care of traumatized children. Through consultation both within and beyond the Network, it analyzes these policies and supports development of new or alternate policies that will have a national impact. The core then works toward the adoption of these policies in collaboration with Network members and national leaders to support positive change in the lives of traumatized children and their families.

The Service Systems Core promotes the well-being of children and families who have undergone trauma by strengthening the ability of child-serving systems to identify and respond to them. It works with Network partners and others to enhance awareness of the impact of child traumatic stress; to improve access to services by decreasing barriers to effective, developmentally appropriate, and culturally competent interventions; and to integrate a continuum of care for traumatized children and their families. The Service Systems Core coordinates partnerships and collaborations with NCTSN centers, service systems, and specific populations and community groups.

The Training Core works to enhance the care of traumatized children, adolescents, families, and communities through the development and provision of education and training for a wide spectrum of professionals, service providers, family members, educators, and others.

The National Resource Center (NRC)

The National Resource Center for Child Traumatic Stress supports the NCTSN by raising professional and public awareness and knowledge of child traumatic stress and enhances the reach and impact of NCTSN activities. It provides numerous audiences with relevant, practical information that promotes improved standards of care and increased access to services for children, their families, and communities. The NRC provides marketing, editorial, public relations, and product development services, guidance, and consultation to the Network. It works

closely with the NCTSN's cores and other groups to help nurture their ideas through the product development stage and bring them to a wide audience.

The goal of the NRC is to be the leading national resource for child traumatic stress information through

1. the acquisition, management, and sharing of existing materials in the field of child traumatic stress;
2. the development of initiatives and production of resources from within the NCTSN, including initiatives in education, professional training, technical assistance to Network centers, data collection, marketing, and media relations; and
3. the widespread distribution of the resources, services, and products of the NCTSN.



School Crisis and Intervention Unit (SCIU)

The SCIU's mission is to raise the standard of school-based care for traumatized children, adolescents, and their families; enhance recovery planning for crises, terrorist events, and disasters at schools; and improve access to school-based mental health services for traumatized children. This unit was formed from expertise and resources within the NCCTS and its Terrorism and Disaster Branch to offer practical guidance to schools and school systems, policy makers, service providers, and education professionals. The SCIU conducts training for school districts across the United States and works in close collaboration with the US Department of Education.

The Terrorism and Disaster Branch (TDB)

In October 2002, SAMHSA launched the Terrorism and Disaster Branch as part of the NCTSN. The TDB's mission is to promote the mental health and well-being of children and families by strengthening our nation's preparedness and response to terrorism and disaster. To fulfill this mission, the TDB enhances public awareness of the need to prepare for and provide coordinated and integrated mental health services for children and families after terrorist and disaster events. It works further to increase the nationwide availability of effective integrated interventions and treatment services.

The TDB works closely with the entire NCTSN to integrate mass casualty expertise as part of the NCTSN child trauma response network and collaborates with other national organizations (such as FEMA, the American Red Cross, and the Centers for Disease Control and Prevention) to enhance their reach and support for children.

Working Groups

Working groups, whose members come from across the Network, operate within the cores to bring concentrated attention to key topics in the field of child traumatic stress. They enable NCTSN members from all over the country, with diverse educational backgrounds and experience, to join forces to develop, disseminate, and adapt effective products and programs for traumatized children and adolescents.

These working groups ensure that the interventions developed and disseminated by the centers are shaped by real-world needs and limitations. They advance knowledge in the field by facilitating dialogue among academicians, scientists, scholars, school personnel, clinicians, other service providers, advocates, and families.

NCTSN Collaborative Working Groups

- Adapted Treatment Standards for Disabilities Working Group
- Adolescent Consortium
- American Indian Working Group
- Child Traumatic Grief Working Group
- Complex Trauma Working Group
- Data Operations Committee
- Early Childhood Training Working Group
- Family Interventions Working Group
- First Responders Working Group
- Forensic Medical Examinations Working Group
- Judges' Training Working Group
- Juvenile Justice Working Group
- Learning from Research and Practice Advisory Group
- Learning from Research and Clinical Practice Committee
- Measures Committee
- Medical Trauma Working Group
- Policy and Advocacy Committee
- Policy Core Advisory Group
- Psychopharmacology Working Group
- Refugee Trauma Working Group
- Residential Treatment Center Working Group
- Rural Consortium
- School Interventions Working Group
- Service Systems Committee
- Sexual Abuse Working Group
- Systems Integration Working Group
- Terrorism and Disaster Branch Data Working Group
- Terrorism and Disaster Branch Training Working Group
- Terrorism and Disaster Branch Intervention Working Group
- Training Committee

Collaboration and a Boy's Recovery: Mark's Story

Collaboration is at the heart of the NCTSN's organizational model, and the ultimate goal of collaboration is to raise the standard of care and improve access to services for children, their families, and their communities. The story of a boy named "Mark" provides one example of Network collaboration and the sharing of an important therapeutic tool that was crucial to his recovery.

Mark, a 17-year-old Italian American boy from Staten Island, was a scholarship student attending an elite public high school in New York City. A talented singer in several choral groups, he began to suffer symptoms of anxiety and depression when he was 15. He had trouble concentrating, slept poorly, and felt isolated from his friends. A teacher referred him to his school's satellite clinic, run by NCTSN site the Jewish Board of Family and Children's Services, where he began to receive counseling.

Following the 9/11 terrorist attacks, New York City's school system screened 10,000 youth who attended school in the vicinity of Ground Zero to determine how many suffered from post-9/11 Post-Traumatic Stress Disorder. Mark was among those screened. Dr. Robert Abramovitz, director of the Jewish Board's Center for Trauma Program Innovation, and his team worked with the National Center for Child Traumatic Stress to tailor a version of the UCLA Post-traumatic Stress Disorder Reaction Index—a trauma exposure and post-traumatic-stress screening instrument—for the district's use.

Mark's score on the assessment showed that he was suffering from a significant degree of post-traumatic stress. Funding from the Jewish Board's NCTSN grant paid for him to receive more comprehensive screening. This process revealed that Mark had been in three serious automobile accidents, the last of which had been life-threatening. He identified that accident as "the thing that bothered him the most now" and confided that he avoided riding in cars and had recurring nightmares of car wrecks. He described intrusive images of the accident, including a "flash-bulb" mental picture of the other car's license plate coming at him. He also remembered his terror at thinking he might die while being pried out of the car by the Hurst Jaws of Life® device.

The trauma screen cast Mark's symptoms in a new light. Once Mark's therapist became aware of the significance of these accidents, she shifted the focus of his therapy, and he made rapid progress. He successfully completed treatment, graduated from high school, and received scholarships that enabled him to attend a university where he is now happily and productively ensconced in campus life.

"The NCTSN actively promotes the importance of assessing trauma history systematically. If you don't ask, children don't talk about the trauma. Avoidance is one symptom of traumatic stress that can be a barrier to a child's receiving proper care."

Robert Abramovitz, MD

Director, Center for Trauma Program Innovation
Jewish Board of Family and Children's Services
New York, NY

Mark's story illustrates why comprehensive trauma screening is crucial to NCTSN's mission. Without formal screening for trauma history and traumatic stress symptoms, the traumatic basis of a child's or adolescent's symptoms may not be evident. As Mark's story shows, even a child or adolescent already in treatment may not disclose the traumatic source of his distress. In fact, one of the most telling symptoms of post-traumatic stress is avoidance of traumatic memories and the feelings associated with them. Paradoxically, talking about those memories is a key to successful treatment.

The 9/11 terrorist attacks led to Mark's being screened for post-traumatic stress. But it was the Jewish Board of Family and Children's Services' membership in the NCTSN that enabled him to receive the more comprehensive screening with an NCTSN-developed screening instrument and treatment with an NCTSN-disseminated model that contributed to his recovery.

Increasing the Availability of and Access to Services

Bringing Care to Children Who Need It, Where They Need It

Central to NCTSN's mission is expanding access to services for traumatized children and their families. Problems with access are well documented. An NCTSN survey of member centers revealed that many adolescents presenting for treatment for the first time had accumulated trauma exposures and long histories of untreated traumatic stress. Surveys performed in Los Angeles-area high schools also found that a large percentage of students had significant trauma histories, high levels of traumatic stress symptoms, and impaired function but had never received any assessment or treatment. Early assessment and intervention are crucial to prevent the long-term developmental consequences of traumatic stress.

Complex, interwoven financial, political, and social factors limit access to services and call for complex and innovative solutions. One barrier to care—stigma—is embedded in the experience of trauma itself. A traumatic event often isolates a child or adolescent, who feels ashamed and unable to ask for help. For example, one young boy told the police, who arrived in time to stop his father from killing the boy's mother and sister and then turning the gun on himself, that he was relieved to see them but also ashamed for them to know what had happened to his family. Adolescents also struggle with the awkwardness of having been made different by a traumatic



experience. Recognizing that the stigma that surrounds trauma and its treatment is a significant barrier to care, NCTSN programs address stigma and misconceptions head-on.

To meet our mission of increasing access to services means more than simply increasing the number of children who receive mental health services. The NCTSN is committed to making sure that the interventions children and adolescents receive are comprehensive and scientifically validated as effective for their particular symptoms and problems. And we must make them available in settings that are integral to children and adolescents' everyday lives. As the President's New Freedom Commission report states, "Because of [the] important interplay between emotional health and school success, schools must be partners in the mental health care of our children." For those children who face the greatest barriers, financial and social, to accessing mental health services, schools are a critical point of access.

As a result of their NCTSN grants, many member centers have been able to expand their school-based services and to implement evidence-based assessments and treatments. Studies have shown that school-based treatments work and that children and adolescents are less likely to drop out of programs offered

at school. NCTSN's school-based programs often include psychoeducational components for family, peers, and community. When teachers, families, and friends come to fully understand a child's or adolescent's traumatic stress, they can join in a network of support that can sustain recovery long after formal treatment ends.

To confront barriers to access, NCTSN centers provide services in a number of settings that extend outside the practitioner's office and community mental health clinic. In addition to its work in schools, NCTSN provides services in hospital emergency rooms, pediatric intensive care units, at the scene of crimes, in natural disaster shelters, on Indian reservations, and in families' homes. NCTSN staff work with clergy, first responders, primary care practitioners and pediatricians, emergency room nurses, judges, foster care administrators, and children's advocates.

To improve access to services, the NCTSN must also bring care to those who cannot or do not ask for it through the usual clinical channels. Underserved populations—the impoverished, ethnic minorities, American Indians, the disabled, those living in rural communities, refugees—often suffer from very high levels of traumatic stress and limited ability to request or receive services through practitioners' offices. The NCTSN has made reaching these underserved populations a priority. To meet this goal, the NCTSN is forming working groups and partnerships with other organizations to examine barriers to service and

create innovative ways of overcoming them. To meet the needs of these populations, the NCTSN must also develop culturally competent interventions. Very young children constitute another population that is often underserved out of a mistaken belief that they are too young to be affected by traumatic events. It is easy to sustain this misconception because our youngest patients cannot ask for help for themselves. Advocating for them requires educating therapists, child advocates, parents, and the public about the impact of trauma on their lives and creating age-appropriate interventions.

To increase access to services, the NCTSN must also address the general public's lack of knowledge, stigma and stereotype, and general underappreciation of the role of childhood traumatic stress. The NCTSN is committed to educating policy makers, child advocates, parents, and the public, through education, training, community outreach, and the media. For necessary shifts in public policy to occur, we must all understand that childhood traumatic stress is pervasive and serious and has far-reaching consequences for society. Effective, evidence-based treatments are available to help children and adolescents and prevent some of traumatic stress's most devastating social consequences. The NCTSN is committed to forming the partnerships with institutions, organizations, policy makers, parents, child advocates, and the public to bring trauma-focused services to every child who needs them.

NCTSN Launches American Indian Working Group

The NCTSN has launched a new working group dedicated to making trauma-focused services more accessible to American Indian and Alaskan Native children and families. Quincey Atkin, PhD, of the Child Trauma Treatment Network - Intermountain West (CTTN-IW), and a member of the Blood Tribe, is the working group's chair. With a history of centuries of oppression, isolation, and impoverishment, American Indian families often suffer from very high levels of traumatic stress and limited access to mental health services. The American Indian Working Group is working to remove the barriers that keep American Indian families from seeking and

receiving care and to help the NCTSN develop, adapt, and disseminate culturally competent treatments for this underserved group.

The American Indian working group will build on the experience of CTTN-IW's American Indian-focused team in Utah. This team, which counts among its members many American Indian clinicians, provides expert consultation and trainings for other clinicians. For example, Fred Lindberg, PhD, a psychologist in Casper, Wyoming, and member of the CTTN-IW, sought consultation from this team in 2003. Dr. Lindberg conducts group psychotherapy at a free-

standing psychiatric hospital where a number of patients are American Indian. Dr. Lindberg's adolescent clients engaged courageously in intensive treatment to overcome Post-traumatic Stress Disorder, depression, anxiety, self-harming behaviors, and suicidality, only to relapse when they returned once more to the stresses and sorrows of reservation life. Dr. Lindberg asked CTTN-IW's American Indian group to help him develop a strategy to provide greater support for the youths after they left the residential program.

The CTTN-IW established contact between Dr. Lindberg and its American Indian leaders. The leaders helped Dr. Lindberg establish a working relationship with the elders of the tribes in order to build greater continuity between the program and tribal life. In this way, the treatment became more informed by the actual stresses American Indian youth face, and when the adolescents left treatment, the tribal support systems helped them to sustain their gains. As a result of CTTN-IW's consultation, Dr. Lindberg and the tribal elders have established a new line of communication and a respectful working

relationship. Their partnership has already had a positive impact on several American Indian adolescents who've successfully continued their progress after returning to reservation life.

In 2003, the University of Oklahoma Health Sciences Center in Oklahoma City was welcomed into the NCTSN and became another important resource for the American Indian working group. The Intervention Development and Evaluation Center is charged specifically with improving services to American Indian children exposed to trauma. Its professionals have extensive experience with American Indian families, with particular expertise in the treatment of child and domestic abuse. Its staff has also trained and served as consultants to clinicians serving American Indian populations throughout the United States. The NCTSN will benefit greatly from the organizational structures, relationships with tribal elders, training expertise, and clinical experience of its American Indian working group as it leads the NCTSN's efforts to increase American Indian families' access to culturally competent services.

Refugee Children: Traumatic Histories Compounded by New Adversities

NCTSN's Refugee Trauma Working Group has advanced its efforts to bring trauma-focused services to refugee children and their families while also systematically expanding knowledge on the effects of refugee trauma. NCTSN sites currently serve refugee children from many countries, including Afghanistan, Bosnia, Sierra Leone, Somalia, and Sudan. Worldwide, 5,000 children become refugees every day, often having lived through horrendous acts of war, torture, and deprivation in their native lands. Once in the United States, they face the secondary adversities of their refugee status—unemployment, poverty, bigotry, and discrimination. NCTSN refugee programs address both traumatic stress and the secondary adversities that compound that stress.

Having survived totalitarian regimes, many refugees are reluctant to seek help, preferring to keep a low profile. Reaching them requires establishing a presence within their own communities and slowly building trust. Effective treatment takes into account how people from different cultures experience and conceptualize traumatic stress, help-seeking, and successful treatment.

For example, for the Khmer people of Cambodia, if someone does not receive a ritual burial, the ghost pays visitation to the bereaved survivor. During the Cambodian war, millions of people died on the fields. A symbolic burial ritual may be an important element in treating a Khmer individual suffering from what an American clinician may regard as traumatic bereavement. "It's important to take a social ecological

perspective. We look at a child embedded within a family, and a school, and a community. The community is a crucial vehicle for refugee children's recovery," says Dr. Dennis Hunt, director of the Center for Multicultural Human Services (CMHS) in Falls Church, Virginia.

Outreach to the Sierra Leonean Community

The Center for Multicultural Human Services offers a model of service to refugee communities for the NCTSN. Established in 1982, the center provides services annually in 34 languages to more than 6,000 refugee children and their families. CMHS has also developed novel forms of outreach to forge partnerships with immigrants in their own communities. In 2003, CMHS targeted the Washington, DC-area Sierra Leonean community for outreach.

Sierra Leonean refugees come to the United States having survived more than a decade of brutal war and atrocities such as the deliberate amputation of the limbs of children. Many Sierra Leonean children living in the United States are orphans being raised by adoptive or host families. To reach Sierra Leonean families, CMHS conducted a systematic outreach that began with CMHS's regular attendance at community gatherings and co-sponsorship of cultural events. CMHS made a commitment to serving the immediate needs of the community, hiring "culture brokers" from the community as liaisons. Aware that many Sierra Leonean families would not be receptive to the

concept of mental health care, CMHS framed its help in terms of improving family communication and children's academic performance, since family bonds and education are both valued highly by the community. Since family communication and academic performance are also adversely affected by traumatic stress, they provide a lens through which the community could understand its effects. CMHS conducted a family communications day followed by an intensive summer camp. At the camp, counselors used Sierra Leonean native cultural forms such as folk tales, drumming, and art to develop children's sense of pride in their history and culture, improve their ability to communicate feelings, increase their sense of safety and security, and improve their expectations for the future.

CMHS staff also worked closely with the Network's Data Core staff to develop scientific measures for evaluating the effectiveness of their summer camp interventions. This allowed CMHS to refine and improve its programs and clarified for CMHS and other NCTSN sites the activities that provide the greatest help for refugee children.

As a result of its outreach, CMHS has created a strong partnership with the Sierra Leonean community, and they now work together to help Sierra Leonean children build constructively on their pasts to create new lives in the United States.

Appreciating the Impact of Trauma in Developmentally Disabled Children

Traumatic stress often goes undiagnosed and untreated in developmentally disabled children, because the extent to which they suffer is underestimated and clinicians feel unprepared to treat them. In fact, children with disabilities are more vulnerable to certain forms of trauma, particularly physical and sexual abuse.

As part of its effort to expand services to the disabled, the NCTSN's Adapted Trauma Treatment Standards Working Group developed educational materials to dispel misconceptions about how developmentally disabled children respond to traumatic events and to develop practitioners' competence in treating them.

"Belonging to the NCTSN has made developing adaptive trauma treatment methods a priority. We're conceptualizing how we modify treatments so that we can receive feedback from our peers and ultimately use this feedback to develop training for others. That would not have happened without the Network's involvement."

Margaret Charlton, PhD
Aurora Mental Health Center
Aurora, Colorado

"Developmentally disabled children may be less able to describe their emotional distress in words, and so may express it by acting out," says Dr. Margaret Charlton, chair of the Adapted Treatment Standards Working Group. For example, a mildly retarded 14-year-old boy, confined to a wheelchair because of a serious infection in his foot, was brought to see Dr. Charlton. Since being in the wheelchair, he had experienced episodes of rage during which he threw objects at other people, scratched and clawed at his wound, and hurled himself from his wheelchair. When Dr. Charlton began to work with him, she learned that he had undergone a liver transplant at age five. During that hospitalization, he'd been physically restrained to keep him from pulling out tubes and scratching at his wounds. Confinement in the chair was serving as a traumatic reminder of the boy's earlier traumatic illness and was bringing back intolerable feelings that he could express only in rage.

The adolescent engaged enthusiastically in therapy. Dr. Charlton helped him to talk about his past experiences, to make a connection between the past and present, and to recognize, understand, and tolerate the intense emotions he felt. When he could express his feelings in psychotherapy sessions, his episodes of rage stopped and he was able to comply with treatment to control his infection.

Bringing Services to the Deaf and Hard-of-Hearing: Luisa's Story

The NCTSN is committed to increasing access to mental health services for children who are deaf and hard-of-hearing, another significantly underserved population. Two NCTSN centers, Mental Health Center of Denver and Child Trauma Treatment Network - Intermountain West of Utah, have taken the lead in developing guidelines for trauma-focused treatment for these children. A shortage of deaf and American Sign Language (ASL)-fluent clinicians and overall inexperience at working with this group are two factors that have limited access to services.

"As important as knowing how to work with sign language and interpreters is understanding the unique family and cultural issues that affect deaf children," says Karen Mallah, PhD, of the Mental Health Center of Denver's Family Trauma Treatment Program. "Ninety percent of deaf children have hearing parents, which means that the child is growing up into a different culture from her parents," explains Dr. Mallah. "Deaf people see themselves as part of a community with a unique positive culture, a beautiful language, particular forms of artistic expression, and a rich history. To them, deafness is a difference, not a disability, as hearing people often think of it."

Forging Her Own Identity

Mary Sterritt, LCSW, who has been a clinician with Mental Health Center of Denver's Deaf Counseling Services for 15 years, recently treated Luisa, a 16-year-old Latina. Ms. Sterritt used ASL to conduct the therapy with Luisa. Born deaf, Luisa was neglected and abused by her biological parents, then adopted as a preschooler by a white, hearing family.

In adolescence, Luisa struggled to be more independent. She yearned to feel more a part of the Deaf and Latino cultures, creating a strain between Luisa and her protective parents. One night, Luisa and a friend went out with some boys they didn't know well. They were both raped. Luisa's mother reacted to her daughter's victimization by becoming more protective. Luisa

reacted by becoming more rebellious, impulsive, and alienated from her family.

Ms. Sterritt used Trauma-Focused Cognitive Behavioral Therapy, an NCTSN-disseminated treatment model, in her work with Luisa and her mother. She found that particular elements of the therapy needed to be adapted for a deaf patient. For example, to conduct a relaxation exercise, the clinician ordinarily instructs the child to shut her eyes and picture a safe place. "But a deaf child does not feel safe with her eyes shut, because that cuts off a major source of sensory input," Dr. Mallah explains. A written trauma narrative, another important component of the therapy, also may not be as effective with a deaf child for whom ASL is the primary language. A deaf child may need to sign the story over and over again, or illustrate it, or act it out.

Devoting adequate time to the family dynamics was central to the success of Luisa's therapy. When Luisa's parents were able to embrace her emerging identities as a member of the Deaf community and as a Latina, Luisa felt less alienated from them and less inclined to engage in high-risk behaviors to prove her independence.

By the end of treatment, both mother and daughter reported that the therapy had been "extremely helpful." "Without the treatment, I would have wound up in a group home or juvenile facility," Luisa wrote.

"Trauma is inherently isolating for every child. These feelings can be even more pronounced for a deaf child who may feel cut off already from other children and hearing family members."

Karen Mallah, PhD
Project Director
Mental Health Center of Denver

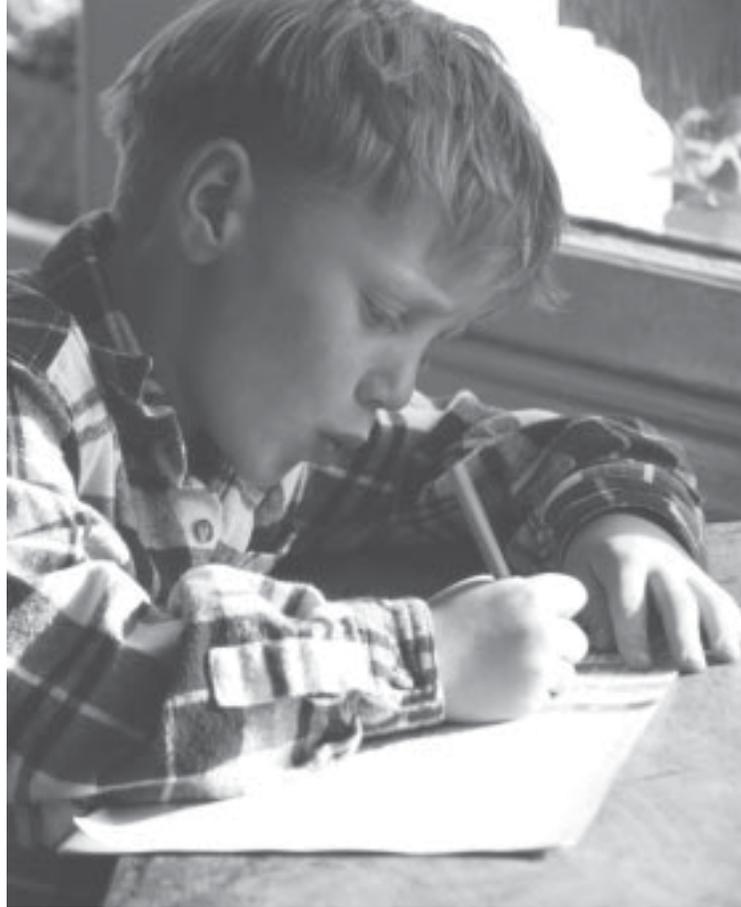
Cognitive-Behavioral Intervention for Trauma in Schools (CBITS)

The Crisis Counseling and Intervention Services of the Los Angeles Unified School District (LAUSD), under project director Marleen Wong, MSW, has begun to disseminate Cognitive-Behavioral Intervention for Trauma in Schools (CBITS), a manualized trauma treatment program with broad applicability for school-based NCTSN efforts.

Ms. Wong and colleagues co-authored a formal study of the program that was published in the August 2003 *Journal of the American Medical Association*. The study, conducted in two LAUSD middle schools in largely Latino neighborhoods, showed the program to be very effective at alleviating symptoms of trauma-related anxiety and depression in sixth graders. The children in the study had all been victims of or witnesses to school violence.

The 10-week program consists of 10 group and one to three individual sessions that students receive in the school setting. It also includes an educational presentation for teachers and group meetings for parents or caregivers. Designed to be readily implemented by existing school personnel, such as school psychologists, counselors, and social workers, the program builds peer and familial support to sustain children once the formal intervention ends.

Ms. Wong and the program's other developers are now disseminating the program to other NCTSN sites and considering how to implement it in such other settings as pediatric and adolescent health clinics and community mental health centers.

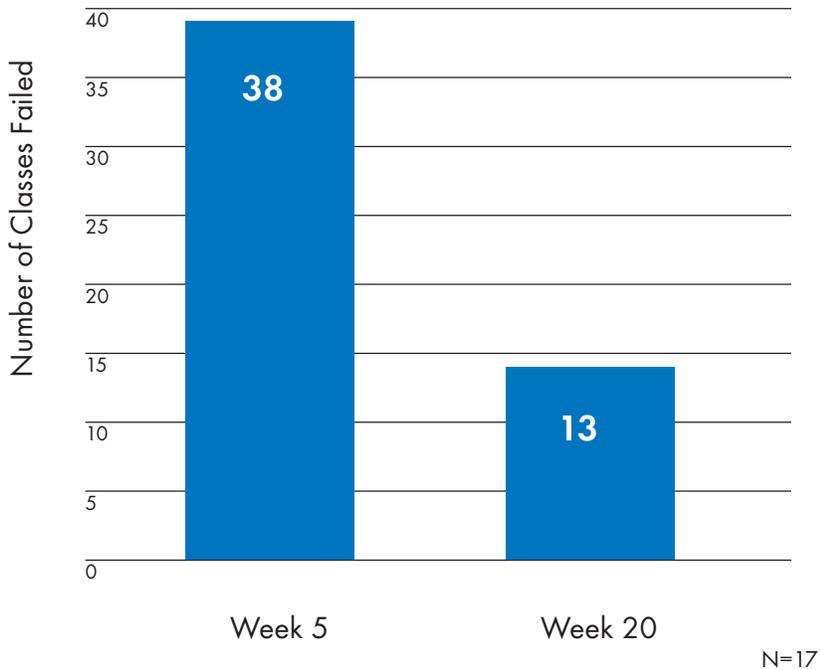


Adapting a School-Based Trauma Program for Diverse Youth in New York

Among the school-based programs disseminated by the NCTSN this year was the UCLA Trauma Psychiatry Service's Trauma/Grief-Focused Group Psychotherapy Program. This manualized intervention, geared to adolescents, is designed to be delivered as either an individual or group treatment. The program addresses both trauma and grief and has been extensively tested and shown to reduce symptoms of distress and improve academic performance among students suffering from post-traumatic stress and traumatic bereavement. It has been used in such diverse settings as postwar Bosnia and urban American schools afflicted by high levels of community violence.

William Saltzman, PhD, of California State University and Miller Children's Hospital in Long Beach, and Chris Layne, PhD, of Brigham Young University, the program's developers, conducted trainings and are providing ongoing consultation for NCTSN centers and other providers in the five New York City boroughs. These efforts have been sponsored by Project Liberty and the Child and Adolescent Trauma Treatments and Services Projects to provide scientific

Adolescents Failed Fewer Classes after Receiving UCLA's Trauma/Grief Focused Group Psychotherapy



Just as academic performance can be impaired by traumatic stress, treatment can result in a significant improvement in academic performance as students' ability to concentrate and motivation for learning increases. The intervention was studied in a Los Angeles suburban high school where the students had been victims of or witnesses to high levels of community violence and crime. The number of classes that 17 students were failing decreased significantly after 20 weeks of the treatment. This finding is typical of the academic recovery that can be brought about by trauma-focused care.

assessment and trauma-focused care for New York City children following the 9/11 terrorist attacks. The UCLA program was selected for use with adolescents aged 12 to 18 after the New York Office of Mental Health conducted an extensive review of available evidence-based programs.

Comprehensive assessment is an integral part of the program. The demographic data collected so far reveal that a significant number of those being served are minority adolescents from low-income families. Additional data suggest that many of these youth have complex trauma histories and continue to live in unsafe environments marked by family and community violence. Preliminary data analyses show a reduction in both PTSD and depression among the youth who've completed the program.

One of the virtues of the Trauma/Grief Program is its flexibility. It contains four modules, with the first devoted to psychoeducation and coping skills, the second to the creation of the trauma narrative, the third to traumatic bereavement and issues surrounding grief and loss, and the fourth to developmental

"The NCTSN sites were very attuned to the communities they were serving and kept us on track in terms of how to adapt this general intervention for the specific needs of their populations. In many cases, we had to bridge multiple ethnic and cultural communities and address the impact of multiple traumas and losses."

William Saltzman, PhD
Miller Childrens Hospital, Long Beach,
California

progression and prosocial, constructive responses to trauma and loss.

The New York City practitioners adapted the program based on the participants' cultural needs. For example, when working with Chinese children and adolescents, Safe Horizon practitioners allowed more time for the relationship between clinician and client to develop. They also slowed the pace of what could

be perceived as the more intrusive aspects of the treatment, such as the trauma narrative. Safe Horizon also recognized that some people from Asian cultures perceive, conceptualize, and express post-traumatic stress differently than do people from Western cultures. Some Asian children and adolescents may be more likely to express their distress in the form of somatic complaints. Instead of describing themselves as “depressed,” they might talk about stomach pain, nausea, dizziness, or fatigue. Acknowledging this cultural distinction, practitioners modified the sessions in which children identify their post-traumatic stress symptoms and reactions to trauma reminders.

The intervention also directly addresses the stigma that surrounds trauma and its treatment. “For adolescents, there’s a stigma associated with being injured or suffering a loss,” says Dr. Saltzman. “Students struggle with the awkwardness of talking about what happened with friends and teachers in a way that doesn’t make them feel worse or revictimized.” The program specifically helps clients with this struggle, enabling them to identify, ask for, and receive the particular forms of support that they need. To win community and family support for the program, New York City sites used various forms of outreach that directly addressed stigma surrounding traumatic stress and its treatment.

NCTSN Centers Expand School-Based Services

Miller Children’s Abuse and Violence Intervention Center (MCAVIC) in Long Beach, California, is one example of an NCTSN member center that has increased its presence in schools as a result of its NCTSN grant. The majority of MCAVIC’s clients are impoverished members of ethnic minorities. NCTSN membership has also enabled Miller to expand its follow-up clinic services for school-based clients needing more therapy, as well as for clients referred directly from schools, community agencies, and Miller Children’s Hospital.

In 2003, MCAVIC added a program with Storefront Schools, an educational last resort for adolescents who’ve been expelled because of violent or disruptive behavior. Cheryl Lanktree, PhD, director of MCAVIC, says that Storefront students are actually “the most severely traumatized adolescents in the school district,” but they are also the population “least likely to receive services because of people’s tendency to regard them as bad kids.”

MCAVIC staff now have an almost daily presence at Storefront and have found that the continuity of contact between students and clinicians is, in itself, therapeutic. Dr. Lanktree explains, “These children and adolescents, many of whom have major trust issues as a result of multiple, severe traumas and losses, have never had anyone advocating for them, and are amazed by the experience.”

Marvin and Melvin's Story: Trying to Feel Safe

An elementary school principal referred nine-year-old African American fraternal twins, Melvin and Marvin, for assessment. Without Miller's Long Beach public school-based program, they would likely have had no access to mental health services.

The twins' moods, academic performance, and social interactions had deteriorated since losing both their father and uncle to community violence. Their uncle had been shot to death, his body left in an alley. Shortly afterward, their father was gunned down in front of their home.

A comprehensive assessment revealed both boys to be suffering from significant post-traumatic stress. They were frightened, hypervigilant, and had difficulty concentrating. Melvin, the shyer of the two boys, and the one who had been most attached to his father, began to wet the bed. He felt guilty for his father's death, telling his therapist, "If only I'd been with him, my father wouldn't have gotten shot. We would have been off somewhere having fun." Both boys had nightmares and refused to spend the night in their own room, sleeping instead on the floor of their older brother's bedroom. Marvin told the therapist, "I'm afraid to play in the front yard because I might get killed by a drive-by shooting."

Therapy included both trauma and grief components. Marvin and Melvin's therapist tried to reestablish in them a sense of safety and a trust in adults to take care of them. Feeling safe would promote their return to the path of healthy development. Marvin processed his feelings about danger and safety through play, building a toy house with a fence around it. He placed figures representing the remaining members of his family safely inside the fence. A soldier stood sentry outside.

But restoring a sense of safety was problematic, given Marvin and Melvin's environment. Once the boys were out on their bikes in the neighborhood and saw a low-rider car coming in their direction. They fled for their house and hid under the beds. Several months into the therapy, someone shot at and shattered a window in their living room. These events were more than traumatic reminders—they constituted new threats. The boys' fears heightened, and their hypervigilance, which had diminished, returned. They lost ground in their therapy.

Marvin and Melvin's mother was able to move the boys into another neighborhood. When the boys felt safe and no longer had to contend with daily reminders of community violence, they progressed in treatment, and their academic performance improved. After about six months, Marvin completed therapy, saying, "I think I'm OK, I don't need to come back here anymore." Melvin has continued on in treatment, where he shows continuous improvement.

"If we weren't in the schools, it's unlikely that many of these children would ever be referred for mental health services."

Cheryl Lanktree, PhD
Director, Miller Children's Abuse and Violence
Intervention Center
Long Beach, California

Improving the Standard of Care

Pioneering Evidence-Based Assessments and Interventions

To meet its mission of improving the standard of care provided to traumatized children and adolescents, the NCTSN aggressively develops, refines, and disseminates evidence-based assessments and treatments. The final report of the President's New Freedom Commission on Mental Health cite as a weakness of the mental health system the time it takes for interventions developed by the academic community to be successfully implemented in community settings. NCTSN's unique integration of Category II and Category III sites streamlines the process by which assessment instruments and interventions are developed, disseminated, and implemented.

For example, Dr. Judith Cohen and her colleagues at Category II site Allegheny General Hospital were developing an assessment tool for traumatic bereavement. Ordinarily, an academic center might spend months or years developing such an instrument before testing it in real-world settings. But the NCTSN has brought together under one mantle some of the nation's most eminent scholars and authorities on child traumatic stress, along with a wide cross-section of wise and experienced service providers. Staff members at Wendt Center, which specializes in



treating children who've suffered losses, began to use Allegheny's proposed instrument immediately. They suggested a number of changes in the interview protocol, the wording of questions and their sequence, that made the questionnaire more effective and less discomforting for clients. They suggested ways that the assessment could be a more fluid element of the therapeutic process, rather than just a scientific tool. This also meant that it was more likely to be embraced by other community providers. Creative collaborations like this ensure not only that NCTSN's interventions reach the community sooner, but that they are, from their inception, culturally competent and sensitive to the real-world needs of providers and the youth they serve.

Even the best-researched and validated assessment instrument is effective only if it can be used to identify those children who need help. As clinical experience and research make clear, many children and adolescents suffering from traumatic stress fall through the cracks, never receiving treatment or receiving care only years after first experiencing traumatic events. That's why the NCTSN is developing and promoting easy-to-use screening tools that can be implemented by non-mental health professionals in the places

where children are often found—schools and pediatricians’ offices, for example—and by the institutions that come into contact with children in crisis, such as child protective services, the juvenile justice system, and residential treatment programs.

The instruments and interventions that the NCTSN disseminates reflect a developmental understanding. Traumatic stress not only takes a direct toll on a child’s life with the symptoms it causes, it also impairs a child’s or adolescent’s function by interfering with the normal developmental trajectory. Effective interventions need to address symptoms but also must restore healthy development. The assessment instruments being implemented through the NCTSN’s Core Data Collection Project provide data on overall development and function as well as on traumatic stress symptomatology. And they provide ongoing profiles of each patient that shape clinical care and also enable the provider to make modifications as needs change.

NCTSN’s treatments are equally sensitive to the developmental consequences of unabated traumatic stress. For example, Trauma Systems Therapy, developed by Boston University Medical Center, first repairs a child’s ability to regulate his or her emotions. Once this developmental deficit has been addressed, the clinician can help the child or adolescent with the emotionally challenging task of processing and understanding traumatic experiences.

The NCTSN’s Learning from Research and Clinical Practice Core (LRCP) has mapped out the epidemiology of trauma across different age groups. This facilitates the development of interventions that reflect the needs of each age group and developmental stage as well as trauma type.

Just as it is important for treatments to reflect a developmental appreciation of traumatic stress, it is also key that they reflect the social ecological environment. The NCTSN’s Service Systems Core works closely with the LCRP so that NCTSN’s interventions meet the needs of such underserved populations as American Indians, the rural impoverished, inner city youth, and refugees. The NCTSN is dedicated to developing treatments that recognize the true complexity of trauma in American children’s lives. For some children, traumatic stress derives from a single life-threatening or horrifying event, such as an act of domestic violence, an accident, or the traumatic loss of a parent. Early intervention is very effective for these patients, and yet research shows that most children and adolescents who suffer a single extreme event never receive trauma-focused care. Part of the NCTSN’s mission is to make sure that they do receive the care they need. For many others, trauma occurs in repeated exposures to community violence, physical abuse, or environments of ongoing danger. Repairing these children’s and adolescents’ lives requires repairing the environments in which they live. By making these American children’s lives safer, we will not only improve the standard of care for child traumatic stress, we will begin to prevent its occurrence.

Addressing Unanswered Questions: The Core Data Collection Project

With the Core Data Collection Project, the NCTSN has moved forward to document the nature and scope of child trauma and treatment and respond to the national need for this critical information. Overseen by the Network's Data Core, this effort will provide an unprecedented picture of the nationwide characteristics of childhood trauma, its assessment, treatment, and outcomes. It will integrate formerly fragmented information so that it can be used successfully by clinicians to improve treatment, by researchers to develop new prevention and intervention strategies, and by lawmakers to formulate national policies for children. It will allow for a new synthesis of knowledge across trauma types and facilitate the timely sharing of information between researchers and community providers.

The need for this knowledge was described in a federal government report ("Effectiveness of Insurance Coverage and Federal Programs for Children Who have Experienced Trauma Largely Unknown," GAO-02-813, August 22, 2002), which concluded that the effectiveness of federally funded programs for traumatized children was largely unknown because of the lack of systematic documentation. The final report of the President's New Freedom Commission also identified trauma as an area where more knowledge is urgently needed.

All NCTSN sites that provide clinical services will participate in the collection of the Core Data Set. The project will reflect the NCTSN's wide diversity of sites: rural clinic, inner city community center, hospital-based medical trauma service, child maltreatment agency, refugee program, and elementary school-based clinic, among others. Each site will complete a Core Clinical Characteristics Form for each child entering treatment. This instrument will include an

innovative method for capturing a trauma history profile, providing a greater understanding of the extent to which children have experienced multiple trauma exposures and clarifying the impact of different types of trauma throughout the course of childhood and adolescence. It will document who is being served by NCTSN sites and illuminate those whose needs are not yet being met. This wide-scale collection effort will illuminate which treatments are being used and whether they are effective in a broad range of youth. It will influence the development of assessment tools and treatment models and so will directly improve the care of traumatized youth nationwide. But the Core Data Collection Project will also have a more immediate impact on the treatment of individual children and adolescents. It will mean that clinicians can receive ongoing measures of an individual child's or adolescent's progress in treatment and overall improvement in functioning. They will be able to see the effect of various interventions and to tailor treatment based on individual response.

NCTSN clinicians will employ three standardized measures: (1) the Child Behavior Checklist, a general measure of a child's problems and function across a wide range of areas, (2) the Trauma Symptom Checklist, and (3) the UCLA PTSD Reaction Index for DSM-IV. Employing standardized measures of symptoms will allow unprecedented comparison across sites, populations, trauma types, and outcome domains.

"The collection of the Core Data Set will enable clinicians to base treatment on accurate and full-dimensional information and to chart improvements in terms of socially relevant outcomes."

Alan Steinberg, PhD
Associate Director
National Center for Child Traumatic Stress-UCLA

Data Collection Raises the Standard of Care: Chadwick Center in San Diego

Data collection has been an important element of Chadwick Center of San Diego's clinical program since the mid-1990s. Barbara Ryan, LCSW, ACSW, Chadwick's director, and her team have created elegant mechanisms to integrate data effectively to inform and shape clinical practice. With the NCTSN's Core Data Collection Project, Chadwick has had the capacity to implement the designated measures into its existing system quickly and to become a model and a test site for the Network. It is working closely with the Data Core to implement the project throughout the Network.

Framed as a way of enhancing their therapeutic judgment rather than replacing it, Chadwick's clinicians have embraced the data collection system. They've already seen the many ways it can advance care. Clinicians at Chadwick receive graphic and readily usable reports at intake and throughout the course of care that show how each child is performing on various standardized measures. The clinician can immediately see not only if a child is suffering from symptoms, but how well a child is doing overall,

at home, in school, and in relationship to family and peers. The data track improvements and identify any emergence of new problems. This allows the clinician to link clinical data to events in the child's life or therapy. Particular findings prompt further assessment options and allow the clinician to modify the treatment plan.

Chadwick's ultimate goal is to link findings to clinical pathways, suggested protocols for systematically addressing a child's most significant problems.

"The Chadwick Center provides a model of how the Core Data Set can be used to directly influence treatment. Chadwick's example gives the rest of the Network the energy and optimism to implement the Core Data Collection Project."

Betsy Farmer, PhD
Director, Data Core
National Center for Child Traumatic Stress
Duke University

Mona's Story: Data Help Parents See Trauma through Their Child's Eyes

Mona, a 10-year-old girl treated by Nicole Taylor, PhD, a psychologist in Chadwick's Trauma Counseling Program, is one example of a child whose care has benefited from Chadwick's data collection. Mona was sexually abused by her mother and went to live with her father and stepmother. They perceived her to be doing well. When Mona's dad completed his formal assessment, he described her as having no post-traumatic symptoms at all. But some symptoms of post-traumatic stress are so internal that they may not be perceived by even the most attentive and loving parent. That's why many of NCTSN's assessment instruments also include self-report. Research and clinical experience

have shown that even very young children can report their traumatic stress symptoms accurately if questions are properly posed. Mona's self-report told a very different story from her father's assessment: she continued to suffer from a number of problems associated with her sexual abuse.

The assessment also gave Mona another avenue for sharing feelings that she might not otherwise have shared directly with her family. Her therapist was able to use the information to explain to Mona that her problems were normal given her experience and that she did not have to hide them.

Developing Trauma-Focused Care for the Youngest Patients

People used to believe that infants and very young children were impervious to traumatic events. Even clinicians assumed that if a child was too young to understand what had happened, the event wouldn't register in memory or would be quickly forgotten. Research and clinical experience, however, have demonstrated that this is not the case—even infants and very young children are profoundly affected by trauma. Helping these young patients requires specialized approaches based on a developmental understanding of how infants and young children react to and recover from trauma, and how traumatic stress can interfere with healthy development.

The Early Trauma Treatment Network (ETTN) is dedicated to developing interventions for NCTSN's youngest patients. Laura was two years old when she and her mother, Ms. Sandovar, entered Parent-Child Psychotherapy with Alicia Lieberman, PhD. Laura was showing aggressive behavior toward her mother and had long and intractable tantrums when frustrated. She had witnessed her mother being punched, slapped, and thrown against the wall by her father. Laura's mother was now raising her alone. Ms. Sandovar had lived in the United States since early childhood, when she arrived from a Central American country devastated by civil war. She had been raised by her aunt because her parents had been killed in front of her when she was nine months old in the countrywide violence that had engulfed the family's remote village. As a mother, Ms. Sandovar was impatient and harsh with Laura. Dr. Lieberman recalls her as being physically punitive and emotionally distant and ridiculed her daughter's needs and extreme emotions. Laura was not only full of rage and prone to tantrums over any minor thwarting of her desires, she also had intense anxiety, had difficulty

sleeping, and woke up screaming during the night. Dr. Lieberman explained that when Laura's mother heard her daughter screaming and crying, it served as a traumatic reminder of her own lonely and unheeded crying, and she responded in a self-protective way by becoming angry instead of feeling helpless.

One goal of Child-Parent Psychotherapy, developed by Dr. Lieberman and her colleagues, is to restore healthy cognitive, emotional, and social development. A young child like Laura may respond to trauma by losing language skills, for example, or the ability to tolerate separations. Child-Parent Psychotherapy also focuses on the bond between child and parent, because young children are dependent on their caregivers and flourish or falter in relationship to them. Trauma causes a breach in the bond because the parent, whom the child regards as an all-powerful protector, has failed to provide the protective shield on which a child relies. Domestic violence may be even more destructive when the parent is the actual source of danger in a child's life. "It's through the relationship that safety is reestablished and that recovery occurs," says Chandra Ghosh Ippen, PhD, the ETTN's research coordinator.

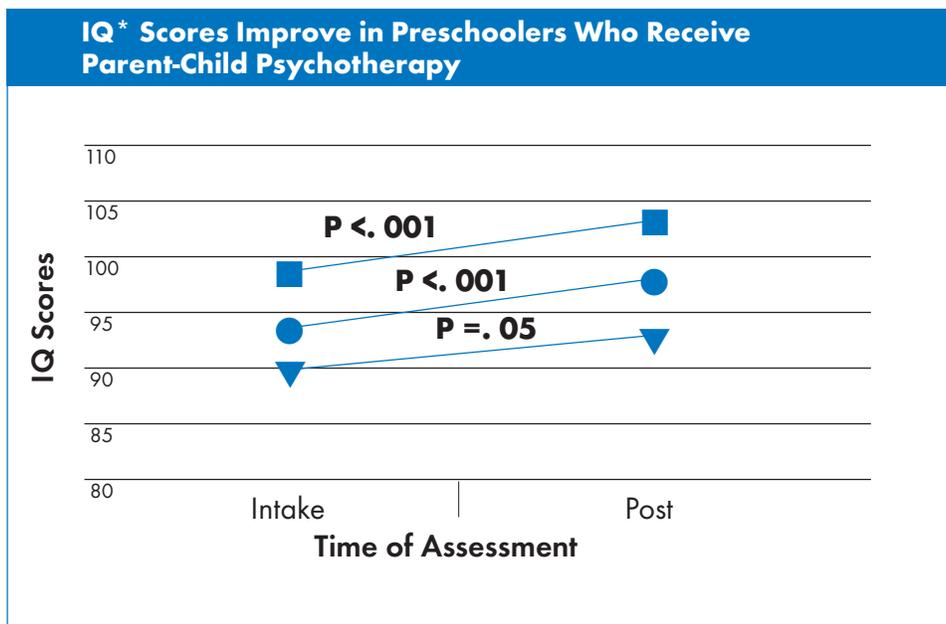
The ETTN not only is a source of improved interventions but also provides an organizational model for development and dissemination. This site comprises four treatment centers that have come together under their NCTSN grant. Headed by the University of California at San Francisco's (UCSF) Child Trauma Research Project, it also includes the Child Violence Exposure Program at Louisiana State University in New Orleans, the Child Witness to Violence Program at Boston Medical Center, and the Tulane University Jefferson Parish Human Services Authority Infant Team. Each site has expertise in different systems. Louisiana State's program works with the local police force, training first responders in how to mitigate the

impact on a child of witnessing a crime, act of domestic violence, or another traumatic event. Tulane interacts closely with child welfare workers. Boston Medical Center's expertise is in working with the court system as well as with the police force. The centers "cross-pollinate each other," says Dr. Lieberman, director of UCSF's project.

Repairing the Bond

Although the notion of transgenerational trauma sounds abstract, the process by which it occurs is concrete. For example, an adult who grew up in a treacherous world conveys to his child a post-

traumatic view of the world—as a dangerous, unpredictable, or even malevolent place. Or, in what may be the worst case, a parent who was abused as a child re-enacts that abuse against her own offspring. Child-Parent Psychotherapy, with its ability to intervene very early, can break this cycle. With Dr. Lieberman's help, Ms. Sandovar began to see how she was passing her own traumatic past on to Laura. After six months of treatment, she no longer countered Laura's rage with rage of her own. They began to negotiate a range of feelings together. An improved standard of care enabled a young girl to move forward on the path of healthy development.



*The Wechsler Preschool and Primary Scale of Intelligence is a battery of tests for young children that assesses intellectual functioning.

It's very important to intervene early with young children. Trauma has a measurable impact on brain development and global cognitive functioning that is reversible with early intervention. Preschoolers who received Parent-Child Psychotherapy following exposure to domestic violence had a significant increase in IQ scores compared to their scores before receiving treatment.

Trauma Systems Therapy: A Promising New Community Approach

Trauma Systems Therapy is one promising new treatment model to emerge out of the NCTSN. Glenn Saxe, MD, director of Boston Medical Center's Center for Medical and Refugee Trauma, designed the program to meet the needs of Boston's inner city youth. It is currently being used with youth from 6 to 18 years of age. "The services we were formerly offering, based solely in a hospital-based clinic," says Dr. Saxe, "were limited by the fact that our patients were exposed to ongoing, significant stress and traumatic reminders in their homes and communities: family and community violence, inadequate housing, huge financial problems." Dr. Saxe and his team began to "think about intervention in a much broader way, intervention that directly addressed the social environment."

Addressing problems in the social environment is not in itself a new idea; distressed families often receive multiple services. The distinction comes with integrating these services under one organizational mantle, so that providers operate as a team with shared goals and understandings. Trauma Systems Therapy starts from the principle that traumatic stress results from two factors: (1) a traumatized child or adolescent who is having difficulty regulating emotional states, and (2) a social environment that is unable to help the child to manage these emotional states. Trauma Systems Therapy addresses the intersection of the child's emotional dysregulation and the social environment's failings. The intervention helps the child or adolescent regulate emotional states and helps make the environment more supportive and less stressful for the child.

Trauma Systems Therapy integrates services and utilizes existing resources. A child in the program may receive home-based services, legal advocacy, office-based psychotherapy, and/or psychotropic medications. Everyone involved in the child's care meets together as a team, and every intervention and action taken is geared toward improving the child's emotional regulation and reducing "triggers" and traumatic reminders in the environment. With the help of his NCTSN grant, Dr. Saxe has been able to manualize Trauma Systems Therapy so that it can be implemented and studied systematically by other centers.

Carlos's Story: Healing the Environment, Healing the Self

When Carlos, a 12-year-old Native American-Hispanic boy, came to Boston Medical Center's Center for Medical and Refugee Trauma, he had already been in several residential treatment programs. Intelligent, affectionate, and gregarious, Carlos was also very troubled. He sometimes set fires at home and in public places and talked about killing himself. The Boston School District had transferred him from one school to another because of disruptive behavior. He was hospitalized most recently when, on his first day in a new school, he curled up in a fetal position on the floor and repeatedly hit his head against the wall.

Carlos spent his early years in the violent and chaotic home he shared with his alcoholic mother, physically abusive father, and siblings. When Carlos entered BMC's program, his father was in jail for domestic violence, his siblings were living with his mother, and Carlos was staying with his grandmother, who struggled to provide a safe and nurturing home with limited resources. Carlos was an ideal candidate for Trauma Systems Therapy because his difficulty in regulating his emotions was being exacerbated by continuous stress in his social environment. Many events—schoolmates making derogatory remarks about his mother, visits with his siblings who were also having problems, and any contact with his mother—could become the trigger causing Carlos to lose control.

B. Heidi Ellis, PhD, associate director of the Center for Medical and Refugee Trauma and Carlos's clinician, set three main goals for his Trauma Systems Therapy treatment: (1) stabilization of home, (2) advocacy for school placement, and (3) emotional regulation. To stabilize the home environment, home-based clinicians began a series of home and community-based interventions. They helped to secure respite care to

relieve Carlos's grandmother of the burden of caring for him alone. They helped Carlos and his grandmother come up with a plan for coping with the impromptu and disruptive visits of Carlos's mother, who often appeared in a drunken rage at their doorstep.

The school district wanted to provide Carlos with home tutoring. Dr. Ellis felt that the right school environment would be better and sought consultation from the team's advocacy attorney. Dr. Ellis, the advocacy attorney, and Carlos's grandmother worked together so that Carlos could receive an appropriate Individualized Educational Plan, the right of every student. Initially, Carlos was placed in a behavioral modification classroom and then mainstreamed to a structured school environment where he has flourished.

To meet the third goal of emotional regulation, Dr. Ellis worked with Carlos in twice-weekly psychotherapy sessions focused on emotion-regulation skills training. Traumatic events in Carlos's life had interfered with his acquiring certain key emotional competencies. In Trauma Systems Therapy, emotion-regulation skills training is the first phase of trauma-focused treatment. A child as emotionally fragile as Carlos needs some mastery over his own emotional responses and arousal level before he can go on to the emotionally difficult work of understanding his traumatic experiences.

With Dr. Ellis's help, Carlos became more conscious of signs that he was becoming upset and could calm himself before losing control. He became able to identify the environmental triggers that led to his agitation and feelings of emotional fragmentation. These triggers were all linked to traumatic reminders of Carlos's early childhood, but as is often the case

when a child's trauma history is so extensive and violent, those triggers had generalized. Many seemingly benign events could overstimulate Carlos and set him off.

Two years after beginning treatment, Carlos is no longer destructive and does not think any more about suicide. His home and school now provide supportive environments for his growth. Carlos recently won his School Spirit Award, and, for the first time in his life, he is making plans for a positive future.

"Often families receive multiple services from different agencies, each having its own agenda and point of view. With Trauma Systems Therapy, everything is integrated and directed toward the same goals of stabilizing the environment and helping the child to regulate emotions."

B. Heidi Ellis, PhD
Associate Director, Center for Medical and
Refugee Trauma
Boston Medical Center

Medical Trauma: NCTSN Addresses an Underrecognized Problem with Novel Approaches

Illness and serious accidents that threaten children's lives and the sometimes invasive and painful medical treatments necessary to save them may be sources of significant traumatic stress to a family. NCTSN centers, led by the Medical Trauma Working Group, are developing innovative assessments and interventions for medical traumatic stress that can reach affected children and their families in the settings where medical care is delivered—clinics, emergency rooms, pediatric intensive care units, and physicians' offices.

Reducing the traumatic stress associated with medical treatment is important not only because of the suffering such stress creates but also because traumatic stress can complicate a family's decision making or affect a child's or adolescent's compliance with treatment.

Children's Hospital in Philadelphia: Pediatric Intensive Care Unit Project

The Pediatric Intensive Care Unit (PICU) Project of the Children's Hospital in Philadelphia's Center for Pediatric Traumatic Stress is an original approach to reducing medical traumatic stress. Anne Kazak, PhD, director of the program, and her team, which includes psychologist Nancy Kassam-Adams, PhD, are pioneers in the field. They know from prior research that one-third of parents whose children are admitted to the PICU for at least two days develop acute stress disorder. Their symptoms include hyperarousal, increased startle responses, anxiety, and intrusive mental images of their child in pain or undergoing invasive procedures. For most, these problems diminish soon after the crisis resolves. But one out of five of these parents goes on to develop PTSD that can linger long afterward.

The PICU project aims to reduce families' acute traumatic stress and to identify and target for more intensive interventions those families at highest risk of developing PTSD. Two postdoctoral psychology fellows work closely with families to mitigate the factors that have been shown to increase the risk of developing medical traumatic stress. For example, life threat and the fear and helplessness that often accompany it have been shown to be crucial risk factors for developing medical traumatic stress. Research has also shown that a child's or family's perception of extreme life threat, even if it does not correspond to the physician's assessment, may have the same negative effects. The fellows in the PICU program help families feel less overwhelmed by serving as reliable sources of information and emotional support. They ensure that a family's perception of a child's medical condition is accurate and that, to the greatest extent possible, they feel involved in medical decisions. Research has shown that when families feel more in control of a child's medical care, even when the threat to life is great, they are less likely to experience the panic and helplessness that contribute to post-traumatic stress responses.



Jolie's Story: Parenting in the Midst of Medical Traumatic Stress

Jolie was three years old when she came down with the flu. When she did not get better, her pediatrician admitted her to the local community hospital. Within a few days, her condition had become critical. In acute respiratory distress, her lungs incapable of delivering oxygen to her body, she was helicoptered to the Children's Hospital in Philadelphia's Pediatric Intensive Care Unit (PICU).

For the first week, Jolie's condition remained precarious. Her parents hung from moment to moment on each up- and downturn in her condition. Her father felt guilty, blaming himself for having "given her the flu." Psychologist Chiara Baxt, PhD, the psychology fellow assigned to the family, intervened in numerous ways. For example, she made sure the medical team provided regular updates and that Jolie's parents comprehended the information.

After a couple of weeks in the PICU, Jolie was no longer in any danger. Nevertheless, her parents continued to react to what her physician regarded as minor setbacks as if they could quickly escalate again into matters of life and death. The medical team called the family "overemotional." Dr. Baxt wondered how prior medical trauma might be contributing to the family's "overreactions." Jolie had been born prematurely and spent the first weeks of her life in a Neonatal Intensive Care Unit (NICU). The PICU's harsh lighting, sounds of monitors beeping, alarms sounding, and children crying brought back memories of those frightening days in the NICU and flooded

Jolie's parents with all the feelings associated with that time. Dr. Baxt helped Jolie's parents recognize the impact of their prior traumatic experience. She also served as a liaison to the medical team, explaining to them why the family had such intense emotional reactions.

As Jolie continued to improve, the medical staff recommended she be moved back to the community hospital for rehabilitation. Jolie's father objected, convinced that if his daughter went back to the place where she had gone into crisis, she would die. Dr. Baxt learned that the prospect of Jolie's being moved reminded her father of his "worst moment" of her illness. Racing down the highway to Children's Hospital, he kept listening for the sounds of the helicopter overhead carrying Jolie. When he didn't hear the chopper, he panicked, fearing that Jolie had already died. When the chopper finally came into view, he felt a wave of relief, followed by anguish at being separated from his daughter and unable to help her himself.

Suggesting that Jolie be moved brought back these traumatic memories and heightened her father's concerns for her safety. Dr. Baxt worked with Jolie's father to understand the role of traumatic stress in his feelings. In the end, the medical team agreed to Jolie's staying at Children's Hospital. Today, Jolie and her family are fine, with no signs of PTSD associated with their ordeal.

Training and Educating Those Who Help Children



Bringing New Skills Quickly to Communities

Providing effective and efficient trainings to mental health professionals and others is an essential element of NCTSN's mission. The NCTSN conducts in-person trainings at many of its member centers as well as at national meetings. It has moved beyond training as one-way, one-time events and piloted the development and dissemination of video training products in multiple formats, including live streaming over the Internet multisite and videoconferencing. It provides mental health professionals with much-needed training in evidence-based interventions and proven practices. The Network also provides education in conducting assessments with scientifically validated instruments and strategies for implementing these assessments widely. Ultimately, the goal of NCTSN's professional training programs is not merely to add new techniques to a clinician's repertoire, but to offer a comprehensive trauma-focused perspective that can integrate all of a professional's knowledge, clinical thinking, and interventions.

As the final report of the President's New Freedom Commission on Mental Health points out, improving the standard of mental health care requires bringing evidence-based treatments to communities more quickly. For clinicians to adopt new treatments requires that they receive not only adequate training but ongoing support. Experience has shown that

clinicians who receive a one- or two-day training without support and follow-up are unlikely to use an unfamiliar treatment model, even if it has been validated by scientific research. Even if clinicians do implement a new model, without ongoing consultation they will revert to more familiar practices at the first sign that a new model doesn't readily match their needs. The NCTSN's unique collaborative infrastructure means not only that trainers within the Network provide this essential ongoing support, but that treatments evolve with trainees' feedback. The learning process of a training goes two ways: to influence practice in the field and to make treatments developed in academic settings more responsive to real world needs. As NCTSN's Category II and Category III Centers work together, the interventions that emerge from academic arenas more closely reflect the needs of clinicians on the front lines. To use NCTSN member Glenn Saxe's expression, the treatments are "disseminatable" from their inception.

The NCTSN's diverse centers provide a variety of settings, systems, patient populations, and clinicians of different educational backgrounds in which to refine interventions' effectiveness. In working groups and other NCTSN collaborative vehicles, professionals with experience treating youth at different develop-

mental stages and who have endured different kinds of traumatic events can compare their experiences and learn from one another. It becomes apparent quickly how to modify a treatment that works for one form of trauma or one developmental stage so that it will also work for others.

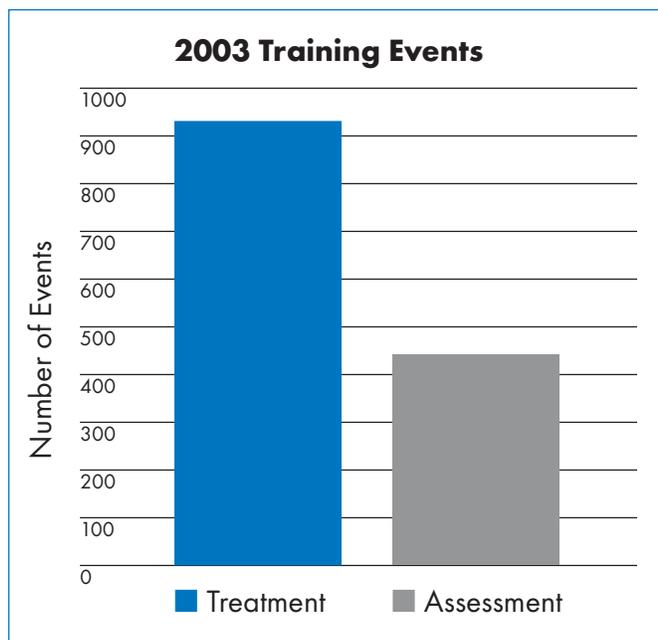
“The biggest difference Network membership has made to Aurora has been the education. We get to pick the best brains in the country on childhood trauma.”

Frank Bennett, PhD
 Director, Aurora Mental Health Center
 Denver, Colorado

In the field of mental health, restrictions on reimbursement have created a barrier to training. Many sources of funding under which agencies and community service providers operate support only direct patient services. The frontline service agencies may not be able to afford the time required for clinicians to become adept at new assessments and treatments. For many centers, NCTSN grants provide the funding essential for trainings that will directly improve the quality of patient care.

In 2003, 39,233 attendees participated in trainings on the treatment of traumatic stress. Training events on the assessment of traumatic stress were attended by 15,367 people.

NCTSN Centers reported a total of 933 training events on the treatment of traumatic stress for 2003. Four hundred thirty-two training events focused on the assessment of traumatic stress.



NCTSN Trainings Reach Rural Providers, Underserved Populations

In fall 2003, the Child Trauma Treatment Network–Intermountain West (CTTN-IW), an NCTSN Community Treatment and Services Center, held a second annual training conference for its affiliated clinicians. More than 100 members attended from the CTTN-IW’s 20 clinician teams, which span seven states: Arizona, Idaho, Montana, Nevada, South Dakota, Utah, and Wyoming. CTTN-IW’s director, Kevin Gully, PhD, developed this unique collaborative model to bring training and consultation to clinicians based in rural, impoverished, and otherwise underserved areas.

Only the team leaders are salaried; the other clinicians join the CTTN-IW voluntarily to improve the quality of care they provide. Many are based in areas where they are called upon to meet all the mental health needs of an entire community. “One clinician may have to treat an adult schizophrenic, do custody evaluations for the court, and treat traumatized children,” Dr. Gully explains. For these providers, training and consultation opportunities are scarce. “These clinicians need training, support, consultation, and a sense of affiliation,” says Dr. Gully.

“CTTN-IW trainings allow rural practitioners to feel more connected to the whole NCTSN endeavor. The Network affords them a sense of affiliation and the opportunity to develop excellence.”

Kevin Gully, PhD, ABPP
Director, Child Trauma Treatment Network
–Intermountain West
Salt Lake City, Utah

The CTTN-IW has been able to offer this service and make a major contribution toward improving the quality of care and availability of services for traumatized children in underserved areas as a result of its NCTSN grant. At the fall meeting in Snowbird, Utah, clinicians received intensive training in manualized, evidence-based interventions and attended sessions on underserved populations and

the particular challenges that confront rural mental health care providers. NCTSN members provided much of the training: Judith A. Cohen, MD, and Anthony Mannarino, MD, educated attendees in Trauma-Focused Cognitive-Behavioral Therapy; David Kolko, PhD, and Karen Stubenbort, PhD, offered training in the Treatment of Physical Abuse; and Chandra Ghosh Ippen, PhD, and Patricia Van Horn, JD, PhD, offered training in Child-Parent Psychotherapy. One of CTTN-IW’s teams based in South Dakota also requested and received training on a later occasion in the UCLA Trauma Psychiatry Service’s School-based Trauma/Grief Psychotherapy Program, another NCTSN-supported effort.

Despite the challenging distances and logistical difficulties, ongoing consultation is built into CTTN-IW’s training programs. Team leaders travel miles to meet face-to-face with rural providers, and trainers offer monthly phone consultations with teams. The CTTN-IW provides a model for the NCTSN on how to build and sustain highly trained provider networks to meet the needs of rural and underserved communities.



Child-Parent Psychotherapy Training: Help for the Youngest Children

NCTSN’s Early Trauma Treatment Network provided Network sites with training in Child-Parent Psychotherapy, an evidence-based manualized treatment developed by Alicia Lieberman, PhD, and Patricia Van Horn, PhD, of the University of California at San Francisco’s Child Trauma Research Project, to help infants and very young children exposed to domestic violence and physical abuse. The trainers continue to work with centers as they adopt and adapt the therapy. The therapy’s developers have found their concept of the therapy and its applications broadened by the diversity of the centers’ clinical experiences.

Sam's Story: I Saw My Father Hurt My Mother

Carla Stover, PhD, of Yale University's Child Development Community Policing Project, received NCTSN training in Child-Parent Psychotherapy and applied it to help a boy named "Sam" who wasn't responding to another form of therapy. "If I hadn't gone to the training and been thinking about the model, I probably wouldn't have attempted it with this child," said Dr. Stover. "But it was the right approach to this case."

Sam was six years old when he stood beside his nine-year-old sister and watched helplessly while their father attempted to strangle their mother. He came to the attention of Dr. Stover, an associate research scientist at Yale, after New Haven police responded to a domestic violence call. The Child Development Community Policing Project, part of the NCTSN, is a model for early intervention. Clinicians at Yale work directly with the New Haven Police Department, accompanying officers to the scene of a crime or act of domestic violence that involves a child so that trauma-focused intervention begins right at the scene. They also educate first responders as to how their actions can help reduce the traumatic stress of a child who witnesses or is a victim of a traumatic event. Yale clinicians were along on the call to Sam's house, and, soon afterward, Sam entered therapy.

Sam was a popular boy who loved to trade Yu-Gi-Oh! cards with his friends. But after watching his father attack his mother, his behavior changed. He became both withdrawn, clinging to his mother and not wanting to be separated from her, and aggressive toward both his sister and other girls at school. Sometimes he put his hands around his sister's neck, as if he were going to strangle her. When the Yale clinicians formally assessed Sam, he had significant symptoms of traumatic stress, including unpleasant, intrusive memories, an exaggerated startle response, and avoidance of traumatic reminders. His imitation of what he'd

watched his father do, an aggressive form of traumatic play, was also a sign of traumatic stress.

Although Sam's first therapist worked to engage him, he balked at being separated from his mother and refused to talk to or play with the clinician. Every session, he retreated to the back of the treatment room. Dr. Stover decided that even though Child-Parent Psychotherapy was geared to children younger than six, it might be the right approach for Sam.

Employing the Child-Parent Psychotherapy model, Dr. Stover brought Sam's mother into the therapy room with him. The boy immediately became more animated. He wouldn't address Dr. Stover directly but played freely while basking in his mother and Dr. Stover's gentle discussion of his feelings. Sometimes Sam would react to a topic raised by throwing his toys, and Dr. Stover would give voice to the symbolic meaning of Sam's behavior, saying, "It seems that Sam is upset by this topic; let's talk about what kind of feelings he might be having." When they talked about Sam's mock-strangulation of his sister, Dr. Stover said, "Sam saw what his father did to his mother and it scared him so much he couldn't get it out of his mind." After she provided this explanation of Sam's traumatic play, his aggressive behavior at home and at school ceased.

Sam also played out his concerns for safety with repeated scenarios about the new security system in his house. He described over and over again what would happen if anyone tried to break in. Dr. Stover recognized that, as with many traumatized children, it was very important for Sam to feel safe again and to hear from his mother that she would protect the family. At the end of treatment, Sam's mother understood him much better, the bond between them was stronger, and Sam seemed back on a steady developmental path.

Disseminating an Evidence-Based Treatment for Sexual Abuse:

Providing training in evidence-based treatments for childhood sexual abuse is one of the NCTSN's highest priorities. Research has shown that about one in four girls in the United States experiences sexual abuse by the time she is 18, and over 300,000 American children are sexually abused each year. Sexual abuse is among the most commonly treated forms of trauma seen by NCTSN sites. Research has also shown that childhood sexual abuse is linked to numerous negative consequences in childhood, adolescence, and adulthood.

Trauma-Focused Cognitive Behavioral Therapy is a manualized, evidence-based treatment developed by NCTSN members Judith A. Cohen, MD, Anthony Mannarino, MD, and Esther Deblinger, PhD, of Allegheny General Hospital's Center for Traumatic Stress in Children and Adolescents. The treatment synthesizes trauma-sensitive interventions with cognitive behavioral principles to target the emotional and behavioral problems that children develop in the wake of traumatic events.

The Trauma Narrative: An Essential Component of the Therapy

One tenet of Trauma-Focused Cognitive Behavioral Therapy is that a child needs to tell the story of what happened so that it is no longer a shameful secret and loses its power to evoke negative feelings. Dr. Cohen says, "Children can come to therapy for months or even years and play or talk about how school is or their family is, and if you don't get to the heart of what's causing their worst post-traumatic stress symptoms—the trauma itself—they won't get better." Constructing a coherent narrative of what happened, and what it means, counters the fragmenting and disorganizing pull of traumatic memory. By creating a trauma narrative with the therapist, the child makes sense of what happened and corrects such cognitive distortions as believing that since the abuser was a man, all men are bad. Through the trauma narrative, the child integrates the event into the larger narrative of his or her life. The abuse no longer defines the child as victim; the child has a larger identity of which the abuse is only one element. Often, through the treatment, the child finds a constructive way of responding to what has happened.

Training Confronts Barriers to the Trauma Narrative

Although many studies suggest that it is important for the child to create a trauma narrative as part of therapy, in actual practice, barriers get in the way. Part of NCTSN's training in Trauma-Focused Cognitive Behavioral Therapy involves identifying and addressing those barriers. Even clinicians experienced at treating child victims of sexual abuse may hesitate to bring up the specific details of the traumatic event, fearing that a child may not be ready. Avoidance of the painful feelings associated with traumatic memories may keep the child from speaking. The child's mistaken belief that the therapist won't be able to tolerate the intensity of feelings associated with those memories can also contribute to an unintentional conspiracy of silence—the clinician doesn't bring up the abuse to protect the client, and the client remains silent partly to protect the therapist.

One of the benefits of the Trauma-Focused Cognitive Behavioral treatment model is its step-by-step framework for creating the trauma narrative. It also arms the child with self-regulation tools, such as relaxation techniques, to exert control over the disturbing emotions and physiological responses that may come up in the process of talking about the trauma.

Culturally Competent Approaches Emerge during Training

As a result of the NCTSN trainings, Trauma-Focused Cognitive Behavioral Therapy's creators learned the extent to which the trauma narrative may need to differ from culture to culture. A number of Category III sites made innovative adaptations to fit their particular client populations. For example, Karen Mallah, PhD, of Mental Health Center of Denver, found ways to make the treatment more suitable for deaf and hard-of-hearing clients.

Some cultures bring their own barriers to the trauma narrative. For example, in cultures where the preservation of the social group is viewed as the greatest good, it may be important to point out the ways in which the narrative serves to protect the sanctity of the family and the culture.

Maria's Story: Nothing Bad Will Happen if I Tell

Brita Beyerlein, MSW, with Aurora Mental Health Center in Colorado, was among the therapists who received NCTSN training in Trauma-Focused Cognitive Behavioral Therapy. She used the model with Maria, a 10-year-old Latina, referred by her public school after the girl revealed to her teacher a one-time incident of sexual molestation. She hadn't told anyone before because she feared telling would result in her being taken away from her family.

Ms. Beyerlein conducted the therapy in Spanish, Maria's first language. Although Maria was fluent in English, Spanish conferred a sense of familiarity and intimacy. The abuse occurred in the midst of a social gathering when Maria got into a car with a male friend of the family, ostensibly to pick up some food. In the course of working together on the trauma narrative, Maria revealed a number of cognitive distortions she held about her abuse that were bound up in her feelings of guilt and shame: the abuse was her fault she felt because she'd gotten into the car without getting permission from her mother. "When I woke up that morning, I had a headache," Maria said, "and whenever I have a headache, something bad happens." Ms. Beyerlein addressed these distortions directly: what about all the times Maria had a headache and nothing bad happened? Yes,

she should have gotten permission from her mother, but what happened was the perpetrator's fault, not hers. Adults are supposed to protect children.

"If we hadn't gone through the trauma narrative and the processing of the trauma," Ms. Beyerlein recalls, "those faulty perceptions might never have come up." Initially Maria could not bear to read her trauma narrative aloud. So her therapist read it to her, helping her to process what had happened.

As a last step, Maria shared her trauma narrative with her mother, who reassured her that she had done the right thing by telling. Bringing a parent into the therapy, another important element of the model, also enabled Maria's mother to confide to the therapist that she had been sexually abused herself as a child in Mexico. Her history left her with conflicting feelings and reactions that were making it hard for her to parent her daughter. She had to acknowledge the sadness and loneliness she still felt for herself as a child who'd had no one she could safely tell. The therapy enhanced Maria's and her mother's ability to support one another, and helped the entire family to recover. By the end of treatment, Maria could read her own trauma narrative aloud. The incident of sexual abuse receded in significance in her life when shorn of the guilt, shame, and secrecy associated with it.

Sharing Knowledge about Child Trauma



Bringing Knowledge to Crucial Audiences

Raising public and professional awareness of child traumatic stress is a fundamental aspect of the NCTSN's mission and vision. In order for children who have experienced trauma to receive help, their parents and caregivers and the professionals who interact with them need to know what child traumatic stress is, how to recognize it, and what to do when a child shows signs of it.

The Network raises public and professional awareness in a variety of ways. Among other activities, the NCTSN

- forms collaborative efforts with other organizations;
- publishes and disseminates member-generated guidelines, reports, fact sheets, and more, both in print and on the World Wide Web;
- markets its resources and engages in extensive media outreach;
- uses technological resources such as videoconferencing and live-streaming www presentations to disseminate knowledge;
- maintains a specialized, public-access research library and website on trauma-related resources and supports members' research presentations and publishing; and

- conducts training for a wide array of professionals, caregivers, first responders, and others (see the chapter "Training and Educating Those Who Help children" of this report).

Forging Collaborations

Because the field of child traumatic stress is relatively young, the Network and the National Center reach out to other organizations in an effort to educate as wide an audience as possible about traumatic stress and the help available for it. One recent joint effort was the collaborative publication and distribution of the fall 2003 special issue of *Claiming Children*, the newsletter of the Federation of Families for Children's Mental Health. The newsletter appeared in both Spanish and English editions. The Federation is a "national family-run organization dedicated exclusively to helping children with mental health needs and their families achieve a better quality of life," with state chapters across the country. Articles published in the special issue included scientifically based information as well as personal stories about children and families experiencing traumatic stress. See the accompanying story, "Adopting and Parenting a Child with a History of Trauma: Stories of Two Children," a Network-generated newsletter essay that combines personal history and sound clinical advice.

“Most of our families have children with significant emotional issues,” says Federation program director Shannon Crossbear. “Often they don’t know the connection between those issues and traumas the children experienced.”

By partnering with the Federation and others, the Network is able to disseminate research-based information about child trauma to the families and communities that most need it. Over the past year the NCTSN has also collaborated with or initiated promising relationships with the following, among others:

- American Academy of Child and Adolescent Psychiatry
- American Academy of Pediatrics
- American Medical Association
- American Professional Society on the Abuse of Children
- American Psychiatric Association
- American Psychological Association
- American Red Cross
- Child Welfare League of America
- DART Center for Journalism and Trauma
- Disaster Technical Assistance Center
- International Society for Traumatic Stress Studies
- National Center for Post-Traumatic Stress Disorders
- National Council of Juvenile and Family Court Justices
- US Centers for Disease Control and Prevention
- US Department of Education
- US Department of Defense
- US Department of Justice

Disseminating Knowledge via Web- and Print-Based Publishing

In 2003 the NCTSN launched a rich, expanded website at www.NCTSN.org. The public side of this site is dedicated to raising public awareness by meeting the informational needs of parents and caregivers, school personnel, professionals, and the media. The members-only side of the site provides platforms for working groups as well as a vehicle for sharing essential Network information, such as internal performance reports, access to research tools, and Network-wide contacts.

The material appearing on the website is generated primarily by the Network and is a product of Network collaboration. Extensive sections such as web pages devoted to terrorism and disaster, school crises, and other issues are designed specifically for easy and efficient web access and use by both the lay public and professionals. Many other NCTSN materials are available in print, electronic format, PowerPoint presentation, and other forms. Examples of multiple-format publications produced over the past year have included, among others:

- *Complex Trauma in Children and Adolescents*, a white paper from the NCTSN Complex Trauma Task Force
- *Review of Child and Adolescent Refugee Mental Health*, a white paper from the NCTSN Refugee Trauma Task Force
- *Childhood Traumatic Grief Educational Materials*, from the Childhood Traumatic Grief Task Force Educational Materials Subcommittee
- *Facts on Traumatic Stress and Children with Developmental Disabilities*, from the Adapted Trauma Treatment Standards Work Group, Subgroup on Developmental Disability
- *Medical Traumatic Stress: Working with Ill and Injured Children*, from the Medical Traumatic Stress Working Group

Building a Library and Website Supporting Research Publication and Presentation

The National Resource Center collects materials from Network centers and identifies and catalogs resources from academic and public sources about the topic of child traumatic stress. The goal of the NRC is to become the most comprehensive and accessible source for information in the new field of child traumatic stress and related issues. The physical resources being collected are cataloged and stored at the NRC site at Duke University in Durham, North Carolina. These physical resources are being made available nationally through a variety of mechanisms:

- Online access to bibliographic databases via the Network's website, www.NCTSNet.org
- Online searchable PILOTS research database linked to the Network website
- Searchable library databases linked to the Duke University Medical Center libraries and a national consortium of libraries
- Directed searches and literature reviews for Network members by NRC librarian and research staff

The NRC Library and website resources promote research, education, and public awareness. Content areas include materials for parents, teachers, healthcare professionals, scholars, students, researchers, and others who encounter children in potentially traumatic circumstances, such as police officers, firefighters, social workers, and judges.

The NRC Library has a collaborative relationship with the library of the National Center for Posttraumatic Stress Disorders in White River Junction, Vermont, where an NCTSN research associate is based. Network members have access to the PILOTS database through this collaboration via the NCTSN website. This database is an electronic index to the worldwide literature on Post-Traumatic Stress Disorder and other mental-health consequences of exposure to traumatic events.

The library offers not only hard copy of materials but also librarian-assisted searches and guidance. Its companion is the virtual library on the Network's website, which includes scientific articles, bibliographies, reports, newsletters, and other downloadable materials. Although full text of research and scholarly articles cannot be posted online due to copyright law restrictions, bibliographies are made available to the public. As the holdings of the National Resource Center continue to expand, continued efforts will make these resources available to public and professional audiences in order to help raise awareness about child traumatic stress and reach the Network's mission of raising the standard of care and improving access to services for children and their families across the United States.



The library at the National Resource Center makes available materials in the emerging field of child traumatic stress.

Reaching out to the Media and Marketing Resources

As part of a comprehensive media relations and public awareness strategy, the Network conducts a wide range of activities to engage the media and bring the story of child traumatic stress to local and national audiences. The Network also actively collaborates with journalists and develops guidelines for more responsible coverage of child traumatic stress issues in the media.

So that the Network can speak with a unified voice, the NCTSN, National Center, and NRC have created “Messages for the General Public” that explain child traumatic stress in easy-to-understand language suitable for a wide range of audiences. Network members use the messages to convey consistent information to families, policy makers, educators, and many other target groups. The messages also allow Network members to provide information about child traumatic stress to members of the media in a consistent, reliable, and effective manner. The messages provide a template for media interviews, letters to the editor, and press releases. Based on these messages, media outreach efforts in 2003 resulted in NCTSN articles, interviews, op-eds, or references in a wide range of venues, including the *New York Times*, *US News and World Report*, *Psychiatric News*, *Journal of the American Medical Association*, *Mental Health Weekly*, *School Violence Alert*, *Psychiatric Times*, *Health and Medicine Week*, *Managed Care Week*, *Biotech Letter*, *Medical Letter on CDC and FDA*, *Drug Week*, KQED Radio, and many others.

Coordinated through the National Resource Center, the NCTSN has also embarked on an extensive expansion of its strategic marketing and public awareness plan, laying the groundwork for further dissemination of information and resources about child traumatic stress to wider national audiences. The plan includes a systematic identification of potential partners to be targeted for strategic collaborative activities. High-quality, effective materials and displays have been created for presentations at conferences and gatherings around the country.

Disseminating Knowledge through New Media

Via the National Center and the NCTSN website, the Network developed the capability to offer live-streamed video of conferences and events. Network members and others may now “attend” selected major gatherings from their desktop computers, which allows for wide dissemination of knowledge without the time and monetary expense of travel.

The National Center sites in Los Angeles and Durham, North Carolina, also make use of extensive videoconferencing, which allows face-to-face meetings through Internet video technology. Network members from other sites also use this technology when visiting either of the two sites for Network meetings. The bicoastal National Center sites also share a common computer drive via the Internet and file transfer protocol to facilitate the sharing of information.

Network members also make extensive use of teleconferencing to increase knowledge transfer. For example, the Child Trauma Treatment Network-Intermountain West Primary Children’s Medical Center of Utah uses teleconferences to communicate with treatment and service providers in the geographically dispersed Intermountain West states of Arizona, Idaho, Montana, Nevada, South Dakota, Utah, and Wyoming. NCTSN sites also have developed training videos for their communities.

In addition to the Network’s use of video and teleconferencing, disseminating information about Network activities was also improved through an expanded, electronic version of the *Network Newsletter*, which reaches public and professional audiences both within and outside of the Network.

Adopting and Parenting a Child with a History of Trauma

Joycee Kennedy and Frank Bennett

Joycee Kennedy, LCSW, and Frank Bennett, PhD, were the clinical coordinator and the project director, respectively, for the Aurora Mental Health Center site of the National Child Traumatic Stress Network when this essay was written. Ms. Kennedy is now an independent writer. They have each been foster or adoptive parents to children with histories of trauma and have served as therapists for many more.

This story originally appeared in the fall 2003 edition of Claiming Children, the newsletter of the Federation of Families for Children's Mental Health. This edition was produced jointly by the Federation and the NCTSN.

Raising a child changes your life, whether the child comes through birth, adoption, or the foster care system. Adopting a child with a history of trauma is particularly challenging. While we don't believe that we have answers to every problem of every family, we believe that the following principles will improve the lives of many families embarking on this journey.

Make the Child's Sense of Safety Your Priority

Provide consistent love and safety. You want to help your child feel safe regardless of his or her behavior at the moment. Once, Joycee's son announced that he was going to run away. Shortly thereafter, Joycee showed up in his room with a suitcase and started packing. He looked at her and asked, "What are you doing?" She said, "I'm going with you." This unexpected maneuver showed him that she was willing to do whatever it took to keep him safe. He didn't run.

Understand the Child's View

Children who've been adopted or brought to a family through the foster care system, especially those who have experienced trauma, may not share certain basic beliefs that other children share with their parents. They may have been moved from home to

home, been physically or sexually abused, or repeatedly been lied to and may not trust adults. More fundamentally, trauma may interfere with children's learning. When a situation reminds them of a traumatic situation, these children may become so anxious that they can't organize their thinking, can't take in new information, or may not even be able to remain in a situation to see how it develops. And they may not be able to describe in words what they are experiencing.

What Works for Other Children May Not Work for Your Child

Joycee's son told her once how important it was that she never let him down. On the other hand, when Frank's daughter by birth took tennis lessons, her parents frequently forgot to pick her up on time. This earned them some glares, which they felt they

deserved, but the relationship was not threatened. Children with histories of trauma may not have the confidence in the relationship that other children do, and the experience of being let down may make them so anxious that they cannot perceive an event as simply annoying rather than life-threatening.

Understand What Discipline Means

The threat of a parent's displeasure is probably the major factor inhibiting inappropriate behavior in children who are securely attached to their parents. That factor may not exist for a child with a trauma history who's been adopted. Physical discipline may recall memories of abuse and set off a chain of fear and anger. Deprivation of privileges may set off a power struggle that doesn't end. Much of the misbehavior of children who've been traumatized is due to their lack of self-control, self-calming abilities, and



everyday positive coping strategies. These skills need to be taught to the children before they will let go of troubling behaviors. For these children, rules must be crystal-clear and consistent. As the children's sense of safety and ability to care for themselves increases, the rules can become more flexible, but patience and repeated practice are needed before a child can feel safe with self-control.

Adjust Your Expectations

What other children can do, children with histories of trauma may not be able to do or may take much longer to learn. One young boy, when first placed in the new home, would retreat to a corner of the room when he met new people. With two years of coaching and practice, the boy learned to shake hands and introduce himself when he met new people. Without a caring relationship and extreme patience, this new pattern could not have been built.

Get Support

Parenting children with trauma histories is hard work. It may be possible to do it alone, but it isn't a good idea. Support can come from support groups, a therapist, family members, friends, colleagues, books, and other materials, or a combination of all of these. Spending time with other parents who have had similar experiences will help you realize that you are not alone. There are apt to be times when other children in the family are stressed and tested by their siblings. They will need support and help. The other children in the family may not greet the suggestion to enter therapy with enthusiasm, but persist. They need to have some understanding of what their sibling is going through and what the family can do to work better together.

Recognize That You Will Not Be Perfect

You will never be able to follow all the helpful advice you get. You will undoubtedly lose your temper at times or do other things that you later wish you hadn't. Relax, forgive yourself, and get ready to face another day.

Never, Ever Give Up

Your children may not do things in the time frame you have imagined for them. Children with histories of trauma, in particular, may take more time than other children to finish school, find work, establish relationships with family and friends, and learn to adapt to society's expectations. When Frank's son was 21, he was homeless and heavily involved in alcohol and drugs. Four years later, he had held down the same job for three years, owned a car, and was paying his rent on time. You never know when the love and concern you give a child may bear fruit.



NCTSN Messages for the General Public

1. Child trauma is more common than you think.

More than 25 percent of American youth experience a serious traumatic event by their 16th birthday, and many children suffer multiple and repeated traumas.

Common sources of trauma include abuse and neglect; serious accidental injury; disasters and terrorism; experiencing or witnessing violence in neighborhoods, schools, and homes; and treatment for life-threatening illness.

A child exposed to a traumatic event is at risk of developing traumatic stress. Children are more vulnerable to trauma because of their size, age, and dependence.

Prior trauma, past mental health problems, or a familial history of such problems may increase a child's risk.

2. Child traumatic stress can be identified.

Children experience a wide range of reactions following traumatic events, and children of different ages react to trauma differently.

Signs of ongoing post-trauma stress include fear, anger, irritability, withdrawal, trouble concentrating, nightmares, and physical complaints.

A child's distress may not be obvious or visible; by talking with them you might find out what is going on inside. A child may feel ashamed, guilty, betrayed, or helpless. They may seem numb because they are trying to avoid feeling their own feelings.

Serious, ongoing traumatic stress reactions that include intrusive thoughts and images, strong emotional and physical reactions to reminders of the trauma, avoidance, and a sense of "being on alert" are hallmarks of Post-Traumatic Stress Disorder (PTSD).

3. Child traumatic stress is serious.

Traumatic stress can interfere with children's ability to concentrate and learn, and it can seriously delay development of their brains and bodies.

It can lead to depression, substance abuse, other mental health problems, educational impairment, acting out, and future employment problems.

It can change how children view the world and their own futures, and it can change their behavior, interests, and relationships with family and friends.

It can take a toll on a family.

4. Caring adults can help.

Not all children exposed to traumatic events develop a traumatic stress reaction. Many children, especially those supported by caring adults, can effectively recover.

Parents who take care of themselves are able to take better care of their children. In many circumstances, parents are traumatized along with their children. Parents may need their own professional help to recover and maintain supportive parenting.

If you think you or your child may have symptoms of a traumatic stress reaction, seek help from a qualified mental health professional.

5. Treatments work.

Treatment from a mental health professional who has training and experience working with traumatized children can reduce child traumatic stress and minimize physical, emotional, and social problems.

Trauma treatments for children may include psychotherapy and medications and may involve families and schools.

6. A new Network is here to help.

The federal government established the National Child Traumatic Stress Network to improve the quality, effectiveness, and availability of therapeutic services to traumatized children and adolescents.

Www.NCTSN.net.org is the web resource on child trauma for parents, health-care workers, and other professionals.

Enhancing Our National Capacity to Respond to Terrorism and Disaster



An eight-year-old girl's drawing of smoke and ash from the Southern California wildfires.

Bringing a Mental Health Response to Disasters

The Network's coordinating National Center and SAMHSA launched the Terrorism and Disaster Branch (TDB) in the fall of 2002. The TDB is directed by Betty Pfefferbaum, MD, JD, at the University of Oklahoma Health Sciences Center. Its goal is to promote the mental health and well-being of children and families by strengthening our nation's preparedness and response to terrorism and disaster. The TDB is committed to ensuring that this mental health response is integrated and coordinated within a comprehensive disaster system of care, including emergency medical services, police, fire and disaster relief personnel, schools, hospitals, and other event-specific essential services and providers.

"Lessons learned after 9/11 have especially heightened our awareness of the need for planning and providing mental health services for children and families after terrorism and disaster. We must act now to enhance the national standard of care and availability of effective services."

Charles G. Curie, MA, ACSW
SAMHSA Administrator

TDB Objectives

The objectives of the TDB are:

1. To raise public awareness of the scope and serious impact of terrorism and disaster on the mental health of our nation's children, families, schools, and communities.
2. To shape and influence public policy to promote effective mental health planning and response for children and families affected by terrorism and disaster.
3. To develop, through collaborative efforts, effective programs of mitigation, preparedness, response, and recovery.
4. To develop products (for example, surveys, intervention protocols, curricula, and training platforms) that can be used within and beyond the NCTSN.
5. To establish collaborative partnerships at federal, state, and local levels that facilitate development and adoption of the best practices of interventions, treatments, and services and improve access to care.
6. To promote and participate in a comprehensive, integrated system of national preparedness and response.

Preparing and Responding in the First Year

Early in its first year, the TDB created the Rapid Response Support Team (RRST), made up of in-house staff with worldwide experience in addressing terrorism and disaster and backed up by NCTSN centers across the United States. The RRST provides federal, state, and local agencies with single-point, 24/7 access to telephone and web-based consultation and technical assistance on child and family mental health issues during and following a mass casualty event. Consultation covers psychological first aid, rapid triage, needs assessment and surveillance, clinical evaluation, intermediate and long-term evidence-based care, and information about children's reactions and resilience for parents, teachers, mental health providers, and the public.

The RRST has been activated in response to the Rhode Island nightclub fire, tornadoes in the Midwest, hurricanes in the Southeast, the sniper attacks in the Washington, DC, area, school shootings, and the devastating Southern California wildfires in the fall of 2003. For example, in response to the wildfires, the RRST reached out to the affected school districts in Los Angeles, San Bernardino, Ventura, and San Diego Counties. The RRST provided technical assistance in the grant application process for FEMA-funded crisis counseling, conducted trainings for school district and county agencies, and helped design screening instruments and school-based intervention programs for students and school personnel.

The TDB, in conjunction with NCTSN's School Crisis and Intervention Unit (SCIU), introduced the NCTSN School and Family Preparedness Initiative during the anniversary week of 9/11 to further prepare the nation's schools and families in the event of terrorism and disaster. Materials disseminated by 25 of the Network's centers to school districts across the country included a School Preparedness Checklist, Family Preparedness Guide, and a Family Preparedness Wallet Card.

Assisting People and Communities Affected by the California Wildfires

The TDB and the NCTSN's School Crisis and Intervention Unit (SCIU) engaged in a coordinated and multilevel response to the Southern California wildfires in the fall of 2003, in which 24 people were killed, over 3,600 homes were lost, and over 745,000 acres destroyed. The TDB activated the Rapid Response Support Team to provide consultation and technical assistance to federal, state, and local agencies in responding to the wildfires. TDB members quickly developed educational and support materials for the NCTSN website and general distribution in the affected areas, conducted media interviews, and reached out to school districts. The following are some of the activities that took place in the days and weeks following the wildfires:

- In San Bernardino County, the RRST met with local school districts and provided technical assistance in developing a recovery program.
- In San Diego County, the RRST assisted the Grossmont Union High School District in preparing the grant application for Federal Emergency Management Agency funds for crisis counseling. TDB and SCIU members conducted a training that included participants from each of the schools within the Grossmont District and several county agencies and addressed issues of developing a school-based mental health program.
- TDB members met with NCTSN members from the Chadwick Center for Children and Families to discuss program design, assessment, and intervention.
- On a state and national level, RRST members worked with the California state mental health disaster coordinator and with the Center for Mental Health Services to provide training in assessment and intervention to partners within the affected areas.

Gina's Story: After the Wildfires

As part of the TDB's assistance to communities during the Southern California wildfires of 2003, NCTSN site Chadwick Center for Children and Families worked with three East San Diego County high schools. A large number of the students at these schools had been directly affected by the fires. Chadwick consulted with TDB staff to design a comprehensive disaster recovery program, including an assessment protocol, coordination with key stakeholders, intervention strategies, and program evaluation. Chadwick's clinicians counseled 55 students in one- or two-session therapy groups, which included assessments to identify students in need of further services. Those students received more intensive therapy and referrals for longer term treatment.

Among the students most profoundly affected by the wildfires was Gina, a 16-year-old girl who lost her home and all her possessions in the fires, which moved so quickly and unpredictably that her family barely had time to escape safely. A few evenings after the fires, Gina experimented with drugs for the first time. She told Chadwick counselor Shelly Hirschberg, PhD, "I just wanted to forget everything." Risk taking and self-destructive behaviors are common responses to traumatic stress in adolescence. Gina began to skip school and ignore her homework. She felt angry at everything and everyone. She had

trouble concentrating and experienced nightmares and intrusive memories of the sights, sounds, and smells of the fire. She particularly remembered standing by helplessly while watching her house burn down. Gina's parents were emotionally distraught and were also saddled with the financial woes of trying to recover from their losses and take care of the family. Not wanting to burden her parents further, Gina felt she had nowhere to turn.

As a result of Chadwick's NCTSN membership and the work of the TDB, Dr. Hirschberg was able to provide Gina with individual therapy. Dr. Hirschberg worked with Gina to help her identify her trauma/loss reminders and to cope more effectively with her reactions to them. She helped her find a support system and get the help she needed from it. Dr. Hirschberg also provided psychoeducation, relaxation training, and overall support. In addition to meeting with Gina alone, she also met with Gina and her parents jointly so that the family could process the trauma together and find ways to support one another.

Gina is now doing very well. She is not using drugs, and her post-traumatic stress symptoms have subsided, although she and her family continue to face secondary adversities associated with the fire. Gina copes by using relaxation techniques, socializing with friends, writing, and playing her guitar.

The 9/11 School Initiative

As the second anniversary of 9/11 approached, the TDB launched a major initiative both to honor the memories of the victims and their families and to take further steps to help prepare our nation's schools and families in the event of large-scale traumatic events. Along with the School Crisis and Intervention Unit, the TDB designed the initiative to provide impetus to the Network centers to strengthen their ongoing partnerships with local schools and to enhance those schools' emergency crisis preparedness.

During the week of September 11, 2003, the TDB/SCIU introduced the NCTSN School and Family Preparedness Initiative to schools across the country.

Participants from 25 Network centers met with their local school districts to disseminate specially prepared materials and engage in a variety of activities to assist them in crisis and disaster planning, including:

- The School Preparedness Checklist
- The Family Preparedness Guide and Wallet Card
- Ongoing school consultation

The School Preparedness Checklist, written in coordination with the US Department of Education, is a comprehensive list to help administrators and

school crisis teams systematically review and address the safety and mental health issues that accompany an emergency.

The Family Preparedness Wallet Card, which allows parents and caregivers to fill in important contact numbers, was made available in a variety of languages. Accompanying the Wallet Card, the Family Preparedness Guide outlines family emergency and communication plans and provides information for parents on making an emergency supply kit. In addition to dissemination during the week of September 11, these materials are available on the NCTSN website.

Some of the major accomplishments of the initiative included:

- The Los Angeles Unified School District translated the wallet cards into five languages, and a local printing company in Los Angeles donated 5,000 cards for distribution.
- The Parsons Child and Family Center of Albany, New York, circulated the materials to 40 local school districts.
- In New York City, the Jewish Board of Family and Children's Services made the Wallet Card available to its clinicians to provide to their clients and indicated it was useful in the subsequent northeast area electrical blackout. The Jewish Board also reached out to the New York City's Office of the Public Advocate for further dissemination.
- The Utah Schools for the Deaf and Blind, an independent Utah school district, made plans to translate the Family Preparedness Guide and Wallet Card into Braille to distribute to over 400 students and the several hundred more students who receive consultation services from the district.
- The US Department of Education disseminated the School Preparedness Checklist in its publication *Challenge: A Publication of the U.S. Department of Education's Office of Safe and Drug-Free Schools*.

- The School Preparedness Checklist was featured in *Security Products: The Integrated Product Newsmagazine for Security, Fire & Safety Professionals*, and a newsletter was circulated to school resource officers across the United States.

The success of the 9/11 initiative relied on the individual Network centers' long-established relationships with their area schools. For example, Network members from Oklahoma felt that, because of inroads already established, they were able to set up meetings with the decision makers at Oklahoma Safe and Drug Free Schools. The TDB/SCIU materials were added to their annual 9/11 anniversary mailing, which was circulated to every public school in Oklahoma.

The initiative also helped strengthen crisis intervention plans already in place. In Utah, following a TDB/SCIU presentation to the district- and school-level administration of the Utah Schools for the Deaf and Blind, the district decided to rewrite its crisis intervention/management plan. The improved plan now addresses events as extreme as terrorist attacks and considers the mental health effects of various types of crises.

Priority Projects in the Upcoming Year

- An NIMH-funded disaster research training program to enhance our national capacity to conduct state-of-the-art rapid-response research in the aftermath of terrorism and disaster.
- Collaboration with the Centers for Disease Control and Prevention to develop protocols for community resilience to enhance the ability of communities to respond to catastrophic events.
- Protocols for "Psychological First Aid" to assist children and families in the acute postimpact phase of disaster and terrorism.
- Development and production of training videos in regard to specific assessment and intervention strategies and techniques for use by professionals and paraprofessionals with children and families after disasters.

TDB Programs, Products, and Partnerships

Programs

The Rapid Response Support Team provides consultation and technical assistance to federal, state, and local agencies and organizations in planning and responding to mass casualty events on behalf of the mental health of children and families. The team, comprising in-house staff with worldwide expertise and backed by the 54 centers nation-wide, provides a single-point, 24/7 contact for access and response coordination.

State Models Initiative: The objective of this project is to develop a guide for state disaster mental health coordinators on strategies to address child and family mental health needs and services following a mass casualty event.

Products

TDB Resilience-Building Protocol: This product will include (1) a brief screen to identify children with anxiety sensitivity and (2) materials for a brief psychosocial intervention to improve ways in which these children respond to cues of danger (for example, media reports and school drills).

Natural Disasters Preparedness and Response: The TDB has developed a comprehensive list of web-based disaster preparedness/response materials (for example, for hurricanes, tornadoes, and floods), assessment tools, and delivery systems for children and families. A Disaster Preparedness and Response Protocol containing identified best practices for children and families will be available through the National Resource Center.

Earthquake Preparedness and Response in Schools: The TDB has compiled the best available school safety and preparedness plans in regard to safeguarding child and family mental health after an earthquake. A paper is underway that will present a critical overview of existing materials and school plans for earthquake preparedness, response, and recovery.

NCCTS School Crisis and Intervention Unit and TDB Advanced Training for School Crisis Response Teams: The NCCTS/SCIU/TDB has developed a two-day crisis-response training program for school-district crisis-response teams. The training covers the organization of school crisis teams, assessment and intervention strategies, threat assessment, and the importance of a comprehensive all-hazards approach. A guidebook is being prepared to supplement the training.

TDB Section of NCTSN Web Site: TDB team members routinely develop web content for dissemination to key stakeholders, including youth, caregivers, professional service providers, media, school personnel, and city planners.

Firefighters Project: The TDB is expanding and adapting the Yale Child Study Center Child Development-Community Policing Program for firefighters. This curriculum and training program provides first responders with critical information and training in regard to the mental health impact of disaster and terrorism on children and families.

Partnerships

The Linkage Program was developed in order to link the Rapid Response Support Team to federal, state, and local agencies and organizations in order to build a more effective capacity to respond to mass casualty events. Current working relationships include the American Red Cross, the Centers for Disease Control and Prevention, the US Department of Education, the US Department of Defense, the State Departments of Mental Health Disaster Assistance Coordinators, State Commissioners of Mental Health, the National Association for State Mental Health Program Directors, and the National Center for PTSD.

The TDB Training Task Force is developing curricula and training materials related to the mental health needs of children and families in the face of terrorism and disaster. These materials are designed for health and mental health professionals, child-care providers, first responders, hospital administrators, state officials, school personnel, community groups, families, and the media.

If you would like to learn more about child traumatic stress, its consequences, and the ways the National Child Traumatic Stress Network is helping children and families, please visit the Network's website at www.NCTSN.org.



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All photos used in this report are stock commercial photography.

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