NCTSN The National Child Traumatic Stress Network

IMPACT

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Inside this issue...

A QUARTERLY PUBLICATION OF THE NATIONAL CHILD TRAUMATIC STRESS NETWORK

Advisory Board Service of Mutual Benefit for Network and Board Members

They work in disparate sectors of the behavioral health, juvenile justice, and public policy worlds, but when NCTSN Advisory Board members convene, their common commitment to the Network's mission helps to shape its future work. According to Board members with whom we spoke, the content and spirit of their meetings have in turn enhanced their own work.

NCTSN Advisory Board members gathered for the annual meeting in June in Durham, NC. Left to right: Sue Badeau (front), Walter Howard Smith (back), Esta Soler, Barbara Feaster, Patricia Barron, Diane Elmore, Teresa Huizar, Vivian Jackson, Michael Howard, Sandra Spencer, and Thom Bornemann. Members not present: James Hmurovich, Peter Pecora, Robert Ursano, Paul Vick.

The annual Advisory Board meeting was held on June 18-20, 2012, again at the Washington Duke Inn in Durham, NC. Network member Abi Gewirtz, PhD, the Steering Committee representative to the Board, remarked, "I was very impressed by the willingness of Board members to engage in collaboration on our behalf. The spirit of partnership around getting the word out on behalf of traumatized kids is very powerful." Added Board member Vivian H. Jackson, PhD, LICSW, of

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Go-Team Delivers On-Call Trauma-Informed 911 Response in Providence

It's a summer day in Providence, RI. Three children playing in their front yard see a seemingly friendly man wave as he approaches them. Suddenly he becomes agitated, takes out a knife, and stabs one of the boys in the side of the head. It's a chaotic and horrific scene. As the boy is taken to the hospital, police search the neighborhood for the perpetrator. After an hour and a half, he is apprehended and taken into custody.

It's the type of case that, prior to 2004, would have been especially troubling for not just the children and family involved but the officers responding to the scene, said Colonel Hugh T. Clements, Jr., Chief of the Providence Police Department. Clements recalled that he was often left wondering how children and families had managed to cope in the wake of incidents that he had cleared.

But in this case, a trained trauma specialist from Family Service of Rhode Island was riding along with the responding officers. She initiated an array of trauma interventions to help the injured boy and his family deal with the violent event. "We followed up on him for a while and he was doing remarkably well, both

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On Becoming a Voice for Foster Youth

In 1999, as Barbara Feaster testified before the Utah Child Welfare Legislative Oversight Panel on behalf of foster youth, she noticed that "All these people were making decisions about how the lives of the youth were going to unfold. But the children and teens—the ones who were living this situation 24/7—were glaringly absent."

Barbara Feaster, cofounder and Executive Director of uFOSTERsuccess.

It was a galvanizing moment for Feaster, who was 26 at the time. Since then, she has testified numerous times before state panels and committees; cofounded uFOSTERsuccess, a nonprofit advocating for foster youth; and served as an NCTSN Advisory Board member. Her aim: to fully apprise legislators and policymakers about "what happens and can happen in foster care."

Giving Voice, Defying the Stigma

Feaster knows firsthand the pain and isolation of undisclosed childhood trauma. She lived in disbelief and denial as she was sexually molested hundreds

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This project was funded by the Substance Abuse and Mental Health Services Administration (SAMHSA), U.S. 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 SAMHSA or HHS.

Chadwick Trauma-Informed Systems Project Presents Guide for Administrators

When designing a guide for infusing trauma-informed knowledge and practices into your system, ask the end-users what they want to know. That was the strategy of Project Manager Lisa Conradi, PsyD, and staff of the Chadwick Trauma-Informed Systems Project when they set out to prepare "Creating Trauma-Informed Child Welfare Systems: A Guide for Administrators."

The guide, released online in June 2012, comprises the first installment of a complete toolkit to be issued at the end of this year as the *Trauma-Informed Child Welfare Practice Toolkit*.

The project was established as an NCTSN Category II Center in the Spring of 2010 to improve services for children involved in the welfare system who have experienced traumatic events. Conradi and staff queried administrators and other members of their diverse, 21-person advisory committee, asking about specific issues they considered important for child welfare administrators to understand.

The 123-page, 14-chapter administrators' guide covers issues ranging from the influence of culture on responses to trauma, to the impact of trauma on the brain. Chapter authors include nationally known child welfare, juvenile justice, and consumer experts. Conradi test-flew the guide at this year's All Network Conference, soliciting additional feedback. The main message, she said, was that the guide was "very dense." Following the conference, Conradi and staff made the guide more user-friendly, organizing its contents around key domains such as background on trauma-Informed child welfare systems, recommendations from the field, and resources. Conradi said the design allows chapters to function as standalone units, and administrators can "pick and choose" the most relevant areas to explore. ■

"Creating Trauma-Informed Child Welfare Systems: A Guide for Administrators" is accessible at www.chadwickcenter.org/CTISP/images/CTISPTICWAdminGuide.pdf (Users are asked to register, for purposes of collecting evaluations to further hone the guide's usefulness.)

Voice for Foster Youth *cont'd from pg. 1*

uFOSTERsuccess Board of Directors, left to right: Shelly Tripp, Barbara Feaster, Lisa McDonald, Celeste Edmunds, and Melissa Singleton. (With the exception of McDonald, all are child abuse survivors and foster care alumnae.)

of times by her father from the age of 14 months until 14 years. When her father decided to confess his actions, to his church bishop and later to police, he was removed from the home. Shortly after, her mother placed her two daughters in foster care. Feaster was upset at first, but she said she now realizes that foster care opened the door to a "new life of hope and possibility" thanks to two caseworkers who treated her "like a real person with potential, not a broken victim." She also understands that this is not the outcome for all children placed in foster care. Presenting their range of stories became even more important for her because most foster care children do not have a voice in the public arena.

As she regularly participated at legislative hearings and other meetings, Feaster also noticed a stigma associated with foster care that did not adequately reflect her own experience or that of the foster youth and alumni she knew. Working with abuse survivors and foster care alumni, she began to shape the goals for a nonprofit agency. "We wanted to raise the standard of care for children and teens in foster care so that they have more opportunities to thrive and heal and be who they are," Feaster said. The agency they created, uFOSTERsuccess, based in Sandy, UT, was incorporated as a 501c3 nonprofit in 2003. Feaster, now the Executive Director, and cofounder Melissa Singleton had known each other since 1990. Another cofounder, Heidi Hansen, and directors Shelly Tripp, Lisa McDonald and Celeste Edmunds, joined at various times. The organization connects foster care alumni and youth; organizes testimony at legislative sessions; and has sponsored uFOSTERsuccess awards for outstanding child advocates and resource parents.

Linkage with the Network

Feaster has been an NCTSN Advisory Board member for the past seven years, and has been embedded in the process of developing products for resource parents and for informing the board and other Network personnel about the foster care experience from the consumer's point of view. "Children in foster care need resource parents with the skills and understanding to help them thrive after having gone through trauma," she asserted.

Ellen T. Gerrity, PhD, Associate Director and Senior Policy Advisor for the UCLA-Duke University National Center for Child Traumatic Stress, who leads the yearly Advisory Board meetings, commented that Feaster "has been a leader in helping us understand the challenges faced by children in foster care and the trauma in their lives. She is knowledgeable, generous, and willing to contribute in whatever way she can. We have been so fortunate to have her and uFOSTERsuccess as a partner."

Feaster said there are still times when her own trauma resurfaces. But she embraces the healing process with resilience. "Whenever a new layer rises up," she said, "I know that I am going to get through it and that there are resources available that I can tap into. That's part of being human, and it doesn't diminish who we are at all." ■

Terrorism and Disaster Program Responds to Colorado's Summer Disasters

The test of any disaster response program is its ability to effectively mobilize in an emergency. The NCTSN's Terrorism and Disaster Program met that test this summer, as it has in more than 100 responses throughout its decade of operation.

Beginning in June, as wildfires raged across Colorado and the West, partner and affiliate agencies were able to access a wealth of resources (both in English and Spanish), including Psychological First Aid and fact sheets targeted to parents, as well as educators, who then were better equipped to help children cope with the devastation and displacement caused by the fires.

Then, just after midnight on July 20, the mass shooting at a theatre erupted in Aurora. By 5 that morning, Melissa J. Brymer, PhD, PsyD, Director, Terrorism and Disaster Programs, initiated the Rapid Response Program and began making contact with the program's primary and secondary liaisons at each of the NCTSN-funded and affiliate centers in Colorado. Within hours, Brymer's team had adapted fact sheets, originally developed in connection with last summer's mass shooting in Norway, to reflect specific needs for the Colorado situation. The revamped fact sheets were then posted to the NCTSN Web site, while all Network partners nationwide, including Colorado's Disaster Behavioral Health Coordinator and SAMHSA's Disaster Technical Assistance Center, were notified through Listserv, Facebook and Twitter alerts.

The Aurora Mental Health Center, a Network affiliate at the epicenter of the Aurora shooting, immediately set up a 24-hour hotline, which provided services to 425 people in Aurora by the end of July. An additional 759 people were served in 18 sites in the greater Denver area (totaling close to 1,400 hours of professional time). The Terrorism and Disaster Program supplied resources for distribution by the center, including the *Child Trauma Toolkit for Educators, Parent Guidelines for Helping Youth after the Recent Shooting,* and the *Secondary Traumatic Stress* fact sheet (totaling more than 5,000 copies). Brymer noted that strong partnerships with other Colorado-based agencies allowed the Terrorism and Disaster Program to access a greater depth of knowledge and support.

The development of Psychological First Aid–and the growing number of professionals trained in PFA–has facilitated more focused responses from behavioral health responders during the recent disasters, said Marlene A. Husson, LPC, a consultant with the Aurora Mental Health Center. A veteran of responses to Oklahoma City, Columbine, and Hurricane Katrina, Husson knows that behavioral health responders can be much more productive with PFA training and age-appropriate, trauma-informed resources under their belts. As the response to the Aurora shooting moves into the recovery phase, NCTSN products targeted to educators have become especially valuable, Husson said. "We don't have enough child therapists in Colorado to cover all 68 schools. It has been a huge plus for us to have the information and be able to disseminate it quickly."

The responses to the Colorado disasters, Brymer said, "showed us that the program and plans we have in place make a difference." ■

Current and Affiliated NCTSN Members in Colorado

Evelin Gomez – Affiliate
Frank Bennett, PhD – Affiliate
Aurora Mental Health Center – Affiliate
Gang Reduction Initiative of Denver – Trauma Treatment Project – Category III
Prevention, Empowerment, and Resiliency Collaborative Center, Colorado State University – Category III
The Denver-Kempe Trauma Collaboration – Category III
Treatment Accountability for Safer Communities, Denver Juvenile Probation Dept. – Category III

Upcoming: Conversations about Historical Trauma

Historical trauma has been defined as "a cumulative emotional and psychological wounding over the lifespan and across generations, emanating from massive group trauma experiences."[1] In individual members of historically traumatized groups, this is often manifested as depression, survival coping behaviors, anxiety, anger, and a tendency for substance abuse to avoid painful feelings. In upcoming issues of *IMPACT*, we will explore, with Network members and renowned researchers, the effects of historical trauma on our nation's populations. We will examine the definition of historical trauma; explore why it is important for professionals working in childhood trauma to be aware of and sensitive to the effects of historical trauma; and discuss how unaddressed historical trauma shapes the experience of and recovery from traumatic events. The articles will focus on the ongoing impacts of racial oppression in African American communities, and the relationship of historical unresolved grief to the historical trauma response in Native American populations. We will also discuss the issues of historical trauma particular to populations of Jewish, Japanese, and Pacific Island/Micronesian descent. ■

1. Brave Heart, Maria Yellow Horse. (2003). The historical trauma response among natives and its relationship with substance abuse: A Lakota illustration. *Journal of Psychoactive Drugs, 35*, 7-13.

The Organizational Journey toward Cultural and Linguistic Competence

Part Three: Linking Finances to Delivery of Culturally and Linguistically Competent Services

The first two installments in this four-part series on organizational cultural and linguistic competence (CLC) appear in the Spring and Summer 2012 issues of *IMPACT*, respectively. They address knowledge of the service population, and promotion of workforce cultural competence and diversity. The third element in delivery of CLC care is allocation of the budgetary resources needed to support the organizational infrastructure for advancing and sustaining CLC services, such as workforce recruitment and development, facilitation of access to services including language access, and so forth.

Who's Walking the Walk?

How agencies apportion resources is generally an indicator of the importance they attach to budget items. This is often the case with CLC initiatives, noted Larke N. Huang, PhD, Director of SAMHSA's Office of Behavioral Health Equity: "You can always know a true commitment [to CLC services] by looking at the budget line." Huang said the delivery of CLC services requires that agencies allocate budget resources not just for personnel training, but for ongoing supervision, coaching and guidance.

Larke N. Huang, PhD, Director of the Office of Behavioral Equity.

However, small nonprofit agencies are often challenged to set aside funds for staff training or protected time for developing CLC initiatives. To explore the degree to which CLC initiatives are taking hold in nonprofit mental health agencies, the Center for Child Trauma Assessment and Service Planning at Northwestern University, an NCTSN Category II center, conducted an anonymous survey of nonprofit mental-health agencies in Illinois. The agencies serve traumatized children and families, including those in state foster care. The survey questions asked about the agencies' dedicated budgets for interpretation and translation services; dedicated dollars for pursuing CLC initiatives; reimbursement of staff travel expenses and/or paid administrative leave to pursue training; and protected time for staff members with responsibilities to promote and advance CLC for the agency.

A total of 31 people, from both urban and rural regions of Illinois, responded to the survey. (It was not known whether these respondents were all from separate agencies.) A total of seven respondents, or 22.6%, reported that their agencies allocated dedicated funds for professional development to promote staff growth in cultural and linguistic competence. Of those responding in the affirmative, one person indicated that mandatory cultural diversity training was provided.

In agencies where CLC-related in-service or other training was not financed, nearly one third of respondents noted that the agencies provided travel expenses or allowed administrative leave for staff who wished to pursue CLC training. The majority of survey respondents (67.7%) reported that their agencies did not designate specific staff members to help promote and advance cultural and linguistic competence.

Taking the Longer View

Huang acknowledged that setting aside money for training, or even allowing staff leave for training purposes, can be a challenge for small agencies; her office has encountered this reality firsthand. The Office of Behavioral Health Equity, established as part of the Affordable Care Act, creates and supports cost-effective trainings to contribute to a diverse behavioral-health workforce—one of the office's five key strategies. Nevertheless, some agencies perceive that even granting leave for cost-effective training equates to a loss of billable hours.

Huang suggested another way to view the incorporation of training into an agency's mandate to deliver culturally and linguistically competent services. "If you are not able to engage diverse populations in your service area," she pointed out, "this can lead to avoided treatment and no-shows, which are very costly for organizations. So, in the long run, those costs [of training] might be 'budget wins' for the agencies, if the training results in more effectively engaging target populations, retaining clients in therapy, and providing increasingly better quality services."

The changing demographics of catchment areas can also present challenges, Huang said. For example, an agency whose highly skilled workforce has been meeting the needs of African American and Latino clients may find itself confronted with a new population of potential clients from a secondary migration of Southeast Asians. Reaching out to community networks to bring in cultural brokers to assist in the "retooling" of staff skill sets can be an invaluable step. Again, this requires staff time, but staff members are often interested and willing to step up to the plate. Huang also noted that examining the agency's communications and messages to the community can reveal opportunities for quality improvement. Agencies can pull in members from diverse populations and ask them for feedback on the language and products being used for community outreach. It may be that funds can be shifted to improve communications with particular communities. "Our office looks at this effort as not just becoming more culturally and linguistically competent, but as a quality improvement effort," Huang said. ■

The NCCTS extends special thanks to Vivian H. Jackson, PhD, for her concept for this series and her continuing editorial guidance; and to Tracy Fehrenbach, PhD, Assistant Professor, Northwestern University Department of Psychiatry and Behavioral Sciences, for posting the survey of agencies and collating responses. The final installment of our series will address engagement with community networks, collaborators, and subcontractors to deliver CLC services.

Go-Team in Providence *cont'd from pg. 1*

emotionally and physically, a short time later," Clements said. "Without our relationship with Family Service, I'm not sure that he would have adjusted as well as he did."

Noted Susan Erstling, LICSW, PhD, Senior Vice President of Trauma, Intake and Emergency Services at Family Service of Rhode Island (FSRI), "What we know about trauma is that the earlier the intervention is deployed, the better the outcome for the child."

Since its inception in 2004, the Police Go-Team partnership between FSRI and Providence police has yielded benefits for children and families, as well as for the police and clinicians involved.

Setting the Stage

Clements was a lieutenant in the Providence Police Department in 2003 when then-Chief Dean Esserman and the CEO of FSRI, Margaret Holland McDuff, began discussions to address the needs of children exposed to violence and trauma. Esserman, while serving as Deputy Chief of Police in New Haven, CT, had participated in the development of the Child Development-Community Policing Program (CD-CP) with Steven Marans of the Yale Child Study Center. The model features the following elements:

- 24 hours of training in child development and trauma for police officers with the rank of sergeant and above.
- For clinicians, a minimum of 50 hours of ride-alongs or walking the beat with officers.
- Attendance by officers and clinicians at weekly command staff meetings to debrief and review cases and to discuss collaborative follow-up or treatment.
- Trauma training for clinicians to become skilled in treating symptomatic children using multiple modalities.
- Clinician availability to police on a 24/7 basis.

Rolling Out the Program

Erstling said that FSRI staff and Providence police officers participated in joint CD-CP training sessions in New Haven. Initial training in Child-Parent Psychotherapy for the staff was supported by a Safe Start grant from the federal Office of

Pictured in the treatment room at the Children's Treatment and Recovery Center, Family Service of Rhode Island, are (left to right): Meghan Martinez, Program Manager; Jennifer Etue, Clinical Administrator of Trauma, Loss and Children's Services; and Matthew Munich, Clinician.

Partners from Family Service of Rhode Island and the Providence Police Department. Left to right: Sgt. Carl Weston, Maj. Thomas Verdi, Susan Erstling (Senior VP of Trauma, Intake and Emergency Services at FSRI), Col. Hugh Clements, Jr., Carla Cuellar (FSRI bilingual police liaison), and Sgt. Mike Wheeler.

Juvenile Justice and Delinquency Prevention. An NCTSN grant furthered training for clinicians, in Trauma Focused-Cognitive Behavior Therapy (TF-CBT), Alternatives for Families (AF)-CBT, and Psychological First Aid (PFA).

The Go-Team partners in Providence soon began adapting the CD-CP model to fit their locale. For example, FSRI's Carla Cuellar, who is bilingual, had a special interest in continuing to do ride-alongs in Providence. With funding from the Rhode Island Foundation, the state's Victims of Crime Act, and the Community Development Block Grant Act, FSRI was able to support a full-time position for Cuellar to do ride-alongs during the 3 to 11 pm shift, often the busiest time for calls involving children and families.

Developing Trust

Relationships between officers and clinicians on the Go-Teams, although cordial at first, have become deeply respectful and interdependent, Erstling said. During travel to trainings and ride-alongs, "we got to know each other," she pointed out. She has attended weekly command staff meetings for nine years, and has observed the relationships building. Officers now welcome FSRI's input as another tool in their toolkit. They regularly page bilingual clinicians to help translate for families and to access FSRI services on a 24/7 basis. For their part, FSRI clinicians have benefitted from police training on drugs and gangs. The Go-Team partnership has also led to closer working relationships with the child welfare department. Expansions to community organizing have led to broader recognition of the Providence model, which received a Special Strategy award in 2010 from the MetLife Foundation Community-Police Partnership Awards Program.

Clements said that the police partnership with FSRI "fits like a glove with our philosophy in the community. It's comforting to know that there's constant communication with Sue [Erstling] and her people, to make the situation right and to make those people as whole as they can be." ■

Advisory Board Meeting *cont'd from pg. 1*

the National Center for Cultural Competence, who has served since 2008: "There is a very warm collegiality between and amongst us."

Ellen Gerrity, PhD, NCCTS Associate Director and Senior Policy Advisor, leads the yearly Advisory Board meetings. "Individually and collectively," she said, "the Board members are very strong partners of the NCTSN." This was most apparent during the past year when Board members stepped up to support the Network's mission, adding their voices to other advocacy efforts to help raise awareness about child trauma.

Featured Updates

Topping the meeting agenda was Gerrity's report on the renewal of NCTSN funding for the coming year. An overall budget of $45.7 million had been approved by Congress, and the structure of the Network was preserved to include the National Center for Child Traumatic Stress (NCCTS), 16 Category II centers, 56 Category III centers, and Affiliate members. The entire NCTSN membership is cycling out as of September 30, 2012, and grant applications for funding were being processed as *IMPACT* went to press.

Following Gerrity's report were updates on specific Network activities. Robert Pynoos, MD, MPH, NCCTS Co-Director at UCLA, summarized 10 years of the Terrorism and Disaster Program accomplishments, such as: responses to more than 100 disasters and emergencies, including disasters in Colorado this past summer (see story on page 3); training more than 26,000 people on terrorism and disaster-related topics; and establishing a three-tiered public mental-health model of post-disaster intervention. Pynoos also talked later in the session about the Core Curriculum on Childhood Trauma, which is now being used in a variety of settings, including graduate schools of social work. John Fairbank, PhD, NCCTS Co-Director at Duke, delivered an update on the Data and Evaluation Program, reporting that the Data Supplement funding has now resulted in published studies in prominent journals including the *Journal of Traumatic Stress* and *Child Welfare* and in policy briefs for federal and state stakeholders.

NCCTS Product Development Coordinator DeAnna Griffin, MA, summarized the Network's completion to date of 210 products in 18 topic areas, and catalogued the products now in the pipeline. Board member Diane Elmore, PhD, MPH, of the American Psychological Association, said she has especially appreciated Network products such as *What Every Policymaker Should Know About Child Traumatic Stress*, a guide published in 2008. "I learn so much every time I attend a meeting, and often use products like this in my day job," she said. "It translates the basic concepts and needs of children and families impacted by trauma into language that policymakers can understand."

Abi Gewirtz remarked on the breadth of NCTSN products: "When you're in the midst of your own Network projects," she said, "you don't often get to see how the whole picture comes together." She also echoed a common theme voiced by Advisory Board members: that the Network needs to step up its public outreach so that it can increase awareness of the Network mission, the available resources, and the needs of traumatized children.

Respect for Differing Viewpoints

Other topics reviewed at the June meeting included the child welfare and juvenile justice initiatives, and a session on cultural and linguistic competence facilitated by Susan Ko, PhD, NCCTS Co-Managing Director. Board member Vivian Jackson spoke of the challenges of achieving cultural and linguistic competence; NCTSN member Carmen Rosa Noroña, MSEd, enumerated the characteristics of high-quality translated materials; and NCTSN member Rick van den Pol, PhD, spoke of cultural issues and trauma treatment in Indian country. The quality and tenor of the discourse illuminated what Jackson sees as the "genuine respect amongst the group, and the careful listening that takes place," she said. "It's not that people are in agreement with everything, but there is the safety to have differences of perspective and opinion and still move forward toward a common outcome and direction."

Benefits and Parallels

Board member Judge Michael L. Howard, along with members Sue Badeau, NCCTS staff Carrie Purbeck Trunzo, MHA, and Heather Langan, presented on the Network's child welfare and juvenile justice initiatives. Howard said he always looks forward to NCTSN meetings. He not only enjoys the stimulating sessions and encounters, he gains important perspectives on his own work. For example, he recalled being impressed, at an All Network Conference, by a presentation about medical trauma by emergency room personnel. He was struck by their message: that for medical personnel, the sights and sounds of an ER are commonplace, but for young children, who do not experience this every day, it is potentially traumatizing."That's exactly what we do in juvenile justice," he realized then. "We're all used to being at court, and for us it's not a big deal, but for the people coming in, it's often an overwhelming experience. This is the kind of awareness I bring back to my court."

A Touch of Nostalgia

On the last morning of the meeting, the Board convened for an executive session in which it commended the NCTSN for its impressive body of work and urged expansion of the stakeholder pool and more media and public relations outreach.

For Board member Patricia M. Barron, BSN, MA, of the Association of the United States Army, the June meeting had a nostalgic quality because the Board's cycle of service ends this December. "We were grateful for the fact that we had this opportunity for our paths to cross," she said, "and hope that more opportunities will emerge." ■

A complete listing of the affiliations and professional accomplishments of Advisory Board members can be accessed at www.nctsn.org/about-us/national-advisory-board

SPOTLIGHT ON CULTURE:

Linguistic Competency: a Conversation with Lisette Rivas-Hermina

Lisette Rivas-Hermina, MS, LMFT, was Senior Training Specialist at the Children's Institute, Inc., in Los Angeles, an NCTSN Category II Center. She now works in L.A. as a consultant and trainer for Trauma Focused-Cognitive Behavioral Therapy (TF-CBT) and participates in Network activities as a member of the Affiliate Advisory Committee. Rivas-Hermina uses Spanish and English with clients in her private practice. She spoke with the Network recently about linguistic and cultural challenges and the role of linguistic competency.

> ***"Culture and language are within us, and affect everything we do–how we dress, think, even how we form attachments."***
>
> *LISETTE RIVAS-HERMINA, MS, LMFT*

Q: What does "linguistic competency" mean to you as a clinician, trainer, and supervisor?

A: Culture and language are within us, and affect everything we do—how we dress, think, even how we form attachments. How we interpret what happens in our sessions is based on our values and internalized language system. Even though I am Latina and speak Spanish, my values may differ from those of my clients. I was born in the U.S. and have values and attitudes that would be considered "American" by a family born and raised in Latin America. I might speak too formally, use slang too informally or come across as being too direct, pushy, or matter-of-fact. It's a delicate balance to be aware of and hold our families' value systems in the session without being judgmental and critical. As clinicians, we must not only be aware of the values within the community in which we work, but of the intricate differences that can exist within a culture.

Q: Can you give an example of exploring these differences within cultures?

A: In my work with a traditional Oaxacan mother and her 15-year-old son, the mom kept repeating, "He needs to respect me. Respect is important to me. He's not following my rules." While I know what "respect" means, I realized that I didn't know how she defined it. So, I finally asked her what she meant by respect. She said, "Respect is when I say something and he does it. No talking back, no disagreeing." Her son looked at me as if to say, "You see why I don't talk?" I said to the mom, "When we ask him to talk, what if he doesn't agree with you? Is that disrespectful?" This helped her open up and feel more connected to me because I had demonstrated I was attuned to her family culture.

Q: Why is linguistic competency important in your work with traumatized children?

A: Linguistic competency is crucial in trauma work because of the way the brain encodes emotions. When babies are born, voice and language form their first connection to their mothers. Engaging a person in the language in which the trauma occurred will bring up more of the emotional content.

Q: Are there important aspects of culture that clinicians might miss in trauma work?

A: Some clinicians still treat only the child and do not include the caregiver. In Latino culture, women tend to be the matriarchs in the home. Excluding them disrupts the family relationship and ignores cultural values. For example, I was treating a 15-year-old girl who was abused by an uncle. Even though there were moments when her mother inappropriately blamed her daughter for the abuse, I needed to include her in order to be culturally competent. I focused on the fact that the mother was actively participating in treatment. I modified the daughter's trauma narrative to highlight the changes in the mother-daughter bond. If I hadn't included the mother, she may have pulled her daughter out of treatment, and we would have lost the chance to repair their relationship.

Q: What is the greatest challenge facing clinicians who work with non-English speakers?

A: We have clinicians doing therapy in Spanish, most of whom have been trained in English. But they don't have supervision in Spanish or training on how to do therapy in Spanish. For example, if supervision is in English, how does the supervisor assess the competency of the work done in Spanish? Something that may sound appropriate in English could be offensive in Spanish. If I am supervised in Spanish, my countertransference and emotions are more likely to be apparent and provide an opportunity for me to reflect, "Oh, that may have been a little too much," or my supervisor may catch other nuances. We're talking here of raising the standard of care through understanding the fine intricacy of interactions. ■

Lisette Rivas-Hermina, MS, LMFT, provides treatment, supervision, and training in English and Spanish.

Have You Heard?

This year, the **Substance Abuse and Mental Health Services Administration (SAMHSA)** is celebrating its 20th anniversary and two decades of milestones in the behavioral health field. The Summer 2012 issue of *SAMHSANews* features *Celebrating Two Decades of Progress in the Behavioral Health Field*, an illustrated history of SAMHSA's accomplishments. The timeline features the creation of the National Child Traumatic Stress Network as the behavioral-health milestone of 2001. "It's hard to believe that when I worked in mental health crisis centers two decades ago, we never inquired about trauma," said **Larke N. Huang, PhD**, Director of SAMHSA's Office of Behavioral Health Equity. "Now we better understand the centrality of trauma in behavioral health conditions."

In June, several Network members presented talks at the **Annual Statewide Conference on Traumatic Stress in Children and Families**, held at the University of Minnesota. This year's program, *Protecting Their Future: Finding and Helping Stressed Children & Families*, featured

- **Audra Langley, PhD**, who spoke on Supporting Children and Families Under Stress: Resilient and Trauma-Informed Schools.
- **Nancy Kassam-Adams, PhD**, on Finding and Helping Stressed Children in Health Care Settings.
- **Abigail Gewirtz, PhD, LP**, on Protecting Their Future: Finding and Helping Stressed Children and Families.
- **Ellen Gerrity, PhD**, who gave closing remarks at the conference.

(In addition to these individual talks, the entire conference is available to view online.)

Staff from the **Center for Success and Independence**, Houston, alongside its Clinical Director, **Marylou Erbland, PhD**, have trained all court personnel of the Harris County (TX) Juvenile Probation Department on trauma-informed best practices within their systems. Trainees included personnel from human trafficking, drug, and mental health courts.

Robert Pynoos, MD, MPH, and **Monique Marrow, PhD**, were invited to teach at the 2012 Certificate Program for Public Sector Leaders offered through the **Center for Juvenile Justice Reform** at Georgetown University's Public Policy Institute. Drs. Pynoos and Marrow used a problem-based learning approach to Behavioral Health and Trauma in this training.

Did You Know?

NCTSN member **Betsy McAlister Groves, MSW, LICSW**, founding Director of the **Child Witness to Violence Project** at Boston Medical Center, is the invited plenary speaker at the **Prevent Child Abuse America (PCAA) 2012 Annual Conference**, to be held October 12-15 in Jacksonville, FL. In a talk entitled "Shelter from the Storm: Supporting Children and Families Affected by Domestic Violence," Groves will address the more than 500 attendees expected at the conference, which also marks the 40th anniversary of the PCAA. The National Center for Child Traumatic Stress has collaborated with James Hmurovich, PCAA President and CEO (and Network Advisory Board member), in planning for the conference, and is also providing copies of NCTSN materials for conference participants. For more information about the PCAA 2012 conference, visit

www.preventchildabuse.org/conference/index.shtml

About IMPACT

IMPACT is a publication of the National Child Traumatic Stress Network (NCTSN). It is produced quarterly by the National Center for Child Traumatic Stress (NCCTS), co-located at UCLA and Duke University. The NCCTS serves as the coordinating body for NCTSN member sites, providing ongoing technical assistance and support.

Managing Editor: Gretchen Henkel
Consulting Editor: Melissa Culverwell
Design & Layout: Sue Oh Design

Established by Congress in 2000, the National Child Traumatic Stress Network (NCTSN) brings a singular and comprehensive focus to childhood trauma. NCTSN's collaboration of frontline providers, researchers, and families is committed to raising the standard of care while increasing access to services. Combining knowledge of child development, expertise in the full range of child traumatic experiences, and dedication to evidence-based practices, the NCTSN changes the course of children's lives by changing the course of their care.

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