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A PUBLICATION OF THE NATIONAL CHILD TRAUMATIC STRESS NETWORK

Integrating Behavioral Health Services in Rural and Urban Native American Communities

There is an urgent need to address traumatic stress among American Indian and Alaska Native youth, said Maureen Murray, Lead Therapist at Youth & Family Services of Rapid City, SD. Socioeconomic disparities, domestic violence, substance abuse, and depression are common in both rural and urban Native American communities. Native American youth also have a higher suicide rate than any other youth demographic, a reality with which Murray and her colleagues have direct experience. From December 2014 through February 2015, nine young people on the Pine Ridge Reservation in South Dakota took their own lives, and more than 100 youth attempted suicide, prompting Oglala Lakota tribal leaders to declare a state of emergency.



Teen in traditional tribal regalia. (Photo courtesy of Native American Health Center, 2016.)

The key for addressing and reversing these tragic circumstances, according to Murray and other rural and urban providers, is to develop trust with leaders and healers in Native American communities. The approach must be holistic, building on resilience and strength with a family-centered focus. In that way, providers can ensure that the physical and behavioral health services they offer are culturally grounded and congruent with Native American practices and beliefs.

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NATIONAL HIGHLIGHT

New Century, New Initiatives for Clifford Beers Clinic and Trauma-Informed Integrated Care

An anniversary as momentous as a centennial calls for celebration, and the Clifford W. Beers Guidance Clinic, an NCTSN Category III site in New Haven, CT, marked its 100th year in 2013 by hosting a gala at the Yale Commons with Glenn Close as keynote speaker.

But Clifford Beers didn't stop there.

Executive Director Alice M. Forrester, PhD, and the clinic's Board of Directors wanted to capitalize on their centennial moment to look forward to the *next* 100 years. The question they asked of themselves was: What should behavioral health treatment for childhood trauma look like going forward? As leaders in the field, the Clifford Beers staff had come to realize that in order to effectively help children who have been traumatized, the service provider must address the needs of the whole family.

"It is very clear that the problem behaviors that bring children to the clinic are often related to the stressors they are experiencing in their environment," Forrester said.

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Healing Leads to Advocacy for Three Survivors of Child Sex Trafficking



As global and national awareness of child sex trafficking builds, child-serving providers are educating themselves about the signs that a child or youth may be the victim of sex trafficking.

In the case of young Anneke Lucas, "There were plenty of signs" that she was being horribly abused as a child in Belgium, her native country. "There's not a single picture of my childhood in which I'm smiling," she said recently. Pimped out from the age of six by her mother, Lucas spent five years trapped in the web of a child pornography syndicate. She was rescued at age 11. After escaping to Paris, London, and later the United States, her journey to healing began.

Lucas and two other survivors of child sex trafficking, Katariina Rosenblatt, LLM, PhD, and Jamie Walton, shared their histories and insights with mental health providers, advocates, child welfare workers, and juvenile justice professionals at an NCTSN Child Trafficking and Trauma Roundtable.

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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 SAMHSA or HHS.

Survivors of Sex Trafficking *cont'd from pg. 1*

held in Chicago last summer. Following many years of healing and intensive personal work, all three of these women have become advocates for victims, working with policymakers and social justice organizations to ensure greater understanding of this childhood trauma.

From Trauma to Helping Others

Lucas's recovery in the United States encompassed years of psychotherapy, yoga, and meditation practice with the Self-Realization Fellowship, headquartered in Los Angeles, CA. When Lucas moved to New York, she began teaching yoga in prison settings, and in 2014 she founded Liberation Prison Yoga (www.liberationprisonyoga.com). Lucas has found that working with prisoners supports her own healing. In addition to training other yoga instructors in the trauma-informed yoga practice for prisons, she works at Rikers Island with adult survivors of sex trafficking, several of whom have been able to leave the life thanks to the group.



Anneke Lucas, in background, leads a yoga class sponsored by the Prison Yoga Project at San Quentin State Prison in CA.

Rosenblatt was a lonely and vulnerable middle-school student living in Miami, FL, when she was “befriended” by another young girl who groomed her and recruited her into sex trafficking. As an adult, Rosenblatt obtained her master's degree in law and doctoral degree in conflict analysis and resolution. In 2014, Rosenblatt went public with her own story when she published *Stolen: The True Story of a Sex Trafficking Survivor*. She now works directly with young victims through her nonprofit organization, There Is Hope for Me (www.thereishopeforme.org).

As a 14-year-old in Venice, FL, Walton was trafficked to Atlanta, GA, and coerced by a man three times her age to have sex with multiple partners. Later, after a successful career as an accounting representative and auditor for large corporations, Walton eventually partnered with film director Kevin Smith to found the Wayne Foundation, which recently set up a Drop-In Center for victims in Charlotte County, FL. Walton has also partnered with the Charlotte County Jail to offer services to the female population.

Most at Risk

Although more research is needed to establish the scope of child sex trafficking in the United States, this much is clear: the children at high risk of falling prey to traffickers are those in the child welfare system due to abuse and neglect; in foster care or group homes; involved with the juvenile justice system; or who have run away from home. LGBTQ youth are at especially high risk because they often experience family rejection, which can lead to homelessness. In 2014, about

one in six endangered runaways who were reported to the National Center for Missing & Exploited Children were likely victims of sex trafficking. Of those, 68% were in the care of social services or foster care when they ran away.

Barriers to Identification and Disclosure

Societal denial can function as an effective shield for perpetrators of child sex trafficking, Lucas noted. During the time she was trafficked, “I tried to speak up but I wasn't believed,” she said. “The truth is that no one had any clue, because no one would ever dream that in a country like Belgium, where most citizens are comfortable and educated, these absolute horrors were happening to kids. That was in a way the perpetrators' best protection.”

In the United States, the Trafficking Victims Protection Act, passed in 2000 and reauthorized in 2013, clearly defines children or youth under 18 as victims, removing the onus on them of proving fraud or coercion to receive protection. And yet, many states continue to criminalize youth, causing them further trauma by charging them as “child prostitutes” and incarcerating them.

Another barrier to identification: youth may be unable or unwilling to disclose their situation. There is the very real danger of violent reprisal against themselves or family members by the trafficker. Even youth who are recently liberated are often unwilling to disclose their trauma. They may not, in fact, perceive themselves as victims. Walton recalled that she was in therapy for two years in her early 20s before she was able to admit that she had been a victim; she had clung to the belief that she had been complicit in her abuse.

Qualities to Cultivate

Lucas, Walton, and Rosenblatt found through their own healing how important it is to remain self-aware and maintain healthy boundaries. “You have to constantly put your internal feelings under a microscope,” Walton said. She has felt the pull to rescue some of the girls served by the Wayne Foundation. “Luckily,” she said, “I have a way to do a reality check with myself and my doctor.” Added Lucas, “If someone is going to feel safe with you, if you are going to become a parental figure for those children, you must be ready. It is important to always self-reflect, to be mindful of your own tendencies toward codependency, or the need to be a savior.”

Victims' stories can be so horrific, and the betrayal of trust so extreme, that providers who work with child sex trafficking victims can be exceptionally vulnerable to secondary traumatic stress. “If your boundaries are not in place, it's very easy to be a rescuer in your clients' lives,” Rosenblatt said. “But then you don't have anything else to give to your family and other survivors.” She urged providers, “Please take care of yourselves. You are needed in this movement.” ■

For more information, visit www.childwelfare.gov/pubs/issue-briefs/trafficking

Clifford Beers Clinic *cont'd from pg. 1*



Alice M. Forrester, PhD,
Executive Director of Clifford
W. Beers Guidance Clinic, New
Haven, CT.

“We have found that their caregivers also require support and services, and if they do not receive any help, it may diminish the family’s ability to heal and thrive.”

Integrating Health Care

The Clifford Beers Clinic has established itself as a local leader for trauma-informed services. With its first SAMHSA grant in 2005, the clinic founded the Morris A. Wessel Trauma Center; and since

December 2012 the clinic has spearheaded the recovery response in Sandy Hook Elementary School in Newtown, CT. Together with quality improvement consultant Jen Agosti, and then-consultant (now Director of Strategic Planning) Rita Berkson, Clifford Beers led a national Breakthrough Series Collaborative in 2013. The findings from the collaborative, encapsulated in a paper entitled “Integrating Physical and Mental Health to Improve Outcomes for Chronically Stressed Families,” helped the clinic develop a new approach to care for families, addressing chronic stress and trauma in an integrated, community-based manner.

These key concepts have driven new initiatives at Clifford Beers, including the creation of partnerships (with the help of a SAMHSA statewide Project LAUNCH grant) to co-locate trauma-informed behavioral services within primary care providers’ offices; and expansion of services for military children and families through the HONORS Project (Homes Obtaining Nurturance, Opportunities, Recovery, and Support),



A teen models the mask she made as part of creative arts therapies at summer camp offered at the annual Military Honors Program, conducted by Clifford Beers at Camp Farnam near Durham, CT.

supported by a current NCTSN grant to the Morris A. Wessel program. In 2014 the clinic formed the New Haven Trauma Coalition, a collaborative system of care that involves the Greater New Haven community. Within the first 18 months of development, the program trained more than 700 professionals from New Haven schools and communities;

implemented Cognitive Behavior Therapy for Trauma in the Schools (CBITS) in eight schools; and offered coordination of care for more than 120 families.

Just as Clifford Beers was beginning to embed clinicians in primary care settings, the team was invited to participate in a Network-sponsored Integrated Care Breakthrough series at Johns Hopkins, and attended the trainings along with their community partners, “which helped strengthen

the implementation,” Berkson said. The new model entailed extensive discussion and cross-training with primary pediatric providers, to define how chronic stress and trauma would be addressed and to create a “warm handoff” system whereby the physician and pediatric providers could redirect children to onsite behavioral health specialists. Currently, two Clifford Beers social workers are integrated into four primary care sites in the New Haven region, and a full-time nurse is embedded in the Yale-New Haven Hospital’s Primary Care Center. The Beers clinic is using the hospital’s electronic medical records system for communication with the hospital staff, which facilitates dialogue between the primary care providers and clinicians.

Connie Catrone, LCSW, clinical consultant, noted that “pediatricians who are not trained in trauma may be loath to ask questions of their patients about bad things that may have happened to them, simply because they haven’t received the training to follow an affirmative answer with a path to treatment.” The Beers clinic staff have found that psychoeducation for both families and practitioners has been a useful introduction to the work.

Serving Military Families Too

The Beers clinic is also continuing to expand its services for military children and families. Forrester reported that the clinic has been invited by the West Haven Veterans Affairs Healthcare System to build office space within the system’s outpatient clinic. Although the VA has many regulations about children at its service sites, she said, “this VA system is moving toward more of a family-friendly environment. We will open a full-service resource center for military families, offering group, family, and individual therapy for the child.”

Outreach to military children is also conducted in the schools, because military families tend to be dispersed throughout the state. Each year, the Beers clinic runs a summer camp for children whose parents are in the military. Forrester said, “It’s a chance for children to be with others in similar situations.”

Further Strides

The Clifford Beers clinic received notice of a \$9.7 million Health Care Innovation Award from the Centers for Medicare & Medicaid Services on September 1, 2014. The goals of the three-year project, known as Wraparound New Haven, are to demonstrate, with intensive coordination of care, outcomes of improved health for the enrolled populations; improved access to and effectiveness of care; and a reduction of 20% in total Medicaid costs of care. The clinic partners with the Connecticut Department of Social Services, the Yale-New Haven Health System, as well as other providers in the community, and has currently enrolled more than 800 community members within the project’s first year. “It is an honor and a challenge to prove that this holistic family model will meet the goals of the Affordable Care Act,” Forrester said. “But we know that helping the whole family to stabilize their health will lead to eventual wellness and stability for the child.” ■

Native American Health *cont'd from pg. 1*

The historical trauma endured by Native Americans goes deep, and the initial waves of genocide have been exacerbated by the forced dislocations and cultural losses that tribes have experienced over the centuries. Healthcare provided by governmental agencies has often come at a cost of increased disempowerment and diminished self-efficacy of those being served. “For many Native people living in geographically isolated reservation communities seeking behavioral healthcare, there is literally no service available,” said Rick van den Pol, PhD, Principal Investigator of the National Native Children’s Trauma Center at the University of Montana, Missoula. The frequent turnover of providers – such as new physicians fulfilling academic commitments by serving in rural areas – has contributed to distrust of governmental services.

Aware of the problem of provider turnover, Youth & Family Services was careful about its own commitment when it was invited to bring trauma-informed care to Crazy Horse School in Wanblee, SD. “We didn’t want to agree to something that would be short term,” Murray said. “We wanted to offer something to which we could commit and continue past the [SAMHSA 2012-2016] grant.”

Crazy Horse School is a two-hour drive from Rapid City. The agency determined that it could visit the school every two weeks and send three staff members to provide assessments and treatment. One of the therapists is an enrolled Lakota tribe member; the other two are well-versed in the tribal culture. The team began by building relationships with the school, parents, and tribal leaders. In the summers, Youth & Family Services co-sponsors a Family Fun Day with Indian Health Services. After four years, the agency has gained a reputation for its commitment and has received requests for services from other schools on the reservation.

Gathering the Family

Native American Health Center, based in Oakland, CA, has been delivering services to Native American clients since 1972. Behavioral health services are housed in the original site. Including the new medical center just down the street, there are two clinics in San Francisco, and one in nearby Richmond. In nine school-based health clinics, teams from the center include dental and nutrition providers, as well as a behavioral health provider.



Juliet C. Kinkade-Black, LMFT, Community Wellness Department, Native American Health Center, Oakland, CA.

said Juliet C. Kinkade-Black, LMFT, of the health center’s Community Wellness Department. Revamping recipes to incorporate traditional flavors without extra sugars and additives is a way to “talk about food as medicine

and address holistic wellness,” she noted. In a recent presentation, the nutritionists demonstrated ways to cook blue cornmeal, a healthy food and traditional for Southwest Indian tribes.

All of the behavioral health providers at Native American Health Center have been trained in the BigFoot/Schmidt cultural adaptation of Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) and in Integrative Treatment of Complex Trauma for Adolescents (ITCT-A; Briere/Lanktree). The latter model is “a perfect fit for us because it is holistic and integrative,” Kinkade-Black said. Gathering the Family for Dinner, a Tuesday night tradition established by Native American Health, draws families from the Native American community each week. The meal is prepared for them and cleanup provided, so the parents can focus on their children. “Particularly for urban Indians, each person in the family has experienced the trauma of being separated from their tribal community,” Kinkade-Black said. “Supporting the whole family allows us to address some of that cultural and attachment injury.”

Building on Strengths

“We need to do everything we possibly can to change the future for our children,” said Roger White, Traditional Language and Culture Consultant at the University of Montana’s National Native Children’s Trauma Center. And the way to do that, White said, is to focus not on reliving the past but evolving rich tribal traditions to strengthen the resilience of youth. An enrolled member of the Fort Peck Assiniboine and Sioux tribes, he has been developing a knowledge-based character-building cultural studies program for local youth for the past five years. The program, Empowering Native Indigenous Tribes, builds on tribal traditions of song, dance, language, and cultural evolution “to bring about a new inspiring perception for the future of our children,” White said. The program also incorporates data collection to build an evidence base for its replication. White has concentrated on maximizing flexibility so that other tribes can adapt the model.

White’s model is just one of many holistic approaches under development at rural and urban NCTSN sites. All are grounded in respect and pride in identity. “Our kids are having difficult times with Western ways of life,” White said. “When you give them the identity they need, and they understand where they come from, this gives them a sense of where they can go. They’re not afraid any more.” ■

A curriculum published by Native American Health Center in Oakland, CA, authored by Art Martinez, PhD, a Chumash tribe member and clinical psychologist, offers a template for providers on holistic behavioral health services. To access the workbook, visit www.nativehealth.org/sites/dev.nh.edeloa.net/files/2014-08-29_curriculum-native-wellness_v01.pdf

Catholic Charities Hawai'i Advances Trauma-Informed Care as NCTSN Affiliate



David Drews, PhD,
Administrator of the Youth
Enrichment Services Division,
Catholic Charities Hawai'i.

For Catholic Charities Hawai'i, NCTSN membership provided the vehicle to put trauma on the state map, said David Drews, PhD, Administrator of the Youth Enrichment Services Division at the agency. Early in their 2009-2012 grant period, Drews and key colleagues traveled to the mainland to participate in a year-long collaborative with Anthony P. Mannarino, PhD, and Judith A. Cohen, MD, the originators of Trauma Focused Cognitive Behavioral Therapy (TF-CBT).

"It was a rare experience to be trained by the developers of the model," he said.

Following that training, Catholic Charities Hawai'i hosted the state's first year-long learning collaborative on TF-CBT, led by TF-CBT master trainer Kelly Wilson, LCSW (then with Catholic Charities Jackson, MS, and now in private practice). The 75 participants were drawn from a wide spectrum of child-serving



Youth participate in culinary arts classes at Catholic Charities Hawai'i. Administrator David Drews, PhD, is in the background.

professionals: staff from the state's Child and Adolescent Mental Health Division; two teams from Tripler Army Medical Center; members of for-profit and nonprofit agencies; and therapists in private practice. "It was a great

mixture of all worlds coming together and collaborating for a whole year, and the first year-long learning collaborative the state had done," Drews recalled. "We still hear about it!"

Catholic Charities Hawai'i has since expanded its partnerships with other agencies. Last June it co-sponsored another TF-CBT learning collaborative, teaming this time with the Child and Adolescent Mental Health Division, which had been awarded a state System of Care grant.

Therapists' Learning Curve

Catholic Charities Hawai'i has sites on every Hawai'ian island. With more than 35 programs, the agency provides services ranging from care for medically fragile infants to programs for seniors. Clients as well as staff members comprise a diverse group. Asians including Japanese, Chinese, Filipinos, and Koreans account for approximately 38% of the total population; Caucasians for 25%; Hawai'ians/Pacific Islanders (including native Hawai'ians, Samoans, Polynesians, and

Micronesians) for 10%; and people of mixed Hawai'ian ancestry, 25%. The fastest growing population of clients served by Catholic Charities is made up of immigrants from the Micronesian islands of Chuuk and Palau, and the Marshall Islands. For these immigrants, there are language as well as cultural barriers.

Drews said that such extensive racial and cultural diversity can create challenges for service providers. He has learned in his 27 years of practice to always approach his clients with humility, and he advises new staff members to try to avoid the trap of adopting Hawai'ian slang, or "pidgin," as a way to ingratiate themselves to locals. He tells them, "It comes across as inauthentic."

"The statewide learning collaborative on TF-CBT was a great mixture of all worlds coming together."

DAVID DREWS, PhD, Administrator of the Youth Enrichment Services Division, Catholic Charities Hawai'i

Far more can be accomplished by establishing trust with local community leaders – for example, a Samoan chief or a local pastor – than by approaching families with a predetermined mindset. This may entail a "steep learning curve" for the therapist, Drews said. For example, some cultures are more accepting of corporal punishment, which may run counter to the beliefs of therapists and social workers trained in the Child Protective Services model, which discourages the use of physical discipline. Navigating such cultural differences within a therapeutic relationship can be difficult, and they are encountered on a regular basis. "You've got to be careful when you get into those areas," Drews emphasized. "I tell all my therapists that if you can successfully do intensive in-home therapy here, you can do therapy anywhere."

Weaving in the Trauma Narrative

The activities and resources available through NCTSN Affiliate membership remain mainstays of Catholic Charities Hawai'i as the agency continues its efforts to advance trauma-informed care. Drews is a member of the NCTSN Affiliate Advisory Group, and is able through Affiliate membership to maintain his involvement with the Network. He continues to infuse the principles of TF-CBT into his work with local youth, many of whom have ACE (Adverse Childhood Experiences) scores as high as 6/10. He has integrated nontraditional programming such as culinary arts, RC (radio-controlled) flying, and music into the organization to help increase youth engagement. When youth write their trauma narratives, they are allowed to craft them into poetry or lyrics, and they have the option to record them at an in-house Catholic Charities studio with the treating therapist present. "They've been able to sing or rap their trauma narratives as well as write them," Drews said. This has proven to be a great source of engagement and has encouraged resilience. ■

At Intersection of Trauma and Disabilities, a New Toolkit for Providers

Patty Shure, Director of Child and Family Services at Las Cumbres Community Services in Española, NM, recently recalled her work three years ago with a young toddler receiving care at the Conjunto Therapeutic Preschool at Las Cumbres. The treatment team believed that the child's developmental and speech delays were due to severe facial injuries she sustained in a car accident before she was a year old. Shure, a social worker who has worked for more than 22 years with children with disabilities and trauma, suspected that the girl's delays might also be related to unresolved traumatic grief over the loss of her mother, who had died in the accident. The family and the teaching staff were not convinced that her behaviors were a trauma reaction – until the grandmother, out driving with the child, had a minor fender-bender. When she jumped out of the car to inspect the damage, her granddaughter, though unharmed, started screaming and was “inconsolable” for more than an hour.



Patty Shure, Director of Child and Family Services at Las Cumbres Community Services in Española, NM, works with a child at the Conjunto Therapeutic Preschool.

“That [event] was the clue for the family and the treatment team that, for her, the trauma was still very present,” Shure said. “It wasn't solely her injuries that caused her inability to communicate and articulate words.”

The preschooler's situation illustrates some of the complexities of

working with clients at the intersection of disability and trauma. “Many clinicians say they would be willing to work with children who have developmental disabilities, if only they knew how,” said Diane M. Jacobstein, PhD, Clinical Psychologist/Senior Policy Associate, Georgetown University Center for Child and Human Development, Washington, DC. But until this year, no tools existed to help clinicians disentangle what might be symptoms of trauma from behaviors related to intellectual and developmental disabilities (IDD).

With the release of the toolkit, *The Road to Recovery: Supporting Children with IDD Who Have Experienced Trauma*, providers well-versed in trauma now have the tools to factor in a new understanding of IDD in their assessment and treatment. And, providers who work with children with IDD can widen their therapeutic lens to “think trauma.”

“This toolkit and its training materials fill an important need in the face of our current workforce crisis,” said Jacobstein, who was a member of the expert panel that developed the toolkit. “They will help therapists gain skills and confidence to serve children with disabilities who experience trauma.”

Developed by the NCTSN, the toolkit was funded by the Hogg Foundation for Mental Health in Austin, TX. The development

panel was chaired by Susan Ko, PhD, UCLA/Duke NCCTS, and comprised of a wide range of nationally known trauma and IDD experts, including NCTSN members The Family Center at Kennedy Krieger Institute and DePelchin Children's Center. Following two initial rounds of pilot trainings, a train-the-trainer session took place in August 2015 in Redondo Beach, CA. Feedback from all trainings was then incorporated into the toolkit.

Daniel Hoover, PhD, ABPP, a Senior Clinical Psychologist at the Kennedy Krieger Institute's Center for Child and Family Traumatic Stress, Baltimore, MD, was one of the participants at the Redondo Beach session. “This is a very innovative toolkit,” he said. “There are so many myths out there about working with children and families who have IDD. You can talk about trauma and you can get some resources on IDD, but until now there has been nothing in the field that combines the two in such a comprehensive way.”

High Risk and Challenges

According to the Hogg Foundation, children with developmental disabilities are twice as likely as those without IDD to experience emotional neglect and physical or sexual abuse; twice as likely to be bullied; and three times as likely to be in families where domestic violence is present. Hoover pointed out that because these children and youth are at high risk of trauma, any behavior that a teacher, pediatrician, or child welfare worker observes “could be an expression of trauma versus just something associated with their disability.”

“The most important thing is taking both trauma and IDD into consideration, and not seeing kids through a lens of behavior alone.”

PATTY SHURE, Director of Child and Family Services at Las Cumbres Community Services in Española, NM

Christopher Beegle, LCSW-C, a Clinical Field Instructor at the Family Connections program, University of Maryland School of Social Work, noted that even trained clinicians may not realize that some of the children with whom they work have an intellectual or developmental disability. He said his participation in the Redondo Beach train-the-trainer session strengthened his understanding about tying in the developmental piece. “The toolkit raises awareness about keeping both frameworks – trauma and IDD – in mind when working with families.”

In the toolkit's Module 2 on development and trauma, providers are reminded of the developmental complexities they must consider in addition to assessing for trauma. A child may have co-occurring medical, genetic, or developmental issues, communication challenges, or attention deficit issues.

>>> cont'd on pg. 7

Disabilities and Trauma *cont'd from pg. 6*

“This module brought up questions about how to structure sessions to best attend to the presenting developmental issues for the families and children we serve, to promote healing,” Beegle said.

‘A Culture Shift’

Colleen Horton, MPAff, MA, Program Officer for the Hogg Foundation, observed that, “One of the biggest challenges in working with children with IDD is the added time it takes to talk with caregivers, and then finding a way an individual child communicates best.” Horton has been a prime mover in the IDD toolkit project. Her involvement stemmed from a congruence of factors. As the parent of a daughter with autism, she could not find appropriate services to help her daughter after a traumatic event. At about the same time, she was asked to join the NCTSN Advisory Board, and she became familiar with trauma toolkits for other populations. She recalled, “I recognized that children with IDD comprised a population for which this information was missing, but very much needed.”

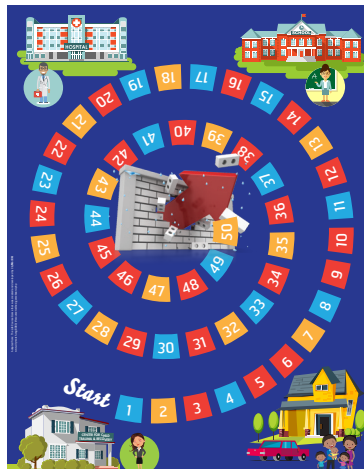
Too often, children and youth with IDD do not receive state-of-the-art mental health treatment, Horton noted. Reflecting the combined expertise of the trauma and IDD communities, the toolkit encourages a culture shift in a provider’s own perception. “We want to get away from a focus on managing behaviors with compliance as the primary goal; and to look at the history and cause of behaviors, to determine if trauma has occurred, and if what we’re doing is creating an environment that continues to produce trauma reminders,” Horton emphasized.

Caregivers, Parents Are Pivotal Team Members

Hoover recently initiated the Horizons Program, a therapeutic clinic dedicated to treating traumatized children with developmental disabilities. He will be participating in a panel on the toolkit at the 2016 All-Network Conference. He praised the toolkit’s incorporation of family members and caregivers, which underlines the message to clinicians to honor the family’s expertise and to approach the family’s perception and knowledge of their child from their point of view.

Anne Fogg, MA, LPC, who works at the Aurora Mental Health Center in Aurora, CO, concurred with Hoover, adding, “The parents of our clients are experts with their child’s disability, but not necessarily with trauma. Having the resources and vignettes in this toolkit really helps people who don’t have as much experience working with this population.” Fogg has begun to use materials from the toolkit in individual sessions with families.

“I cannot say enough good things about this toolkit,” said Mayra Mendez, PhD, LMFT, Certified Group Psychotherapist, CAMFT Certified Supervisor at Saint John’s Child and Family Development Center in Santa Monica, CA, who also participated in the Redondo Beach training.



This board game, adapted from The Life Course Game created by CityMatCh, accompanies the IDD toolkit. It is a teaching aid to communicate family resilience as well as risk factors. Players draw from decks of brick or water-droplet cards that give instructions based on circumstances. An example of a brick card, used to signify a protective factor: Sally has a very close relationship with her mom. Move forward one space. Example of a droplet card, which signifies a risk factor: Glen worries that he might be assaulted while walking home from school. Move back one space.

that parents, when their emotions are triggered, do not “spin out of control.” Parents need to keep coping, she emphasized: “That’s the trick with trauma.”

Changing the Lens

The toolkit also underscores the need to dispel common myths surrounding work with children with IDD – mainly, that these children cannot engage in mental health treatment. At Las Cumbres, Shure has begun training clinicians and school staff together and has observed that each group has pushed the other to expand their ability to perceive clues about possible trauma. “The most important thing is taking both trauma and IDD into consideration,” Shure noted, “and not seeing kids through a lens of behavior alone.”

Once the treatment team at Conjunto Therapeutic Preschool realized that trauma was affecting the young toddler’s ability to speak, the team and the family began to work through that piece of the treatment process. The girl was able to make progress with the help of clinical services and speech therapy. When clinicians understand that they are not just seeing “willful behaviors,” and design ways to support the child to work through his or her trauma, “you get to see change and you get to see hope,” Shure said. “And that makes a huge difference.” ■

“The developers gave great thought to using understandable concepts in the PowerPoint slides.” Mendez has already begun training clinicians at her agency, and last November she launched a training group for parents. The group was so successful that the parents requested she offer an ongoing series on coping with trauma – “not just the trauma of abuse or bullying,” she said, “but the trauma of dealing with the world, because having a child with a disability is traumatic for the parents, too.” Part of their traumatic stress arises from the need to negotiate resources for their children; and changing developmental phases also introduce new challenges. Mendez praised the structure of the IDD toolkit, which requires a skilled facilitator to help ensure

Have You Heard?

Marta Casas, LMHC, MEd, Director of Clinical Services at **Justice Resource Institute**, and two clinical staff colleagues just returned from a two-week cross-cultural collaboration in Guatemala. Along with students and faculty from William James College in Boston and the Universidad del Valle in Guatemala City, they worked with indigenous Mayan communities in Sololá. This rural region near Lake Atitlán was severely affected by the civil war violence that raged for 36 years in Guatemala. More than 200,000 people were killed during the violence, and more than 80 percent of them were Mayan.

In her capacity as a consultant with William James College, Casas has been involved in this cross-cultural collaboration for five years. Justice Resource Institute became a partnering organization starting this year. Casas described the collaboration as a reciprocal and “co-constructive” project to develop a strategy for trauma-informed intervention that is congruent with the Latin American view of psychology and the community. “We are not necessarily going to *train* them or impose upon them a foreign framework or model for approaching trauma,” Casas said. “They will help us become more knowledgeable and aware of how to work with the community.”

Casas graduated as a clinical psychologist in 1981 from Javeriana University in Bogotá, Colombia. She moved to Boston in 2002 and since then has been with Justice Resource Institute, initially as a clinical staff member at the Trauma Center. Through the years, she has been active in the NCTSN Culture Consortium, and she is currently co-chair of the Translations Review Committee. Casas has done extensive reflection and consultation on the interplay between psychological trauma and cultural identity of both provider and client in the clinical relationship.

Casas noted that her awareness of culture and trauma was heightened when she moved to the United States and began doing clinical work. “I never took the time to reflect about myself as a cultural being while in Colombia,” she said. “Perhaps it was because I was part of a majority group. But my experiences as an immigrant clinician definitely had an impact. I started becoming more and more aware of my own biases and preconceptions about others, as well as more aware of potential assumptions that others, both colleagues and patients, had about me. And I decided to build upon this experience of cultural differences to enrich my clinical practice.”

From 2011 to 2014, Casas worked at the Child Witness to Violence Project at Boston Medical Center. In addition to her clinical work she was part of the training team and cultural liaison of the Massachusetts Child Trauma Project, an initiative funded by the US Administration for Children and Families to support training and consultation in evidence-based trauma practices at the Massachusetts Department of Children and Families.

Culture and trauma remain central in Casas’s work at Justice Resource Institute. She is currently developing strategies to enhance the institute’s ability to deliver culturally and linguistically competent services. “I don’t think it’s possible to do clinical work without taking into account the cultural identity of both the patient and the therapist,” she said. “Culture should always be part of the conversation in all clinical activities.”

About IMPACT

IMPACT is a publication of the National Child Traumatic Stress Network (NCTSN). It is produced 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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Water Walk ceremony at Ocean Beach in San Francisco. The Water Walk, originated by Josephine Mandamin as an Ojibwe ceremony on the Great Lakes, has spread and evolved into an intertribal ceremony through Mandamin’s work and encouragement. (Photo courtesy of Native American Health Center, 2016.)