UCSF Benioff Children's Hospital Oakland Center for the Vulnerable Child & Early Intervention Services

Understanding the Impact of Trauma on the Wellbeing of Young African American Children and their Families

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Our Story

This project seeks to improve mental health service delivery to young African Americans (under age 5) and their families through the development of a primary care and mental health provider-training curriculum. The goal of the curriculum is to increase the knowledge, and awareness of these providers of the existence, history, scope and impact of trauma, multigenerational trauma, racism and oppression on African American families with young children; to increase provider empathy for these families; and to equip them with skills to provide culturally responsive and trauma informed services to this population.

Our team drew upon the experiences we had in teaching about African American psychology, cultural competency, trauma, family systems and intervention work. We decided that one of the main mechanisms and goals of this training would be to increase empathy- to expand the capacity of providers to understand, connect with and feel compassion for those they serve. We identified that gaps in knowledge about the history and impact of trauma, racism and oppression often pose barriers to empathy; that if a provider doesn't fully understand the impact of trauma on behavior, or historical contexts of the legacy of historical trauma and oppression, they might interpret a child or family's behavior as threatening, out of control, aggressive or problematic.

But, with empathy and compassion, and an understanding of the multiple factors like trauma, and racism, there can be less negative interpretations of behavior and more successful engagement. With these goals in mind we developed a curriculum plan, where each session would follow the same format: beginning with a clinical example of both struggle and resilience exemplified in digital stories, followed by didactics, self-reflection and resources. In this way, we believe we can change the lives of African American families with young children, and of the primary and mental health care providers who wish to help them.

Sincerely,
Allison Briscoe-Smith
Director, Center for the Vulnerable Child
Children's Hospital & Research Center

Understanding the Impact of Trauma on the Wellbeing of Young African American Children and their Families: An innovative Approach to Training Community Partners

Purpose:

The purpose of this project is to address the recommendations outlined in the "African American Utilization Report". In that report barriers to access and inadequacy of services to African American in Alameda County were outlined. The current project seeks to improve service delivery to young African Americans (under age 5) and their families through the development of a curriculum to be used to train service providers in the county with the following goals:

Goals
- Increase the knowledge, skills and awareness of mental health and medical providers of young African American children and their families of:
    - The impact of trauma on these families
    - The impact of racism on these families
    - Multigenerational/ intergenerational trauma
    - How to provide culturally responsive and trauma informed services to this population
    - Increase provider empathy for these families

Method

The above goals were informed by the African American Utilization Report, but also derived from a lengthy and comprehensive data collecting process involving providers and consumers which will be described below.

The team behind this work is a group of African American, female mental health providers and advocates who work at both Early Intervention Services and Center for the Vulnerable Child at Children's Hospital & Research Center Oakland. The team includes a family partner, administrator, instructors and clinicians- all of which have extensive experience with advocacy for African American families. Through their contacts with families, medical residents, family partners, and parents.

There were 7 focus groups conducted with a total of 45 participants. Flyers, emails, phone calls and reaching out to personal contacts were used to gain access to these groups. The team met to create the format for the focus group and to create the guiding questions. At the beginning of each focus group a questionnaire was completed and then discussion followed. The focus groups were audio recorded and transcribed.

Participants:
Focus group participants included ethnically diverse participants. The consumer groups were predominantly, if not entirely African American.

- Harris Early Childhood Training program students
- Early Connections Family Partners
- Alameda County Child Welfare Workers
- Medical Residents
- Parent and consumer groups

Analysis:

We completed a grounded theory based qualitative analysis of the focus group surveys and transcripts. The team member who did not attend the focus groups conducted the data analysis. This process included multiple close readings of the transcripts, a highlighting of recurring themes, presentation of the themes to the team to vet them, and then another iterative reading of the transcripts. Several themes and trends emerged:

- trauma is difficult to talk about
- issues related to race and racism can be challenging for some participants to talk about
- many participants have limited knowledge of the concept of "intergenerational transmission of trauma"
- trauma in the African-American community does not only impact the socio-economically marginalized or those exposed to community violence; middle class African Americans experience trauma due to their experiences of racism
- Generational differences impact how African Americans and individuals working with African Americans perceive trauma and its intersection with race and class
- Some service providers have NO knowledge of the history of African Americans
- There is limited recognition of bi-racial/multi-racial, African American identified individuals

Curriculum Development

The team met to review the data themes and then worked to address the gaps in knowledge articulated above. We drew upon the experiences we had in teaching about African American psychology, cultural competency, trauma, family systems and intervention work. We also decided that one of the main mechanisms and goals of this training is to increase empathy- to expand the capacity of providers to understand, connect with and feel compassion for those they serve. We identified that the gaps in knowledge above often pose barriers to empathy. That if a provider

doesn't fully understand the impact of trauma on behavior, or historical contexts of the legacy of historical trauma and oppression they might interpret a child or family's behavior as threatening, out of control, aggressive or problematic. But, that with empathy and compassion and an understanding of the multiple factors like trauma, racism and development that there can lead to less negative interpretations of behavior and more successful engagement. With these goals in mind we developed the following curriculum plan. Each session would follow the same format. That format is to begin with a clinical example of both struggle and resilience exemplified in digital stories, followed by didactics, self-reflection and resources. Each session will also be guided by reflective questions that guide the conversation.

We then presented a summary of the materials and our process to three more focus groups, two of parent consumers and one of mental health providers. We received helpful feedback which highlighted excitement about this project, a need for this kind of learning and support for a focus on empathy development. Concerns were also raised about making sure that the person(s) providing the training were able to facilitate difficult conversations and had a substantial background and familiarity with the information provided.

A summary of the curriculum is provided below:

Key Assumptions:
- Service Providers of African American families of young children
  - Not only mental health
- Cohort fashion, such that the group will stay with each other over the course of the series
- That the providers will be diverse in terms of ethnicity, race culture and other significant identities
- We encourage the group to be no more than 12- relationships are a primary focus for this training and as such groups that are much larger will not benefit in the same ways from this training
- It is suggested that all pieces of this curriculum are provided in the order stated here.
- The first session is to be conducted in four hours, there will be 9 other sessions, each are three hours
- The instructor will have a deep knowledge of the content provided and will be skilled at facilitating difficult dialogue. Resources to help with this include:
  - http://www.crlt.umich.edu/publinks/racialguidelines
  - https://www.lclark.edu/live/files/8832-excerpted-content

- o http://www.cmu.edu/teaching/resources/Teaching/CourseDesign/InstructionalStrategies/HotMomentsClassroom.pdf
- o https://www.jbfcs.org/about/agency-initiatives/confronting-organizational-racism/anti-racism-resources-to-download/

- It is strongly suggested that participants keep a journal through this work. There are reflective questions throughout. While the slides do not explicitly mention the journal, it is recommended that the instructor encourage sharing and or processing through journal writing. While many of the didactics are content heavy, several of them provide the time and space for reflection and struggling with the material and journaling is key to this process.
- Each session follows the same format of beginning with "our stories" followed by didactic, reflection and then resources.

Sessions:
Assessment:
Session One: Introduction, setting the stage
- the purpose of this session is to set ground rules for communication, set basic assumptions for the training and to perform initial assessments

Multigenerational Trauma:
Session Two: What is multigenerational Trauma?
- the next two sessions focus on defining multigenerational trauma and pull heavily from the work of Dr. Joy DeGruy.
- This is a content and emotionally heavy two sessions
- The first session will focus on the historical contexts of trauma

Session Three: Multigenerational Trauma Today
- This session continues the work from the previous one, yet focuses on present day manifestations of the historical trauma

Session Four: Interrupting the Cycle
- This session begins to highlight opportunities for success and resilience within African American families

Impact of Trauma on African-Americans and their young children
Session Five: Psychosocial Determinants of Health
Session Six: Impact of Trauma Continued
* The above two sessions are used to detail present day implications of racism in health and mental health. There is guided discussion that is based on the

documentary (which should be shown in full) "Unnatural Causes". This is a rich opportunity for learning and discussion.

Session Seven: Impact of trauma on young children
- This presentation focuses on the impact of trauma directly on young children

Healing practices
Session Eight: Cultural Healing Practices
Session Nine: Evidenced Based Treatment
- These two sessions are used to highlight resilience and to begin to develop awareness about intervention and skills that can be used to reduce the impact of trauma and racism on African American families

Session Ten: Wrap up reflections
  - o This is an opportunity for reflection on the experience, to collect feedback and to conduct post tests assessment

Dear Curriculum Users,

In our search to examine the impact of intergenerational transmission of trauma on the lives of African-Americans, we found many sources to help us to better understand the historical challenges, present day barriers, and the need for future research and interventions. The following resources have increased our knowledge, broadened our perspectives, and deepened our capacity to understand one more individual's struggle in the world. As result of our exploration, we suggest you also look for articles, videos, and other Internet resources to support your discussions and to add to the exploration of this topic. The following is a list of resources which are available online. Please note: if you choose to reprint or distribute these resources, ensure that you have expressed permission from the author in order to do so.

Sincerely,

Kimberly Bradley, Psy.D

Allison Briscoe-Smith, Ph.D

Jill Miller, Psy.D

Suggested Resources and Readings

https://www.childwelfare.gov/topics/responding/trauma/

http://childwelfaresparc.org/wp-content/uploads/2013/11/Implementing-Trauma-Informed-Practices.pdf

http://www.thenationalcouncil.org/wp-content/uploads/2012/11/Natl-Council-Webinar-8-2012.pdf

http://www.georgiadisaster.info/MentalHealth/MH23%20BuildingResiliency/Ecological%20Model.pdf

http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1448601/Impact of Racial Trauma on African-Americans

Therapy with African Americans and the Phenomenon of Rage (authors Kenneth V. Hardy and Tracey Laszloffy)

Birth Parents with Trauma Histories and the Child Welfare System: A Guide for Child Welfare Staff (National Child Traumatic Stress Network)

Evidence-based Treatments for Traumatized Youth (National Child Traumatic Stress Network)

In Our Own Voice: African-American Stories of Oppression, Survival, and Recovery in Mental Health Systems (author Vanessa Jackson)

Post Traumatic Slave Syndrome (Dr. Joy DeGruy, YouTube videos)

Ken Hardy's Tasks of Participants in Discussions about Race and Other Aspects of Social Identity (author Ken Hardy, Ph.D, retrieved from ANTI-RACISM RESOURCES TO DOWNLOAD https://www.jbfcs.org/about/agency-initiatives/confronting-organizational-racism/anti-racism-resources-to-download/)

The Lost Children of Wilder: The Epic Struggle to Change Foster Care (author Lisa Bernstein)

Arvidson, Joshua , Kinniburgh, Kristine , Howard, Kristin , Spinazzola, Joseph ,Strothers, Helen , Evans, Mary , Andres, Barry , Cohen, Chantal and Blaustein, Margaret E.(2011) 'Treatment of Complex Trauma in Young Children: Developmental and Cultural Considerations in Application of the ARC Intervention Model', Journal of Child & Adolescent Trauma, 4: 1, 34 — 51. Retrieved from http://dx.doi.org/10.1080/19361521.2011.545046

Contributors to this project:

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Ayannakai Nalo, LCSW

Understanding the Impact of Trauma on the
Wellbeing of Young African American
Children & Their Families

Session 1:

Introduction

For the presenter, the goal of this session is to orient participants to the series and to perform baseline assessments. These assessments should be collected and given again at the end of the series. The MCKASS assessment must have prior signatures completed and must follow the utilization request form prior to completion. Please read, the attached utilization request. Pre and post assessments and information should be kept. The idea is to facilitate discussions of these measures during this class.

Our Stories

VOICES: Hearing from African American Families about Trauma (13:59)

(n.d.). Retrieved from
https://umconnect.umn.edu/aafamtrauma1/

I Am Sean Bell...Black Boys Speak (11 min)

(n.d.). Retrieved from http://youtu.be/UeQJn1jHEJQ

Didactic

- The goal of this training is to:
  - Create a greater understanding of the impact of trauma on the well being of young African American Children (0-5) and their families
  - With this greater understanding will be more empathy and also the provision of more culturally responsive treatment

Assumptions of this training

- Who:

  Service Providers of African American families of young children
  - Not only mental health
  - That the providers will be diverse in terms of ethnicity, race culture and other significant identities

- How

  Cohort fashion, such that the group will stay with each other over the course of the series

  We encourage the group to be no more than 12

  relationships are a primary focus for this training and as such groups that are much larger will not benefit in the same ways from this training
- It is suggested that all pieces of this curriculum are provided in the order stated here.
- The first session is to be conducted in four hours,
- there will be 9 other sessions, each are two hour

How these trainings are organized

- Our stories
  - A window into families and their experiences
  - Connecting with both the struggles and the resilience of these families
- Didactic
  - Presentation of information: facts, figures, theories etc.
  - Also presentation of videos
- Self Reflection
  - In class: guiding questions to help us explore, connect and make meaning
  - Journaling: an opportunity to continue to reflect, and opportunity for those
- Resources
  - Links to original references
  - Other places to learn and explore

Needs of young African Americans and their families

- What do you see are the needs of African American Families?

Reflection

- To begin we want assess:
  - Our assumptions
  - Set a baseline so we can mark our growth and improvement

MKASS

- Spend the next 10 minutes completing this assessment
- As a group let's discuss-
  - What did you think of the questions raised
  - Have you been asked this before
  - What came up for you

Please review permission for use.

The latest presentation, critique, and user guidelines for the MCKAS is presented in:

Ponterotto, J. G., & Potere, J. C. (2003). The Multicultural Counseling Knowledge and Awareness Scale (MCKAS): Validity, reliability, and user guidelines. In D. P. Pope-Davis, H. L. K. Coleman, W. M. Liu, & R. Toporek (Eds), <u>Handbook of multicultural competenices in counseling and psychology</u> (pp. 137-153). Thousand Oaks, CA: Sage. (Any user of the MCKAS must read this source.)

Implicit Attitude test

https://implicit.harvard.edu/implicit/

(n.d.). Retrieved April 1, 2015, from https://implicit.harvard.edu/implicit/

* Presenter- please be sure to have sent out the link to participants before, have them complete the task

Implicit Attitudes

- Definition
  - "Implicit bias refers to the attitudes or stereotypes that affect our understanding, actions, and decisions in an unconscious manner"
    - Occur without introspective awareness
    - Are automatic
- Discussion
  - Most Americans, regardless of race display pro-white/anti-black bias on IAT
  - Even children as young as 6 display this bias

- *"for a deep and lasting equality to evolve, implicit biases must be acknowledged and challenged; to do otherwise is to allow them to haunt our minds, our homes and our society into the next millennium."* (Rudman, L. (2004). Social Justice in Our Minds, Homes, and Society: The Nature, Causes, and Consequences of Implicit Bias. *Social Justice Research, 17*(2), 125-142.)

* Quote retrieved from State of the Science Implicit Bias Review 2013. (2013, May 29). Retrieved April 9, 2015, from http://kirwaninstitute.osu.edu/docs/SOTS-Implicit_Bias.pdf

Implicit attitudes

- Happens at a biological level
  - IAT linked to fear center activation of brain
  - Linked to skin conductance tests
- More likely to emerge/ or be operated upon when:
  - Time pressure
  - Busy
  - Cognitive overload
  - When need to make multiple decisions

So what….

- Impacts decision making
- Shoot don't shoot
- Subtle cues-
  - Speaking errors
  - Eye blinking
  - avoidance
- Leakages
  - Micro-aggressions

EMPATHY TESTS

The Davis Interpersonal Reactivity Index
Retrieved from
http://www.sjdm.org/dmidi/Interpersonal_Reactivity_Index.html

What's Your EQ (empathy quotient)?

Retrieved from
Http://downloads.self.com/self/pdfs/whats-your-empathy-quotient.pdf

To the trainer: please provide copies of these for members to complete

The Davis Interpersonal Reactivity Index
'The Interpersonal Reactivity Index (Davis, 1980, 1983) is a measure of dispositional empathy that takes as its starting point the notion that empathy consists of a set of separate but related constructs. The instrument contains four seven-item subscales, each tapping a separate facet of empathy. The perspective taking (PT) scale measures the reported tendency to spontaneously adopt the psychological point of view of others in everyday life ("I sometimes try to understand my friends better by imagining how things look from their perspective"). The empathic concern (EC) scale assesses the tendency to experience feelings of sympathy and compassion for unfortunate others ("I often have tender, concerned feelings for people less fortunate than me"). ' The following statements inquire about your thoughts and feelings in a variety of situations

1.I daydream and fantasize, with some regularity, about things that might happen to me.
2. I often have tender, concerned feelings for people less fortunate than me.
3. I sometimes find it difficult to see things from the "other guy's" point of view.
4. Sometimes I don't feel very sorry for other people when they are having problems.

Reference: Davis, M. H. (1980). A multidimensional approach to individual differences in empathy. JSAS Catalog of Selected Documents in Psychology, 1980, 10, 85.
Davis, M. H. (1983). Measuring individual differences in empathy: Evidence for a multidimensional approach. Journal of Personality and Social Psychology, 44(1), 113-126.
doi: 10.1037/0022-3514.44.1.113
The measure: Davis (1980) IRI.doc

What's your EQ (empathy quotient)?
        This quiz, adapted from a common psychological test of empathy, gauges two key empathy types: concern for others and perspective (the ability to imagine someone's point of view).

Reflection continued

- How to do you think racism impacts your work
- How do you try to overcome these issues?
- What help do you need to improve your cultural accountability
  - How do you become an ally?

Becoming an Ally in the Therapeutic Relationship

Knowing Oneself
Being vigilant about the dynamics of oppression – being able to identify, acknowledge and validate with others requires us to first start with ourselves by making conscious of that which do not see, do not want to see, or see but don't know what to do so we remain silent. It is by Acknowledging and Interrupting the dynamics of oppression that are enacted unconsciously.

Becoming an Ally is a journey
The journey of becoming and being an ally involves the process of acknowledging the experience of being the target of oppression, healing from the hurts of oppression, recognizing one's privilege and developing into an ally.

Privilege
Is about being aware of those places and spaces of privilege you hold whether you want it or not, whether you like it or not.

Our privilege as clinicians
Those of us who are working with members of the community and who are unaware of the forces of privilege will miss dynamics that may very well be a key in a client's healing.

Therapist as Ally
Continuing to examine your location in relation to your clients. Continually seeking and building knowledge about cultural identity, racial identity development. Being willing to interrupt oppression by getting in the way of oppression, to stop it when it is occurring.

Vasquez, H., & Magraw, S. (2005). Building Relationships across Privilege · BECOMING AN ALLY IN THE THERAPEUTIC RELATIONSHIP.
In *Psychotherapy with Women Exploring Diverse Contexts and Identities* (pp. 65-83). Guilford Press.

Knowing Oneself
Being vigilant about the dynamics of oppression – being able to identify, acknowledge and validate with others requires us to first start with ourselves by making conscious of that which do not see, do not want to see, or see but don't know what to do so we remain silent. It is by Acknowledging and Interrupting the dynamics of oppression that are enacted unconsciously. Those ways in which we unintentionally and unconsciously use our privilege during our work or fall back on stereotypes about clients and/or deny that we hold a position of power and privilege over our clients.
What are the effects that racism and oppression has racism on you (ingrained fears, unchecked stereotypes, walls of separation, guilt and shame)?

Becoming an Ally is a journey
"Healing leads to recognition of privilege, which in turn opens the door to developing into an ally" The journey of becoming and being an ally involves the process of acknowledging the experience of being the target of oppression, healing from the hurts of oppression, recognizing one's privilege and developing into an ally. It is the ally's role and responsibility to work toward the elimination of oppression, both on individual and institutional levels. It is first healing ourselves around how oppression has been and/or is impacting you.

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Is about being aware of those places and spaces of privilege you hold whether you want it or not, whether you like it or not.

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Becoming an Ally in the Therapeutic Relationship

Effects of social oppression
Understanding that oppression is the root cause of emotional trauma and should be included in the clinical assessment of a client's problems – giving importance to the client's social, political, and cultural experiences primary importance within the treatment

Interrupting Internalized Oppression
- Talking about the origins of a client's negative beliefs and how they stem from social forces beyond their control
- Talk about examples of positive social contributions from client's culture
- Talk about how their behavior is or has been a resistance strategy against oppression
- Help clients identify how they have resisted internalized oppression in both adaptive and self-destructive ways
- Support clients with exploring and identifying how they can replace the destructive coping mechanisms they have used as their strategy for surviving oppression and the "isms" they are impacted with new more positive, healthy, empowering, alternatives.

Institutional Oppression: Expanding the Treatment plan
Including how institutions in our social system impact on those who occupy the place and space of disadvantage, marginalization, subjugation, discrimination

Effects of Multigenerational trauma
Recognizing the multigenerational trauma of the past as it continues its harmful impact on the present.

Using a Cultural Genogram during assessment
This a tool that can assist those working with children and families (1) locating yourself in relation to various cultural issues, (2) understand the impact of oppression (3) learn the effect of cultural treatment and mistreatment

Vasquez, H., & Magraw, S. (2005). Building Relationships across Privilege - BECOMING AN ALLY IN THE THERAPEUTIC RELATIONSHIP. In *Psychotherapy with Women Exploring Diverse Contexts and Identities* (pp. 65-83). Guilford Press.

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Understanding that oppression is the root cause of emotional trauma and should be included in the clinical assessment of a client's problems – giving importance to the client's social, political, and cultural experiences primary importance within the treatment, as part of the treatment goals and plan, as part of the cultural considerations related to your client.

Interrupting Internalized Oppression
Talking about the origins of a client's negative beliefs and how they stem from social forces beyond their control
Talk about examples of positive social contributions from client's culture
Talk about how their behavior is or has been a resistance strategy against oppression
Help clients identify how they have resisted internalized oppression in both adaptive and self-destructive ways
Support clients with exploring and identifying how they can replace the destructive coping mechanisms they have used as their strategy for surviving oppression and the "isms" they are impacted with new more positive, healthy, empowering, alternatives.

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Including how institutions in our social system impact on those who occupy the place and space of disadvantage, marginalization, subjugation, discrimination

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Recognizing the multigenerational trauma of the past as it continues its harmful impact on the present

Using a Cultural Genogram during assessment

This a tool that can assist those working with children and families (1) locating yourself in relation to various cultural issues, (2) understand the impact of oppression (3) learn the effect of cultural treatment and mistreatment

The Practice of Being An Ally

The practice of being an ally involves:

- Identifying racism, classism, sexism, heterosexism and other "isms" as the root causes of mental illness,

- Acknowledging, validating and interrupting internalized oppression

- Viewing client problems within the context of social oppression, including an examination and analysis of institutional oppression

- Examining and acknowledging how the effects of multigenerational trauma impacts the client's functioning

Vasquez, H., & Magraw, S. (2005). Building Relationships across Privilege · BECOMING AN ALLY IN THE THERAPEUTIC RELATIONSHIP. In *Psychotherapy with Women Exploring Diverse Contexts and Identities* (pp. 65-83). Guilford Press.

Four Processes of Development as an Ally

- **Process I:** Unconscious Incompetence
  "I don't know that I don't know"

- **Process 2:** Conscious Incompetence as an Ally
  "Now I know that I don't know very much, and I know I need to learn"

- **Process3:** Conscious Competence as an Ally
  "With the knowledge that I've learned, how do I bring this thinking into the room with the client as well as into my interactions and relationships with African Americans in general?"

- **Process 4:** Unconscious Competence as an Ally
  "As I continue in my work or as I continue on my life's journey as an ally, what can I do to strengthen and sustain my capacity and ability to think contextually and see through a multicultural lens?"

Vasquez, H., & Magraw, S. (2005). Building Relationships across Privilege · BECOMING AN ALLY IN THE THERAPEUTIC RELATIONSHIP. In *Psychotherapy with Women Exploring Diverse Contexts and Identities* (pp. 65-83). Guilford Press.

References

- The Davis Interpersonal Reactivity Index
  Retrieved from
  http://www.sjdm.org/dmidi/Interpersonal_Reactivity_Index.html
- Implicit Attitudes Test
  (n.d.). Retrieved April 1, 2015, from https://implicit.harvard.edu/implicit/
- Vasquez, H., & Magraw, S. (2005). Building Relationships across Privilege ·
  BECOMING AN ALLY IN THE THERAPEUTIC RELATIONSHIP.
  In *Psychotherapy with Women Exploring Diverse Contexts and
  Identities* (pp. 65-83). Guilford Press.
- What's Your Empathy Quotient?
  Retrieved from
  Http://downloads.self.com/self/pdfs/whats-your-empathy-quotient.pdf

Session Two:

What is Multigenerational Trauma?

Presenter, the goal of the next two sessions are to thoroughly embed participants in a deep understanding of multigenerational trauma. This is an intense exploration that is sure to raise anxiety and dicussion. There is a lot of material here and in the next session that is intersperssed with compelling video from Dr. Degruy. Having a good understanding of her work (Post Traumatic Slave Syndrome) is important. She has a workbook as well which may be an additional resources.

Session Two:
Agenda

Our stories

Didactic
- What is Multigenerational Trauma?
- *What Happened To Us?:* Timeline of Significant Historical and Collective Experiences in the Lives of African Americans
- Video – Joy DeGruy

Reflection
- Guiding questions
- What are the psychological residuals of …?

Resources
* Post Trauma Slave Syndrome by Dr. DeGruy

"Theoretically... the severe trauma and emotional sufferings of African American people based on living in this society is deep and generational, having passed down since slavery and the severe discrimination and segregation that African Americans have historically faced in this country. These wounds are deep. However, African Americans as a community have not healed from these wounds. Instead, the emotional and psychological wounds fester in our communities and are passed on and on. "

Rev. Tamara E. Lewis

Lewis, R. (n.d.). The Failure of the African American Church in Society. Retrieved April 15, 2015, from http://www.timbooktu.com/rvtamara/failure.htm

Our Stories

- *Intergenerational Trauma and Healing* *(3 Parts)*. (n.d.). YouTube.

Part 1 (7:26 mins) (n.d.). Retrieved from https://youtu.be/OMCfOXrVbQo

Part 2 (9:45mins) (n.d.). Retrieved from https://youtu.be/b_bIEdS8cOA

Part 3 (6:02 mins) (n.d.). Retrieved from https://youtu.be/6p1PuzMn5bw

- *I Am Sean Bell...Black Boys Speak* **(11 min)**

(n.d.). Retrieved from http://youtu.be/UeQJn1jHEJQ

Our Stories

Post Traumatic Slave Syndrome - Dr. Joy DeGruy
- **Part 2 (33 min)**

Retrieved from (n.d.). http://youtu.be/RsPY0TJtA6I?t=5m
- **Part 3 (33 min)**

Retrieved from (n.d.). http://youtu.be/xZggmGBJB9s

- Initial group reactions (10 min)

- Digital story discussion questions

What is Historical Trauma?

"Historical trauma is defined... as "a constellation of characteristics associated with massive cumulative group trauma across generations". Historical trauma differs from other types of trauma in that the traumatic event is shared by a collective group of people who experience the consequences of the event, as well as the fact that the impact of the trauma is held personally and can be transmitted over generations."

Michaels, MPH, C. (2010, October 1). Historical Trauma and Microaggressions: A Framework for Culturally-Based Practice. Retrieved from http://www.extension.umn.edu/family/cyfc/our-programs/ereview/docs/cmhereviewOct10.pdf

Historical Trauma

- This type of trauma that is often overlooked is historical trauma. Historical trauma is most easily described as multigenerational trauma experienced by a specific cultural group. Historical trauma can be experienced by "anyone living in families at one time marked by severe cumulative and collective".

- The impact of this type of trauma manifests itself, emotionally and psychologically, in members of different cultural groups (Brave Heart, 2011).

- As a collective phenomenon, those who never even experienced the traumatic stressor, such as children and descendants, can still exhibit signs and symptoms of trauma.

How Being Trauma-Informed Improves Criminal Justice System Responses: Historical Trauma Fact Sheet. (2011). Retrieved from http://gainscenter.samhsa.gov/cms-assets/documents/93078-842830.historical-trauma.pdf

The Legacy of Historical Trauma for African Americans

The legacy of trauma is reflected in many behaviors and beliefs of African Americans; behaviors and beliefs that at one time were necessary to adopt in order to survive, yet today may serve to undermine efforts to be successful. Behaviors that are then passed down through generations.

DeGruy, J. (2005). *Post Traumatic Syndrome : America's Legacy of Enduring Injury and Healing*. Milwaukie, Oregon: Uptone Press.

The legacy of Trauma

- Debilitating beliefs and assumptions are also part of the legacy of trauma such as having no assumptions that even though you are a good person, very capable, and smart that you will be successful.

- How many times does a person have to see and hear about others like him or herself being physically and psychologically brutalized to be impacted?

DeGruy, J. (2005). *Post Traumatic Syndrome : America's Legacy of Enduring Injury and Healing*. Milwaukie, Oregon: Uptone Press.

Historical Unresolved Grief

Historical trauma may manifest itself as **Historical Unresolved Grief**: Grief as the result of historical trauma that has not been adequately expressed, acknowledged, or otherwise resolved. Examples include the psychological residuals of slavery, the impact of European colonization on Native Americans, Holocaust survivors.

How Being Trauma-Informed Improves Criminal Justice System Responses: Historical Trauma Fact Sheet. (2011). Retrieved from http://gainscenter.samhsa.gov/cms-assets/documents/93078-842830.historical-trauma.pdf

Historical Trauma and Grief

Disenfranchised Grief

Grief as the result of historical trauma when loss cannot be voiced publicly or that loss is not openly acknowledged by the public. For example, the lack of recognition of the generations of loss among African Americans from generations of white supremacy/racism, physical and psychological slavery and brutality, oppression, poverty, disenfranchisement, social/political/economic injustice and inequality in addition to other factors, and the corresponding lack of recognition of their right to grieve these collective experiences.

How Being Trauma-Informed Improves Criminal Justice System Responses: Historical Trauma Fact Sheet. (2011). Retrieved from http://gainscenter.samhsa.gov/cms-assets/documents/93078-842830.historical-trauma.pdf

Historical Trauma and Internalized Oppression

As the result of historical trauma, traumatized people may begin to internalize the views of the oppressor and perpetuate a cycle of self-hatred that manifests itself in negative behaviors. Emotions such as anger, hatred, and aggression are self-inflicted, as well as inflicted on members of one's own group. For example, self-hatred among Blacks/ African Americans who act out their aggression on people who look like them.

How Being Trauma-Informed Improves Criminal Justice System Responses: Historical Trauma Fact Sheet. (2011). Retrieved from http://gainscenter.samhsa.gov/cms-assets/documents/93078-842830.historical-trauma.pdf

Intergenerational Transmission of Trauma

- Children of survivors can experience symptoms similar to their parents despite the fact that they were not directly exposed to the trauma. Examples of historical trauma include planned violence or segregation (genocide, massacres, imprisonment [such as slavery]), prevention of cultural or spiritual practices (forced conversion designed to de-culturate and assimilate an entire group of people), and environmental decisions (radioactive dumping in specific geographic areas that affect specific groups of people).

- Children of survivors may not exhibit clinical symptoms as a result of their parent's trauma, but they may experience greater trauma when faced with a new stressor.

Michaels, MPH, C. (2010, October 1). Historical Trauma and Microaggressions: A Framework for Culturally-Based Practice. Retrieved from http://www.extension.umn.edu/family/cyfc/our-programs/ereview/docs/cmhereviewOct10.pdf

Historical Response to Trauma

- The term *historical trauma response has been* defined as "the cumulative effect of historical trauma brought on by centuries of colonialism, genocide, and oppression".

- Evans-Campbell and Walters have also defined the term *colonial trauma response (CTR). This term incorporates the historical* group trauma response but also includes contemporary and individual responses to injustice, trauma or microaggression.

- Several factors can influence the degree to which an individual experiences historical trauma. Having two traumatized parents increases the risk of a historical trauma response in children. The loss of a spouse or child is a particular risk in producing a response of historical trauma in offspring.

- This can be particularly important for African Americans who have experienced the loss of children due to the forced removal of children from their families – during slavery and through the child welfare system.

Michaels, MPH, C. (2010, October 1). Historical Trauma and Microaggressions: A Framework for Culturally-Based Practice. Retrieved from http://www.extension.umn.edu/family/cyfc/our-programs/ereview/docs/cmhereviewOct10.pdf.

Why Post Traumatic Slave Syndrome?

While standardized definitions such as PTSD reflect some of the symptoms resulting from historical trauma, researchers have noted that they are "limited in their ability to explore the additive effects of multiple traumatic events occurring over generations." Simpson has noted that definitions of PTSD overlook the variety of types of posttraumatic syndromes and neglect communal responses to trauma.

Evans-Campbell identifies how definitions could be expanded to better reflect the historical trauma experience by (1) capturing the compounding nature of responses to multiple stressors, (2) addressing familial and social impacts of trauma reactions (not just individual), (3) exploring how historical and contemporary traumas interact, and (4) including factors that buffer the impact of trauma.

Michaels, MPH, C. (2010, October 1). Historical Trauma and Microaggressions: A Framework for Culturally-Based Practice. Retrieved from http://www.extension.umn.edu/family/cyfc/our-programs/ereview/docs/cmhereviewOct10.pdf

Post Traumatic Slave Syndrome
(PTSS)

- Post Traumatic Slave Syndrome is a condition that exists when a population has experienced multigenerational trauma resulting from centuries of slavery and continues to experience oppression and institutionalized racism today.
- Added to this condition is a belief (real or imagined) that the benefits of the society in which they live are not accessible to them.
- PTSS is a syndrome. A syndrome is a pattern of behaviors that is brought about by specific circumstances. The circumstances that produce PTSS – multigenerational trauma and continued oppression plus a real or imagined lack of access.

DeGruy, J. (2005). *Post Traumatic Syndrome : America's Legacy of Enduring Injury and Healing.* Milwaukie, Oregon: Uptone Press.

The Multigenerational transmission of Trauma

- The individuals and families that survived the slave experience reared their children while simultaneously struggling with their own psychological injuries (DeGruy, pg. 123)
- They often exhibited the symptoms associated with Post Traumatic Stress Disorder.
- The children lived and learned behaviors and attitudes of their often injured and struggling parents. Today, we are those children. (DeGruy, pg. 123)
- In addition to family, the legacy of trauma is also passed down through the community. During slavery, the black community was a suppressed and marginalized group. Today, the African American community is made up of individuals and families who collectively share differential anxiety and adaptive survival behaviors passed down from prior generations of African Americans, many of whom likely suffered from PTSD.
- The community serves to reinforce both the positive and negative behaviors through the socialization process.

DeGruy, J. (2005). *Post Traumatic Syndrome : America's Legacy of Enduring Injury and Healing.* Milwaukie, Oregon: Uptone Press.

How are the effects of trauma transmitted through generations?

- For the most part, parenting is one of a myriad of skills that is passed down generation to generation – Basically, we raise our children based on how we were raised.
- What do you expect gets passed down through generations if what was experienced were lifetimes of abuse at the hands of slave masters and other authorities?
- What do you think the result would be if generation after generation of young men were not allowed the power and authority to parent their own children?
- What do you think the result would be if education was prohibited for generations?
- What do you think the result would be if the primary skills that mothers teach their children are those associated with adapting to a lifetime of torture?

How the legacy of trauma is transmitted

- ...Viewed from a family systems perspective, what happened in one generation will affect what happens in the older or younger generation, though the actual behavior may take a variety of forms.

- Within an intergenerational context, the trauma and its impact may be passed down as the family legacy even to children born after the trauma. (DeGruy)

Michaels, MPH, C. (2010, October 1). Historical Trauma and Microaggressions: A Framework for Culturally-Based Practice. Retrieved from http://www.extension.umn.edu/family/cyfc/our-programs/ereview/docs/cmhereviewOct10.pdf

DeGruy, J. (2005). *Post Traumatic Syndrome : America's Legacy of Enduring Injury and Healing*. Milwaukie, Oregon: Uptone Press.

Histories of African Americans Timeline

- During focus groups, African American parents shared concern and dismay that providers either lack or have very limited understanding and knowledge about the history and experience related to what has happened to African American people in this country.
- Many providers shared that they actually did not have adequate understanding or knowledge about the experience of historical and multigenerational trauma of African Americans.
- Therefore, a timeline of selected historical facts pertaining to the African Americans in the U.S. is being provided here.

African American Historical Timeline

- **1619** - The first African slaves arrive in Virginia
- **1793** - A federal fugitive slave law is enacted, providing for the return slaves who had escaped and crossed state lines.
- **1857** - The Dred Scott case holds that Congress does not have the right to ban slavery in states and, furthermore, that slaves are not citizens.
- **1861** - The Confederacy is founded when the deep South secedes, and the Civil War begins.
- **1863** - President Lincoln issues the Emancipation Proclamation, declaring "that all persons held as slaves" within the Confederate states "are, and henceforward shall be free."

http://www.infoplease.com/spot/bhmtimeline.html

1865

- Congress establishes the Freedmen's Bureau to protect the rights of newly emancipated blacks (March).
- The Civil War ends (April 9).
- Lincoln is assassinated (April 14).
- Slavery in the United States is effectively ended when 250,000 slaves in Texas finally receive the news that the Civil War had ended two months earlier (June 19).
- Thirteenth Amendment to the Constitution is ratified, prohibiting slavery (Dec. 6).

1865-1866 Black codes are passed by Southern states, drastically restricting the rights of newly freed slaves. *Black Code - U.S. Hist.*(in the ex-Confederate states) - any code of law that defined and esp. limited the rights of former slaves after the Civil War.

http://www.infoplease.com/spot/bhmtimeline.html

1865-1877 Reconstruction Era – post Civil War

- The Ku Klux Klan is formed in Tennessee by ex-Confederates (May 1865). The Ku Klux Klan and others used lynching as a means to control African Americans, forcing them to work for planters and preventing them from exercising their right to vote. Mob violence arose as a means of enforcing white supremacy and verged on systematic political terrorism. The Ku Klux Klan, paramilitary groups, and other whites united by frustration and anger ruthlessly defended the interests of white supremacy.

- After the war, southern whites struggled to maintain social dominance. Secret vigilante and insurgent groups such as the Ku Klux Klan (KKK) instigated extrajudicial assaults and killings to keep power and to discourage freedmen from voting, working and getting educated.

1868 - Fourteenth Amendment to the Constitution is ratified, defining citizenship. Individuals born or naturalized in the United States are American citizens, including those born as slaves. This nullifies the Dred Scott Case (1857), which had ruled that blacks were not citizens.

http://en.m.wikipedia.org/wiki/Lynching

1870 - Fifteenth Amendment to the Constitution is ratified, giving blacks the right to vote.

1877 - Early 1900's Reconstruction ends in the South. Federal attempts to provide some basic civil rights for African Americans quickly erode.

- The "nadir of American race relations" was the period in History of the Southern United States when racism in the country is deemed to have been worse than in any other period after the American Civil War. During this period, African Americans lost many civil rights gains made during Reconstruction. Anti-black violence, lynching, segregation, legal racial discrimination, and expressions of white supremacy increased. Violence in the United States against Black Americans, especially in the South, rose in the aftermath of the Civil War, after slavery had been abolished and recently freed black men were given the right to vote.

- By the end of Reconstruction in 1877, with fraud, intimidation and violence at the polls, laws were passed across the South to make voter registration more complicated, reducing black voters on the rolls. The result was that black voters were stripped from registration rolls and without political recourse. Since they could not vote, they could not serve on juries. They were without official political voice.

- https://www.boundless.com/u-s-history/textbooks/boundless-u-s-history-textbook/world-war-i-1914-1919-23/the-american-181/the-race-problem-986-8844/

1879

- The Black Exodus takes place, in which tens of thousands of African Americans migrated from southern states to Kansas.

- The Jim Crow laws and the high rate of lynchings in the South were major factors in the Great Migration during the first half of the 20th century. Because opportunities were so limited in the South, African Americans moved in great numbers to northern cities to seek better lives, becoming an urbanized population.

http://www.infoplease.com/spot/bhmtimeline.html

1880's Jim Crow laws

- Jim Crow laws, in U.S. history, statutes enacted by Southern states and municipalities, beginning in the 1880s, that legalized segregation between blacks and whites. The name is believed to be derived from a character in a popular minstrel song. *The Supreme Court ruling in 1896 in Plessy v. Ferguson that separate facilities for whites and blacks were constitutional encouraged the passage of discriminatory laws that wiped out the gains made by blacks during Reconstruction.* Railways and streetcars, public waiting rooms, restaurants, boardinghouses, theaters, and public parks were segregated; separate schools, hospitals, and other public institutions, generally of inferior quality, were designated for blacks. By World War I, even places of employment were segregated, and it was not until after World War II that an assault on Jim Crow in the South began to make headway. A march on Washington by over 200,000 in 1963 dramatized the movement to end Jim Crow.

http://www.infoplease.com/encyclopedia/history/jim-crow-laws.html

1882 – 1968 Nearly 3,500 African Americans and 1,300 whites were lynched in the United States, mostly from 1882 to 1920.

1896 - *Plessy* v. *Ferguson*: This landmark Supreme Court decision holds that racial segregation is constitutional, paving the way for the repressive Jim Crow laws in the South.

1915 - After the release of the movie *The Birth of a Nation,* which glorified lynching and the Reconstruction-era Klan, the Klan re-formed. Unlike in its earlier form, it was heavily represented among urban populations, especially in the Midwest. In response to massive immigration of people from southern and eastern Europe, the Klan had an anti-immigrant, anti-Catholic and anti-Jewish stance, in addition to exercising oppression of blacks.

1932 - The U.S. government begins a 40-year study in Tuskegee, Ala., on the effects of syphilis in 400 African American men, never telling the subjects they have the disease or offering any treatment. President Bill Clinton will apologize in 1997.

1948 - Although African Americans had participated in every major U.S. war, it was not until after World War II that President Harry S. Truman issues an executive order integrating the U.S. armed forces.

1954 - The Supreme Court rules on the landmark case *Brown* v. *Board of Education of Topeka, Kans.*, unanimously agreeing that segregation in public schools is unconstitutional. The ruling paves the way for large-scale desegregation. The decision overturns the 1896 *Plessy* v. *Ferguson* ruling that sanctioned "separate but equal" segregation of the races, ruling that "separate educational facilities are inherently unequal." It is a victory for NAACP attorney Thurgood Marshall, who will later return to the Supreme Court as the nation's first black justice.

http://www.infoplease.com/spot/civilrightstimeline1.html

1955

- Fourteen-year-old Chicagoan Emmett Till is visiting family in Mississippi when he is kidnapped, brutally beaten, shot, and dumped in the Tallahatchie River for allegedly whistling at a white woman. Two white men, J. W. Milam and Roy Bryant, are arrested for the murder and acquitted by an all-white jury. They later boast about committing the murder in a *Look* magazine interview. The case becomes a cause célèbre of the civil rights movement (August).

- (Montgomery, Ala.) NAACP member Rosa Parks refuses to give up her seat at the front of the "colored section" of a bus to a white passenger, defying a southern custom of the time. In response to her arrest the Montgomery black community launches a bus boycott, which will last for more than a year, until the buses are desegregated Dec. 21, 1956. As newly elected president of the Montgomery Improvement Association (MIA), Reverend Martin Luther King, Jr., is instrumental in leading the boycott (December).

http://www.infoplease.com/spot/civilrightstimeline1.html

1957

- The Southern Christian Leadership Conference (SCLC), a civil rights group, is established by Martin Luther King, Charles K. Steele, and Fred L. Shuttlesworth (Jan.-Feb.)

- Nine black students are blocked from entering the school on the orders of Governor Orval Faubus. (Sept. 24). Federal troops and the National Guard are called to intervene on behalf of the students, who become known as the "Little Rock Nine." Despite a year of violent threats, several of the "Little Rock Nine" manage to graduate from Central High

1963

- Martin Luther King is arrested and jailed during anti-segregation protests in Birmingham, Ala. He writes "Letter from Birmingham Jail," which advocated nonviolent civil disobedience (April 16).

- During civil rights protests in Birmingham, Ala., Commissioner of Public Safety Eugene "Bull" Connor uses fire hoses and police dogs on black demonstrators. These images of brutality, which are televised and published widely, are instrumental in gaining sympathy for the civil rights movement around the world (May).

http://www.infoplease.com/spot/bhmtimeline.html

1963

- The March on Washington for Jobs and Freedom is attended by about 250,000 people, the largest demonstration ever seen in the nation's capital. Martin Luther King delivers his famous "I Have a Dream" speech. The march builds momentum for civil rights legislation (Aug. 28).
- Despite Governor George Wallace physically blocking their way, Vivian Malone and James Hood register for classes at the University of Alabama.
- Four young black girls attending Sunday school are killed when a bomb explodes at the Sixteenth Street Baptist Church, a popular location for civil rights meetings. Riots erupt in Birmingham, leading to the deaths of two more black youths (Sept. 15).

http://www.infoplease.com/spot/bhmtimeline.html

1964

- President Johnson signs the Civil Rights Act, the most sweeping civil rights legislation since Reconstruction. It prohibits discrimination of all kinds based on race, color, religion, or national origin (July).

- (Neshoba Country, Miss.) The bodies of three civil-rights workers—two white, one black—are found in an earthen dam, six weeks into a federal investigation backed by President Johnson. James E. Chaney, 21; Andrew Goodman, 21; and Michael Schwerner, 24, had been working to register black voters in Mississippi, and, on June 21, had gone to investigate the burning of a black church. They were arrested by the police on speeding charges, incarcerated for several hours, and then released after dark into the hands of the Ku Klux Klan, who murdered them (August).

1965

- (Harlem, N.Y.) Malcolm X, black nationalist and founder of the Organization of Afro-American Unity, is shot to death. It is believed the assailants are members of the Black Muslim faith, which Malcolm had recently abandoned in favor of orthodox Islam (Feb 21.)

- (Selma, Ala.) Blacks begin a march to Montgomery in support of voting rights but are stopped at the Pettus Bridge by a police blockade. Fifty marchers are hospitalized after police use tear gas, whips, and clubs against them. The incident is dubbed "Bloody Sunday" by the media. The march is considered the catalyst for pushing through the voting rights act five months later (March 7).

- Congress passes the Voting Rights Act of 1965, making it easier for Southern blacks to register to vote. Literacy tests, poll taxes, and other such requirements that were used to restrict black voting are made illegal (Aug 10).

- Asserting that civil rights laws alone are not enough to remedy discrimination, President Johnson issues Executive Order 11246, which enforces affirmative action for the first time. It requires government contractors to "take affirmative action" toward prospective minority employees in all aspects of hiring and employment (Sept 24).

http://www.infoplease.com/spot/civilrightstimeline1.html

1967 - The Supreme Court rules in *Loving* v. *Virginia* that prohibiting interracial marriage is unconstitutional. Sixteen states still have anti-miscegenation laws and are forced to revise them.

1968

- Martin Luther King, Jr., is assassinated in Memphis, Tenn. (April 4).

- President Johnson signs the Civil Rights Act of 1968, prohibiting discrimination in the sale, rental, and financing of housing (April 11).

- The Fair Housing Act was passed to address continued segregation and prohibit discrimination in housing. When the Fair Housing Act became law in 1968, high levels of residential segregation had already become entrenched. However, the Act's promise as a tool for deterring discrimination and dismantling segregation remains unfulfilled. During the 40 years since the Act was passed, these segregated housing patterns have been maintained by a continuation of discriminatory governmental decisions and private actions that the Fair Housing Act has not stopped.

1972 - The infamous Tuskegee Syphilis experiment ends. Begun in 1932, the U.S. Public Health Service's 40-year experiment on 399 black men in the late stages of syphilis has been described as an experiment that "used human beings as laboratory animals in a long and inefficient study of how long it takes syphilis to kill someone."

http://www.infoplease.com/spot/bhmtimeline.html

1978 - The Supreme Court case, *Regents of the University of California* v. *Bakke* upheld the constitutionality of affirmative action, but imposed limitations on it to ensure that providing greater opportunities for minorities did not come at the expense of the rights of the majority (June).

1981 to 1997

The United States Department of Agriculture discriminated against tens of thousands of African American farmers, denying loans provided to white farmers in similar circumstances. The discrimination was the subject of the Pigford v. Glickman lawsuit brought by members of the National Black Farmers Association, which resulted in two settlement agreements of $1.25 billion in 1999 and of $1.15 billion in 2009.

1988 - Overriding President Reagan's veto, Congress passes the Civil Rights Restoration Act, which expands the reach of non-discrimination laws within private institutions receiving federal funds.

http://www.infoplease.com/spot/civilrightstimeline1.html#events-1971
http://www.infoplease.com/spot/bhmtimeline.html#AAH-1850

1991 - After two years of debates, vetoes, and threatened vetoes, President Bush reverses himself and signs the Civil Rights Act of 1991, strengthening existing civil rights laws and providing for damages in cases of intentional employment discrimination (Nov. 22).

1992 - The first race riots in decades erupt in south-central Los Angeles after a jury acquits four white police officers for the videotaped beating of African-American Rodney King (April 29).

1996

- AIDS is found to be the leading cause of death among African American women aged 25-44.

- Amid growing racial tension in the South, nearly 40 primarily African American churches are burned there.

- Texaco settles a racial discrimination suit for $176 million. The case was initially filed by six African American Texaco employees who charged they had been denied promotion and pay increases because of their race; it later grew to cover 1,400 employees.

http://www.infoplease.com/spot/bhmtimeline.html
http://www.pbs.org/wnet/aaworld/printable_pages/timeline_print.html

1997

- Haitian immigrant Abner Louima is beaten and sodomized with a broomstick by officers while in New York City Police Department custody, causing a national outcry. In 2002, a federal court will overturn the conviction of the three NYPD officers.
- A California court upholds the constitutionality of Proposition 209, which outlaws state affirmative action programs.

1999

- Amadou Diallo, an unarmed African American man, is mistakenly shot and killed by four white policemen in New York City, raising a national furor.
- A group of African American farmers wins a suit against the U.S. Department of Agriculture for discriminating against them in giving out loans and subsidies.

2000 - In the largest settlement ever in a U.S. racial discrimination suit, the Coca-Cola Company agrees to pay out $192.5 million to roughly 2,000 African American employees.

http://www.pbs.org/wnet/aaworld/timeline/modern_04.html

Reflection

- What comes up or stands out to you from your experience today? How might this impact your work with African American children and families from this point forward?

- How has this experience and learning this information personally impacted you? And how do you think that pertains to your work with African American children and families?

- What additional knowledge do you need and/or want to gain about the impact of historical trauma, multigenerational trauma in addition to past and present racial traumas on African Americans in the United States?

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The Multigenerational Trauma Today

session 3

Our Stories

Show digital story:

Inter-Generational Trauma: Ripples Felt for Generations (3:00 mins.)

Retrieved from
http://www.youtube.com/watch?v=Vja83KLQXZs

- Initial group reactions (10 mins.)
- What do you think multigenerational trauma looks like today in the African-American community and family?
- How do we know it when we are witnessing it?
- What are the signs and indicators that the individual in front of you is suffering from multigenerational trauma?

Didactic : What you need to know when working with survivors of multigenerational trauma

- Multigenerational trauma impacts individuals, families and communities. The ways that African-Americans have come to see who they are and who they are not, the ways in which they respond to stress, parenting styles employed by some, relationships to children, significant others, and extended family, and view of family are just some of the ways of being which is reflected through the prism of race, class, oppression, power and privilege.

- The following content highlights the impact of multigenerational trauma on the African-American family, in addition to providing context for understanding some of their struggles and their perseverance.

Impact of multigenerational trauma on families: roles/relationships, esteem, and anger

- The legacy of trauma is passed down through parenting practices and skills; what was encouraged and/or discouraged; communities also reinforced negative and positive behaviors through the socialization process.
- The trauma is reflected in the behaviors and beliefs of those affected; some of the behaviors and beliefs once held in order to survive, are still maintained, and undermine current needs for surviving and thriving.
- Areas of impact and injury: a) belief in goodness, belief in positive outcomes (hope); b) self-esteem (belief about one's value); c) expression of anger and aggression; d) internalization of racist socialization; e) interpersonal relationships with family members and others.

DeGruy, J. (2005). *Post Traumatic Syndrome : America's Legacy of Enduring Injury and Healing*. Milwaukie, Oregon: Uptone Press.

Impact of multigenerational trauma on families: roles/relationships, esteem, and anger cont'd

- Suppressing or denying the historical, racial, or social contexts of an African-American family's or individual's lived experience, clouds, over-pathologizes, minimizes, or misconstrues the distress or life challenges being experienced.

- African-American families are shaped by the effects of oppression, for better or non-conventional. Family structures have been determined by the survival needs; "overriding purpose has been to survive and to thrive until better times come, as we struggle for empowerment and the ending of oppression our hopes and dreams".

McAdams-Mahmoud, V. (2008). Understanding Families in the Context of Cultural Adaptations to Oppression. In *Re-visioning Family Therapy* (2nd ed.). Guilford Press.

Impact of multigenerational trauma on families: roles/relationships, esteem, and anger cont'd

- There is great diversity in the African-American family, and the repeated exposure to racism and oppression create a shared experience of being African-American in the United States.
- The shared psychological experiences linked to oppression and racism include: rage, alienation, and self-hatred.

"Rage is a natural and inevitable response to the painful degradation of racial oppression"-K. Hardy

- Rage in the African-American community is an experience that is often misunderstood or over-pathologized, or avoided or minimized.
- Distinctions between rage and anger?
a) The main difference is related to time and intensity.
b) Anger is an emotion that "rises in the moment", its emotional release usually reduces the tension. Rage is the result of anger, when it's denied expression and grows in intensity over time.

Hardy, K., & Laszloffy, T. (1995). Therapy with African Americans and the Phenomenon of Rage. Retrieved from http://www.mass.gov/eohhs/docs/masshealth/cbhi/faculty-therapy-with-african-americans-and-phenomenon-of-rage.pdf

Impact of multigenerational trauma on families: roles/relationships, esteem, and anger cont'd

- Rage can be functional or dysfunctional; dysfunctionality is associated with the suppression of rage. Suppressed rage can ultimately be volatile and explosive, emotionally and physically.
- The endurance of hardship in silence can lead to rage; African-Americans have a history of oppression and being silenced.

  "Because the forces of oppression still require Blacks to endure their pain and humiliation in silence, rage remains a pervasive emotion"- K. Hardy
- What to do about the rage?
a) Acknowledging the oppressive and discriminatory forces; naming the invisible wounds
b) Acknowledge the rage that comes out of these experiences.
c) Creating space for functional and healthy expression of rage.

Hardy, K., & Laszloffy, T. (1995). Therapy with African Americans and the Phenomenon of Rage. Retrieved from http://www.mass.gov/eohhs/docs/masshealth/cbhi/faculty-therapy-with-african-americans-and-phenomenon-of-rage.pdf

Diana Baumrind

Styles of Parenting

Diana Baumrind is known for her research on parenting styles.

Her research on parenting styles were based on two aspects:
1. Parental responsiveness: which refers to the degree the parent responds to the child's needs.
2. Parental demandingness: extent to which the parent expects more mature and responsible behavior from a child.

3 Styles of Parenting

- Authoritarian

- Authoritative

- Permissive (a.k.a Indulgent or Non - Directive)

The Authoritarian Parent

- High in demandingness and low in responsiveness
- Attempts to shape and control child's behavior and attitudes with an absolute set of rules
- Values obedience
- Favors punitive and forceful measures of punishment
- Assigns household chores to instill a respect for work
- Regards a high preservation of order
- Does not engage in verbal give and take; believes child should take his/her word as what is right
- Highly controlling

Effects of the Authoritarian Parent on the Child

- Performs moderately in school

- Less likely to become involved in deviant behavior

- Poorer social skills when compared to children of Authoritative parents

- Lower Self-Esteem

- Higher levels of Depression

The Authoritative Parent

- High in both demandingness and responsiveness
- Attempts to direct behavior using an issue-oriented manner
- Encourages verbal give and take
- Shares reasoning behind decisions
- Reinforces his/her perspective, but recognizes child's interests and special ways
- Affirms child's current qualities but set a standard for future conduct
- Uses reason, power, reinforcement to achieve desired behavior

Effects of the Authoritative Parent on the Child

- Perform well scholastically

- Exhibit few internalizing or externalizing behaviors

- More socially competent

- Confident

- Less likely to get into trouble

The Permissive Parent

- Low in demandingness and high in responsiveness
- Attempts to behave in a nonpunitive and acceptant manner toward a child's behavior and needs
- Consults with child when making decisions
- Gives reason for family rules
- Few demands for responsibility or orderly behavior
- Presents as a resource for th child to use as he/she wishes
- Allows child to regulate own behavior
- Does not encourage the child to adhere to defined standards
- Uses reason and manipulation to achieve desired goals

Effects of the Permissive Parent on the Child

- High Self-Esteem

- Better Social Skills

- Lower levels of depression

- Disengaged in school

- Higher chance of deviant behavior including drug and alcohol abuse

Use of Punishment

- Baurmind's research found that mild punishment can have a beneficial side effects because it can suppress unacceptable responses and/or behavior
- If punishment is to be used effectively and humanely by parents, they should remember...
  - Timing of the punishment in relationship to the inappropriate act
  - To accompany punishment with an explanation of what the desirable act should consist of or look like
- Baumrind is frequently quoted during discussions on spanking and corporal punishment. View a few recent articles for her thoughts.

    New York Times   APA.org   Irregular Times   APA.org

Additional Information on Parenting Styles

http://www.athealth.com/Practitioner/ceduc/parentingstyles.html

http://www.ericdigests.org/1999-4/parenting.htm

Additional articles on Parenting Styles and the effects on children

Amato, P.R. & Fowler, F. (2002). Parenting practices, child adjustment, and family diversity. *Journal of Marriage and the Family*, 64 (3) 703-716 .

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Julian, T.W., McKenry, P.C., & McKelvey, M.W. (1994). Cultural variations in parenting: Perceptions of caucasian, african-american, hispanic, and asian-american parents. *Family Relations*, 43 (1), 30-37.

Kandel, D.B. (1990). Parenting styles, drug use, and children's adjustment in families of young adult . *Journal of Marriage and the Family*, 52, (1), 183-196.

Wentzel, K.R. (2002). Are effective teachers like good parents? Teaching styles and student adjustment in early adolescence. *Child Development*, 73, (1) 287-301.

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Baumrind, D. (1966). Effects of Authoritative Parental Control on Child Behavior, *Child Development*, 37(4), 887-907.

Baumrind, D. (1967). Child care practices anteceding three patterns of preschool behavior. *Genetic Psychology Monographs, 75(1),* 43-88.

Dornbusch, S.M., Ritter, P.L., Leiderman, P.H., Roberts, D.F.,& Fraleigh, M.J. (1987). The relation of parenting

style to adolescent school performance. *Child Development,* 58(5), 1244-1257.

Lamborn, S.D., Mounts, N.S., Steinberg, L., & Dornbusch, S.M. (1991). Patterns of competence and adjustment

among adolescents from authoritative, authoritarian, indulgent, and neglectful families. *Child Development, 62 (5), 1049-1065.*

Weiss. L.H. (1996). The relationship between parenting types and older adolescents' personality, academic

achievement, adjustment, and substance abuse. *Child Development,* 67, 2101-2114.

Impact of multigenerational trauma on families: roles/relationships, esteem, and anger cont'd

- The traumatic stress one experiences in childhood impacts that same individual in their adult life.
- Childhood trauma affect the adult's ability to regulate emotions, maintain physical and mental health, engage in relationships, parent effectively, and maintain family stability.
- Parents' past or present experiences of trauma can also affect their ability to keep their children safe, work effectively with child welfare staff, and engage in their own or their children's mental health treatment.
- If you are a service provider working with the children and their families you will need to understand the birth parents' trauma history in order to provide effective service.

Birth Parents with Trauma Histories and the Child Welfare System: A Guide for Child Welfare Staff (2011). *National Child Traumatic Stress Network.*

Impact of multigenerational trauma on families: roles/relationships, esteem, and anger cont'd

It is important to note that while trauma does not affect every parent in the same way, and not all parents will develop posttraumatic reactions after a traumatic event, a history of traumatic experiences may:

• Create a challenge for parents to form and maintain secure and trusting relationships, including those with their children.

• Compromise parents' ability to make appropriate judgments about their own and their child's safety, e.g. overprotection and/or failing to notice situations that could be dangerous for their child.

• Impair parents' capacity to regulate their emotions, leading to ineffective coping strategies, such as abusing substances.

• Lead to poor self-esteem and a negative view of oneself as a parent, contributing to unhealthy interpersonal relationships.

• Negatively affect parents' feelings and behavior toward caseworkers, resource parents, and service providers–particularly when they experience or re-experience a loss of control.

• Make the family more vulnerable to other life stressors, including poverty, lack of education, and inadequate social support that can increase trauma reactions.

Birth Parents with Trauma Histories and the Child Welfare System: A Guide for Child Welfare Staff (2011). *National Child Traumatic Stress Network.*

Impact of multigenerational trauma on families: roles/relationships, esteem, and anger cont'd

What can a provider do?

• Watch for signs of a parent appearing numb, disengaged, or angry, and consider whether interactions with the child welfare and/or mental health system could be serving as reminders for that parent.

• Keep in mind that parents may be reminded of their trauma histories by their children's traumatic experiences or behavior, or by a traumatic event they went through with their children.

• Viewing birth parents through a "trauma lens" helps mental health professionals see how traumatic experiences have influenced their perceptions, feelings and behaviors.

• Work to establish a sense of safety, trust, personal choice, collaboration, and hope for the child and parent, and family to reach their goals.

• Building a strong therapeutic relationship acknowledging family and individual strengths.

• Understand the benefits of trauma-informed care, and know resources and referrals to support the healing of children and their families.

• Be familiar with the responses to and impact of trauma, including neurobiological (impact on the brain)

Birth Parents with Trauma Histories and the Child Welfare System: A Guide for Child Welfare Staff (2011). *National Child Traumatic Stress Network*.

Reflection:

- What are the legacies of multigenerational trauma in African-American families today?

References:

- Baumrind, Diana. Parenting Style and Its Correlates.
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  http://www.athealth.com/Practitioner/ceduc/parentingstyles.htmlhttp://www.ericdigests.org/1999-4/parenting.htm
- Birth Parents with Trauma Histories and the Child Welfare System: A Guide for Mental Health Professionals. (2011). Retrieved from http://www.nctsn.org/products/birth-parents-trauma-mental-health-professionals
- DeGruy, Joy. *Post Traumatic Slave Syndrome: America's Legacy of Enduring Injury and Healing*. Portland, OR: Joy DeGruy Publications, 2005. Print.
- Hardy, K., & Laszloffy, T. (1995, January 1). Therapy with African Americans and the Phenomenon of Rage. Retrieved from http://www.mass.gov/eohhs/docs/masshealth/cbhi/faculty-therapy-with-african-americans-and-phenomenon-of-rage.pdf
- McAdams-Mahmoud, V. (2008). Understanding Families in the Context of Cultural Adaptations to Oppression. In *Re-visioning Family Therapy* (2nd ed.). Guilford Press.

Session 4

Interrupting the Cycle

Presenter, in addition to the didactic here there are a number of articles that can be used as places for conversation. While there is a lot of content presented here, there should be lots of pauses provided for folks to think about how what they have been learning is impacting their work. This session is also strongly related and will link up to the session on evidence based practice. If you feel its necessary you can reference or bring back these slides in that session

Session 4: Interrupting the Cycle

- **Our stories**
  - A window into families and their experiences
  - Connecting with both the struggles and the resilience of these families
- **Didactic**
  - Presentation of information: facts, figures, theories etc.
  - Also presentation of videos
- **Self Reflection**
  - In class: guiding questions to help us explore, connect and make meaning
  - Journaling: an opportunity to continue to reflect, and opportunity for those
- **Resources**
  - Links to original references
  - Other places to learn and explore

Our Stories

VOICES: Hearing from African American Families about Trauma (13 min)

(n.d.). Retrieved from
https://umconnect.umn.edu/aafamtrauma1/

- Initial group reactions (10 mins.)
- Film Discussion

Didactic: Resilience Among Trauma Survivors

A full understanding of the resilience that trauma survivors may bring to the challenge of trauma recovery requires that clinicians and researchers attend to the influence of cultural and contextual mediators of traumatic. While symptoms of PTSD have been found among trauma survivors of both genders, all ages, and diverse racial, ethnic, and cultural groups, it is also true that particular events (e.g., incest, rape, or spousal abuse) and symptoms (e.g., dissociation, somatic complaints) may have quite different meanings in different cultural contexts. Cultural and community values exert profound influence over a victim's willingness to disclose (or not) a particular incident of violation or abuse, for example, and cultural interpretations of the events to which they have been exposed shape survivors' own understandings of these events. Finally, cultural groups may differ considerably in their definitions of what is and is not resilient.

Harvey, M. R. (2007) Towards an Ecological Understanding of Resilience in Trauma Survivors: Implications for Theory, Research, and Practice. Hawthorne Press Inc.

Use of the Trauma Model to Address The Impact of Racial Trauma on African Americans

- The impact of racial experiences on the functioning of African Americans in the United States as traumatic.
- Traumatic experiences and recovery from trauma explains the impact of stressful social experiences on African Americans in a way that explains some of the variations in functioning that is observed.
- The trauma model does not focus on pathology and it explains both poor and exemplary responses to stressful events.
- The trauma model suggests the recovery of African Americans from real or perceived dangers will vary, and in large numbers of persons can be seen across a continuum of recovery.
- Furthermore, the model makes specific suggestions about how to intervene to improve functioning. Many of these interventions are cost effective and non-stigmatizing.

Smith, W.H. (2010). *The Impact of Racial Trauma on African Americans*. African American Men and Boys Advisory Board . The Heinz Endowments.

Many of us observe variations in levels of functioning of persons with similar experiences. For example, two children live in the same family, with the same parents, and share many similar experiences and challenges. Yet, one child seems to have little problems managing and coping with stresses, and the other child has severe psychological symptoms with little stress.

The Trauma Model

- A traumatic event overwhelms the nervous system because there is real or perceived danger. We organize our functioning to respond and cope with the threat to our life. As our nervous systems do not very well distinguish between real and perceived threats, what is dangerous is not universal among humans. As a result, threatening acts and behaviors are not the determinant of what is traumatic but it is the child's or parent's perception of danger that determines what is traumatic.

- Because perception shapes what is dangerous, past experiences become important in understanding how people interpret what situations and experiences are dangerous.

- When threatened, living organisms respond in four basic ways: physical distance, emotional withdrawal, freeze, and aggression. These variations in response to the same threat routinely occur with any threat and dangerous circumstance. No one response is universally best or wrong.

Smith, W.H. (2010). *The Impact of Racial Trauma on African Americans*. African American Men and Boys Advisory Board . The Heinz Endowments.

As our nervous systems do not very well distinguish between real and perceived threats EXAMPLE: A parent raising a fist and threatening violence may cause one child to laugh and another child to withdraw in fear. The laughing child could be old enough to know the parent was joking, but the younger, frightened child was traumatized by the threat of injury. In another example, a racial joke that most people in an office finds humorous can make the workplace dangerous for an African American employee that identifies with the character in the joke.

Perception shapes what is dangerous EXAMPLE: A man, who as a boy was traumatized by domestic violence characterized by loud, shouting battles between his parents, becomes nervous and agitated when in a crowd of excited, elated football fans. The man holds his seven-year old son's hand while in the crowd and the son associates his father's fear with the crowd noise. The boy becomes nervous in crowds. This example not only illustrates the role of perception in determining what is dangerous but also illustrates how we can learn what is dangerous through relationships and not merely by direct experience.

Traumas Related to Race

Racism and other social biases describe social conditions that contain traumatic events for large numbers of persons. Traumas related to race have three forms:

1. *African Americans experience specific events of danger related to race that overwhelm the nervous system and require them to recover. These dangers may be real or perceived discrimination, threats of harm and injury, police incidents, and humiliating and shaming events.*

    - The aggressors may be black or white. These events stand out in their memory and have long-term impact on their perception of themselves and their social environments.

    - Some African Americans are stronger after recovering from these events, and others have long-term declines in their ability to cope with future stresses and threats.

Smith, W.H. (2010). *The Impact of Racial Trauma on African Americans.* African American Men and Boys Advisory Board . The Heinz Endowments.

Traumas Related to Race

2. *A second way African Americans experience danger is witnessing harm and injury to other African Americans because of real or perceived racism.*

   - This secondary trauma is widely recognized in the child abuse treatment field and occurs to therapists that repeatedly experience the traumas of abused children.

   - Repeatedly witnessing African Americans suffering on television news is painful, and for some triggers very strong emotion.

   - For example, the Rodney King incident triggered very strong emotional reactions to a publically viewed altercation between police and an African American male. Of course, not every African American watching the incident on television is traumatized but some viewers experienced traumatic responses and needed to recover.

Traumas Related to Race

3. *A third way African Americans experience danger related to race is living in difficult social conditions because of poverty and race, and traumatic events occur because of these conditions.*

    - Segregation by race and social class is common in the United States, and very common. Living in black and poor neighborhoods increases one's risk of experiencing traumatic events like community violence, police incidents, and domestic violence, and it increases the risk of experiencing secondary traumas in witnessing these dangers.

    - These communities are socially isolated, monitored vigorously by police, have fewer resources for daily living (food stores, gasoline stations, hardware stores), and have high levels of exposure to drugs and alcohol.

The Two Phases of Trauma

The experience of trauma occurs in two phases.

Arousal Phase:

- Nervous system ramps up to respond and manage the threat.
- Sense of time narrows to the present and we loose our focus on the future.
- Become less empathetic and more self-centered, and shift to fight-flight and other primitive responses.
- Vigilantly scan our environment to look for more danger.
- Gravitate to persons similar to us and become more suspicious of people different from ourselves.
- Having control over our lives becomes important to experiencing the world as safer and less dangerous.
- *Resilience response:* The best functioning people are able to plan and decide the best course of action while emotionally aroused by the trauma. These persons can creatively invent new responses to threats and dangers, and they can quickly self-correct if a way of responding is not working.

Smith, W.H. (2010). *The Impact of Racial Trauma on African Americans*. African American Men and Boys Advisory Board . The Heinz Endowments.

The Two Phases of Trauma

Recovery Phase:

- The recovery phase of trauma is how we cope with danger once it is over.

- The best functioning persons learn from the traumatic experiences, become more confident about managing future threats and challenges, and gain improved coping skills.

- Poor recovery from trauma takes many forms, but generally persons live as if the trauma is ever-present.

- Remain vigilant and sensitive to possible dangers.

- Experience intense emotional responses to small threats.

- Avoid situations, people, relationships and events that trigger re-experiencing danger or strong emotions.

- Experience numbness and do not accurately perceive dangers and real threats.

- One way to remain numb is to re-create dangerous situations that re-trigger numbness or to numb one's self with food, alcohol, drugs, helping others, work, and exercise.

- *Resilience Response*: Functioning is better after recovery than before the trauma, and a way to use the traumatic experience to make their lives more meaningful and purposeful is found.

Smith, W.H. (2010). *The Impact of Racial Trauma on African Americans*. African American Men and Boys Advisory Board . The Heinz Endowments.

Potential Responses to Trauma of African Americans Living in Racially Segregated Neighborhoods

- **Increase aggression** – Street gangs, domestic violence, defiant behavior, and appearing tough and impenetrable are ways of coping with danger by attempting to control our physical and social environment
- **Increase vigilance and suspicion** – Suspicion of social institutions (schools, agencies, government), avoiding eye contact, only trusting persons within our social and family relationship networks
- **Increase sensitivity to threat** – Defensive postures, avoiding new situations, heightened sensitivity to being disrespected and shamed, and avoid taking risks
- **Increase psychological and physiological symptoms** – Unresolved traumas increase chronic stress and decrease immune system functioning, shift brains to limbic system dominance, increase risks for depression and anxiety disorders, and disrupt child development and quality of emotional attachment in family and social relationships
- **Increase alcohol and drug usage** – Drugs and alcohol are initially useful (real and perceived) in managing the pain and danger of unresolved traumas but become their own disease processes when dependency occurs
- **Narrowing sense of time** – Persons living in a chronic state of danger do not develop a sense of future, do not have long-term goals, and frequently view dying as an expected outcome

Smith, W.H. (2010). *The Impact of Racial Trauma on African Americans.* African American Men and Boys Advisory Board . The Heinz Endowments.

Signs of Resiliency and Recovery From Trauma

How one responds and copes with a traumatic event shapes how one copes with future stresses. The indicators of successful recovery include the:

- Ability to develop an explanation of what happened that accurately accounts for when future dangerous situations will occur (not over-generalizing or denying)
- Ability to manage traumatic experiences so that they do not interfere with our ability to achieve important life goals (not blaming self or others; not helplessness)
- Ability to self-regulate emotional arousal and thoughtfully assess if future situations are dangerous (not react to every perception of danger)
- Ability to use family and social relationships to manage trauma
- Ability to find meaning and purpose from the traumatic experience

Smith, W.H. (2010). *The Impact of Racial Trauma on African Americans.* African American Men and Boys Advisory Board . The Heinz Endowments.

Characteristics of Supportive Trauma Interventions

• Help that does not label, categorize or diagnosis recipients as having a "problem."

• Help that creates opportunities for children, teens, and adults to tell their stories of trauma, and re-process and re-interpret what occurred to accurately attribute responsibility and causation.

• Help that teaches yoga, marital arts, meditation, diaphragmic breathing, and other forms of emotional self-regulation, and assures they are regularly practiced and applied when stresses and threats of danger escalate.

• Help that empowers recipients to have control over the kind, type, direction, and amount of their help.

• Helps that uses successful survivors of trauma to guide others.

• Help that explores, teaches, and practices specific alternative responses and behaviors to future dangers.

• Help that teaches information about trauma and its impacts.

Smith, W.H. (2010). *The Impact of Racial Trauma on African Americans*. African American Men and Boys Advisory Board . The Heinz Endowments.

Characteristics of Supportive Trauma Interventions

- Recovery group experiences that are structured to help recipients learn personal responsibility for managing their responses to trauma and teaches specific alternative ways of managing traumatic reactions when they reappear.
- Help that prepares recipients to relinquish past ways of adapting to trauma, and prepares them to experience increased anxiety, fear, and stress during recovery.
- Help that exposes isolated children, teens, and adults to social experiences of the larger society.
- Emotional support by itself is not enough to resolve trauma. Merely talking about the traumatic event does not resolve trauma. Recipients must re-experience the trauma and change their understanding of what has occurred.
- Do not place recipients in groups that reinforce their current view of trauma.
- Help must not encourage recipients to avoid re-experiencing the trauma – avoidance is a common symptom of post-traumatic stress.

Smith, W.H. (2010). *The Impact of Racial Trauma on African Americans*. African American Men and Boys Advisory Board . The Heinz Endowments.

SUPPORTIVE INTERVENTIONS for
Mental Health Professionals

Whether your role is that of the parent provider, child provider, or family provider, there are certain things mental health professionals can do:

- Know that many parents involved in the child welfare system have their own trauma histories. You will be more successful in engaging them in treatment (their children's or their own) if you first establish a sense of safety, trust, personal choice, collaboration, and hope for reaching their goals.

- Keep in mind that parents may be reminded of their trauma histories by their children's traumatic experiences or behavior, or by a traumatic event they went through with their children. Watch for signs of a parent appearing numb, disengaged, or angry, and consider whether interactions with the child welfare and/or mental health system could be serving as reminders for that parent.

Birth Parents Trauma Resource for Mental Health Professionals. (n.d.). Retrieved April 15, 2015, from http://www.nctsn.org/products/birth-parents-trauma-mental-health-professionals

SUPPORTIVE INTERVENTIONS for
Mental Health Professionals

- Identify opportunities for the child and parent to use their strengths and develop skills to make sense of—and achieve mastery over—their traumatic experiences. Help channel parents' desires to be effective and supportive of their children.

- Empower parents to participate in meetings and to play a role in choosing services and goals. With appropriate help, parents will feel more supported by the child welfare system and, in turn, will be more able to support their children.

- Provide psycho-education about the impact of trauma on both parents and children. By talking about how trauma can affect parents and their children generally, clinicians can start a conversation and begin to promote safety, trust, and collaboration. For many parents, hearing a professional say that there is a connection between their traumatic events and their present reactions can empower and motivate them to make positive changes.

Birth Parents Trauma Resource for Mental Health Professionals. (n.d.). Retrieved April 15, 2015, from
http://www.nctsn.org/products/birth-parents-trauma-mental-health-professionals

Supportive Interventions for
Caseworkers/Child Welfare Workers

- Understand that parents' anger, fear, or avoidance may be a reaction to their own past traumatic experiences, not to the caseworker him/herself.

- Assess a parent's history to understand how past traumatic experiences may inform current functioning and parenting.

- Remember that traumatized parents are not "bad" and that approaching them in a punitive way, blaming them, or judging them likely will worsen the situation rather than motivate a parent.

- Build on parents' desires to be effective in keeping their children safe and reducing their children's challenging behaviors.

- Help parents understand the impact of past trauma on current functioning and parenting, while still holding them accountable for the abuse and/or neglect that led to involvement in the system. For many parents, understanding that there is a connection between their past experiences and their present reactions and behavior can empower and motivate them.

Birth Parents Trauma Resource for Case Workers. (n.d.). Retrieved April 15, 2015, from http://www.nctsn.org/products/birth-parents-trauma-histories-and-child-welfare-system

Supportive Interventions: Treatment Resources

What Treatment Resources are best for treating children and parents affected by trauma?

- To optimize their ability to support their children's recovery, some parents may need to work on their own trauma issues in individual therapy. Generic interventions that are not trauma-informed—such as anger management or parenting classes—will often be ineffective in addressing these needs. Fortunately, there are many evidenced-supported trauma interventions for both adults and children.

- Mental health professionals should choose interventions that address the needs of the family while taking into account clinical focus, level of intervention, phase of treatment, and co-occurring disorders.

Birth Parents Trauma Resource for Mental Health Professionals. (n.d.). Retrieved April 15, 2015, from http://www.nctsn.org/products/birth-parents-trauma-mental-health-professionals

Supportive Interventions

Many effective trauma treatments include the following components:

- Building a strong therapeutic relationship acknowledging family and individual strengths
- Psycho-education about responses to trauma, including neurobiological (impact on the brain)
- Relational engagement and attachment
- Enhancing family and social supports
- Emotional expression and self-regulation skills
- Cognitive processing or reframing

Birth Parents Trauma Resource for Mental Health Professionals. (n.d.). Retrieved April 15, 2015, from http://www.nctsn.org/products/birth-parents-trauma-mental-health-professionals

Supportive Interventions

When working directly with parents, assess for co-morbid conditions, such as depression, substance abuse, anxiety, and dissociation. Substance use—which may be a way the parent copes with posttraumatic symptoms—can heighten trauma-related symptoms. When treating parents with trauma reactions and substance abuse problems, clinicians should treat the two problems in an integrated manner, rather than sequentially.

Birth Parents Trauma Resource for Mental Health Professionals. (n.d.). Retrieved April 15, 2015, from http://www.nctsn.org/products/birth-parents-trauma-mental-health-professionals

REFLECTION

- In what ways can you as a provider to African American children and families interrupt the cycle of trauma within your work?

- What are new practices you plan to implement into your approach and work with clients that has the intended goal?

- What kind of support and/or knowledge will you need to be more effective with your practices and interventions while implementing these new and future practices?

References

Birth Parents Trauma Resource for Mental Health Professionals. (n.d.). Retrieved April 15, 2015, from
http://www.nctsn.org/products/birth-parents-trauma-mental-health-professionals

Birth Parents Trauma Resource for Case Workers. (n.d.). Retrieved April 15, 2015, from
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Trauma-Informed Child Welfare Practice. (n.d.). Retrieved April 15, 2015, from
http://cascw.umn.edu/portfolio-items/winter-2013-cw360/

Smith, Jr., Ph.D, W. (2010, February 16). The Impact of Racial Trauma on African Americans. Retrieved April 15, 2015, from
www.heinz.org/.../ImpactOfRacialTraumaOnAfricanAmericans.pdf

Psychosocial Determinants of Health

Session 5

To the instructor, if possible have the participants read either or both of the articles attached as resources. You can structure this session as more didactic heavy and use the power point slides attached in the folder, or you can use both of the videos attached which provide good overview for the ACES study. Then discussion should focus on how this information fits with prior sessions, and also be focused on thinking about how providers can begin to address these issues and be allies to African American families. Suggestions for this section include individual reflection after video, paired sharing and doing a open report out of all participants.

Please note that the presentation is pulled from the following website: http://www.acesconnection.com/blog/presentations they state the following about its use: These PowerPoints, videos and webinars focus on the ACE Study,and trauma-informed and resilience-building practices. They are available for anyone to use. To be useful for ACEsConnection members, this list strives to point out the best presentations; it's not meant to be all-inclusive. We welcome additions! If you have other presentations that you'd like to see added to this list, send the link in a message to Jane Stevens, ACEsConnection manager.

Our Stories

- Lets watch Nadine Burke Harris, a local doctor talk about her work- and see her as an example of resilience in our community

Retrieved from (n.d.).
http://www.youtube.com/watch?v=wgnJsTVSsd4

To the presenter please note that Dr. Burke Harris also has a Ted talk with similar information.

What is the ACEs

- You can either review detail from the attached slides in the resources section and/or watch the following videos:
- http://www.youtube.com/watch?v=P9wp449hc0M
- http://www.youtube.com/watch?v=_3ugrwJkK5k
- The entire series is actual very interesting and helpful, the series is:
- IIMLH Trauma Across the Lifespan

Didactic

- ACES study

- Please see the attached slide show which DETAILS the ACES study:
- **Vincent J. Felitti, M.D**
- **Robert F. Anda, M.D**

Discussion

- How does this information fit with what we have learned about trauma experiences within the African American community?

Reflection

- What are the similarities that you see in the families you serve
- How does this impact the services you provide

Resources

- Walla walla washington article

Retrieved from (n.d.).
http://acestoohigh.com/2012/04/23/lincoln-high-school-in-walla-walla-wa-tries-new-approach-to-school-discipline-expulsions-drop-85/

- Measure Y data from Oakland Retrieved from (n.d.).
http://oaklandunite.org/wp-content/uploads/2011/05/RFP-Needs-Assessment-DRAFT-v-1.pdf

Works Cited/Referenced

- Felitti, V. J., & Anda, R. F. (1997.)The Adverse Childhood Experiences (ACE) Study. Centers for Disease Control and Prevention. Retrieved from http://www.cdc.gov/ace/index.htm

The Relationship of Adverse Childhood Experiences to Adult Health Status

A collaborative effort of Kaiser Permanente and The Centers for Disease Control

Vincent J. Felitti, M.D.
Robert F. Anda, M.D.

Retrieved from http://www.thenationalcouncil.org/wp-content/uploads/2012/11/Natl-Council-Webinar-8-2012.pdf

For permission see: http://www.thenationalcouncil.org/consulting-best-practices/national-council-shareables/

The Adverse Childhood Experiences (ACE) Study

- The largest study of its kind ever done to examine the health and social effects of adverse childhood experiences over the lifespan (18,000 participants)

What do we mean by Adverse Childhood Experiences?

- Experiences that represent medical and social problems of national importance.
  - childhood abuse and neglect
  - growing up with domestic violence, substance abuse or mental illness in the home, parental loss, or crime

This slide presents the ACE study design. It is formatted into three sections.

The first section presents information about the surveys. Survey Wave 1 is complete. Out of a population of 15,000 people, 13,454 were contacted and 9,508 responded. This is a 71 percent response rate. All medical evaluations were abstracted.

Survey Wave 2 also has a sample size of 15,000. Medical evaluations are being abstracted.

The second section states the study is examining the present health status of the participants.

The third section indicates the study further examines mortality with National Death Index data as well as morbidity from data on hospital discharge, outpatient visits, emergency room visits, and pharmacy utilization.

The Adverse Childhood Experiences (ACE) Study

Summary of Findings:
- Adverse Childhood Experiences (ACEs) are very common
- ACEs are strong predictors of later health risks and disease
- This combination makes ACEs *the leading* determinant of the health and social well-being of our nation

Categories of Adverse Childhood Experiences

	Category Prevalence (%)
Abuse, by Category	
Psychological (by parents)	11%
Physical (by parents)	11%
Sexual (anyone)	22%
Household Dysfunction, by Category	
Substance Abuse	26%
Mental Illness	19%
Mother Treated Violently	13%
Imprisoned Household Member	3%
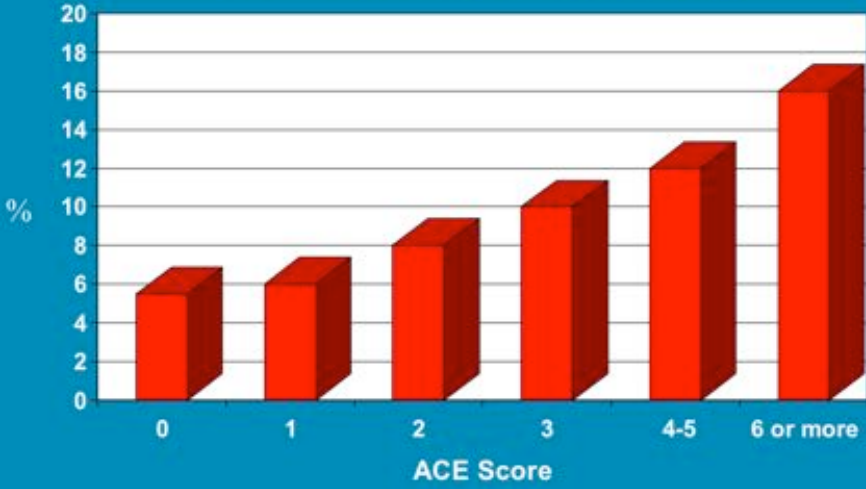
This slide is a bar chart representing adverse childhood experiences versus current smoking.

ACE Score	Percentage
0	5.5
1	6
2	8
3	10
4 to 5	12
6 or more	16

This slide is titled smoking to self-medicate and contains a picture of a middle-aged man.
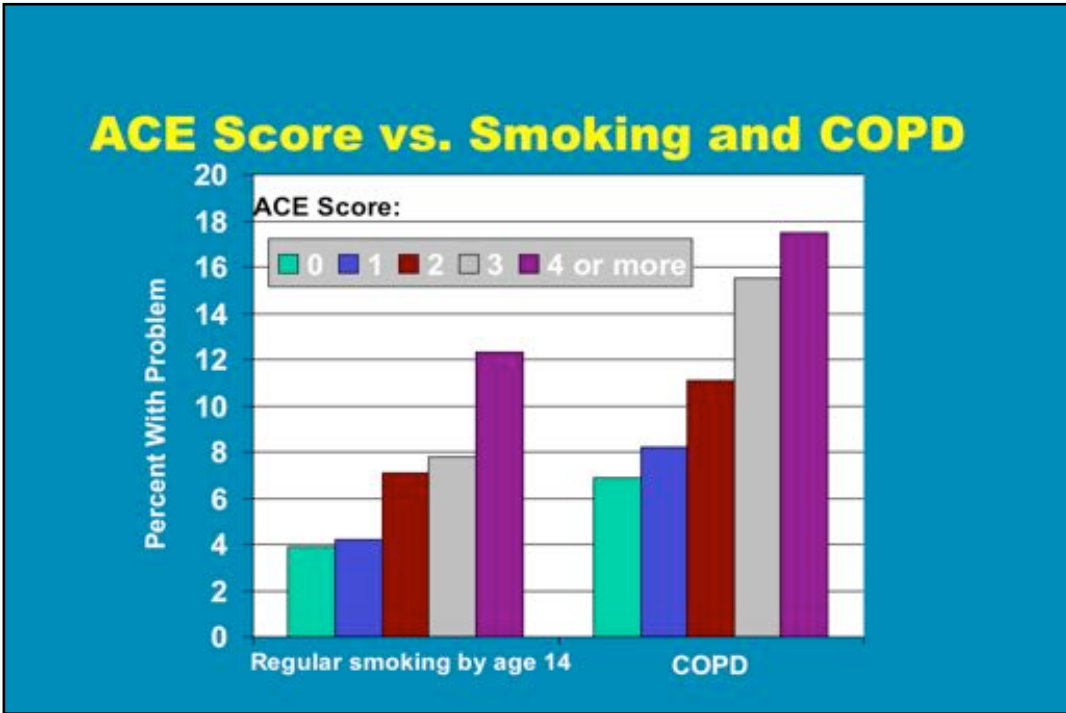
This slide has a bar graph titled ACE score versus smoking and COPD (chronic obstructive pulmonary disease).

ACE Score	Regular smoking by age 14 (percent with problem)	COPD (percent with problem)
0	3.9	6.9
1	4.2	8.2
2	7.1	11.1
3	7.8	15.5
4 or more	12.3	17.5

This slide is titled molestation in childhood and has a picture of a heavy-set, middle-aged woman.
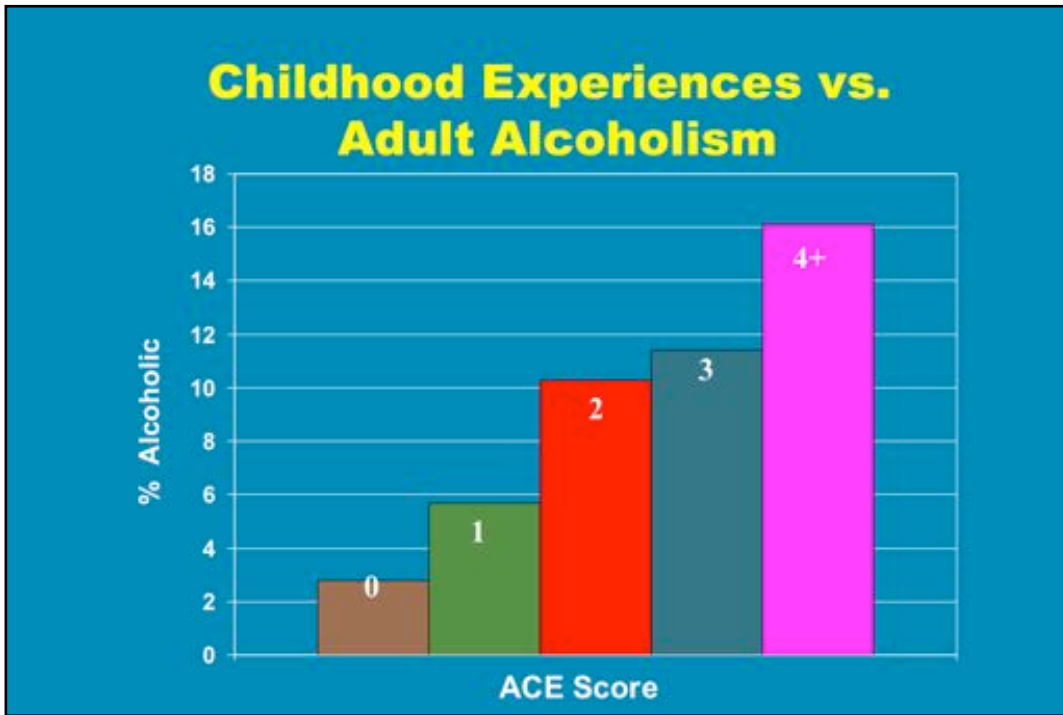
This slide is a bar chart titled child experiences versus adult alcoholism.

ACE score

Percent alcoholic

0

2.8

1

5.7

2

10.3

3

11.4

4 or more 16.1

Some say depression is genetic.
Some say depression is due to a chemical imbalance.

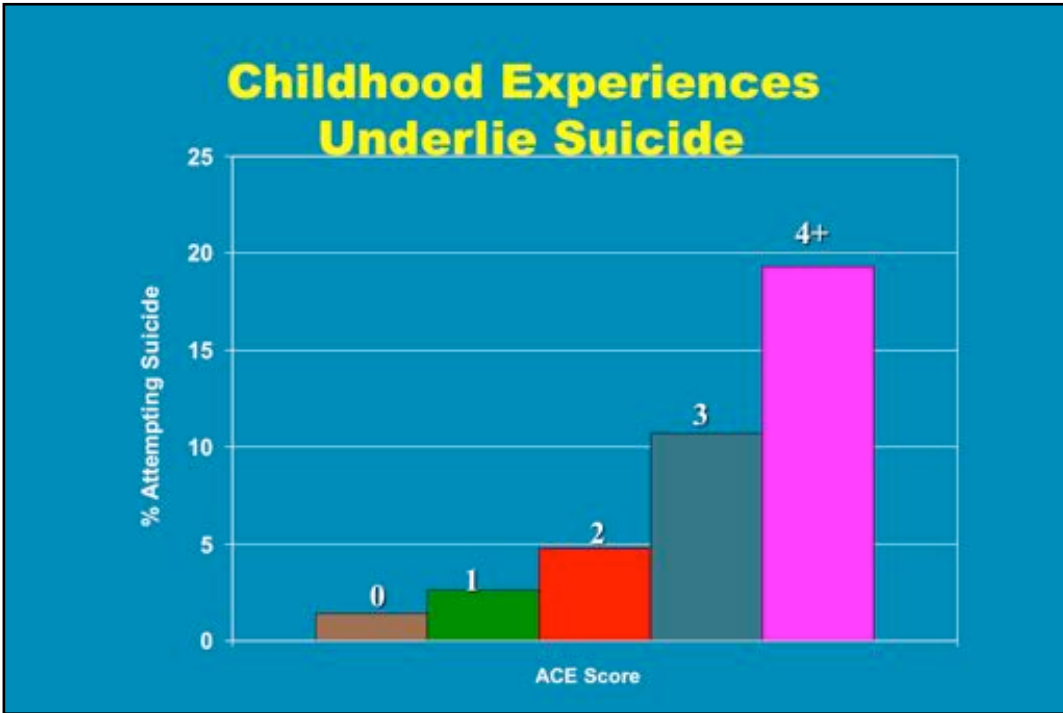Might depression be a *normal* response to *abnormal life experiences*?

Childhood Experiences Underlie Chronic Depression
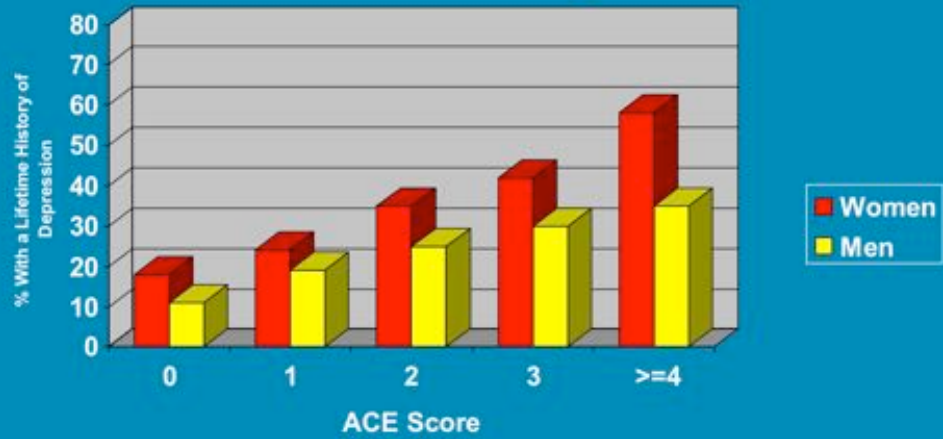
This slide contains a bar graph titled childhood experiences underlie chronic depression with statistics on the percentage of women and men with a lifetime history of depression.

ACE Score	Percentage of Women	Percentage of Men
0	18	11
1	24	19
2	35	25
3	42	30
Greater than or equal to 4	58	35

This slide contains a bar graph titled childhood experiences underlie suicide and presents ACE scores and the percentage of people attempting suicide.
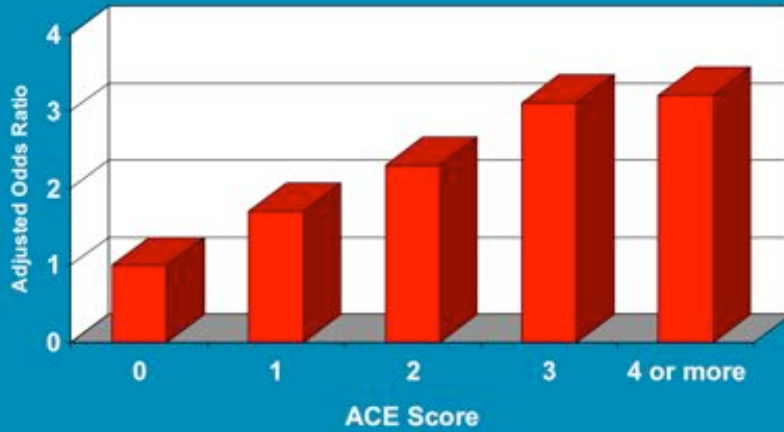
ACE Score	Percent attempting suicide
0	1.4
1	2.6
2	4.8
3	10.7
4 or more	19.3

Estimates of the Population Attributable Risk*
of ACEs for Selected Outcomes in Women

Mental Health	PAR
Current depression	54%
Chronic depression	41%
Suicide attempt	58%

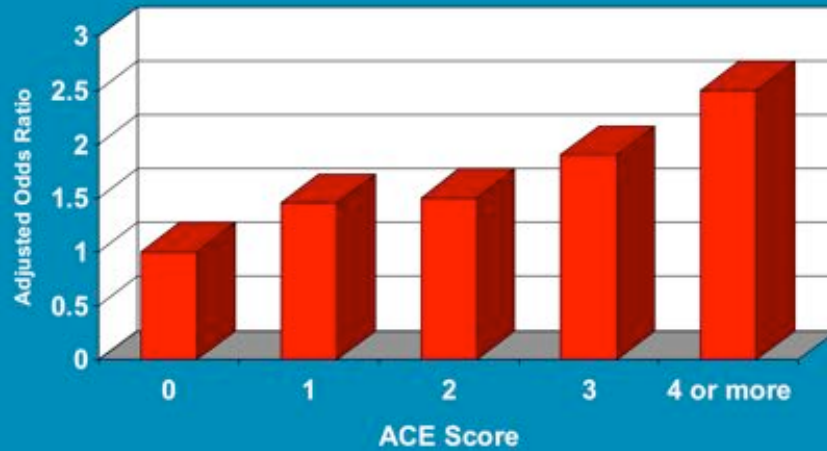*That portion of a condition attributable to specific risk factors

This slide is a bar graph titled adverse childhood experiences versus likelihood of more than 50 sexual partners.

ACE Score	Adjusted Odds Ratio
0	1
1	1.7
2	2.3
3	3.1
4 or more	3.2

This slide contains a bar graph titled adverse childhood experiences versus history of STD (sexually transmitted disease).

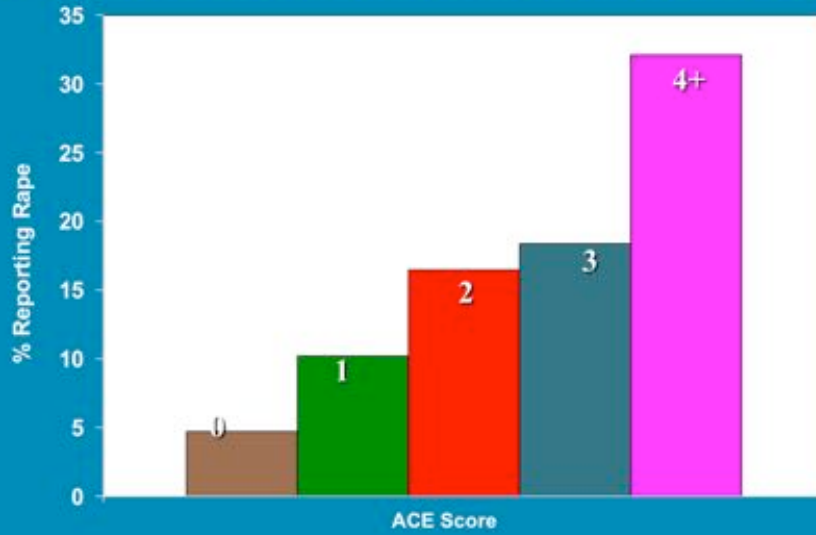| ACE Score	Adjusted Odds Ratio
0	1
1	1.45
2	1.5
3	1.9
4 or more	2.5

Adverse Childhood Experiences and the Risk of:

| ACE Score	Multiple Sexual Partners*	3 or More Marriages*	Had Unwanted Pregnancy* (abortion)
0	1.0	1.0	1.0
1	1.6	1.5	1.5
2	1.9	1.6	1.7
3	3.4	2.3	2.3
4	4.4	2.9	2.1
≥5	5.8	3.8	2.9

*Adjusted Odds Ratio

This slide is a bar chart titled childhood experiences underlie rape and presents the ACE scores and percentage of people reporting rape.

ACE Score	Percent reporting rape
0	4.7
1	10.2
2	16.5
3	18.4
4 or more	32.1
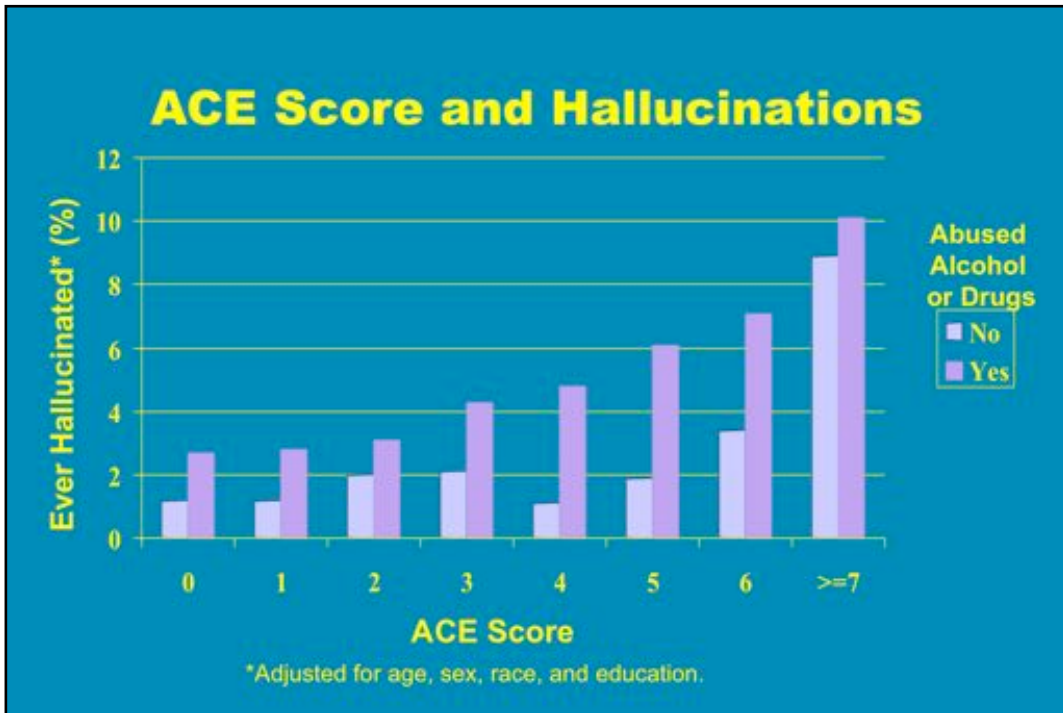
This slide is a bar graph titled ACE score and hallucinations. It presents the ACE scores of people who had abused alcohol or drugs and people who had not and the percent of each who had ever hallucinated. (Adjusted for age, sex, race, and education.)

ACE Score hallucinated	Percentage of ever hallucinated	Percentage of not ever
0	1.2	2.7
1	1.2	2.8
2	2	3.1
3	2.1	4.3
4	1.1	4.8
5	1.9	

Adverse Childhood Experiences and the Risk of:

ACE Score	Intimate Partner Violence*	Being Raped*
0	1.0	1.0
1	1.9	2.0
2	2.1	2.8
3	2.7	4.2
4	4.5	5.3
≥5	5.1	8.9

*Adjusted Odds Ratio

Estimates of the Population Attributable Risk*
of ACEs for Selected Outcomes in Women

	PAR
Depression and Suicide	48%
Crime Victim	
Sexual Assault	62%
Domestic Violence	52%

*That portion of a condition attributable to specific risk factors

We find that:

"Addiction highly correlates with characteristics intrinsic to that individual's childhood experiences."
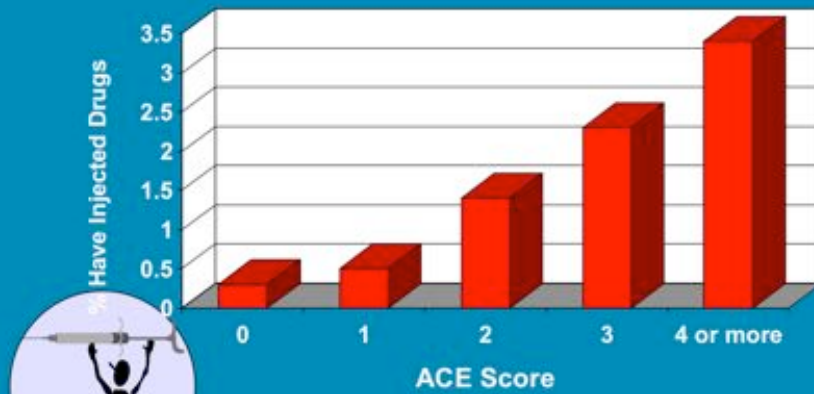
This slide is a bar graph titled ACE score versus intravenous drug use. It presents ACE scores and the percent of people who had injected drugs. The population size is 8,022 and the confidence level is less than .001.

ACE Score	Percent that have injected drugs
0	.3
1	.5
2	1.4
3	2.3
4 or more	3.4

Adverse Childhood Experiences and the Risk of:

ACE Score	Alcoholism*	Parenteral Drug Abuse*	Attempted Suicide*
0	1.0	1.0	1.0
1	1.9	1.0	1.8
2	2.1	2.5	4.0
3	2.7	3.5	4.0
4	4.5	3.8	7.2
≥5	5.1	9.2	16.8

*Adjusted Odds Ratio

Estimates of the Population Attributable Risk*
of ACEs for Selected Outcomes in Women

Drug Abuse	PAR
Alcoholism	65%
Drug abuse	50%
IV drug use	78%

*That portion of a condition attributable to specific risk factors

Adverse Childhood Experiences determine the likelihood of the ten most common causes of death in the United States.

Top 10 Risk Factors: smoking, severe obesity, physical inactivity, depression, suicide attempt, alcoholism, illicit drug use, injected drug use, 50+ sexual partners, history of STD (sexually transmitted disease).

With an ACE Score of 0, the
majority of adults have few,
if any, risk factors for these diseases.

However, with an ACE Score of 4 or more, the majority of adults have multiple risk factors for these diseases or the diseases themselves.

Effect of ACEs on Mortality
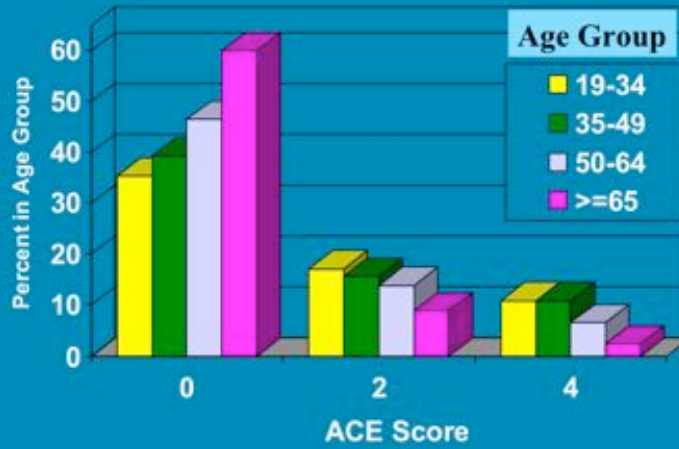
This slide is a bar graph titled effect of ACEs on mortality and presents statistics for the age groups of 19 to 34, 35 to 49, 50 to 64, and 65 and older.

ACE Score	Percent aged 19 to 34	Percent aged 35 to 49	Percent aged 50 to 64	Percent aged 65 and older
0	35.4	39.3	46.5	60
2	17.2	15.6	13.9	8.9
4	10.9	10.9	6.6	2.4

Many chronic diseases in adults are determined decades earlier, in childhood.
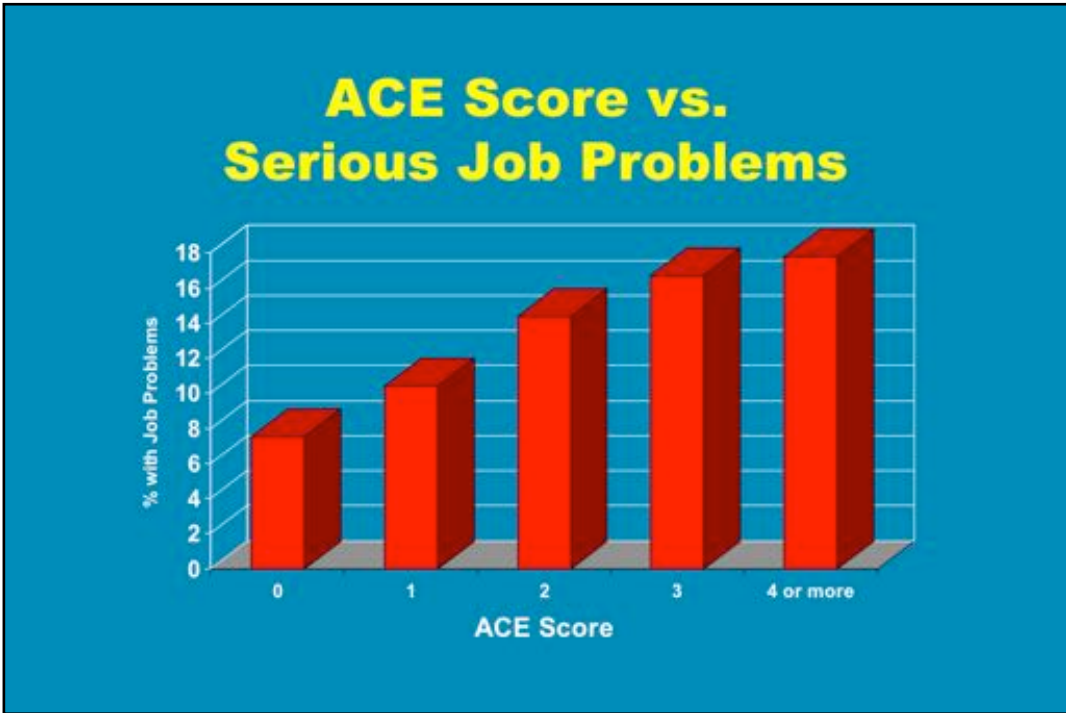
Their risk factors are also reliable markers for antecedent problems.

"In my end is my beginning."

T.S. Eliot - Quartets

Dismissing them as "bad habits" or "self-destructive behavior" totally misses their function.

This slide is a bar graph titled ACE score versus serious job problems.

ACE Score	Percent with Job Problems
0	7.5
1	10.4
2	14.4
3	16.7
4 or more	17.8

Much of what causes time to be lost from work is actually predetermined decades earlier by the adverse experiences of childhood.

Premature mortality and excess morbidity are typically the result of a small number of common diseases.

ACE = Parental Loss

Evidence from ACE Study Suggests:
These chronic diseases in adults are determined decades earlier, by the experiences of childhood.

Affective Response

Evidence from ACE Study Suggests:

Risk factors for these diseases are initiated during childhood or adolescence . . .
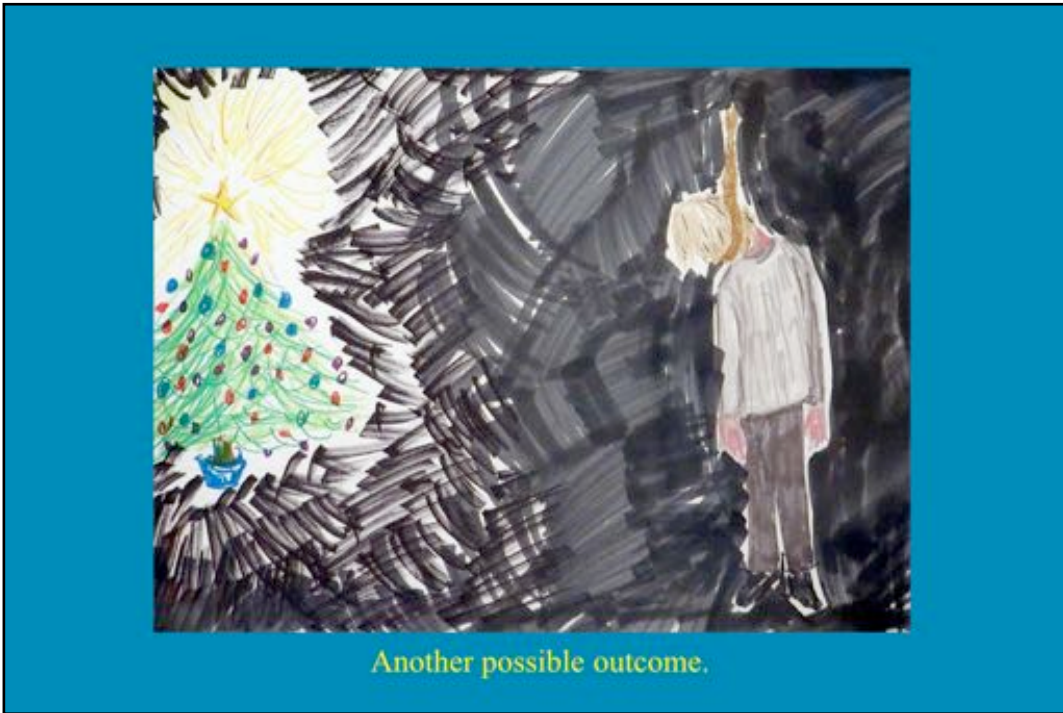
Seeking to Cope

Another possible outcome.

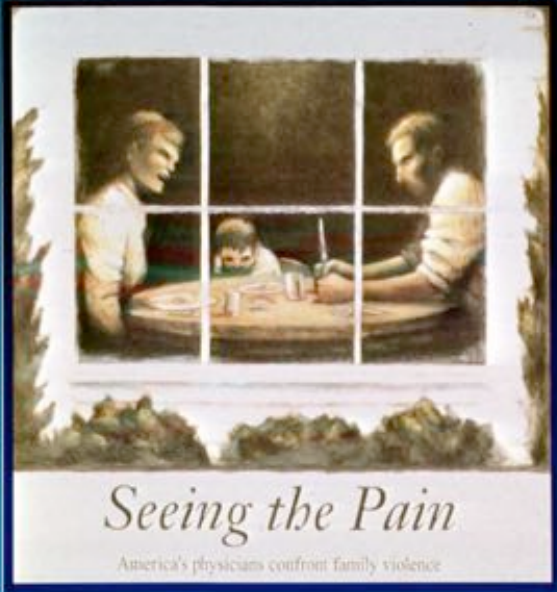This slide has a drawn picture of a person by a Christmas tree who has committed suicide by hanging.

Seeing the Pain

America's physicians confront family violence

Why is this so difficult to treat later?

CDC

This slide is a sketch with a caption of seeing the pain – America's physicians confront family violence. It consists of a mother, father, and child sitting around a dinner table. The mother and father appear to be arguing.

This slide shows positron emission tomography (PET) scan graphics of the temporal lobes in a healthy and abused brain.

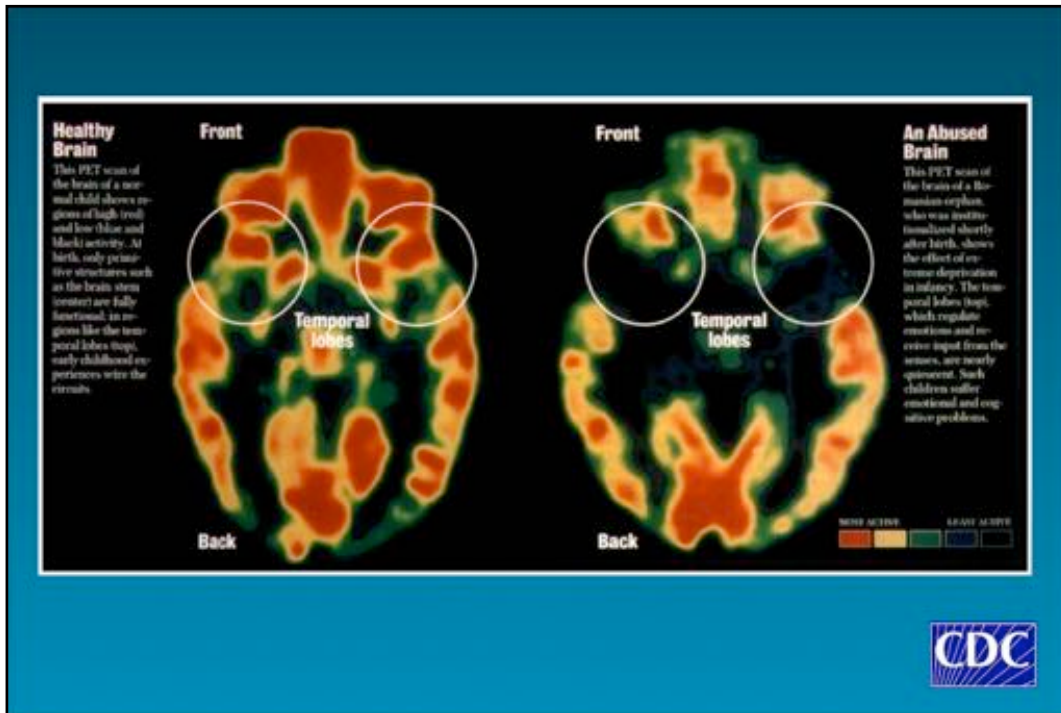Healthy brain: this PET scan of the brain of a normal child shows regions of high (shown in red) and low (shown in blue and black) activity. At birth, only primitive structures such as the brain stem (in the center of the brain graphic) are fully functional; in regions like the temporal lobes (at the top of the graphic), early childhood experiences wire the circuits.

Abused brain: this PET scan of the brain of a Romanian orphan, who was institutionalized shortly after birth, shows the effect of extreme deprivation in infancy. The temporal lobes (at the top of the graphic), which regulate emotions and receive input from the senses, are nearly quiescent. Such children suffer emotional and cognitive problems.

What is conventionally
viewed as a problem
is actually a solution to
an unrecognized prior
adversity.

Evidence from ACE Study Suggests:

Adverse childhood experiences are the most basic cause of health risk behaviors, morbidity, disability, mortality, and healthcare costs.
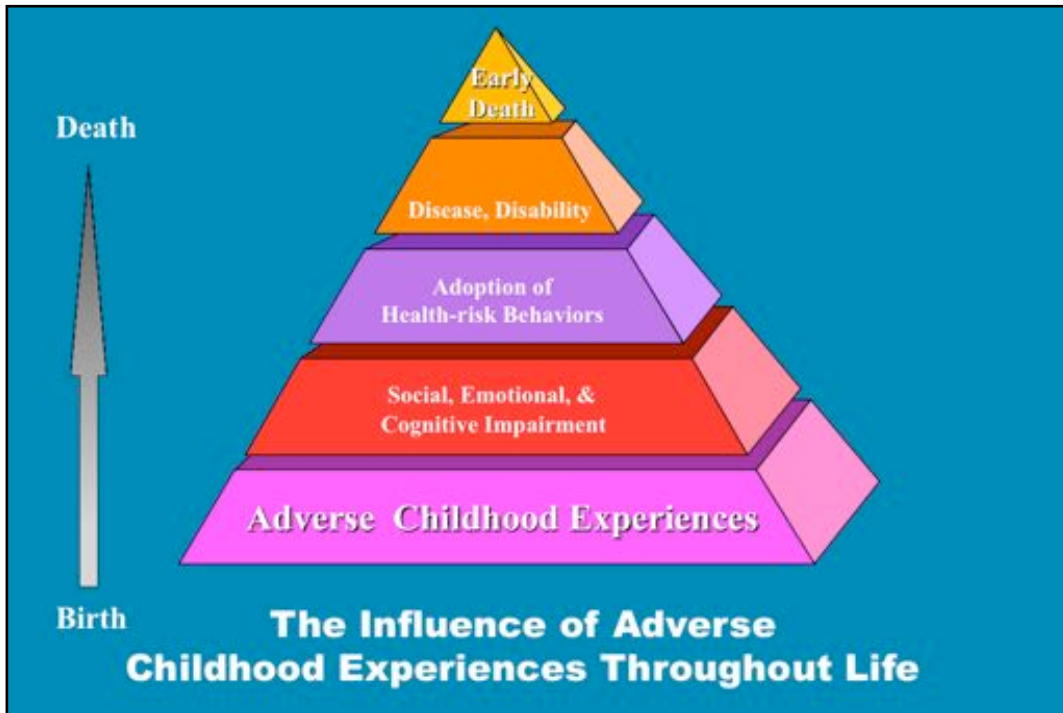
This slide is titled the influence of adverse childhood experiences throughout life and contains a pyramid of five levels from birth, at the bottom of the pyramid, to death, at the top of the pyramid.

The first level at the base of the pyramid is labeled adverse childhood experiences.

The next level up is labeled social, emotional, and cognitive impairment.

The next level up is labeled adoption of health-risk behaviors.

The next level up is labeled disease, disability.

The last level, at the tip of the pyramid, is labeled early death.

"The truth about childhood is stored up in our bodies and lives in the depths of our souls. Our intellect can be deceived, our feelings can be numbed and manipulated, our perceptions shamed and confused, our bodies tricked with medication, but our soul never forgets. And because we are one, one whole soul in one body, someday our body will present its bill."

Alice Miller
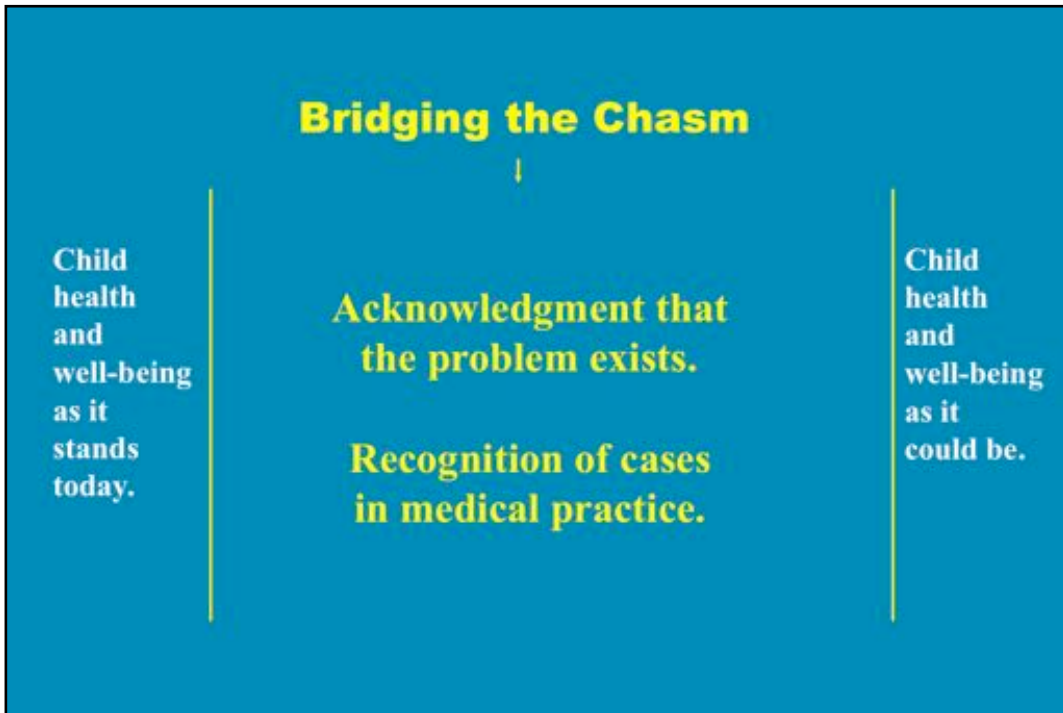
This slide is titled bridging the chasm. The left side of the slide represents child health and well-bring as it stands today. The middle, or bridging the chasm, represents acknowledgment that the problem exists and recognition of cases in medical practice. The right side represents child health and well-being as it could be.

What Can We Do Now?

- Routinely seek history of adverse childhood experiences from *all* patients
- Acknowledge their reality by asking, *"How has this affected you later in life?"*
- Arrange a return appointment to discuss possibilities for helping them.

Psychosocial Determinants of Health- cont'd

Session 6

To the instructor, the focus of this session is to review the very powerful videos/ documentary listed here. It should be noted that while there are some clips available, the goal of this session is to watch Episode 2 of Unnatural Causes when the bough breaks, this will require purchasing or borrowing the DVD. There is a lot of information and it is expected that there will be guided discussion using the suggested guide and link listed in the resource section.

Our Stories

"... a lifetime of exposure to racism can literally get inside the body and affect the health of our newborns."-Unnatural Causes

View:
http://www.unnaturalcauses.org/video_clips_detail.php?res_id=210

/

Examining "When the Bough breaks"

- * instructors you should purchase the DVD described here,
- Here are some clips to use as well:
- http://www.unnaturalcauses.org/ episode_descriptions.php?page=2

- Use questions from discussion guide:
- http://www.unnaturalcauses.org/assets/ uploads/file/UC_DiscussionGuide_2.pdf

* instructors you should purchase the DVD described here.

Key points from the video:

- U.S. infant mortality rate – one of the worst in industrialized world. White America alone would rank 23rd.

- Pre-term birth is the second leading cause of death for infants in the U.S.

- One month's stay in a neonatal intensive care unit averages $68,000.

- Infant mortality among white American women with a college degree or higher is approximately 4 deaths per 1,000 live births. For similarly educated African American women, the rate is three times as high, 12 per 1,000 live births. Babies of white women who haven't finished high school experience a lower rate of infant mortality than college educated African American women.

- The rate of low birth-weight babies born to African immigrants to the U.S. is comparable to the rate for white Americans. But the daughters of African immigrants experience a higher rate of low birth-weight babies - comparable to the general African American population.

Taken from the discussion guide of Unnatural Causes DVD

Discussion and reflection

- How does this information fit with what you have learned so far?

Reflection

- What are the similarities that you see in the families you serve
- How does this impact the services you provide

As in the previous section this reflection should be done with paired sharing first and then report out

Impact of Violence on Young Children

Session 7

Compassion is...

The feeling of unbearableness at the sight of
other people's suffering, and in order to
generate that feeling, one must first have an
appreciation of the seriousness or intensity of
another's suffering. So the more fully one
understands suffering and the various kinds of
suffering we are subject to, the deeper will be
one's level of compassion.

- Dalai Lama

Begin with this quote to help them get grounded in the work. This class will
expose them to the wtinessing others suffering and will do so in detail. It will
at times be graphic and they should monitor their responses. Get them to talk
about their responses to this quote. Then move on to first free write exercise
the multiple definitions of domestic violence

Definitions

- "We define domestic violence as a pattern of abusive behavior in any relationship that is used by one partner to gain or maintain power and control over another intimate partner. Domestic violence can be physical, sexual, emotional, economic, or psychological actions or threats of actions that influence another person. This includes any behaviors that intimidate, manipulate, humiliate, isolate, frighten, terrorize, coerce, threaten, blame, hurt, injure, or wound someone."
- http://www.justice.gov/ovw/domestic-violence

Have them in grous come up with a definition

Please note on the following slides the definitions come from: http://www.justice.gov/ovw/domestic-violence and participants can generate their own definitions as well.

Specific behaviors include

- Physical
  - Punching, hitting, striking with hands
  - Kicking
  - Restraining or blocking exit
  - Biting
  - Throwing objects
  - Use of weapons

  - http://www.justice.gov/ovw/domestic-violence

- Sexual
  - Physically forcing unwanted sexual activity
  - Coercing unwanted sexual activity
  - Deliberately exposing to sexual pain, harm or risks

Other behaviors

- Financial
  - Coercing economic submission
  - Coercing economic support
  - Preventing partner from attending work or school
  - Property damage or theft

- Emotional
  - Restrictive/isolative behavior
  - Excessive jealousy
  - Nonverbal intimidation
  - Psychological manipulation
  - Using the children
  - Threats (to harm self, spouse or children)

http://www.justice.gov/ovw/domestic-violence

After this do a video clip or several to demonstrate- get their reactions and thoughts.
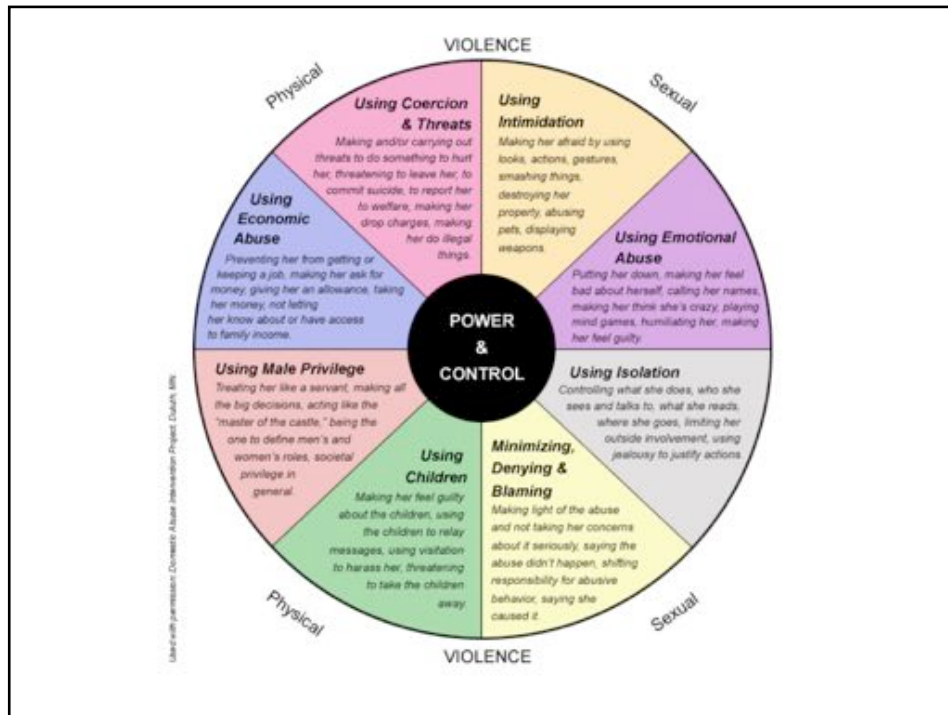
Feminist approaches the most common which focus on patriarchy which systematic affords benefits, control and power to men- out of this is the power control wheel and most of the common perceptions about dv, also most of the batterers and victims programs incorporate this thiniking

From the minnesota Duluth project, which has created one of the first and widely used mechansims of explaining domestic violence. This theory is about power and control.

Have them watch the 20/20 video and have them "code" for the above behaviors

Rates and Realities of Domestic Violence

- Nearly 1 in every 3 women experiences at least one physical assault by a partner during adulthood
- Between 21% and 34% of all women will be physically assaulted by an intimate male during adulthood. (Straus & Gelles, 1980)

- Approximately 4 million American women experience a serious assault by an intimate partner during a 12-month period
- About half of all victims of intimate partner violence between 1993 and 1998 reported the violence to law enforcement authorities

  » National Crime Victimization Study collected by the Bureau of Justice Statistics

According to the National Crime Victimization Study conducted by the Bureau of Justice Statistics approximately 4 million American women experience a serious assault by an intimate partner during a 12 month period. This number, however, is sure to be an underestimate because these statistics could only take into account those report incidents. The question of how many children witness domestic violence has been difficult to quantify. The first case study of child witnesses appeared in the 1970′s with the first empirical research following in the 1980′s and early 1990′s (Kitzman, et.al, 2003). That research has found that relative to the general population, families with *documented* domestic violence have significantly higher numbers of children in the home, especially children under the age of 5. Data from a 5 city study found that families with domestic violence are more than twice as likely to have children in the home than families without d.v.. Once again, this study found that children under the age of 5 were more likely to be exposed to d.v. incidents.. Another way of phrasing thisis that younger children are more at risk of experiencing domestic violence than children over the age of 5. The estimation of 3.3 million is a commonly sited figure within research materials. The figure, however, was collected almost 20 years ago and did not include children under the age of 3.

Works Referenced here:

Rates and Realities

- Half of female victims of intimate partner violence reported a physical injury,
- about 4 out of 10 of these women sought professional medical treatment
- 691,710 nonfatal and 1,247 fatal violent victimizations committed by intimate partner in 2001
- Approximately 30% of female murder victims are killed by intimate partners
  - National Crime Victimization Study collected by the Bureau of Justice Statistics

Rates and Realities

- Recidivism rates in domestic violence cases are high with estimates of 40% to 80% or more of repeat violence when victims are followed longitudinally and interviewed directly

- Considered by age category (1993-1998), women ages 16-24 experienced the highest per capita rates of intimate violence (19.6 of 1000 women)
  - National Crime Victimization Study collected by the Bureau of Justice Statistics

These findings from the National Crime Victimization Study collected by the Bureau of Justice Statistics. They collect this information from a nationally representative sample of households in the U.S.. Between 1993 and 1998 293,000 households and 574.000 individuals were interviewed.

Children's Exposure

- Approximately 3.3 million children witness physical and verbal spousal abuse each year. *The figure, however, was collected over 20 years ago and did not include children under the age of 3.*
- (Straus & Gelles, 1980)

Children's Exposure

- Physical violence highest early in marital relationship, when children are younger
- Families with domestic violence experience more stress
    - Lower income
    - More frequent moves
    - Lesser education
    - More alcohol problems
    - (Margolin and Gordis, 2000)

The Effects of Family and Community Violence on Children

Annual Review of Psychology

Vol. 51: 445-479 (Volume publication date February 2000)

DOI: 10.1146/annurev.psych.51.1.445

Convergence of Types of Violence

- Studies have shown that 60% to 75% of families with intimate partner violence have children who are also battered

- Children exposed to domestic violence
  - 15 times more likely to be abused than the national average
  - 30-70% overlap with child abuse
  - at serious risk of sexual abuse

- Battered women
  - twice more likely to abuse their children than comparison groups

(Osofsky, 2003; Edleson,1999; Margolin & Gordis, 2000)

Given this risk we need to constantly assess for presence of children in the home

We need to ask if children witness the event, try to intervene, witness the aftermath of the event

Parents are heavily invested in underestimating their children's exposure to violence

Resources cited:

1Osofsky, J. Prevalence of children's exposure to domestic violence and child maltreatment: Implications for prevention and intervention. *Clinical Child and Family Psychology Review*. 2003; 6(3):161-170.

2Edleson, J. Children's witnessing of adult domestic violence. *Journal of Interpersonal Violence*. 1999; 14(8):839-870.

3Margolin G, Gordis E. The effects of family and community violence on children. *Annual Review of Psychology*. 2000; 51:445-479.

Health- Pregnancy

- Six percent of all pregnant women are battered and pregnancy complications, including low weight gain, anemia, infections, and first and second trimester bleeding, are significantly higher for abused women, as are maternal rates of depression, suicide attempts, and substance abuse.
- A study of 2,043 pregnant women aged 18 to 59 years old found that among women who had experienced IPV in the past 5 years, nearly 40% reported that the pregnancy was unwanted, compared to 8% of those who did not experience IPV
- IPV is the leading cause of female homicides and injury-related deaths during pregnancy
  - Ellsberg M and Heise L. Researching Violence Against Women: A practical Guide for Researchers and Activists. Washington DC, United States: World Health Organization. PATH, 2005

Family violence prevention fund

Pregnancy

- A 2001 study by the Journal of the American Medical Association showed that homicide was the most common cause of death among pregnant women in Maryland. This study is easily extrapolated to the rest of the United States, and this number is probably higher in reality because only 17 states and New York City list on death certificates whether or not a woman was pregnant at the time of death. This study was undertaken to categorize the major health risks associated with pregnancy. The results were a surprise to researchers

Horon IL1, Cheng D. Enhanced surveillance for pregnancy-associated mortality--Maryland, 1993-1998
JAMA. 2001 Mar 21;285(11):1455-9.

Horon IL1, Cheng D. Enhanced surveillance for pregnancy-associated mortality--Maryland, 1993-1998

JAMA. 2001 Mar 21;285(11):1455-9.

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Children's Exposure

- 30 to 60 percent of families affected by intimate partner violence children are also directly abused.
- Young children are more vulnerable to abuse due to their dependence on their parents and their inability to get out of harm's way.
- Adolescents more frequently intervene to stop the violence, thereby putting themselves at greater risk for injury.
  - (Groves et. al. 2002)

Betsy McAlister Groves, Marylyn Augustyn, Debbie Lee, Peter Sawires. Identifying and responding to domestic Violence Consensus recommendationfsor children and adolescent health providers. (2002). Family Violence Prevention Fund

The Impact of IPV Exposure
On Children
- Domains of Disrupted Development:

  – Physical
  – Emotional
  – Cognitive/Intellectual
  – Behavioral
  – Attachment/
    Interpersonal

- Lieberman, A., **Briscoe-Smith, A**. and Van Horn, P. (2005) Violence in infancy and early
- childhood. *Pediatric Roundtable; Interventions for Children Exposed to Violence;* Johnson and Johnson Pediatric Roundtable. 65-75.

Lieberman, A., **Briscoe-Smith, A**. and Van Horn, P. (2005) Violence in infancy and early

childhood. *Pediatric Roundtable; Interventions for Children Exposed to Violence;* Johnson and Johnson Pediatric Roundtable. 65-75.

Moderating Factors

- Risk/Resilience Factors:
  - Age, severity, frequency and duration of exposure
  - Child's temperament
  - Degree of primary adult's ability to consistently attune/attend/protect
  - Attachment to others
  - Intelligence and creativity

- Lieberman, A., **Briscoe-Smith, A**. and Van Horn, P. (2005) Violence in infancy and early
- childhood. *Pediatric Roundtable; Interventions for Children Exposed to Violence;* Johnson and Johnson Pediatric Roundtable. 65-75.

While the literature is becoming increasingly clear about the sequelae of exposure to violence the field is still muddied as to why some children do well despite their exposure to violence. For example…

This finding raises many important questions: what is it about that 37% that helps protect them from the impact of violence? In what ways are they "doing better", how long do they do better?- but perhaps the most important question raised by this 37% is "what can we learn from children to inform our treatments?"

Kitzmann, K. M., Gaylord, N. K., Holt, A. R., & Kenny, E. D. (2003). Child witnesses to domestic violence: A metaanalytic

review. Journal of Consulting and Clinical Psychology, 71, 339--352.

Many theorists and researchers have looked towards "resilient" children for ideas about treatment, yet there are some problems with the concept of resilience

Health of children

- Children who are exposed to intimate partner violence are more likely to exhibit :
  - behavioral problems
  - physical health problems
  - chronic somatic complaints,
  - depression
  - anxiety
  - violence towards peers
  - attempt suicide
  - abuse drugs and alcohol
  - run away from home,
  - engage in teenage prostitution
  - and commit sexual assault
  - have increased difficulties with learning and school functioning.
  - Symptoms of trauma including sleep difficulties, hyper-vigilance, poor concentration and distractibility which interfere with a child's ability to focus and to complete academic tasks in a school setting
- Lieberman, A., **Briscoe-Smith, A**. and Van Horn, P. (2005) Violence in infancy and early
- childhood. *Pediatric Roundtable; Interventions for Children Exposed to Violence;* Johnson and Johnson Pediatric Roundtable. 65-75.

Lieberman, A., **Briscoe-Smith, A**. and Van Horn, P. (2005) Violence in infancy and early

childhood. *Pediatric Roundtable; Interventions for Children Exposed to Violence;* Johnson and Johnson Pediatric Roundtable. 65-75.

Developmental Exercise

Developmental Impact of Childhood Exposure to Intimate Partner Violence Across the Stages of Childhood

Development Domain/ Stages and Ages	Infancy (0-18 months)	Toddler (18 months – 5)	Latency/School Age (6-12)	Adolescent (13-18)
Physical				
Emotional				
Intellectual/Cognitive				
Behavior				
Attachment/Inter-Personal/Social				

http://www.youtube.com/watch?v=pSe40tX-oTA

Sequelae of Exposure to Violence

- Increased aggression and externalizing problems

- Increased levels of depression and poor self-esteem/self-concept

- Impaired social interactions and peer relationships

- Delayed cognitive development and poor academic functioning

(Margolin & Gordis,2000)

Important to remember that there is a wide heterogenity in both the events and the responses to event, and important to remember that not all of those exposed to abuse experience problematic symptoms, that there is resilience.

There is a robust research literature that documents the sequelae of exposure to violence through child abuse, witnessing domestic violence, exposure to community violence and exposure to war and its consequences on children. Trauma affects children's behavior, views of self, interactions with others and academic/cognitive functioning.

Diagnosis

For Children
- PTSD
- ADHD
- ODD
- MDD

For Adults
- PTSD
- MDD
- Anxiety Disorders
- Borderline PD
- Complex PTSD

When those who experience abuse are symptomatic they are often diagnosed with the following disorders.

Let me pause to talk about an area of interest of mine and where my pervious research has investigated.

Pause here to talk about some of my previous research.

Post Traumatic Stress Disorder

- That traumatic event must cause fear, horror, or helplessness and the person experiencing or witnessing that even must be confronted with death, serious injury or a threat to the physical integrity of themselves or others

- Reexperiencing
  - Intrusive thoughts
  - Distressing dreams
  - Flashbacks/reliving
  - Intense distress at trauma cues
  - Physiological reactivity
- Avoidance
  - Efforts to avoid thoughts, people, places and reminders
  - Inability to recall
  - Feelings of detachment
  - Restricted affect
  - Sense of foreshortened future
- Increased Arousal
  - Sleep disturbance
  - Irritability
  - Difficulty concentrating
  - hypervigillance

But what does the field give us, it gives up PTSD (I'm taking a side track)

What's wrong with PTSD

- Created with war and single event rape trauma in mind
  - Heterogeneity of etiology
- Inadequacy for children
  - 9 of 12 criteria require verbalization
- Gender disparities
- Comorbidity with other disorders

- **Briscoe-Smith, A.**. and Hinshaw, S. (2006) Linkages between child abuse and attention-
- deficit/hyperactivity disorder in girls: Behavioral and social correlates. *Child Abuse*
- *and Neglect.* 30(11) 1239-1255.

Remind them about the numbers of kids who are exposed to trauma under the age of 3

Briscoe-Smith, A.. and Hinshaw, S. (2006) Linkages between child abuse and attention-

deficit/hyperactivity disorder in girls: Behavioral and social correlates. *Child Abuse*

and Neglect. 30(11) 1239-1255.

What's wrong with PTSD

- National Child Traumatic Stress Network Core Data Set, a national sample of 9,336 children receiving services at NCTSN child trauma centers.
  - Over 70% of these children experienced multiple forms of trauma and adversity,
  - 48% exhibiting clinically significant behavior problems in the home or community,
  - 41% academic problems,
  - 37% behavior problems in school/daycare,
  - 31% attachment problems, and 11% suicidality.
  - only 24% were reported to meet diagnostic criteria for PTSD

What's wrong with PTSD?

- The majority of children exposed to traumatic events don't meet criteria
- Child and Adolescent Needs and Strengths (CANS) dataset of 7,668 foster children in Illinois Department of Children and Family Services
  - (44%) had been exposed to sexual abuse, physical abuse, or domestic violence,
  - 3785 (49%) had been neglected,
  - and 1199 (16%) had experienced emotional abuse.
  - Based on CANS ratings, 4872 of these children (63%) exhibited trauma-related symptoms, including but not limited to PTSD.
  - Only 272 of these children (5.5% of the children with trauma symptoms) met full criteria **Pynoos et al. (2009)**

Pynoos, Steinberg, Layne, et al. (2009). DSM-V PTSD diagnostic criteria for children and adolescents: A developmental perspective and recommendations
Journal of Traumatic Stress
, Vol. 22, No. 5, October 2009, pp. 391–398 (
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[W]
2009

Commonalities between sequelae of abuse and ADHD

- Abuse
  - severe aggression and "acting out"
  - increased risk for delinquency
  - earlier onset of behavior problems
  - difficult peer interactions
  - internalizing/ depression

  - lower cognitive functioning

- ADHD
  - marked aggression

  - high rates of delinquency
  - characterized by early onset of behaviors
  - extremely peer rejected

  - higher levels of depression and poor self concept than other children w/o ADHD
  - learning difficulties

Briscoe-Smith, A.. and Hinshaw, S. (2006) Linkages between child abuse and attention-

deficit/hyperactivity disorder in girls: Behavioral and social correlates. *Child Abuse and Neglect.* 30(11) 1239-1255.

My impression working with kids is that I worked with an awful lot of children with diagnoses of adhd who had trauma histories.

Traumatic Stress Disorder

- Existence of a traumatic event
- Re-experiencing the trauma
- Numbing of responsiveness or interference with developmental momentum
- Increased arousal
- New symptoms (fears or aggression) that were not present before the event

(DC 0-3, 1994)

Traumatic Stress Disorder

- Re-experiencing:
  - Repetitive posttraumatic or reenactment play
  - Distress with reminders
  - Dissociation episodes
  - Nightmares
- Numbing of responsiveness or interference with developmental momentum
  - social withdrawal
  - restricted affect
  - loss of skills
  - Constriction of play   (DC 0-3, 1994)

Traumatic Stress Disorder

- Increased arousal
    - sleep disorder
    - short attention span
    - Hypervigilance
    - startle response
    - Increased irritability, lability, temper tantrums
- New fears/aggressions
    - aggressive behaviors
    - clinging behavior
    - fear of toileting or other fears

                                                (DC 0-3, 1994)

Developmental Trauma Disorder

- **A. Exposure. The child or adolescent has experienced or witnessed multiple or prolonged adverse events over a period of at least one year beginning in childhood or early adolescence, including:**
- A. 1. Direct experience or witnessing of repeated and severe episodes of interpersonal violence; and
- A. 2. Significant disruptions of protective caregiving as the result of repeated changes in primary caregiver; repeated separation from the primary caregiver; or exposure to severe and persistent emotional abuse

Pynoos, Steinberg, Layne, et al. (2009). DSM-V PTSD diagnostic criteria for children and adolescents: A developmental perspective and recommendations
Journal of Traumatic Stress
, Vol. 22, No. 5, October 2009, pp. 391–398 (
C

DTD

- **B. Affective and Physiological Dysregulation. The child exhibits impaired normative developmental competencies related to arousal regulation, including at least two of the following:**
- B. 1. Inability to modulate, tolerate, or recover from extreme affect states (e.g., fear, anger, shame), including prolonged and extreme tantrums, or immobilization
- B. 2. Disturbances in regulation in bodily functions (e.g. persistent disturbances in sleeping, eating, and elimination; over-reactivity or under-reactivity to touch and sounds; disorganization during routine transitions)
- B. 3. Diminished awareness/dissociation of sensations, emotions and bodily states
- B. 4. Impaired capacity to describe emotions or bodily states

Pynoos, Steinberg, Layne, et al. (2009). DSM-V PTSD diagnostic criteria for children and adolescents: A developmental perspective and recommendations
Journal of Traumatic Stress
, Vol. 22, No. 5, October 2009, pp. 391–398 (
C

- **C. Attentional and Behavioral Dysregulation: The child exhibits impaired normative developmental competencies related to sustained attention, learning, or coping with stress, including at least three of the following:**
- C. 1. Preoccupation with threat, or impaired capacity to perceive threat, including misreading of safety and danger cues
- C. 2. Impaired capacity for self-protection, including extreme risk-taking or thrill-seeking
- C. 3. Maladaptive attempts at self-soothing (e.g., rocking and other rhythmical movements, compulsive masturbation)
- C. 4. Habitual (intentional or automatic) or reactive self-harm
- C. 5. Inability to initiate or sustain goal-directed behavior

DTD

- **D. Self and Relational Dysregulation. The child exhibits impaired normative developmental competencies in their sense of personal identity and involvement in relationships, including at least three of the following:**
- D. 1. Intense preoccupation with safety of the caregiver or other loved ones (including precocious caregiving) or difficulty tolerating reunion with them after separation
- D. 2. Persistent negative sense of self, including self-loathing, helplessness, worthlessness, ineffectiveness, or defectiveness
- D. 3. Extreme and persistent distrust, defiance or lack of reciprocal behavior in close relationships with adults or peers
- D. 4. Reactive physical or verbal aggression toward peers, caregivers, or other adults
- D. 5. Inappropriate (excessive or promiscuous) attempts to get intimate contact (including but not limited to sexual or physical intimacy) or excessive reliance on peers or adults for safety and reassurance
- D. 6. Impaired capacity to regulate empathic arousal as evidenced by lack of empathy for, or intolerance of, expressions of distress of others, or excessive responsiveness to the distress of others

Pynoos, Steinberg, Layne, et al. (2009). DSM-V PTSD diagnostic criteria for children and adolescents: A developmental perspective and recommendations
Journal of Traumatic Stress
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- E. Posttraumatic Spectrum Symptoms. The child exhibits at least one symptom in at least two of the three PTSD symptom clusters B, C, & D.
- F. Duration of disturbance (symptoms in DTD Criteria B, C, D, and E) at least 6 months.
- G. Functional Impairment. The disturbance causes clinically significant distress or impairment in at two of the following areas of functioning:

- Scholastic: under-performance, non-attendance, disciplinary problems, drop-out, failure to complete degree/credential(s), conflict with school personnel, learning disabilities or intellectual impairment that cannot be accounted for by neurological or other factors.

- Familial: conflict, avoidance/passivity, running away, detachment and surrogate replacements, attempts to physically or emotionally hurt family members, non-fulfillment of responsibilities within the family.

- Peer Group: isolation, deviant affiliations, persistent physical or emotional conflict, avoidance/passivity, involvement in violence or unsafe acts, age-inappropriate affiliations or style of interaction.

- Legal: arrests/recidivism, detention, convictions, incarceration, violation of probation or other court orders, increasingly severe offenses, crimes against other persons, disregard or contempt for the law or for conventional moral standards.

- Health: physical illness or problems that cannot be fully accounted for physical injury or degeneration, involving the digestive, neurological (including conversion symptoms and analgesia), sexual, immune, cardiopulmonary, proprioceptive, or sensory systems, or severe headaches (including migraine) or chronic pain or fatigue.

- Vocational (for youth involved in, seeking or referred for employment, volunteer work or job training): disinterest in work/vocation, inability to get or keep jobs, persistent conflict with co-workers or supervisors, under-employment in relation to abilities, failure to achieve expectable advancements.

Pynoos, Steinberg, Layne, et al. (2009). DSM-V PTSD diagnostic criteria for children and adolescents: A developmental perspective and recommendations
Journal of Traumatic Stress
, Vol. 22, No. 5, October 2009, pp. 391–398 (
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Cultural Healing Practices

Session eight

Presenter, this session is a great opportunity for folks to continue to think about how they will apply what they are learning into their practice. Paired sharing and group work and guided discussion are to be used. There are links to readings that can also be used as dicussion points.

One Path to Healing

Our stories:

- Open reflection on witnessing and/or encouraging healing
- Questions or concerns regarding the process of healing individuals, families, and communities who experience inter-generational trauma.

Didactic: Exploring Practices to Induce and Better Understand Healing in Our Work with African-American Families

"It is from the impacts of past assaults that we must heal, and it is from the threats of continuing assaults that we must learn to defend ourselves, our families, and our communities". Dr. Joy DeGruy

Didactic: Exploring Practices to Induce and Better Understand Healing in Our Work with African-American Families to Healing

Steps to Engage Families in Healing Practices (Joy DeGruy):

- Recognition and acceptance of complexity of African-American identity
- Identification of strengths
- Focusing attention to healing self, family, and community
- Active engagement regarding physical and psychological health and well-being, e.g building self-esteem, stress management, positive racial socialization, speaking truth about the individual's and community's experience, intentional modeling, and positive racial socialization.

Purpose: To identify and acknowledge how service providers can support African-American individuals with telling their story and history in addition to uncovering a new story which includes their sense of power and agency.

Didactic: Exploring Practices to Induce and Better Understand Healing in Our Work with African-American Families to Healing

Using the "Healing Questions"(Vanessa Jackson:)

- a) "What happened to you?"
- b) "How does what happened to you affect you now?
- c) "What do you need to heal?"

Purpose: To empower African-Americans to voice their experience, to reclaim their voices and no longer be silenced. To allow provider an opportunity to hear and explore the family's unique story, and desires for and/or beliefs about change.

Didactic: Exploring Practices to Induce and Better Understand Healing in Our Work with African-American Families to Healing

"Testimony Therapy": Practices and Healing Questions (Makungu Akinyela)

- What is a "testimony"? (An African-American cultural-spiritual tradition in which members are invited and encouraged to tell their story of challenge, perseverance, and the role of their faith in the triumph; "testifyin'".)
- Discuss the need for African-centered healing practices as they incorporate: self-determination, indigenous practices, and spiritualities
- Holding hope as foundational to healing, and the listening for victorious moments in the person's or family's life.
- Use of Vanessa Jackson's "Healing questions" with the addition of one more question: "After all that's happened to you and the effect that this has had on you, what gives you strength to hold on?"

Purpose: To infuse spiritual practices and ways of being into the healing process.

Reflection

How can we empower and support African-Americans in the healing of themselves and their communities?

Practicing the Practices

- Separate into triads for this next section, and incorporate your learnings (cognitive and emotional) thus far into your responses to the following discussion questions.
- In this exercise every role is important, there will be two listeners, whenever one is speaking; please be mindful in your sharing of time, be mindful and attentive in your listening, and be thoughtful in your sharing.

Discussion Questions

- During this exercise, we will break into groups of three to respond and discuss the questions below. We will then respond and discuss the last question together in the larger group.

- What happened to African Americans in the US from the middle passage until now?

- How does what happened to the African American population/community affect them now? What has been the effect of and responses to the cultural and multigenerational transmissions of trauma and oppression?

- In spite of what happened and continues to happen to them, how did and does the African American population/community make it through? How have they been able to triumph?

- What do African Americans need to heal? And how can I as someone working with African American children and families be part of the healing processes of family and community?

Paths to Healing

Resources:

- Akinyela, Makungu. "Once They Come: Testimony Therapy and Healing Questions for African American Couples." *Re-visioning Family Therapy, 2nd Edition*. 356-66. Print.

- Jackson, Vanessa. "In Our Own Voice:African-American Stories of Oppression, Survival and Recovery in Mental Health Systems." Web.

- Leary, Joy DeGruy. Post Traumatic Slave Syndrome: America's Legacy of Enduring Injury and Healing. Portland, OR: Joy DeGruy Publications, 2005. Print.

- *Recommended Reading*: Boyd-Franklin, Nancy. "Working with African Americans and Trauma: Lessons for Clinicians from Hurricane Katrina. " *Re-visioning Family Therapy, 2nd Edition*. 344-355. Print.

Historical Trauma and Oppression within the African American Community

These healing questions have been rephrased in a way that allows us to think about how they apply to the African American population/community as a whole and the history and both past and current experiences of trauma and oppression. It is our hope that by thinking about and responding to these questions, it will assist you with the following:

∞ Identifying and acknowledging how you can support individuals with telling their story and history in addition to uncovering a new story which includes their sense of power and agency.

∞ Identifying and acknowledging how you support the African American client community with telling their truth in the world, stories of their past, and hopes and dreams about their present and future directions with the overall goal of supporting individuals from a sense, perspective and experience of extreme powerlessness to a greater sense of power, understanding, knowing and a foundation for change and action.

During this exercise, participants will break into groups of three to respond and discuss the questions below. Then, the larger group will respond and discuss the last question together.

1. What happened to African Americans in the US from the middle passage until now?

2. How does what happened to the African American population/community affect them now? What has been the effect of and responses to the cultural and multigenerational transmissions of trauma and oppression?

3. In spite of what happened and continues to happen to them, how did and does the African American population/community make it through? How have they been able to triumph?

4. What do African Americans need to heal? And how can you as someone working with African American children and families be part of the healing process?

Session Nine

Evidence Based Treatments

Please watch the following clip:

Our stories:
Black Folks Don't Do Therapy. Retrieved from
http://www.youtube.com/watch?v=dVPl0SQXan8

Initial group reactions (10 mins)

To the Instructor:
This section will either require pre work, assigning readings before, or require time within the session for reading. If you need to do the whole activity wihtin the class it would be most helpful to either have multiple handouts and/or have laptops with wifi available so folks can engage in the tasks outline. The goal of this session is to help people identfy both trauma informed evidenced based practice, but also to think through the cultural appropriateness of these models given the prior sessions of work. Lastly, given what everyone has learned there is a "build a treatment" activity that asks folks to think about what they would do to help young african american children and their families, given what they have learned. The bulk of this session is dicussion and group work based.

Discussion

In small groups please discuss:

- What comes up for you watching this?
- What are the barriers articulated to therapy here?
- What impact does this have on black folks accessing care?
- What contributes to these beliefs?

Didactic

- What could you do about the barriers talked about before?

- For this discussion please focus on:

   Toolkit for Modifying Evidence-Based Practices to Increase Cultural Competence. Retrieved from

   – http://ssrdqst.rfmh.org/cecc/sites/
   ssrdqst.rfmh.org.cecc/UserFiles/ToolkitEBP.pdf

National Child Traumatic Stress Network

- The National Child Traumatic Stress Network (NCTSN) is a key resource for service providers and families
- It is expected that you would be familiar with this website and the resources it provides
- http://nctsn.org/resources/training-and-education/training-archives

Evidenced Based Treatments

- Take a look at the following treatments
- In small groups discuss what you have learned about the treatment
- What more would you like to know about it before using it
- What kind of modifications or changes would you want to make for working with young African American families and their children

- Handouts of the slides will be needed. Groups should spend about ten minutes in class reviewing treatment tables and treatment related articles. If someone in the class has had experience with the treatment they should be put into that group.

The three that focus on young children are:
- Attachment, Regulation & Competency Model (ARC)
- Parent Child Interaction Therapy (PCIT)
- Child Parent Psychotherapy (CPP)

Additional therapies useful for working with children and adolescents include:
- Trauma Focused Cognitive Behavioral Therapy (TF-CBT)
- Trauma Focused Systems Therapy (TST)

The following activity should take about half an hour, with group discussion and a report out of each group

EVIDENCED-BASED TREATMENT OF TRAUMA IN CHILDREN AND ADOLESCENTS

Attachment, Regulation & Competency (ARC) model	The ARC framework is a components-based model that identifies three core domains of treatment intervention for children and adolescents who have experienced trauma and their caregiving system systems: attachment, self-regulation, and competency. Within those three domains, nine building blocks of intervention and identified. A 10th target of intervention, trauma experience integration, involves an integration of all other targets, including both external resources and individual skills, addressed within this intervention framework. Retrieved from http://www.nctsn.org/resources/topics/treatments-that-work/promising-practices
Parent-Child Interaction Therapy (PCIT)	Parent-child interaction therapy (PCIT) is a family-centered treatment approach proven effective for abused and at-risk children ages 2 to 8 and their caregivers—birth parents, adoptive parents, or foster or kin caregivers. During PCIT, therapists coach parents while they interact with their children, teaching caregivers strategies that will promote positive behaviors in children who have disruptive or externalizing behavior problems. Research has shown that, as a result of PCIT, parents learn more effective parenting techniques, the behavior problems of children decrease, and the quality of the parent-child relationship improves. Retrieved from https://www.childwelfare.gov/pubPDFs/f_interactbulletin.pdf.

EVIDENCED-BASED TREATMENT OF TRAUMA IN CHILDREN AND ADOLESCENTS

Child Parent Psychotherapy (CPP)	An intervention for children from birth through age 5 who have experienced at least one traumatic event (e.g., maltreatment, the sudden or traumatic death of someone close, a serious accident, sexual abuse, exposure to domestic violence) and, as a result, are experiencing behavior, attachment, and/or mental health problems, including posttraumatic stress disorder (PTSD). The primary goal of CPP is to support and strengthen the relationship between a child and his or her parent (or caregiver) as a vehicle for restoring the child's sense of safety, attachment, and appropriate affect and improving the child's cognitive, behavioral, and social functioning. The type of trauma experienced and the child's age or developmental status determine the structure of CPP sessions. For example, with infants, the child is present, but treatment focuses on helping the parent to understand how the child's and parent's experience may affect the child's functioning and development. With older children, including toddlers, the child is a more active participant in treatment, and treatment often includes play as a vehicle for facilitating communication between the child and parent. When the parent has a history of trauma that interferes with his or her response to the child, the therapist (a master's- or doctoral-level psychologist, a master's-level social worker or counselor, or a supervised trainee) helps the parent understand how this history can affect perceptions of and interactions with the child and helps the parent interact with the child in new, developmentally appropriate ways. Retrieved from http://www.nrepp.samhsa.gov/ViewIntervention.aspx?id=194

EVIDENCED-BASED TREATMENT OF TRAUMA IN CHILDREN AND ADOLESCENTS

Trauma-focused Cognitive Behavioral Therapy (TF-CBT)	Trauma-focused cognitive behavioral therapy (TF-CBT) is an evidence-based treatment approach shown to help children, adolescents, and their caretakers overcome trauma-related difficulties. It is designed to reduce negative emotional and behavioral responses following child sexual abuse and other traumatic events. The treatment—based on learning and cognitive theories—addresses distorted beliefs and attributions related to the abuse and provides a supportive environment in which children are encouraged to talk about their traumatic experience. TF-CBT also helps parents who were not abusive to cope effectively with their own emotional distress and develop skills that support their children.
Trauma-focused systems therapy (TST)	Community-based program designed to facilitate enhanced ability of the child to regulate emotional and behavioral response to social environmental stressors. Program designed to address barriers toward families' engagement in treatment. Program designed to be used in community settings with populations facing significant, ongoing stressors.

Retrieved from http://www.nctsn.org/resources/topics/treatments-that-work/promising-practices

What are you going to do about it

- If you could build a therapy based on:
  - What you know of the needs of young African American children and their families
  - The history and legacy of multigenerational trauma
  - Evidence on what's effective for working with trauma

  What kind of therapy would you build....

Participants should be in groups and have large paper to build out their therapy.

Therapy Build

- Who would provide it?
- Where?
- How long?
- What would it look like?
- How would you pay for it?

References

- Child Parent Psychotherapy Intervention Summary. June 2010. SAMHSAs National Registry for Evidenced-based Practices, The National Registry of Evidence-based Programs and Practices (NREPP) Retrieved from http://www.nrepp.samhsa.gov/ViewIntervention.aspx?id=194

- Child Welfare Information Gateway. (2013). *Parent-child interaction therapy with at-risk families.* Washington, DC: U.S. Department of Health and Human Services, Children's Bureau. Retrieved from https://www.childwelfare.gov/pubPDFs/f_interactbulletin.pdf.

- National Child Traumatic Stress Network www.NCTSN.org

- Samuels, J., Schudrich, W., & Altschul, D. (2009). *Toolkit for modifying evidence-based practice to increase cultural competence.* Orangeburg, NY: Research Foundation for Mental Health. Retrieved from http://ssrdqst.rfmh.org/cecc/sites/ssrdqst.rfmh.org.cecc/UserFiles/ToolkitEBP.pdf

Child-Parent Psychotherapy (CPP)

Child-Parent Psychotherapy (CPP) is an intervention for children from birth through age 5 who have experienced at least one traumatic event (e.g., maltreatment, the sudden or traumatic death of someone close, a serious accident, sexual abuse, exposure to domestic violence) and, as a result, are experiencing behavior, attachment, and/or mental health problems, including posttraumatic stress disorder (PTSD). The primary goal of CPP is to support and strengthen the relationship between a child and his or her parent (or caregiver) as a vehicle for restoring the child's sense of safety, attachment, and appropriate affect and improving the child's cognitive, behavioral, and social functioning.

The type of trauma experienced and the child's age or developmental status determine the structure of CPP sessions. For example, with infants, the child is present, but treatment focuses on helping the parent to understand how the child's and parent's experience may affect the child's functioning and development. With older children, including toddlers, the child is a more active participant in treatment, and treatment often includes play as a vehicle for facilitating communication between the child and parent. When the parent has a history of trauma that interferes with his or her response to the child, the therapist (a master's- or doctoral-level psychologist, a master's-level social worker or counselor, or a supervised trainee) helps the parent understand how this history can affect perceptions of and interactions with the child and helps the parent interact with the child in new, developmentally appropriate ways. In studies reviewed for this summary, mother-child dyads participated in weekly sessions for approximately 1 year with therapists who principally used a CPP treatment manual (Don't Hit My Mommy!).

Descriptive Information

Areas of Interest	Mental health promotion Mental health treatment
Outcomes	**Review Date: June 2010** 1: Child PTSD symptoms 2: Child behavior problems 3: Children's representational models 4: Attachment security 5: Maternal PTSD symptoms 6: Maternal mental health symptoms other than PTSD symptoms
Outcome Categories	Family/relationships Mental health Social functioning Trauma/injuries
Ages	0-5 (Early childhood) 18-25 (Young adult) 26-55 (Adult)
Genders	Male Female
Races/Ethnicities	Asian Black or African American Hispanic or Latino White Race/ethnicity unspecified
Settings	Home Other community settings
Geographic	Urban

Locations	Suburban Rural and/or frontier
Implementation History	CPP was developed in the 1980s through an adaptation of the infant-parent psychotherapy model, which was developed in the 1970s by Selma Fraiberg and colleagues. The first efficacy trial of CPP began in 1985. The Child Trauma Research Program began disseminating CPP through the National Child Traumatic Stress Network (NCTSN) in 2002. Since then, approximately 143 sites have implemented the intervention. Five randomized controlled trials have been conducted, and the findings from these studies have been published. In addition, reports have been written on the evaluation of dissemination efforts, including the dissemination of CPP within the NCTSN. Since 1996, more than 527 individuals have received training in CPP. Approximately 10 additional individuals per year have received CPP training through internships and fellowships with the Child Trauma Research Program, and other internships and fellowships in CPP are available through the Child Witness to Violence Program; the Tulane University Infant Team; the Louisiana State University Child Violence Exposure Program; and the Mount Hope Family Center, University of Rochester.
NIH Funding/CER Studies	Partially/fully funded by National Institutes of Health: Yes Evaluated in comparative effectiveness research studies: Yes
Adaptations	The program has been adapted for use in a randomized trial involving Latino immigrant mothers and their infants.
Adverse Effects	No adverse effects, concerns, or unintended consequences were identified by the developer.
IOM Prevention Categories	Selective Indicated

Quality of Research
Review Date: June 2010

Documents Reviewed

The documents below were reviewed for Quality of Research. The research point of contact can provide information regarding the studies reviewed and the availability of additional materials, including those from more recent studies that may have been conducted.

Study 1

Lieberman, A. F., Ghosh Ippen, C., & Van Horn, P. (2006). Child-Parent Psychotherapy: 6-month follow-up of a randomized controlled trial. Journal of the American Academy of Child and Adolescent Psychiatry, 45(8), 913-918. PubMed

Lieberman, A. F., Van Horn, P., & Ghosh Ippen, C. (2005). Toward evidence-based treatment: Child-Parent Psychotherapy with preschoolers exposed to marital violence. Journal of the American Academy of Child and Adolescent Psychiatry, 44(12), 1241-1248. PubMed

Study 2

Toth, S. L., Maughan, A., Manly, J. T., Spagnola, M., & Cicchetti, D. (2002). The relative efficacy of two interventions in altering maltreated preschool children's representational models: Implications for attachment theory. Development and Psychopathology, 14(4), 877-908. PubMed

Study 3

Toth, S. L., Rogosch, F. A., Manly, J. T., & Cicchetti, D. (2006). The efficacy of Toddler-Parent Psychotherapy to reorganize attachment in the young offspring of mothers with major depressive disorder: A randomized preventive trial. Journal of Consulting and Clinical Psychology, 74(6), 1006-1016. PubMed

Supplementary Materials

Lieberman, A. F., Ghosh Ippen, C., & Marans, S. (2008). Psychodynamic treatment of child trauma. In E. B. Foa, T. M. Keane, & M. J. Friedman (Eds.), Effective treatments for PTSD: Practice guidelines from the International Society for Traumatic Stress Studies (pp. 370-387). New York: Guilford Press.

Lyons, J. (2008). Evidence-based trauma interventions for foster children in Illinois. Presentation to funders and stakeholders, Chicago, IL.

Toth, S., Manly, J. T., Rogosch, F. A., & Cicchetti, D. (n.d.). IPP Intervention Fidelity Checklist.

Outcomes

Outcome 1: Child PTSD symptoms

Description of Measures	Child PTSD symptoms were assessed using the Semistructured Interview for Diagnostic Classification DC: 0-3 for Clinicians. This clinician-administered caregiver interview uses a standardized format to systematize the traumatic stress disorder diagnostic criteria of the Diagnostic Classification Manual for Mental Health and Developmental Disorders of Infancy and Early Childhood, Diagnostic Classification: 0-3.
Key Findings	In a study involving preschool children exposed to marital violence, mother-child dyads were randomly assigned to the intervention group or a comparison group, which received case management services plus individual psychotherapy in the community for mother and/or child, at a clinic chosen by the mother. From pre- to posttest, children in the intervention group had a significant decrease in PTSD symptoms relative to those in the comparison group (p < .0001). This result had a medium effect size (Cohen's d = 0.63).
Studies Measuring Outcome	Study 1
Study Designs	Experimental
Quality of Research Rating	3.7 (0.0-4.0 scale)

Outcome 2: Child behavior problems

Description of Measures	Child behavior problems were assessed using an age-appropriate version of the Child Behavior Checklist (CBCL), a parent-report questionnaire that indicates the extent of maladaptive behavioral and emotional problems in children who are 2-3 years old (CBCL/2-3) and 4-18 years old (CBCL/4-18). The Total Behavior Problems score of the CBCL includes stress-related behaviors (e.g., staring into space, smearing feces, refusing to eat, showing too little fear of getting hurt, destroying his or her own things).
Key Findings	In a study involving preschool children exposed to marital violence, mother-child dyads were randomly assigned to the intervention group or a comparison group, which received case management services plus individual psychotherapy in the community for mother and/or child, at a clinic chosen by the mother. Children in the intervention group had significant decreases in behavior problems relative to those in the comparison group from pre- to posttest (p < .05) and from pretest to 6-month follow-up (p < .05). The effect sizes were small (Cohen's d = 0.24 and 0.41, respectively).
Studies Measuring Outcome	Study 1
Study Designs	Experimental
Quality of Research Rating	3.3 (0.0-4.0 scale)

Outcome 3: Children's representational models

Description of Measures	Children's representational models were assessed using the MacArthur Story Stem Battery. This narrative instrument for children ages 3-7 uses a standardized set of narrative beginnings ("story stems") to elicit the child's state of mind about family relationships, parental availability, and conflict situations through age-relevant situations (e.g., spilling juice, parental arguing, a monster under the bed, a scraped knee, a scary dog, parental departure and return). Eleven narrative story stems were administered to children at baseline and at the postintervention evaluation by research assistants who were trained in the procedure and were blind to the study condition coding of the stories. Narratives were coded using the MacArthur Narrative Coding Manual --Rochester Revision, which involves a presence-absence method of coding content, including story themes, emotional tone, controllingness, and representation of parent. The following items were evaluated: • Adaptive maternal representation, a composite score of the following maternal representations: positive mother (the maternal figure is described or portrayed as protective,

affectionate, providing care, warm, or helpful) and disciplining mother (the maternal figure is described or portrayed as an authority figure who disciplines the child)
- Maladaptive maternal representation, a composite score of the following maternal representations: negative mother (the maternal figure is described or portrayed as punitive, harsh, ineffectual, or rejecting), controlling mother (the maternal figure is described or portrayed as controlling the child's behavior, independent of disciplining actions), and incongruent mother (the maternal figure is described or portrayed as dealing with the child-related situations in an opposite or inconsistent manner)
- Child self-representation, which was coded for the following self-representations: positive (a child figure is described or portrayed as empathic or helpful, prideful, or feeling good about self), negative (a child figure is described or portrayed as aggressive toward self or other, experiencing feelings of shame or self-blame), and false (a child figure is described or portrayed as overly compliant or reports inappropriate positive feelings)

In addition, the children's mother-child relationship expectations, as given in the children's narratives, were assessed using a modified version of Bickham and Fiese's Global Relationship Expectation Scale. Research assistants rated relationship dimensions on a 5-point scale ranging from very low (participants described or portrayed the mother-child relationship as dissatisfying, unpredictable, and/or dangerous) to very high (participants described or portrayed the mother-child relationship as fulfilling, safe, rewarding, and reliable).

Key Findings	In a study of preschool children maltreated by their families, mother-child dyads were randomly assigned to the intervention group, the psychoeducational home visitation (PHV) group, or the community standard (CS) group. Mother-child dyads from nonmaltreating (NC) families served as a comparison and had access to standard services and resources for child and family functioning provided through the local department of social services. From baseline to the postintervention evaluation: • Children in the intervention group had a significant decline in maladaptive maternal representations compared with children in the NC group ($p < .05$). Children in the intervention group also had a decline in maladaptive maternal representations compared with children in the CS group, but the result was not statistically significant. • Children in the intervention group had a significant reduction in negative self-representations compared with children in the PHV ($p < .01$), CS ($p < .01$), and NC ($p < .05$) groups. • The mother-child relationship expectations of children in the intervention group became significantly more positive compared with the expectations of children in the NC group ($p < .05$). The mother-child relationship expectations of children in the intervention group also became more positive compared with children in the PHV group, but the result was not statistically significant. • No significant between-group differences were found for adaptive maternal representations and false self-representations.
Studies Measuring Outcome	Study 2
Study Designs	Experimental
Quality of Research Rating	3.8 (0.0-4.0 scale)

Outcome 4: Attachment security

Description of Measures	Attachment security was measured using Strange Situation, which was conducted with mothers and their toddlers to assess the toddler's attachment relationship with the mother. In this assessment, the child was observed playing while caregivers and strangers entered and left the room, recreating the flow of familiar and unfamiliar presences in most children's lives. The situations varied in stressfulness, and the child's responses were videotaped. Two raters separately coded all videotaped sessions, and the raters were unaware of the diagnostic and group statuses of individual mother-child dyads. On the basis of their behaviors, the children were categorized as insecure or secure.
Key Findings	In a study of mothers who had experienced major depressive disorder (MDD) since their child's birth, mother-child dyads were randomized to the intervention group or the MDD comparison group, which received other forms of mental health treatment (including psychotherapy and the use of antidepressants and other medication). Mothers with no current MDD or history of MDD and their toddlers were recruited for a nondepressed control group, which received no therapy or treatment. From baseline to the postintervention assessment, the percentage of children whose category changed from insecure to secure was significantly higher for the intervention group (54.3%) than

the MDD comparison group (7.4%) (p < .001) and the nondepressed control group (14.3%) (p < .001). No significant difference was found between the MDD comparison group and the nondepressed control group in attachment security.

Studies Measuring Outcome	Study 3
Study Designs	Experimental
Quality of Research Rating	3.9 (0.0-4.0 scale)

Outcome 5: Maternal PTSD symptoms

Description of Measures	Maternal PTSD symptoms were assessed using the Clinician-Administered PTSD Scale. This semistructured interview assesses core PTSD symptoms and yields intensity and frequency scores for symptoms, including reexperiencing, avoidance, and hyperarousal symptoms, as well as a total score for PTSD symptoms.
Key Findings	In a study involving preschool children exposed to marital violence, mother-child dyads were randomly assigned to the intervention group or a comparison group, which received case management services plus individual psychotherapy in the community for mother and/or child, at a clinic chosen by the mother. From pre- to posttest, mothers in the intervention group had significant reductions in avoidance symptoms relative to those in the comparison group (p < .05). This result had a medium effect size (Cohen's d = 0.50). No significant differences were found from pre- to posttest between mothers in the two groups in regard to total PTSD symptoms or reexperiencing or hyperarousal symptoms.
Studies Measuring Outcome	Study 1
Study Designs	Experimental
Quality of Research Rating	3.7 (0.0-4.0 scale)

Outcome 6: Maternal mental health symptoms other than PTSD symptoms

Description of Measures	Maternal mental health symptoms were assessed using the Symptom Checklist-90-Revised (SCL-90-R). This 90-item self-report checklist measures current psychiatric symptoms in nine dimensions: somatization, obsessive-compulsive, interpersonal sensitivity, depression, anxiety, hostility, phobic anxiety, paranoid ideation, and psychoticism. The Global Severity Index of the SCL-90-R, the average of all 90 items, indicates current distress and was used to assess maternal functioning.
Key Findings	In a study involving preschool children exposed to marital violence, mother-child dyads were randomly assigned to the intervention group or a comparison group, which received case management services plus individual psychotherapy in the community for mother and/or child, at a clinic chosen by the mother. From pre- to posttest, mothers in the intervention group had a decrease in mental health symptoms relative to those in the comparison group, but the result was not significant. From pretest to 6-month follow-up, mothers in the intervention group had a significant decrease in mental health symptoms relative to those in the comparison group (p < .05). This result had a small effect size (Cohen's d = 0.38).
Studies Measuring Outcome	Study 1
Study Designs	Experimental
Quality of Research Rating	3.3 (0.0-4.0 scale)

Study Populations

The following populations were identified in the studies reviewed for Quality of Research.

Study	Age	Gender	Race/Ethnicity
Study 1	0-5 (Early childhood) 18-25 (Young adult)	52% Female 48% Male	41.3% Race/ethnicity unspecified 28% Hispanic or Latino

	26-55 (Adult)		14.7% Black or African American 9.3% White 6.7% Asian
Study 2	0-5 (Early childhood) 18-25 (Young adult) 26-55 (Adult)	55.7% Male 44.3% Female	76.2% Race/ethnicity unspecified 23.8% White
Study 3	0-5 (Early childhood) 18-25 (Young adult) 26-55 (Adult)	52.8% Male 47.2% Female	92.9% White 7.1% Race/ethnicity unspecified

Quality of Research Ratings by Criteria (0.0-4.0 scale)

External reviewers independently evaluate the Quality of Research for an intervention's reported results using six criteria:

1. Reliability of measures
2. Validity of measures
3. Intervention fidelity
4. Missing data and attrition
5. Potential confounding variables
6. Appropriateness of analysis

For more information about these criteria and the meaning of the ratings, see Quality of Research.

Outcome	Reliability of Measures	Validity of Measures	Fidelity	Missing Data/Attrition	Confounding Variables	Data Analysis	Overall Rating
1: Child PTSD symptoms	4.0	4.0	2.5	4.0	4.0	3.5	**3.7**
2: Child behavior problems	4.0	4.0	2.5	3.5	2.5	3.5	**3.3**
3: Children's representational models	4.0	4.0	3.0	4.0	3.5	4.0	**3.8**
4: Attachment security	4.0	4.0	3.5	4.0	4.0	4.0	**3.9**
5: Maternal PTSD symptoms	4.0	4.0	2.5	4.0	4.0	3.5	**3.7**
6: Maternal mental health symptoms other than PTSD symptoms	4.0	4.0	2.5	3.5	2.5	3.5	**3.3**

Study Strengths

The studies included measures that are widely used and supported by the literature and have good psychometric properties. The intervention was manualized, and all therapists were trained in the delivery of the intervention. Sessions were monitored weekly and videotaped monthly to assess implementation fidelity, and therapists used an adherence checklist. Differential attrition (i.e., differences between dropped and retained subjects) was evaluated appropriately, and the analyses accounted for missing data. Data analysis methods were thorough and appropriate.

Study Weaknesses

Although fidelity was monitored, it was not measured systematically, and no standard fidelity instruments or measurements were used. In one of the studies, the small sample size and high attrition at the 6-month follow-up raise concerns about potential confounds for two outcomes: child problem behaviors and maternal mental health symptoms other than PTSD.

Readiness for Dissemination
Review Date: June 2010

Materials Reviewed

The materials below were reviewed for Readiness for Dissemination. The implementation point of contact can provide information regarding implementation of the intervention and the availability of additional, updated, or new materials.

Child-Parent Psychotherapy in Clinical Practice: A Follow-Up Survey of Clinicians Trained in CPP

Child-Parent Psychotherapy Learning Collaborative. (2008). Faculty agenda learning sessions one to three.

Child-Parent Psychotherapy Learning Collaborative. (n.d.). Improving capacity for early childhood mental health providers and trauma intervention application.

Child-Parent Psychotherapy Supervision Checklist

Child-Parent Psychotherapy Training Checklist

Habib, M., Schneider, A., Knoverek, A., Van Horn, P., Hastings, J., Kisiel, C., et al. (2008). Partnerships that work: Applications of trauma-focused interventions for children and adolescents. Poster presented at the 24th annual meeting of the International Society for Traumatic Stress Studies, Chicago, IL.

ICF Macro & the NCTSI Cross-site Evaluation Team. (2009). AIFI summary report: Child-Parent Psychotherapy. Cross-site evaluation of the National Child Traumatic Stress Initiative. Atlanta, GA: Author.

Lieberman, A. F., & Van Horn, P. (2005). Don't hit my mommy!: A manual for Child-Parent Psychotherapy with young witnesses of family violence. Washington, DC: ZERO TO THREE.

Lieberman, A. F., & Van Horn, P. (2008). Psychotherapy with infants and young children: Repairing the effects of stress and trauma on early attachment. New York: Guilford Press.

Lieberman, A. F., & Van Horn, P. (n.d.). Using Child-Parent Psychotherapy to treat young children exposed to trauma [PowerPoint slides].

Lyons, J. (2008). Evidence-based trauma interventions for foster children in Illinois. Presentation to funders and stakeholders, Chicago, IL.

Program Web site, http://childtrauma.ucsf.edu/

Toth, S., Manly, J. T., Rogosch, F. A., & Cicchetti, D. (n.d.). IPP Intervention Fidelity Checklist.

Van Horn, P., & Lieberman, A. F. (n.d.). Child Parent Psychotherapy: A manual for trainers.

Readiness for Dissemination Ratings by Criteria (0.0-4.0 scale)

External reviewers independently evaluate the intervention's Readiness for Dissemination using three criteria:

1. Availability of implementation materials
2. Availability of training and support resources
3. Availability of quality assurance procedures

For more information about these criteria and the meaning of the ratings, see Readiness for Dissemination.

Implementation Materials	Training and Support Resources	Quality Assurance Procedures	Overall Rating
3.4	4.0	3.5	**3.6**

Dissemination Strengths

Implementation materials are current and professionally produced, and they include case illustrations to highlight clinical themes, assessments and interpretations of clinical data, treatment planning guidance, and information on intervention strategies. Core components of the therapeutic practices are clearly delineated and described. CPP's theoretical foundations, as well as information on the knowledge areas and skill sets required for therapists, are detailed and easy to understand. Highly developed training and support resources are available for new and current therapists, supervisors, and trainers of practitioners, including a scripted training manual and training videos for trainers and case vignettes for therapists. Quality assurance and outcome measurement are emphasized as key components of implementation. Standardized assessment instruments assist the therapist in structuring CPP's highly individualized interventions. Multiple forms and processes support quality of care and fidelity to CPP's core components.

Dissemination Weaknesses

The training manual lacks details regarding the elements essential for model implementation and the necessary requirements of therapist certification. The administration of standardized instruments is recommended as part of the initial assessment, but little information is provided for ongoing measurements of parent and child progress throughout treatment or as part of supervision related to quality assurance and fidelity. Similarly, discussion on supervision related to quality assurance and fidelity does not include details on measuring

the accomplishment of goals listed in the case plan.

Costs

The cost information below was provided by the developer. Although this cost information may have been updated by the developer since the time of review, it may not reflect the current costs or availability of items (including newly developed or discontinued items). The implementation point of contact can provide current information and discuss implementation requirements.

Item Description	Cost	Required by Developer
Psychotherapy With Infants and Young Children: Repairing the Effects of Stress and Trauma on Early Attachment (manual)	$35.79 for hardcover, $28 for paperback, or $21.95 for Kindle edition	Yes
Don't Hit My Mommy!: A Manual for Child-Parent Psychotherapy With Young Witnesses of Family Violence	$24.95 each	Yes
1-year full-time internship at specialized NCTSN sites (includes intensive didactic training, clinical practice, and weekly supervision by multiple supervisors)	Free	Yes (one training option is required)
1.5-year training through the NCTSN Learning Collaborative Model (includes three 2- to 3-day workshops for therapists, a half-day training for supervisors, and bimonthly phone consultation)	Free, except for travel expenses	Yes (one training option is required)
1.5-year training for a learning community (i.e., multiple agencies sharing the cost of training) or an individual agency (includes three 2- to 3-day workshops for therapists, a half-day training for supervisors, and bimonthly clinical consultation in person, by phone, or by video chat)	$1,500-$3,000 per day of training (depending on trainer experience) for up to 30 participants, plus travel expenses	Yes (one training option is required)
Additional phone, email, or in-person consultation	$150-$350 per hour (depending on trainer experience), plus travel expenses if necessary	No
Intervention fidelity checklist, training checklist, and supervision checklist	Free	No

Replications

Selected citations are presented below. An asterisk indicates that the document was reviewed for Quality of Research.

Cicchetti, D., Rogosch, F. A., & Toth, S. L. (2000). The efficacy of Toddler-Parent Psychotherapy for fostering cognitive development in offspring of depressed mothers. Journal of Abnormal Child Psychology, 28(2), 135-148. PubMed

Cicchetti, D., Rogosch, F. A., & Toth, S. L. (2006). Fostering secure attachment in infants in maltreating families through preventive interventions. Development and Psychopathology, 18(3), 623-649. PubMed

Cicchetti, D., Toth, S. L., & Rogosch, F. A. (1999). The efficacy of Toddler-Parent Psychotherapy to increase attachment security in offspring of depressed mothers. Attachment and Human Development, 1(1), 34-66. PubMed

Habib, M., Schneider, A., Knoverek, A., Van Horn, P., Hastings, J., Kisiel, C., et al. (2008). Partnerships that work: Applications of trauma-focused interventions for children and adolescents. Poster presented at the 24th annual meeting of the International Society for Traumatic Stress Studies, Chicago, IL.

Lieberman, A. F., Weston, D. R., & Pawl, J. H. (1991). Preventive intervention and outcome with anxiously attached dyads. Child Development, 62(1), 199-209. PubMed

Lyons, J. (2008). Evidence-based trauma interventions for foster children in Illinois. Presentation to funders and stakeholders, Chicago, IL.

Contact Information

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Consider these Questions to Ask (PDF, 54KB) as you explore the possible use of this intervention.

This PDF was generated from http://nrepp.samhsa.gov/ViewIntervention.aspx?id=194 on 4/20/2015

Child Welfare Information Gateway

PROTECTING CHILDREN ■ STRENGTHENING FAMILIES

Parent-Child Interaction Therapy With At-Risk Families

Parent-child interaction therapy (PCIT) is a family-centered treatment approach proven effective for abused and at-risk children ages 2 to 8 and their caregivers—birth parents, adoptive parents, or foster or kin caregivers. During PCIT, therapists coach parents while they interact with their children, teaching caregivers strategies that will promote positive behaviors in children who have disruptive or externalizing behavior problems. Research has shown that, as a result of PCIT, parents learn more effective parenting techniques, the behavior problems of children decrease, and the quality of the parent-child relationship improves.

What's Inside:

- What makes PCIT unique?
- Key components
- Effectiveness of PCIT
- Implementation in a child welfare setting
- Resources for further information

1912 2012

Children's Bureau

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This issue brief is intended to build a better understanding of the characteristics and benefits of PCIT. It was written primarily to help child welfare caseworkers and other professionals who work with at-risk families make more informed decisions about when to refer parents and caregivers, along with their children, to PCIT programs. This information may also help parents, foster parents, and other caregivers understand what they and their children can gain from PCIT and what to expect during treatment. This brief also may be useful to others with an interest in implementing or participating in effective parent-training strategies.

What Makes PCIT Unique?

Introduced in the 1970s as a way to treat young children with serious behavioral problems, PCIT has since been adapted successfully for use with populations who have experienced trauma due to child abuse or neglect. The distinctiveness of this approach lies in the use of live coaching and the treatment of both parent and child together. PCIT is the only evidence-based practice in which the parent and child are treated together throughout the course of all treatment sessions. As a result, it is a more intensive parenting intervention and most applicable for children with serious behavioral problems, parents with significant limitations (e.g., substance abuse, limited intellectual ability, mental health problems), and/or parents at risk for child maltreatment. In randomized testing, including families identified by the child welfare system, PCIT has consistently demonstrated success in improving parent-child interactions. Benefits

of the model, which have been experienced by families along the child welfare continuum, such as at-risk families and those with confirmed reports of maltreatment or neglect, are described below.

"Parent-child interaction therapy is one of the most effective evidence-based practices in the field today. Using an *in vivo* training technique, parents acquire more effective parenting skills, children's behavioral problems improve, and together they develop a more positive and affectionate relationship. The positive affiliative nature developed as a result of participation in PCIT strengthens attachment and builds resilience in at-risk families."

Anthony Urquiza, Ph.D., Director of Mental Health Services and Clinical Research at the University of California at Davis CAARE Center

Reduces Behavior Problems in Young Children by Improving Parent-Child Interaction

PCIT was originally designed to treat children ages 2 to 8 with disruptive or externalizing behavior problems, including conduct and oppositional defiant disorders. These children are often described as negative, argumentative, disobedient, and aggressive.

PCIT addresses the negative parent-child interaction patterns that contribute to the disruptive behavior of young children (Bell & Eyberg, 2002). Through PCIT, parents learn to bond with their children and develop more effective parenting styles that better meet their children's needs. For example, parents learn to model and reinforce constructive

ways for dealing with emotions, such as frustration. Children, in turn, respond to these healthier relationships and interactions. As a result, children treated using PCIT typically show significant reductions in behavior problems at home and at school (Brinkmeyer & Eyberg, 2003; Gallagher, 2003; McNeil, Eyberg, Eisenstatdt, Newcomb, & Funderburk, 1991; McNeil & Hembree-Kigin, 2010; Nixon, Sweeney, Erickson, & Touyz, 2003; Schuhmann, Foote, Eyberg, Boggs, & Algina, 1998).

Treats the Parent and Child Together

While many treatment approaches target either parents or children, PCIT focuses on changing the behaviors of both the parent and child together. Parents learn to model positive behaviors that children can learn from and are trained to act as "agents of change" for their children's behavioral or emotional difficulties (Herschell & McNeil, 2005). Sitting behind a one-way mirror and coaching the parent through an "ear bug" audio device, therapists guide parents through strategies that reinforce their children's positive behavior. In addition, PCIT therapists are able to tailor treatment based on observations of parent-child interactions. As such, PCIT can help address specific needs of each parent and child.

Decreases the Risk for Child Physical Abuse and Breaks the Coercive Cycle

PCIT has been found effective for physically abusive parents with children ages 2 to 12 (Borrego, Urquiza, Rasmussen, & Zebell, 1999; Chaffin et al., 2004; Chaffin et al., 2009; Hakman, Chaffin, Funderburk, & Silovsky, 2009; Chaffin, Funderburk, Bard, Valle, & Gurwitch, 2011). PCIT is appropriate where physical abuse occurs within the context of

child discipline, as most physical abuse does. While child behavior problems and child physical abuse often co-occur, PCIT may help change the parental response to challenging child behaviors, regardless of the type of behavior problem.

Foundational research has shown that many complex factors contribute to abusive behaviors, including a coercive relationship between the parent and child (Fisher & Kane, 1998; Urquiza & McNeil, 1996). Abusive and at-risk parents often interact in negative ways with their children, use ineffective and inconsistent discipline strategies, and rely too much on punishment. These same parents rarely interact in positive ways with their children (e.g., rewarding good behavior). At the same time, some physically abused and at-risk children learn to be aggressive, defiant, noncompliant, and resistant to parental direction (Kandel, 1992; Larzelere, 1986). The reciprocal negative behaviors of the parent and child create a harmful cycle that often escalates to the point of severe corporal punishment and physical abuse. The negative behaviors of the parent—screaming and threatening—reinforce the negative behaviors of the child—such as unresponsiveness and disobedience, which further aggravates the parent's behavior and may result in violence. PCIT helps break this cycle by encouraging positive interaction between parent and child and training parents in how to implement consistent and nonviolent discipline techniques when children act out.

Parents and caretakers completing PCIT typically:

- Show more positive parenting attitudes and demonstrate improvements in the ways that they listen to, talk to, and interact with their children (McNeil & Hembree-Kigin, 2010)

- Report less stress (Timmer, Urquiza, Zebell, & McGrath, 2005)

- Use less corporal punishment and physically coercive means to control their children (Chaffin et al., 2011)

In addition, parent satisfaction with PCIT is typically high (Chaffin et al., 2004).

Offers Support for Caregivers Including Foster Parents

PCIT is now recognized as a way to help support foster parents caring for children with behavioral problems by enhancing the relationship between foster parents and foster children and by teaching foster parents behavior management skills. In addition to reporting decreases in child behavior problems, foster parents frequently report less parental stress following PCIT and high levels of satisfaction with the program (McNeil, Herschell, Gurwitch, & Clemens-Mowrer, 2005; Timmer, Urquiza, & Zebell, 2005). One benefit of providing foster parents with PCIT skills is that they can use these same effective parenting skills with future generations of foster children.

Uses Live Coaching

PCIT is a behavioral parent-training model. What makes PCIT different from other parent training programs is the way skills are taught, using live coaching of parents and children together. Live coaching provides immediate prompts to parents while they interact with their children. During the course of this hands-on treatment, parents are guided to demonstrate specific relationship-building and discipline skills.

The benefits of live coaching are significant:

- Parents are provided with opportunities to practice newly taught skills.

- Therapists can correct errors and misunderstandings on the spot.

- Parents receive immediate feedback.

- Parents are offered support, guidance, and encouragement as they learn.

- Treatment gains (e.g., increases in child compliance) are recognized by the parent "in the moment"–which supports continued use of effective parenting skills.

Research is currently underway to determine if PCIT training can be administered via the Internet with Remote Real-Time (RRT) training. The University of Oklahoma is piloting these studies (see http://www.oumedicine. com/pediatrics/department-sections/ developmental-behavioral-pediatrics/child-study-center/programs-and-clinical-services/ parent-child-interaction-therapy/information-for-professionals/pcit-research-at-ouhsc).

Adaptations for Various Populations

While PCIT was originally applied to Caucasian families, it has been adapted for use with various populations and cultures, including:

- Families in which child abuse has occurred (Chaffin et al., 2011; Timmer, Urquiza, Zebell, & McGrath 2005)

- Trauma victims/survivors (The National Child Traumatic Stress Network, n.d.; Urquiza, 2010)

- Children with prenatal exposure to alcohol (e.g., Bertrand, 2009)

- Children aged 18–60 months with externalizing behaviors who were premature births (Bagner, Sheinkopf, Vohr, & Lester, 2010)

- Children with developmental delays and/or mental retardation (Bagner & Eyberg, 2007)

- Older children (McNeil & Hembree-Kigin, 2010)

- Foster parents and maltreated children (Timmer, Urquiza, & Zebell, 2005)

- African-American families (Fernandez, Butler, & Eyberg, 2011)

- Latino and Spanish-speaking families (Borrego, Anhalt, Terao, Vargas, & Urquiza, 2006; McCabe & Yeh, 2009)

- Native American families (Bigfoot & Funderburk, 2011)

Limitations of PCIT

While PCIT is very effective in addressing certain types of problems, there are clear limitations to its use. For the following populations, PCIT may not be appropriate, or specific modifications to treatment may be needed:

- Parents who have limited or no ongoing contact with their child

- Parents with serious mental health problems that may include auditory or visual hallucinations or delusions

- Parents who are hearing impaired and would have trouble using the ear bug device, or parents who have significant expressive or receptive language deficits

- Sexually abusive parents, or parents engaging in sadistic physical abuse, or parents with substance abuse issues

Key Components

PCIT is typically provided in 10 to 20 sessions, with an average of 12 to 14 sessions, each lasting about 1 to 1.5 hours. Occasionally, additional treatment sessions are added as needed.

The PCIT curriculum uses a two-phase approach addressing:

1. Relationship enhancement

2. Discipline and compliance

Initially, the therapist discusses the key principles and skills of each phase with the parents. Then, the parents interact with their children and try to implement the particular skills. The therapist typically observes from behind a one-way mirror while communicating with the parent, who wears a small wireless earphone. Although not optimal, clinicians who do not have access to a one-way mirror and ear bug may provide services using in-room coaching. Specific behaviors are tracked on a graph over time to provide parents with feedback about the achievement of new skills and their progress in positive interactions with their child.

Phase 1: Relationship Enhancement (Child-Directed Interaction)

The first phase of treatment focuses on improving the quality of the relationship between the parent and the child. This phase emphasizes building a nurturing relationship and secure bond between parent and child. Phase I sessions are structured so that the child selects a toy or activity, and the parent plays along while being coached by the

therapist. Because parents are taught to follow the child's lead, this phase also is referred to as child-directed interaction (CDI).

During Phase I sessions, parents are instructed to use positive reinforcement. In particular, parents are encouraged to use skills represented in the acronym "PRIDE":

- **Praise.** Parents provide praise for a child's appropriate behavior—for example, telling them, "good job cleaning up your crayons"—to help encourage the behavior and make the child feel good about his or her relationship with the parent.

- **Reflection.** Parents repeat and build upon what the child says to show that they are listening and to encourage improved communication.

- **Imitation.** Parents do the same thing that the child is doing, which shows approval and helps teach the child how to play with others.

- **Behavioral Description.** Parents describe the child's activity (e.g., "You're building a tower with blocks") to demonstrate interest and build vocabulary.

- **Enjoyment.** Parents are enthusiastic and show excitement about what the child is doing.

Parents are guided to praise wanted behaviors, like sharing, and to ignore unwanted or annoying behaviors, such as whining (unless the behaviors are destructive or dangerous). In addition, parents are taught to avoid criticisms or negative words—such as "No," "Don't," "Stop," "Quit," or "Not"— and instead concentrate on positive directions.

In addition to the coached sessions, parents are given homework sessions of 5 minutes each day to practice newly acquired skills with their child. Once the parent's skill level meets the program's identified criteria, the second phase of treatment is initiated.

Phase II: Discipline and Compliance (Parent-Directed Interaction)

The second phase of PCIT concentrates on establishing a structured and consistent approach to discipline. During this phase, also known as parent-directed interaction (PDI), the parent takes the lead. Parents are taught to give clear, direct commands to the child and to provide consistent consequences for both compliance and noncompliance. When a child obeys the command, parents are instructed to provide labeled or specific praise (e.g., "Thank you for sitting quietly"). When a child disobeys, however, the parents initiate a timeout procedure. The timeout procedure typically begins with the parent issuing the child a warning and a clear choice of action (e.g., "Put your toys away or go to timeout") and may advance to sending the child to a timeout chair.

Parents are coached in the use of these skills during a play situation where they must issue commands to their child and follow through with the appropriate consequence for compliance/noncompliance. In addition, parents are provided with strategies for managing challenging situations outside of therapy (for example, when a child throws a tantrum in the grocery store or hits another child). Parents also are given homework in this phase to aid in skill acquisition.

Assessments

In addition to clinical interviews, PCIT uses a combination of observational and

standardized assessment measures to assess interactions between parent and child, child behaviors, and parental perception of stress related to being a parent, as well as parents' own perceptions of the difficulty of their child's behaviors and their interactions with their child. Assessments are conducted before, during, and after treatment.

Effectiveness of PCIT

The effectiveness of PCIT is supported by a growing body of research and increasingly identified on inventories of model and promising treatment programs.

Demonstrated Effectiveness in Outcome Studies

At least 30 randomized clinical outcome studies and more than 10 true randomized trials have found PCIT to be useful in treating at-risk families and children with behavioral problems. Research findings include the following:

- **Trauma adaptation.** PCIT is now commonly referred to in the cluster of trauma-informed strategies. Trauma adaption to the model was examined in a study of PCIT in meeting the needs of mother-child dyads exposed to Interpersonal Violence (IPV) by reducing children's behavior problems and decreasing mothers' distress (Timmer, Ware, Urquiza, & Zebell, 2010).

- **Reductions in the risk of child abuse.** In a study of 110 physically abusive parents, only one-fifth (19 percent) of the parents participating in PCIT had re-reports of physically abusing their children after 850 days, compared to half (49 percent) of the

parents attending a typical community parenting group (Chaffin et al., 2004). Reductions in the risk of abuse following treatment have been confirmed in other studies among parents who had abused their children (e.g., Hakman et al., 2009; Chaffin et al., 2011).

- **Improvements in parenting skills and attitudes.** Research reveals that parents and caretakers completing PCIT typically demonstrate improvements in reflective listening skills, use more prosocial verbalization, direct fewer sarcastic comments and critical statements at their children, improve physical closeness to their children, and show more positive parenting attitudes (McNeil & Hembree-Kigin, 2010).

- **Improvements in child behavior.** A review of 17 studies that included 628 preschool-aged children identified as exhibiting a disruptive behavior disorder concluded that involvement in PCIT resulted in significant improvements in child behavior functioning. Commonly reported behavioral outcomes of PCIT included both less frequent and less intense behavior problems as reported by parents and teachers, increases in clinic-observed compliance, reductions in inattention and hyperactivity, decreases in observed negative behaviors such as whining or crying, and reductions in the percentage of children who qualified for a diagnosis of disruptive behavior disorder (Gallagher, 2003).

- **Benefits for parents and other caregivers.** Examining PCIT effectiveness among foster parents participating with their foster children and biological parents referred for treatment because of their children's behavioral problems, researchers found

decreases in child behavior problems and caregiver distress for both groups (Timmer, Urquiza, & Zebell, 2005).

- **Lasting effectiveness.** Follow-up studies report that treatment gains are maintained over time (Eyberg et al., 2001; Hood & Eyberg, 2003).

- **Usefulness in treating multiple issues.** Adapted versions of PCIT also have been shown to be effective in treating other issues such as separation anxiety, depression, self-injurious behavior, attention deficit hyperactivity disorder (ADHD), and adjustment following divorce (Johnson, Franklin, Hall, & Preito, 2000; Pincus, Choate, Eyberg, & Barlow, 2005).

- **Adaptability for a variety of populations.** Studies support the benefits of PCIT across genders and across a variety of ethnic groups (Capage, Bennett, & McNeil, 2001; Chadwick Center on Children and Families, 2004; McCabe, 2005).

Recognition as an Evidence-Based Practice

Based on systematic reviews of available research and evaluation studies, a number of expert groups have highlighted PCIT as a model program or promising treatment practice, including:

- The California Evidence-Based Clearinghouse for Child Welfare (http://www.cebc4cw.org/program/parent-child-interaction-therapy)

- The National Child Traumatic Stress Network (http://www.nctsn.org/sites/default/files/assets/pdfs/pcit_general.pdf)

- National Crime Victims Research and Treatment Center and The Center for Sexual Assault and Traumatic Stress; Office for Victims of Crime, U.S. Department of Justice (http://academicdepartments.musc.edu/ncvc/resources_prof/OVC_guidelines04-26-04.pdf)

Implementation of PCIT in a Child Welfare Setting

When introducing PCIT as a referral option that child welfare workers may consider for children and families in their caseload, administrators will want to ensure that workers have a clear understanding of how PCIT works, the values that drive it, and its effectiveness. Training for child welfare staff on the basics of PCIT, how to screen at-risk children with behavior problems, and how to make appropriate referrals can expedite families' access to effective treatment options.

A free online training on the fundamentals of PCIT, the "PCIT for Traumatized Children Web Course" can be accessed from the UC Davis PCIT Training Center website (http://pcit.ucdavis.edu/). This is a 10-hour web course with eight separate modules that discuss and show the basics of PCIT treatment and three supplemental modules on cultural considerations of treatment, parent factors affecting PCIT provision, and strategies for engaging parents in treatment. Module 2, "Overview of PCIT," was designed to educate professionals who work with children in the child welfare system. This training may help a child welfare professional decide whether to refer a family to a qualified therapist for PCIT.

Finding a Therapist

Caseworkers should become knowledgeable about commonly used treatments before recommending a treatment provider to families. Caregivers should receive as much information as possible on the treatment options available to them. If PCIT is an appropriate treatment model for a family, seek a provider who has received adequate training, supervision, and consultation in the PCIT model. If feasible, both the caseworker and family should have an opportunity to interview potential PCIT therapists before beginning treatment.

PCIT Training

Mental health professionals with at least a master's degree in psychology, social work, or a related field are eligible for training in PCIT. Training involves 40 hours of direct training, with ongoing supervision and consultation for approximately 4 to 6 months, working with at least two PCIT cases through completion. Fidelity to the model is assessed throughout the supervision and consultation period.

Questions to Ask Treatment Providers

In addition to the appropriate training, it is important to select a treatment provider who is sensitive to the individual and cultural needs of the child, caregiver, and family. Caseworkers recommending a PCIT therapist should ask the treatment provider to explain the course of treatment, the role of each family member, and how the family's cultural background will be addressed. Family members should be involved in this discussion to the extent possible. The child, caregiver, and family should feel comfortable with, and have confidence in, the therapist with whom they will work.

Some specific questions to ask a potential therapist regarding PCIT include:

- How will the parent be involved in this process?

- What is the nature of your PCIT training? When were you trained? By whom? How long was the training? Do you have access to follow-up consultation? What resource materials on PCIT are you familiar with? Are you clinically supervised by (or do you participate in a peer supervision group with) others who are PCIT trained?

- Why do you feel that PCIT is the appropriate treatment model for this child? Would the child benefit from other treatment methods after they complete PCIT (i.e., group or individual therapy)?

- What techniques will you use to help the child manage his or her emotions and related behaviors?

- Do you use a standard assessment process to gather baseline information on the functioning of the child and family and to monitor their progress in treatment over time?

- Do you have access to the appropriate equipment for PCIT (one-way mirror, ear bug, video equipment)? If not, how do you plan to structure the sessions to ensure that the PCIT techniques are used according to the model?

- Is there any potential for harm associated with treatment?

Conclusion

PCIT is a parent-training strategy with benefits for many families with child welfare involvement. PCIT's live coaching approach guides parents while they develop needed skills to manage their children's behavior. As parents learn to reinforce positive behaviors, while also setting limits and implementing appropriate discipline techniques, children's behavioral problems decrease. Notably, the risk for re-abuse in these families also declines. PCIT holds much promise to continue helping parents and caregivers build nurturing relationships that strengthen families and provide healthy environments for children to thrive.

Resources

The California Evidence-Based Clearinghouse for Child Welfare
http://www.cachildwelfareclearinghouse.org/

Chadwick Center on Children and Families
http://www.chadwickcenter.org

Child Welfare Information Gateway
https://www.childwelfare.gov/

National Child Traumatic Stress Network
http://www.nctsn.org

Parent Child Interaction Therapy International
http://www.pcit.org/

Parent Child Interaction Therapy Training Center PCIT for Traumatized Children Web Course
http://pcit.ucdavis.edu/pcit-web-course/

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U.S. Department of Health and Human Services
Administration for Children and Families
Administration on Children, Youth and Families
Children's Bureau

ACF

Children's Bureau

Wrap Up and Reflections

Session 10

Please note that in preparation for this you should have the originals of the pre tests which were completed in session one. The goal of this session is to be guided reflection and processing. There are key questions listed throughout. Note to the instructor: you will need to either create time in the session to conduct and score the assessments, or deliver them before.

Re-Evaluations

Re-take initial assessments
Review scores from pre-tests:
- MCKAS
- Implicit Attitudes Test
- Empathy Scale

- What do the changes in these tell you

The goal of this session is to be guided reflection and processing. There are key questions listed throughout. Note to the instructor: you will need to either create time in the session to conduct and score the assessments, or deliver them before.

Further Considerations

- How will you continue your learning?
- Who can you ask for help?
- What is your personal commitment to do next?
- What do we all need to be doing to better serve our young African American families and their children?

Below is the usage information for the MCKAS scale, for your information. The scale itself can be found by obtaining one of the published materials below.

March 10, 2005

Dear MCKAS User:

   Enclosed is the MCKAS, scoring directions, and the "Utilization Request Form" which must be carefully read, endorsed, and returned prior to MCKAS use.

   Please note that the development and _initial_ validity studies on the MCKAS (originally titled the MCAS) were published as a lengthy chapter in the following book:

> **Ponterotto, J.G. et al. (1996). Development and initial validation of the Multicultural Counseling Awareness Scale. In G.R. Sodowsky & J.C. Impara (Eds.), Multicultural assessment in counseling and clinical psychology (pp. 247-282). Lincoln NE: Buros Institute of Mental Measurements.**

The book can be ordered through Buros by calling 402-472-6203; or by writing to Buros Institute of Mental Measurements, Department of Educational Psychology, 135 Bancroft Hall, University of Nebraska, Lincoln, NE 68588-0348.

The revised MCKAS is presented in:

> **Ponterotto, J.G., Gretchen, D., Utsey, S. O., Riger, B. P., & Austin, R. (2002). A revision of the multicultural counseling awareness scale. Journal of Multicultural Counseling and Development, 30, 153-181.**

The latest presentation, critique, and user guidelines for the MCKAS is presented in:

> **Ponterotto, J. G., & Potere, J. C. (2003). The Multicultural Counseling Knowledge and Awareness Scale (MCKAS): Validity, reliability, and user guidelines. In D. P. Pope-Davis, H. L. K. Coleman, W. M. Liu, & R. Toporek (Eds), Handbook of multicultural competenices in counseling and psychology (pp. 137-153). Thousand Oaks, CA: Sage. (Any user of the MCKAS must read this source.)**

Critical reviews of the MCAS/MCKAS and other multicultural competency measures can be found in:

> Constantine, M. G., & Ladany, N. (2001). New visions for defining and assessing multicultural counseling competence. In J.G. Ponterotto, J.M. Casas, L.A. Suzuki, & C.M. Alexander (Eds.), Handbook of multicultural counseling (2nd ed., pp. 482-498). Thousand Oaks, CA: Sage Publication.

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Utilization Request Form

In using the Multicultural Counseling Knowledge and Awareness Scale (MCKAS), I agree to the following terms/conditions:

1. I understand that the MCKAS is copyrighted by Joseph G. Ponterotto (Ph.D.) at the Division of Psychological and Educational Services, Fordham University at Lincoln Center, 113 West 60th Street, New York, New York 10023-7478 (212-636-6480); Jponterott@aol.com.

2. I am a trained professional in counseling, psychology, or a related field, having completed coursework (or training) in multicultural issues, psychometrics, and research ethics, or I am working under the supervision of such an individual.

3. In using the MCKAS, all ethical standards of the American Psychological Association, the American Counseling Association, and/or related professional organizations will be adhered to. Furthermore, I will follow the "Research with Human Subjects" guidelines put forth by my university, institution, or professional setting. Ethical considerations include but are not limited to subject informed consent, confidentiality of records, adequate pre- and post-briefing of subjects, and subject opportunity to review a concise written summary of the study's purpose, method, results, and implications.

4. Consistent with accepted professional practice, I will save and protect my raw data for a minimum of five years; and if requested I will make the raw data available to scholars researching the multicultural counseling competency construct.

5. I will send a copy of my research results (for any study incorporating the MCKAS) in manuscript form to Dr. Ponterotto, regardless of whether the study is published, presented, or fully completed.

Signature:_____ Date:_____

Name:_____Phone:_____

Address:_____

_____

_____

If a student, supervisor/mentor's name and phone number, affiliation, and signature:

Name:_____Phone:_____

Affiliation:_____

Signature:_____Date:_____