Center for Advanced Studies in Child Welfare

# Practice Notes

## *Responding to Traumatic Events: Children in Life-Threatening Circumstances*

Issue #20, Fall 2007

There is never a one-time trauma. As human beings, we think, we feel, we remember.

*- Interview with Dr. L. Read Sulik, MD, FAAP, Medical Director, Child and Adolescent Psychiatry, St. Cloud Hospital Behavioral Health Clinic*

## EDITORIAL COMMENTS

Trauma suffered by children has struck a deep chord within the Child Welfare system. Workshops, conferences, networks, and research centers have all recently emerged, dealing with some aspect of an horrific event experienced by children. Perhaps this is a residue of recent events: 9/11; school shootings; the Katrina disaster; and parents turning up with child refugee survivors of murderous violence in war-torn countries. There appears to be a lingering perception of an unsafe world for children.

In Minnesota, a busload full of children on a collapsing bridge was a startling reminder of how unexpectedly tragedy can strike. We have had other reminders of traumatic events: community violence and witnessing the arrest and turmoil of parents in immigration raids. In this edition of Practice Notes, we have acknowledged a few of these episodes. We have attempted to understand the children's experiences and the therapeutic responses to their condition. Practitioners in the field have provided the essential content, for this edition of *Practice Notes*.

IN THIS EDITION:



In reviewing the literature, we raised a question: Can an external, horrific event, experienced in childhood, create behavioral changes that go beyond the immediate impact and actually create internal changes that may last a lifetime? The researchers in the field say, "yes," and assert that a traumatic event can produce panic, irritability, hyper-vigilance that may shake confidence in oneself to master life's events, inflicting a sense of a severely limited future—the essence of depression. That is the key to the importance of the topic. Children and military personnel from Iraq share the same symptoms of Post-Traumatic Stress Disorder (PTSD).

It should be remembered that the chances of a child experiencing a horrific event are small. Yet this metropolitan community is fortunate in having many therapists who have mastered reliable methods of therapeutic interventions. We are grateful to them for taking the time to share with us their therapeutic experiences. (Please see "Acknowledgements" section.)

This group and others have been active in training teachers and parents how to respond to the first stages of trauma, events which are full of confusion and chaos; how to handle stress; and how to provide assurance that adults can be protective and nurturing.

The phenomenon of childhood trauma in the very early years has opened up research on memory systems and brain development with a guiding question: What is remembered from the earliest years?

This observation comes from therapists: children who have no explicit memory of a traumatic event are more likely to be diagnosed with ADHD, because they appear to be reacting out of context and have no way of explaining their own behavior. Some in the research field are suggesting that we should rethink the origin of behavioral disorders in children: the root cause may not be developmental, but rather lodged in an early traumatic event that went untreated.

CURA Center for Urban and Regional Affairs

SCHOOL OF SOCIAL WORK

COLLEGE OF EDUCATION + HUMAN DEVELOPMENT

UNIVERSITY OF MINNESOTA

The extent to which services for trauma treatment are available within the Child Welfare system varies, regionally, across the state, and this disparity needs attention.

The definition of "trauma" is undergoing changes. The forthcoming DSM-V will include a definition of PTSD specifically for children, allowing for consistent diagnosis.

We should revisit this topic when new definitions and fresh research findings are disclosed. Trauma and the implications for Child Welfare is a work in progress. -*E.W.*

## DEFINITIONS

*Trauma*

Trauma is defined as the internal, emotional impact on an individual, resulting from experiencing or confronting a significant unanticipated event often threatening death or serious injury, or threat to the physical integrity of oneself or others. A child's response to the traumatic incident often includes intense fear, disorganized and agitated behavior, helplessness or horror.

*Post-Traumatic Stress Disorder: PTSD*

Post-traumatic stress disorder (PTSD) is an anxiety disorder that develops following exposure to an extreme stressor. In young children, repetitive play or trauma-specific reenactment may occur in which themes or aspects of the trauma are expressed. Symptoms may also include disorganized or agitated behavior, difficulty falling or staying asleep, irritability or outbursts of anger, hypervigilance, or exaggerated startle response. PTSD is specified if the symptoms endure for more than three months.

*Diagnostic and Statistical Manual of Mental Disorders: DSM-IV*

Published by the American Psychiatric Association (APA), the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) is the most widely referenced psychiatric reference in the world, providing practitioners the ability to share common understandings of mental disorders. The most recent version published in 2000 covers all mental disorders and causes currently recognized in adults and children. The forthcoming DSM-V, expected to reach practitioners in 2011, will include a definition of PTSD specifically for children.

SOURCES:

American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders. (DSM IV-TR), fourth edition.* Washington, DC, APA.

Barker, R. L. (2003). *The Social Work Dictionary, 5th Ed.* Washington, DC, NASW Press.

National Child Traumatic Stress Network Complex Trauma Task Force. (2003). *Complex trauma in children and adolescents: White paper.* (Eds.) Cook, A., Blaustein, M., Spinazzola, J., and VanderKolk, B.: Los Angeles, CA.

## A LITERATURE NOTE: THE COPING BEHAVIORS OF CHILDHOOD TRAUMAS

*Dr. Lenore C. Terr, MD, Practicing Psychiatrist, San Francisco, CA*

Dr. Lenore Terr, a noted scholar in the field of childhood trauma, observed that all childhood traumas originate from external sources. Childhood traumas are divided into two basic types:

- Type I trauma: resulting from one sudden blow, entirely unexpected, rendering the child temporarily helpless and breaking with past coping behaviors. Children often continue to demonstrate the ability to retrieve detailed and full memories afterword and give impressively clear, detailed accounts of their experiences.
- In type II trauma, according to Dr. Terr, the child suffers repeated exposure to extreme repeated external events, such as physical and sexual abuse. The responses stirred up by Type II traumas are denial and psychic numbing, sometimes noted as an absence of feeling, an emotional shutdown; a sense of rage; unremitting sadness. These emotions exist side by side. These behaviors under the scrutiny of mental health professionals may be diagnosed as "conduct disorders."

The author suggests four characteristics related to childhood trauma. These are: visualized or otherwise repeatedly perceived memories of the traumatic event, repetitive behaviors such as self-soothing, trauma-specific fears and changed attitudes about people, aspects of life and the future.

The tendencies toward revised ideas about life, people and the future seem to persist for years after the traumatic episodes.

Derived from: Terr, L.C. (1991). Childhood Traumas: An Outline and Overview. *American Journal of Psychiatry, 148*(1): 10-20.

# *Overview*

## CHILD TRAUMATIC STRESS: AN OVERVIEW

*Interview with Abigail Gewirtz, Ph.D., L.P., Project Director of the Minnesota Child Response Center, Assistant Professor in the Department of Family Social Science and the Institute of Child Development at the University of Minnesota.*

**Q: Trauma appears to be the focus of attention for child welfare and clinical interests. Why do you think this is now a "hot topic?"**

A: Actually, this subject, trauma, has been a long time in coming. Throughout the 1990s there was increased awareness of the impact on children of exposure to violence. This history provides the source of our most recent attention. Furthermore, the events of September 11, 2001, and their effect on individuals nationwide galvanized an intense movement to focus on preventing the effects of post-traumatic stress disorder (PTSD). The allocation of funding through congressional initiative: the Donald J. Cohen National Child Traumatic Stress Initiative, was passed in 2001 and formalized the federal government's attention to the effects of traumatic experiences on children.

**Q: The definition of trauma appears to be somewhat arguable. We intended to concentrate chiefly on children who had endured an external, horrific event such as children on the bus trapped on the 35W bridge as it collapsed; school shootings; witnessing rape, torture, or genocide in their villages in war-torn nations, (i.e., children who had faced death or severe injury). Should the definition include children who have been exposed to domestic violence?**

A: Yes. Exposure to severe domestic violence is arguably the most common form of traumatic experience for U.S. children. Domestic violence exposure as a trigger for PTSD would fall within the DSM-IV criteria as a traumatic event which may result in post-traumatic stress disorder. (Refer to definitions – page 2).

**Q: Are there factors that distinguish the 'phenomenon of trauma' from the more common experiences of a child caught in the adverse experiences of child protection cases, such as neglect?**

A: Yes, the child who experiences trauma has encountered an event that goes beyond the boundaries of one's usual experience, as we know it. The event confronts the child with potential loss of life, helplessness and disorganization. Arguably, the most traumatic event for a child, particularly a young child, is one in which there is a threatened or actual loss of a parent. This threat, or actual loss via violence may overwhelm the child's capacity to cope, resulting in the child manifesting PTSD or other emotional or behavioral problems.

Parents and caretakers should look for the following disruptions:

- Sudden changes in children's behavior
- Changes in eating and sleeping patterns
- Behaviors that are characteristic of younger children, such as excessive clinginess, and/or bed-wetting, among others. When these symptoms last longer than 2-4 weeks after the event it is time to get a mental health evaluation and treatment for the child.

**Q: How can child protection staff and others who are in the front-line respond to the child who has suffered a traumatic event?**

A: Listen carefully to children, understanding that the child's account of the experience (particularly for young children) may not exactly resemble the accounts of others who were involved. Do not jump to conclusions. Pay close attention to the child's experiences and post-trauma difficulties. Understand that, particularly in the acute aftermath of a traumatic event, children who may appear "unfazed" (e.g., watching television or running around playing) may actually be in shock or extremely agitated as a result of the event. Because children don't have as much access to words as adults do, they are more likely to act out the impact of trauma in age-appropriate ways. Thus, it's important that both providers and parents understand that certain child responses are "normal" in the aftermath of traumatic exposure.

**Q: Are there age-related factors in the assessment process?**

A: For interviews with young children, under the age of five years, clinicians rely heavily on parental reports. Another important source of outside information is a police report, where one is available.

Q: Are there factors that could predict a child's ability to cope, with some resilience, to a traumatic event?

A: Yes; research indicates that the more 'scaffolding' a child has, the more resources s/he will have access to for recovery. One critical predictor of recovery is caregiving stability and parenting. For example, we recently found in a study of children and their mothers who were recently exposed to domestic violence, that mothers with positive effective parenting shortly after the violent event had children who recovered faster (i.e. showed fewer signs of distress, and recovered more rapidly) than children whose mothers struggled in their parenting. Conversely, children with a history of multiple foster placements, or instability of caregivers may be more compromised and thus sensitive to subsequent trauma experiences.

Q: Are there circumstances in which a parent has shared the traumatic experience?

A: Yes, and if the parent, usually the mother, can put aside her own grief and loss in order to comfort and be available to the child, that will help the child to recover.

Q: You have emphasized the importance of assessment as a key feature for practice. Does this require referral sources?

A: Yes and the field is developing. The dissemination of evidence-based practices (EBP) available to all communities through the National Child Traumatic Stress Network (see end note) is an excellent contribution. Locally, evidence-based practices for trauma are being disseminated through the Minnesota Child Response Center (http://www.childresponse.org/). We are working in collaboration with the State of Minnesota's Division of Children's Mental Health and community mental health centers throughout Minnesota to train and collaborate with professionals to deliver EBPs for trauma, such as trauma-focused cognitive behavior therapy and parent training/coaching interventions.

---

## UNDERSTANDING A TRAUMATIZED YOUNG CHILD

*Selected Adaptations from Bruce D. Perry, MD, PhD, Senior Fellow, Child Trauma Academy*

The distinguishing feature of a traumatic event, as experienced by a child is that **the event catches the child by surprise**.

- Symptoms are expressed in such a way as to reflect the personality of the child: Some children will daydream; gaze off into nowhere; give unfocused and evasive verbal responses.
- The child's response—an increased heart rate, respiration, hypervigilance—reflects a very primitive state observed in all human beings under threat.

Guidelines for Helping the Child

- Do not be afraid.
- Provide a consistent, predictable pattern for the day.
- Be nurturing, comforting, and affectionate, but be sure that this is an appropriate context.
- Talk with the child. Tell the child the truth, even when it is emotionally difficult. . . Honesty and openness will help the child develop trust.

Derived from: The ChildTrauma Academy, Houston, TX, (2007). www.ChildTrauma.org

---

## A LITERATURE NOTE: LONG-TERM CONSEQUENCES OF EARLY CHILDHOOD TRAUMA: THE ACQUISITION OF COPING SKILLS

The phenomenon of childhood trauma in the very early years has opened up research on memory systems and brain development with a guiding question: What is remembered from the earliest years? This observation comes from therapists. Children who have no explicit memory of a traumatic event are more likely to be diagnosed with ADHD (Attention deficit hyperactive disorder) because they appear to be reacting out of context and have no way of explaining their own behavior.

"Events that are reminiscent of the original trauma can evoke acute traumatic reactions and post-traumatic symptoms. Caregivers often want to believe that the child was too young to remember the trauma and therefore may not draw a connection between the child's behavior and the traumatic reminder" (2006, 374).

Derived from: Kaplow, J., Saxe, G., Putnam, F., Pynoos, R., and Lieberman, A., (2006). The Long-Term Consequences of Early Childhood Trauma: A Case Study and Discussion. *Psychiatry, 69*(4): 362-375.

# SELECTED OBSERVATIONS: UNDERSTANDING CHILDREN CAUGHT IN THE EXPERIENCE OF A TRAUMATIC EVENT

*Interview with Dr. L. Read Sulik, MD, FAAP, Medical Director, Child and Adolescent Psychiatry, St. Cloud Hospital Behavior Health Clinic*

## The Neurophysiological Response

- We have built-in arousal responses: "freeze and withdrawal" or "flight or fight." Some children will shut down and disassociate while other will take control.
  - "freeze and withdrawal" describes the flat affect and tendency to disassociate entirely during and following the experience;
  - "flight or fight" describes the child's ability and reaction to run away from or actively confront the situation, often resulting in combative, extreme ADHD related behavior problems.
- We can demonstrate the neurophysiology responses by tracking the parts of the brain that control emotional memories and language.
- Children who are dealing with a one-time, isolated, horrific event or with the chronic high stress of very high risk environments, as we see in some child protection cases, share similar responses…a persistent state of hyperarousal.

## The Overarching Characteristic: Hyperarousal

The hyperarousal state alerts "super" awareness of the brain to all sensory information.

- The "freeze and withdrawal" response to fear is manifested in the child who appears to be stunned, fearful, or unemotional. Sometimes the child cannot speak or react and is in a state of dissociation
- Children who are in a persistent state of hyperarousal may display confusion, anger and an uncontrollable feeling of rage. This response may actually be associated with fear and anxiety
- The child may be in a state that resembles a panic attack: heart pounding, racing or skipping beats, visible trembling, or an uncontrollable feeling of terror.

## Post-Traumatic Stress Disorder

- We are all well aware of Post-Traumatic Stress Disorder (PTSD) due to the experiences of many Vietnam veterans. The formal system of definitions and characteristics which guide the behavioral professions have identified trauma in its outlines in DSM-III and in an update in DSM-IV added "witnessed" to its definition. The forthcoming DSM-V will include a definition of PTSD specifically for children.
- The post-traumatic response occurs when the child experiences severe distress in response to a cue (internal or external) that resembles the traumatic event.
- In the post-traumatic response, the child may experience flashbacks, or illusions that cause the child to act or feel as if the event is actually happening again. The behavior is characterized by mood instability, poor impulse control, episodic aggression toward self and others.
- For some children, the traumatic episode cannot be translated into words, leaving the child confused and isolated. When questioned about erratic behavior in the form of "Why?" children may respond with "I don't know." That may be the case, rather than not wanting to talk about it.
- There are factors that enable a child to return to a safe place (and feel protected by their parents): Children who can put words to what they are experiencing demonstrate that they are in a safe enough place to describe the event.

## Practice Implications

- Uncertainty of an event is a powerful element in a child's interpretation of experiences because children will creatively "fill in the gaps." Here we have practice implications: children need a lot of explanations; clear up as much confusion as you can; be sure the children are consistently in tune with the truth of what happened. Do not assume a child understands what is happening.
- Treatment responses may include behavioral approaches; psychotherapy; pharmacology; relaxation; and biofeedback techniques.
- **In the child welfare context, mental health evaluations are indispensable and must be initiated as soon as possible. We make far too many assumptions about children**. **It is quite possible to misinterpret "looking okay" as "feeling okay."**

## TRAUMA-FOCUSED THERAPEUTIC INTERVENTIONS

**1. Cognitive Behavioral Intervention for Trauma in Schools**

- Cognitive Behavioral Intervention for Trauma in Schools, also known as "CBITS", is a program intended for use with groups of school children (ages 11-15) who have experienced significant traumatic experiences and are suffering from related emotional or behavioral problems, in particular, post-traumatic stress disorder or depression. The CBITS manual is written for social workers, psychologists, psychiatrists, or school counselors with mental health intervention experiences. The program uses a skills-building, early intervention approach, and is therefore most appropriate for students with moderate levels of symptoms. The manual is especially focused on reduction of symptoms of post-traumatic stress disorder. Since depression and anxiety also accompany PTSD, many of the techniques in this manual are targeted toward depressive and general anxiety symptoms as well.
- All techniques are based on the premise that thoughts and behaviors can cause negative emotions and patterns of interactions with others.

Sources:
Jaycox, L. (2004). *Cognitive Behavioral Intervention for Trauma in Schools*. Sopris West Educational Services: Longmont, CO.
Stein, B. D.; Jaycox, L.; Katoaka, S. H.; Wong, M.; Tu, W.; Elliott, M. N.; Fink, A. (2003). A Mental Health Intervention for Schoolchildren Exposed to Violence. *JAMA: Journal of the American Medical Association, 290*(5): 603-611.

***2. Mind-Body Therapy**

- Mind-Body Therapy is a psycho-social model which focuses on the interactions between mind and body and the powerful ways in which you can use meditation, guided imagery, biofeedback, words, drawings, and group support to help yourself and your patients/clients.

Source: Center for Mind-Body Medicine, Washington, DC, (2007). http://www.cmbm.org.

**3. Narrative – Talking Therapy**

- The goal of narrative processing is for the patient to reconstruct a complete narrative of the traumatic experience without re-living the experience. The creation of a detailed coherent narrative with a beginning, middle, and end brings together the fragmented images of the trauma.

Source: Trauma Recovery Institute, Morgantown, West Virginia, (2007). http://www.traumarecoveryinstitute.org

**4. Play Therapy**

- When play therapy is the primary mode of treatment, the therapy room usually includes a variety of drawing materials, toys, and other materials that permit the youth to focus on or deviate from focusing exclusively on traumatic themes.
- Techniques such as drawings, stories, board games, or specific rule-guided interactions may be used when play therapy is a component of other treatments.

Source: Boyd Webb, N. 2004. *Mass Trauma and Violence*. Guilford Productions: New York, NY.

---

## *AN ILLUSTRATION: FOR THE YOUNGER CHILDREN ON THE BUS

***Interview with Lora Matz, MS, LICSW, Educator, psychotherapist, lecturer and writer***

A puppet show had been designed featuring a mouse needing to cross a bridge in order to gather berries. The mouse had been terrified and afraid that he could never cross a bridge again because he had been on it the day that the bridge had fallen down. As the stress levels of the mouse increased, Mousie was told by the children to "Just breathe, Mousie!" The message of the story: "Courage is facing fear, not living in its absence." Following the puppet show, which had helped to prepare the younger children to face their fears with Mousie, they joined the older children on the bus. After riding around the neighborhood for awhile they came to a crossroads: "Should we cross a bridge?" Only six of 48 children preferred not to cross the bridge on the bus. Instead, they walked across the bridge to meet their fellow students on the other side. At the end of the ride a five year old asked one of the facilitators if Mousie had gotten the berries. When the facilitator responded, "No, net yet, Mousie is still a little scared." The empowered little boy said, "I'm not so afraid now that I went on a bus and crossed the bridge, tell Mousie that I'll get some berries for her."

# *Children on the Bus*

## RESPONDING TO THE CHILDREN ON THE COLLAPSING I-35W BRIDGE

On Wednesday, August 1, 2007, at 6:01 p.m., the Interstate 35W bridge collapsed into the Mississippi River. A school bus under the auspices of Waite House, a settlement house with Pillsbury United Communities, was returning from a local water park. The bus carried 52 children, ranging in age from 5 to 16 years. This was to be a celebratory event to mark the closure of summer camp. As the bridge collapsed, the school bus plummeted several levels, as the slab of road on which it sat dropped and cracked. Only the guardrail kept the bus from falling over the precipice.

## OBSERVATIONS FROM CASEY LADD, MSW, LICSW, LMFT, FAMILY THERAPIST WITH FAMILY AND CHILDREN SERVICES

The response was immediate and active. Twenty clinicians from community agencies arrived and were supervised chiefly by Sy Gross of the Hennepin County Children's Mental Health Emergency Response Team. The response of the staff of Waite House, was immediate, concerned, and supportive, "like a second family". The day following the disaster, Francisco Segovia, the Director of Waite House, had the presence of mind to gather the families for a meal and to provide an opportunity to meet with the mental health providers and translators. This action, remembered by all involved, had a large impact, immediately beginning the calming and healing process.

As is usual in these traumatic circumstances, rumors and misinformation spread quickly. The children heard that someone had broken their neck. They were confused about the extent of injuries suffered by children, staff members, and the bus driver.
Parents were experiencing severe trauma, as well. Immediately following the bridge collapse, rumors were spread that the bus was submerged in the river. Many started walking from Waite House to the bridge through downtown Minneapolis. Following the crisis and the immediate aftermath, a grandmother of one of the children on the bus made a poignant observation: "The untold story here is that these children took care of each other."

Of the 52 children who were on the bus, only four demonstrated behaviors which appeared to require therapeutic response. A primary concern of the involved clinicians was the availability of interpreters for the parents. A document prepared by the American Psychological Association was translated into Spanish for the parents. Several Spanish-speaking clinicians and a few translators from the Somali community were present. Clinicians still worry that parents who were uninsured or undocumented did not and will not seek help in the aftermath of this bridge collapse. A general instruction to therapists not to force the children to tell of their experience was introduced. This conveys an observation: therapists were unacquainted with ways of approaching children in large-scale traumatic events.

## MIND BODY INTERVENTION

***Interview with Lora Matz, MS, LICSW, Educator, psychotherapist, lecturer and writer***

During the week following the collapse of the bridge, Lora Matz and another colleague first met with parents to outline a model that could be helpful with their children's recovery from trauma and teach them skills that would be useful for life. Lora had designed and, with the help of 11 other volunteer trained facilitators, implemented a series of three weekly intensive skill building and empowering group sessions to take place at Waite House, each lasting three hours. These sessions focused on teaching the children how to "be the boss of their bodies," by teaching them to recognize symptoms of stress and to respond with creative and fun stress busters. 48 of the 52 children participated in these sessions. The goal has been to promote the beginning of individual and community recovery by beginning to teach the children and parents empowering relaxation techniques. These techniques could be used as an antidote to the symptoms of acute stress and anxiety they were experiencing and to prepare the children for the return to school, which would necessitate a return to riding on buses for many.

Although the techniques themselves are generally the same for older and younger children, they are taught differently depending on the age group of the children. The Waite House children who had been on the bus ranged in age from 5-16. On the last day of the initial three week groups, the goal was to help the children face their fear of boarding or riding another bus. This was important since school would be beginning the following week and all of the children had been so traumatized they were previously not willing to get on a bus. Older children were encouraged to take roles of leadership as they boarded a school bus. They were reminded to use the techniques that they had been learning. They were reassured that the adults were there to help them as fear arose.

# THE TRAUMA OF CHILDREN LIVING WITH AN UNDOCUMENTED PARENT

*Interview with Maria Diaz, Community Organizer in Willmar with Raíces*

Impact on Children of Work Site Raids

Over the past year, Immigration and Customs Enforcement (ICE) has intensified enforcement actions by conducting several raids. Willmar, Minnesota, was the site of one of these raids. In the week of April 10th, immigration attorneys estimated that more than 50 people had been arrested. The raid was carried out in a door to door search of the homes of suspected families. Children witnessed parents being shackled and taken away with little information regarding their destination.

> Undocumented parents who may be vulnerable for immigration detention, because of their undocumented status, are strongly encouraged to identify trusted relatives or friends who could act as guardians for their children in the event that they are arrested and deported.
> *- Mary Jo Avendaño, Ph.D., LMFT, Clinician with Centro and Tubman Family Alliance*

Children suffered a high anxiety level fueled by the shock of the raid. Some children had "panic attacks," and refused to go to school. Long after the raid, children hid under beds and tables when there was a knock on the door. Older children had to assume responsibility for younger children when parents were arrested, interfering with school attendance. In some instances when parents were deported, children followed, suffering serious problems adapting to a country that was unfamiliar to them.

Maria Diaz, a community organizer with Raíces*, invited a consultant, Roberto Dansie, Ph.D., to Willmar from May 14 -15. Dr. Dansie is widely regarded as an expert on emotional trauma experienced by children and operates with the belief that under extenuating circumstances, teachers can and should become healers. His two-day consultation began his training of teachers and volunteers as "promotores de salud" (health educators) and traditional healers. He connected with a large number of parents, service providers, and young people in the community.

**Raíces is a four-state, four year project focused on building community capacity in rural Latino communities in Iowa, Minnesota, Idaho, and Oregon. The project is a partnership between the Northwest Area Foundation, the University of Iowa Institute for Support of Latino Families and Communities, and the Main Street Project (a Minnesota-based nonprofit organization associated with the long-standing League of Rural Voters). This partnership highlights Raíces' premise that long-term collaboration among organizations and community members is a means to build the capacity of rural Latino communities.*

The Impact: Uncertainty of a Parent's Status

- Living with fear of a parent's disappearance, imprisonment, or separation creates vulnerability within a child.
- For children, the threatened loss of a parent is always experienced as traumatic.
- Maintaining secrecy, silence, and anonymity to protect a parent may prove particularly stressful to children, especially if they do not understand why they must do so.
- Being forced to prioritize protecting one's identity over seeking help in an emergency situation, immigrant families and children may feel prohibited from seeking medical care unless the condition is extreme.

Common reactions of children who have been separated from their parents include: separation anxiety; hypervigilance; physical complaints; changes in eating patterns; sleep disturbances (e.g., nightmares); withdrawal; and dissociation.

The Acquisition of Coping Skills

> If children are not provided this information, they will likely "fill in the blanks" with their own imaginations
> *- Personal Communication, Dr. L. Read Sulik*

Children need to know, understand, and be reassured of:

- What is happening to their parent(s).
- With whom they will stay in the interim.
- How long it will be until they see their parent again.
- That they are safe, even without their parent(s).
- Furthermore, children need to be provided a safe place to express anger, fear and grief.

Derived from:
Children's Bureau. (2007). Why Considering Children When Parents are Arrested is Important. *Promising Practices, 8*(9), 13-19.
National Center for Children Exposed to Violence. Yale University Child Study Center, New Haven, CT. (2007). http://www.nccev.org

# *Children from War-Torn Nations*

## REFUGEE CHILDREN FROM WAR-TORN NATIONS EXPERIENCING TRAUMA

> Child survivors that we are getting now are much more impaired and have a much longer course of treatment and recovery because their development was arrested at the point of the trauma. They do not have the skills they need to recover.
> *-Interview with Dr. Patricia Shannon, Ph.D, LP Director of the New Neighbors/Hidden Scars Program*, funded and implemented by the Center for Victims of Torture.*

**A Trio of Case Illustrations**

1. A 19-year old African female was taken at the age of 10 years by rebel soldiers to be a sex slave in the camps. She was released after three years – and was later forcibly circumcised. One long-term effect of these events is that she does not trust anyone. Her concept of a relationship is about what one can get from someone else.

2. A young man in his 20s has survived the Rwandan genocide. Sadly, his family did not survive. This gentleman was nine years old when he lost his family. As an adult, he cannot function in the adult world because he is disappointed by all of the adults around him. He has learned minimal English from the Church, whom he cannot trust because the Church was complicit in the genocide.

3. An 18-year old boy from West Africa was physically injured during the war. He was taken by rebels but refused to fight with them. He was beaten and thrown into a cavern. He last saw his father when he was four years old. When he reconstructs the memory with his therapist, it is evident that there was no way his father could have escaped, and was most likely killed. Despite this logical conclusion, he continues to look for his father. He was recently reunited with his mother, and is trying to develop this relationship. Essentially, he was not a parented child, and is now trying to survive.

Traumatic experiences impact the body, mind, spirit, and relationships. Therefore, it is vital to approach the traumatized individual from a holistic perspective, offering support through a variety of treatments and encouraging a network of service providers.

- Mind-body relaxation techniques provide a holistic approach by calming the mind while calming the body's responses to trauma.
- Rationalizing methods allow the victim to logically process the traumatic event in order to encounter any recurring or invasive thoughts and feelings. Psychotherapy methods enable survivors to cognitively and emotionally process overwhelming traumatic events.
- Pharmacological treatments help survivors manage the debilitating symptoms of depression and post-traumatic stress disorder that interfere with recovery processes.
- Cognitive Behavioral Intervention for Trauma in Schools, (CBITS), founded by Lisa Jaycox at UCLA, is the most successful school-based approach, and has been empirically tested. Doable within ten one-hour sessions, this therapy asks the child to describe the experience, while slowing down, and discussing details. In this way, the child realizes that triggers have nothing to do with the experience. CBITS helps the child to make connections. By slowly retelling the story until the thermometer comes down. This therapy enables children to process traumatic events in a relaxed state. It also slows down reactivity by helping children to understand the connections between thoughts, feelings, and actions. Students report making better choices, decreased symptoms, and improved academic performance after the groups.

The concept of a network of supportive services, (coming out of the response to 9/11), is important to identify gaps in the system and to work to fill the gaps in order to create a responsive environment for newly arrived victims of war-torn nations.

**The New Neighbors/Hidden Scars Program, under the auspices of the Center for Victims of Torture, brings together schools, clinics, churches and other organizations to help these new residents heal from their physical and emotional wounds, creating a vital network to address any gaps. Dr. Shannon also continues in her role as a therapist with survivors of torture.*

## STAGES OF MIGRATION: SOURCES OF TRAUMA

Children trapped in war-town areas of severe conflict suffer experiences of significant emotional distress at each stage of their flight from danger to resettlement in a safe country.

In the **departure stage**, while circumstances under which families leave are varied, there are painful decisions regarding who will leave or stay; various degrees of deprivation and violence may accompany this stage. In the **transit stage,** again various circumstances prevail but children may suffer from unsafe boat journeys, dangerous pathways on foot, and perhaps long delays in a detention center or waiting in a refugee camp. The **resettlement stage** carries challenges in experiencing the differences in expectations and reality of new surroundings.

The undocumented status carries the threat of deportation.

> At each of these stages, children may be witness to their parents' struggle with depression, suicide attempts, and substance abuse.

At one stage in the migration journey, children may have been detached from their family and arrive as an "unaccompanied minor." These children may have suffered not only separation from family but extreme deprivation, as well. In areas of severe conflict, these youngsters may have witnessed killing or injury of a sibling or parent.

Guidance on Retrieving the Experience

> It is essential to have access to consultation if the remembered trauma reopens emotional wounds.

There is tremendous variability in how survivors present themselves and their stories. Remembering what happened and putting it into words has wide variation. Recounting what happened is a gradual process that unfolds over time. Trust is slowly and carefully established. Experiences can be presented in a variety of ways from: detached fragments to a coherent and full account.

Derived from:
Pine, B. & Drachman, D. (2005). Effective Child Welfare Practice with Immigrant and Refugee Children and Their Families. *Child Welfare, 84* (5), 537–562.
Herman, J. (2001). *Center for Victims of Torture. New Neighbors/Hidden Scars Handbook.* Chapter 3: Reaching Out: Serving Traumatized Refugees Effectively. http://www.cvt.org/new_neighbors/index.htm

---

## A RESOURCE UNDER DEVELOPMENT: THE CHILD-FAMILY INITIATIVE SPONSORED BY THE CENTER FOR VICTIMS OF TORTURE

*Contribution from Rosa Garcia-Peltoniemi, PhD, LP, Senior Consulting Clinician with the Center for Victims of Torture*

Currently, there is a severe shortage of resources, both locally and nationally, that are specifically intended to help refugee children who have endured torture. Indeed, a surprising number of children have survived torture; 20 percent of the adult clients at the Center for Victims of Torture were tortured as children. Mental health services are inadequate and often non-existent, as there is nearly a complete lack of social support, and schools are ill-equipped to address the problems faced by these children.

The Child-Family Initiative intends to develop an evidence-based model of care for treating children who have survived torture. Additionally, this project intends to create models of care for families, including separated families, and to address special groups of children torture survivors including child soldiers.

## COMMENTARY FOR CASE PLANNING

*Interview with Anne Gearity, PhD, LICSW, Principal consultant for the Washburn Child Guidance Center's Day Treatment Program; adjunct faculty, University of Minnesota School of Social Work; consultant with the Center for Excellence in Children's Mental Health.*

**Q: Are there children who recover quickly, with little or no after-effect following a traumatic episode? If so, do we know what their apparent resilience is due to?**

A: For children, trauma happens within a relational context. A primary "coping operation" for children is turning towards their parents. Children need help both in the moment and over the course of developmental time.

Several protective factors are likely to permit resilience:

- The availability of parents / adults to soothe, bracket the event, and provide meaning that keeps danger in check
- The type of event: Singular or isolated? Pervasive or on-going?
- The ability to have other things that occupy the mind, thereby limiting hypervigilance. The children on the bus, for example, were a part of a larger picture. The companionship likely provided them with some protection. The ones we worry about are those who have had earlier traumas, are predisposed to anxiety and/or have families who are already struggling, and cannot provide the degree of support and reassurance they need.

**Q: Is the referral system in place for children who have experienced trauma?**

A: After the bridge collapse, there was a rush to serve – many people volunteered to work with the children. This is unusual. For most children who experience the traumas of maltreatment or who are living in perpetually traumatic environments, who are victims of a cascade of traumatic experiences, there is little clearly delineated help. They may or may not be able to enter the mental health treatment systems.

**Q: In the process of assessing or case planning for children, do staff members include a specific question regarding the suffering of a traumatic experience?**

A: Not to my knowledge, but this would be highly recommended. Possible words for the question: "Have there been events in your child's life that have been traumatic or difficult?" Defining trauma would also be a good intervention as it could help parents understand, thereby creating a "first-tier" protection.

The worry about trauma is not the single event, but the compounding effects when there are a series of cascading events.

Another issue, as referred to in the literature, is called complex trauma. This includes attachment "danger" – when the caretaking experience becomes harmful or a source of trauma. This is especially an issue when the attachment relations are described as "frightened/frightening", which is the hallmark of maltreatment. The same person who offers help is the one who causes harm. These are called "traumas of human design".

---

## CONCLUDING STATEMENT: TRAUMA AND THE EMOTIONAL IMPACT

The enormity of psychological damage that may occur within a child experiencing a traumatic incident is that the event violates basic human needs: trust, safety, intimacy,and a sense of well-being and control of their environment. The consequences are serious: interference with learning, concentration, and sleep. The emotional residue may produce life shaping consequences.

# *Assessment Instruments, Networks & Organizations*

## ASSESSMENT INSTRUMENTS

While chiefly for therapists, these instruments have been recommended to create a streamlined approach to assessing trauma and PTSD in children and adolescents.

1. UCLA PTSD Index for the DSM-IV
   - This instrument, offered free of charge, is self-administered with versions for parents, adolescents and children.
   - Designed by Dr. Robert Pynoos and revised in 1998, this tool is widely used among practitioners in the field of child welfare: primarily therapists.

Reference:
R. S. Pynoos; et al, *UCLA PTSD INDEX FOR DSM IV* (Child Version, Revision 1). (1998).
Available: http://chipts.ucla.edu/assessment/IB/List_Scales/UCLA_PTSD_Adolescents.htm

2. Trauma Symptom Checklist for Children (TSCCTM)
   - Designed by Dr. John Briere, Ph.D. and offered free of charge, this measure involves self-reporting of post-traumatic stress and is directed toward children aging 8-16 years.
   - A different measure is recommended for younger children ages 3-12 years: the Trauma Symptom Checklist for Young Children (TSCYCTM).

Reference:
Briere, J. (1996). *Trauma Symptom Checklist for Children (TSCC) Professional Manual*. Odessa, FL: Psychological Assessment Resources.
Available: http://www3.parinc.com/products/product.aspx?Productid=TSCC

3. Child PTSD Symptom Scale (CPSS)
   - This method involves the self-reporting of a child through the use of visual depictions of thermometers demonstrating the degree or severity by which a trauma was experienced.
   - This measure involves approximately 30 items and is commonly used with immigrant children.

Reference:
Foa, E.B., Johnson, K.M., Feeny, N.C., & Treadwell, K.R.H. (2001). The Child PTSD Symptom Scale: A preliminary examination of its psychometric properties. *Journal of Clinical Child Psychology, 30*(3), 376 – 384.

## ORGANIZATIONS AND NETWORKS: FOR YOUR INFORMATION

- International Society for Traumatic Stress Studies http://www.istss.org
- National Center for Child Traumatic Stress http://www.nctsn.org
  Local Partner: Minnesota Child Response Center (MCRC)
  *Contact:* Dr. Abigail Gewirtz, Ph.D., L.P.: agewirtz@umn.edu.
- Child Trauma Academy, Dr. Bruce Perry http://www.childtrauma.org
- Child Witness to Violence Project http://www.childwitnesstoviolence.org
- National Center for Children Exposed to Violence http://www.nccev.org
- Center for Victims of Torture http://www.cvt.org
  *Contact:* Lora Matz, MS, LICSW: loramatz@earthlink.net

# *Acknowledgements*

## FOR FURTHER READING:

Boyd Webb, N. (2004). *Mass Trauma and Violence: Helping Children and Families Cope*. The Guildford Press: New York, NY.

Center for Victims of Torture. (2005). *New Neighbors Hidden Scars: Handbook for Working with Refugees Who May Be Torture or War Trauma Survivors.* Center for Victims of Torture: Minneapolis, MN. Available: http://www.cvt.org/new_neighbors/index.htm.

Jaycox, L. (2004). *Cognitive Behavioral Intervention for Trauma in Schools.* Sopris West Educational Services: Longmont, CO.

Taylor, N. and Siegfried, C. (2005). *Helping Children in the Child Welfare System Heal from Trauma: A Systems Integration Approach.* National Child Traumatic Stress Network: Los Angeles, CA.

National Child Traumatic Stress Network Complex Trauma Task Force. (2003). *Complex trauma in children and adolescents: White paper.* (Eds.) Cook A., Blaustein, M., Spinazzola, J., and VanderKolk, B.: Los Angeles, CA.

National Child Traumatic Stress Network Complex Trauma Task Force. (2005). *Mental Health Interventions for Refugee Children in Resettlement: White paper II.* National Child Traumatic Stress Network: Los Angeles, CA.

## ACKNOWLEDGEMENTS

This edition of Practice Notes reflects, to a large extent, practice wisdom from the field. Among those who contributed their therapeutic expertise, we thank: L. Read Sulik, M.D.; Child & Adolescent Specialty Center, St. Cloud Hospital; Abigail Gewirtz, Ph.D., Assistant Professor, Family Social Science, University of Minnesota; Casey Ladd, MSW, LICSW, LMFT, Family Therapist, Family and Children Services; Patricia Shannon, Ph.D., L.P., Project Manager, New Neighbors/Hidden Scars, Center for Victims of Torture; Anne Gearity, Ph.D., LICSW; Adjunct Professor, School of Social Work, Clinical Social Worker.

We also appreciate the guidance and suggestions of Rosa Garcia Peltoniemi, Ph.D., Senior Consulting Clinician, Center for Victims of Torture; Seymour Gross, Ph.D., L.P., Chief Clinical Psychologist, Hennepin County Mental Health Center; Maria Diaz, Community Organizer, Raíces, Willmar, Minnesota; Mary Jo Avendaño, Ph.D., LMFT, Centro & Tubman Family Alliance; and Lora Matz, M.S., LICSW, Center for Mind-Body Medicine.

Jeff Edleson, Ph.D., Professor and Director, MINCAVA, and Dante Cicchetti, McKnight Presidential Chair and Professor, Institute of Child Development and Department of Psychiatry provided important references.

**Editor for *Practice Notes***
Esther Wattenberg, with support from the Center for Urban and Regional Affairs and assistance from Annie Welch, MSW/MURP Candidate, School of Social Work, Hubert H. Humphrey Institute of Public Affairs.

**Support Staff**
Mary Kaye LaPointe, CASCW, CURA
Design provided by Heidi Wagner, CASCW