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Renew House: A Place for Teenagers to Find Healing from Adverse/traumatic Events and Experiences

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Renew House

A place for teenagers to find healing from adverse/traumatic events and experiences.

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University of Washington Tacoma

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Introduction

Background

In the United States, it is estimated that twenty-six percent of children will witness or experience a traumatic event before the age of four years old (Briggs-Gowan, Ford, Fraleigh, McCarthy, & Carter, 2010). This topic is significant because children with early experiences of trauma, adverse experiences, and an insecure attachment are less likely to develop a resilient disposition. Additionally, those who have experienced trauma are more likely to struggle emotionally, behaviorally, intellectually and socially. This demographic is at-risk for substance abuse, mental illnesses, and poverty, which could become an intergenerational pattern without effective treatment (Orbke & Smith, 2012). Lack of appropriate treatment for children who have experienced trauma has a wide array of physical, emotional, behavioral, and financial repercussions. It is pertinent to discover adequate techniques for fostering resiliency in later developmental stages so that there is a stronger opportunity to achieve success.

The processes of providing treatment for youth would not only benefit the individual, but there are a number of health, behavioral health and criminal justice costs that can be reduced through advocacy and awareness. With trauma having a correlation to substance abuse, affectively treating youth can reduce substance abuse costs. Moreover, it is suggested that 90% of U.S. juvenile offenders have experienced some sort of childhood trauma (Dierkhising, et. al., 2013). These youth require treatment in order to change the trajectory of their behavior leading into adulthood that can result in chronic adult offenses and ultimately, prison expenses. Adverse childhood experiences (ACE) have been found to cause many chronic health conditions which lead to death (Felitti, et.al., 1998). Healthcare costs can be cut by effectively addressing the traumatic experience and educating children on how to positively cope and learn how their health is affected. For example, children with past traumatic experiences may be more susceptible to anxiety and high blood pressure. Learning effective ways to cope with stress and developing healthy patterns during adolescence can help change the trajectory of their health in a positive way.

There is a lack of attention in the state of Washington regarding the identification and treatment of children who have experienced trauma. There are 84 Mental Health Division (MHD)-funded inpatient beds for children with "severe psychiatric disturbance" (Children's Long Term Inpatient Program for Washington State, 2014). There are extensive wait lists for children to receive care. In researching services available in Pierce County, it was disclosed by local key informants like local therapists and those working in the schools and community mental health agencies that there are not enough services, funding, or quality providers to meet the need of this prevalent issue.

The NASW Code of Ethics states that a "social worker's primary responsibility is to promote the well-being of clients" (National Association of Social Workers, 2008). This program would promote the health and wellness of clients through psycho-education regarding the effects of trauma and teach children positive coping styles. Social workers value social

justice and providing a voice for marginalized citizens. This program will provide treatment for at-risk youth and simultaneously promote social justice by advocating for a vulnerable population.

Personal Motivation for Program

Some of my personal motivation for creating this program derives from experience working alongside youth in various organizations. These include the juvenile justice system, elementary schools, church youth groups, and in-patient psychiatric facility for adolescents. I was able to witness firsthand the emotional and behavioral disruptions trauma can cause and the long-lasting repercussions that interrupt a child's ability to function in positive ways. It is my opinion that it is necessary to reach children at an earlier age then adolescence. A primary concern is that far too many children are not screened for this issue. There are many adolescent children who fall through the cracks and have not received proper attention by the time they reach high school. It would be beneficial to reach this population prior to transitioning into the adult stage of development.

Purpose

The purpose of this program is to provide an outpatient treatment program for adolescent age youth who have experienced early trauma. The program will focus on teaching youth skills to manage and change behavior patterns that may have been shaped by traumatic events or adverse circumstances in early childhood. Additionally, the program will seek to provide psychoeducation about the effects of trauma and educate adolescents about ways to create healthy lifestyle habits that will negate unhealthy habits which often result in poor health conditions. This program will seek to be a gateway into other community resources that can also aid in future treatment.

Theoretical Framework

Multiple theories will be used as a foundational premise for this program.

Social Learning Theory is a primary framework for this program. This theory is "based on the premise that behavior is malleable, knowledge of operant, respondent, and observational learning is used to beneficially modify client behavior through the use of tested, ethical procedures" (Turner, p. 437). Certain forms of therapy that fall under this such as Art Therapy will be used in this program. Art Therapy can help change negative brain pathways that were structured during early childhood because of trauma (Persons, 2009).

Self-Efficacy Theory will be an important part of treatment it is particularly helpful when working with clients who lack resiliency. It is suggested that through gaining self-efficacy the individual will gain self-worth, they will gain confidence relationally, and have less inclination towards self-harm (Orbke & Smith, 2012, p. 52). During the adolescent stage of development, these children are beginning to form self-efficacy in a unique way. This program will reinforce their development of self-efficacy. A client's self-efficacy will shape their behavior and attainment of goals while in the program. A client's success will be reinforced and highlighted in order to build their feeling of self-efficacy.

Cognitive Behavior Theory is suggested to be effective at reducing symptoms of PTSD (Kruczek & Salsman, 2006 p. 467). Cognitive Behavior Theory is, "Built on the three waves of behavioral theory, this approach holds that with active client participation, behavior can be modified through a wide range of tested techniques" (Turner, 2011, p. 77). Children who have experienced early trauma may struggle with negative hopeless and helpless thinking patterns. Cognitive Behavior Therapy which is based off of this theory can be used to re-shape those thinking patterns to be more positive. Another effective form of therapy this program will use which falls under this theory is Trauma Focused-Cognitive Behavior Therapy (TF-CBT).

Relational Theory can be useful when working with this population. This theory "emphasizes the restorative elements of the therapeutic relationship as a major contributor to change by stressing relatedness, which views the self as being shaped in interaction, more fluid than finished" (Turner, 2011, p. 401). In this program it will be fundamental to create a supportive therapeutic bond with the client that is validating (Orbke & Smith, 2012).

Empowerment Approach and a Strengths Based Perspective will be embedded throughout this program. This program will attempt to use empowerment and strengths-based approach to help clients identify areas for growth, highlight some of the strengths they already possess and help them to re-write their trauma narrative (Turner, 2011, Orbke & Smith, 2012). This program will seek to make sure that the clients feel safe and feel heard regarding their treatment. We will encourage the client to be an active participant in their treatment and highlight that they have power to make changes. The program will seek to focus in on what the client's strengths, and protective factors are and try to build upon existing ones. *Narrative Theory* is another approach that therapists may utilize to help client's process some of the traumatic events that they have experienced.

Program Description

Location

This program will utilize a house or private residence as the location where the program is conducted. An article about trauma through the life cycle states, "The most important task is the establishment and maintenance of a physical and emotional sense of safety" (Straussner & Calnan, 2014, p. 331). Providing a safe environment is one of the foundational elements in allowing youth to open up and process traumatic history. Therefore this program will seek to create a calm, warm and inviting environment such as a home which would be preferable to a commercial building as a location for the program to be held.

Intake Assessment

When clients are referred or seek treatment they will begin with an intake assessment conducted by program staff member.

Treatment Plan

Each client will have an individualized treatment plan created with an assigned program counselor that they have determined they work well with.

Weekly Check-in/ Progress Note

Each week client will check in with their assigned counselor to discuss progress. Counselor will complete progress note that they will keep in the client's chart.

Psychoeducation

Each client will complete a trauma psychoeducation course as the first part of treatment plan. This will be an hour long class that is offered each week/as needed. Clients are only required to take this class once at the beginning of their treatment. Trauma psychoeducation will also be incorporated into weekly check-ins and the DBT Group Skills sessions.

Habits of Healthy Living

Each client will be required to complete a 30 minute course on habits of healthy living. As a part of weekly check-ins, counselors will have discussion with clients about how they are doing with their practice of healthy habits. Referrals to community agencies that can aid in healthy habits such as the YMCA, other fitness facilities or dieticians will be available to help clients who may request additional help.

14 Week Dialectical Behavior Therapy Skills Group

Each client will be offered the opportunity to take part in a 14 week DBT Skills Group. The group will be offered twice a week lasting one hour. Additional groups can be added or subtracted based on the amount of need. The group will have a focus on mindfulness, and learning new skills each week. The group will include diary cards which enable participants to practice the skills and make record of it each week. Reinforcements will be provided for participation in the group and for completing diary cards. Participants will receive a certificate at the completion of the 14 weeks. Participants with a DBT-Skills completion certificate will have the chance to apply to become a (client) co-facilitator of the group.

Counseling

Clients will have the option to attend additional specialized counseling sessions with therapists who are trained in TF-CBT, Narrative Therapy, Art Therapy, Grief Counseling, and Eye Movement Desensitization and Reprocessing on a case by case basis.

<u>Mindfulness Activities</u>

Mindful type activities such as Yoga and Martial Arts will be available to clients on monthly basis at the center offered by trained professionals who have a contract with the center.

<u>Resources to Community Agencies</u>

The center will have a list of various community agencies that may be advantageous to refer the client to.

<u>Website/Book and Journal Resources</u>

The center will have a list of websites, books, and journals that may be helpful for clients and their family.

Note to Facilitators:

Children who have experienced trauma have a wide array of symptoms and defense mechanisms at play. It is suggested that some youth have high cortisol levels which make them hypervigilant, making it difficult to remain composed when aroused or triggered. Many of the children will struggle with emotion regulation, positive social functioning, problem solving skills, positive coping habits and may be inclined toward risk-taking behavior. Many clients have hopeless thinking patterns and feel powerless. It is important to help the client feel empowered and enable them to be the director of their treatment. It is vital that clients feel they are in a safe environment and are working with adults who they can trust. When a youth is triggered, it is important to utilize de-escalation techniques. De-escalation techniques include remaining calm, waiting out a melt-down, talking through what triggered the client once they have calmed down, and making sure the client's basic needs are met. It is also vital that those who work with youth are trained to understand how these youth may behave differently to their peers who have not experienced trauma. They are not "bad" kids. They are not a "problem" that needs to be fixed. They are valuable human beings that will require extra patience, love, and unconditional support. Rather than labeling their behavior as bad, clinicians must keep in mind what their behavior is a result of emotional dysregulation caused by traumatic experiences. An example of this might be: Suzie is feeling out of control and is seeking to gain control by cutting. A clinician should recognize that Suzie has been triggered and her emotions are dysregulated. How can we support her? How can we promote harm reduction? The ultimate goal is to help the client achieve resiliency and feel empowered, rather than label this teenager as "crazy" with "bad behavior". Self-efficacy is one of the primary theoretical underpinnings of this program. When a youth gains the power to control some of the negative behaviors that have ruled their life, they will gain a sense of self-efficacy. Another primary goal of the program is to transform negative hopeless thinking patterns to patterns in which a client feels hopeful and in control. Many youth may be triggered by controlling adult behavior. When a youth is triggered it will be of the utmost importance to have a counselor take time to process triggers and destructive behavior that

might follow. Counselors should be readily available at the center to assist youth when needed. Straussner & Calnan (2014) discussed that it is pertinent to determine if an individual is suicidal or homicidal. This is an additional need to be identified when working with youth who have experienced early trauma. It must be identified in the initial assessment if the client has any risk factors that make them more likely to have suicidal or homicidal ideation. Proper referrals should be made if they are identified to be at-risk and safety planning is required if a client admits to current suicide or homicidal ideation.

Volunteers Needed

Renew Center

Seeking Volunteer Mentors and Counselors to support at-risk youth who have experienced childhood traumatic events.

Skills Required:

Ability to communicate with youth, parents and mental health professionals.

Effective problem solving skills.

Spanish speaking/ other languages is a plus.

Background working with at-risk youth is a plus.

Benefits Offered:

Training opportunities.

Career Development opportunities.

Ability to make a positive difference in the lives of youth.

We welcome you to an evening of information about our program and how you might be able to get involved. Pizza dinner provided

Date: August 12, 2017

Time: 6:30pm

Location: Renew Center 123 Fictional Street Tacoma, Washington 98406

RSVP: annikasj@uw.edu

Or call Annika at 555-555-5555

Feel free to call or e-mail with any additional questions.

Assessment

Assessment Date: _____

Client Name:
_____Address:_____

DOB: _____ Age: _____ Phone Number:
_____

Presenting Problem:

Medications:

Allergies:

Events in the Past 90 days:

Psychiatric Emergency Room Visits:

Psychiatric Facility Nights:

Hospital Encounters:

Arrests:

Jail Encounters:

Psychosocial History

Living Situation:

Education Situation:

Financial Situation:

Relationships/Support:

Spiritual Considerations:

Cultural Considerations:

Mental Health History (Client/Family Mental Health):

Trauma History:

Impairment/Disability (Developmental, Hearing/Vision Impairment, Physical Impairment, Communication etc.):

Substance Use:

    Substances used:

Amount consumed per day:

Years of usage:

Drink/Use Alone:

Previous Detox:

Previous Treatment:

Health History (Client/Family Health):

Personal Interests/Social Life:

Mental Status Exam

Appearance:

Behavior:

Posture:

Mood:

Affect:

Speech Quality:

Thought Associations:

Stream of Thought:

Thought Process:

Thought Content:

Delayed Recall:

Hallucinations:

Delusions:

Memory and Reasoning:

Attention:

Insight:

Sleep Disturbances:

Appetite:

A/OX3:

Risk Assessment (Provide Description and Date)

Cutting/Self-Mutilation:

Suicide Ideation:

Suicide Attempt(s):

Risk of harming others:

Access to guns or weapons:

Risk Factors (Abuse, trauma, possession of weapons, prior attempts, current/past ideation, current/past psychiatric disorders, family history of suicide attempts, Precipitants/Stressors/Interpersonal, Change in treatment):

Based on Risks is Client in need of Referral/Safety Plan?

No___ Yes____

Referral_____

___

Safety
Plan_____

Preliminary Treatment Goals:

Risk Factors:

Protective Factors (Strengths, Resources, Supports):

Diagnostic Impression:

Code:_____

Signatures:

_____   _____

Client signature   MHP Signature

Treatment Plan

Name (Full Name):_____

Treatment Plan Date:_____

DOB: _____ age: _____

Presenting Problem/Primary Needs/Primary Issues:

_____

Goal 1:

_____

Treatments:

_____

Measurement of Goal:

_____

Goal 2:

_____

Treatments:

_____

Measurement of Goal:

_____

Goal 3:

_____

Treatments:

_____

Measurement of Goal:

_____

Review
Date(s):_____

       Review every 4 weeks

Date Plan Completed: _____

Evaluation Tool Dates (Pre and Post Survey):_____

Signatures:

_____

_____

Client signature   MHP signature

_____

Parent/legal guardian signature

Progress Note

Name: _____   Date of Service Provided: _____

Service Provided: _____

Goals:

_____

Progress toward goals:

_____

Interventions:

_____

Response to Interventions:

_____

Recommendations for next service:

_____

_____

Provider Signature

Date/Time of next Appointment:

14 Week DBT-Skills Group Session Schedule

**Please read over Note to Facilitator on Page 9 of Program Description prior to facilitating group.

1. Week One: Introduction to DBT and Mindfulness
   a. Establish Group Norms and Rules
   b. Establish reinforcement system for completing diary cards for example candy, movie tickets for completing x amount of diary cards etc. (practicing skill during the week and reflecting in a diary entry the skill used)
   c. Groups will be facilitated by DBT trained professional and co-facilitated by clients who have completed 14-Weeek DBT-Group can be candidates to aid in leading the groups.
2. Week Two: Wise Mind
3. Week Three: What Skills
4. Week Four: How Skills
5. Week Five: Interpersonal Effectiveness: DEARMAN
6. Week Six: Interpersonal Effectiveness: GIVE
7. Week Seven: Interpersonal Effectiveness: FAST
8. Week Eight: Distress Tolerance: Everyday Acceptance, Radical Acceptance, Turning the Mind, Willingness
9. Week Nine: Distress Tolerance: Burning Bridges and Building New Ones, ACCEPTS
10. Week Ten: Distress Tolerance: IMPROVE the Moment, Self-Soothe
11. Week Eleven: Emotion Regulation: Problem Solving, Four Options for Dealing with Problems, Pros & Cons, SOLVED
12. Week Twelve: Emotion Regulation: Opposite to Action, Anger Control, Attend to Relationships,
13. Week Twelve: Emotion Regulation: PLEASE, ROUTINE, Build Positive Experience, Mastery
14. Week 14: Celebration Party, Certificate of Completion, Peer Counselor Interest

Note: DBT Skills worksheets to be developed will be adapted from:

Linehan, M. M., (2015). *DBT Skills Training Manual* (2nd ed.) New York, NY: Guilford Press.

DBT Skills Group Agenda

Note: It is intended that groups have a DBT-Trained professional leading each group and a co-counselor (MHP). Co-counselors should be available to help with clients who may be triggered and aid them as they responds to triggers that may be set off by group topics/discussions. This group is intended to have peer counselors who aid in facilitating the group. Peer counselors are to be clients who have completed the 14 week group and have gone through an informal application process and a brief training on peer counselor role and how to be a part of leading a group. Having peer counselors is an important part of empowering clients. Each group it is important to set the norms and rules. Additionally it is important for leaders to empower the client's voice, reinforce any participation and discourage clients putting down peers during groups. Please be mindful of some of the risk factors that these kids struggle with and possible triggers discussed on page 9 in program description. Be wary of altered behavior that may suggest suicidal/homicidal type behavior. Seek to use de-escalation techniques when needed.

Week___ DBT Skill_____

1. Facilitator co-counselors and peer counselors to meet and discuss agenda 30 minutes before group.

2. Review group norms and rules

3. Mindfulness Activity

4. Review the last skill learned: _____

    a. Peer counselors check completed diary cards. Peer counselors provide clients who have completed diary cards group established reinforcements.

5. Introduce this Weeks skill: _____

6. Activity (Team Building, Self-Esteem Building, Video Clip that depicts skill, Game that exemplifies skill)

7. Facilitator and Co-Counselor Model Skill (Through Role Play or Discussion)

8. Peer Counselors and Group Members Model Skill (Through Role Play or Discussion)

9. Feedback

10. Diary Cards

a. Peer Counselors lead group members in brainstorm about how they might practice skill throughout the week
b. Peer Counselors discuss how to use diary card when completing skill during the week.

Psychoeducation PowerPoint

Slide 1
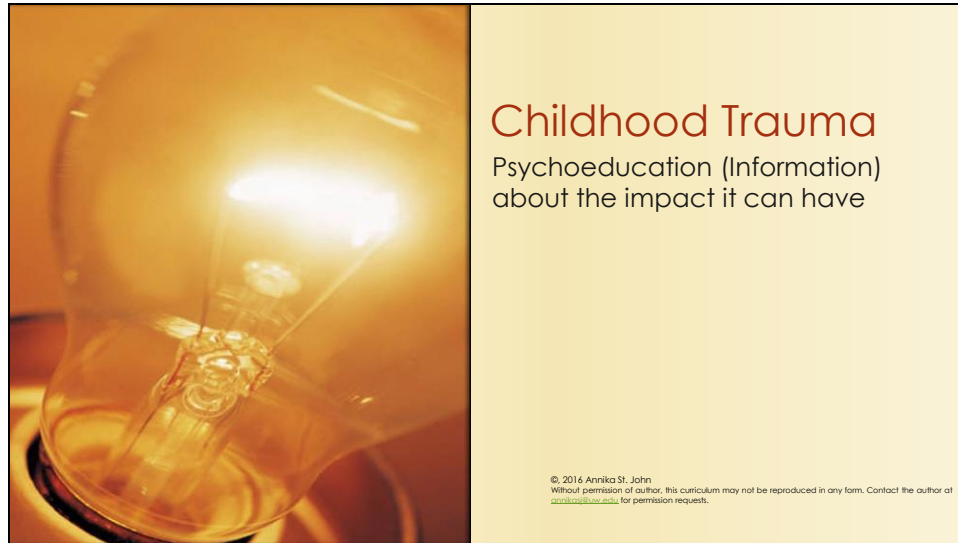
For Instructors: The intent of this PowerPoint is to inform adolescent aged youth and their caregivers about the impacts of childhood trauma. This PowerPoint is meant to be highly interactive with the participants. Allow time for brainstorming with open ended questions. Take time throughout PowerPoint to allow for questions to be asked. It would be beneficial to have an additional counselor in the room to meet privately with anyone who appears to be triggered by topic/discussion.

Slide 2
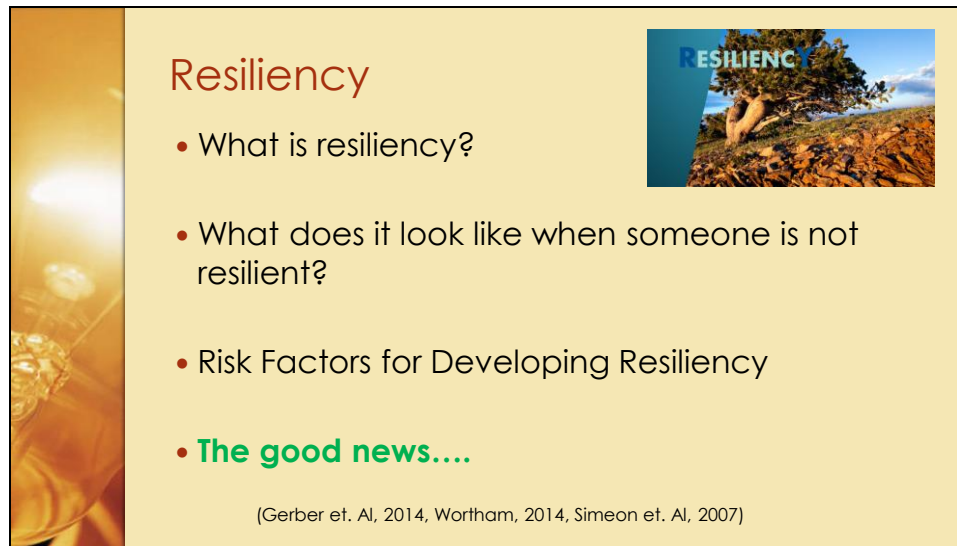
For Instructors: Briefly go through the list of topics (goals) that will be discussed during this PowerPoint. Ultimate goal of this is to educate. Knowledge is what_____? Knowledge is power, it can allow people the ability to make changes based on what they know.

Allow participants to ask questions at the end of this slide.

Slide 3

For Instructors:
• What is resiliency? Allow participants to brainstorm ideas about what resiliency is.

Resiliency can be a subjective experience for each person. Each person may define it differently. Some researchers have theorized that resiliency is displayed by "individuals [who] take responsibility for their recovery and are able to accept and integrate their experiences" (Gerber, Hogan, Maxwell, Callahan, Ruggero, & Sundberg, 2014 p.113). These researchers further defined resiliency as being able to arrive at a similar level of functioning as before the trauma took place. Other researchers characterized resilience as "the ability to display healthy social interaction, optimism, and emotional control" (Wortham, 2014, p. 59). **Resilient people are able to successfully cope and adapt after distressful, life-changing events.** It's not always about being the same exact person prior to traumatic event, those events shape you, many times into a stronger more mature individual. It's about being able to live through a traumatic event and continue to function in a constructive way.

2. What would it look like if someone was not resilient? Allow participants to brainstorm.

Example: People who are not resilient may "spiral downward or out of control" each time a challenging experience takes place. They may cope with drugs, alcohol, risky behavior that can result in life-threatening situations and death. They may be unable to manage their emotions, struggle relationally and behaviorally.

3. Brainstorm what "risk factors" mean.

How does resiliency relate to trauma?

In a research study regarding factors associated with resilience in adults, it was found that **the greatest risk factor is childhood trauma** (Simeon, Yehuda, Cunill, Knutelska, Putnam, & Smith, 2007). This is a consistent finding in many of the research articles observed regarding risk factors.

There is a physiological effect on the brain/body when we experience trauma. When we are young (early childhood development) humans experience important developmental stages, brain patterns and hard wiring that is being formed and can have a lifelong impact on how we will continue to deal with difficult situations. Trauma can have a huge impact on early childhood development and a person's ability to be resilient.

4. The good news: The brain has neuroplasticity it has the ability to form new connections between brain cells throughout a person's life. There are ways in which we can re-shape patterns of the brain that may have been impacted by trauma or adverse circumstances during early childhood. It is possible for youth to develop into a more resilient person during later developmental stages.

Slide 4

For Instructors:

• What is a protective factor?

2. Protective Factors, "**personal beliefs, humor, optimism, intelligence, social skills, mental health of parents, parenting stress, and family environment**" (Wortham, 2014, p. 59). Agaibi and Wilson (2005) discussed some of the protective factors related to resilience in a review of the literature on the topic. They stated, the **ability to moderate emotions, cope with stressors and manifest positive responsiveness to stressors** as protective factors. Additionally, Agaibi and Wilson (2005) highlight that **effective parenting increases self-efficacy, self-esteem, and self-confidence, which can help foster a resilient person**.

 Along with many other articles that were surveyed, the following list presents additional characteristics that help create a resilient person: **secure attachment, intellectual skills, social cognitive abilities, the ability to make meaning of an experience, "interaction with fellow survivors", altruism, sense of self as a survivor, and locus of control** (Agaibi & Wilson, 2005). Among these, some other things that can support **resiliency are spirituality and extended support systems outside of the family unit** (Orbke & Smith, 2013).

3. Risk Factors: It has been conferred that genetic factors such as temperament and personality can have an effect on resiliency (Orbke & Smith, 2013). **A negative home environment and genetic predisposal to a high-strung temperament or personality**. Low baseline cortisol levels may be attributed to a higher threat for developing PTSD there is

indication that **cortisol levels** in the body could be raised due to childhood trauma. An **insecure attachment** is another factor that places a person at risk for resiliency.
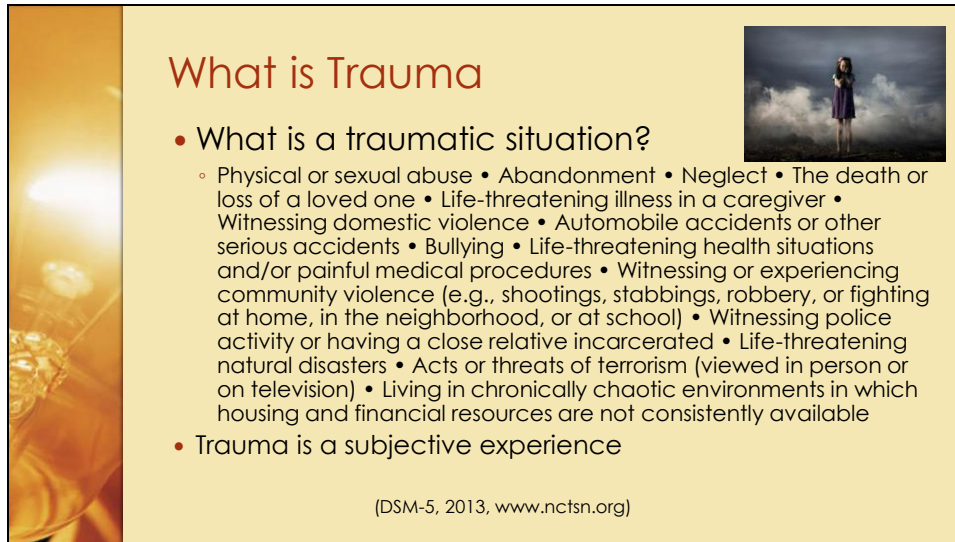
Slide 5

For Instructors: This slide can be left out/skipped over based on time.

1. This is one of the key findings from an unpublished qualitative research study that Annika St. John, MSW (The writer of this PowerPoint) completed in 2015. The diagram above states some of the risk and protective factors identified by clinicians who work with at-risk adolescent aged youth. It was suggested by this study that growing protective factors and decreasing risk factors is an effective intervention. There were limitations to the study, it was a small study, and may have lacked diversity in clinicians many of whom worked in-patient settings.

Slide 6

What is Trauma

- **What is a traumatic situation?**
  - Physical or sexual abuse • Abandonment • Neglect • The death or loss of a loved one • Life-threatening illness in a caregiver • Witnessing domestic violence • Automobile accidents or other serious accidents • Bullying • Life-threatening health situations and/or painful medical procedures • Witnessing or experiencing community violence (e.g., shootings, stabbings, robbery, or fighting at home, in the neighborhood, or at school) • Witnessing police activity or having a close relative incarcerated • Life-threatening natural disasters • Acts or threats of terrorism (viewed in person or on television) • Living in chronically chaotic environments in which housing and financial resources are not consistently available
- **Trauma is a subjective experience**

(DSM-5, 2013, www.nctsn.org)

For Instructors:
1. Brainstorm with group what a traumatic situation might look like.

2. Allow the group to read through some of the traumatic situations identified by the National Child Traumatic Stress Network. According to National Child Traumatic Stress Network, these are some situations that can be traumatic: • Physical or sexual abuse • Abandonment • Neglect • The death or loss of a loved one • Life-threatening illness in a caregiver • Witnessing domestic violence • Automobile accidents or other serious accidents • Bullying • Life-threatening health situations and/or painful medical procedures • Witnessing or experiencing community violence (e.g., shootings, stabbings, robbery, or fighting at home, in the neighborhood, or at school) • Witnessing police activity or having a close relative incarcerated • Life-threatening natural disasters • Acts or threats of terrorism (viewed in person or on television) • Living in chronically chaotic environments in which housing and financial resources are not consistently available (www.nctsn.org)

3. Read the DSM-5 Definition of Trauma. According to the DSM-5: Childhood trauma can be described as an event that takes place in which normal functioning of life is threatened, thus threatening the development of coping skills. According to the DSM V child trauma under the age of 6 is defined as, "exposure to actual or threatened death, serious injury or sexual violence through directly witnessing event in person as it occurred to others (especially caregiver), or learning that the traumatic event occurred to a parent or caregiving figure" (DSM-5, 2013).

4. Trauma is subjective, not everyone will experience trauma in the same way. What may not be traumatic for one may be traumatic for someone else and vice versa.

Slide 7

For Instructors:
- Have group members read through the signs of trauma identified by the **National Child Traumatic Stress Network.** Individuals begin to exhibit physical signs as noted on this slide.
- **On a side note for caregivers:** Each person has various defense mechanisms that kick into play when we experience trauma. In ego psychology there are dozens of psychological defense mechanisms that a person may use in order to deal with traumatic experiences for example: denial, projection (attributing terrifying anxieties to someone in external world), acting out, dissociation (painful memory separated from the feelings attached to it), regression, repression, reaction formation(transforming an unacceptable with into an acceptable one), displacement, undoing and so forth.
- When a student is impacted by trauma, which of these signs might impact their school performance?
- Which of these signs might impact a person's social relationships and ultimately their network of support? Remember, network of support is a protective factor for resiliency and therefore the experience of trauma may isolate a person from having that support that is so necessary at overcoming difficult situations.

Slide 8

Trauma and Physical Health

• There is a link between Adverse Childhood Experiences and chronic health conditions such as:
◦ Heart failure
◦ Cancer
◦ Chronic lung disease
◦ Liver disease
◦ High blood pressure
◦ High levels of C-reactive protein
Some of these chronic conditions may result in early death.

(Felitti et al., 1998, Center for Substance Abuse Treatment, 2014)

For Instructors:
1. Brainstorm if any participants are aware of the ACE study.
2. Discuss the study: ACE (Adverse Childhood Experience) originated in a study by Kaiser Permanente beginning in 1995 that examined childhood abuse and its correlation to being a leading cause in adult deaths (Felitti, Anda, Nordenberg, Williamson, Spitz, Edwards, Koss, & Marks, 1998). Specifically, this study looked at how adverse childhood experiences relate to chronic health conditions such as heart failure, renal failure, high blood pressure, diabetes, and so forth.
3. Healing from trauma can have positive impacts a person's physical health.

Slide 9

Trauma and Physical Health

- Disturbances in:
  - ◦ Sleep, gastrointestinal
  - ◦ cardiovascular
  - ◦ neurological
  - ◦ musculoskeletal
  - ◦ respiratory
- Dermatological disorders
- Urological problems
- Substance use disorders
- Hyperarousal, hypervigilance

(Center for Substance Abuse Treatment, 2014)

For Instructors:
1. Read through these additional ways trauma can effect physical health.

Slide 9

Slide 10

Trauma and Mental Health

- Thought Process Changes
  - Cognitive Errors, Excessive or Inappropriate Guilt, Idealization, Trauma-Induced Hallucinations or Delusions, Intrusive Thoughts or Memories.
- Changes in Limbic System Functioning, Changes in Cortisol Levels, Neurotransmitter-Dysregulation of Arousal
- Anxiety
- Depression
- Suicide Attempts
- Acute Stress Disorder
- Post-Traumatic Stress Disorder
- Eating Disorders

(Center for Substance Abuse Treatment, 2014, Silverman et al., 1996)

For Instructors:

1. Read through ways in which trauma effects mental health.

Slide 10

Slide 11

Attachment and Learning to Regulate our Emotions

- What is attachment?

- How do we learn to regulate our emotions?

- How is this related to resiliency and trauma?

(Siegel, 2001)

For Instructors:

1. Attachment John Bowlby began theory on attachment (all or nothing process). Mary Ainsworth Strange Situation Procedure with 3 forms of Attachment Styles: Secure, Insecure, Insecure Ambivalent/Resistant. When children go through a traumatic experience at a young age, or perhaps their caregiver experiences the traumatic event at the same time as the child, it may result in the child having an insecure or disorganized attachment to their caregiver. This in turn affects the way a child will relate to others throughout their lives.

2. Siegel (2001) discusses that children who have a disorganized attachment often have "unresolved trauma or grief" (p.77). He further discusses how a child's relationship to their caregiver is supposed to provide "joy, connection, and emotional soothing which instead offers alarm, fear, and terror and a lack of ability to be soothed" (Siegel, 2001, p. 78). Siegel confers the child is meant to learn how to cope and deal with emotional dysregulation from their caregiver. It is problematic if the adult is unable to display a healthy example of this behavior to their child. Furthermore, Siegel discusses the importance of the developing mind and how integrative processes through secure attachments in the brain are, "at the core of emotional well-being and psychological resilience" (Siegel, 2001, p. 90). The ability to have positive emotional regulation is one of the primary skills that can help a child to cope when distressed. This is a trait that will be needed throughout life internally and externally in social relationships.

3. **Your interaction with your caregiver and a secure attachment is fundamental for emotional well-being and psychological resilience.**

3. How is attachment related to resiliency and trauma? Brainstorm with the group.
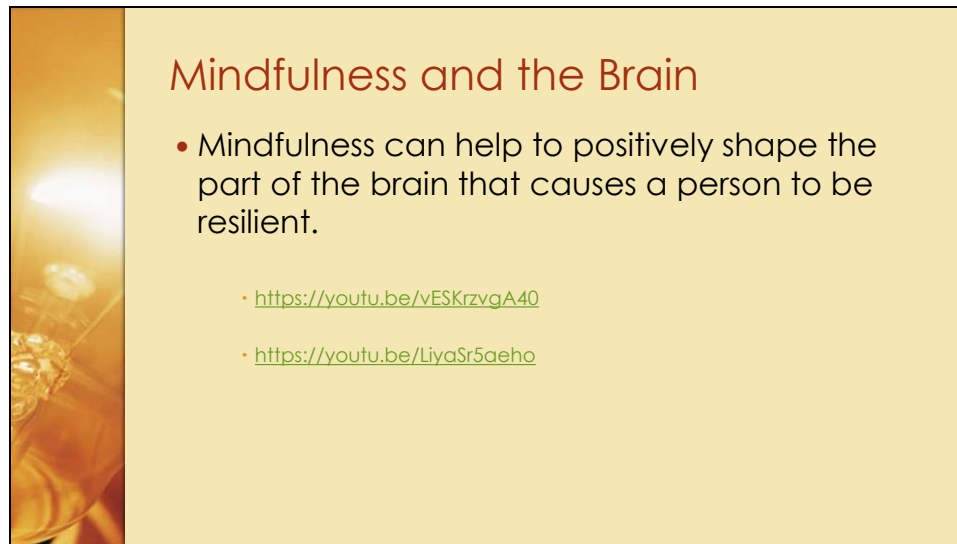
Slide 12
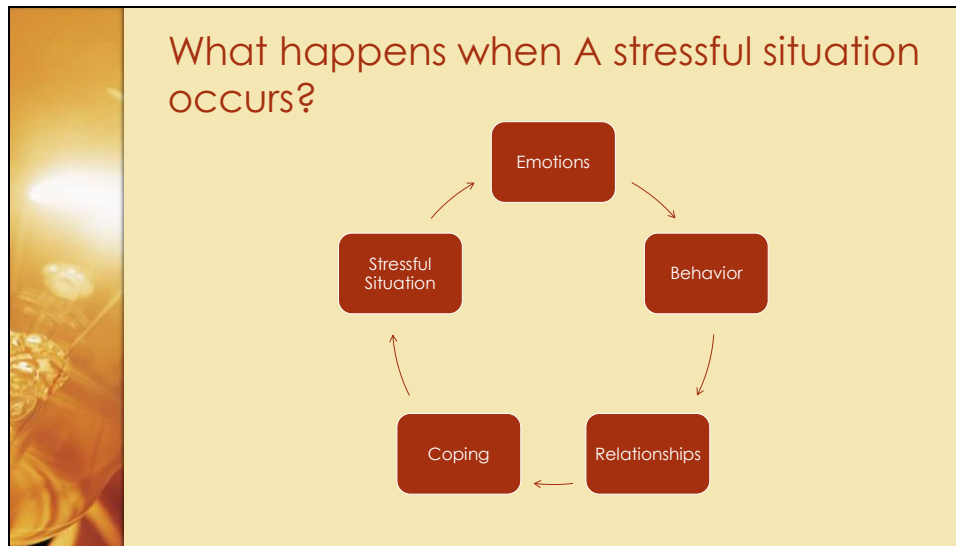
For Instructors:
1. When a stressful situation occurs our emotions are impacted, which causes us to behave in a certain way which effects the relationships and interactions with others. From this stressful situation we react by coping with what has happened. There are positive and negative coping habits that we can engage in.

2. Can somebody name a stressful situation you have experienced recently? (Example: bad grade, girlfriend/boyfriend broke up with you)

3. What is a natural reaction to this stressful situation?

4. What are some of the positive ways we can cope with something stressful?

5. What are some negative ways we can cope with something stressful?

6. What might be the difference in the way a person who has experienced childhood trauma vs a person who has not experienced childhood trauma might react when faced with stressful situations?

7. But remember the good news… (The brain has neuroplasticity, it has the ability to grow and form new patterns throughout developmental stages.)

Slide 13

For the Instructors:
Mindfulness is one of the powerful ways to help an individual to develop the part of the brain that causes resilience and aids in building the ability to regulate emotions. **I recommend previewing these videos prior to class.** You can show one or both of these videos with Neuroscientist Dr. Dan Siegel. In these videos, Dr. Siegel discusses how mindfulness affects the brain in order to build traits that can increase resilience and decrease reactive and destructive behavior.

First Video:
 Can start at the beginning. This video describes the benefit mindfulness can have at giving a child the ability to pause and think before reacting to a situation. The more we practice mindfulness the more our brain has the ability to pause and think in such a way that can promote the best possible outcome. It enables an individual to be empathetic.

Second Video:
Start Video at 11:59
This video can be used if there is time, it also discusses the benefit of mindfulness. This video uses Dan Siegel as well as a teenager and he discusses with the teenager how mindfulness affects the brain.

Questions to Ask:

What are the benefits to being able to pause and reflect before you react?

What are the benefits to being able to tune in to what other people are thinking?

Dan Seigel suggests that reflection and caring and connecting relationships stimulated the growth of the fibers or part of the brain that build resilience. What is your reaction to this?

Other facts about mindfulness:

Mindfulness-based therapies can be successful at treating anxiety and mood problems (Hofmann, Sawyer, Witt, & Oh, 2010). Additionally it can have overall positive health outcomes and better sense of well-being (Davidson et al., 2003)

Slide 14

What can help a youth who has experienced childhood trauma to **heal**?
- Mindfulness
  ◦ Martial Arts, Yoga
- Dialectical Behavior Therapy (DBT)Skills
- Cognitive Behavior Therapy (CBT)
- Trauma-Focused Cognitive Behavior Therapy (TF-CBT)
- Narrative Therapy
- Art Therapy
- Eye-Movement Desensitization and Reprocessing (EMDR) Therapy

For Instructors:

- These are some of the effective treatments that can help a person heal from traumatic experiences.
- DBT helps individuals with interpersonal skills (relationally), with distress tolerance (coping with stress), emotional regulation, and problem solving.
- CBT helps individuals reshape thinking patterns, people who may have hopeless thoughts can reshape them to be feeling hopeful.
- TF-CBT focuses on reshaping thought patterns affected by trauma.
- Creating a trauma narrative can give an individual the ability to process trauma and have power in their own voice over the traumatizing experience.
- Art-therapy can be particularly helpful when working through grief and loss.
- EMDR therapy often used with people with PTSD utilizes looking at a light while processing a traumatic event, it is an evidenced based treatment for people who have experienced traumatic events.

Slide 15

Goals

- Resiliency
  - Risk and Protective Factors
- What is Trauma?
- Attachment and Learning to Regulate Emotions
- Trauma and Physical Health
- Trauma and Mental Health
- What can help a youth who has experienced childhood trauma to **heal**?
- Mindfulness

For Instructors:

- Review goals. Reiterate the purpose of this presentation is to provide knowledge about the impacts of trauma. Knowledge is power and it can be used to make changes that can have long-lasting positive effects.
- Questions?
- Feedback?

Slide 16

Resources

- http://www.nctsn.org/
- http://www.cdc.gov/violenceprevention/acestudy/index.html
- http://childtrauma.org/cta-library/
- http://www.childtraumaacademy.com/
- http://www.samhsa.gov/trauma-violence
- http://www.utexas.edu/research/cswr/tfcbt/therapist.html
- https://depts.washington.edu/hcsats/PDF/TF-%20CBT/pages/psychoeducation.html#\
- http://www.emdria.org/?page=2

Habits of Healthy Living PowerPoint

Slide 1

HABITS OF HEALTHY LIVING

Slide 2

MIND

- Sleep
  - It is recommended by the National Sleep Foundation that Teenagers should aim to receive around 8-10 hours of sleep a night.
  - Receiving the appropriate amount of sleep can positively affect your mood and help you to avoid getting sick.
- Avoid Mood Altering Drugs
  - There are many risks associated with using drugs that can have a negative impact on your health in the long run and some can cause immediate death.
  - Some drugs are addictive and can be a challenge to stop, additionally can have negative financial repercussions.
  - Some studies have shown that marijuana use by teenagers under the age of 18 are twice as likely to develop psychosis (Kuepper et. al., 2011).

(Linehan, 2015, Pederson, & Pederson, 2012)

Slide 3

MIND

- Activities and Hobbies
  - Make a list of your favorite activities and hobbies that bring you joy.
  - Make it a priority to daily spend time doing activities that you enjoy.
  - When feeling distressed consider diverting your attention to one of your activities or hobbies.

(Linehan, 2015, Pederson, & Pederson, 2012)

Slide 4

MIND

- Distress Tolerance
  - When feeling distressed practice positive coping skills to bring relief:
    - Diversion: Read a book, Write, Draw, Go for a Walk, Watch Television or a Movie, Play a game, Organize.
    - Social: Call a friend, write a note to someone you care about, humor, serve someone in need, spend time with a pet, Encourage Others, spend time with family/friends.
    - Cognitive: Write list of what you are grateful for, brainstorm solutions, write a list of pros and cons, discover an action opposite to how you are feeling to act upon, practice radical acceptance of the situation, read something inspirational.
    - Relaxation: Guided meditation, cry, meditation, exercise, punch a pillow, practice deep breathing techniques.

(Flannery, 2014, Linehan, 2015, Pederson, & Pederson, 2012)

Slide 5

BODY

- Identify a Primary Care Provider
  - Make it a priority to see your doctor regularly.
  - When you feel you may be getting sick do not push yourself too hard. Make a doctor appointment if necessary.
  - Be aware of physical health symptoms and how they may be affect other parts of your life for example your emotions or mind.

(Linehan, 2015, Pederson, & Pederson, 2012)

Slide 6

BODY

- Eating Habits
  - The food that we ingest has a direct impact on how we feel, and our overall health.
  - Eating processed foods, foods high in sugar and fat content can have many negative effects over time. Attempt to eat whole foods rather than processed foods.
  - Make it a point to incorporate more fruits and vegetables, lean fats, and whole grains.
  - Stay hydrated with water, avoid sugary drinks.
  - Attempt to eat balanced meals.
  - Limit caffeine especially within a few hours of bed time.
  - Rigid quick fix diets can sometimes result in rapid weight gain after the diet is completed, stick to healthy lifestyle changes in balanced exercise and balanced diet.
  - Do not withhold indulgences, this can result in binge eating. Enjoy small indulgences on a regular basis.

(Linehan, 2015, Pederson, & Pederson, 2012)

Slide 7

BODY

- Exercise Regularly
  - The Center for Disease Control and Prevention recommends that teenagers do at least 60 minutes of physical activity a day.
  - Exercise not only improves physical fitness it can also have a positive impact on your energy and mood.

(http://www.cdc.gov/physicalactivity/basics/children/)

Slide 8

SPIRIT

- Meditation
- Faith
- Make a list of what you value in life. Hold true to what you value.
- Spend time in nature.
- Find a cause you believe in and get involved.

(Linehan, 2015; Pederson, & Pederson, 2012)

Slide 9

ROUTINE

- Developing a routine can help to bring order and balance.
- Creating a sleep routine of going to bed at a regular time and waking up a regular time creates a pattern that may make it easier to sleep.
- Identify limits of what you can handle in your routine. Cut out activities that may be pushing you over your limit. Prioritize what is most important.
- Include activities that bring you joy into your routine.

(Linehan, 2015; Pederson, & Pederson, 2012)

Slide 10

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Local Resource List

Updated: March 2016

Pierce County Crisis Line

 1 (800) 576-7764

King County Crisis Line

 (206) 461-3222 or 1 (800) 244-5767

WA Warm Line which provides peer to peer support phone counseling services Wednesday-Sunday 5-9pm.

1-877-500WARM (9276)
Local 206-933-7001

City of Tacoma Domestic Violence Help Line

1-800-764-2420 or 253-798-6050 TTD

YWCA of Pierce County

Emergency Shelter

 253-383-2593

https://www.ywcapiercecounty.org/emergency-shelter

Children's Program with YWCA for therapeutic support for children who have witnessed Domestic Violence

253-272-4181 ext. 248

Exodus Housing

Emergency Housing Domestic Violence

253-862-6808

http://exodushousing.org/

Mental Health

Catholic Community Services
(253) 759-9544 (Main)
(800) 566-9053 (Toll Free)

http://www.ccsww.org/site/PageServer?pagename=families_familypreservation_tacoma

Bridges: A Center for Grieving Children

253-403-1966

https://www.multicare.org/bridges-center-grieving/

Sea Mar Behavioral Health Tacoma

Counseling Services, Tacoma WA

Phone: 253-396-1634

http://www.seamar.org/location.php?xserloc=37

Comprehensive Life Resources

Counseling Services, Tacoma WA

253-396-5800

http://comprehensiveliferesources.org/Home_Page.html

Greater Lakes Mental Health

Counseling Services, Lakewood WA

253-581-7020

http://www.glmhc.org/services/#ChildFamily

Consejo Counseling

Mental Health, Substance Abuse Treatment and Gang Prevention and Intervention Services

Offices in Bellevue, Kent, Seattle and Tacoma

206-461-4880, 253-414-7461

Kwawachee Counseling Center

Puyallup, WA

(253) 593-0247

http://www.eptha.com/Kwawachee.html

Good Samaritan Behavioral Health

Children and Family Support

1-888-445-8120

https://www.multicare.org/behavioral-health-programs-families-child/

Sexual Assault Center for Pierce County

http://www.sexualassaultcenter.com/

253-474-7273or 1-800-756-7273

Pierce County Regional Support Network (Optum Health)

253-292-4200 or 1-866-673-6256

https://www.optumhealthpiercersn.com/

<div align="center">

Housing

</div>

Tacoma/Pierce County Youth Shelter Services

Beacon Senior Center 415 South 13th Street
Tacoma, WA

Open daily 6:30pm – 6:30am. Doors Close at 10pm.

The shelter at this location will be open through 3/31/16, has 40 beds and serves young people ages 18-24.

253-256-3087

http://www.communityyouthservices.org/piercecounty.shtml

Access Point 4 Housing

This is the entry to most housing options in Pierce County, do this first.

(253) 682-3401

Helping Hand House

http://helpinghandhouse.org/

(253) 848-6096 or
toll-free (1-855) HHH-FAMILY (1-855-444-3264)

MDC Housing Programs

(253) 597-6728

http://mdc-hope.org/housing/housing-for-the-homeless

Associated Ministries

Family Emergency Fund

(253) 383-3056 ext. 109

http://associatedministries.org/fef/

Tacoma Housing Authority

(253) 207-4400
TDD/TTY: 1 (800) 545-1833 EXT. 249

http://www.tacomahousing.net/

Pierce County Housing Authority

253.620.5400

http://www.pchawa.org/

<div align="center">

Substance Use

</div>

MDC The Center for Substance Abuse Recovery

The Center Tacoma, 721 Fawcett, Ste 201

253-593-2740

Consejo Counseling

Mental Health, Substance Abuse Treatment and Gang Prevention and Intervention Services

Offices in Bellevue, Kent, Seattle and Tacoma

206-461-4880, 253-414-7461

Lakeside Milam Recovery Centers

253-272-2242

http://www.lakesidemilam.com/

Youth Services

Big Brothers and Sisters of Puget Sound

253.292.2599

https://www.bbbsps.org/

Boy Scouts Pacific Harbor

253-682-2217

http://pacificharbors.org/

Girl Scouts of Western Washington

http://www.girlscoutsww.org/

Gateways For Youth

http://www.gatewaysforyouth.org/

Oasis Youth Center

LGBTQ Resource

http://www.oasisyouthcenter.org/

YMCA

Morgan Family Y

253-564-9622

Maranatha Youth Outreach Center

253-471-3880

Outward Bound

Adventure Therapy Program

http://www.outwardbound.org/about-outward-bound/schools/northwest-outward-bound-school/

Community Youth Services

Website with Local Youth Programs and Services

http://www.communityyouthservices.org/index.shtml

Family Preservation Services

Program Contact
Joan O'Connell
Sr. Administrative Assistant
(360) 918-7881

Education

Tacoma Community House

253-383-3951

http://www.tacomacommunityhouse.org/youth-services/

MDC Talent Search/ Scholars College Bound

College preparation program for low-income, first-generation students in grades 6-12 in the Tacoma & Bethel School Districts.

 (253) 536-6085

http://mdc-hope.org/education

Tutor Hunt

Online website to locate tutor

http://www.tutorhunt.com/

Website/Book Resources

1. National Child Traumatic Stress Network

   a. http://www.nctsn.org/

2. SAMHSA

   a. http://www.samhsa.gov/trauma-violence

3. Child Trauma Academy

   a. http://childtrauma.org/

4. Free Online Courses about Child Trauma from the Child Trauma Academy

   a. http://www.childtraumaacademy.com/

5. Building Resilience after Trauma by Texas Mental Health Transformation

   a. http://www.utexas.edu/research/cswr/tfcbt/index.html

6. UW Medicine Center for Sexual Assault and Traumatic Stress

   a. https://depts.washington.edu/hcsats/PDF/TF-

      %20CBT/pages/psychoeducation.html#\

7. EMDR (Eye Movement Desensitization and Reprocessing) International Association

   a. http://www.emdria.org/

8. Center for Disease Control Ace Study

   a. http://www.cdc.gov/violenceprevention/acestudy/index.html

9. National Institute of Mental Health

   a. http://www.nimh.nih.gov/health/topics/coping-with-traumatic-

      events/index.shtml

10. Center for Study of Traumatic Stress

    a. http://www.cstsonline.org/

11. Resolving Post-Traumatic Stress

      a.   http://www.post-traumata.com/index.html

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Appendix A

Mind Map

What I know

-Early trauma impact on coping style

-Attachment affected by trauma

-Protective factors

-Risk factors

-DBT and CBT are EBP to help in treatment

What I do not know

-Cortisol levels

-What are the resources for children?

-Do juvenille halls offer services to help with this?

-How are mental health diagnoses affected by this?

Children who have experienced early trauma are vulnerable to emotional dysregulation and struggle to develop a sense of resiliency.

Relevant Theoretical Foundation

-System's Theory

-Attachment Theory

-Person & Environment

-Client-Centered Theory

-Narrative Theory

-Self-Efficacy Theory

-Empowerment Approach

-Relational Theory

Who/how to obtain more information

-Focus group

-Psychiatrist/counselors that work with this population

Appendix B: Force Field Analysis

100% --- (elimination of the problem)

Expensive, Inadequate funding, Let the Juvenile Detention System deal with it, How does it benefit average citizen?, Stigma attached to "treatment", Lack of Treatment facilities, "It's your problem, deal with it", Lack of value in mental health treatment, There other higher priorities, youth become disengaged and resist help…

Restraining

Forces
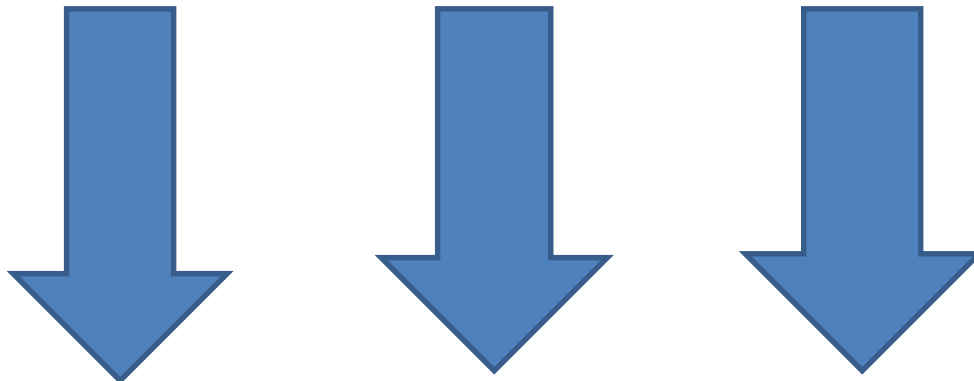
Goal Statement: Access to effective treatment for adolescents who lack resilient traits.

Driving

Forces
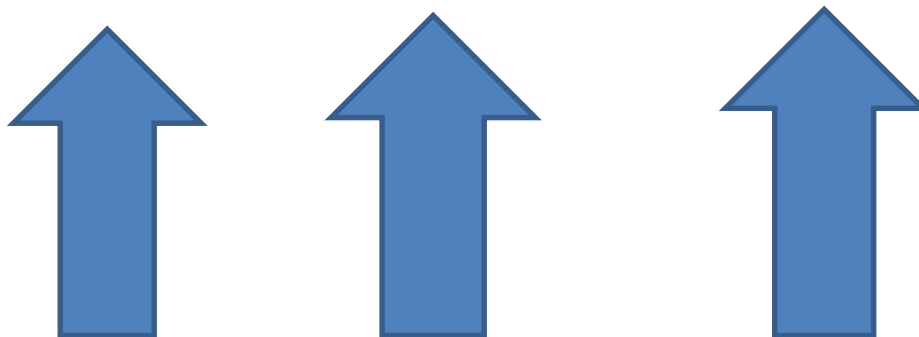
0%_____no improvement to problem intensity

Rates of Juvenile Dropouts, Rates of Juvenile's in psychiatric treatment and long waiting lists to receive in-patient adolescent treatment, Rates of Juvenile Crimes and Detention, Rates of intergenerational trauma-rates of foster care costs, adolescent suicide rates, rates of child abuse and neglect, No Child Left Behind Act…

Appendix C

Topical Template

1. The historical and current understanding of the topic or project target population,

Template 2: Provides historical information about the juvenile justice system. The article discusses studies that have been done about children who have faced adverse childhood experiences and how that correlates to juvenile offenders.

Topical Template 6: Author gives background and current information, and statistics about children who have experienced early trauma.

Template 16: Historical perspective on treatment with youth who are sexual offenders.

2. The impact of economics, difference and diversity

Template 1: Focuses on the economic return through investing in disadvantaged children.

Template 2: Provides information on the costliness of juvenile offences and how much it could save to take more of a preventative approach in policies and programs. Pp. 163 gives specific numbers and figures.

3. The impact of relevant developmental stages (of the population, or project evolution).

Template 1: This author discusses the effect of starting treatment at earlier stages vs later stages of development.

Template 6: Gives detailed information of the developmental effects on childhood trauma from early childhood up until adulthood.

Template 7: This article suggests different treatment approaches based on the developmental stage of the migrant or refugee clients.

4. Cultural, systemic, and global influences

Template 1: Focuses on how to interact with people who are economically disadvantaged. Discusses systemic problems that perpetuate poverty and economic disadvantage among certain populations.

Template 2: Looks at the juvenile justice system and seeks to promote changes to the system through screening and utilizing treatment to prevent future violent offenses.

Template 10: Suggests that children who live in rural areas receive less specialized mental health services due to the availability in their area.

Template 7: This articles interacts with cultural factors when approaching treatment with clients who have faced trauma. The article additionally suggests the global influences that can sometimes be a cause of the client's trauma.

Template 8: The premise of the article is to contribute to knowledge about culture and diversity as it relates to child trauma.

Template 9: This research study utilizes TF-CBT an evidenced based practice and finds it successful in treating adolescent youth in the foster care system.

Template 13: This informant with the regional support network (RSN) in Pierce County provided information about mental health services for youth in this area. They discussed the system in which children are able to gain access to services.

5. NASW ethical practice guidelines; identify areas for potential ethical dilemmas, and/or ways in which ethical concerns are addressed.

Template 10: It is ethically unfair that people in rural settings have less access to specialized/mental health resources due to their geographic location.

6. Identify and discuss the role theory(ies) have on the structure of the project and potential services.

Template 3: Social Learning Theory is "based on the premise that behavior is malleable, knowledge of operant, respondent, and observational learning is used to beneficially modify client behavior through the use of tested, ethical procedures" (Turner, p. 437). The article suggests that through art therapy it can help change negative brain pathways that were structured during early childhood because of trauma.

Template 4: Stress Reaction Theory is promoted in this article to be considered in intervention. This theory is commonly considered with people who are diagnosed with PTSD. Cognitive Behavior Theory which is, "Built on the three waves of behavioral theory, this approach holds that with active client participation, behavior can be modified through a wide range of tested techniques" (Turner, 2011, p. 77). This author suggest that CBT is able to reduce symptoms of PTSD symptoms (Kruczek & Salsman p. 467).

Template 6: Self Efficacy Theory "emerged from the tradition of learning theory, and builds on the belief in one's capacity to organize and execute action patterns required to produce given attainments" (Turner, 2011, p. 428). It is suggested that through gaining self-efficacy the individual will gain self-worth, they will gain confidence relationally, and have less inclination towards self-harm (Orbke & Smith, 2012, p. 52). Relational Theory which "emphasizes the restorative elements of the therapeutic relationship as a major contributor to change by stressing relatedness, which views the self as being shaped in interaction, more fluid than finished" (Turner, 2011, p. 401). Author emphasizes the importance of creating a supportive therapeutic bond with the client that is validating (Orbke & Smith, 2012). Empowerment approach which "deals with empowering people, across the life span as individuals, families, groups, and communities, to develop potential and assets to change environments and make them more just" (Turner, 2011, p. 157). The authors suggest that through an empowerment and strengths based approach you can help the client identify areas for growth, highlight some of the strengths they already possess and help them to re-write their trauma narrative. Narrative theory is another approach that is not listed here but could help the client to "explore life stories to find alternative view of reality as sources of strength and ways of dealing with ambiguity" (Turner, 2011, p. 315).

Template 11: Person and Environment: Clinician stated, "I think a lot of times resilience need(s) a boost. And you need to have the right setting and support for it to blossom." She spoke about the importance of having supportive people in the individual's life as well as having a positive environment being supremely important. The informant also stated, "I mean your family is what your family is and you can wish maybe things were different, but you can't make it happen. And just to understand that the one person you do have some power over to change is yourself-is a really part of resiliency too." This informant discussed the importance of empowering the client so that they feel that they have power to change their lives.

Self-Efficacy Theory. Clinician discussed, about one client "And at the same time firmly believed he didn't belong here that there was really nothing that much wrong with him… sometimes denial is a

good thing." Strengths perspective was a key theory for this clinician. She stated, "Yes, a lot of times when we do an intake or preadmission we will look at what the risk factors might be and what kind of strengths the child and the family have and try to wade them out in terms of what is going to be helpful for them. What kind of things do they need to reduce and what kind of things do they need to increase?"

7. Which Need(s) Exist in relation to this topic, population or project. Contributing research interventions influencing the design of the project.

Template 3: This study identifies nine psychological needs such as "Identity issues, Need for security, need for freedom, need for ideal parental relationships, need for affiliation and affection, erotic and sexual needs, expression of depression, expression of childhood trauma, and other psychological problems, spiritual or religious needs" (Persons, 2009, p.439) Study suggests that the needs are able to be expressed in art therapy and can be processed with the patients.

Template 10: This article emphasizes the need to reach out to adolescents who lack mental health services in rural areas. Utilizing telemedicine seems like a helpful way to improve the gap in mental health care for this population.

Template 14: The need to help the adolescent feel safe, feel heard, empowered, be the director of treatment, and feel supported relationally (especially with peers).

Template 12: This key informant was able to identify some of the needs locally. Such as she spoke about how there is a lack of quality clinicians. She also discussed the need for children who have experienced early trauma to be able to connect to their clinician and feel safe. She additionally discussed the importance of having a safe environment. This clinician discussed there is a lack of funds to cover the cost to address this need. This informant further discussed some of the local agencies that they connect with to help the children in need.

Template 19: This article discussed ""The most important task is the establishment and maintenance of a physical and emotional sense of safety" (Straussner & Calnan, 2014, p. 331). It is pertinent to determine if individual is suicidal or homicidal.

8. Contributing research interventions influencing the design of the project.

Template 3: Author discusses the use of Art Therapy in a research study about this intervention method.

Template 4: Author discusses various evidence based interventions that can be utilized in the school setting such as: five level approach when a school disaster occurs; psychoeducation, psychological debriefing, CBT, Creative Therapies, and tertiary prevention.

Template 5: Suggested interventions to meet current need to help children not only with their biological parents but also children in the foster system who have experienced early trauma. Intervention is based on utilizing child-parent psychotherapy.

Template 10: The article focuses on providing access to TF-CBT which is an evidenced based treatment through the means of Telemedicine.

Template 9: TF-CBT was found to be helpful in the treatment of adolescent youth in the foster care system.

Template 11: CBT was in important perspective according to this clinician. She discussed the importance of reshaping the thoughts that the clients have about themselves and developing self-

efficacy for the children to have a more positive self-view. DBT Skills was another important intervention method utilized at this treatment center. They also incorporated Milieu Therapy to interact with the clients peers and develop secure attachment and strong peer support.

Template 14: CBT, Empowerment Theory, and Strengths Based Approach were all discussed by this key informant as theories that she utilized.

Template 15: Discusses evidenced based practices recognized by Washington State as reported by the Department of Social and Health Services.

Template 17: Discusses Wilderness Adventure Therapy (WAT) history and effectiveness.

9. Identify all potential micro, mezzo and/or macro level interventions to resolve, in whole or in part, the emerging needs (even though you may only work on a portion of this information).

Template 3: Suggested that this method of intervention (Art Therapy) be implemented on a mezzo level as a county program for their Juvenile Justice System. It can also be used a micro level where a therapist processes the art with individual offenders. This method may be implemented on a macro level mandated by perhaps a state to be used among all their Justice Systems.

Template 4: Author discusses intervention methods that can be used on a micro level for individuals in the schools who have faced trauma, on a mezzo level through screenings, and on a macro level within the school if a school disaster or natural disaster was to occur.

Template 5: This is a research study about a micro level intervention that focuses on helping the family unit process early trauma through psychotherapy. It could be adopted by larger systems such as the foster care system to help alleviate some of the effects that trauma can have on the individuals in the system.

Template 10: This article suggests that this method of treatment can be helpful on a micro level to serve populations who otherwise may not receive mental health services. This program could be implemented on a more widespread level reaching out to more rural areas.

Template 9: This intervention is used on a micro level with adolescent children and families in the foster care system, but also could be used in a more widespread level in the foster care system.

Template 11: Included Micro Level Intervention with CBT, and Mezzo Level Intervention DBT-Skills, Milieu Therapy, Mindfulness.

Template 14: CBT and Mindfulness were interventions that the key informant utilized.

10. Which ideas sound most effective to you at this point? Identify your ideas for the project under consideration.

Template 10: Suggested interventions to meet current need for adolescents who have experienced trauma that live in rural areas through telemedicine.

Template 3: Art therapy seems to be an effective and cost-effective form of therapy to utilize in many arena's such as school, juvenile detention, and in community agencies.

Template 4: This articles suggested various evidenced-based practices such as psychoeducation, creative therapies, CBT, etc. that could be utilized to treat adolescents who have faced trauma in schools.

Template 6: Includes some helpful theory framework and therapeutic approaches to consider when working with children who have experienced trauma.

Template 7: Includes important factors to consider when working with migrant and refugee children.

Template 8: Includes cultural factors to consider when doing trauma work with diverse populations.

Template 9: TF-CBT is another effective form of intervention for adolescent children who have faced trauma.

Template 11: Peers support seems like an important factor in intervention methods. DBT-Skills is another best practice to help children who have faced trauma. Growing the child's protective factors and decreasing risk factors are other parts that I would like to incorporate into treatment. This clinician spoke about the importance of helping children who have faced adverse experience to feel safe. Safety planning should be incorporated into treatment. Mindfulness seems to be an important way to help youth overcome trauma.

Template 14: This clinician utilized CBT, Empowerment, Strengths Based Approach and Mindfulness. She also connected children to activities such as Martial Arts.

Template 18: This article discusses DBT and EMDR as evidence based intervention methods in residential settings that seem most-effective.

Template 19: This article discusses evidence based intervention methods that seem most-effective.

11. What challenges are there to be worked out, what is well supported by the data gathered to date, and what still remains to be answered?

I have found many different types of intervention methods. What still needs to be worked out is: how to pay for access to a program to serve this population. Some of the intervention methods are expensive. For example requiring Ph.D. clinicians to provide psychotherapy to the client and their family. Additionally, I would like to further investigate the benefits/feasibility of combining various evidence based practices into one program. There are many adolescent children affected by trauma who could benefit from services in different systems such as in the schools, in the juvenile justice system, in the foster care system. How could my program provide access to one/all of these systems and populations of adolescent youth? Some missing pieces that I would like to further investigate include looking at more community programs that are successful.

An additional piece to consider that I discovered while researching is that there is evidence that earlier intervention is more effective and cost effective when treating children with trauma then it is to treat and adolescent aged children. The earlier, the better it is for the individual. One of the social workers at my field placement mentioned that when children are younger, it is harder to detect because the behaviors are often not as blatant as when they are when they are teenagers. Also, when younger, they are somewhat masked in the family unit. The family unit sometimes prevents the child's voice from being heard. When the children reach adolescent age, they have begun to separate more from the family unity and are more likely to be vocal about their trauma experience.

Early screenings could help this process. In my program it may be helpful to promote early screenings.

I would like to further research mindfulness, yoga, martial arts, and Equine Therapy to be incorporated into intervention methods. I also could benefit from having more cultural information on what evidence-based practices work with varying cultures. I additionally would like to identify more information about the historical perspective on trauma treatment for children.

Key Informants:

Juvenile Justice System: Rebekah Vaughn, Mental Health Specialist for Pierce County Probation
Child Long Term In-Patient Program at Western State Hospital: Ilys Hernandez
Wraparound Facilitator: Leann Axel

Key Informants to include:

Schools- High Schools: Rebekah Vaughan- Waiting to receive questionnaire back
Community Program: Catholic Community Services Dnos Mbajah-Waiting to hear back from
Western State MHP: Amy-Will contact
Foster Care System: Janelle-Will contact

Topical Template ___1___

Citation:
Heckman, J. (2006). Skill Formation and the economics of investing in disadvantaged children. *Science, 312*(5782), 1900-1902.
Themes: (2) Impact of Economics (4) Systemic Influences on Target Population (3) Influences on Developmental Stages (4) Cultural Influences on Target Population
Key content 1.   Discussing the economic return of investing in disadvantaged children. 2.   Focuses on how there is greater economic return from investing in early intervention rather than programs that seek to intervene during later years. Includes graphs and figures to support findings. 3.   Focus on certain policies and programs such as No Child Left Behind, Head Start Program, Smaller Class Size Initiatives, and Second Chance Programs. 4.   Although they focus on early intervention as key, they still recognize the value in investment of older children and young adults and see it as beneficial. Perhaps many of these policies are going about it the wrong way? 5.   Article provides many statistical data about literacy rates and facts about children who have adverse childhood experiences. "The economic return from early intervention is high, and the return from later investments is lower. Remedial programs in the adolescent and young adult years are much more costly in producing the same level of skill attainment in adulthood" (Heckman, 2006, p. 1902).

"Early interventions targeted toward disadvantaged children have much higher returns than later interventions such as reduced pupil-teacher ratios, public job training, convict rehabilitation programs, tuition subsidies, or expenditure on police" (Heckman, 2006, p. 1902)

Contributions to article:
Funding sources increasingly focus on evaluation of effectiveness and efficiency while promoting multidisciplinary teams

Topical Template __2___

Citation: Fox, B., Perez, N., Cass, E., Baglivio, M., & Epps, N. (2015). Trauma changes everything: Examining the relationship between adverse childhood experiences and serious, violent and chronic juvenile offenders. *Child Abuse and Neglect, 46*, 163.

Themes:
(1) Historical and current understanding
(2) Impact of Economics
(4) Systemic influences on Target Population

Key Findings:
1. Provides information about the correlation between ACE scores and juvenile offenders.
2. This gives information about the costliness of not providing intervention to children who have faced early trauma.
3. This is a recent study that provides information about the current understanding of adverse childhood experience and also gives some background information about early ACE screenings.

"One of the most significant and recurring findings in the literature is that SVCs (serious, violent and chronic offenders) are disproportionately victims of trauma, abuse, neglect, and maltreatment during childhood, as compared to the less severe or non-offending juvenile population"

"Specifically, new research shows that 90% of juvenile offenders in the United States experience some sort of traumatic event in childhood (Dierkhising et al., 2013), and up to 30% of justice-involved American youth actually meet the criteria for post-traumatic stress disorder due to trauma experienced during childhood (Dierkhising et al., 2013)" (Fox, Perez, Cass, Baglivio, & Epps, 2015, p.164).

"Maxfield and Widom's (1996) seminal study on child abuse also found that experiencing trauma and abuse during childhood increased the odds of juvenile violent behavior by more than 200%" (p. 164).

"The development of a SVC screening tool would allow those routinely in contact with children (such as doctors, school nurses, teachers, and criminal justice practitioners) to proactively identify children at risk for SVC offending before it starts and intervene with targeted therapeutic

programs, in order to help prevent the devastating outcomes associated with childhood trauma and abuse" (Fox, Perez, Cass, Baglivio, & Epps, 2015, p. 165).

"It has also been suggested that many negative outcomes associated with high ACE scores are innate solutions adopted to respond and cope with trauma in the absence of healthier and more positive coping options, such as the allostatic load and other developmental pathologies that were previously discussed (Larkin, Felitti, & Anda, 2014)" (Fox, Perez, Cass, Baglivio, & Epps, 2015, p. 165).

"By understanding the impact that trauma and adversity in childhood has on the increased risk of the serious, violent, and chronic juvenile offending, a more proactive stance on the prevention and reduction of childhood abuse and SVC offenders may be developed" (Fox, Perez, Cass, Baglivio, & Epps, 2015, p. 166).

"The findings also support the predictions of Moffitt's developmental taxonomy, as the youth with the most significant developmental and environmental risk factors (i.e., those who experienced multiple events of childhood trauma and abuse, had an early criminal onset, had high levels of impulsivity), were significantly more likely to become serious, violent, and chronic juvenile offenders" (Fox, Perez, Cass, Baglivio, & Epps, 2015, p. 170).

"Similar results were also found by the 2000 Nobel Prize in Economics winner James Heckman, as he showed that there was $8.70 in savings to society for each $1 invested in trauma-specific prevention programs (Heckman & Krueger, 2003)" (Fox, Perez, Cass, Baglivio, & Epps, 2015, p. 171).

Contributions to article:
The findings suggest there be more preventative measures put in place to avoid the negative outcome of childhood trauma.

Topical Template __3___

Citation:
Persons, R. (2009). Art therapy with serious juvenile offenders. *International Journal of Offender Therapy and Comparative Criminology, 53*(4), 433-453.
Themes: (8) Contributing Research Interventions (9) Micro, Mezzo, and Macro Interventions (6) The role of theories (7) Psychological Needs that can be processed with youth as an important part of intervention (10) Most Effective Interventions

Key Findings:
    1. This therapy utilizes social learning theory and suggests that through art therapy it can help reformat negative brain pathways that were structured during early childhood due to trauma.
    2. Psychological needs were displayed in the outcomes of what was processed by the incarcerated youth in their art therapy. Article includes a table that displays what

psychological needs were processed and at what percentage. 5.4% of the participants processed or expressed in the art therapy childhood trauma. Table 2 highlights 8 benefits of art therapy that 100% of the 46 participants suggested.

3. It is noted that some see CBT as an effective intervention, however this article highlights shortcomings with this method such as not accounting for "family, community, original causation factors for delinquency. Furthermore, it suggest it is criticized as being too intellectual, and is superficial in receiving compliant behavior while incarcerated and once released affects are reduced."

4. Includes three brief case illustrations.

"Persons (1966, 1967) conducted a successful individual and group therapy program for serious delinquent offenders based on social learning theory" (Persons, 2009, p. 433).

"Gussak (2004) found that prison inmates who participated in art therapy broke fewer institutional rules, improved socialization skills, had an improved attitude, and were less depressed"(Persons, 2009, p. 434).

"The focus of art therapy was making meaning, learning about themselves, enjoying themselves, learning to be more proficient, and not ever giving up"(Persons, 2009, p. 437).

"…the boys painted and talked about their paintings for at least 4 to 10 hr per week for 8 months may have helped brain development through fostering new neural connections to the more reasoned cerebral cortex"(Persons, 2009, p. 445).

"…teaches new response styles that result in physiological and psychological calming may help reverse earlier brain structure by transferring activity and information from the limbic system to the cerebral cortex (Heide & Solomon, 2005; Van der Kolk, 1996)" (Persons, 2009, p. 445).

Contributions to article: Added understanding to the benefits of Art Therapy, contributed information about the psychological needs that can be processed with incarcerated youth.

Topical Template __4__

Citation:
Kruczek, T. and Salsman, J. (2006), Prevention and treatment of posttraumatic stress disorder in the school setting. *Psychology in the Schools*, *43*(4): 461–470. doi: 10.1002/pits.20160

Themes:
(8) Contributing to research interventions
(9) Micro and mezzo level interventions
(6) Role of Theories
(10) Most Effective Interventions

Key Findings:
1. Highlights the importance of school staff to be able to identify signs of PTSD.
2. Identifies the reactions and adaptations of PTSD
3. Highlights risk, protective and cultural factors

4. Treatment includes: five level approach when a school disaster occurs; psychoeducation, psychological debriefing, CBT, Creative Therapies, and tertiary prevention.
5. Discusses the need in more extreme cases to make referrals out into community based mental health treatment for more extensive treatment.

"Klingman (2001) integrated the Institute of Medicine (1994) guidelines with Caplan's (1964) classic levels of prevention to create a five-level approach to school-based preventive intervention strategies" (Kruczek & Salsman, 2006, p. 465).

"Three studies (Cohen & Mannarino, 1996; Goenjian et al., 1997; March et al., 1998) examined the efficacy of cognitive behavioral therapy (CBT) when implemented with children and adolescents in school-based settings. In these indicated preventive interventions, students with a specific trauma exposure who participated in CBT group and/or individual counseling sessions demonstrated a reduction in stress disorder symptoms" (Kruczek & Salsman, 2006, p. 467).

"There is evidence to support use of psychoeducational groups as a short term primary prevention intervention in school settings, particularly following a Type I trauma (Cohen, 1998)" (Kruczek & Salsman, 2006, p. 466).

Contributions to article: Contributes to the research and findings about how to utilize evidenced base practices to treat children with PTSD in the school setting.

Topical Template ___5___

Citation:
Ippen, C. G., Harris, W. W., Van Horn, P., & Lieberman, A. F. (2011). Traumatic and stressful events in early childhood: Can treatment help those at highest risk? *Child Abuse & Neglect: The International Journal, 35*(7), 504-513. doi:10.1016/j.chiabu.2011.03.009
Themes:
(8) Contributing research interventions
(9) Micro level interventions
Key Findings:
1. Research study with children who had witnessed/experienced marital violence that took place over 50 weeks with 39 girls and 36 boys. Treatment included psychotherapy and case management with Ph.D level clinicians.
2. The study was found to be effective. "The data provides evidence that Child-Parent Psychotherapy (CPP) is effective in improving outcomes for children who experienced four or more traumatic and stressful life events (TSEs) and had positive effects for their mothers as well" (Ippen, Harris, Van Horn, & Lieberman, 2011, p. 504).
3. For children with multiple risk factors this study was proven to be especially helpful. "The findings suggest that including the parent as an integral participant in the child's treatment may be particularly effective in the treatment of young children exposed to multiple risks" (ppen, Harris, Van Horn, & Lieberman, 2011, p. 504).

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4. This intervention may not be most effective because of the costliness in utilizing Ph.D level clinicians to operate parent child psychotherapy. There is a lack of psychotherapists to offer this service on a larger level.

Contributions to article: Below are a list of various contributions that this research study had for the information about helping children who are at high risk from experiencing traumatic events: "…the high incidence of risk factors [found in this study] highlights the importance of systematically assessing for adverse and traumatic events in young children referred to treatment" (Ippen, Harris, Van Horn, & Lieberman, 2011, p. 511).

"Given recent research suggesting the connection between these adverse experiences and later health risk behaviors and mental and physical health disorders (e.g., Felitti et al., 1998), these findings highlight the need for screening and treatment programs that target young children" (Ippen, Harris, Van Horn, & Lieberman, 2011, p. 511).

"the data suggest that the CPP relationship-based treatment approach can be particularly effective for children who experienced multiple risks and confirm the importance of including caregivers in treatment, as recommended by Cohen (1998) practice parameters for the treatment of PTSD in children and adolescents" (Ippen, Harris, Van Horn, & Lieberman, 2011, p. 511).

"the study presents preliminary data that CPP is effective not only in reducing PTSD symptoms but also in reducing co-occurring symptoms and disturbances that are associated with exposure to complex trauma (Cook et al., 2005; Cloitre et al., 2009)" (Ippen, Harris, Van Horn, & Lieberman, 2011, p. 511).

</div>

Topical Template __6__

| Citation: |
| Orbke, S., Smith, H.L., (2012). A developmental framework for enhancing resiliency in adult survivors of childhood abuse. *International Journal of the Advancement of Counseling. 35*(1). 45-56. 10.1007/s10447-012-9164-6 |
| Themes:
(1) Current and historical understanding
(6) Role of Theories
(3) Impact of Relevant Development Stages of the Population
(10) Effective Treatment Approach |
| Key Findings:
1. Discusses three dimensions of the client context as: individual, family, and community
2. Discusses the dynamic of the person and the environment, with genetic factors and how they can be modified by the environment.
3. Discusses factors for promoting resilience in childhood as well as during adolescent age.
4. Discusses developmental effects of childhood abuse.
5. Importance of utilizing theories such as strengths based approach, relational theory, empowerment approach, and self-efficacy theory. |

Contributions to article: Provides in depth information about fostering resilience in adult survivors of abuse with many theoretical perspectives to help the client.

Topical Template __7__

Citation:
Batista-Pinto Wiese, E. (2010). Culture and migration: Psychological trauma in children and adolescents. *Traumatology, 16*(4), 142-152.
Themes:
(3) Impact of Relevant Developmental Stages
(4) Cultural and Global influences on the topic
(10) Effective approach
Key Findings:
1. Many migrant families, and refugees seek mental health treatment, "This article aims at scrutinizing some aspects of the relationship between culture, migration, acculturative stress, and psychological trauma in childhood and adolescence" (Batisto-Pinto Wiese, 2010, p. 142).
2. Provides information about culture and migration.
3. Describes a child's acculturation experience and implications for treatment.
4. Explains how migration can be a major factor in an adolescent's trauma experience.
5. Gives minimal information about treatment modalities for working with clients of this background but does give some considerations to be cognizant of in the treatment process.
Contributions to article:
This article contributes to information about how to work with migrant and refugee families and children.

Topical Template __8__

Citation: Toi, H. B., Carlisle, L. L., Sargent, J. & Primm, A.B. (2010). Trauma and diverse child populations. *Child and Adolescent Psychiatric Clinics of North America, 19*(4), 869-887.
Themes: (4) Cultural and Global Influences on the topic
(10) Effective approach
Key Findings:
1. Includes a literature review on the influence of culture on: "incidence of trauma, mental health impact of trauma, resilience, and cultural approaches to care and healing "(Toi, Carlisle, Sargent, & Primm, 2010, p.870).

2. Includes clinical assessment/diagnostic challenges which are presented in four categories: behavioral, social, cognitive, emotional, and cultural.
3. Gives detailed information about treatment for adolescents from diverse cultures with a case example.

Contributions to article: This articles provides helpful information about how to therapeutically approach adolescents who have faced early trauma.

Topical Template __9__

Citation: Dorsey, S., Pullmann, M. D., Berliner, L., Koschmann E., McKay, M., & Deblinger, E. (2014). Engaging foster parents in treatment: A randomized trial of supplementing Trauma-focused Cognitive Behavioral Therapy with evidence-based engagement strategies. *Child Abuse & Neglect, 38*(9), 1508-1520.

Themes:
(6) Role of Theories
(8) Contributing Research Interventions
(9) Mezzo, Macro Interventions
(10) Most Effective

Key Findings:
1. Research study that focused on TF-CBT with 47 adolescent children in the foster care system, included engagement with the foster parents.
2. Found that the treatment was successful with "significant improvements" for those that participated (Dorsey, Pullmann, Berliner, Koschmann, McKay & Beblinger, 2014, p. 1508).
3. Through the study was able to identify that through engagement intervention it was able to achieve higher retention rates.
4. Identified various barriers for retention that could change the outcomes such as clinician's being flexible about the times to meet, providing child-care and transportation.
5. Through this research, "findings suggest that TF-CBT may be beneficial for this population based on both child and foster parent report of significantly reduced PTS, depression, internalizing and externalizing symptoms, and increased strengths" (Dorsey, Pullmann, Berliner, Koschmann, McKay & Beblinger, 2014, p. 1517).

Contributions to article: They contribute to the research about short term evidenced based practices for children and adolescents in the foster care system.

Topical Template __10__

Citation: Shealy, D., Jones, L., & De Arellano, M.A. (2015). Delivering an evidence-based mental health treatment to underserved populations using telemedicine: The case of a trauma-affected

adolescent in a rural setting. *Cognitive and Behavioral Practice, 22*(3), 331-344.
doi:10.1016/j.cbpra.2014.04.007

Themes: (5) NASW Code of Ethics
(4) Cultural and Systemic Influences
(8) Contributing Research Interventions
(9) Micro, Macro level interventions

Key Findings:
1. Children who live in rural areas have less access to mental health services.
2. It is an ethical issue that many children who live in rural areas that have faced traumatic events lack access to specialized mental health treatment.
3. The article focuses on providing access to TF-CBT which is an evidenced based treatment through the means of Telemedicine. Telemedicine is medicine that is performed from a distance through a form of videoconferencing.
4. Article provides a case report with pretreatment and posttreatment assessments to measure the outcomes.
5. Some of the findings from this article include: "Telemedicine can reduce barriers for receipt of evidence-based trauma treatments. Telemedicine increases access to specialized treatment for underserved populations. Telemedicine reduces burden to providing outreach services in remote areas" (p. 331).

Contributions to article:
Give evidence of the effectiveness of Telemedicine as well as some of the benefits and downsides to this practice.

Topical Template __11__

Citation:
Ilys, Hernandez, LICSW
Child Study & Treatment Center
8805 Steilacoom Blvd SW
Lakewood, WA 98498
253-756-2539

Themes:
(6)Role of theories
(7)Research Interventions
(8)Micro, Mezzo Level Interventions

Key Findings:
1. Key informant provided information about children who have faced early trauma and what she has found as a clinician to aid in the treatment of these children.
2. She identified that growing the protective factors is beneficial and seeking to decrease any of the risk factors.
3. DBT-Skills has been an effective mode of treatment.
4. Mindfulness can also help aid in treatment.
5. Peer support and relationships play a major role in treatment and in the development of resiliency and healing from past trauma.
6. This clinician utilizes Empowerment Theory and Self-efficacy Theory.
7. Creating a Safety Plan and ensuring the child feels safe is a major part of treatment.

8. Strengths perspective plays a foundational role in treatment.
9. Milieu Therapy is another form of therapy that is used.

Topical Template __12__

Citation: Rebekah Vaughan Mental Health Specialist for Remann Hall Probation (253) 798-7929
Themes: (7) Needs related to this population

Key Findings:
    1. This informant provided information about the Juvenile Justice System in Pierce County.
    2. She discussed that she does not feel there is enough services to reach all of the children with a history of early trauma.
    3. The informant stated that the children are screened when they first come into the system with MAYSI and probation officers will do a PACT screening to identify areas of concern. Screenings are used to connect kids to a MHP at a later time.
    4. She stated about local resources they utilize are: "Most of the community mental health agencies such as Greater Lakes Mental Health, Comprehensive Life Resources, Hope Sparks, and Good Samaritan Mental Health have therapist who are trained in trauma focused CBT techniques. They are able to help youth create a trauma narrative and talk about their traumatic event."
    5. She discussed that she does not think there is enough funding to meet the needs.
    6. She discussed that she does not think there enough quality clinicians "who have done extensive work with youth who have experienced trauma".
    7. She identified that the youth having a positive connection to their clinician and feeling safe plays a major role in the youth getting effective treatment.
    8. She identified that a positive environment and allowing the child to be the director, feeling empowered is key to effective treatment.
    9. A barrier that was identified is the child not feeling safe or ready to talk.
    10. A success story involved a girl who was removed from a bad situation with her mother and having a quality clinician that she was able to work with.
Contributions to article: Speaking with this informant gave me more information about the local juvenile justice system and what services they provide.

Topical Template 13

Citation: Optum Health Pierce RSN (866) 673-6256
Themes: 4 Systemic Influences
Key Findings: 1. There is a crisis line in Pierce County for, people (youth/adults) looking for extra resources or who have mental health concerns 1-800-576-7764. The crisis line is the main entry

point for adult or child with mental health issues to gain access to the mental county system.
For the most part youth need to have Medicaid to access mental health system. Sea Mar is recommended for those without insurance. For those with insurance redirected to private insurance to utilize mental health options. For those with Medicaid they are directed to these four mental health agencies in the area: Comprehensive Life Resources, Greater Lakes Mental Health, Catholic Community Services, and Good Samaritan Behavioral Health.
2. In order to have access to the referrals they need to access the crisis line first.

Template 14

Citation: Leann Axlen, MSW
Wraparound Facilitator
Community Psychiatric Clinic
11000 Lake City Way NE Suite 200
Seattle, WA 98125
206-619-5451

Themes: (8) Role of Theories
(9) Micro Level Interventions
(10) Most Effective Interventions

Key Findings:
1. This informant gave me information about her work with at-risk adolescent children who utilize wraparound services.
2. She utilizes a strength's based approach. Constantly looking at how to turn any negative things and using them to build the individual to be empowered.
3. They work on anger management with the youth, they work on mirroring responses to the youth.
4. This informant discussed how they practice Cognitive Behavior Therapy (CBT). They "reframe everything we can to be supportive, encouraging and empowering."
5. Empowerment approach is an important part of working with children who have faced early trauma. Allowing the child to decide how they would like treatment to go and defining what their goals are and where they would like to be is another important part of treatment.
6. One of the barriers the clinician discussed is the temptation to lead the youth to discuss something or work through something they are not ready to work through.
7. Connecting children to activities that can boost self-efficacy and self-esteem can be helpful to the youth.
8. Martial Arts is one of the activities she connected one of the youths she worked with to when she described a success story.

Template 15

Citation:
 Washington State Department of Social and Health Services. (2014). Report to the Legislature: Evidence-based and research-based practices updates and recommendations: Engrossed second substitute House Bill 2536, section 3 chapter 232, laws of 2012. *Evidence-Based and Research-Based Practices*. Retrieved from: https://www.dshs.wa.gov/sites/default/files/BHSIA/dbh/Mental%20Health/Evidence-Based%20and%20Research-Based%20Practices%20E2HB2536-%202014.pdf

Themes: (1)Current understanding on target population
Intervention Methods

Key Findings:
1. This is a report from the Washington State Department of Social and Health Services to the Legislature about "recommended strategies, timelines, and costs for increasing the use of evidence-based and research-based practices" as is mandated by the law in H.B. 2536.
2. Provides summary of research completed by the University of Washington, Evidence-Based Practice Institute about Gaps Analysis of Research/Evidence-Based Treatment for Children's Public Mental Health in Washington State.
    - Report suggest the following are diagnoses for Medicaid children and youth based on state billing database:
- Depressive Disorders (32%)
- Anxiety Disorders (21%)
- Adjustment Disorders (11%)
- Trauma/PTSD (9%)
- Conduct Disorders (9%)
- ADHD (6%)
- Bipolar Disorders (2%)
- Psychotic Disorders (1%)

3. This report states that evidence based practices for child welfare include: Intensive Family Preservation Services (Homebuilders), Parent Child Interaction Therapy, and Safecare in the intervention category. In prevention, evidence based practices include: Health Families America, Nurse-Family Partnership, Parents as Teachers and Triple P (system). Although of the prevention programs, only Triple P is cost beneficial.
4. Report discusses that there is little evidence-based practices that have been tested among tribal communities.
5. Report acknowledges concern that stakeholders feel there is not enough cultural responsiveness to the EBPs.
6.

Template 16

Citation: Rasmussen, L. (2013). Young People Who Sexually Abuse: A Historical Perspective and Future Directions. *Journal of Child Sexual Abuse, 22*(1), 119-141.

Themes: (1) Historical and Current Understanding

Key Findings:

1. Article gives historical understanding of the treatment for children with sexually abusive behaviors and sexual behavior problems.
    2. Historical perspective begins in the 1980's when assessment and treatment for this behavior was first begun.
    3. U.S. National Task Force on Juvenile Sexual Offending began in 1993 which led to much of the research and development of standard guidelines and practice related to this topic.
    4. Creation of sex-offender specific cognitive behavior therapy (CBT) was developed which utilized "confrontational and emphasis was on accountability; youth were expected to disclose full details of their sex offenses to their peers in group treatment" (Rasmussen, 2013, p. 121).
    5. "As sex-offender specific CBT was widely implemented across the nation in juvenile sexual offender treatment programs, understanding one's sexual abuse cycle, learning to have empathy for the victim, and designing a relapse prevention plan (Gray & Pithers, 1993) became staples of the sexually abusive youth's treatment" (Rasmussen, 2013, p. 121).
    6. "Authors pointed out CBT was not sensitive to developmental status or cognitive capacities and asserted that directive techniques of CBT should not be used alone when treating young children (or youth with low intellectual functioning or learning disabilities) but only in tandem with experiential interventions (Longo, 2004; Rasmussen, 2001; Rasmussen & Cunningham, 1995)" (Rasmussen, 2013, p. 121).
    7. Discusses the historical use of play therapy for children with sexual trauma.
    8. This article calls out the importance of applying developmental appropriateness as a primary need when taking an intervention method and applying it to youth.

Template 17

Citation: Jones, C., Lowe, L., & Risler, E. (2004). The Effectiveness of Wilderness Adventure Therapy Programs for Young People Involved in the Juvenile Justice System. *Residential Treatment For Children & Youth, 22*(2), 53-67.

Themes: Intervention Methods
Mezzo Intervention

Key Findings:

1. Discusses history of wilderness adventure therapy (WAT) and its use by the juvenile justice system after children are released from system.
2. "The goal of these programs is to provide a supportive environment away from the distractions of home, school, and the community so that the participants can learn and practice effective behaviors. (Jones, Lowe, & Risler, 2004, p. 54).
3. "Through these experiences, WAT programs seek to improve the participants' interpersonal skills, group skills, sense of trust, self-confidence, self-esteem, physical abilities/fitness, and awareness of the natural world (Moote & Wodarski, 1997)" (Jones, Lowe, & Risler, 2004, p. 54).
4. Outward Bound, an intervention program for at-risk youth was developed in the 1970's. Early studies depicted positive effects for children in WAT programs.
5. Later studies during the 90's also showed positive effects yet lacked validity.
6. Some other more recent studies which had more reliability displayed "the variations in the program practices, types of activities used, and the qualifications of the staff members in these programs make it difficult to produce generalizable research in the field" (Jones, Lowe, & Risler, 2004, p. 56).
7. Current research suggests that WAT programs do have positive results on participants' self-concepts, social functioning, and individual behaviors (Milner & Nisbet, 1997)" (Jones, Lowe, & Risler, 2004, p. 56).
8. The authors of this article completed a research study to see if the recidivism rates were better for children in WAT programs in comparison to children going to group homes after leaving the juvenile justice system.
9. "The overall findings of the study indicated that there were no significant differences between the recidivism rates for the participants in wilderness programs and those who were placed in group home programs. Participants in both programs had lower recidivism rates at 6 months (25% wilderness and 27% group home) than at 12 months (60% wilderness and 63.6% group home). These findings are consistent with the literature that indicates programs tend to lose effectiveness over time" ((Jones, Lowe, & Risler, 2004, p. 63).

Template 18

Citation: Lovelle, Carole. (2005). Dialectical Behavioral Therapy and EMDR for Adolescents in Residential Treatment: A Practical and Theoretical Perspective. *Residential Treatment for Children & Youth, 23*, 27-2), p.27-43.

Themes: Interventions
Mezzo Level Interventions

Key Findings:

1. "DBT focuses on such skills and behaviors as mindfulness and distress management. During these processes survivors are taught new behavioral alternatives to replace their old, trauma-induced behavioral repertoires. They also address dysfunctional cognitions that have kept them tied to old behaviors"(Lovelle, 2005, p. 33).
2. "EMDR uses intentional exposure to thoughts about traumatic incidents, while employing planned eye movement and sometimes tactile and auditory experiences to reintegrate brain activity" (Lovelle, 2005, p. 33).

3. "DBT addresses the core issue of emotional dysregulation. Teen-agers who suffer intense emotional pain frequently engage in emotional avoidance and escape behaviors" (Lovelle, 2005, p. 34).

4. "The role of EMDR is to help the client Promising Practices/Best Practices 37 Downloaded by [University of Washington Libraries] at 15:56 05 December 2015 access and metabolize the memory, and transform it to a more neutral and healthier form. EMDR is distinguished from other trauma treatments by the accelerated information processing effect, which in most cases condenses the healing process into a very brief period" (Lovelle, 2005, p. 38).

5. "DBT has been found to be effective for an assortment of conditions including borderline personality disorder (Linehan et al., 1991; Verheul et al., 2003) depression (Bohus et al., 2000; Bradley & Fallingstad, 2003), suicidal ideation (Bohus et al., 2000), dissociation (Bohus et al., 2000), stress (Bohus et al., 2000), self-harm (Bohus et al., 2000; Hawton et al., 2000) , substance abuse (Linehan et al., 1991; Linehan et al., 1999), and eating disorders (Telch, Agas, & Linehan, 2001). These same studies have found DBT to be effective across multiple treatment settings from private practice to residential programs, 40 BEST PRACTICES IN RESIDENTIAL TREATMENT Downloaded by [University of Washington Libraries] at 15:56 05 December 2015 and across multiple age groups, from adolescents to elders"(Lovelle, 2005, p.40-41).

6. "EMDR has also received extensive clinical testing and has been supported in numerous trials as effective for treating trauma and trauma-related disorders. Sixteen randomized trials and 6 non-randomized trials have found EMDR to be superior to other forms of therapy for treating trauma. A single, non-randomized trial found cognitive behavior therapy to be more effective than DBT (EMDR Institute, 2007). In addition, a meta-analysis conducted by Van Etten and Taylor (1998) concluded that EMDR and behavior therapy were both more effective than psychotropic medication" (Lovelle, 2005, p.41).

7. "Both DBT and EMDR are effective, evidence-based approaches to treating conditions produced by trauma, such as post-traumatic stress disorder. They are based on sound theory and are consistent with both other well-supported and with what has been learned through empirical tests of other treatment methods. Both have been shown to be effective in clinical trials. DBT is effective for treating additional conditions that may exist comorbidly with or be related to stress disorders. The current author has used them conjointly to produce positive benefits in a variety of age groups. DBT and EMDR, administered conjointly, remain a little-explored, yet highly promising approach to providing sensitive, effective residential treatment for adolescents" (Lovelle, 2005, p.41).

Template 19

Citation: Straussner, S., & Calnan, L. (2014). Trauma Through the Life Cycle: A Review of Current Literature. *Clinical Social Work Journal, 42*(4), 323-335.
Themes: Interventions Mezzo Level Interventions Most Effective
Key Findings: 1. "Child-Parent Psychotherapy (CPP) (Lieberman and Van Horn 2008). CPP is a psychodynamically based therapeutic approach has shown to be very effective in treating

2. "Parent–Child Interaction Therapy (PCIT; Eyberg and Bussing, 2010). While not specific to traumatized children, it is an empirically-based behavioral short term intervention for children age 2–7 who are experiencing emotional and behavioral disorders" (Straussner & Calnan, 2014, p. 329).

3. "TF-CBT is a psychosocial intervention found to be effective in treating PTSD and other behavioral and emotional problems related to a variety of traumatic experiences in children and adolescents "(Straussner & Calnan, 2014, p. 329).

4. "Psychoeducation is the ''process of teaching clients with mental illness and their family members about the nature of the illness, including its etiology, progression, consequences, prognosis, treatment and alternatives'' (Barker 2003, p. 347)." (Straussner & Calnan, 2014, p. 330).

5. Author discusses three additional forms of CBT that have been proven to be effective in treatment of children with a history of trauma. They are: - "**Exposure/Desensitization**, which consists of direct confrontation with trauma by having individuals visualize the event, talk about it, and expose themselves gradually to stimuli which reminds them of the trauma" (Straussner & Calnan, 2014, p. 330). "Another empirically supported cognitive-behavioral treatment for PTSD is Dialectical Behavior Therapy **(DBT**)" ((Straussner & Calnan, 2014, p. 330).   "Treatment model found to be effective in treating traumatized adults is Eye Movement Desensitization and Reprocessing (**EMDR)** (Shapiro 1995)" (Straussner & Calnan, 2014, p. 330).

6. "Narrative therapy thus allows for the completion and reframing of the traumatic event. While there is some evidence showing the effectiveness of this approach (Amir et al. 1998; Schaal et al. 2009), there seems to be no single narrative treatment model. Further research is needed in order to identify the best narrative approaches" (Straussner & Calnan, 2014, p. 330).

7. "While group therapy has been found to be effective at providing support for individuals in many circumstances, the use of certain group approaches, such as Critical Incidence Stress Debriefing (CISD) has been shown to have the potential for retraumatization" (Straussner & Calnan, 2014, p. 331). However "One highly effective treatment model, used mainly in group settings, is Seeking Safety, developed by Lisa Najavitis (2006)" (Straussner & Calnan, 2014, p. 331).

8. "The most important task is the establishment and maintenance of a physical and emotional sense of safety" (Straussner & Calnan, 2014, p. 331). It is pertinent to determine if individual is suicidal or homicidal.

Topical Template __20__

Citation:
Enos A. Mbajah, M.A., LMFTA, MHP, CMHS
Clinical Supervisor & Family Therapist
Catholic Community Services
5410 North 44th Street
Tacoma, WA 98407
(253) 759-9544 office
(253) 732-3443 Cell

Themes: (8) Role of Theories (9) Micro Level Interventions (10) Most Effective Interventions
Key Findings: **Questionnaire** 1. Currently this organization finds a private therapist who they refer clients to in order to work with youth who have experienced trauma. 2. This community provider finds there are not enough youth services to meet the amount of need in the community. 3. A barrier this community provide related to "WISE (wraparound with intensive services) services which are intensive home based long term services that are a result of the class action lawsuit. At this time they are only available to youth and families who have med coupon." 4. They find there is not enough funding and access are barriers to children receiving treatment. 5. The intervention method this therapist found to be most effective is, "I am a systemic therapist, so from my perspective any intervention which encourages each member of the family to change will in turn be helpful to the youth who has experienced trauma. From a systems perspective, issues often don't arise in isolation so change shouldn't either. This is not to say that individual trauma work isn't important, rather with youth inclusion of family members helps in fostering an environment conducive for change."

Topical Template __21__

Citation: Kim Lubin, NBCT, LCSW Part-Time Lecturer UW Tacoma Social Worker Gig Harbor High School lubink@u.washington.edu
Theories:

Key Findings:
1. In her school, counselors piece together trauma in what they have seen and what they have heard. They do a lot of guessing, there is not a trauma screen that has been completed. There is no official screen for trauma in the schools.
   3. The alternative high school has no social worker, which this professional finds problematic.
   4. The school does not have suicide risk screening.
   5. Currently as far as referrals for youth who have experienced trauma, this social worker has built a network of who the good therapists are to refer to. Insurance and transportation presents as a barrier. Kim stated that it is easier when adolescents drive and do not have to have parental permission to go to counseling. Sometimes clients want it to be confidential, but if they access insurance then it is not confidential from the parents.
   6. Kim finds there are not many therapist locally who are well-grounded.
   7. There is no psycho-education that the school offers. The social worker does offer it herself when she can.
   8. Kim stated that the school does not offer any preventative curriculum for trauma.
   9. Priorities in the schools are much more focused on academics.

10. With different leadership, this social worker feels that a trauma psychoeducation could be put in with a health curriculum.
11. This public school has no drug and alcohol curriculum, and no bullying prevention curriculum and finds there are so many things that are needed, so where do you fit all of this in between 7:30-2:00pm?
12. There is a big gap in identifying kids who have experienced trauma, there needs to be an automatic pipeline to getting clients referred to a trauma program such as a pipeline from the criminal justice system, the foster care system, domestic violence, and immigrants.

Appendix D

Information Report

Annika St. John

University of Washington Tacoma

Teresa Holt-Schaad, MSW, LICSW

T SOCW 532 Advanced Integrative Practice 1

December 10, 2015

Information Report

Introduction

This information report comprises material regarding effective treatment for adolescent children who have experienced early trauma and/or adverse childhood experiences. The included data has been identified through a literature analysis of peer-reviewed articles and books related to the subject matter. Additionally, interviews were conducted in order to gain a more comprehensive perspective on the subject from knowledgeable informants. The names of the informants have been changed in order achieve anonymity and protect any sensitive information disclosed about this topic.

Historical and Current Understanding

In the United States, it is estimated that twenty-six percent of children will witness or experience a traumatic event before the age of four years old (Briggs-Gowan, Ford, Fraleigh, McCarthy, & Carter, 2010). Children with early experiences of trauma, adverse experiences and an insecure attachment are less likely to develop a resilient disposition, are more likely to struggle emotionally, behaviorally, intellectually and socially (Orbke & Smith, 2012). They are also at-risk for substance abuse, mental illnesses, poverty which could become an intergenerational pattern without effective treatment (Orbke & Smith, 2012). Based on these alarming statistics regarding the long-term effects of childhood adversity, it is pertinent to provide effective treatment for these children so that there is a stronger opportunity to achieve personal success.

A historical perspective regarding treatment for children who have experienced sexual trauma has roots dating back to the 1980's. In 1993 the U.S. National Task Force on Juvenile Sexual Offending began much of the research and development of standard

guidelines and practice related to this topic. This prompted the creation of sex-offender-specific cognitive behavior therapy (CBT). The approach was, "confrontational and emphasis was on accountability; youth were expected to disclose full details of their sex offenses to their peers in group treatment" (Rasmussen, 2013, p. 121). Unfortunately, this practice of CBT did not take into account developmental disabilities, cognitive function, or developmental appropriateness. Sex-offender CBT is still currently practiced with sexually offending youth but now takes a victim-centered approach. Additionally, developmentally sensitive interventions are commonly used (Rasmussen, 2013).

Impact of Economics

There is a cost-benefit to investing in effective treatment for children who have experienced early trauma. Economist and Nobel Prize winner James Heckman has revealed that if we invest $1 dollar in trauma-specific prevention programs, it will save our society $8.70 dollars per child (Heckman & Krueger, 2003). Likewise, Campbell et al. (2014) stated that investing in our children not only benefits them when they are young, but continues to benefit them in their adult lives.

Another economic impact is the proven correlation between children who have experienced neglect or abuse and the likelihood that they will commit a violent crime; furthermore there has been found to be a link between child maltreatment and the development of psychopathology (Fox, Perez, Cass, Baglivio, & Epps, 2015). This is supported by research published in 2013 suggesting that nearly 90% of U.S. juvenile offenders have experienced some sort of a traumatic event as a child (Dierkhising, et. al., 2013). Trauma prevention and early trauma treatment among disadvantaged youth can reduce the amount of juvenile offenders becoming chronic adult offenders. It could also could

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reduce the risk for the development of mental illnesses (Fox, Perez, Cass, Baglivio, & Epps, 2015). Heckman (2006) states, "The economic return from early intervention is high, and the return from later investments is lower. Remedial programs in the adolescent and young adult years are much more costly in producing the same level of skill attainment in adulthood" (p. 1902). Earlier intervention is an important issue to address and promote in public policy. However, it cannot be ignored that there are many adolescent children who have not received early intervention. The social, emotional, and psychological behaviors begin to appear in a devastating way during the adolescent stage of development. Risks of suicide and homicide become a higher risk. Therefore it is pertinent to address this problem for adolescent youth and provide access to intervention.

Systemic and Global and Cultural Influences

Poverty can contribute to a child's adverse childhood experience. There are many political policies that perpetuate concentrated poverty through lack of infrastructure in disadvantaged neighborhoods and lack of subsidies to allow low income people to move out of poorer neighborhoods into more safe locations (The Editorial Board, 2015). Concentrated poverty causes children to live in areas that are often unsafe and lack resources including access to good education or employment (Lichter, Parisi, & Taquino, 2012). Some policies in America that cause concentrated poverty are driven by the fear of integrating differing social classes into geographical areas. On a national systemic level there is a need to integrate rather than continuing to segregate and discriminate racially and socioeconomically.

In Pierce County, a regional support network (RSN) plays a systemic role in access to treatment. They are the gateway to mental health services. There is a crisis line in Pierce County for youth and adults with mental health concerns seeking additional resources

(Optum Health, Personal Communication, November 20, 2015). The crisis line is the main

entry point for adult or child with mental health issues to gain access to the mental health

system. For the most part, youth need to have Medicaid to access mental health system. One

agency, Sea Mar is recommended for those without insurance. For those with insurance, they

are redirected to private insurance to utilize their mental health options. For those with

Medicaid they are directed to these four mental health agencies in the area: Comprehensive

Life Resources, Greater Lakes Mental Health, Catholic Community Services, and Good

Samaritan Behavioral Health (Optum Health, Personal Communication, November 20,

2015).

The juvenile justice system is seeking to make change through the promotion of

mental health treatment and screening tools "to proactively identify children at risk for SVC

[seriously violent and chronic offenders] offending before it starts and intervene with

targeted therapeutic programs, in order to help prevent the devastating outcomes associated

with childhood trauma and abuse" (Fox, Perez, Cass, Baglivio, & Epps, 2015, p. 165). One

key informant who works in the Pierce County Probation Services stated "the children are

screened when they first come into the system with Massachusetts Youth Screening

Instrument (MAYSI) and probation officers will do a Positive Achievement Change Tool

(PACT) screening to identify areas of concern. Screenings are used to connect kids to a

MHP at a later time" (Rachel Vesper, Personal Communication, November 24, 2015). She

also discussed that every child who comes into the system has the potential for receiving a

Functional Assessment Service Team (FAST). She further stated that at Optum, the RSN

decides if they are eligible (Rachel Vesper, Personal Communication, November 24, 2015).

On the outpatient side of juvenile justice, youth have the opportunity to be a part of WISE

Wraparound services. The key informant stated that in probation, they use a team approach: the probation officers work with the family, and they hold monthly team meetings in a team model (Rachel Vesper, Personal Communication, November 24, 2015).

An additional systemic issue is brought to light by Shealy, Jones, & De Arellano (2015) about how children who live in rural areas have less access to mental health services. This article describes how rural adolescents are provided access to TF-CBT which is an evidenced-based treatment through the means of Telemedicine. Telemedicine is medicine that is performed from a distance through a form of videoconferencing. In a research study by Shealy, Jones, & De Arellano (2015) they found, "Telemedicine can reduce barriers for receipt of evidence-based trauma treatments. Telemedicine increases access to specialized treatment for underserved populations. Telemedicine reduces burden to providing outreach services in remote areas" (p. 331).

Another cultural consideration that should require screening is if a child has recently emigrated. Batista-Pinto (2010) discusses how migration can be a major factor in an adolescent's psychological trauma experience. "After migration, the person's psychological adjustment to environmental and cultural changes has the tendency to take place progressively" (Batista-Pinto, 2010, p. 144). The acculturation process causes the youth to adjust from their culture of origin to the new culture which can be rather challenging. It is further discussed that "it can be very important to have interpreters or bicultural therapists participating as mediators in mental health treatment" (Batista-Pinto, 2010, p.149). Mental health professionals should seek to be familiar with the cultural background of the client they are working with as they interpret symptoms and make diagnoses. Another factor to

recognize is the need for the client to connect to their new culture as they continue to heal from past traumatic experiences (Batista-Pinto, 2010).

Developmental Stages

Orbke & Smith (2012) discuss that during the early childhood developmental stage, the supportive relationship with an adult is key to the ability to achieve a resilient disposition. They state, "Current models of children's resilience focus on three elements: characteristics of the child, family support and extra-familial support from schools, neighborhoods and communities" (Orbke & Smith, 2012, p. 48). They further discuss the importance of good parenting which provides abundant love, clear expectations, support, they provide the child with a secure attachment, show the child how to show empathy for others, and teach the child positive emotional regulation habits.

In contrast, during the adolescent stage teenagers are influenced by larger systems such as peers and their environment rather than the family unit. The theory of person and environment plays a larger role for this developmental stage. They are able to have more control over their environment as an active participant (Orbke & Smith 2012). "By this stage in development, individuals are beginning to acquire more advanced cognitive abilities and are starting to perspective take, engage in self-reflection and understanding, consider situations from multiple perspectives, and practice making conscious decisions regarding their actions" (Orbke & Smith, 2012, p 49). Additionally, at this stage they are breaking away from the family unit and creating an individualized identity for themselves. This results in decisions that will lead to engagement in either constructive or destructive activities. Consistent parenting and clear limit-setting is also important for youth during this stage. The

growth of social skills with peers through mastering the ability to engage in close supportive relationships is another important milestone during this phase.

NASW Ethical Practice Guidelines

The NASW code of Ethics states that we have the responsibility to promote a client's right to self-determination (NASW, 2008). Social workers can promote this through inclusive citizenship theory as discussed by Lister (2007) in four elements: it is just, it recognizes "the intrinsic worth of all human beings," it is self-determining, and includes solidarity" (p. 50-51). Each citizen, including children are valuable and deserve the right to live a healthy life. Inability to access effective treatment puts them at risk for achieving this goal that we all hope to achieve. Social workers value for social justice and providing a voice for marginalized citizens. Providing treatment for at-risk youth promotes social justice and gives a voice to a vulnerable population. Many of these children are not of age to vote on policies and issues that relate to their access to treatment. Therefore it is a social workers role to provide voice and advocacy to a group that lacks power to create effective change.

Theory

Multiple theories were identified through the articles surveyed in this literature review. In an article about Art Therapy for juvenile offenders Social Learning Theory was applied (Persons, 2009). This theory is "based on the premise that behavior is malleable, knowledge of operant, respondent, and observational learning is used to beneficially modify client behavior through the use of tested, ethical procedures" (Turner, p. 437). The article suggests that Art Therapy, can help change negative brain pathways that were structured during early childhood because of trauma.

Stress Reaction Theory is promoted in an article about trauma intervention in schools (Kruczek & Salsman, 2006 p. 467). The authors discuss that this theory is commonly considered with people who are diagnosed with PTSD. Additionally it is suggested that CBT is effective at reducing symptoms of PTSD (Kruczek & Salsman, 2006 p. 467). Cognitive Behavior Theory is, "Built on the three waves of behavioral theory, this approach holds that with active client participation, behavior can be modified through a wide range of tested techniques" (Turner, 2011, p. 77). Many intervention methods that are used with people who have faced trauma utilize CBT.

Orbke & Smith (2012) discuss the importance of Self-Efficacy Theory when working with clients who lack resiliency. Self-Efficacy Theory "emerged from the tradition of learning theory, and builds on the belief in one's capacity to organize and execute action patterns required to produce given attainments" (Turner, 2011, p. 428). It is suggested that through gaining self-efficacy the individual will gain self-worth, they will gain confidence relationally, and have less inclination towards self-harm (Orbke & Smith, 2012, p. 52). Children begin to develop self-efficacy during adolescence.

Additionally, one key informant who is a clinician that works with in-patient at-risk adolescent youth utilized Self-Efficacy Theory. She stated about one of her clients "And at the same time he firmly believed he didn't belong here, that there was really nothing that much wrong with him… sometimes denial is a good thing" (Imogene Henderson, Personal Communication, April 30, 2015). The client's perception and gained confidence helped their behavior to change. It helped the client to achieve positive goals while in the program.

Relational Theory can be useful when working with this population. This theory "emphasizes the restorative elements of the therapeutic relationship as a major contributor to

change by stressing relatedness, which views the self as being shaped in interaction, more fluid than finished" (Turner, 2011, p. 401). Orbke & Smith (2012) echo this theory when they emphasize the importance of creating a supportive therapeutic bond with the client that is validating (Orbke & Smith, 2012).

Empowerment approach is another important element of treatment suggested by Orbke & Smith (2012). This approach "deals with empowering people across the life span as individuals, families, groups, and communities to develop potential and assets to change environments and make them more just" (Turner, 2011, p. 157). The authors suggest that through an empowerment and strengths-based approach you can help the client identify areas for growth, highlight some of the strengths they already possess and help them to re-write their trauma narrative. Narrative Theory is another approach that could help the client to "explore life stories to find alternative views of reality as sources of strength and ways of dealing with ambiguity" (Turner, 2011, p. 315). Strengths perspective was a key theory for one clinician key informant. She stated,

> Yes, a lot of times when we do an intake or pre-admission we will look at what the risk factors might be and what kind of strengths the child and the family have and try to wade them out in terms of what is going to be helpful for them. What kind of things do they need to reduce and what kind of things do they need to increase? (Imogene Henderson, Personal Communication, April 30, 2015)

A strengths-based approach finds that "all people have a natural power within themselves that can be released" and social workers can partner to develop the clients ability for growth by tapping into that natural reservoir of strength (Miley, O'Melia, & DuBois, 2013, p. 76).

Orbke & Smith (2012) honed in on Person and Environment Theory specifically when working with adolescent youth. Key informant Imogene Henderson also used this theory. She stated, "I think a lot of times resilience need(s) a boost. And you need to have the right setting and support for it to blossom" (Personal Communication, April 30, 2015). She further spoke about the importance of a positive environment and support. The informant similarly stated, "Your family is what your family is and you can wish maybe things were different, but you can't make it happen. And just to understand that the one person you do have some power over to change is yourself-is a real part of resiliency too" (Imogene Henderson, Personal Communication, April 30, 2015). This informant discussed the importance of empowering the client to feel that they can be an active participant in their environment and have the power to change their lives.

Identified Needs

In an article research study about Art Therapy, nine psychological needs are identified when working with juvenile justice system clients. They are: "Identity issues, need for security, need for freedom, need for ideal parental relationships, need for affiliation and affection, erotic and sexual needs, expression of depression, expression of childhood trauma, and other psychological problems, spiritual or religious needs" (Persons, 2009, p.439) This study suggests that the needs are able to be expressed in art therapy and can be processed with the patients.

As discussed in an article noted earlier, there is a need to reach out to adolescents who lack mental health services in rural areas (Shealy, Jones, & De Arellano, 2015). Utilizing telemedicine can be a helpful way to improve the gap in mental health care for this population.

Key informant Leandra Ames who is a Wraparound Facilitator for a Community Psychiatric Clinic identified the need to help the adolescent feel safe, feel heard, empowered, be the director of treatment, and feel supported relationally especially with peers (Personal Communication, April 30, 2015).

Key informant Rachel Vesper who works in probation mental health was able to identify some local needs. She discussed that she does not think there is enough funding to effectively help. Moreover, she does not believe that there are enough quality clinicians "who have done extensive work with youth who have experienced trauma" (Rachel Vesper, Personal Communication, November 24, 2015). The informant agreed that youth having a positive connection to their clinician and feeling safe plays a major role in receiving effective treatment. A barrier she identified is the child not feeling safe or ready to talk (Rachel Vesper, Personal Communication, November 24, 2015).

A literature review article about trauma through the life cycle states, "The most important task is the establishment and maintenance of a physical and emotional sense of safety" (Straussner & Calnan, 2014, p. 331). It is further discussed that it is pertinent to determine if an individual is suicidal or homicidal. This is an additional need to be identified when working with youth who have experienced early trauma.

Contributing Research Interventions Including Micro, Mezzo and Macro

Art Therapy utilizes social learning theory and it is suggested that it can help reformat negative brain pathways that were structured during early childhood due to trauma. "[Art Therapy]…teaches new response styles that result in physiological and psychological calming may help reverse earlier brain structure by transferring activity and information from the limbic system to the cerebral cortex (Heide & Solomon, 2005; Van der Kolk, 1996)"

(Persons, 2009, p. 445). Varying Psychological needs can be exposed in this form of intervention by what is depicted in the youth's artwork. In the juvenile justices system, artwork is later processed with a mental health counselor in 4-10 hours of sessions during the week. In a research study by Persons (2009) it is found that 5.4% of the participants processed or expressed childhood trauma in the art therapy childhood trauma. Additionally, 100% of the 46 participants in Persons (2009) study suggested that Art Therapy was beneficial. Some critiques of Art Therapy include that it does not take into account family, community, and the original factor that led to law-breaking (Persons, 2009). This method of intervention could be implemented on a mezzo level as a county program for their Juvenile Justice System. It can also be used on a micro level when a therapist processes the art with individual offenders. This method may be implemented on a macro level mandated by perhaps a state to be used among all their Justice Systems.

Kruczek & Salsman (2006) discuss various evidence-based interventions that can be utilized in the school setting such as: five level approach when a school disaster occurs; psychoeducation, psychological debriefing, CBT, Creative Therapies, and tertiary prevention. The authors confer that "Students with a specific trauma exposure who participated in CBT group and/or individual counseling sessions demonstrated a reduction in stress disorder symptoms" (Kruczek & Salsman, 2006, p. 467). They also state that psychoeducation in groups has been effective in treating Type I Trauma. These intervention methods can be used on a micro level for individuals in the schools who have faced trauma, on a mezzo level through screenings, or on a macro level within the school if a school disaster or natural disaster was to occur.

Ippen et al. (2011) performed a small-scale research study with children who had witnessed/experienced marital violence that took place over 50 weeks with 39 girls and 36 boys. Treatment included child-parent psychotherapy and case management with Ph.D. level clinicians. It was found to be an effective intervention for traumatized children, especially those with multiple risk factors. This intervention may not be most effective because of costliness through utilizing Ph.D level clinicians to operate parent-child psychotherapy. There is a lack of psychotherapists to offer this service on a larger level. This is a micro level intervention. It could be adopted by larger systems such as the foster care system to help alleviate some of the effects that trauma can have on the individuals and families.

Another intervention that was researched by Shealy, Jones, & De Areallano (2015) provides access to mental health services such as TF-CBT for adolescents in rural settings. TF-CBT is an evidenced-based treatment providing access to rural youth through Telemedicine. Telemedicine is performed from a distance through a form of videoconferencing. Shealy, Jones, & De Arellano (2015) provide a case report with pretreatment and posttreatment assessments to measure the outcomes. Some of the findings from this article include: "Telemedicine can reduce barriers for receipt of evidence-based trauma treatments. Telemedicine increases access to specialized treatment for underserved populations. Telemedicine reduces burden to providing outreach services in remote areas" (p. 331). The article focuses on providing access to TF-CBT which is an evidenced-based treatment through the means of Telemedicine. This method of treatment can be helpful on a micro level but could be implemented on a more widespread level.

Jones, Lowe, & Risler, 2004 discuss the effectiveness of Wilderness Adventure Therapy (WAT). They focus primarily on it being utilized for children exiting the juvenile justice

system. Some research has found WAT to have positive effects especially on the individual's self-concept, social functioning, and their behavior (Jones, Lowe & Riser, 2004). In this article, they compare two groups of youth leaving the system: one group participates in WAT while the other goes to a group home. "The overall findings of the study indicated that there were no significant differences between the recidivism rates for the participants in wilderness programs and those who were placed in group home programs" (Jones, Lowe, & Risler, 2004, p. 63). Long term, the outcomes were similar for both options.

Clinician Imogene Henderson utilized CBT when working with patients. She discussed the importance of reshaping thoughts that the clients have about themselves and developing self-efficacy for the children to have a more positive self-view (Personal Communication, April 30, 2015). DBT was another important intervention method utilized at the residential treatment center where the clinician works. They also incorporated Milieu Therapy which reinforced positive interaction between the clients and their peers. Other interventions included Recreation/Adventure Therapy, and Mindfulness. These intervention models included micro level intervention performing CBT between client and clinician. Mezzo Level Intervention was practiced as a group in DBT-Skills, Milieu Therapy, and Mindfulness.

Key informant Leandra Ames utilized CBT, Empowerment Theory, and Strengths Based Approach and found that all were important elements in treatment when working in Wraparound services with at-risk youth.

Most Effective

Straussner & Calnan (2014) completed a literature review on the topic of Trauma through the life cycle. In this article, the authors discuss various evidence-based intervention methods that seem most-effective. They include Child-Parent Psychotherapy which has been

found to be effective in reestablishing the family by repairing the impact that trauma has had (Straussner & Calnan, 2014). Parent-Child Interaction Therapy PCIT is another short term intervention that is helpful especially to younger children (2-7). This intervention is empirically-based and is not specific to traumatized children (Straussner & Calnan, 2014). TF-CBT was discussed as favorable especially for children diagnosed with PTSD (Straussner & Calnan, 2014). Psychoeducation was noted as another important factor in working with children who have experienced trauma (Straussner & Calnan, 2014). Other forms of CBT which are evidence-based practices for treatment of trauma are eye movement desensitization (EMDR) and DBT. Straussner & Calnan, (2014) discussed narrative therapy as an adequate means for processing trauma. However, they stated "there seems to be no single narrative treatment model" (Straussner & Calnan, 2014, p. 330). They suggested that further research is needed to find the best treatment model. Authors additionally cautioned when using group approaches such as Critical Incidence Stress Debriefing (CISD) which may cause re-traumatization (Straussner & Calnan, 2014). However they state, "One highly effective treatment model, used mainly in group settings, is Seeking Safety, developed by Lisa Najavitis (2006)" (Straussner & Calnan, 2014, p. 331).

One of the articles mentioned earlier by Kruczek & Salsman (2006) discussed working in schools with adolescents who have a history of trauma and suggested various evidenced-based practices that seem most effective. They are: psychoeducation, creative therapies, CBT and tertiary prevention. Art therapy seems to be another effective and cost-effective form of therapy to utilize in many areas such as school, juvenile detention, and in community agencies.

Orbke & Smith, (2012) provided multiple theory frameworks and therapeutic approaches to consider when working with children who have experienced trauma. They discuss Self-Efficacy Theory, Social Learning Theory, Relational Theory, Empowerment Approach, and Strengths Based Approach.

Dorsey et al. (2014) completed a research study that focused on the use of TF-CBT with 47 adolescent children in the foster care system, which included engagement with the foster parents. They found that the treatment was successful with "significant improvements" for those that participated (Dorsey, Pullmann, Berliner, Koschmann, McKay & Beblinger, 2014, p. 1508).

They were able to identify through the study that engagement intervention was able to achieve higher retention rates. This evidence-based practice of working with parents and children seems to be another most effective approach.

Key informant Imogene Henderson identified that peer support is an important factor in intervention methods. She also identified DBT-Skills as the best practice to help children who have faced trauma. Developing a child's protective factors as well as decreasing risk factors are additional aspects that I would like to incorporate into treatment. This clinician spoke about the importance of helping children who have faced adverse experience to feel safe. Safety planning should be incorporated into treatment. Mindfulness is another feature this clinician used in her treatment methods which seems to be an important way to help youth overcome trauma. Similarly, Leandra Ames utilized CBT, Empowerment, Strengths Based Approach and Mindfulness. She also connected children to activities such as Martial Arts. I would like to look into another type of Mindfulness activity such as Yoga.

In a Legislative report from the Washington State Department of Social and Health Services it stated, "recommended strategies, timelines, and costs for increasing the use of evidence-based and research-based practices" as is mandated by the law in H.B. 2536. This report states that evidence-based practices for child welfare include: Intensive Family Preservation Services (Homebuilders), Parent Child Interaction Therapy, and Safecare in the intervention category. For prevention, evidence-based practices include: Health Families America, Nurse-Family Partnership, Parents as Teachers and Triple P (system). Of the prevention programs, only Triple P is cost beneficial. Some of these currently recognized practices may be helpful to keep in mind when creating a program to support this population.

Lovelle (2005) discusses DBT and EMDR as evidence based intervention methods in residential settings. She further highlights how EMDR is found to be relatively shorter in length as a treatment approach and highly effective. She states, "EMDR uses intentional exposure to thoughts about traumatic incidents, while employing planned eye movement and sometimes tactile and auditory experiences to reintegrate brain activity" (Lovelle, 2005, p. 33). She further discusses the benefits to utilizing DBT when working with traumatized clients. "DBT focuses on such skills and behaviors as mindfulness and distress management. During these processes, survivors are taught new behavioral alternatives to replace their old, trauma-induced behavioral repertoires" (Lovelle, 2005, p. 33). Both of these approaches have been mentioned multiple times in the articles that I have read and seem to be an effective and important form of treatment to be considered when working with this population.

Conclusion

Providing effective treatment for adolescent children who have experienced early trauma can have many positive effects. It is cost-effective, it promotes social justice and human rights, it allows children to develop properly, and helps them become contributing members of society. There are many factors to consider when working with this population, including historical context, developmental stages, theory, needs, systemic and global influences. Additionally, there are many evidence-based interventions that can be utilized to help this population finding healing and recovery. From an economic standpoint, promoting access for effective treatment can save money over time. Federal and State funding should make this issue a priority by providing proper services for this vulnerable population.

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Appendix E: Logic Model

Needs Statement: Youth who have experienced trauma need strategies to better manage their emotional regulation in order to achieve a more resilient disposition and reduce rates of behavior problems.						
Theory & Key Assumptions	**Resources**	**Activities (Process Objectives)**	**Outputs* (Outcomes/ Summative Objectives)**	**Outcomes (Short Term Goals)**	**Outcome Indicators* (Outcome/S ummative Objectives)**	**Long Term Goal**
Social Learning Theory-Will utilize Art Therapy which is based off of this theory. This theory finds behavior is malleable, learning through art can beneficially help modify behavior through use of Art Therapy. **Self-Efficacy Theory**- This theory is known to be helpful when working with people who	The following resources are needed in order to achieve goals: Room/Space for treatment Results of Research Mental Health Workers to work individually with clients. DBT Trained Professionals	Recruit volunteers, train and create poster to recruit. Develop and adapt 14 week DBT-Skills and Mindfulness Curriculum for groups. Hire Core Program Staff of MHPs. Recruit and Contract with DBT trained Facilitators and Counselors. Develop Treatment Plan and Treatment Goal paperwork. Develop psychoeducation PowerPoint.	14 Week DBT Skills and Mindfulness Group-60 minutes per session. Bi-Monthly psychoeducati on for parents and clients about impacts of trauma. Bi-monthly education about health and wellness. Individual Counseling available on a daily basis.	**Outcome 1.** Reduced Violent Behavior **Outcome 2.** Improved social functioning	**Outcome Indicator 1a**. Reports fewer verbal altercations. **Outcome Indicator 1 b.** Reports using de-escalation techniques. **Outcome Indicator 2a.** Shows constructive level of assertiveness **Outcome Indicator 2b.**	Reduced rates of behavior problems

lack resilience. This theory emerges from social learning theory and finds that a person's belief in their ability to execute a task is necessary to "produce given attainments" (Turner, 2011, p. 428). It is suggested that through gaining self-efficacy the individual will gain self-worth, they will gain confidence relationally. (Orbke & Smith, 2012 **Relational Theory**- People who struggle with emotional regulation often have interpersonal	to lead DBT Groups Volunteers/ Students to help facilitate DBT Groups Curriculum Whiteboard Writing Utensils Group Games Art Supplies Partnership with community (Schools, Juvenile Justice System, FAST Wraparound Services, Catholic Community Services, Yoga	Develop health and wellness PowerPoint. Develop a list of Resources	Individualized Treatment plan for each client with treatment goals. Make referrals for additional grief work to outside community resources. Weekly Collaboration Meetings of MHP and Volunteers Weekly check-ins with participants.		Relates positively with peers.	

difficulties. This theory is based on the "restorative elements of the therapeutic relationship as a major contributor to change self as being shaped in interaction" (Turner, 2011, p. 401). DBT-Skills utilizes this theory in the mastering of Interpersonal Effectiveness. **Stress reaction theory**-can be utilized when assessing people who are suffering from PTSD and determine the individual's natural response to stress.	Studios, Martial Arts)					

Cognitive Behavior Theory- This can be used to adjust behavior through active client participation and can also help alter negative coping habits into positive ones. **Empowerment Approach**- This theory is based on, "empowering people to develop potential and grow assets to change environments and make them more just" (Turner, 2011, p. 157). Additionally a strengths-based					

approach can help the client identify areas for growth, highlight some of the strengths they already possess and help them to re-write their trauma narrative. **Narrative Theory**- This is an approach that could help the client to "explore life stories to find alternative views of reality as sources of strength and ways of dealing with ambiguity" (Turner, 2011, p. 315). **Person & Environment**- This theory is founded upon					

the idea that a person is an agent of change in the problems that they are affected by in their environment. The environment can be a source of much of the person's distress. Through altering the environment it can also produce change. This theory will be utilized and reflected upon by the client regarding their environment and how it could be altered to affect change in their behavior and life.					

Appendix F

Student Name: Annika St. John
Program Name: University of Washington Tacoma Master of Social Work

Data Collection Worksheet

OUTCOMES/CRITERIA	TOOLS	DATA COLLECTION PROCESS	DATA COLLECTION METHOD	VALIDITY

Outcome 1: **Reduced Violent Behavior**
  Criteria to achieve outcome 1: **A&B**
 	
Indicator A: **Reports Fewer Verbal Altercations**
  Criteria to achieve indicator A
Survey: Answer to Question #1 must increase by at least one point.
 	
Indicator B: **Reports using De-Escalation Techniques**
  Criteria to achieve indicator B
Survey: Answer to Question #2 & #3 must increase by at least one point.
 	
Outcome 2: **Improve Social Functioning**
  Criteria to achieve outcome 2: **A&B**
 	
Indicator A: **Shows constructive level of assertiveness**
  Criteria to achieve indicator A
Staff/Teacher Pre and Post Observation: Positive behavior as defined in the guide must be exhibited at least 5 times per week.
 	
Indicator B **Relates positively with peers**
  Criteria to achieve indicator B
Staff/Teacher Pre and Post Observation: Positive behavior as defined in the guide must be exhibited at least 5 times per week.
	Please attach copy of current tools. **Discuss only the tools used to measure the outcomes and indicators listed on the left**
	
	Outcome 1: **Pre and post survey used to measure improvement of behavior and use of de-escalation techniques.**
	
	Outcome 2:
	Observation tool used to understand improvement in goals related to assertiveness and relating positively to peers.
		Process used to collect data
		
		Who - **Treatment Team Staff/ client's school teacher.**
		
		When– **Pre Surveys and Pre Observation Data will be completed/collected prior to beginning treatment plan. Post Surveys and Observation Data gathered after the completion of 10 week curriculum and client meets their treatment goals in treatment plan.**
			Do you gather data on ALL Clients?
			
			YES
			
			Data and Surveys completed/collected for 100 or less people will be attainable.
				Focus group will be held to test language used in survey and observation tool in order to ensure a consensus in meaning.
				
				Staff will be trained in how to use observation tool.
				
				RELIABILITY
				
				Staff that collect data in observation tool will be trained prior to data collection and debriefing after data is collected.
				
				Reliability will be ensured by having the same observer complete both observation.

Appendix G

Pre and Post Test

(Prior to test, staff member will discuss language on the test and ask the clients if they need any clarification about any of the test questions)

1. On a weekly basis, how often are you experiencing verbal altercations with peers?
   a. Everyday
   b. Three to four times a week
   c. One to two times a week
   d. Less than once a week
2. How often do you use your DBT-Skills when you are faced with a verbal altercation?
   a. Every time
   b. Almost every time
   c. Seldom
   d. Never
3. How often do DBT-Skills help when you are faced with a verbal altercation?
   a. Every time
   b. Almost every time
   c. Seldom
   d. Never
4. How natural is it for you to use de-escalation techniques:
   a. Very Natural
   b. Somewhat natural
   c. Somewhat unnatural
   d. I do not use de-escalation techniques at all
5. How often do you use de-escalation techniques when you find it difficult to manage your emotions?
   a. Every time
   b. Almost every time
   c. Seldom
   d. Never

Appendix H

Observation Tool Pre-Test

**Observer_____ Organization/School_____ Client's
Name_____**

Date	Shows Constructive Level of Assertiveness	Relates Positively with Peers	Comments

Observation Tool Post-Test

**Observer_____ Organization/School_____ Client's
Name_____**

Date	Shows Constructive Level of Assertiveness	Relates Positively with Peers	Comments

Appendix I

Project Proposal

Annika St. John

University of Washington Tacoma

Teresa Holt-Schaad, MSW, LICSW

T SOCW 533 Advanced Integrative Practice II

February 11, 2015

Project Proposal

Description of Project

This is a call to the city of Tacoma to support an outpatient treatment program aimed at reaching adolescent youth who have experienced early trauma. These adolescents often require strategic support to help manage emotional regulation, to reduce rates of behavior problems, and to help achieve a more resilient disposition. This program is meant to be run by mental health professionals (MHP's) such as licensed social workers, licensed counselors, and psychologist etcetera. The program would also utilize support from volunteers who have experience working with at-risk adolescents/ or in the mental health fied. One of the fundamental ways to reach children who have experienced trauma is to create a sense of psychological and physical security (Straussner & Calnan, 2014). Therefore a calm, warm and inviting environment such as a home would be preferable to a commercial building as a location for the program to be held. The first portion of the outpatient trauma program will include psycho-education for children and their families relating to the effects of trauma. Parent/caregiver-support groups will be provided as well as educational sessions to instill strategies that promote resilience. Each client in the program will begin with an intake assessment followed by an individualized treatment plan. Part of treatment plans will utilize Attachment and Relational Theories, aiming to develop positive attachments as well as support networks. Moreover, treatment plans will seek to identify both risk and protective factors. Employing Person and Environment Theory within this program will strive to support clients in the development of protective factors while reducing risk-factors. The program will offer a ten week Dialectical Behavior Therapy (DBT)-Skills group. DBT is an evidence-based practice proven to be effective for adolescent youth who lack traits of resiliency. DBT-Skills help youth to cultivate positive skills related to emotional regulation, interpersonal effectiveness, problem-solving, distress tolerance, and the ability to build a fulfilling life. DBT utilizes Self-Efficacy Theory which suggests that by gaining self-efficacy an individual will gain self-worth, and, in turn, gain a sense of relational confidence (Orbke & Smith, 2012). DBT-Skills also utilizes principles of Attachment and Relational Theories, Self-Efficacy, and Social Learning Theory. This program will help children reshape patterns of hopeless and powerless thinking patterns by applying Cognitive Behavior Theory and Empowerment Approach. Clients who have mastered skills will be given the chance to develop into leaders of groups and will have the opportunity to offer peer support. The program will have a strong focus on mindfulness. There is much research that states mindfulness causes an individual to slow down and can help build the part of the brain that causes resiliency (Siegel, 2001). Also, the program will incorporate yoga and martial arts programs, which are methods that are similar to mindfulness. The program will offer individual counseling on a weekly basis for children to process trauma. Therapists may utilize TF-CBT, Art Therapy, and Narrative Therapy to aid in the child creating a trauma narrative. The outpatient center will partner with other community resources including the Catholic Community Services, the YMCA, Wraparound, Outward Bound and more. In

addition, the center will be prepared to make referrals for more intensive treatment programs and outside trauma counselors who take Medicaid/private insurance. Overall, this program will promote habits of positive health and wellness for children and adolescents who would otherwise have little to no support. Classes about healthy eating habits, sleeping habits, exercise habits will help children to get a holistic picture of how to care for themselves.

Background

Children who have experienced trauma are more likely to struggle emotionally, behaviorally, intellectually and socially, and are less likely to develop a resilient disposition (Orbke & Smith, 2012). They are at-risk for substance abuse, mental illnesses, and poverty which could become an intergenerational pattern without effective treatment (Orbke & Smith, 2012). Lack of appropriate treatment for children who have experienced trauma has a wide array of physical, emotional, behavioral, and financial repercussions. Affectively treating youth who have experienced trauma can reduce the number of adults with substance abuse disorders and criminal justice costs related to substance use. Research published in 2013 suggests that nearly 90% of U.S. juvenile offenders have experienced some sort of a traumatic event as a child (Dierkhising, et. al., 2013). Trauma prevention and early trauma treatment among disadvantaged youth can reduce the amount of juvenile offenders that become chronic adult offenders and can save the justice system substantial amounts of money long-term. Furthermore, it is identified that children with adverse childhood experiences (ACE) are at risk for physical health problems. ACE has been found to be a leading cause of death in adults through correlations with a variety of chronic health conditions. Reducing the effects of trauma can have positive effects on a person's health as they develop into adults. This in turn can reduce healthcare costs. As stated above, underprivileged individuals are more likely to be at-risk for childhood trauma. People in poverty are more likely to be enrolled in Medicaid. Medicaid costs can be reduced through providing treatment to children who have been affected by trauma. It may make them less likely to suffer long-term health problems. Trauma has many poisoning effects on the life of a child. The antidote to trauma is the ability to achieve a sense of resiliency and overcome adversity.

The NASW Code of Ethics states that a "social worker's primary responsibility is to promote the well-being of clients" (National Association of Social Workers, 2008). This proposed program would promote the health and wellness of clients through psycho-education about the effects of trauma and teaching children positive coping styles when feeling distressed. Social workers value social justice and providing a voice for marginalized citizens. Providing treatment for at-risk youth promotes social justice and gives a voice to a vulnerable population. In the state of Washington there are 84 Mental Health Division (MHD)-funded

inpatient beds authorized to be made available for children with "severe psychiatric disturbance" (Children's Long Term Inpatient Program for Washington State, 2014). There are four bed-holding locations offered through Washington State with their Children's Long Term Inpatient Program (CLIP) (Children's Long Term Inpatient Program for Washington State, 2014). Fifty-nine of those beds are located in Pierce County; however, access to this facility is not determined by a client being from Pierce County. Many children are from within the state who are placed in the Pierce County facility. There are lengthy wait lists to get into this inpatient program. With these wait lists, it can be determined that there is a great need for more treatment. Eighty-four inpatient beds cannot serve the need for the thousands of children in this state who have been affected by trauma. Schools are overwhelmed with children who are unable to sit still, complete assignments and function properly because of their history of trauma. Therefore, this program would be indispensable.

Personal Motivation for Intervention: The person proposing this program has a background working as a CASA (Court Appointed Special Advocate) alongside children involved in court dependency cases. The children that the writer interacted with were victims of early traumatic experiences that caused significant impairment in their lives. The writer completed foundational field practicum at Pearl Street Center, one of the four CLIP programs in Washington State. A majority of the clients placed at this center had experienced some sort of trauma. Additionally, the writer spent time in the elementary school system assisting in counseling services to children of need. The writer spent time working with children who were severely abused and were asked to focus in the school while exhibiting problematic behavior that often results in disciplinary actions. The writer has also spent time working in the hospital. The writer has noted a commonality in many of the patients who have substance use problems that also admit to a history of childhood trauma. Trauma is a pervasive reality that all too many children in our society face. Research and awareness of the negative impacts are beginning to become more prevalent and with that, additional treatment options need to be made more readily available. Our systems are overwhelmed. I hope to be a part of solving this rampant problem.

Risk/opportunities

Benefit of the Project: There is a cost-benefit to investing in effective treatment for children who have experienced early trauma. Economist and Nobel Prize winner James Heckman has shown that if we invest $1 dollar in trauma-specific prevention programs, it will save our society $8.70 dollars per child (Heckman & Krueger, 2003). Likewise, Campbell et al. (2014) stated that investing in our children not only benefits them when they are young, but continues to benefit them in their adult lives. There are healthcare system costs that can be reduced as well as substance abuse costs, criminal justice costs, and less cyclical patterns of child abuse that could be prevented by investing in trauma specific treatment. Furthermore, this program will give children the chance to achieve a resilient disposition and prepare for future troublesome times throughout their lives.

Feasibility of the Project: This project will take a lengthy amount of time to get started. Some of the ground work will include identifying a location, hiring trained professionals, purchasing curriculum, marketing, and identifying volunteers and clients. It is feasible to create such a program, however it would take a few key entrepreneurs to get the project started.

Potential Barriers impacting successful implementation: Inadequate funding, lack of ability to obtain resources and/or professionals.

Liabilities: The safety of clients and keeping client information confidential could be potential liabilities.

Political Climate: On a political and national level, adverse childhood experiences (ACE) have begun to gain some awareness. In the year 2011 H.R. 1965 was passed with the goal of shrinking ACEs in America through public and private sectors. Additionally, in 2014 Vermont passed the H. 762 Bill to require ACE screenings into medical health and school settings. In order to receive Medicaid reimbursement, the hospitals in Vermont are required to perform ACE screenings. By completing ACE screening in schools, hospitals, juvenile justice systems and so forth, children can be identified and given the chance at receiving treatment in order to live a more healthy and meaningful life. This program would offer children the chance to process and heal from past trauma and gain a sense of resiliency.

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Appendix J: Additional Research by Author

Literature Review:

Childhood Trauma and Resiliency

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T SOCW 505 B: Foundations of Social Welfare Research

February 3, 2015

Abstract

This is a review of the literature pertaining to childhood trauma, and how to foster resiliency in people throughout developmental stages despite having faced an adverse upbringing. In this review is an analysis of the risk factors and protective factors which appear to be established during the early stages of development. These factors often serve as a blueprint for how a person will respond to adversity throughout their life cycle. Do traumatized children have the ability to change their hard-wiring brain patterns and if so, how can practioners help these clients to respond to hardships with resiliency? This paper will seek to investigate what current research provides to answer this question.

Keywords: Childhood Trauma, Resilience, Attachment, Intervention, Development

Literature Review: Childhood Trauma, Attachment, and Resiliency

This paper will examine recent literature concerning the topics of childhood trauma and resiliency. Included will be a discussion of the major effects of trauma, as well as current intervention methods, gaps in the literature, and a preview of a research study that I will be working on associated to this topic. Current literature on resiliency suggests that this trait begins to be developed at birth and is heavily impacted by the first interactions with the child's caregiver. This topic is relevant because children raised within a hostile environment are more susceptible to lose this protective wiring in their brain patterns, causing lasting negative effects throughout their lives. Therefore, it is pertinent to discover adequate techniques for fostering resiliency in later developmental stages so that those facing early trauma have the opportunity to achieve success.

Effects of Childhood Trauma

Childhood trauma can be described as an event that takes place in which normal functioning of life is threatened, thus threatening the development of coping skills. According to the DSM V child trauma under the age of 6 is defined as, "exposure to actual or threatened death, serious injury or sexual violence through directly witnessing event in person as it occurred to others (especially caregiver), or learning that the traumatic event occurred to a parent or caregiving figure" (DSM-5, 2013). One effect childhood trauma has is it can develop into the diagnosed illness of Post-Traumatic Stress Syndrome (PTSS) and Post-Traumatic Stress Disorder (PTSD). Other effects of childhood trauma include anxiety, depression, childhood aggression, sleep disturbance, and risk for alcohol and substance abuse disorders (De Bellis & Zisk, 2014). There is also indication that cortisol levels in the body can be raised due to childhood trauma which in turn can negatively affect other biological

stress systems in the body such as, "heart rate, metabolic rate, blood pressure and alertness" (De Bellis & Zisk, 2014, p. 187). Furthermore, childhood trauma has been found to effect brain development during later stages of life causing, "deficits in IQ, memory, working memory, attention, response inhibition, and emotion discrimination" (Straussner & Calnan, 2014, p. 325).

Siegel (2001) discusses that children who have a disorganized attachment often have "unresolved trauma or grief" (p.77). He further discusses how a child's relationship to their caregiver is supposed to provide "joy, connection, and emotional soothing which instead offers alarm, fear, and terror and a lack of ability to be soothed" (Siegel, 2001, p. 78). Additionally, Seigel confers the child is meant to learn how to cope and deal with emotional dysregulation from their caregiver. It is problematic if the adult is unable to display a healthy example of this behavior to their child. It can be supremely important to help these types of children receive intervention from their traumatic experience so they may thrive, and in turn prevent multigenerational trauma that may repeat (Siegel, 2001). Furthermore, Siegel discusses the importance of the developing mind and how integrative processes through secure attachments in the brain are, "at the core of emotional well-being and psychological resilience" (Siegel, 2001, p. 90). The ability to have positive emotional regulation is also one of the primary skills that can help a child to cope when distressed. This is a trait that will be needed throughout life internally and externally in social relationships.

Resiliency

Some researchers have theorized that resiliency is displayed by "individuals [who] take responsibility for their recovery and are able to accept and integrate their experiences (Gerber, Hogan, Maxwell, Callahan, Ruggero, & Sundberg, 2014 p.113). These researchers

further defined resiliency as being able to arrive at a similar level of functioning as before the trauma took place. Other researchers characterized resilience as "the ability to display healthy social interaction, optimism, and emotional control" (Wortham, 2014, p. 59). Resilient people are able to successfully cope and adapt after distressful, life-changing events.

Some major discussions regarding resiliency are related to it being a genetic trait versus a developmental process. It has been conferred that genetic factors such as temperament and personality can have an effect on resiliency (Orbke & Smith, 2013). Additionally, "environmental factors including maternal warmth influenced cognitive behavioral resilience; however, more noteworthy, is the notion that genetic components can be modified by the environment" (Orbke & Smith, 2013, p. 48). Therefore it could be argued that genetic and environmental factors play a role in the developmental process of resiliency.

There are various risk factors that can stifle a person's ability to develop proper tactics of resilience. In a research study regarding factors associated with resilience in adults, it was found that the greatest risk factor related to childhood trauma (Simeon, Yehuda, R., Cunill, Knutelska, Putnam, & Smith, 2007). This is a consistent finding in many of the research articles observed regarding risk factors. Other risks have been noted by, Simeon, et al. (2007), who found that low baseline cortisol levels may be attributed to a higher threat for developing PTSD. An insecure attachment is another factor that places a person at risk for a negative impact on resiliency. Siegel (2001) states: "[an] insecure attachment can be associated with emotional rigidity, difficulty in social relationships, impairments in attention, difficulty in understanding the minds of others, and risk in the face of stressful situations"

(Siegel, 2001, p. 77). All of these associations will have long-lasting negative repercussions in a child's life.

A negative home environment and genetic predisposal to a high-strung temperament or personality could also serve as a risk factor. Related to this, Straussner and Calnan (2014) highlighted in their literature review some preliminary research performed that begs the question as to whether there can be a prenatal trauma impact. The study compared expectant mothers who were traumatically affected by September 11, 2001 to other pregnant women who were not. They found that there was negative influence on "neurocognitive development" of the children whose mothers were affected traumatically (Straussner & Calnan, 2014, p.325).

Some protective factors can be attributed to, "personal beliefs, humor, optimism, intelligence, social skills, mental health of parents, parenting stress, and family environment (Wortham, 2014, p. 59). Agaibi and Wilson (2005) discussed some of the protective factors related to resilience in a review of the literature on the topic. They discussed the ability to moderate emotions, cope with stressors and manifest positive responsiveness to stressors as protective factors. Additionally, Agaibi and Wilson (2005) highlight that effective parenting increases self-efficacy, self-esteem, and self-confidence, which can help foster a resilient person. Along with many other articles that were surveyed, the following list presents additional characteristics that help create a resilient person: secure attachment, intellectual skills, social cognitive abilities, the ability to make meaning of an experience, "interaction with fellow survivors", altruism, sense of self as a survivor, and locus of control (Agaibi & Wilson, 2005). Among these, some other things that can support resiliency are spirituality and extended support systems outside of the family unit (Orbke & Smith, 2013).

It must be noted that for early child development, secure attachment to a caregiver is a primary condition to producing a resilient personality. However in later developmental periods, such as the adolescent stage, it may be fostered in a different way. Peltonen, Qouta, Diab, & Punamäki (2014) studied 482 children who faced war trauma in Palestine during war. One of their major findings was, "that peer relations and especially friendship quality was the main predictor of child resilience, which may indicate that in middle childhood these relations are very salient" (Peltonen, Qouta, Diab, & Punamäki, 2014). The age group that was sampled was children ages 10-13 years of age. This reveals that during this developmental stage, friendship was the more important predictor of resilience whereas during early childhood it was more closely related to a secure attachment.

<div align="center">Intervention Methods</div>

So far we have determined through available literature that resiliency is fashioned through many influences that are promoted differently during each developmental stage. It appears that the most critical stage is the earliest. However, "findings from neuroscience in fact suggest that the brain remains plastic, or open to continuing influences from the environment, throughout life" (Siegel, 2001, p.70). Therefore the brain patterns remain open to change throughout the life-cycle in ways that could create a sense of resiliency. Orbke & Smith (2013) discuss, "positive relationships later in life that can produce positive outcomes despite early risk factor and adversity" (p. 48). Other interventions to nurture resiliency are related to strength based approach. Straussner & Calnan (2014) highlight three ways: "1. A belief that one can influence one's environment (self efficacy), 2. The ability to handle one's thoughts and feelings (cognitive-behavioral skills), and 3. The capacity to form caring relationships" (329). This article highlights a strengths-based approach to help a child

recognize their internal ability and their external resources (Orbke & Smith, 2013). The National Institute for Trauma and Loss in Children (TLC) also makes use of a strength-based approach and resilience-focused interventions. Specifically, they use Structured Sensory Interventions for Traumatize Children, Adolescents, and Parents (SITCAP). Their work focuses on helping children to process hidden away memories through a method that promotes well-being, emotional regulation, and empowerment (Steele & Kuban, 2014, p. 19). Their therapeutic method often is practiced with drawing, which "allows [the] children to access and externalize the sensations, memories, and iconic images shaped by trauma" (p.19). The therapeutic model by SITCAP includes reframing of the mind, particularly for the child to shift their identity from victim to survivor. It is also important to build an environment where a child can create, "trusting bonds and repetitive safe and structured activities that provide new opportunities for youth to view themselves and their world with hope and resolve" (Steele & Kuban, 2014, p. 20). Strength based approaches appear to be a consistent method of intervention for youth who struggle with resiliency.

María Cristina Richaud who works with Interdisciplinary Center of Mathematical and Experimental Psychology Research (CIIPME), and National Council of Scientific and Technological Research, Argentina (CONICET) discusses an approach that alters the environment of at-risk children. In this approach, the child's school environment is modified to support and boost resilience. Richaud states: "It is fundamental to remember that given an adequate and facilitative environment, people have the capacity for positive change and the ability to develop at least some characteristics of resilience throughout their lives (p. 752). This is highlighting the idea that people can be influenced by their environments throughout development. Richaud discusses her intervention which consists of, "strengthening social

skills, attachment, executive functioning (impulse control, establishing norms, planning ability, understanding instructions, attention), attribution style, positive emotions" (Richaud, 2013, p. 754). Along with other typical school subjects like math and science, these methods are introduced to the students through qualified and skilled teachers who practice this approach in their classroom with at-risk youth.

Another suggested method for growing resiliency can be through mindfulness. Tan and Martin (2012) performed a research study with 106 adolescents between the ages of 13-18 and found that, "as predicted, mindfulness correlated positively with self-esteem and resiliency" (p. 8). Other methods that have been proven to be helpful interventions include: Trauma Focused Cognitive Behavior Therapy (TF-CBT) and Cognitive Behavior Therapy(CBT), exposure therapy, psychoeducation, desensitization and imaginal flooding, eye movement desensitization and reprocessing (EMDR), narrative therapy, group therapy and medications (Straussner & Calnan, 2014, p. 330) .

Gaps in the Literature

The vast majority of available and relevant literature appears to focus on the earliest stage of development. This is understandable because this stage of life serves as the baseline in producing a more resilient person. There is far less information available regarding more effective approaches to gain resiliency in later stages of development.

Future Research Project

I would like to conduct a qualitative research survey of practitioners who have worked with at-risk adolescent children. My research question is what allows an at-risk adolescent to master a sense of resiliency. My hypothesis is: children who are able to form

secure attachments with their peers, learn to manage their emotions, and find meaning within their circumstances are more likely to show signs of resiliency.

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Final Research Proposal

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T SOCW 505 B: Foundations of Social Welfare Research

March 10, 2015

Final Research Proposal

This is a research proposal related to the topics of childhood adversity and resiliency. I would like to conduct a qualitative research study that explores various aspects that help create a sense of resiliency in adolescents who have faced trauma or harsh conditions in early stages of life. In the United States, it is estimated that twenty-six percent of children will witness or experience a traumatic event before the age of four years old (Briggs-Gowan, Ford, Fraleigh, McCarthy, & Carter, 2010). This topic is important because children with early experiences of trauma or an insecure attachment are less likely to develop a resilient disposition. Therefore, it is pertinent to discover adequate techniques for fostering resiliency in later developmental stages so that there is a stronger opportunity to achieve success. My aim is to gain a qualitative understanding of how clinicians who work with at-risk adolescents are able to offer support in gaining a sense of resiliency. Through understanding their perspective we may find connections in successful intervention methods amongst varying practitioners. Moreover, it could be helpful to understand where there may be gaps in the broad clinical understanding of risk and protective factors and if this relates to successful or unsuccessful clinical treatment.

Literature Review

Current literature on resiliency suggests that this trait is initially developed at birth and is heavily impacted by the first interactions with a child's caregiver. Much of the literature on resiliency is focused on protective factors and risk factors which are developed or lacking during the earliest stages of development. In this section, I will highlight what some of the research states about resiliency during the earliest stages of life. As I focus my research study, I would like to know what fundamental concepts about resilience are widely

acknowledged by practioners and how these early risk and protective factors might impact their intervention methods during later stages of development.

This begs the question, "what is resiliency?" Some researchers have theorized that resiliency is displayed by "individuals [who] take responsibility for their recovery and are able to accept and integrate their experiences" (Gerber, Hogan, Maxwell, Callahan, Ruggero, & Sundberg, 2014, p.113). These researchers further defined resiliency as being able to arrive at a similar level of functioning as before the trauma took place. Other researchers characterized resilience as "the ability to display healthy social interaction, optimism, and emotional control" (Wortham, 2014, p. 59). Resilient people are able to successfully cope and adapt after distressful, life-changing events.

Some major discussions regarding resiliency are related to it being a genetic trait versus a developmental process. It has been conferred that genetic factors such as temperament and personality can have an effect on resiliency (Orbke & Smith, 2013). Additionally, "environmental factors including maternal warmth influenced cognitive behavioral resilience; however, more noteworthy is the notion that genetic components can be modified by the environment" (Orbke & Smith, 2013, p. 48). Therefore it could be argued that genetic and environmental factors play a role in the developmental process of resiliency. It would be informative to learn the view clinicians hold regarding the cause or influences of resilient clients and how this view may impact their practice.

There are various risk factors that can stifle a person's ability to develop proper tactics of resilience. Some of these include a negative home environment and genetic predisposal to a high-strung temperament or personality. In a research study regarding factors associated with resilience in adults, it was found that the greatest risk factor is childhood

trauma (Simeon, Yehuda, R., Cunill, Knutelska, Putnam, & Smith, 2007). Childhood trauma can be described as an event that takes place in which normal functioning of life is threatened, thus threatening the development of coping skills. According to the DSM V child trauma under the age of 6 is defined as, "exposure to actual or threatened death, serious injury or sexual violence through directly witnessing event in person as it occurred to others (especially caregiver), or learning that the traumatic event occurred to a parent or caregiving figure" (DSM-5, 2013). Other risk factors that can lower the ability to develop resiliency have been noted by, Simeon, et al. (2007), who found that low baseline cortisol levels may be attributed to a higher threat for developing PTSD. There is indication that cortisol levels in the body could be raised due to childhood trauma (De Bellis & Zisk, 2014, p. 187). I wonder what the consensus is among clinicians about childhood trauma and cortisol levels and how this influences their treatment of at-risk youth.

An insecure attachment is another factor that places a person at risk. In a review of scientific findings related to the interpersonal relationships and the development of the brain, neuroscientist Siegel (2001) discusses that children who have a disorganized attachment often have "unresolved trauma or grief" (p.77). He further discusses how a child's relationship to their caregiver is meant to provide "joy, connection, and emotional soothing which instead offer alarm, fear, and terror and a lack of ability to be soothed" (Siegel, 2001, p. 78). Seigel confers that the child is meant to learn how to cope and deal with emotional dysregulation from their caregiver. It is problematic if the adult is unable to display a healthy example of this behavior to their child. Furthermore, Siegel discusses the importance of the developing mind and how integrative processes through secure attachments in the brain are "at the core of emotional well-being and psychological resilience" (Siegel, 2001, p. 90). The

ability to have positive emotional regulation is one of the primary skills that help one cope when distressed. This trait will be necessary throughout life internally and externally in social relationships. During later stages of development it would be interesting to see if developing a secure attachment and stimulating emotional regulation may also play role in intervention methods for clients.

Some protective factors can be attributed to, "personal beliefs, humor, optimism, intelligence, social skills, mental health of parents, parenting stress, and family environment" (Wortham, 2014, p. 59). Agaibi and Wilson (2005) discussed some of the protective factors related to resilience in a review of the literature on the topic. They discussed the ability to moderate emotions, cope with stressors, and manifest positive responsiveness to stressors as protective factors. Additionally, Agaibi and Wilson (2005) highlight that effective parenting increases self-efficacy, self-esteem, and self-confidence, which can help foster a resilient person. Along with many other articles that were surveyed, the following list presents additional characteristics that help create a resilient person: secure attachment, intellectual skills, social cognitive abilities, the ability to make meaning of an experience, "interaction with fellow survivors", altruism, sense of self as a survivor, and locus of control (Agaibi & Wilson, 2005). Among these, some other things that can support resiliency are spirituality and extended support systems outside of the family unit (Orbke & Smith, 2013). In this proposed research study, it would be interesting to discover if some of these protective factors can be developed and supportive during later stages of development.

As has been stated, during early child development, secure attachment to a caregiver is a primary condition to producing a resilient personality. However, in later developmental periods such as the adolescent stage, it may be fostered in a different way. Peltonen, Qouta,

Diab, & Punamäki (2014) studied 482 children who faced war trauma in Palestine during war. One of their major findings was, "that peer relations and especially friendship quality was the main predictor of child resilience, which may indicate that in middle childhood these relations are very salient" (Peltonen, Qouta, Diab, & Punamäki, 2014, p. 236). The age group that was sampled was children ages 10-13 years of age. This reveals that during this developmental stage, friendship was the more important predictor of resilience. I would like to know if practitioners have observed this, and if they have been successful at increasing that friendship bond.

Gaps in the Literature

The vast majority of available and relevant literature concentrates on the earliest stage of development and is prevention focused. This is understandable because this stage of life serves as the baseline in producing a more resilient person. There is far less information available regarding more effective approaches to gain resiliency in later stages of development.

Methods

I would like to conduct a qualitative research study of practitioners who have worked with at-risk adolescent children. My research question is: what allows an adolescent who has experienced childhood adversity to master a sense of resiliency. The goal is to better understand which intervention methods were successful for children during the adolescent stage of development. I will seek to understand what the practitioner's current understanding of some of the risk and protective factors are and how this understanding might correlate to their intervention methods. This research will seek to exhibit how common knowledge about the earliest stage of resiliency may be useful in treatment during later stages.

Through using a qualitative study I will use a survey of questions related to the topics of resiliency and childhood adversity. The survey will seek to recognize how clinicians define resilience. I will assess whether the clinician's view resilience is caused by genetic or environmental factors and how that may shape their practice. Other questions will relate to risk factors, protective factors, attachment, and the understanding that practitioners have relating to these ideas and their effect on the development of resilient character during the teenage stage. This study will seek to discover successful clinical practice methods when working with at-risk adolescents in nurturing resiliency.

The eligibility for participants in this research study will be practitioners who have worked with at-risk adolescents for a minimum of three years. They must have at least a master's degree level of education in the fields of social work, psychology or counseling. Through having more rigorous eligibility criteria it should help to secure dependability in the data that is collected. The study will last about 2 months beginning March 30th and will be completed on June 3rd. Due to the brief amount of time that is available for this project, the sample size of participants will consist of four individuals. The interviews with these participants will last 30-40 minutes. Each interview will be voice recorded with a recording device and later transcribed.

After the first interview there will be a follow-up interview to allow myself or the interviewee to ask any follow-up questions. Additionally, the participant will be given a copy of the transcription from their interview to allow for any clarification or modification that they may feel is necessary to provide. If there is anything they feel uncomfortable with or would like to change I will delete it from the data. When the information has been transcribed, this data will be deleted in order to secure confidentiality. Additionally, each

participant will be assigned a pseudonym and will only be referred to as their pseudonym throughout the study to further augment privacy.

The prospective contributors for this study will be identified purposively through inquiry of individuals who meet the qualifications. They will additionally be identified through utilizing a snowball sample method. I will ask practitioners if they know of other practitioners who may be valuable and eligible to be interviewed for this study. In order to account for sample representativeness, I will seek to interview people who are of both genders and diverse races. I will also attempt to find practitioners from outside of Washington State if at all possible. My approach to recruitment will be through first having a phone call to practitioners to see if they are interested. If they show interest, I will set up time to meet and discuss the consent form with them.

The consent form will state the researchers' statement, the purpose of the study, the study procedures, risks, stress or discomfort, benefits of the study, confidentiality of research information, and other information. After reading the consent form and asking any questions about the study, the potential participants will be given a week's time to check in about whether they would like to participate in this study. I will allow the potential participants more time if they need it to make their final decision. A $5 Starbucks gift card will be offered to participants who offer to participate in this study which will be disclosed to the participant at the time of the consent form meeting. They will receive the gift-card on the day of the first interview. Prior to the first interview the participants will receive an e-mail of the questions that will be asked during the interview in order to allow the practitioners some time to think over their knowledge base about these topics.

The data for this study will be measured through interview questions that will be focused on how the clinicians view resiliency, and what their current knowledge is related to risk and protective factors. The questions will also seek to understand what intervention methods are most affective. In this interview I will ask questions about how the risk and protective factors which were developed during the earliest stages may be related to those during the child's adolescent stage of development. The initial questions asked will be broad with additional probing questions to ensure that all of the inquiries are answered. You may find the interview questions in Appendix A at the end of this paper. In order to enhance trustworthiness of this measurement tool, I will have multiple colleagues look over the questions to ensure that the right message is getting across and that all of the questions are clear.

Analysis Plan

I will be utilizing grounded theory in my qualitative analysis to better understand how the ideas shared by the varying clinicians relate to one another. After the first interview, I will look for any themes that emerge and examine if any of those themes continue to surface in the following interviews. The themes will be coded and multiple coders (my colleagues) will look at the data throughout the analysis process in order to identify if similar themes are discovered by multiple people. This will help me to understand if any conclusions I assess based on the gathered research are observable to those who are experts in their field. After comparing the ideas and themes that I discover from the participants I will follow up through member checking. I will share some preliminary results with the participants in order to increase trustworthiness in the results that I find. If they do not see some of the themes or agree with my analysis I will have to go back to the data and observe it again.

Discussion

This research may have contributions to current discussions on resiliency, supplementing data that practitioners have observed. The data may add further discussion about where there may be gaps in a clinician's understanding about risk and protective factors that children face. It may also help other practitioners learn how to overcome some of the barriers they may be facing in their practice with at-risk adolescents. This study may encourage practitioners to gain a broader understanding of what methods are most often utilized amongst their peers. It is equally possible that the study will bring light to information that might not be prevalent about this subject.

There are some possible limitations with this study that I will need to be aware of as I conduct this research project. For example, the interaction effects of selection biases may be a threat to validity if I was to have a problem with getting a random sample. Another threat to validity is through history. For instance, some of the answers I receive about types of treatment may be a pervasive practice at this time in history and may not be particularly the most effective. Another way that history could be a threat to validity is if there was a tragedy or economic hardship, this could skew the way treatment is successful for a clinician in one geographical area verses another. The small sample size for this study is a constraint because it makes it more challenging to ascertain the universal validity of deduced themes. Another drawback to my experimental design is there could be a reactive effect on data through sending the interview questions to the practitioners beforehand. This may lead them to have a more researched awareness to the questions. However, I feel it would be more helpful for the purpose of this study for the practitioners to be afforded some thoughtful time to think about how they will answer these questions.

Conclusion

Adverse childhood experiences are a prevalent problem in this country and they have generational impacts. As an MSW student, I have spent the last year of my field practicum working at a trauma/psychiatric facility for children. One of the primary roadblocks that I continually witness is the heightened struggle for children and adolescents to overcome life obstacles. One small upset such as a fight with a peer can send a child into a rapid downward spiral. Many of them face complicated obstacles daily, including court dependency battles regarding their placement following their time spent at the facility. Equally difficult they frequently struggle to find ways to manage various triggers from their past trauma or abuse. For these children, there needs to be a promotion of research about how to best support them at gaining a sense of resiliency in order to secure a more promising and healthy future.

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Appendix A

The people who will be interviewed for this study are clinicians who have worked with at-risk children, youth and adults. You are someone who has been identified as having this type of practice. This research project focuses on resilience and how to foster a sense of resilience despite an adverse upbringing or early trauma. This study will not seek to assess your methods or interventions. It will rather seek to identify themes in which children are able to achieve resiliency despite early hostile experiences.

Interview Questions

1.) How do you define resilience?

2.) Do you think there is a genetic or environmental factor that causes resilience?

3.) What is your understanding about protective factors and resilience?

4.) What is your understanding about risk factors and resilience?

      a. Do these factors play a role in your intervention methods?

5.) To what degree does attachment affect resilience?

6.) To what degree does childhood trauma affect resilience?

7.) What role do peer relationships play in resiliency?

8.) What role does emotion regulation play in your intervention methods?

9.) What intervention methods have you found to be most successful in fostering a sense of resiliency?

10.) What are some of the challenges you have come across during intervention methods?

11) Do you have a specific case example where an adolescent lacked resiliency and was able   to gain a sense of this trait?

Resiliency:

A Clinician's View of

Childhood Adversity and Implications for At-Risk Adolescent Intervention

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Abstract

This is a qualitative research study focused on a clinician's perspective on and use of intervention methods related to fostering a sense of resiliency in adolescents. Risk factors and protective factors are first established during the early stages of development. These factors often serve as a blueprint for how a person will respond to adversity throughout their life cycle. There is a wide amount of research related to these factors during early development. This study seeks to understand resiliency beyond the first few years of life. Four clinicians who work with troubled teenagers were interviewed in order to learn more about resiliency and how it can be further developed in children who appear to lack the trait. The results give a further understanding about risk and protective factors and how they can be used in intervention methods in order to support and develop a resilient disposition in adolescents who are without this quality. The results also illumine some of the intervention methods that have been successful for the clinicians who were interviewed for this study and some possible gaps in the understanding of trauma and a child's resiliency.

Keywords: Childhood Trauma, Resilience, Attachment, Intervention, Development, At-risk Adolescent

In the United States, it is estimated that twenty-six percent of children will witness or experience a traumatic event before the age of four years old (Briggs-Gowan, Ford, Fraleigh, McCarthy, & Carter, 2010). This topic is important because children with early experiences of trauma, adverse experiences and an insecure attachment are less likely to develop a resilient disposition. It is pertinent to discover adequate techniques for fostering resiliency in later developmental stages so that there is a stronger opportunity to achieve personal success. My aim is to gain a qualitative understanding of how clinicians working with at-risk adolescents offer clients support in gaining a sense of resiliency. Through understanding their perspective we may find connections in successful intervention methods amongst varying practitioners. Moreover, it could be helpful to understand where there may be gaps in the broad clinical understanding of risk and protective factors and if this relates to successful or unsuccessful clinical treatment.

Literature Review

Current literature on resiliency suggests that this trait is initially developed at birth and is heavily impacted by the first interactions with a child's caregiver. Much of the literature on resiliency is focused on protective factors and risk factors which are either developed or lacking during the earliest stages of development. In this section, I will highlight what some of the available research communicates about resiliency and some of the interventions that are effective.

Defining Resiliency

This begs the question, "what is resiliency?" Some researchers have theorized that resiliency is exhibited by "individuals [who] take responsibility for their recovery and are able to accept and integrate their experiences" (Gerber, Hogan, Maxwell, Callahan, Ruggero, & Sundberg,

2014, p.113). These researchers further define resiliency as being able to arrive at a similar level of functioning as before ~~the~~ trauma took place. Other researchers characterized resilience as "the ability to display healthy social interaction, optimism, and emotional control" (Wortham, 2014, p. 59). Resilient people are able to successfully cope and adapt after experiencing distressful, life-changing events.

Risk and Protective Factors

There are various risk factors that can stifle a person's ability to develop proper tactics of resilience. Some of these include a negative home environment and genetic predisposal to a high-strung temperament or personality. In a research study regarding factors associated with resilience in adults, it was found that the greatest risk factor is childhood trauma (Simeon, Yehuda, R., Cunill, Knutelska, Putnam, & Smith, 2007). Childhood trauma can be described as an event that takes place in which normal functioning of life is threatened, thus threatening the development of coping skills.

Some protective factors can be attributed to a child's belief system, sense of humor, positive or negative outlook, intellect, their parent's mental health, home life, and stress in the family (Wortham, 2014). Agaibi and Wilson (2005) discussed some of the protective factors related to resilience in a review of literature on the topic. They described some protective factors as the ability to moderate emotions, cope with stressors, and manifest positive responsiveness to stressors. Additionally, Agaibi and Wilson (2005) highlight that effective parenting increases self-efficacy, self-esteem, and self-confidence. Along with many other articles that were surveyed, the following list presents additional characteristics that help create a resilient person: secure attachment, intellectual skills, social cognitive abilities, the ability to make meaning of an experience, "interaction with fellow survivors", altruism, and sense of self as a

survivor (Agaibi & Wilson, 2005). Among these, some other things that can support resiliency are spirituality and extended support systems outside of the family unit (Orbke & Smith, 2013). What is less clear and necessary to research is whether these factors can be fostered later in childhood.

Attachment/ Emotion Regulation

Attachment and emotional regulation are closely linked topics of research associated with resilience. Prominent neurobiologist Dan Siegel discusses these two topics in relation to brain development. In a review of scientific findings regarding interpersonal relationships and the development of the brain, Siegel (2001) discusses that children who have a disorganized attachment often have "unresolved trauma or grief" (p.77). Therefore, unresolved attachment and trauma may have correlations in how they affect a person's resiliency.

Siegel further discusses how a child's relationship to their caregiver is meant to provide comfort and support but in some situations they receive the opposite (Siegel, 2001). A child is meant to learn coping skills from their caregiver and how to deal with emotional dysregulation. Early stages of life set a pattern for how they will cope when distressed for the rest of their life. It is problematic if the adult is unable to display a healthy example of regulating emotions. Brain development and integrative processes through secure attachment are essential in achieving psychological resilience and emotional regulation (Siegel, 2001). Preventative measures are vital to understand in order to inform new moms about creating a secure bond with their infant. Further research would be valuable to understand interventions related to developing healthy emotional regulation patterns and enhancing a secure attachment during later stages of development.

Peer Relationships

As has been stated, during early child development secure attachment to a caregiver is a primary condition to producing a resilient personality. However, in later developmental periods such as the adolescent stage, it may be fostered in a different way. Peltonen, Qouta, Diab, & Punamäki (2014) studied 482 children who faced war trauma in Palestine during war. One of their major findings was "that peer relations and especially friendship quality was the main predictor of child resilience, which may indicate that in middle childhood these relations are very salient" (Peltonen, Qouta, Diab, & Punamäki, 2014, p. 236). The age group that was sampled was children ages 10-13 years of age. This reveals that during this developmental stage, friendship is an important predictor of resilience. Whether practitioners have observed this is something that would be valuable to discover.

Intervention Methods

Strengths Based Approach/ Empowerment

So far we have determined through available literature that resiliency is fashioned through many influences that are promoted differently during each developmental stage. Often noted in literature is that the earliest stage is most critical. Some interventions nurture resiliency is through a strength-based approach. Straussner & Calnan (2014) highlight three ways: "1. A belief that one can influence one's environment (self efficacy), 2. The ability to handle one's thoughts and feelings (cognitive-behavioral skills), and 3. The capacity to form caring relationships" (329). This article highlights a strengths-based approach to help a child recognize their internal ability and available external resources (Orbke & Smith, 2013). The National Institute for Trauma and Loss in Children (TLC) also makes use of a strength-based approach and resilience-focused interventions. Specifically, they use Structured Sensory

Interventions for Traumatize Children, Adolescents, and Parents (SITCAP). Their work focuses on helping children to process hidden away memories through a method that promotes well-being, emotional regulation, and empowerment (Steele & Kuban, 2014, p. 19). The therapeutic model by SITCAP includes reframing of the mind, particularly for the child to shift their identity from victim to survivor.

Environment

María Cristina Richaud who works with Interdisciplinary Center of Mathematical and Experimental Psychology Research (CIIPME), and National Council of Scientific and Technological Research, Argentina (CONICET) discusses the importance of an intervention approach that alters the environment of at-risk children. In this approach, the child's natural environment is modified to support and boost resilience. Richaud discusses how a positive environment allows the child to thrive and continue to develop resilient characteristics during later stages of their life (Richaud, 2013).

Other methods that have been noted as helpful interventions include: Trauma Focused Cognitive Behavior Therapy (TF-CBT) and Cognitive Behavior Therapy(CBT), exposure therapy, psycho-education, desensitization and imaginal flooding, eye movement desensitization and reprocessing (EMDR), narrative therapy, group therapy and medications (Straussner & Calnan, 2014, p. 330) . Dialectical Behavior Therapy (DBT) is an intervention that has been found to be effective in treatment of adolescents who have faced adverse childhood experiences and struggle with emotional regulation (McClellan & Hamilton, 2006). DBT has a focus on mastering healthy emotion regulation skills, distress tolerance skills and interpersonal effectiveness. Further research about what methods of intervention are most used and helpful would be advantageous for the field of social work.

Gaps in the Literature

The vast majority of available and relevant literature concentrates on the earliest stage of development and is prevention focused. This is understandable because this stage of life serves as the baseline in producing a more resilient person. There is far less information available regarding more effective approaches to gain resiliency in later stages of development.

I conducted a qualitative research study through interviewing practitioners who have worked with at-risk adolescents. My research question was: what allows an adolescent who has experienced childhood adversity to master a sense of resiliency. The goal was to better understand which intervention methods are successful for children during the adolescent stage of development. This study sought to understand what the practitioner's current understanding of some of the risk and protective factors are and how this understanding might correlate to their intervention methods.

Methods

Research Design

In this qualitative study I utilized a survey of questions related to the topics of resiliency and childhood adversity. The survey was used to recognize how clinicians define resilience. Other questions related to risk factors, protective factors, attachment, and how practitioners relate these ideas to their treatment process. After completing the interviews, an analysis was conducted to assess the clinician's view about the development of resilience during adolescence.

Eligibility

The eligibility for participants in this research study is practitioners who have worked with at-risk adolescents for a minimum of three years. They have at least a master's degree level of education in the fields of social work, psychology or counseling. The eligibility criteria should help to further secure reliability in the collected data.

Recruitment/ Consent

The prospective contributors for this study were identified purposively through inquiry of individuals who met the qualifications. I utilized a snowball sample method through an initial participant who identified a few other eligible candidates for this study. Only one of those clinicians identified through this method responded and was available to meet with me. The other practitioners were identified through internet searches of clinicians who work with at-risk adolescent youth. I approached these individuals through phone calls and e-mail. After they responded, I gave further information and sent the consent form for them to read. A few of the participants had further questions which were addressed. The consent form stated the researchers' statement, the purpose of the study, procedures, risks, stress or discomfort, benefits of the study, confidentiality of research information, and other information. A $5 Starbucks gift card was offered to the participants for participating in this study. Additionally, after participants agreed to take part, they received an e-mail of the interview questions in order to prepare to talk about these topics.

Sample

The study began March 30th and ended on June 2nd. Due to the brief amount of time available for this project, a smaller sample size of four participants was used. In order to account for sample representativeness, people of different gender and cultural background were sought for this interview. However, the people who responded to be interviewed included one male

and three females who are Caucasian. It was also intended to interview some clinicians out of the state but there was a low call back/e-mail rate. This posed a challenge. Three of the participants for this study work in Pierce County and one works in King County. The background of the people who were interviewed includes three practitioners who work at in-patient facilities for adolescent youth. Two of the clinician's work at Western State Hospital, one with children ages 11-14 and the other worked with children ages 14-17. The other in-patient clinician works for Pierce County at an in-patient psychiatric center for children ages 11-18. The fourth participant works in King County with children in Wraparound services, which involves individualized coordinated care. Three of the clinicians hold their Masters of Social Work and one is a Licensed Marriage and Family Therapist. All of the participants have worked with at-risk adolescent youth for more than three years.

Measures

Two interviews took place in offices where the practitioner's worked. One interview took place in a park and the final interview took place over Skype. When we met for the interview, participants signed the consent and kept one copy. For the skype interview the clinician signed the consent and sent a copy through e-mail. Before each interview began, I gave the participants some further information. They were informed that they would be given a copy of the transcription along with some preliminary themes and analysis from the data. They were welcomed to let me know if they saw some necessary modifications in the transcript or themes. It was disclosed that they would be referred to by a pseudonym throughout the study and the audio recording would be deleted by June 2, 2015 in order to secure confidentiality. The interviews with these participants lasted 17-35 minutes.

The data for this study was measured through analysis of interview questions that were focused on how the clinicians view resiliency (See Appendix A). The interview questions included broad, open-ended questions with additional probing questions to ensure that all of the inquiries were answered. This interview sought to get a thorough understanding from the clinician about at-risk teenagers. The questions focused on what their current knowledge is relating to risk and protective factors, attachment, trauma, peer relationships, and emotion regulation. The questions also attempted to understand what intervention methods are most effective and what barriers are sometimes faced in their practice. Additionally, I asked for specific case examples of clients who lacked resiliency yet were able to gain a sense of this trait. The data was voice recorded and I wrote down after each interview some of my reactions.

Trustworthiness

Some peers analyzed my data and came up with their own themes in order to compare them to mine and determine some validity in my early findings. After viewing the analysis I was able to identify different ways of understanding the data. Furthermore, each participant received an e-mail with the themes and early analysis of the data. They gave me some feedback about my findings. I recognize that I may have my own biases particularly related to my time spent working with children. I resolved to remain aware of my biases throughout this study and how they could potentially affect my research conclusions. I utilized an audit trail to help check my thoughts on the themes and topics and what data lead to my conclusions (See Appendix C). I bracketed my responses to what the clinicians had to say and was reflective of my own perceptions throughout this project.

Data Analysis

I utilized grounded theory in my qualitative analysis to better understand how the ideas shared by the varying clinicians related to one another. After transcribing each of the interviews, I used an open coding method by going through each transcription line by line, recording key ideas in the margins to note themes that emerged. I used descriptive codes by using a word or phrase to describe each key idea. I used an inductive approach in order to find similarities, and understand what the data meant. I made preliminary lists of all the descriptive codes for each transcript in Word documents and sought to pin point identifiable topics from the data (See Appendix B). I then entered the themes and their codes into a situation/consideration matrix to further organize the data and discover more parallels between what each of the practioners had to say (See Appendix C). From there I was able to better classify a list of sub themes. I followed up on my themes through member checking when I shared some preliminary results with the participants. Most of the participants replied back and stated that I was on the right track and had adequately summed up the main ideas from our interview.

Findings

My major findings are categorized in the themes of: Defining Resiliency, Risk and Protective Factors, and Intervention Methods and Barriers. In the literature review, I discussed several risk and protective factors. A number of these factors were highlighted during these interviews and for that reason they are subthemes in my research findings. Other subthemes that I categorized are under Intervention Methods which are: Shaping/Cognitive Behavior Therapy/Clinician's View of the Client, Emotion Regulation/Dialectical Behavior Therapy, and Child is the Director/Empowerment.

Defining Resiliency

Each of the practitioner's gave varying definitions of resilience which also correlated to how this term was defined in the literature review. Some parallel ideas they discussed related to a client going through an obstacle, or barrier and being able to move on, fully come out, or get back to where they desired to be. Participant Two gave this definition of someone who is resilient: "In addition to what the library might say or the dictionary or thesaurus, I see it as someone who has very little or no self-pity, has a lot of common sense, has a goal [and] focus and has at least one area in their life functioning well, whether that's academics or family life or social support." In this definition, the participant highlights some of the factors for a person who is resilient.

Risk and Protective Factors

Perception/ Self View

Many of the clinicians spoke about the client's perceptions, including their self-view and goals. They gave specific details about how these factors affected intervention in a positive or negative way. Some of the success stories shared had an element of the child being able to take on a view of self-power and ability to achieve success. Participant One stated, "Whether they view themselves as being a passive participant like… bad things just happen and there's nothing you can do about it or whether they view themselves as having their own power within that and to be able to you know, 'when bad things happen I can be able to do these thing to then control my situation and move on'" This clinician found that a person's world-view could affect their ability to be resilient. Participant Two discussed a similar perspective on a client's personal viewpoint. She states about one successful client, "And at the same time [he] firmly believed he didn't belong here, that there was really nothing that much wrong with him… sometimes denial is a good thing (laughs)." Many of the practitioners had

success stories relating to their client displaying self-efficacy and being able to have a positive view of themselves as a major factor in achieving resiliency.

Safety and Environment

It may seem an obvious factor, but for many children who have faced a traumatic and chaotic childhood, establishing a safe and stable environment was discussed as a primary goal for achieving resiliency. Participant Three stated, "You know, I mean you try to set up a safe environment, at least for us here you know we set up a safe environment where their safe. And sometimes for our kids, it's the first time they have ever been any place where they've been safe." Participant Three further discloses that a safe, secure space is essential to their ability to discuss and deal with their struggles. This topic was discussed 16 times in various ways throughout their interview. Having a safe environment coincides with the reviewed research conducted by Richaud who suggests the environment can be used as a catalyst to promote resiliency.

Power/Control

An evident topic that developed through the interviews was the concept of at-risk children struggling with feeling powerless and without control. This idea was mentioned ten times throughout the interview with Participant One. It was mentioned that one of the risk factors that their client faced was having an over-controlling parent. The clinician stated, "Having people around you that shape your worldview around not being able to have power and not being able to effect change and kind of people that push you down are really huge risk factors." She discusses how the interaction with others along with being controlled by others can place a person at risk for having powerless thinking patterns along with frequent feelings of hopelessness and helplessness. The hopeless/helpless ideology was a major topic in that

interview. Participant two shared this idea when she said, "And just to understand that the one person you do have some power over to change is yourself, is really part of resiliency too." It can be frustrating for adolescents to lack the ability to change their family members. This participant went on to talk about being persistent, and being able to see the temporariness of obstacles as being a way to find power in a powerless situation.

Attachment

Attachment can cause protection for the adolescents and consequently, a disorganized attachment is a major risk factor. This was a common subtheme that was discussed in the interviews. Participant One stressed this about attachment: **"**So early attachment can really shape a person's worldview and so adolescents that I've worked with often times will come in with that hopelessness and helplessness, a feeling of unloved and uncared for, um and that sort of like detachment from their family or um or insecurity from that really winds up creating a lack of resiliency." She went on to discuss how working with in-patient treatment she often witnesses some of the most serious cases of children in distress and how rare it is to meet a child who shared a secure attachment. She associated that reason with the idea that children with a secure attachment often have support that keeps them at a safer level even if they have mental health issues. Participant Three's experiences resonated with this idea. He stated, "It they are attached and they feel safe and they can have the trauma and it can be there and they realize that, they don't forget those things but they deal with it because they have the safety of the people around them. If they don't have that, that world becomes very unsafe and you're left with your own thoughts and in your own head and then all you do is feed your own dragons to a great extent you know." He attributed the lack of support to deep feelings of loneliness which can cause other mental health problems.

Peer Support

Connected to the idea of attachment, peer support provides a means for children to create a

healthy attachment bond. When I asked Participant One about how peer relationships might

affect resiliency, she discussed how positive peer support is empowering and can increase

resiliency. She also touched on how bullying can be a way to tear down at a person's ability

to be resilient. This concept is shared by Participant Two who described one particular client

who had a "charm" about her which helped her to build peer support. When this client faced

bullying by new students, her peers "…just sort of adopted her and protected her." Therefore,

proper peer support can have a shielding element against risks. The types of friends that the

adolescent is drawn to can either build them up or tear them down. Participant Three

considered how often children gravitate towards friendships with people who have similar

backgrounds to them. He says, "I know a lot of times they do that because those are the

people that will associate with them and those are the people that understand them and they

do that and that can put them in a, I think, can really put them at a higher risk." An important

element that Participant Three touched on is that in in-patient treatment facilities, kids lack

positive peer support with the other children in treatment. This is because they are all in

treatment due to having some sort of struggle that poses a risk. Many of the in-patient

facilities focus on building the support of whomever the child would be placed with at

discharge whether it is family or their foster care family.

Intervention Methods

       Shaping/Cognitive Behavior Therapy/Clinician's View of the Client

Through the interview, many different intervention methods were discussed by the

practioners. One of the primary subthemes within the intervention category was the

clinician's view of the client and reshaping the client's view of themselves and the world. Participant One focused on the client's feelings of powerlessness and used reframing to help them move beyond some of those thinking patterns. This is a common practice used in Cognitive Behavior Therapy. Participant One states, **"**Changing the words and reframing it from something that sounds powerless and hopeless and helpless into something where there might be a little bit of ability to change the situation and a little bit of power that they have and control over the situation..." Participant Four utilizes a reframing CBT type method often in her intervention methods with the youth.

The clinician's view of the client is an important part of intervention. When participant two was asked about risk factors/protective factors and how they might play a role in intervention methods she said, "A lot of times kids come to us and all they can talk about is the negative stuff and we try to start out with what are your strengths, what makes you feel good, what gives you joy and look at a child in terms of probably 85% of the kid is fine and the 15% is not so fine." A couple of the interviewees discussed holding a more positive view of the client as a valuable element of treatment.

Child be the Director/Empowerment

Some of the intervention methods focused on letting the child choose what it is that they want to work on. Participant Four, states, "… top thing we need to do is hear from the client what it is they want help with and what it is they are trying to achieve resiliency on. We can't decide that for them and we can't decide for them what resiliency for them looks like." She went on to say that sometimes the clinician may envision a better outcome then the client can see, but respecting boundaries is more important. Furthermore, many of the clinicians touched on the idea of empowerment and strengths-based approach in their intervention with

the children. Participant Four said the most important intervention method is, "… being strengths based and just reframing everything we can to be really supportive and encouraging and empowering." Some of the clinicians seek to view the strengths of the family as a whole and focusing on throughout the treatment process.

Emotion Regulation/Dialectical Behavior Therapy

Emotion regulation plays a primary role in each of the clinician's intervention methods with at-risk youth. Each of the *in-patient* clinician's practices Dialectical Behavior Therapy (DBT) as part of their treatment program. Participant Three states, "We are a DBT cottage, and we use that as the main focus so, emotional regulation is just part of what we do most of the time." Participant Four who works in Wraparound mentioned about emotion regulation, "So, I like to mirror a lot of that in body language, I like to kind of just help reflect to people like, 'Hey, you know you said this but you're showing me this, it's a little confusing to me, like what are you feeling?'" Anger management is another piece that is touched on in her treatment as well.

Discussion

This research sought to contribute to current discussions on resiliency and supplement data that practitioners have already observed. This data may supply further information for discussion on where there may be gaps in a clinician's understanding about risk and protective factors that children face. This study may encourage practitioners to gain a broader understanding of what methods are most often utilized amongst their peers. It is equally possible that the study will bring light to information that might not be prevalent about this subject.

Interpretation of Data

One question asked that I had anticipated being more of a major subject throughout these interviews was about childhood trauma. I asked, "To what degree does childhood trauma affect resilience?" This was one of the questions that had a shorter response than other questions that were asked to the clinician's. From the answers I received and infrequency of it being brought up, it seemed to be an area that the clinicians had less knowledge or less of a focus in their intervention methods. This may represent a possible gap in the understanding of the impact that trauma may have on a child's ability to be resilient.

Many of the themes and subthemes which related to the child's environment, supports, worldview, self-view are interrelated. For example, a child who has a negative environment with poor support will likely be impacted by the people in that environment and feel a certain way about themselves based on what the influential people in their environment make them believe (See Figure 1). Patterns of thinking are often established based on these factors in the child's life. Cognitive behavior therapy is helpful to rewire some of those thinking patterns and negative views in order for the child to achieve success. CBT is also affective for reshaping hopeless thinking (See Figure 2). One of the findings I discovered was that many of the clinicians viewed self-efficacy and a client's positive self-view as instrumental in gaining a sense of resiliency.

DBT addresses some of the fundamental areas that children who lack resiliency struggle with such as emotional regulation, interpersonal skills, and distress tolerance (See Figure 3). Each of the in-patient case workers uses this form of therapy with their clients. This approach is a major part of treatment and has been something that is helpful to clients.

The intervention methods that allows the child to be the director, strengths based and empowerment approach relates to the theme of power and control (See Figure 4). For many of the children who feel helpless and without control, giving them power to direct their therapy gives them a freedom that they have really struggled with throughout their lives. Additionally, a strength based approach empowers the child to no longer focus on their deficits which may have been a primary thinking pattern. One clinician focused on how she viewed that the risk factors do not seem to help or do anything beneficial for the client. So much of their life has been focused on the negative and risks. Therefore focusing on growing protective factors, and what the client does good has proven to be a more helpful approach at helping the youth achieve resiliency. A more in-depth research study that focused solely on the clinician's view of the client and self-efficacy would be helpful discover how this may change the outcomes of intervention.

Healthy social support and attachment are a primary part of achieving resiliency. It was noted in the findings that many of the children who are in in-patient treatment lack the ability to attach to healthy peers due to the type of peers they are able to interact with while in treatment. This may be a weakness in these in-patient programs. Further research should be conducted about how to foster healthy peer attachments for children who struggle with resiliency.

Another focus that the clinician's narrowed in on was growing the client's protective factors and decreasing or working through their risk factors (See Figure 5). Participant Four was very strong in her position that focusing on a client's deficits will not help the client.

Social Work Implications

In a broader scheme, information about fostering a sense of resiliency during later stages of development needs to be more pervasive in the field of social work. It should be common knowledge by all social work practitioners what the risk and protective factors are. Risk factors are valuable in order to identify children who are at-risk. Knowing appropriate intervention methods such as empowerment, strengths-based approach, cognitive behavior therapy, dialectical behavior therapy, and shaping a child's environment is invaluable information that can be monumental in effectively serving the client. This knowledge is also fundamental in order to make proper treatment referrals. In order to better serve our clients we must know what it is that has been proven to be affective in treatment.

Limitations

This research study is not without limitations. For example, the interaction effects of selection biases may have been a threat to validity. I struggled to find practioners of varying cultural backgrounds. There was also a larger sample of people who worked with in-patient treatment. The small sample size for this study was a constraint because it made it challenging to ascertain the universal validity of deduced themes, and therefore difficult to apply these findings to the broader population. History could pose another threat to validity. For instance, some of the answers I received about types of treatment may be a more pervasive practice at this time in history and that is why it was most commonly discussed. Another drawback to my experimental design is there may have been a reactive effect on data through sending the interview questions to the practitioners beforehand. This may lead them to have a more researched awareness to the questions. However, I feel it was more helpful for the purpose of this study that the practitioners to be afforded some thoughtful time

to think about how they would answer these questions. Though I tried to remain objective throughout this research process, I recognize my own bias may have posed a threat to validity. This project was conducted by just one researcher which made it a challenge to bounce ideas around. The workload was a bit heavier during a short amount of time than it may have been with a partner. Having a partner may have afforded a more in-depth understanding of the data with multiple minds interpreting it throughout the process.

Conclusion

Adverse childhood experiences are a prevalent problem in this country and they have generational impacts. As an MSW student, I have spent the last year of my field practicum working at a trauma/psychiatric facility for children. One of the primary roadblocks that I continually witnessed was the heightened struggle for children and adolescents to overcome life obstacles. I observed a lack of common knowledge in the social work field about how to foster resiliency in adolescents who lack this quality. For these children, there needs to be a promotion of research and widespread knowledge about how to best support them at gaining a sense of resiliency in order to secure a more promising and healthy future.

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Resiliency: A Clinician's View of Childhood Adversity and Implications for At-Risk Adolescent Intervention

Background

"In the United States, it is estimated that twenty-six percent of children will witness or experience a traumatic event before the age of four years old." This topic is important because children with early experiences of trauma, adverse experiences and an insecure attachment are less likely to develop a resilient disposition. Much of the resiliency literature is focused on prevention and the earliest stage of development. There is far less information available regarding more effective approaches to gain resiliency in later stages of development. I conducted a qualitative research study through interviewing practitioners who have worked with at-risk adolescent children. My research question was, "What allows an adolescent who has experienced childhood adversity to master a sense of resiliency?" The goal was to better understand which intervention methods are successful for children during the adolescent stage of development. This study sought to understand what the practitioner's current understanding of some of the risk and protective factors are and how this understanding might correlate to their intervention methods.

Methods

Research Design

A qualitative study with a survey of questions related to the topics of resiliency and childhood adversity.

Eligibility

Practitioners who have worked with at-risk adolescents for a minimum of three years. Have at least a master's degree level of education in the fields of social work, psychology or counseling.

Sample

Four Practioners: One male Social Worker who works in-patient treatment for at-risk youth ages 14-17 in Pierce County.
One female social worker who works in-patient treatment for at-risk youth ages 11-13 in Pierce County.
One female licensed marriage and family therapist who works in-patient at-risk adolescent youth ages 11-18 in Pierce County.
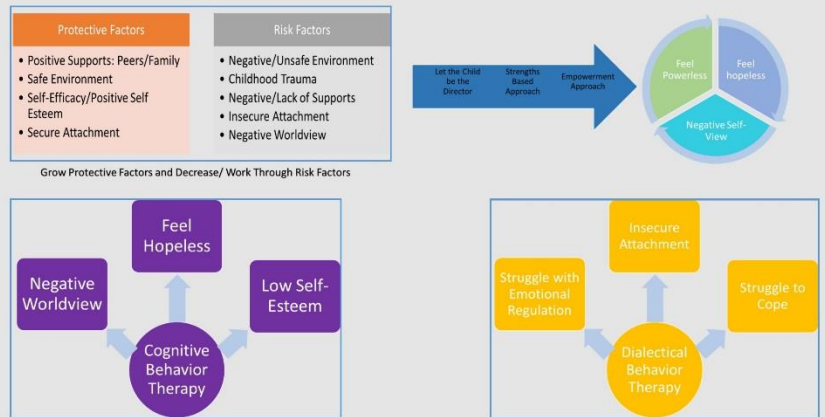One female social worker who works in wraparound services in King County.

Data Collection

Data was collected through interviews that were voice recorded and later transcribed.

Measures

The data for this study was measured through analysis of interview questions that were focused on how the clinicians view resiliency. The interview questions included broad open ended questions with additional probing questions to ensure that all of the inquiries are answered. This interview sought to get a thorough understanding from the clinician about at-risk teenagers and resiliency. The questions focused on what their current knowledge is related to risk and protective factors, attachment, trauma, peer relationships, and emotion regulation. The questions also strived to understand what intervention methods are most effective and the barriers they may face in their practice. Additionally, I asked for specific case examples of clients who lacked resiliency yet were able to gain a sense of this trait. The data was voice recorded and I wrote down after each interview some of my reactions and non-verbal things to remember about the data.

Results

Major Themes

Risk and Protective Factors

Perception/ Self View

- Many of the clinicians interviewed spoke about the client's perceptions, their self-view and goals. A teen's world-view and view of self affected their ability to be resilient. Some success stories that were shared related to the client's self-efficacy and being able to have a positive view of themselves as a major factor in achieving resiliency. "[he] firmly believed he didn't belong here, that there was really nothing that much wrong with him... sometimes denial is a good thing (laughs)." -Participant Two

Safety and Environment

- Establishing a safe and stable environment was discussed as a primary and factor and goal for many of the adolescents to achieve resiliency.

Power/Control

- At-risk children struggle with feeling powerless and without control. They frequently display a hopeless/helpless ideology which is opposite to how a person who feels empowered or in control. "And just to understand that the one person you do have some power over to change is yourself, is really part of resiliency too." Participant Two

Attachment

- Attachment can cause protection for the adolescents and consequently a disorganized attachment can be a risk factor. Lack of support may lead to some deep feelings of loneliness which can cause other mental health problems for the children.

Peer Support

- Peer supports provide a way for children to create a healthy attachment bond. Positive peer supports can empower and help increase the resiliency in youth that struggle and lack it. Bullying can be a risk factor for children who have faced early trauma or an adverse upbringing.

Intervention Methods

Shaping/Cognitive Behavior Therapy/Clinician's View of the Client

- Many at-risk youth feel powerless, through reframing a situation it can help them move beyond some of those thinking patterns. Cognitive Behavior Therapy is an effective intervention method. A clinician's view of the client with a more positive view can be helpful in treatment.

Child be the Director/Empowerment

- Letting the child choose what it is that they want to work on and when they are ready and meeting the client where they are at is in an important element. Empowerment and strengths based approach is an important element in successful intervention with at risk teens. "... top thing we need to do is hear from the client what it is they want help with and what it is they are trying to achieve resiliency on. We can't decide that for them and we can't decide for them what resiliency for them looks like." -Participant Four

Emotion Regulation/Dialectical Behavior Therapy

- Emotion regulation played a big role in each of the clinician's intervention methods with at-risk youth. Each of the in-patient clinician's practices Dialectical Behavior Therapy (DBT) as part of their treatment program.

Conclusions

- At-Risk adolescents who struggle with feeling powerless relates to the intervention method of empowerment, letting them be the director and a strengths based approach.

- CBT is effective and focuses on reframing thinking patterns that have been established in children who have faced adverse childhood experiences.

- DBT is effective and focuses on gaining skills in emotion regulation, interpersonal effectiveness and distress tolerance.

- Focusing on growing protective factors, rather than focusing on the client's deficits is a helpful approach in fostering resiliency.

  - Healthy social support and attachment are a primary part of achieving resiliency.

Social Work Implications

- Social Workers should push for making information about fostering a sense of resiliency during later stages of development more well-known.

- It should be common knowledge by all social work practitioners what the risk and protective factors are.

- Risk factors are valuable in order to identify children who are at-risk. Knowing appropriate intervention methods such as empowerment, strengths based approach, cognitive behavior therapy, dialectical behavior therapy and shaping a child's environment are valuable information that can be monumental in effectively serving the client.

Interventions

Protective Factors
- Positive Supports: Peers/Family
- Safe Environment
- Self-Efficacy/Positive Self Esteem
- Secure Attachment

Risk Factors
- Negative/Unsafe Environment
- Childhood Trauma
- Negative/Lack of Supports
- Insecure Attachment
- Negative Worldview

Grow Protective Factors and Decrease/ Work Through Risk Factors

Let the Child be the Director → Strengths Based Approach → Empowerment Approach → Feel Powerless / Feel hopeless / Negative Self-View

Cognitive Behavior Therapy: Feel Hopeless, Negative Worldview, Low Self-Esteem

Dialectical Behavior Therapy: Insecure Attachment, Struggle with Emotional Regulation, Struggle to Cope

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By Annika St. John

RENEW HOUSE

Annika St. John

Problem Statement: Children who have experienced early trauma are vulnerable to experience emotional dysregulation and struggle to develop resiliency.

Key Research Findings

- Children who have experienced trauma are more likely to struggle emotionally, behaviorally, intellectually and socially, and are less likely to develop a resilient disposition. They are at-risk for substance abuse, mental illnesses, and poverty which could become an intergenerational pattern without effective treatment (Orbke & Smith, 2012)

- Research suggests that nearly 90% of U.S. juvenile offenders have experienced some sort of a traumatic event as a child (Dierkhising, et. al., 2013). Providing outpatient treatment to children affected by trauma can have a positive impact on juvenile offenders.

- Adverse Childhood Experiences are a major risk factor for many chronic health conditions which can ultimately lead to death (Felitti, et.al., 1998). Providing treatment to children who have experienced adverse circumstances can have a positive impact on a child's long term health.

- TF-CBT is an effective treatment for children diagnosed with PTSD (Straussner & Calnan, 2014). Psychoeducation is noted as important part of treatment for children who have experienced trauma. Other forms of CBT which are evidence-based practices for treatment of trauma are eye movement desensitization for reprocessing (EMDR) and Dialectical Behavior Therapy (DBT) (Straussner & Calnan, 2014). .

- "DBT [Dialectical Behavior Therapy] focuses on such skills and behaviors as mindfulness and distress management. During these processes, survivors are taught new behavioral alternatives to replace their old, trauma-induced behavioral repertoires" (Lovelle, 2005, p. 33) . DBT seeks to positively alter many of the core behaviors and coping patterns formed by early trauma. Children can learn more positive ways to cope, relate to others and build resilience.

- Practicing mindfulness and acceptance can help individuals who have experienced trauma to develop psychological resilience (Thompsom, Amkoff & Glass, 2011).

Needs Statement: Youth who have experienced trauma need strategies to better manage their emotional regulation in order to achieve a more resilient disposition and reduce rates of behavior problems.

A place for teenagers to find healing from adverse/ traumatic events and experiences.

Outpatient Program

1. Intake Assessment and Treatment Plan
2. Mindfulness, Martial Arts, Yoga
3. Psycho-Education about impacts of Trauma
4. Dialectical Behavior Therapy Group
5. Individual Counseling-Cognitive Behavior Therapy, Art Therapy, Narrative Therapy, Trauma Focused-Cognitive Behavior Therapy, Eye Movement Desensitization and Reprocessing

6. Education about Habits of Healthy Living

7. Resources and Referral to Community Agencies and Providers

Anticipated Outcomes

Outcome 1. Reduced Violent Behavior

Outcome 2. Improved social functioning

Outcome Indicator 1a.
Reports fewer verbal altercations.
Outcome Indicator 1 b.
Reports using de-escalation techniques.

Outcome Indicator 2a.
Shows constructive level of assertiveness
Outcome Indicator 2b.
Relates positively with peers.

Evaluation Criteria
1. Pre and Post Survey

2. Observation Tool performed by staff and client's teachers

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Economist and Nobel Prize winner James Heckman has shown that if we invest $1 dollar in trauma-specific prevention programs, it will save our society $8.70 dollars per child (Heckman & Krueger, 2003).

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