NCTSN The National Child Traumatic Stress Network

In partnership with:

NATIONAL CHILDREN'S ALLIANCE®

CAC Directors' Guide to Mental Health Services for Abused Children

June 2008

This project was funded by the Substance Abuse and Mental Health Services Administration (SAMHSA), US Department of Health and Human Services (HHS).

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From the Children's Advocacy Center Directors' Guide Workgroup of the Child Welfare Committee, National Child Traumatic Stress Network, and the National Children's Alliance

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Established by Congress in 2000, the National Child Traumatic Stress Network (NCTSN) is a unique collaboration of academic and community-based service centers whose mission is to raise the standard of care and increase access to services for traumatized children and their families across the United States. Combining knowledge of child development, expertise in the full range of child traumatic experiences, and attention to cultural perspectives, the NCTSN serves as a national resource for developing and disseminating evidence-based interventions, trauma-informed services, and public and professional education.

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Alicia T. Vega and Jung Mi Yi of the Chicago Children's Advocacy Center, Chicago, Illinois

Mary Ann Cernak from the Monmouth County Child Advocacy Center in Howell Township, New Jersey

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Foreword

Development of This Guide

This Guide was developed by a mix of grantee centers from the National Child Traumatic Stress Network and Children's Advocacy Centers (CACs). Developers had a particular interest in improving staff mental health responses to child trauma victims and their families seen by centers around the country. In 2005, Charles Wilson from the Chadwick Center for Children and Families at Rady Children's Hospital-San Diego, Connie Carnes of the National Children's Advocacy Center, and Libby Ralston from the Dee Norton Low Country Children's Center, approached the leadership of the National Children's Alliance about undertaking a project to produce a mental health guide for CAC leaders around the country. They noted that the NCA has an accreditation standard for CACs in the area of mental health, but many people believed that the standard could be better met if CACs had some concrete guidelines and assistance. Charles and Libby presented this idea to various CAC Directors at NCA's 2005 National Leadership meeting, and secured a group of CAC Directors willing to join forces with a handful of NCTSN Centers in drafting, producing, and disseminating the Guide.

This group met over the next two years to conceptualize and plan their work. The goals of the group were to:

1. Improve the awareness and understanding among CAC leaders of best practice mental health interventions for traumatized children
2. Improve understanding among CAC team members of the value and most effective timing of mental health intervention
3. Assist CAC directors to plan and implement improvements in the mental health response to the needs of children seen at their CAC
4. Link CACs to the resources (including products, services, training, and relevant committee activity) of the NCTSN
5. Provide suggestions to the NCA Board on changes in the mental health accreditation standard
6. Provide guidance to CAC directors and clinical directors on relevant policy issues such as confidentiality
7. Provide guidance for key questions that CAC staff or directors face relevant to the mental health component of their program

The result of the work is this Guide.

Purpose of This Guide

Across the nation, Children's Advocacy Centers (CACs) provide services to tens of thousands of children each year. Many of these children have been abused or exposed to violence. Abuse and exposure to violence are common forms of emotional trauma experienced by children and can have lifelong consequences (Felitti, et al., 1998). Historically, the staffs of CACs and their multidisciplinary partners have focused on working to determine the accuracy and validity of concerns about—or reports of—abuse, especially sexual abuse. To that end, forensic interviews, medical exams, and coordinating with law enforcement and child protective services (CPS) are the major investigatory functions of the CACs.

To be true to and fulfill the promise of the CAC mission, it is important for CAC directors and staff to expand their focus, their resources, and their abilities to increase each child's potential for recovering from identified abuse and for living a full and productive life. To be successful in this task, CAC staff must fully understand the issues surrounding—and the impact of—childhood traumatic stress, as well as the most effective interventions for treating the sequelae of trauma.

This guide is intended to provide CAC directors with information to:

- Support and expand the existing mental health services component within CACs
- Include evidence-based, trauma-informed assessments and interventions in services offered to clients
- Strengthen, expand, and enhance existing community mental health resources;
- Expand the CAC's role as a broker for evidence-based assessment and treatment for children and their families
- Clarify mental health roles and boundary issues in the delivery of services within the Multidisciplinary Team (MDT)

Representatives from multiple disciplines often meet and collaborate within the CAC to sustain an integrated approach to the investigation and assessment of child abuse victims and referral to appropriate aftercare, especially mental health services. The director can positively influence this process when he/she has experience with and knowledge about how children respond to trauma, how they make disclosures, and what other services may be useful in supporting victims and their families through the investigative, assessment, and recovery processes.

Directors of CACs that do not provide mental health services are nevertheless in a good position to become effective brokers for mental health services in the community. This guide

can help directors evaluate options for offering mental health services, and assess and compare the quality of services available in the community. The guide will also provide CAC directors, many of whom are not trained mental health professionals, with information that can strengthen, focus, and enrich center services through the use of additional evidence-based practices and trauma-informed care.

For purposes of this guide, *evidence-based practice* (EBP) is defined as practice that is based on the best empirical research evidence and the best clinical experience and is consistent with the values of the clients the CAC treats (Sackett, et al., 1996). EBP may also be defined as a treatment, intervention protocol, or practice that has at least some scientific, empirical research evidence for its efficacy with its intended target problems and populations (Sackett, et al., 1996).

Trauma-informed care refers to services that are based on the best available knowledge of trauma and its impact on children. A trauma-informed provider of services is aware of the child's trauma history and understands the connection between the child's trauma and his/her behavior. This knowledge is then used by the provider to offer the most appropriate interventions to the child to alleviate the traumatic symptoms.

This guide is a joint project of the National Children's Alliance (NCA) and the National Child Traumatic Stress Network (NCTSN), with support from Substance Abuse Mental Health Services Administration (SAMHSA) and the National Center for Child Traumatic Stress (NCCTS). Utilization of the information in this guide will support the mission of the NCTSN: "To raise the standard of care and improve access to services for traumatized children, their families and communities throughout the United States."

Section 1: Overview of Child Traumatic Stress

All professionals serving children through CACs should have a general understanding of child traumatic stress and its impact on children and families. Regardless of their roles within the CAC, staff members who grasp the importance of these overarching issues will be better equipped to meet the needs of their clients.

Traumatic events often produce great emotional stress. This emotional stress may be clearly observed as the family begins to access services at the CAC. Therefore, all staff members who have contact with the family must learn to recognize the manifestations of child traumatic stress, especially the connection between the trauma and children's observed behaviors. Trauma-informed staff can then use their knowledge to conduct appropriate assessments and offer the most efficacious interventions to the child and family.

The CAC director is in an ideal position to provide leadership in creating a trauma-informed culture within the organization. Trauma-informed service providers are aware of children's trauma histories and understand the connection between child traumatic stress and children's behavior. They also grasp the consequences for children if services do not acknowledge the current research in child traumatic stress. Accordingly, this section offers an overview of child traumatic stress, highlighting children's reactions to traumatic stress according to developmental stage, and summarizing the immediate and potential long-term effects of exposure to trauma.

What Is Child Traumatic Stress?

Child traumatic stress refers to the physical and emotional responses of a child to events that threaten the life or physical integrity of the child or someone critically important to the child (such as a parent or sibling). Exposure to a single traumatic event that is limited in time (such as an auto accident, a gang shooting, or a natural disaster) is called an *acute trauma*. *Chronic trauma* refers to repeated assaults on the child's body and mind (e.g., chronic sexual or physical abuse or exposure to ongoing domestic violence). Finally, *complex trauma* is a term used by some trauma experts to describe both exposure to chronic trauma and the immediate and long-term impact of such exposure on the child (Cook et al., 2005).

As a general rule, traumatic events overwhelm a child's capacity to cope and elicit intense physical and emotional reactions that can be as threatening to the child's physical and psychological sense of safety as the event itself. These reactions include terror, intense fear, horror, helplessness, and disorganized or agitated behavior. Children may also experience physical sensations (rapid heart rate, trembling, dizziness, or loss of bladder or bowel control) in reaction to traumatic stress.

How Do Children Experience Trauma?

For some children, child traumatic stress may manifest in destructive and maladaptive ways that can impair the child's ability to relate to others, to succeed in school, and to control his/her emotions and behaviors. A number of factors influence how a child experiences and reacts to traumatic events. Children's reactions to trauma can vary depending on the number and severity of traumatic episodes, and the time period of exposure to the event(s). Children are also affected by their proximity to the event (if it happened to a friend or family member), and the event's personal significance for them.

Children's responses to trauma are also shaped by the extent to which their support systems are disrupted during and after the trauma. For instance, being separated from non-offending caregivers during or after the trauma can often affect children's reactions. Other factors that can influence children's responses to trauma include the following:

- The child's age and developmental stage
- Preexisting psychopathology and past experiences with trauma
- The child's perception of the danger faced
- Whether the child was the victim or a witness
- The child's relationship to the victim or perpetrator
- Parental psychopathology and distress
- The adversities the child faces in the aftermath of the trauma
- The presence/availability of adults who can offer help and protection
- Interactions with first responders and other helping professionals
- Genetic predisposition (Bradley et al., 2008)

Developmental Differences in Children's Responses to Trauma

As noted above, the child's experience of and response to trauma can be affected by multiple factors and situations. Research has found that there are some common age-related patterns of response to trauma.

Preschool children

Preschool children often have a difficult time adjusting to change and loss. They often feel helpless and powerless, and are unable to protect themselves (American Red Cross, 2001). Children in this age range are still developing the skills necessary to cope with stressful

situations. They are dependent on the protection and support of caregiving adults (SAMHSA, 2002). Preschool children tend to be strongly affected by the reactions that their parents or caregivers have to the traumatic event. The more severely their parents or caregivers react to the event, the more likely children are to show traumatic stress-related difficulties (NIMH, 2002).

It is common for traumatized preschool children to show regressive behaviors. This means they might appear to lose skills or behaviors that they had previously mastered (e.g., bladder control) or that they might revert to behaviors they had previously outgrown (e.g., thumb sucking). Similarly, traumatized preschool children often become clingy and may be unwilling to separate from familiar adults, including teachers. They may also resist leaving places where they feel safe (e.g., their home or classroom), or be afraid to go places that may trigger a memory of a frightening experience. Significant changes in eating and/or sleeping habits are also common, and these young children may complain of physical aches and pains (e.g., stomachaches and headaches) that have no medical basis. (SAMHSA, 2002).

Additional behaviors that traumatized preschool children may show include:

- Crying, whimpering, screaming
- Appearing to be frozen
- Moving aimlessly
- Trembling
- Speech difficulties
- Irritability
- Repetitive reenactment of trauma themes in play or other activities
- Fearful avoidance and phobic reactions
- Magical thinking related to trauma (e.g., " . . . and then I jumped out the window and flew away.")

Elementary school-aged children

Elementary school-aged children may also exhibit regressive behaviors such as asking adults to feed or dress them (SAMHSA, 2002). They may report unexplained physical symptoms, just as traumatized preschool children do. However, elementary school-aged children can more fully understand the meaning of a traumatic event, and this can result in feelings of depression, fear, anxiety, emotional "flatness," anger, or feelings of failure and/or guilt (NIMH, 2002). Because of these feelings, school-aged children may withdraw from their

friends, show increased competition for attention, refuse to go to school, or behave more aggressively. They may also be unable to concentrate and their school performance may decline (SAMHSA, 2002).

Additional behaviors that traumatized elementary school-aged children may exhibit include:

- Sadness and crying
- Poor concentration and other behaviors commonly seen in attention deficit disorder (ADD) or attention deficit hyperactivity disorder (ADHD)
- Irritability
- Fear of personal harm, or other anxieties and fears (e.g., fear of the dark)
- Nightmares and/or sleep disruption
- Bedwetting
- Eating difficulties
- Attention-seeking behaviors
- Trauma themes in play/art/conversation

Although elementary school-aged children understand what occurred more fully than do younger children, they are not always able to understand why the traumatic event occurred. Therefore, elementary school-aged children may be preoccupied with the details of the event and want to talk about it continually, or may act it out in play (American Red Cross, 2001). Repetition of the event is one way children unconsciously attempt to come to terms with what they experienced.

Adolescents

Traumatized adolescents may exhibit some behavior changes also seen in other age groups. For example, adolescents may report vague physical complaints, seek attention from parents, caregivers, and teachers, withdraw from others, experience sleep difficulties, avoid school, and show regressive behaviors, such as an inability to handle tasks and chores that they had formerly mastered (SAMHSA, 2002).

However, traumatized adolescents face other challenges that are specific to their developmental stage. Adolescents tend to place more importance on peer groups, to rebel against authority, and to feel immune from physical danger. These qualities can complicate the adolescent's efforts to come to terms with traumatic events. Traumatized adolescents may isolate themselves, resist authority, or become highly disruptive. Their distress, coupled

with age-appropriate feelings of immortality, may motivate them to experiment with high-risk behaviors such as substance use, promiscuous sexual behavior, or other "at-risk" behaviors, such as driving at high speeds or picking fights (SAMHSA, 2002).

Adolescents may also:

- Feel extreme guilt if they were not able to prevent injury to or loss of loved ones
- Fantasize about revenge against those they feel/know caused the trauma
- Be reluctant to discuss their feelings or even deny any emotional reactions to the trauma (in part because adolescents typically feel a very strong need to fit in with their peers)
- Show traumatic responses similar to those seen in adults, including flashbacks, nightmares, emotional numbing, avoidance of reminders of the trauma, depression, suicidal thoughts, and difficulties with peer relationships (NIMH, 2002)

In addition, traumatized adolescents may begin to exhibit delinquent and/or self-destructive behaviors; changes in school performance; detachment and denial; shame about feeling afraid and vulnerable; abrupt changes in or abandonment of former friendships; "pseudo-mature" actions, such as getting pregnant, leaving school, or getting married.

Immediate, Delayed, and Long-Term Reactions to Child Traumatic Stress

Children's reactions to trauma are varied and complex, and may manifest at different periods following the event or their removal from the traumatic situation. Not all children who experience trauma are adversely affected. How a child responds and how long reactions linger are a result of the objective nature of the events plus the child's subjective response to those events. However, research has shown that trauma-related stress is associated with myriad short- and long-term adverse outcomes. As explained below, effects immediately following the event may vary. Delayed reactions may include posttraumatic stress disorder (PTSD) or other disorders. In addition, long-term effects on learning and physical and psychological health can last into adulthood.

Immediate reactions to traumatic stress

Children's immediate reactions to traumatic stress may vary. Children who were not physically hurt, or who have no idea that what they experienced at the hands of others was wrong may exhibit little or no immediate reaction. Children who experienced pain or know that the abuse was wrong may, in the short-term, display intense reactions. These reactions may run the gamut from an expressed longing/concern for their nonoffending caregivers, to numbness, detachment, disbelief, emotional lability, intense anger, a frozen ("deer in the

headlights") state, tearfulness, agitation, excitement, or clinginess with caregivers. These reactions can be normalized by reassurance from the caregiver. If reactions persist over time, professional intervention may be required.

Symptoms of posttraumatic stress disorder (PTSD) and other disorders

Most people experience posttraumatic stress symptoms up to several weeks post-trauma. Children and adolescents who have experienced trauma may display symptoms that meet the diagnostic criteria for several mental disorders, including PTSD (American Psychiatric Association, 2000). (For the complete diagnostic criteria for PTSD, see Appendix F.) Full-scale PTSD is most common in children and adolescents who have experienced severe, chronic, or interpersonal trauma. Although most traumatized children do not develop full-scale PTSD, many will display one or more symptoms of the disorder. In addition, some traumatized children and adolescents may meet the criteria for other psychiatric disorders, such as acute stress or adjustment disorder.

Child traumatic stress and learning impairment

Exposure to trauma can also impair a child's ability to learn. A study by Sullivan and Knutson (1998) found that 12.6% of maltreated boys developed some form of language/speech impediment (as compared to 8.4% for control groups). Whether as a risk factor for abuse or because of the trauma, 9.1% of maltreated boys had some form of mental retardation as compared to 1.3% of controls. Nine percent of the boys had a hearing impairment versus 7.5% of controls. In addition, 7.4% of maltreated boys (versus 2.6% of controls) had a learning disability, and 3.9% (versus 0.8% of controls) had ADD.

The impact on learning may be related to the role trauma plays in the development of the brain. In some cases of child abuse and neglect, areas of the brain fail to develop properly, which impairs physical, mental, and emotional development (Perry, 2002). In cases of chronic abuse, the stress experienced by the victim may result in the hyperarousal of certain areas of the brain, which may then produce anxiety, sleep disturbances, and hyperactivity. This hyperarousal renders children more vulnerable to developing PTSD, ADD, ADHD, conduct disorder, and learning and memory problems (Perry, 2001).

Long-term reactions to child traumatic stress

It is important to recognize and understand the significant longer-term consequences of exposure to trauma. A major research project, called The Adverse Childhood Experiences (ACE) study (Felitti, et al., 1998), investigated whether adverse childhood experiences might affect adult health decades later. The adverse childhood experiences included: 1) abuse categories (recurrent physical abuse, recurrent emotional abuse, and sexual abuse); and 2) household or family dysfunction categories (growing up in a household where someone was in prison; the mother was treated violently; an alcoholic or drug user was present;

or someone was chronically depressed, mentally ill, or suicidal; and where at least one biological parent was lost to the child). The authors found that adults who had experienced multiple adverse childhood experiences were at increased risk of developing adverse health behaviors such as smoking, alcohol abuse, drug abuse, depression, suicide attempts, and having over 50 sexual partners.

Putnam (2003) cites studies showing that among those who have suffered the trauma of sexual abuse as a child, the incidence of later psychological disorders runs very high and includes: "major depression, borderline personality disorder, somatization disorder, substance abuse disorders, posttraumatic stress disorder (PTSD), dissassociative identity disorder, and bulimia nervosa." Victims of child sexual abuse, says Putnam, also manifest many "problematic behaviors and . . . neurobiological alterations."

Traumatized children are also more likely to become substance abusers than are their non-traumatized peers, with 25% of children with PTSD eventually becoming substance abusers. Even when full criteria for PTSD are not present, 14.9% of traumatized children became substance abusers, compared to 3.7% of children with no identified trauma (Giaconia et al., 1995). Sexually abused children are especially at risk for later abuse of drugs or alcohol (Chaffin, et al., 1996).

In another study, Ackerman et al. (1998) tracked the development of psychiatric disorders in children who had been physically or sexually abused. **Table 1** on the following page illustrates the major findings of that study.

Table 1. Prevalence of Psychiatric Disorders in a Sample* of Physically and Sexually Abused Children

Diagnoses	ABUSE GROUPS						
		Sexual (N=127)		Physical (N=43)		Both (N=34)	
	Total %	Boys %	Girls %	Boys %	Girls %	Boys %	Girls %
ADHD	29	40	22	36	10	67	26
Oppositional Defiant Disorder	36	46	22	56	20	64	47
Conduct Disorder	21	44	11	21	10	67	21
Major Depression	13	12	11	12	20	8	32
Bipolar Disorders	9	4	9	9	20	0	21
Dysthymia	19	16	13	24	20	17	42
Separation Anxiety/Overanxious	59	44	58	48	100	59	79
Phobic	36	44	36	24	30	25	58
Obsessive-Compulsive	14	0	14	18	20	8	27
Avoidant	10	12	7	18	30	8	0
PTSD	34	20	35	18	50	58	53

*62% of subjects were outpatients, 25% inpatients, and 13% were referred by local agencies.

Reprinted from *Child Abuse and Neglect, 22*(8), Ackerman, P. T., Newton, J. E., McPherson, W. B., Jones, J. G., & Dykman, R. A, Prevalence of post traumatic stress disorder and other psychiatric diagnoses in three groups of abused children (sexual, physical, and both), 759–774, Copyright (1998), with permission from Elsevier.

Many studies have documented negative long-term consequences of abuse and trauma, and have shown that trauma is cumulative. Although many CACs focus on the investigation of one allegation of abuse, it is critical when developing treatment interventions unique to each child that the full trauma history of the child be considered. CAC directors need to be familiar with research findings regarding child abuse and other forms of trauma. CACs have a responsibility to recommend and/or provide interventions that comprehensively address the child's needs beyond the immediate needs associated with the investigation of abuse. Incorporating this information into the services delivered to children and families will increase the efficacy of interventions provided or recommended by CACs.

Section 2: Child Traumatic Stress and the Investigative Process

When they participate in the investigative process, mental health professionals must have specialized training in the dynamics of child abuse. It is important to know how to question children to increase the likelihood of eliciting factual information. This section of the guide focuses on how children talk about abuse: why they often don't tell, when they do tell, and why they may delay their disclosure.

When mental health professionals begin working with child abuse victims, they may have some preconceived and often inaccurate notions about children's reactions to traumatic stress. They may expect children to act depressed, traumatized, and/or frightened, and to be hoping to be saved from the abuser and the trauma-related environment. Yet sometimes children apparently long to be with their abuser, appear to be extremely attached to the offender, or exhibit little or no emotion as they disclose abuse. Without an accurate understanding of how children recall traumatic events, mental health professionals may misinterpret children's behavior and statements, thus putting them at continued risk for traumatization. This section is intended to assist the CAC director and staff in creating an accurate and well-informed perception of how traumatized children describe the events that bring them to the CAC.

Mental health professionals who work with children immediately following a report of abuse are interacting with them at a critical moment. Understanding how trauma affects a child's overall behavior and recollection of the event enables mental health professionals to conduct a more accurate investigation and can assist investigators in providing the child with a framework for future healing. If investigators misinterpret the manifestation of trauma in the child's presentation as evidence of a false report, this can have devastating effects on the child's overall health and well-being. In addition, if a case is deemed unfounded based on this misinterpretation, it places the victims and other children at risk of potential future abuse by the offender.

Mental health professionals need to understand that a child's disclosure or non-disclosure does not occur in a vacuum. In the child's mind, the investigative process may be perceived as part of the continuum of traumatic events. Thus, the investigation itself, if not handled in a trauma-informed manner, can induce additional traumatic stress. The child's ability to disclose may also be influenced by the family, by the initial response regarding the abuse allegations, and by the offender and the child's community network. As outlined in the previous section, the child's developmental stage affects how the child copes with traumatic stress and subsequent disclosure. And because traumatic stress can impede the child's

development, this can also affect the disclosure process. Finally, feelings of fear, shame, responsibility, and embarrassment affect not only the child's response to traumatic stress but the entire investigative process.

How Trauma Affects Children's Ability to Recount Events

Overall, it is important for investigators to take into account the effects of traumatic stress on children and on their ability to recount the abusive event. The sexual abuse of children may occur over a long period of time, and may include any or all of the following: threats of harm, use of force, violations of trust, physical pain, or penetration. These factors make it less likely that the child will tell someone about the abuse (Arata, 1998). Children may not disclose the abuse because they are afraid of the offender or feel shame about the abuse. Many will be incapable of telling their story due to the effects of traumatic stress on their state of mind and conscious memory of the incident. Children who have experienced traumatic stress may have memory loss, be unable to disclose details of the abuse, or incorporate fantastic elements into their disclosure statements (Everson, 1997; Dalenberg, et al., 2002).

Memory loss

It is important for investigators to distinguish between children's resistance to questioning and the trauma-related behaviors that affect their ability to respond to inquiries. Inability to respond to questions or to give details of the trauma should not be misinterpreted as indicators of a false allegation.

Many studies have documented the phenomenon of memory loss (sometimes referred to as "event amnesia") in survivors of many types of trauma (Briere & Conte, 1993; Williams, 1994; Loftus, et al., 1994; Chu, et al., 1999). Recent research supports the existence of brain mechanisms that can account for this phenomenon. One recent paper in *Science* (Depue et al., 2007) identified a mechanism in which the brain's prefrontal regions orchestrate suppression of emotional memories via a two-phase process. Whether memories of traumatic events are "repressed," "dissociated," "suppressed," "compartmentalized," or "isolated" remains a matter of semantic debate. As discussed here, memory loss does not necessarily mean repressed memory or amnesia, but rather a child's inability to remember *at the moment of questioning* what may have occurred. Understanding this difference will help professionals to be sensitive to pacing when questioning children about traumatic events. It is critical to give children the time they need to respond as they are able to remember, and not to expect disclosure of all details at one time.

Several theories have been proposed to explain why children may experience memory loss when asked to recount abusive situations. One possible explanation, according to Freyd

(1996), is that because most children are abused by trusted and loved adults, the abuse and betrayal must be forgotten in order for the child to preserve essential attachments to the abuser. The child may not be able to recall the abuse until he/she gets older, or even enters adulthood, and is no longer emotionally tied to the offender.

Memory is sustained in the brain by a process of rethinking or rehearsing of events, often within the context of a relationship. Many child abuse victims do not have adults nearby with whom they can safely discuss what has happened to them. Without adults they can trust to help them process and understand traumatic events, children are less able to create a coherent account of the event within their sustained memory. On the other hand, victims of nonabusive trauma, such as those exposed to natural disasters or accidents, are more likely to discuss a traumatic event with a supportive adult. Such discussion can facilitate processing of the trauma and aid in creating a coherent account of the event (Epstein & Bottoms, 2002). However, disclosing abuse to an adult does not always help the child remember. Even adults with good intentions (but without trauma-specific training) may tell a child: "Forget about it" and/or "Don't tell anyone else."

The child's ability to remember traumatic abuse can also be affected if the offender warned the child not to tell or told the victim to forget what happened (Epstein & Bottoms, 2002).

Incomplete disclosure of details of abuse

Sometimes a child can clearly relate to investigators the events preceding and following an abusive event but is unable to give a full account of the abuse itself. Again, there may be several reasons for incomplete disclosure of the details of abuse. Sometimes during an abusive event, dissociation may occur. This is an unconscious defense mechanism by which a person's emotional or mental response separates from consciousness. This survival mechanism may occur during the first event or during subsequent events in a situation of chronic trauma. It is especially common in situations where child victims do not have control over their bodies.

Investigators may have observed children who suddenly stop talking during an interview in which they have been disclosing abuse. This can be due to the child's feelings of embarrassment or shame. Or, the child may be experiencing a flashback of the incident. When this occurs, the child may appear to look "spaced out" or "not present."

Some children may say they don't remember as a way of avoiding the issue of their abuse. This information is important to consider during the forensic interview of the child. By framing questions regarding what the child remembers at that moment (versus asking the child to tell everything that happened), over time the child may remember and be able to tell more of his/her abusive experience.

Fantastic statements

At the opposite extreme from nondisclosure are unbelievable or "fantastic statements." These may sometimes crop up during interviews with children about their abuse. Although there are certainly cases where false allegations are made and children do not tell the truth, a child's inability to recount the event or the making of fantastic statements could also be attributed to the trauma he/she has experienced. It has been shown that children aged 4-9 whose abuse was severe and violent are more likely to incorporate bizarre and impossible details into their abuse accounts (Davis & Bottoms, 2002) than are children whose abuse was less traumatic. Some children may incorporate details of what they wished could have happened, such as, "Then I jumped out the window and ran away."

Other dynamics affecting disclosure of abuse

Children who have been sexually abused may have complicated relationships with their abusers. A child may express a desire to be with the abuser, exhibit extreme attachment to the abuser, or display no emotion during disclosure. All of these behaviors can be symptoms of traumatic stress.

Children are dependent upon adults around them and often are not able to make sense of an abusive situation. Roland Summit (1983) described what he called the Child Sexual Abuse Accommodation Syndrome (CSAAS) as one way in which children cope with abuse:

> "The child 'accommodates' to the abuse to reduce both internal conflict and conflict with the offender, as well as to preserve a relationship with the non-offending caretaker. The child will therefore often return to the offender, regardless of the severity or duration of the abuse. In other words, the child accepts or submits to the abuse, then learns to live with it, because (s)he concludes that there is no other choice and no hope of escape."

Although this theory has not been proven in a scientific sense, it does describe a phenomenon in which children seem to accommodate to abusive situations because "that's the way life is."

There is no question that in some cases strong bonds form between abusers and their victims. A variety of psychodynamic theories have been advanced which explain that this is an adaptive response in which victims identify their survival with the well-being of the victimizer. There are various names for this process (e.g., Stockholm syndrome, traumatic attachment, anxious attachment, Lima syndrome, capture bonding, etc.), which has been best described in adults caught in prolonged hostage situations and in domestic violence (Dutton & Painter, 1983; James, 1994).

At times during the investigative interview, children may present with a flat affect or appear to be very matter-of-fact. When the child reveals little or no emotion, it can be difficult for those who interact with the child to believe that the incident occurred. If children have had to tell their story multiple times, they may become desensitized to the feelings when asked yet again to describe their abusive experience. If a child dissociated during the abusive events, the report of the experience may be delivered with the affect of an observer rather than with that of a traumatized person.

In the case of observed flat affect, investigators should seriously consider the possibility that the child is suffering from depression. This is more likely if children have been abused by someone they know or have experienced chronic traumatic stress. Lanktree et al., (1991) studied a sample of child and adolescent psychiatric outpatients with sexual abuse histories, and found that they were four times more likely to be suffering from major depression than were patients with no molestation history.

It can be difficult to separate signs of false abuse allegations from some trauma-related symptoms. If investigators are having difficultly with these determinations, it may prove helpful to consult with a mental health professional for guidance.

Crisis Intervention during the Investigative Process

When families are involved in allegations of child abuse, emotions run high and anxiety levels rise, regardless of whether the allegations are true or false. The allegation alone can cause stress in families. Parents and caregivers may fear the child will be removed from their home; that the child truly was a victim of abuse; or that they and the child will suffer social stigma attached to child abuse. They also may be worried about the potential financial, social, and personal losses associated with abuse allegations and resulting legal proceedings. These stressors on families should be anticipated in almost all child abuse investigations.

If abuse allegations are proven to be true, families will experience additional severe stressors during the investigation process. It is important to create safeguards for families should the stress escalate to crisis mode. Services may then need to focus on stabilizing the parent/caregiver and child.

If a crisis develops during the interviewing process, it may be necessary to interrupt the forensic interview so that an assessment can be made about whether to proceed. This is a critical step to prevent additional system-induced stress for the child. Such assessments should be made by a team consisting of the investigator, the interviewer, the child welfare worker, and any mental health professional involved with the child. The forensic interview should be terminated if the child 1) says he/she is unwilling to continue; 2) becomes too

emotionally upset to continue; or 3) expresses anything that is considered a real or perceived threat to his/her safety or well-being by the alleged perpetrator. When these crises occur, the child may need to be referred for mental health treatment. The interview process may then need to be completed over several sessions.

Children who are victims of child abuse and their families may suffer psychological crises resulting from traumatic stress. Family members may exhibit disorganized thinking and impulsiveness. They may become outwardly hostile, or distance themselves emotionally from others. Some families develop an extreme dependence on investigators during this process, while others are resistant and may appear to lack motivation to cooperate with the investigation.

It is important to recognize that the presence of these characteristics does not mean that the family is truly uncooperative. It may simply mean that they need additional time and/or assistance to cope with the crisis situation. Such psychological states may be temporary and do not necessarily indicate a mental illness, but they should be addressed, if possible, before the investigation proceeds.

However, if a child or parent/caregiver displays violent, suicidal, or homicidal behavior, then psychiatric assessment and even hospitalization may be needed to rule out significant mental health concerns and/or to help the client become emotionally stable.

The investigation may be impeded if the child or family is pressured to provide information or is treated in a punitive manner. If the investigation is thwarted due to these factors, the safety of the child takes precedence until the barriers have been identified and resolved, at which time the investigation can be completed.

Section 3: Trauma Assessment within the CAC

The CAC director should be a resource and guide to staff members and community providers in establishing the use of appropriate assessment protocols. Assessment of the child's current condition—including the type of trauma experienced, the impact of the trauma on the child, and the internal and external resources available to the child—is necessary to identify the mental health treatment needs of the child and family.

A first step in establishing assessment protocols may be to create an expectation within the CAC community that an initial trauma assessment is a part of mental health best practices. Most treatment providers conduct some basic form of assessment when a child comes to treatment. This usually includes gathering demographic information, asking why the child and family are seeking help at the current time, and assessing the current problems and/or symptoms the child and his/her family are experiencing.

In addition to these basic components, mental health professionals conducting trauma-specific assessments gather a thorough trauma history. In this type of assessment, the professionals attempt to identify all forms of traumatic events experienced or witnessed by the child (i.e., each child abuse incident, any automobile accidents, exposure to family or community violence, painful medical procedures, or other types of traumatic experiences). Using trauma-specific, standardized clinical measures to identify the types and severity of symptoms the child is experiencing helps to obtain a more thorough and focused history, to devise an appropriate treatment plan, and to track progress over time.

Comprehensive trauma assessments conducted by mental health professionals use standardized measures that are shown to be reliable (consistent over time) and valid (measure what they are supposed to be measuring). They include some measures that are specific to trauma, such as assessing for PTSD symptoms and other common trauma reactions (e.g., dissociation and sexual reactivity). Some common trauma-specific measures include:

- The UCLA PTSD Reaction Index for DSM-IV (parent, child, and adolescent versions) (Steinberg, et al., 2004)
- The Child PTSD Symptom Scale (CPSS) (Foa, et al., 2001)
- Trauma Symptom Checklist for Children: Professional Manual (Briere, 1996)
- Trauma Symptom Checklist for Young Children: Professional Manual (Briere, 2005)
- Child Sexual Behavior Inventory: Professional Manual (Friedrich, 1997)

Comprehensive trauma assessments also focus on general symptoms such as depression, anger, and anxiety, which are often seen in traumatized children. In addition, strong programs gather information about how well the family is functioning and about the child's developmental level so that treatment can be developmentally and systemically appropriate. Because caregivers and children often do not agree on the problems that the child and family are experiencing, it is wise to ask additional informants (e.g., teachers, clergy, reliable community members), to provide information. Finally, best practice assessment programs, such as the Trauma Assessment Pathway model (see Appendix E and *www.chadwickcenter.org*) link the information gathered during the assessment process to the treatments selected for each individual child.

Using information from the trauma assessment, therapists can develop treatment goals with measurable objectives designed to reduce the negative effects of trauma and reduce risk. They can then evaluate these objectives at regularly established intervals. Within the CAC setting, trauma assessments also can provide valuable program outcomes information for use by both center directors and individual clinicians working with children (Gothard et al., 2000).

Sharing the results of standardized measures with caregivers and children offers family members an opportunity to become more actively involved in treatment planning and to take responsibility for the child's participation and progress in treatment.

Standardized assessment measures can also provide demographic data, which can help identify trends in the types of clients served within the CAC. The CAC director can use this data to focus on hiring staff and providing training that can best meet the needs of the center's unique client population. Agency directors can view these data in aggregate form to make decisions about where to focus efforts to improve services. For example, if clients' depression scores decrease over time, but their PTSD symptoms remain elevated, the center can allocate more resources to target PTSD symptoms. Those who fund components of the CAC may also welcome the use of standardized assessment measures that can demonstrate that children are making progress in recovering from the trauma.

Assessments help the mental health clinician gain a comprehensive understanding of the child as an individual with a unique history, family system, and levels of developmental, cognitive, and emotional functioning. A unique client picture of the child is developed. Children who can benefit from specific evidence-based treatments can then be triaged to the most appropriate intervention. When an evidence-based treatment approach does not exist for a certain cluster of symptoms or a more complex presenting problem, appropriate interventions can still be selected and utilized for the child.

Section 4: Parent/Caregiver Engagement in the CAC

Children experience their world in the context of family relationships. Parents, kin, and other caregivers are the full-time and long-term supports for their children, and they will typically be involved in the child's life longer than will the mental health professional or the abuse investigators. In many cases, the family system is experiencing traumatic stress along with the child. How parents and other family members react to and cope with the traumatic event influences the child's coping. Promoting resilience and improving coping skills among family members helps them deal with traumatic events and prepares them for future challenges. Finally, family members are critical participants in service planning and delivery within the CAC and beyond.

When the atmosphere in the CAC is welcoming and supportive, families will most likely view the CAC in a positive light. The director of the CAC plays an important role in setting the tone for the ways in which staff members engage families in services. Families tend to see the CAC as a valuable resource when staff help them understand the systems involved in their lives and the traumatic stress experienced by their children. When staff members provide support to the nonoffending caregiver and convey hope that the trauma can be healed, families are more likely to remain involved with the CAC (Massat & Lundy, 1999).

Child Protective Service investigation of child sexual abuse may add to an already distressing situation by creating an adversarial relationship between the family and the community system. This relationship, coupled with the crisis the family is experiencing, can result in negative outcomes for the child, the family, and the investigation. Conducting interviews in a neutral, fact-finding manner in a child-friendly setting can help redefine these relationships. When approached from a supportive rather than an adversarial position, the investigation can enable the mental health professionals to join with the nonoffending caregiver in a partnership for the protection of the child.

When interacting with a caregiver, mental health professionals should model the behaviors they would like the caregiver to exhibit toward the child. One of the primary purposes of such interventions is to empower the caregiver to become a protective resource for the child. The aim is to help the nonoffending caregiver make the shift from passive caregiver to an active, protective caregiver. To enable this shift, mental health professionals must be supportive. They must clearly communicate and model their expectations for the caregiver's becoming a protective resource for the child. This positive and supportive approach to the caregiver is preferred to the shaming and blaming that some mental health professionals in the past have conveyed to the nonoffending caregiver during the investigation of abuse. This approach

is also consistent with the CAC mandate to reduce secondary trauma resulting from the investigation (Ralston & Sosnowski, 2004).

During the assessment period, mental health professionals should strive to engage the caregiver in the investigative process. They can accomplish this by defining the caregiver as the expert about the child and themselves as the experts about abuse. Their common goal is to join in a partnership for the protection of the child. By setting this tone, and engaging caregivers, mental health professionals can help prepare the caregiver for the required protective role. In addition, the caregiver will be a valuable source of information about the family's and child's histories across multiple domains (e.g., medical, mental health, abuse, trauma, substance abuse, employment, education, and legal histories).

The assessment process also includes eliciting information regarding how the family functions: its rules, methods of discipline, and interpersonal boundaries. It will be helpful for the interviewer to ascertain from the caregiver the child's previous exposure to sexual information and material, names that the family has given for sexual parts, and the initial indicator of abuse. Also important: eliciting information about the caregiver's response to the initial indicator of abuse, the child's perception of the caregiver's concern, what the child was told about the interview, and the caregiver's desired outcome. This history-gathering process provides foundational information to help understand the child's behavioral and verbal responses during the forensic interview; and it allows the interviewer to assess the caregiver's willingness and ability to be a protective resource for the child (Ralston & Sosnowski, 2004).

The caregiver can also be invited to play a positive role in the forensic interview by being the one to give the child permission to talk to the interviewer. With young children the caregiver also assures the child that the caregiver will be waiting for him/her following the interview.

After the child is interviewed, the caregiver (without the child present) is given feedback. Forensic interviewers are often trained mental health professionals and bring specialized training to this critical portion of the forensic interview. The interviewer shares his/her professional opinion regarding risk to the child and reports any alleged offenders as identified by the child. The forensic interviewer and/or the mental health professional then help the caregiver manage the feedback so he/she will be better able to help the child cope with what has happened.

Many CACs have separate units of mental health professionals that provide ongoing therapy. These professionals can be called upon to assist the forensic interviewer in supporting and educating the parent/caregiver. If ongoing therapy services are to be provided to the child

and family, it may be appropriate at this juncture to begin the transition from the forensic program into the mental health program.

All of these approaches are designed to identify barriers to the caregiver's ability and willingness to be a protective resource for the child, and to develop interventions designed to reduce or remove those barriers (Ralston & Sosnowski, 2004). Barriers associated with the parent/caregiver's own abilities to be protective (such as limited cognitive abilities, mental health issues, medical conditions, abuse history, or substance abuse) must be identified; and interventions to address and overcome these barriers provided. External barriers to provision of protection may include lack of financial resources, lack of a support system, lack of transportation, and a history of domestic violence. Finally, any child characteristics that may be barriers to the caregiver's ability or willingness to be a protective resource must be identified. Some of these barriers might include the caregiver's inability to manage the behavioral consequences of the child's abuse, the child's mental health or medical problems, and sexual reactivity of the child.

Although symptom reduction is the target of treatment, it is common for children to experience elevations in certain symptoms as they work through other issues related to the trauma. For instance, as a sexually abused child works through a narrative and processes feelings related to the trauma, he/she might demonstrate more sexual reactivity, a common outcome of sexual abuse. The CAC needs to provide interventions to address this behavior, which, if left untreated, may result in a child's sexually acting out with others. Treatment of sexual reactivity is an intervention that can reduce risk to the child victim and to other children in his/her environment. The mental health member of the multidisciplinary team (MDT) often has the skills necessary to identify these and other needs and to advocate within the team for the interventions and resources necessary to meet them (Ralston et al., 2005).

The child abuse literature suggests that the child's ability to recount the events, to testify in court, and to recover from the abuse are enhanced by the involvement of a supportive and protective nonoffending caregiver. When child protection and law enforcement responses are experienced as adversarial and/or ambivalent, the caregiver may become confused or angry. The literature also clearly shows that the nonoffending caregiver's response to child sexual abuse is critical to the psychological outcome for the child victim (Conte & Schuerman, 1987; Deblinger et al., 1999). CACs have an opportunity to maximize positive outcomes for traumatized children by being supportive to the nonoffending caregiver. They can also offer education about the challenging behaviors that children who have experienced trauma may exhibit.

Section 5: Trauma-Informed, Evidence-Supported Treatments

After the CAC has trained staff on trauma and appropriate assessment protocols, the next step is to determine how to select and integrate the most efficacious mental health treatment available to traumatized children and their families. This can be accomplished by incorporating additional trauma-informed treatments into the CAC's services or by partnering to secure treatment through referrals to other community agencies. A Trauma Assessment Pathway model, developed by the Chadwick Center at Rady Children's Hospital-San Diego, integrates three components: assessment, triage, and selection of the most appropriate intervention model (*www.chadwickcenter.org*, see Appendix E).

CAC directors play a key role in setting the expectation that treatment interventions should be selected based on the specific needs and unique clinical picture of the children who access services at the CAC. The director should repeatedly check in with the staff by asking, "Why was that intervention selected and used?" and "How do you know the intervention you selected is working for your client?"

The field of evidence-based practice is growing. CAC staff should strive to use the most efficacious treatment available to promote a child's healing. Adopting research-supported practices requires a large investment of staff time for training, supervision, and ongoing monitoring for model fidelity. Therefore, centers will understandably move toward implementing evidence-based practices one step at a time.

As Saunders (2004) noted, empirical evidence has not traditionally been a criterion for treatment selection in the field of child traumatic stress. Many interventions in common use today have never been empirically studied. The field has also suffered from limited funding for conducting solid empirical research that would identify the best trauma treatments for particular populations.

Although there are some successful treatment models that have proved through repeated studies to be efficacious, dissemination of research and models has not been widespread. The result is that few mental health professionals in the real world of service delivery, including those employed at CACs, know about evidence-based treatments or are trained in their use. Thus, there is a disconnect between current scientific knowledge and real-world practice.

The CAC director should be a bridge between the scientific knowledge and the use of best practices by developing an agency culture in which staff members understand the value of implementing best mental health practices for CAC clients. For CACs that serve as brokers

for mental health services, knowledge of evidence-supported practices will allow them to evaluate the quality of services available in their community and to support the development of such services where they do not exist.

Characteristics of Treatments with Empirical Support

The current research on treatment models for child traumatic stress suggests several common elements found in evidence-based practices that will likely result in effective trauma treatment. CAC staff should be able to identify these common elements in any proposed treatment plan—whether they are providing trauma treatment themselves or referring clients for treatment. In an evidence-based practice:

- Both the child and the parent/caregiver are involved in the treatment process
- The mental health professional is active and directive
- The theoretical base tends to be behavioral or cognitive-behavioral
- Practitioners use a structured approach, with specific procedures, that does not allow for much free-styling
- The treatments are goal directed. They target specific problems and encourage a more focused approach with less distraction by the "crisis of the week"
- Procedures are matched to specific problems and focus on aiding the client to replace maladaptive skills with adaptive ones
- The protocol can be recreated or taught

Some of the treatment modalities that have strong research support include Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) (Cohen et al., 2006) to treat sexually abused children (see Appendix A) and Abuse-Focused Cognitive-Behavioral Therapy (AF-CBT) (Kolko & Swenson, 2002) to treat physical abuse (see Appendix B).

CACs also would be well advised to include Parent-Child Interaction Therapy (PCIT) in their therapeutic menu (see Appendix C). PCIT was developed for families with young children experiencing behavioral and emotional problems. PCIT is a parent/caregiver-mediated service shown to be effective with physically abusive parents/caregivers in cases where the abuse is related to efforts to discipline the child (Chaffin, 2004).

Additional Resources

Many resources exist to help CACs and their mental health partners identify efficacious and evidence-supported practices. Some of these resources include:

- *Child Physical and Sexual Abuse: Guidelines for Treatment* (Saunders et al., 2004), available through the Medical University of South Carolina (*http://academicdepartments.musc.edu/ncvc/resources_prof/reports_prof.htm*)
- California Evidence-Based Clearinghouse for Child Welfare *(www.cachildwelfareclearinghouse.org)*
- The Center for the Study and Prevention of Violence at the University of Colorado at Boulder makes available the Blueprints project online (*www.colorado.edu/cspv/blueprints*)
- *Closing the Quality Chasm in Child Abuse Treatment: Identifying and Disseminating Best Practices—The Findings of the Kauffman Best Practices Project to Help Children Heal From Child Abuse,* available from the Chadwick Center (*http://www.chadwickcenter.org/Documents/Kaufman%20Report/ChildHosp-NCTAbrochure.pdf*)
- Substance Abuse and Mental Health Services Administration's National Registry of Effective Programs and Practices (NREPP) (*http://nrepp.samhsa.gov/*)
- Additional resources are also available through the NCTSN Web site (*www.nctsn.org*)

Practitioners should seek out opportunities to acquire training on evidence-based practices. Treatment developers frequently offer training in these interventions at national meetings and conferences or may contract with organizations to provide training. The NCTSN and the American Professional Society on the Abuse of Children (*http://www.APSAC.org*) are good information sources for training opportunities.

Section 6: Implications of Mental Health Treatment for the Juvenile and Criminal Justice Systems

Traumatized children and their families are often involved with multiple service systems, including law enforcement, child welfare, the courts, schools, primary care, and mental health. When different systems have different and potentially competing priorities, there is a risk that children and their families will receive mixed or confusing messages—or simply fall through the cracks.

The challenge faced by each type of court (whether juvenile, civil, family, or criminal) is to collaborate with mental health professionals in a manner that minimizes retraumatizing the child or family. At the same time, the court must meet its obligations to remain objective and unbiased. Aside from the clinical benefits associated with traditional psychotherapy, mental health treatment/involvement has direct implications for child and family participation in the legal system.

The CAC MDT presents a venue for greater integration of mental health recommendations and treatment with existing practices of medical providers, forensic interviewers, law enforcement officers, child protective service social workers, and district attorneys. By incorporating into the MDT a clinician with a specific focus on intervention in the wake of abuse and neglect, a CAC may become more effective in facilitating engagement in treatment and in ensuring quality of care that is built on evidence-based models.

A written MDT report can feature recommendations that address child safety, permanency, and well-being in a discrete, clear, and concise manner. Such a report may be available to district attorneys, judges, court-appointed child advocates, and other legal team members based on local protocol prior to a child's court appearance.

A mental health professional on an MDT may serve a number of different roles. Role clarity is essential to avoid inappropriate disclosure of information and confusion of forensic and treatment functions that can compromise the investigation and compound clients' mistrust in the systems and professionals involved in their lives. The mental health professional operating as part of a CAC team must be clear about his/her role in the CAC. Self-monitoring for the blurring of boundaries between the role of forensic interviewer and treatment provider must be a priority for the mental health professional. Whenever possible, the forensic interviewer should not be the treating mental health professional for a child he/she interviewed. Conversely, a mental health professional who has treated a child or who has a therapeutic relationship with a child should not conduct a forensic interview with that child.

The primary purpose of the communication between an MDT mental health professional and the court should be clearly understood in every situation. A policy should be developed within the CAC to determine how the mental health professional shares recommendations with the client and to whom information can be released. Local statutes regarding privilege need to be included in any policy developed regarding the release of mental health information to the court, CPS, and/or attorneys. The policy should clarify whether the child client and/or his/her parent(s) will have access to this report through any of the professionals who receive it. Assuming this report is prepared and presented by a qualified licensed professional or expert, the judge may order that the recommendations be followed. He or she may also require a return to court within a designated time period to monitor and ensure that progress has been made. Examples of report contents sometimes furnished to the court might include: recommended interventions to reduce the risk to the child and to foster permanency for the child; explanations of the long-term effects of maltreatment; and recommendations for specific evidence-based interventions.

Court Preparation

According to the US Department of Justice (Office for Victims of Crime, 1999), the adult-oriented court system can create additional stress for traumatized children. Court proceedings often appear confusing and frightening to children. They may be required to face the alleged perpetrator in a public setting, which may be the first time they have seen the accused since their abuse. Aggressive cross-examination and isolation from supportive adults during the period of testifying may heighten children's anxiety and reticence. The court system often requires multiple appearances or episodes of testimony but may fail to engage children in a developmentally appropriate manner. As with forensic interviewing, it may be advisable to reduce the number of testimonial appearances while increasing preparation, support, and developmentally appropriate inquiry for children. In this way, MDTs may help promote child well-being and functioning.

The American Bar Association (1996) cites that for some children court appearances can be traumatic. For others, giving testimony can be therapeutic, enabling them to forge a more active and empowered position in the face of prior victimization. Children's attorneys and their court-appointed advocates are encouraged to consult with children's mental health providers in making decisions about the involvement of their young clients in the court process.

Although the majority of children evaluated through CACs are unlikely to testify in court, mental health providers may play a key role in the preparation of those who do participate formally in the court process. Court preparation or "court school" models address both children's cognitive competence as well as their psychological readiness for a court appearance.

Mental health practitioners, through direct intervention with children and families and consultation with their legal colleagues, play an important role in ensuring that efforts to prepare children are carried out in a developmentally sensitive and appropriate way. One aspect of cognitive preparation involves helping the child understand the difference between telling the truth and lying. The ability to relate one's experiences in a factual manner represents a developmental achievement, yet even preschool children can understand distinctions between truths and lies, and can follow a moral imperative to tell the truth. However, younger children are also more susceptible to outside influences and to altering their responses due to personal concerns, such as feelings of guilt or fear of punishment (Talwar et al., 2002).

In court school models, children meet with court officials and learn about the legal process through developmentally appropriate activities including role-playing, art projects, and related activities (Office for Victims of Crime, 1999; Office of the General Counsel, Administrative Office of the Courts, 1999). Relaxation techniques and cognitive coping strategies are taught to help children avoid common courtroom experiences of confusion, crying, and distress. Parents and caregivers participate in concurrent sessions to address their concerns and questions, and to get assistance with supporting their children during the legal process. Both parent/caregiver and child components are designed to foster a less stressful courtroom experience that mitigates secondary trauma and improves the quality of testimony.

In a community, a court school program may be best located in a neutral and objective agency dedicated to both child protection and advocacy. The CAC appears to be an ideal agency to offer such services. In collaboration with other community partners, the CAC director may determine that a court school or court advocacy program would be a valuable additional component for the center. The CAC director can seek buy-in from all community partners in developing and implementing a court school program. As in the area of mental health services, there must be oversight of the program to ensure that the most current methods for dealing with children's memory, ability to offer testimony, and safety are researched and integrated into the court school program.

Court school programs (where state law and court decisions allow) may be augmented by alternatives to live testimony. These alternatives may include videotaped and remote location testimony, and victim impact statements completed by the child. Children have a basic right to meaningful participation in court hearings that affect them. With this underlying principle, the CAC and the MDT can develop an approach to court preparation that combines necessary knowledge about court systems and their operation with clinical interventions to reduce a child's stress, improve effective coping, and enhance comprehension. Preparatory efforts that combine these elements will be more effective in fulfilling the legal standard for children's participation (American Bar Association Center of Children and the Law, 1996).

The Kids and Teens in Court Program (Chadwick Center for Children and Families, 2006), offered in San Diego County for the past 18 years, is beginning to incorporate many of the components of TF-CBT into the process of preparing children to testify in court. The use of this evidence-based practice in court preparation provides children with skills that enhance their ability to understand the interplay of their feelings, thoughts, and behaviors; to regulate their emotions; and to increase their ability to keep themselves safe. As part of the therapeutic process, these skills can be transferred to other areas of the children's lives.

Psychotherapy and Court Proceedings

Because court proceedings may extend over months, and sometimes years, a mental health professional may become an integral part of CAC follow-up. Mental health professionals can help promote the child's safety, permanency, and well-being by alleviating symptoms, helping to improve psychosocial functioning, and working to prepare the child for periods of heightened distress in response to court activity. Treatment may bolster the child's capacity to participate meaningfully in the legal process and may make a profound contribution to the future well-being and development of victimized children.

In addition to direct interventions to ameliorate such symptoms as depression and PTSD, quality mental health care provides an opportunity for children to master effective techniques for coping with anticipatory anxiety related to legal proceedings and to address unwarranted feelings of guilt or responsibility for their abuse. Particularly for abused children contending with PTSD symptoms, treatment may involve the development of a "trauma narrative" (Deblinger & Runyon, 2005). The narrative allows them to recall and consider their experiences over time in a manner that is less overwhelming.

Some attorneys advise against children's participating in therapy prior to a court appearance, concerned that therapy may result in a child's testimony appearing too polished or rehearsed. Research indicates, however, that therapy is beneficial because it helps children learn effective coping strategies that tend to reduce anxiety and distress and improve their ability to participate in the legal process (Cohen, et al., 2006). Prosecuting attorneys may need to be given information on the functions of therapy to help dissuade them from dispensing inappropriate advice to families.

As cases extend for months and years, the legal system bears witness to despair, victimization, and family dysfunction—none of which it can effectively address. Since implementation of The Adoption and Safe Families Act in 1997, courts face an increased responsibility to ensure safety, permanency, and well-being for children in the child welfare system. The courts are unlikely to meet this mandate unless they develop close collaboration with mental health and prevention systems and providers (Lederman & Osofsky, 2004).

Mental health providers may assist courts in developing recommendations for treatment and best practice models that draw upon available evidence for the effectiveness of particular interventions to help further the courts' efforts to act in the "best interests of the child" (Goldstein et al., 1996). Clinicians may also serve as consultants to courts, providing an important developmental perspective on child trauma, maltreatment, and their potential manifestations in the legal context including recommendations regarding treatment, placement, permanency, and competence to provide testimony (Office for Victims of Crime, 1999; Osofsky et al., 2002; Cohen & Youcha, 2004). Faced with decisions about custody, placement, parental rights, and culpability for abuse, courts are increasingly challenged to act "in the best interest of the child" while facing choices that may represent only a "least detrimental alternative."

Given the potential benefits to the child and family, as well as to the legal process, mental health treatment for child victims of abuse should be introduced as early as possible. Accurate and timely evaluation of the child sets the stage for recovery. Treatment that utilizes evidence-based interventions allows children a more complete return to the appropriate developmental tasks consistent with their age.

Section 7: Mental Health Treatment, the CAC Team, and Issues of Confidentiality

The National Children's Alliance (NCA) standard for CACs requires that mental health services be made available as part of the MDT response. However, the relationship between the mental health providers and the other members of the MDT varies from center to center. Some CACs have an in-house mental health program, while others refer children and families to mental health providers in the community. Whatever the arrangement for providing mental health services, these mental health professionals can make important contributions to the team.

The following are examples of ways in which mental health professionals deliver services to CAC clients:

- In some cases, mental health professionals provide the treatment only, and do not interact with the MDT beyond taking the referral. Thus, the mental health professional does not release case-specific information to the team unless there is something that is reportable by law, a signed release of information, or a valid subpoena from a court overseeing the case.
- Mental health professionals may attend case reviews for the specific cases with which they are involved to hear the status of the investigation and to share information on safety concerns, the family's status, and perhaps the child's state of mind and ability to testify.
- Mental health professionals may also serve as consultants, attending case reviews without specific knowledge of or relationships with the children who are being discussed, but helping to identify particular mental health concerns relevant to the cases under discussion.

Client Confidentiality and Sharing of Information

Once an investigation is complete, law enforcement and CPS staff may have limited (or no) contact with the family. Mental health professionals, however, may work with the family for months after the investigation is complete, and typically will form strong, trusting relationships with families. The mental health professional is in a unique position to recognize the strengths of—and potential risks for—a family, and to learn what the family's greatest concerns are related to the investigation and its outcome. Thus, the sharing of information between the mental health provider and the team can be beneficial both to the family and to the team's effort to conduct a thorough investigation and successfully resolve the case.

Confidentiality laws, including Health Insurance Portability and Protection Act (HIPPA) regulations, also extend to clients' mental health records. Mental health professionals are legally and ethically bound to adhere to these laws. Mental health professionals providing treatment as a component of a CAC's multidisciplinary approach should inform a family at the beginning of treatment about the team relationships in the CAC.

Confidentiality should also be discussed as treatment begins and proceeds. For example, if the mental health professional is a participant in a weekly case review in which the status and progress of cases are discussed, he or she should explain to the family the purpose of the case review meeting. Therapy records should include documentation signed by clients indicating that they understand the protection of their private health information. A mental health professional affiliated with a CAC can ask clients referred by MDTs to sign authorizations to release information to the law enforcement and/or child protective services staff working with the family.

During the consent process, the mental health professional should discuss with the family the potential benefits of authorizing the release of information, and make clear that they also have the right to decline to sign the authorization. Any authorization form used within the CAC should comply with all local laws and professional standards as well as CAC policies and procedures. (See Sample Release/Authorization in Appendix G.) Authorization forms should specify what kind of information would be shared, to whom the information would be provided, the purpose in sharing the information, and the date or condition under which such authorization may expire.

The CAC director who understands the legal and ethical obligations of maintaining client confidentiality, and the conditions under which information can be released to benefit the child, is a valuable resource to the staff and the MDT. With this knowledge the director can:

- Help protect the CAC from client complaints regarding release of protected health care information, and from legal problems
- Provide guidance on ethical issues such as violations of professional boundaries and blurring of roles
- Develop agency policies and procedures, thus helping the staff to act with confidence in treating child victims

The CAC director would be wise to maintain regular contact with mental health professional organizations in order to remain current on changes in laws and professional standards that will have an impact on client care. Access to legal consultation is also recommended.

Subpoenas and Court Orders

Mental health professionals should be informed about the possibility of being served with a subpoena or court order to provide information about the nature of the treatment and the sequelae of traumatic stress following the child's abuse. They should share this potentiality with their clients. Mental health professionals should be aware of how information can be released upon receipt of a subpoena. A court order may be necessary in order to release specific types of mental health information. CAC directors need to ensure the existence of—and compliance with—policies and procedures regarding the release and sharing of information with related agencies in the community system.

The mental health professional should also communicate clearly to families which types of information must be shared without the client's consent such as suspected child abuse, adult and domestic abuse, and suicidal or homicidal threats. Certain safety issues found in some families dealing with sexual abuse fall in this category including re-abuse and contact with the alleged perpetrator when such contact has been disallowed by CPS.

Section 8: Securing Quality Trauma-Informed Mental Health Services for CAC Clients

The CAC director confronts a formidable task in determining how best to secure quality, trauma-informed mental health services for CAC clients. The CAC director may be responsible for evaluating and upgrading existing services within the CAC, or developing new mental health services. If the director oversees a CAC that does not have mental health services, he or she must become familiar with community providers to whom mental health referrals may be made. In the latter case, the CAC director may be in a position to influence the practices of community mental health professionals, and foster movement toward delivery of more research-based, trauma-informed mental health care. Whether supervising the CAC's delivery of such care or care delivered by community providers, the director must possess knowledge about trauma-informed, evidence-based interventions that will allow him/her to evaluate the quality of mental health services both within the CAC and in the community that serves CAC clients.

Obtaining Trauma-Informed Therapy for CAC Clients

Not all children who have been abused need a trauma-specific intervention. Some children have amazing natural resilience, and are able to make sense of and come to terms with traumatic events with the help of their natural support systems such as parents, other caregivers, and teachers. Other children who have experienced traumatic events will clearly benefit from trauma-specific interventions.

Many mental health professionals and agencies that provide mental health services to traumatized children lack the awareness, training, and experience necessary to deliver these research-proven interventions. To develop a successful internal or external mental health component in a CAC, the director needs to ensure that all individuals/agencies providing treatment to CAC clients support the use of evidence-based models and are incorporating them into their practice.

Although no one treatment intervention is appropriate for all children who have been abused, there are evidence-supported interventions that are appropriate for many children. These interventions share many common elements. By familiarizing themselves with these common elements, CAC directors (with or without mental health training and experience) can take the following steps to ensure that their clients receive trauma-informed treatment, whether in the CAC or in the community:

- Ensure that all individuals and/or agencies providing therapy for CAC clients conduct a comprehensive trauma assessment (as described in Sections 3 and 5)

- Determine the clinician's or agency's familiarity with evidence-based treatment models (see Section 5)
- Ask clinicians what specific training they have had in an evidence-based model (when, where, by whom, how much)
- Determine what ongoing clinical supervision and consultation an individual/agency provides to its staff including how model fidelity is monitored
- Determine which approach(es) the clinician/agency uses with children and families, and if the model to be used has any empirical support in the peer-reviewed mental health literature
- Determine how parent support, conjoint therapy, parent training, and/or psychoeducation are offered (see Section 4)
- Determine which techniques are used for assisting with:
  - Building a strong therapeutic relationship
  - Affect expression and regulation skills
  - Anxiety management
  - Relaxation skills
  - Cognitive processing/reframing
  - Construction of a coherent trauma narrative
  - Strategic exposure to traumatic memories and feelings in tolerable doses, so that they can be mastered and integrated into the child's experience
  - Personal safety/empowerment activities
  - Resiliency and closure
- Determine adherence to cultural competency and special needs issues
- Determine the mental health professionals' willingness to participate in the MDT meetings and in the court process, as appropriate

Monitoring and Evaluating Mental Health Services

The CAC director should continually monitor and evaluate the appropriateness and quality of mental health services delivered to CAC clients. In recent years, some funding agencies and professional organizations have recommended or mandated that the effectiveness of services be evaluated as a prerequisite for ongoing monetary support.

A variety of methods can be used to evaluate treatment. If none is in place at the CAC, the director can research other CACs or mental health facilities to find reliable and valid methods/instruments. Partnering with researchers in local academic institutions can facilitate this process. (Also see Section 3, which outlines the use of standardized measures that can provide management with measures of progress and clinical outcomes.)

Section 9: Influence of Culture on Responses to Traumatic Events

Culture is defined as a set of beliefs, attitudes, values, and standards of behavior passed from one generation to the next; this can include different notions about wellness, healing techniques, and childrearing patterns (Abney, 1996). Cultural identity and cultural references can be influential in shaping the ways in which children and their families identify the threat posed by traumatic events, interpret them, and manifest distress.

Attitudes toward child sexual abuse can be affected by beliefs about who are victims or perpetrators, the prevalence of sexual abuse, and the impact of sexual abuse on victims. Some cultural values (e.g., conservative beliefs about sex) can contribute to feelings of shame experienced by child sexual abuse victims, which has been tied to negative outcomes (Feiring et al., 2002).

Evidence suggests that mental health outcomes related to child sexual abuse vary with ethnicity. For example, Morrow and Sorrell (1989) found that Hispanic and African American children who were sexually abused displayed significantly more behavioral problems, depressive symptoms, and self-esteem difficulties than did Caucasian children. In addition, Hispanic female sexual abuse victims have been found to experience more depression (Mennen, 1995; Sanders-Phillips et al., 1995) and more anxiety (Mennen, 1995) than do African American or Caucasian non-Hispanic female victims. Other studies have found some evidence of cultural variations of symptom patterns among victims of trauma (Hough et al., 1996). For example, somatic symptoms (e.g., headaches, gastrointestinal distress, nondescript aches and pains), are reported more frequently in Hispanic populations (Canino et al., 1992) than in other ethnic minority groups.

A number of guidelines have been proposed for culturally competent assessment and treatment of ethnic minority populations. These guidelines (Rossello & Bernal, 1996; American Psychological Association, 2002; Lopez et al., 2002) emphasize the importance of adapting the approach to treatment with the families by considering their cultural context (Santiago-Rivera et al., 2002; Vera et al., 2003).

All of the following should be considered during clinical assessment of a family: their preferred language, cultural beliefs, current community, social support system, socioeconomic status, preconceived notions about mental health treatment, and history (e.g., sociopolitical history of country of origin).

For example, possible issues to assess when serving recent immigrant Hispanic families from rural areas in Mexico or other areas of Latin America include immigration history, spirituality, beliefs about sex (e.g., the importance of virginity), and health (e.g., reliance on folk healing). Any cultural group has beliefs and practices in common; however, it is essential to not make assumptions regarding a child or family's beliefs. The degree to which families adhere to beliefs and practices, and the ways in which those beliefs and practices may affect the trauma-exposed child and family, should be assessed (de Arellano & Danielson, 2006).

Although the need for trauma services spans all cultures and ethnicities, the availability, accessibility, utilization, and appropriateness are not consistent across cultures. In a 2001 RAND study, researchers found that "on average, only one-fourth of children in need of mental health care get the help they need" (Ringel & Sturm, 2001). In *Mental Health: Culture, Race, and Ethnicity* (US Department of Health and Human Services, 2001), it was reported that minorities in treatment often receive a poorer quality of mental health care and are underrepresented in mental health research.

Ensuring appropriate services for racial and ethnic minorities requires an understanding of the disparities in knowledge about, access to, utilization of, and quality of mental health care available. It also requires willingness to continue to expand research, improve access to treatment, reduce barriers, and improve the quality of services provided.

The cultural background of CAC staff members can also influence their perceptions of child traumatic stress and how to intervene. Therefore, assessment of a child's trauma history should always take into account the cultural background and modes of communication of both the assessor and the child. Staff members should also be aware that even speaking about child maltreatment or sexual issues is taboo in some cultures.

The CAC should also support CAC-affiliated mental health professionals in developing their ability to deliver treatment appropriate to age, developmental and physical disabilities, gender, race, ethnicity, and culture (Office of the Surgeon General, 1999).

For additional guidelines for incorporating cultural beliefs and practices into a trauma assessment, please refer to de Arellano & Danielson (2008). Guidelines for cultural competency in CACs have also been developed in support of the NCA Cultural Competency Accreditation standard (*www.nca-online.org/pages/page.asp?page_id=4032*).

Section 10: Supervising a Mental Health Component When You Are Not a Mental Health Practitioner

When supervising a mental health component, the CAC director needs to address two areas: administrative and clinical. While there is significant crossover between them, each requires separate program development. Administrative supervision comprises:

- Staffing issues, including initial and ongoing background checks
- Defining the scope of care, including specific populations to be served
- Setting productivity standards and implementing tools to track productivity performance
- Developing policies and procedures
- Dealing with legal and other liability issues
- Handling malpractice insurance issues
- Maintaining financial viability, including developing and maintaining relationships with a variety of funding sources
- Creating and developing the resources needed for staff to learn, implement, and maintain best/evidence-based practices
- Developing and maintaining relationships with community partners
- Creating linkages between the mental health and other components of the CAC

A CAC director with a good understanding of trauma issues can provide administrative oversight to the mental health component. To ensure a high-quality mental health component within a CAC, it is also necessary to designate a clinical supervisor to oversee the treatment aspects of the program. That clinical supervisor must have experience in treating childhood trauma within the context of the child's family, and must be committed to providing evidence-based and trauma-informed interventions within the CAC.

Clinical supervision includes, among other duties, developing a procedure for screening referrals to ensure that the clients who are accepted fit within the CAC's scope of care. The clinical supervisor is also responsible for establishing clinical policies and procedures as well as record-keeping processes. He or she must oversee the confidentiality of all clinical information to ensure its consistency with state and federal regulations. In addition, the supervisor will establish a Client Bill of Rights, identify a HIPPA compliance officer, develop and maintain a trauma assessment procedure, and ensure the delivery of quality services through training in evidence-based practices. Other clinical supervision duties include:

- Providing individual and group supervision for CAC mental health professionals
- Providing clinical case consultation
- Creating an atmosphere in which countertransference issues can be explored
- Ensuring that clinical staff have continual opportunities to grow professionally
- Providing oversight functions for high-risk clinical issues
- Monitoring indicators of secondary traumatic stress and ensuring effective management and interventions for staff members who experience it
- Developing procedures that consider how the treatment of family members is coordinated within the CAC
- Overseeing a quality assurance or continuous quality improvement process for therapy cases
- Evaluating outcomes of treatment

There are several models for providing clinical supervision in a CAC. If only a small number of in-house staff are providing clinical services, an outside clinical supervisor can be a viable choice. In this model, the clinical supervisor works closely with the CAC director, but has the authority to direct and supervise staff. Two of the issues to consider when determining the degree to which clinical supervision must be available on-site are (1) skill and experience levels of the staff, and (2) the ability to handle emergencies when the clinical supervisor cannot be reached (for example, designating an experienced staff mental health professional as a backup).

A second model utilizes in-house clinical supervision. In this model, the clinical supervisor becomes immersed in the CAC culture. As part of the staff, the on-site supervisor can influence practice on a daily basis and understands the challenges facing each staff member. He/she is available to support staff in managing client crises and can handle crises in the place of staff when appropriate and necessary.

Regardless of the model for clinical supervision, it is imperative that the clinical supervisor and CAC director work together as a team. The CAC staff members are frequently working under stressful conditions. A consistent approach to clinical issues and staff concerns about these issues is essential. Clear communication, well-defined job responsibilities, and willingness to support each other are essential to a good working relationship between the director and clinical supervisor.

Section 11: Securing Financial Support for Trauma Treatment

The financing of children's mental health services generally follows a diverse and inconsistent path across—and even within—states and local communities. These differences reflect in part the multi-agency, public-private sector nature of mental health services for children and families, as well as the fragmented nature of responsibility for mental health care and funding of services. For children and youth, the fragmentation is compounded by the fact that this population is seen and served by multiple systems.

Sustainability of funding to support all services within the CAC falls under the director's purview. Knowledge of potential funding sources will enable the director to maximize the revenue produced within the CAC and to avoid the termination of valuable services when funding streams end. And although the process for developing and maintaining funding is often complicated, several sources do exist and should be considered. This section outlines a variety of potential funding sources.

The CAC director also needs to understand the strong linkage between funding and clinical practice. Use of evidence-based practices increases the likelihood of buy-in from both private and public funding agencies, and strengthens the case for strategic funding of these services. The CAC director needs to develop a method to gather outcomes data and metrics required to refine and sustain funding for trauma-focused mental health treatment.

Potential Sources of Funding

The responsibility for providing mental health services to traumatized children and their families may be shared by many entities: health and social welfare, mental health, child welfare, juvenile justice, and education systems. As a result, a variety of funding streams have been developed. The major categories of financing for children's mental health include:

- Private health insurance
- Medicaid
- State and local government funds
- Public and private sector grants
- Crime victim and court-ordered compensation programs
- Community and civic organization funds

Private health insurance

Private health insurance is an important potential source of funding for mental health services for children, but the limits on coverage, specialty care, and service type restrict its utility and reach. According to the National Institute for Health Care Management, while over two-thirds of children have private insurance coverage, less than half of children's mental health treatment is paid by this source (Van Landeghen & Hess, 2005). Insurance policies often cap mental health services at a certain number of sessions or dollar amount, which often is inadequate, given the complexities involved in child abuse cases. Available care also may not be trauma-specific. Families are often forced to choose from a fixed list of managed care (empaneled) providers, often with little consideration of the provider's level of experience with or expertise in child abuse, domestic violence, or other traumatic stress cases.

Furthermore, both public and private insurance coverage typically does not include critically important services, such as a mental health professional's consultation with the child's school, doctor, social worker, attorneys, or other professionals involved with the family. Insurance policies may also limit the site of service to a clinic office, making access more difficult, and inhibiting the use of house visits, school-based interventions, and other community-based services.

Medicaid

Access to mental health care is most difficult for children who are uninsured. In 2006, the US Census Bureau estimated the percentage of uninsured children in the US at 11.7%—or 8.7 million children. With an uninsured rate in 2006 of 19.3%, children in poverty were more likely to be uninsured than all other children (DeNavas-Walt, et al., 2007). In 1998, one in five children with diagnosed mental health problems was publicly insured (Glied & Cuellar, 2003). Medicaid historically has borne a disproportionate share of mental health service costs for children, paying nearly 30% of the costs while covering 20% of children with mental health concerns (Van Landeghen & Hess, 2005). Additionally, although Medicaid's benefit package for children is much more comprehensive than that of most private insurance plans, Medicaid coverage of specific treatment options varies across states.

As states have increasingly used managed care programs within Medicaid, they have implemented a wide range of financing and service delivery approaches to children's mental health (Van Landeghen & Hess, 2005). While a few states have no Medicaid managed care programs, most states do. Many states carve out children's mental health services from their managed care plans as fee-for-service. Some states have Medicaid managed care programs designed specifically for children with mental health problems; other states provide special treatment options within the plan for children with severe emotional disturbances or who are on Supplemental Security Income (SSI) due to a mental health disability. Still others

combine a number of approaches and variables including diagnosis, disability status, degree of system involvement, geography, or other factors. Despite state-by-state restrictions and variability, Medicaid reimbursement remains an important source of funding for mental health services, and is widely considered the largest funder of mental health services for children (Howell, 2004).

State and local government funds

More than 20% of children's mental health costs are paid by state and local agencies from sources other than public or private insurance (Van Landeghen & Hess, 2005). Additionally, states invest significant funding in children's mental health, primarily for treatment services, and increasingly as Medicaid matching funds. State- and county-funded mental health services have long served as safety nets for people unable to obtain or retain access to privately funded mental health services. Counties are typically seen as the payer of last resort.

In some areas of the country, counties have entered into relationships with CACs to help finance needed mental health services for children and families without access to insurance or Medicaid. Counties save money by providing this kind of trauma-focused treatment earlier in the services continuum, rather than later, when the consequences and costs to the child, the family, and community are greater.

In rare circumstances, cities have partnered with CACs to provide seed money, matching dollars, in-kind support, or other funding of needed mental health or related services to children seen in CACs.

Federal, state and local grants

The mix and specific uses of grant funds vary significantly from state to state. Federal grant support for treatment comes from mental health, child welfare, and juvenile justice funds. Federal grant funds also support system development and coordination. These funds can offer flexibility not available with insurance or Medicaid, and can be used to finance some of the services that are limited or unavailable through insurance (e.g., outreach to families following an interview; mental health professional consultations with school staff, social workers, doctors; participation in team meetings). On the downside, grant funding typically is not a secure source of financing for mental health services, as funds may be limited or unavailable. Competition for scarce grant dollars can be fierce.

Crime victim and court-ordered compensation programs

Funding associated with the Victims of Crime Act and the Violence Against Women Act may be good sources for financing mental health services. Financial assistance for crime victims is available in every state in the US as well as in the jurisdictions of Washington DC, Puerto

Rico, the Virgin Islands, and Guam. In federal fiscal year 2006, crime victim compensation programs promoted the recovery of nearly 200,000 victims and their families by paying out close to $444 million annually in compensation to crime victims (National Association of Crime Victim Compensation Boards, 2008).

Each government entity operates and administers its program under its own laws, determining who and what to pay. The vast majority of the money to fund crime victim compensation programs comes from offender fees and fines, rather than from taxpayer dollars. In federal fiscal year 2006, a third of the funding for crime victim compensation came from the federal Victims of Crime Act (VOCA) fund, which covers all 50 states, Washington DC, Puerto Rico, the Virgin Islands, and Guam (National Association of Crime Victim Compensation Boards, 2006). Victims of violent or personal crimes (including assault, domestic violence, rape, child abuse, and drunk driving) are eligible for victim compensation, as are family members of murder victims.

Victims of child abuse comprised 17% of the recipients of crime victim compensation in federal fiscal year 2006 (National Association of Crime Victim Compensation Boards, 2008). Although mental health services are an allowable expense in crime victim compensation programs, the percentage of funds actually utilized for these services varies greatly by state. The eligibility requirements and maximum awards for mental health counseling also vary from state to state and are determined by state—not federal—statutes. Across all states in federal fiscal year 2006, total crime victim compensation funding for mental health counseling was about $35.5 million, or 8% of total payments. This percentage compares with 53% allotted for medical expenses; 18% for economic support (lost wages for injured victims, and lost family support in homicides); and 11% for funeral bills (National Association of Crime Victim Compensation Boards, 2008).

Crime victim compensation reimburses the crime victim directly for the expense of the treatment. Each state covers crimes within its jurisdiction. Therefore, the victim of crime should apply first in the state where the crime occurred, regardless of the victim's current state of residency. Agreements between states may allow for secondary or additional reimbursement from the state of residency. The application requirements are generally similar across states. To be eligible for such funds, victims must:

- Report the crime promptly
- Cooperate with law enforcement
- File the application in a timely manner
- Be innocent of wrongdoing and not have contributed to the crime in any way

- Have an expense or loss not covered by insurance or another public benefit program, like the Veterans Administration, TriCare (formerly known as CHAMPUS), Medicaid, and other federal programs

Disadvantages of using crime victim compensation funds to finance mental health services include arduous application processes; long waits for reimbursement; and inflexible caps on numbers of sessions or total reimbursable dollar amounts. Because the funding for this reimbursement source is partly based on offender fees and fines, in some states, offenders may be aware of how much treatment a victim has received and where the treatment was provided. This can put victims at additional risk for harm by the perpetrator. CACs and their clients may prefer to do a risk-benefit analysis of receiving such funds in states where offenders can access such information about victims' treatment.

Numerous states fund programs for victims of sexual assault, and these grant dollars may be available to fund mental health services for children involved with CACs. These grant programs may provide funding for mental health and mental health-related services under grant areas such as "supportive services," "support groups," and "peer support."

In addition, some states and some jurisdictions allow the use of court orders that mandate convicted perpetrators to pay directly for their victim's assessment and treatment services.

Community and civic organization funds

Organizations like the Junior League, United Way, and Community Chest may be sources of seed money, matching funds, or general support for specialized trauma-informed mental health services. Organizations that have as their focus the needs, welfare, and success of children (e.g., local chapters of Rotary International) also may be interested in supporting trauma-informed, evidence-based assessment and treatment services designed to meet the needs of maltreated children.

Some CACs have successfully raised funds in their communities for specialized mental health services for children who have experienced abuse or neglect. Private corporations that are significant employers in a community or state may have interest in providing funds for these services. Private funds can be an important source of match money when applying for other government dollars like VOCA grants.

Other Funding Strategies and Considerations

Depending on the region, county and city grants and/or donation dollars comprise funding of last resort for mental health treatment. These funds are typically reserved for people who are uninsured, are unable to pay for services, or who have exhausted insurance or Medicaid coverage.

Interagency and public-private collaboration are essential to developing and financing trauma-informed mental health services for children and families seen in CACs. Successful strategies, once set in motion, should be strengthened by formal mechanisms (e.g., memoranda of understanding, contracts, legislation, regulation, and other formal guidance). CACs need to build or strengthen collaborative relationships in the service of systematic funding strategies that can support these important mental health services. Consumers, parents, and caregivers must be involved in these relationships and can assist the effort as leaders, spokespersons, and advocates.

In developing funding for a mental health component within a CAC, it may be best to start small. Applying for small grants or turning to local foundations may jump-start a community- or state-level planning process, which can then build on other collaborations or funding sources. Starting small also makes it easier to pilot test new service approaches to ensure they fit with the needs of the community, and provide evidence of their efficacy.

When assessing potential funding streams, CAC directors must examine the barriers they pose. For example, does the state Medicaid plan pay for all necessary services including child and family treatment as well as consultations and team meetings? Does the crime victim compensation program allow perpetrators access to information about the victim's treatment? Directors may need to weigh various factors when pursuing funding streams. If one funding source pays only for direct service, another source may be found to pay for attendance at team meetings and consultations to child welfare, education, or other systems. Multiple funding sources may then be used to support the continuum of families' needs.

Section 12: Secondary Traumatic Stress

CAC directors must have a thorough understanding of the impact of child traumatic stress on the child victims and families served. It is just as important to recognize that staff members and the directors themselves—by the very nature of their work—are at risk of experiencing alterations in their feelings, in their relationships, in their lives, and in their thinking about their world.

Providing help to victims of child abuse inevitably involves exposure to traumatic events. CAC staff can be stressed by hearing detailed reports of trauma from children on a daily basis and from having to deal with their own powerful emotional responses to witnessing the impact of abuse and violence on children. Dealing with a community system with limited resources that is not always responsive to the needs of abused children can also be stressful for CAC staff. The frustrations of navigating a complicated, often insensitive system can leave staff feeling helpless in their efforts to heal these children, increasing their risk of developing emotional and physical problems (Perry, 2003).

Multiple terms are used to describe the exposure to trauma commonly experienced by those in a helping role. Three terms are most common: compassion fatigue, vicarious traumatization, and secondary traumatic stress.

> *Compassion fatigue* describes a deep physical, emotional, and psychological exhaustion that can arise as a result of exposure to another person's trauma particularly when there is a constant thwarting of efforts to help.
>
> The terms *vicarious traumatization* and *secondary traumatic stress* (STS) are generally used to describe a transformative process in which exposure to traumatic material from an abuse victim begins to affect the helper's internal state. They may result from working with traumatized individuals, from talking to others about the trauma, from working indirectly with victims, or from reading, researching, and teaching about trauma. Staff members suffering from vicarious traumatization/STS may experience emotional reactions that parallel those of the traumatized children with whom they work, including intrusive thoughts, nightmares, dissociation, anger, and other symptoms of PTSD.

Burnout is another term sometimes used to describe the impact of working with trauma victims. However, Pine, et al. (1981) described burnout as

> "a state of physical, emotional and mental exhaustion caused by long-term involvement in emotionally demanding situations. Unlike secondary traumatic stress, burnout can be described as emotional exhaustion, depersonalization and a reduced feeling of personal accomplishment."

Regardless of the terminology used to describe this risk, CAC directors must be aware that exposure to the trauma of others has the potential to cause psychological harm to staff and to impede the therapeutic process. Even staff who do not have direct contact with victims may be affected by the nature of the CAC's work. At times the entire atmosphere of the CAC may be permeated with trauma, particularly when victims associated with high-profile or egregious cases of child trauma receive services at the center.

CAC staff may unconsciously defend against their constant exposure to trauma and to their overwhelming feelings by developing responses that become problematic. These can include an unwillingness or inability to believe what the child is saying, or a tendency to minimize or avoid the traumatic information. Staff members may distance themselves from their clients, which decreases their capacity for empathy or rapport building. They may fail to follow through with services, in essence abandoning the child psychologically.

When individuals who see themselves as helpers begin to experience these non-therapeutic reactions, they may become punitive and blame their reactions on the behaviors or characteristics of the child, the child's caregiver, or the shortcomings of the service delivery system. They also experience alterations in how they think about their work, and how they feel about themselves and others. STS can cause alterations in staff members' professional and personal relationships, and have an impact on their parenting and on their sexual relationships with their significant others. They can experience disturbances in sleep and eating patterns, or suffer from depression.

In an effort to deal with these STS-produced alterations, staff members may unconsciously turn to risky coping strategies. Although the goal is to ease discomfort, many of these strategies are potentially harmful. For instance, people may turn to alcohol or substance abuse to numb their feelings, or they may withdraw from others. These types of coping strategies may adversely affect staff members' responses to their clients. They can lead to attempts to control the child or situation, boundary violations, or attempts to rescue the child.

The CAC director has an obligation to staff members to help them understand the potential negative impact of constant exposure to the abuse of children, and to help integrate and transform their reactions to STS in positive ways. Failure to develop awareness and effective coping strategies creates potential risks to the child, to the helper, and to the goals of the CAC.

Management Strategies

As mentioned, the first step for CAC directors is to understand the risk of STS to themselves and to their staff members, and to understand the need and value of consistently helping staff identify and manage the difficulties associated with their jobs. The second step is for CAC directors to communicate this awareness to their staff and to work with them to develop a formal risk management plan. Staff members need management support to examine their own coping styles and their needs related to trauma work. Figley (1995) advises "normalizing the reality of secondary traumatic stress and supporting staff in developing positive coping skills."

Risk management plans can include on-the-job support systems that provide staff (individually or in groups) opportunities to process their experiences and reactions. These systems can be supervised by in-house mental health professionals or by peers.

In addition, more formal and comprehensive plans can be developed to meet the needs of individual staff members. These may include ongoing therapy to help staff examine their individual reactions to specific clients or types of trauma. Employee Assistance Programs are one way to fulfill this need. The director can create a work environment that generates respect, that is safe and confidential, and that provides support for continuing education, supervision, consultation, and planned mental health breaks.

There are other ways in which the CAC director can help reduce the risk of STS. Directors can offer opportunities for staff members to express themselves creatively and to develop a variety of roles for themselves. It is always important to ensure that staff members receive adequate pay, benefits, vacation, and personal leave time.

Perry (2003) provides information in his manual, *The Cost of Caring,* which can provide some focus to CAC directors as they consider these critical issues. He identified a list of Individual Indicators of Distress including:

- **Emotional Indicators:** anger, sadness, prolonged grief, anxiety, and depression
- **Physical Indicators:** headaches, stomachaches, lethargy, and constipation
- **Personal Indicators:** self-isolation, cynicism, mood swings, and irritability with spouse and family
- **Workplace Indicators:** avoidance of certain clients, missed appointments, tardiness, and lack of motivation

Perry also provides recommendations regarding individual self-care strategies for combating secondary trauma, including:

- **Physical:** sleeping well, eating well, dancing, walking, jogging
- **Psychological:** self-reflection, pleasure reading, saying no to commitments, smiling, seeking solitude
- **Emotional:** seeing friends, crying, laughing, praising yourself, using humor
- **Workplace:** taking breaks, setting limits, arranging for peer support and supervision, using vacation time

Awareness and a plan that provides positive coping strategies are critical to minimizing the potential risk that STS poses to staff and to program success. CAC directors and CAC boards of directors need to advocate for their staff who work with victims of traumatic events. They must cooperate to create programs to increase awareness of STS, to support systems that help prevent stress-related problems, and to prevent negative impact on the quality of services delivered.

CAC directors must create a safe environment in the CAC that allows staff to express a full range of thoughts and feelings regarding their work. The atmosphere created for the staff will be reflected in the care they are able to provide to the children and families. For a more comprehensive understanding of this important subject, including risk management strategies, consult Perry (2003); Saakvitne & Pearlman (1996); and Figley (2002).

Section 13: Summary

This Guide, prepared collaboratively by the NCA and the NCTSN, has outlined basic issues with which a CAC director should be familiar in order to provide leadership in offering quality mental health services to children who have been abused, traumatized, and/or exposed to violence.

Each CAC is unique. Within the NCA's standards (*www.nca-online.org*), the specifics of services within each accreditation component can be determined internally by the CAC staff. Thus, mental health services may be offered within the CAC or through collaboration with community providers.

In preparing this Guide, it was recognized that some CAC directors may not have experience in the field of mental health treatment for childhood trauma victims. This Guide was designed to review the critical issues a director may encounter both within the CAC and in the larger community of organizations treating child abuse victims.

The director can serve as a valuable resource on childhood abuse and trauma to other community organizations, and in developing collaborations and partnerships that enhance the well-being of children. The director of a CAC may function on a macro level, influencing the way the community responds to child victims. Under the director's leadership, the CAC may galvanize other community organizations that want to join forces to advocate for children. Inevitably, disputes will arise among community partners; however, the relationships that the director has developed may sustain the collaborative entity during times of stress and disagreement.

Within the CAC, the director plays a pivotal role in setting the emotional and professional climate. A client's first impression of how he/she is treated at the CAC is often established during the first encounter with the staff, and may determine whether the child and family return for additional services. It is the director's responsibility to ensure that all levels of staff are cognizant of the manifestations of trauma at various developmental stages, and of cultural issues associated with trauma. This awareness will help staff form appropriate expectations for traumatized children and their families, and may prevent frustration, confusion, and, in the long-term, burnout.

A formal mental health assessment process is also an important element in the CAC's service continuum. The CAC director can set the standard for the assessment protocol, which can augment the clinician's understanding of the child's current level of functioning and guide the development of the treatment plan. The assessment process can form a baseline

for measuring a child's progress in treatment. The CAC director can utilize the measurable results to demonstrate positive outcomes when they are achieved, and to identify areas in which the staff needs additional knowledge and training.

Another viable way to measure the CAC's provision of mental health services is through feedback from the outside community. Through such vehicles as consumer satisfaction surveys and assessments by community partners the agency can gain invaluable perspectives.

The CAC director must also know how to select evidence-based or supported practices, complete quality assurance tasks, and review practices for model fidelity. Although these functions can be delegated to CAC clinical staff, ultimately the director is responsible for the overall quality of mental health services.

This Guide also provides the director with information on obtaining and sustaining funding sources to support the CAC's mental health services. Functions discussed include regularly evaluating the financial viability of the mental health services, seeking relevant funding sources congruent with the CAC's mission, developing relationships with private foundations, and maintaining awareness of legislation that impacts services.

Whether mental health services to child victims are offered within the CAC or through linkages with community partners, this Guide provides CAC directors with a map through the issues intrinsic to providing these services, and may also help stimulate discussions about how mental health services are structured in the CAC. Additional resources are listed throughout, and, along with the information in the appendices, can continually help the CAC staff deliver enhanced mental health services.

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Section 15: Appendices

Interventions

A. Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)

B. Abuse-Focused Cognitive Behavioral Therapy (AF-CBT)

C. Parent-Child Interaction Therapy (PCIT)

D. Cognitive-Behavioral Group Therapy for Children with Sexual Behavior Problems (CSBP)

Sources for Training or More Information

E. Assessment-Based Treatment for Traumatized Children:
A Trauma Assessment Pathway Model (TAP)

F. Posttraumatic Stress Disorder (DSM-IV-TR)

G. Sample Release of Information/Authorization

H. Links to Additional Relevant Resources

Appendix A: Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)

Abstracted from the California Evidence-Based Clearinghouse for Child Welfare (2006) *www.cachildwelfareclearinghouse.com.*

Basic Principles	Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) is a conjoint child and parent/caregiver psychotherapy model for children who are experiencing significant emotional and behavioral difficulties related to traumatic life events. It is a components-based hybrid treatment model that incorporates trauma-sensitive interventions with cognitive behavioral, family, and humanistic principles.
Essential Components	P - Psychoeducation P - Parenting skills R - Relaxation techniques such as focused breathing, progressive muscle relaxation, and teaching children to control their thoughts (thought stopping). A - Affective expression and regulation: Helping children and parents/caregivers learn to control their emotional reactions to reminders by expanding their emotional vocabulary, enhancing their skills in identifying and expressing emotions, and encouraging self-soothing activities. C - Cognitive coping and processing or cognitive reframing: Helping children learn to think in new and healthier ways about the abuse and their role in it. T - Trauma narrative: Gradual exposure exercises including verbal, written, and/or symbolic recounting (e.g., utilizing dolls, art, puppets) of abusive events so children learn how to discuss the events when they choose in ways that do not produce overwhelming emotions. I - In vivo exposure: Gradual exposure to non-threatening trauma reminders in children's environment (e.g., basement, darkness, school) so they learn they can control their emotional reactions to things that remind them of the trauma. C - Conjoint parent/caregiver/child sessions, typically toward the end of the treatment, including psychoeducation, sharing the trauma narrative, anxiety management, and correction of cognitive distortions. Family works to enhance communication and create opportunities for therapeutic discussion regarding the trauma. E - Enhancing personal safety and future growth: Training and education on personal safety skills and healthy sexuality/interpersonal relationships; encouraging the utilization of skills learned to manage future stressors and/or trauma reminders.

Relevant Research	Authors	Study and Outcomes
	Cohen, J. A., & Mannarino, A. P (1996). A treatment outcome study for sexually abused preschool children: Initial findings. *Journal of the American Academy of Child and Adolescent Psychiatry, 35,* 42–50.	Randomized controlled trial (RCT) demonstrating superiority of TF-CBT over nondirective supportive therapy for 68 sexually abused children aged 3–7 and their nonoffending caregivers in dealing with posttraumatic stress; and internalized, externalized, and sexual behavior problems. Measures included: Child Behavior Checklist (CBCL), Child Sexual Abuse Inventory (CSAI), and Weekly Behavior Report (WBR).
	Cohen, J. A., & Mannarino, A. P. (1997). A treatment study of sexually abused preschool children: Outcome during one-year follow-up. *Journal of the American Academy of Child and Adolescent Psychiatry, 36,* 1228–1235.	Demonstrated that initial differences between TF-CBT and nondirective supportive treatment (NST) groups were maintained at 6- and 12-month follow-ups, with TF-CBT remaining superior to NST in multiple domains of outcome. [Same measures and sample as previous article.]
	Cohen, J. A., & Mannarino, A. P. (1998). Interventions for sexually abused children: Initial treatment findings. *Child Maltreatment, 3,* 17–26.	Eighty-two sexually abused children, aged 8–15, and their primary caretakers were randomly assigned to TF-CBT or nondirective supportive therapy. The results demonstrated the superior effectiveness of TF-CBT in reducing self-reported depression and in improving social competence.
	Cohen, J. A., Mannarino, A. P, & Knudsen, K. (2005). Treating sexually abused children: One-year follow-up of a randomized controlled trial. *Child Abuse and Neglect, 29,* 135–146.	Eighty-two sexually abused children, aged 8–15, and their primary caretakers were randomly assigned to TF-CBT or nondirective supportive therapy. Measures included: Children's Depression Inventory (CDI), Trauma Symptom Checklist for Children (TSC-C),

Relevant Research *(continued)*	Authors	Study and Outcomes
		State-Trait Anxiety Inventory for Children (STAIC), Child Sexual Behavior Inventory (CSBI), and Child Behavior Checklist (CBCL). Among treatment completers, TF-CBT resulted in significantly greater improvement in symptoms of anxiety and depression, sexual problems, and dissociation at 6-month follow-up and in PTSD, and in dissociation at 12-month follow-up. Intent-to-treat analysis indicated group X time effects in favor of TF-CBT on measures of depression, anxiety, and sexual problems.
	Cohen, J. A., Deblinger, E., Mannarino, A. P., & Steer, R. (2004). A multi-site, randomized trial for children with sexual abuse-related PTSD symptoms. *Journal of the American Academy of Child and Adolescent Psychiatry, 43,* 393–402.	A multi-site RCT for 229 children with sexual abuse–related PTSD symptoms; more than 90% had experienced multiple types of traumas in addition to sexual abuse. Measures included: Schedule for Affective Disorders and Schizophrenia for School-Age Children - Present and Lifetime Version (K-SADS) [for this study, the PTSD, Psychosis, and Substance Use Disorders sections were used], Children's Depression Inventory (CDI), State-Trait Anxiety Inventory for Children (STAIC), and Children's Attributions and Perceptions Scale (CAPS). TF-CBT was superior to Child Centered Therapy (CCT) in improving PTSD, depressive, anxiety, shame, and behavioral symptoms, as well as abuse-related cognitions in children; and in improving depression, parenting skills, caregiver distress about the child's abuse, and support of the child among caregivers who participated in treatment.

Relevant Research *(continued)*	Authors	Study and Outcomes
	Deblinger, E., Lippmann, J., & Steer, R. (1996). Sexually abused children suffering posttraumatic stress symptoms: Initial treatment outcome findings. *Child Maltreatment, 1,* 310–321.	RCT for 100 sexually abused children, aged 8–14, and their nonoffending parents assigned to TF-CBT for child only, parents only, parents and child, or to community-based treatment as usual (TAU). Children receiving TF-CBT experienced significantly greater improvement in PTSD symptoms; children whose caregivers received TF-CBT treatment experienced significantly greater improvement in depression and behavior problems, and their caregivers experienced significantly greater improvement in parenting skills. Measures included: Schedule for Affective Disorders and Schizophrenia for School-Age Children (K-SADS-E), Children's Depression Inventory (CDI), State-Trait Anxiety Inventory for Children (STAIC), Child Behavior Checklist (CBCL), and Parenting Practices Questionnaire.
	Deblinger, E., Steer, R., & Lippmann, J. (1999). Two-year follow-up study of cognitive behavioral therapy for sexually abused children suffering posttraumatic stress symptoms. *Child Abuse and Neglect, 23,* 1371–1378.	Improvements in PTSD, depression, and externalizing behaviors that were found at post-treatment were maintained across groups at 3 and 6 months and at one- and two-year follow-ups, with TF-CBT retaining its advantage over TAU.
	Deblinger, E., Stauffer, L., & Steer, R. (2001). Comparative efficacies of supportive and cognitive behavioral therapies for children who were sexually abused and their non-offending mothers. *Child Maltreatment, 6,* 332–343.	RCT for 44 children, aged 2–8, and their mothers demonstrated that mothers participating in TF-CBT groups reported greater improvements in intrusive thoughts and caregivers' emotional distress related to their children's abuse than did mothers participating in supportive groups.

Relevant Research *(continued)*	Authors	Study and Outcomes
		Children participating in the TF-CBT groups demonstrated greater improvement in their knowledge regarding body safety skills than did children who participated in supportive groups.
	King, N., Tonge, B. J., Mullen, P., Myerson, M., Heyne, D., Rollings, S., Martin, R., & Ollendick, T. H. (2000). Treating sexually abused children with posttraumatic stress symptoms: A randomized clinical trial. *Journal of the American Academy of Child and Adolescent Psychiatry, 59,* 1347-1355.	RCT for 36 Australian sexually abused youth aged 5-17 assigned to child-only, child+family, or wait list (WL) control condition groups. Improvements in PTSD symptoms were noted in both treatment groups; both were superior to WL; those in the child-only group improved more on depression; child-only improved more than child+family on anxiety symptoms at post-treatment follow-up. At 3-month follow-up, child+family improved more on fear indicators than did child-only condition.

References

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1. Cohen, J. A., & Mannarino, A. P. (1993). A treatment model for sexually abused preschoolers. *Journal of Interpersonal Violence, 8,* 115-131.
2. Cohen, J. A., & Mannarino, A. P. (2004). Treating childhood traumatic grief. *Journal of Clinical Child and Adolescent Psychology, 33,* 820-233.
3. Deblinger, E., Thakkar-Kolar, R., & Ryan, E. (2006). Trauma in Childhood. In V. M. Follette, & J. Ruzek (Eds.), *Cognitive behavioral therapies for trauma.* New York: Guilford Press.

Contact Information

Contact name: Judith Cohen, MD
Affiliation/Agency: Allegheny General Hospital, Drexel University College of Medicine
Email:jcohen1@wpahs.org
Phone:412-330-4321
Fax number: 412-330-4377

Contact name: Esther Deblinger, PhD
Affiliation/Agency: UMDNJ-School of Osteopathic Medicine
E-mail: deblines@umdnj.edu
Phone: 856-566-7036
Fax: 856-566-6108

Appendix B: Abuse-Focused Cognitive-Behavioral Therapy (AF-CBT)

Abstracted from the California Evidence-Based Clearinghouse for Child Welfare (2006), *www.cachildwelfareclearinghouse.com.*

<table>
<tr><td>Brief Description</td><td colspan="2">Abuse-Focused Cognitive-Behavioral Therapy (AF-CBT) is a treatment based on principles derived from learning and behavioral theory, family systems, cognitive therapy, and developmental victimology. It integrates specific techniques to target school-aged abused children, their offending caregivers, and the larger family system.

Through training in specific intrapersonal and interpersonal skills, AF-CBT seeks to promote the expression of appropriate/prosocial behavior, and to discourage the use of coercive, aggressive, and violent behavior.</td></tr>
<tr><td>Essential Components</td><td colspan="2">Educate individuals and families about relevance of CBT model and physical abuse.

Establish agreement with family to refrain from using physical force and to discuss any incidents involving the use of force within the family.

Review the child's exposure to emotional abuse in the family and provide education about the parameters of abusive experiences (causes, characteristics, and consequences) to help child and caregiver to better understand the context in which they occurred.

Identify and address cognitive contributors to abusive behavior in caregivers (e.g., misattributions/high expectations) and/or their consequences in children (e.g., views supportive of aggression, self-blame) that could maintain any physically abusive or aggressive behavior.

Teach affect-management skills.

Teach caregivers behavioral strategies to reinforce and punish children's behavior as alternatives to physical discipline.

Teach prosocial communication and problem-solving skills to the family and help them establish these skills as everyday routines.</td></tr>
<tr><td rowspan="2">Relevant Research</td><td>Authors</td><td>Study and Outcomes</td></tr>
<tr><td>Kolko, D. J. (1996). Clinical monitoring of treatment course in child physical abuse: Psychometric characteristics and treatment comparisons. Child Abuse and Neglect, 20(1), 23-43.</td><td>The individual child/parent CBT and family therapy components now integrated in AF-CBT were evaluated separately and compared to a third condition, consisting of routine community services (RCS) in a randomized clinical trial (N=38) that evaluated key outcomes through a one-year follow-up assessment.</td></tr>
</table>

Relevant Research *(continued)*	Authors	Study and Outcomes
		Weekly child and caregiver ratings of caregivers' use of physical discipline/ force and anger problems during treatment decreased for both treatment groups, but the decline was significantly faster for the individual CBT condition. Measures included the Conflict Tactics Scale (CTS), the cohesion subscale of the Family Environment Scale (FES), the general functioning scale of the Family Assessment Device (FAD), the Child Abuse Potential Inventory (CAPI), the Parenting Scale, and the Beck Depression Inventory (BDI).
	Kolko, D. J. (1996). Individual cognitive-behavioral treatment and family therapy for physically abused children and their offending caregivers: A comparison of clinical outcomes. *Child Maltreatment, 1,* 322–342.	Overall outcomes through follow-up: Individual child/caregiver CBT and family therapy conditions reported greater improvements than did RCS on: Certain child outcomes (e.g., less child-to-caregiver aggression, child externalizing behavior), Caregiver outcomes (e.g., lower child abuse potential, individual treatment targets reflecting abusive behavior, psychological distress, drug use), and Family outcomes (e.g., less conflict, more cohesion). Official records for the entire study period revealed lower, albeit nonsignificant, rates of recidivism among the adults who participated in the individual CBT (5%) and family therapy (6%) conditions, compared to those in the routine services condition (30%). Parallel rates of recidivism were found for the identified abused children in this study in the three conditions: CBT (10%), family therapy (12%), and routine services (30%). There were few differences between individual CBT and family therapy.

Relevant Research *(continued)*	Authors	Study and Outcomes
		Further, the outcomes were not influenced by child age, gender, ethnicity, parent education, one-parent versus two-parent household, SES, or the levels of child behavior problems, parental distress, and family violence. Both CBT and family therapy were conducted with high fidelity, had high rates of session attendance, and had high consumer satisfaction ratings.
References	1. Kolko, D. J. (2002). Child physical abuse. In J. E. B. Myers, L. Berliner, J. Briere, C. T. Hendrix, C. Jenny, & T. Reid (Eds.), *APSAC handbook of child maltreatment* (2nd. ed., pp. 21-54). Thousand Oaks, CA: Sage Publications. 2. Kolko, D. J., & Swenson, C. C. (2002). *Assessing and treating physically abused children and their families: A cognitive behavioral approach.* Thousand Oaks, CA: Sage Publications.	
Contact Information	Contact name: David J. Kolko, Ph.D Affiliation/Agency: University of Pittsburgh, School of Medicine Email: kolkodj@upmc.edu Phone: 412-246-5888 Fax:412-246-5341	

Appendix C: Parent-Child Interaction Therapy (PCIT)

Abstracted from the California Evidence-Based Clearinghouse for Child Welfare (2006) *www.cachildwelfareclearinghouse.com.*

Brief Description	Parent-Child Interaction Therapy (PCIT) was developed for families with young children experiencing behavioral and emotional problems. Therapists coach caregivers, during interactions with their children, to teach new parenting skills designed to strengthen the caregiver-child bond, decrease harsh and ineffective discipline control tactics, improve child social skills and cooperation, and reduce child negative or maladaptive behaviors. PCIT is an empirically supported treatment for child disruptive behavior and is a recommended treatment for physically abusive caregivers.
Essential Components	Parent Child Interaction Therapy consists of two components: *1. Child-Directed Interaction (CDI)* Caregiver-child dyads attend treatment sessions together, and caregivers learn to follow the child's lead in play. Caregivers are taught how to decrease the negative aspects of their relationship with their child and to develop positive communication. Caregivers' CDI skills are coded during the first five minutes of each session to assess progress and to guide skills learned through coaching during session. Caregivers are taught and coached on CDI skills: the use of differential social attention by giving positive attention to the child following positive (e.g., nonnegative) behavior and by ignoring negative behavior including: Giving labeled praise following positive child behavior Reflecting or paraphrasing the child's appropriate talk Using behavioral descriptions to describe the child's positive behavior Avoiding the use of commands, questions, or criticism (because these verbalizations are intrusive and often give attention to negative behavior) Skills are observed and coached through a one-way mirror at each treatment session. After the first session, at least half of each session is spent coaching parents in CDI utilizing a bug (listening device) in the ear. Behaviors are tracked and charted on a graph at each session to provide caregivers with immediate feedback regarding progress in positive interactions and the achievement of skill mastery. Caregivers are provided with homework to enhance skills learned between sessions. Families do not proceed to the Parent-Directed Interaction (PDI) until the caregivers demonstrate mastery of the CDI.

Essential Components *(continued)*	*2. Parent-Directed Interaction (PDI)* Caregiver-child dyads attend treatment sessions together, and parents learn skills to lead the child's behavior effectively. Caregivers are taught how to direct the child's behavior when it is important that the child obey. Caregivers' PDI skills are coded during the first five minutes of each session to assess progress and guide the coaching of the session. After the first session, at least half of each session is spent coaching the caregiver in PDI, utilizing a bug in the ear. Caregivers learn to incorporate into the CDI effective instructions and commands (e.g., commands that are direct, specific, positively stated, polite, given one at a time and only when essential, and accompanied by a reason that either immediately precedes the command or accompanies the praise for compliance). Caregivers learn to follow through on direct commands by giving labeled praise after each time the child obeys and beginning a time-out procedure after each time the child disobeys. Caregivers learn a time-out procedure that proceeds from the direct command, to warning, to time-out chair, to time-out room if the child refuses to obey a direct command. Caregivers are coached to use the PDI algorithm, which gives the child an opportunity to obey and stop the time-out procedure at each step. Behaviors are tracked and charted on a graph at each session to provide caregivers with immediate feedback regarding progress in their PDI skills. After caregivers demonstrate mastery of the procedures, they are given homework that gradually increases the situations as the child learns to obey. Treatment does not end until the caregivers meet preset mastery criteria for both phases of treatment and the child's behavior is within normal limits on a parent-report measure of disruptive behavior at home. For additional information, visit the PCIT homepage at www.pcit.org and select "PCIT Integrity Checklists and Materials."	
Relevant Research	**Authors**	**Study and Outcomes**
	Brestan et al. (1997).	Randomized controlled trial. Intervention group exhibited significant reduction in caregiver-rated behavior problem frequency and intensity; wait list group did not exhibit pre- or post-assessment change. Positive effects of intervention generalized to siblings of target children.

Relevant Research *(continued)*	Authors	Study and Outcomes
	Chaffin et al. (2004).	Randomized controlled trial. Tested the effectiveness of PCIT in preventing re-reports of physical abuse among abusive caregivers. Physically abusive caregivers were assigned to one of three interventions: 1) PCIT, 2) PCIT plus individualized enhanced services, or 3) a standard community-based parenting program. Results: 19% of caregivers assigned to PCIT had a re-report for physical abuse compared to 49% of caregivers assigned to the standard community group. Additional enhanced services did not improve the efficacy of PCIT.
	Eyberg et al. (1995).	Randomized controlled trial. Treatment group exhibited significant reduction in caregiver-rated behavior problem frequency and intensity; wait list group did not exhibit pre- or post-assessment change. Intervention group scores fell within normal range after treatment and positive effects generalized to siblings of target children.
	Nixon et al. (2003)	Randomized controlled trial. Caregiver ratings of behavior problems decreased from clinical range to normal range after treatment; scores for the wait list group remained in the clinical range. Oppositional Defiance Disorder (ODD) symptom severity ratings were significantly decreased for the intervention group, as compared to the control group. Treatment gains maintained at 6-month follow-up.
	Schuhmann et al. (1998)	Randomized controlled trial in highly controlled setting. Treatment group exhibited significantly improved compliance at post-treatment (23% versus 47%); wait list group remained unchanged. None of the children in treatment group met DSM criteria for ODD after completing treatment. Caregiver ratings of behavior problems decreased from clinical range to normal range at post-treatment; scores for wait list group remained in clinical range. All treatment gains were maintained at 4-month follow-up.
References	*Research Articles* Boggs, S. R., Eyberg, S. M., Edwards, D., Rayfield, A., Jacobs, J., Bagner, D., & Hood, K. (2004). Outcomes of parent-child interaction therapy: A comparison of dropouts and treatment completers one to three years after treatment. *Child & Family Behavior Therapy, 26*(4), 1–22.	

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Hood, K. K., & Eyberg, S. M. (2003). Outcomes of parent-child interaction therapy: Mothers' reports on maintenance three to six years after treatment. *Journal of Clinical Child and Adolescent Psychology, 32,* 419–429.

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Werba, B., Eyberg, S. M., Boggs, S. R., & Algina, J. (2005). Predicting the outcome of parent-child interaction therapy: Success and attrition. *Behavior Modification, 30*(5), 618–646.

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Bagner, D., & Eyberg, S. M. (2003). Father involvement in parent training: When does it matter? *Journal of Clinical Child and Adolescent Psychology, 32,* 599–605.

Bell, S., Boggs, S. R., & Eyberg, S. M. (2003). Positive attention. In W. O'Donohue, J. D. Fisher, & S. C. Hayes (Eds.), *Empirically supported techniques of cognitive behavior therapy: A step-by-step guide for clinicians.* New York: Wiley.

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Eyberg, S. M. (2005). Tailoring and adapting parent-child interaction therapy for new populations. *Education and Treatment of Children, 28,* 197–201.

Urquiza, A. J., & McNeil, C. B. (1996). Parent-child interaction therapy: An intensive dyadic intervention for physically abusive families. *Child Maltreatment, 1*(2), 132–141.

Contact Information	Contact name: Sheila M. Eyberg, PhD Affiliation/Agency: University of Florida, Department of Clinical & Health Psychology, Gainesville, FL 32610 Email: pcit@phhp.ufl.edu Phone: 352-273-5239 Fax: 352-273-6156 Website: www.pcit.org

Appendix D: Cognitive-Behavioral Group Therapy for Children with Sexual Behavior Problems (CSBP)

Abstracted from the National Center for Sexual Behavior on Youth, *www.ncsby.org.*

Brief Description	Cognitive-Behavioral Group Therapy for Children with Sexual Behavior Problems (CSBP) is a group therapy model for children who exhibit sexual behavior problems. CSBP is grounded in behavior modification and psychoeducational principles. It is highly structured and uses a teaching-learning model with children aged 6-12, and addresses topics including sexual behavior rules, impulse control techniques, social skills, empathy, and sex education. A concurrent CBT caregiver group focuses on psychoeducation and behavior management skills. This treatment model has been modified for use with preschool children aged 3-5.
Essential Components	*Children's Group Components* Highly structured and directive School-age group (aged 6-12): open-ended; graduation determined individually Preschool group (aged 3-5): 12-week, closed group Children are taught: Five sexual behavior rules, identifying inappropriate sexual behavior, and conceptualizing physical boundaries Feeling identification and expression Relaxation techniques (e.g., deep breathing and muscle relaxation presented in age-appropriate ways) Impulse control techniques (presented in age-appropriate manner) Basic sex education Abuse prevention Social skills Empathy and acknowledging inappropriate sexual behavior *Caregiver's Group Components* Psychoeducational Developmentally normal and atypical sexual behavior in children Caregivers are taught: Same learning skills taught in the children's group so they can support the child as he/she implements these skills at home Behavioral management skills for responding to sexual behaviors How to supervise children with sexual behavior problems Mutual support skills

Relevant Research	Authors	Study and Outcomes
	Bonner, B. L., Walker, C. E., & Berliner, L. (1999). *Children with sexual behavior problems: Assessment and treatment-final report.* Grant No. 90-CA-1469. National Clearinghouse on Child Abuse and Neglect.	A total of 201 children with sexual behavior problems were randomly assigned to either a 12-session, CBT group treatment program or a 12-session play therapy group. Short-term reductions in both sexual behavior and nonsexual behavior problems were found among children in both treatment groups, with no significant difference between them.
	Carpentier, M., Silovsky, J. F., & Chaffin, M. (2006). Randomized trial of treatment for children with sexual behavior problems: Ten-year follow-up. *Journal of Consulting and Clinical Psychology, 74*(4), 482–488.	Prospective study following 135 children, aged 5-12, with sexual behavior problems from randomized trial, comparing CBT group therapy and group play therapy. Utilized comparison group of 156 general clinic children with nonsexual behavior problems. Results support use of CBT group for children with sexual behavior problems. Children in CBT group had significantly fewer future sex offenses than did children in the play group, and were indistinguishable from children in the comparison group.

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2. Berliner, L., & Rawlings, L. (1991). *A treatment manual: Children with sexual behavior problems.* Seattle, WA: Harborview Sexual Assault Center.
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5. Friedrich, W. N., Fisher, J., Broughton, D., Houston, M., & Shafran, C. R. (1998). Normative sexual behavior in children: A contemporary sample. *Pediatrics, 101*(4), E9.
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Contact Information	Contact name: Jane Silovsky, PhD Affiliation/Agency: University of Oklahoma Health Sciences Center Email: jane-silovsky@ouhsc.edu Phone: 405-271-8858 Fax: 405-271-2931

Appendix E: Assessment-Based Treatment for Traumatized Children: A Trauma Assessment Pathway Model (TAP)

Abstracted from the California Evidence-Based Clearinghouse for Child Welfare (2006), *www.cachildwelfareclearinghouse.org.*

Brief Description	Assessment-Based Treatment for Traumatized Children: A Trauma Assessment Pathway Model (TAP) is a treatment model that incorporates assessment, triage, and essential components of trauma treatment into clinical pathways. The goals of TAP include: 1) providing treatment center staff with the knowledge and skills to incorporate standardized assessments into the intake and ongoing treatment process; 2) providing a treatment model that is directed by the uniqueness of the child and his/her family; and 3) providing guidelines for clinicians to make decisions regarding trauma treatment strategies based on the child's unique presentation. TAP is divided into two parts. Part I describes the assessment process, how to develop a Unique Client Picture, how to triage, and when to make referrals. Part II focuses on trauma treatment and includes an explanation of evidence-supported interventions found in the literature that are organized into a "Trauma Wheel" and used to create a "Treatment Pathway."
Essential Components	Assessment: Interview, behavioral observations, and standardized assessment measures help clinicians organize and understand client's symptom presentation, history, cultural, and family influences. This process leads to the Unique Client Picture, and guides clinicians as they hypothesize about the bases for the client's problems and identify treatment needs. Triage: Referring children to the most appropriate and available evidence-based treatment [i.e., Trauma-Focused Cognitive Behavioral Therapy (TF-CBT), Abuse-Focused Cognitive Behavioral Therapy (AF-CBT), or Parent-Child Interaction Therapy (PCIT)] based on the needs of the child and his/her family through assessment and the Unique Client Picture. Decision trees are available to help the clinician make appropriate triage decisions. Treatment: The treatment component is defined through the Trauma Wheel and the Treatment Pathway. These identify and structure the use of essential elements of trauma treatment for children based on the most current research evidence. They are used when a child either does not fit specific criteria for existing evidence-based treatment models or needs additional treatment after receiving treatment through the referred treatment model. The Trauma Wheel and the Treatment Pathway are also used when the most appropriate evidence-based treatment is not available (e.g., no training or appropriate setting). The Trauma Wheel consists of the following components: Relationship Building Child Development Cultural Influences Psychoeducation and Skill Building

Essential Components *(continued)*	Addressing Maladaptive Cognitions Affect Regulation Trauma Integration System Dynamics The first three features of the wheel are considered ongoing influences and considerations. These aspects of the wheel influence how a clinician proceeds with therapy and the decisions made about types of interventions used during the course of treatment. The other five features are considered essential components of trauma treatment for children. Suggested tasks and types of interventions are listed in the manual. *The Treatment Pathway* This pathway helps the clinician decide where to begin treatment based on the Unique Client Picture. During the course of treatment, the clinician spends time on each component of the Trauma Wheel, but length of time and order of intervention depends on the Unique Client Picture, and may fluctuate based on ongoing assessment efforts and on the wishes of the child and family. Decisions concerning order of interventions and any changes in treatment are influenced by ongoing assessment including follow-up standardized assessments, clinical observations, and interview.	
Relevant Research	**Authors**	**Study and Outcomes**
	Cook, A., Blaustein, M., Spinazzola, J., & Van der Kolk, B. (Eds.). (2003). *Complex trauma in children and adolescents.* National Child Traumatic Stress Network. www.nctsn.org.	This paper explores complex trauma in children and adolescents including: Definitions and domains of impairment (attachment, biology, affect regulation, dissociation, behavioral control, cognition, and self-concept) Impact of complex trauma and the importance of family and community influences Approaches to assessment and treatment Clinical interview, behavioral observation, and standardized assessment as part of a thorough assessment of complex trauma in children and adolescents Key aspects of treating complex trauma in children including: Safety in child's home, school, and community Skills development in affect regulation and interpersonal functioning Making sense of traumatic experiences Increasing resiliency and integration into the social network

Relevant Research *(continued)*	Authors	Study and Outcomes
	Gothard, S., Ryan, B. E., & Heinrich. T. (2000). Treatment outcome for a maltreated population: Benefits, procedural decisions, and challenges. *Child Abuse and Neglect, 24*(8), 1037–1045.	This paper reviews: Benefits, challenges, and procedural decisions to consider when implementing and managing a treatment outcome program for traumatized children Reasons to implement a treatment program Decisions regarding procedures Challenges likely to be encountered based on literature in the field What the authors experienced in developing the program The authors recommend careful measurement selection, early and ongoing staff involvement, support from higher management, a well-developed database and client tracking system, a coordinator and support staff, determining clinical utility of each measure used, planning for fiscal impact, and flexibility to contend with challenges. The authors conclude that the richness of clinically and administratively useful information derived from an outcome program far outweighs the challenges and costs of establishing and maintaining an outcome program.
	Hazen, A., Taylor, N., Landsverk, J., Ryan, B. E., Garland, A., & Wilson, C. (2006). *Clinician perspectives on the use of standardized assessments in mental health services for maltreated children.* Unpublished manuscript.	In a mental health program for maltreated children 35 clinicians responded to a self-report survey inquiring about their attitudes and practices associated with the use of standardized assessment measures. Participants provided moderately positive evaluations of the utility of assessments for identifying client problems, developing treatment goals and initial treatment plans, and monitoring progress in treatment. Standardized measures were perceived to be less useful for selecting treatment approaches and for guiding decisions about altering treatment approaches. Reported barriers to the use of standardized assessments included burden to clients and clinicians, client comprehension of assessments, and other informant issues.

Relevant Research *(continued)*	Authors	Study and Outcomes
		Suggestions to decrease these barriers included providing pathways for clinicians to follow for assessment and treatment decisions, and increasing clinical training on standardized assessment and providing results to clients.
References	1. Taylor, N., Gilbert, A., Mann, G., & Ryan, B. E. (2006, July). *Assessment-based treatment for traumatized children: A trauma assessment pathway model (TAP).* Chadwick Center for Children & Families, Children's Hospital, San Diego. Retrieved September 8, 2006 from www.chadwickcenter.org	
Contact Information	Contact name: Alicia Gilbert, PhD Affiliation/Agency: Chadwick Center for Children & Families at Rady Children's Hospital and Health Center in San Diego. Email: agilbert@rchsd.org Phone: 858-576-1700, ext. 8682 Fax:858-966-7524	

Appendix F: Posttraumatic Stress Disorder (PTSD)

Abstracted from the *Diagnostic and Statistical Manual of Mental Disorders DSM-IV-TR (4th Ed.),* 2000, American Psychiatric Association.

To meet full diagnostic criteria for PTSD the following must be present:

1. The person experiences a traumatic event in which both of the following were present:

- The person experienced or witnessed or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others
- The person's response involved intense fear, helplessness, or horror

2. The traumatic event is persistently reexperienced in any of the following ways:

- Recurrent and intrusive distressing recollections of the event, including images, thoughts, or perceptions
- Recurrent distressing dreams of the event
- Acting or feeling as if the traumatic event were recurring (e.g., reliving the experience, or having illusions, hallucinations, and dissociative flashback episodes including those upon wakening or when intoxicated)
- Intense psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event
- Physiological reactivity on exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event

3. Persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness (not present before the trauma), as indicated by at least three of the following:

- Efforts to avoid thoughts, feelings, or conversations associated with the trauma
- Efforts to avoid activities, places, or people that arouse recollections of this trauma
- Inability to recall an important aspect of the trauma
- Markedly diminished interest or participation in significant activities
- Feelings of detachment or estrangement from others
- Restricted range of affect (e.g., unable to have loving feelings)

- Sense of a foreshortened future (e.g., not expecting to have a career marriage, children, or a normal life span)

4. Persistent symptoms of increased arousal (not present before the trauma) as indicated by at least two of the following:
   - Difficulty falling or staying asleep
   - Irritability or outbursts of anger
   - Difficulty concentrating
   - Hypervigilance
   - Exaggerated startle response

5. The symptoms on Criteria 2, 3, and 4 last for more than one month.

6. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Appendix G: Sample Release of Information/Authorization

Authorization for Use or Disclosure of Health Information

AUTHORIZATION: I hereby authorize (Name and address of facility or individual):

_____

to furnish to {or} to obtain from (Name and address of facility or individual):

_____

health records and information pertaining to medical history, mental or physical condition, services rendered, or treatment of:

(Name of Patient) _____ Date of Birth: _____

Dates of Service: _____

This authorization is limited to the following medical records and type of information:

☐ Discharge Summary ☐ History ☐ Consultation Reports ☐ Progress Notes
☐ Photographs, videotapes, digital, or other images ☐ Other (please specify any limitations):

_____

USES: The requestor may use the medical records and type of information authorized only for the following purposes:

☐ Continuing Care ☐ Inspection of Record Only ☐ Legal Matter ☐ Insurance Claim
☐ Personal Copy

DURATION: I understand this authorization may be revoked in writing at any time, except to the extent that action had been taken in reliance on this authorization. Unless otherwise revoked, this authorization will expire six months from the date of this authorization.

RESTRICTIONS: I understand that (Name and address of facility or individual):

_____

may not further use or disclose the medical information unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law. I hereby release (Name and address of facility or individual):

_____

from any/all legal liability that may arise from the release of this information to the party named above.

ADDITIONAL COPY: I further understand that I have a right to receive a copy of this authorization upon my request.

SIGNATURE:

_____
Signature Date

_____
Relationship to Patient Area Code & Phone Number

_____
Witness

Appendix H. Links to Additional Relevant Resources

National Children's Alliance
www.nca-online.org

Substance Abuse Mental Health Services Administration
www.samhsa.gov

National Child Traumatic Stress Network
www.NCTSN.org

Established by Congress in 2000, the National Child Traumatic Stress Network (NCTSN) is a unique collaboration of academic and community-based service centers whose mission is to raise the standard of care and increase access to services for traumatized children and their families across the United States. Combining knowledge of child development, expertise in the full range of child traumatic experiences, and attention to cultural perspectives, the NCTSN serves as a national resource for developing and disseminating evidence-based interventions, trauma-informed services, and public and professional education.