illinois childhood trauma coalition

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Illinois Childhood Trauma Coalition White Paper: Child Trauma as a Lens for the Public Sector

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December 1, 2010

1. INTRODUCTION

Childhood Trauma can disrupt a child's normal development and lead to physical, emotional, cognitive, behavioral and social problems. Defined as "the emotionally painful or distressful experience of an event by a child that results in lasting mental and physical effects," childhood trauma is reported with high frequency among children served in the public sector. For example, a federal study of a juvenile detention center in Chicago found that 84% of the youth reported multiple exposures to trauma, with a majority exposed to six or more events. By definition, all children taken into custody by child welfare are suspected to have been abused or neglected, which may be traumatic events.

Traumatized children often exhibit disruptive behaviors that challenge our child welfare, education, mental health and juvenile justice systems. Even pre-school programs dismiss acting out children. Difficult to recognize, childhood trauma requires long-term, coordinated care. Left untreated, it can lead to a lifetime of struggles and early death. There is hope for traumatized children but only if we understand the context in which these issues arise.

Our state governments have always struggled with how to deal with acting out youth that are not properly cared for within the traditional family structure. The United States Constitution grants states both police powers and parens patriae (parental) powers. Police powers allow states to protect their citizens from dangerous individuals and led to, among other things, the development of penal institutions for youth who acted out. Parental powers allow states to care for citizens who cannot care for themselves, which led to the development of orphanages for children who were not properly cared for. Thus, from the start, our states have taken both a punitive and paternalistic view of youth- and struggled to resolve the inconsistencies.

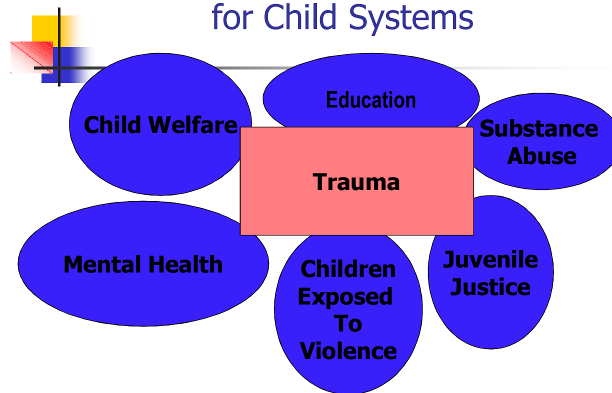
Today, the public sector is more sophisticated and specialized in dealing with youth. Penal institutions have evolved into the juvenile justice system and orphanages have evolved into the child welfare system. In addition, we have developed agencies that deal with various other aspects of the child, including his/her health, education, mental health, substance abuse, and exposure to violence. Some of these agencies are more prescriptive (health and education) while others are more proscriptive (juvenile justice, substance abuse) and intervene when problems arise. Each agency has a different focus and mandate. Each views the child from its own perspective and intervenes accordingly. Unfortunately, this means that the various public sector approaches to youth are not consistent and, in fact, may directly conflict with one another.

Current best practice calls for coordinated services through a system of care. However, this is extremely difficult for the public sector to achieve as there is no generally shared view of the child. Agencies do not have a common view of normal child development. Nor do they

agree as to what causes a disruption in normal development. Most public sector agencies do recognize similar disruptive behaviors in children. However, depending on which adult is assessing the child, the disruptive behaviors may be interpreted very differently. The youth may be referred to different public sector agencies for the same disruptive behaviors. Yet the treatment that a child receives can vary greatly by agency (incorporating the classic punitive/paternalistic debate). Given that the referral is based on the adult's interpretation of the youth's behavior, it is essential to understand how the adult views the youth and how this drives the public sector response.

Current research on brain development is beginning to offer a scientific basis for understanding child development. Further, new theories of child trauma offer explanations for how particular experiences can disrupt normal brain development and result in multiple problems, including disruptive behaviors. These two concepts of brain development and child trauma cut across the public sector system. These concepts can drive methods of prevention, early intervention, treatment and followup care. Finally, brain development and child trauma offer a common goal for public sector interventions- the return to normal development.

Figure 1: A Common Theme for Child Systems



2. CHILD AND ADOLESCENT BRAIN DEVELOPMENT

In the past ten years, researchers have published a wave of studies relating to brain development. This research is now possible due to the great advances in medical technology. Historically, brain research was conducted using invasive or post-mortem procedures. With the advent of MRIs and PET scans, human brains can be studied in exquisite detail and over time without any invasive procedures. Scientists can watch the brain grow and see how brains process stimuli.

The brain is composed of billions of cells. Each cell can develop connections to many other cells, resulting in trillions of connections in the brain. This complex series of connections produces huge processing power. Yet the human brain, fully grown, weighs only about three pounds and would be about the size of your two fists held together.

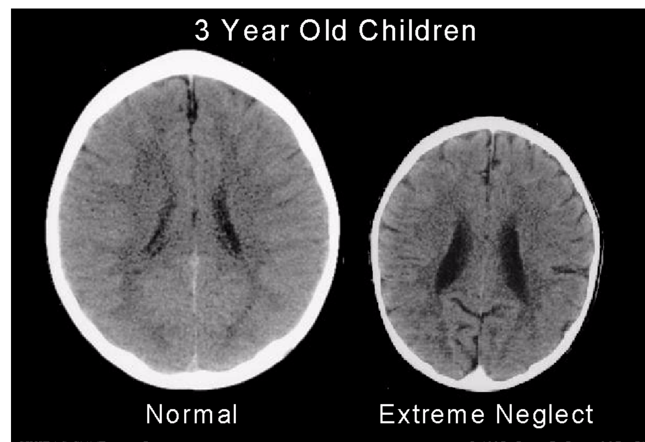
A key concept in brain development is plasticity. That is, the brain is constantly changing based on what it is exposed to. Everyone is born with more brain cells than they will use. As a baby starts to grow, the brain begins to prune itself, getting rid of brain cells that are not being used, thereby making it more efficient. Cells that are used and connect to other cells will be preserved. Timing also matters, so that a brain is prepared to learn certain functions at certain ages. But this can only happen if the brain receives appropriate exposure and stimulation

at that time. Early deprivation can result in delayed or failed development of some functions (e.g. vision, attachment, language).

A person's brain controls multiple functions, including basic life functions (e.g. breathing, heart rate, and temperature), emotions and thinking. In utero, the part of the brain that controls basic physical life functions starts to develop first, followed by the emotional centers and, finally, the thinking centers. Thus, at birth, the basic life functions are in place, while the child's emotional functioning is just beginning and many of the thinking functions (such as language and long term memory) are still a ways off. All these functions will develop naturally if the baby is cared for and stimulated appropriately.

What the new research has discovered is that the growth of brain cells and pruning process that occurs in early childhood repeats itself in adolescence. A key point is that the brain development in adolescence progresses in the same functional order. That is, adolescence starts with puberty and physical changes (around ages 10 – 13). Children get bigger and start to develop sexual characteristics. Next comes the emotional development, where a teenager's moods become more intense and quicker to change. A youth's highs are higher and lows are lower and the youth does not think an adult can possibly understand the intense feelings that he/she is experiencing. Finally, the child's thinking matures. The youth becomes less impulsive, more risk averse and better at planning. This last cognitive function does not finish developing until the youth is in his/her younger twenties. Thus, during the teenage years, the youth is getting bigger and stronger with more intense emotions but does not have the capacity to completely regulate these functions until he/she is older. It is like giving a teenager a new car with a great body and a lot of horsepower (physical), a gas pedal that goes from 0 – 60 in a few seconds (emotional), but an incomplete brake system (thinking).

The U.S. Supreme Court relied, in part, on this brain research when it ruled in 2005 that it was unconstitutional to give the death penalty to juveniles (Roper v. Simmons) and, again, in 2010, when it ruled that it was unconstitutional to give life without parole to juveniles in nonhomicide cases (Graham v. Florida). The court, in effect, recognized that, while some youth have done terrible things, the youth are still changing and, with time, may mature. Normal development and maturation is not guaranteed, however, because it depends, in part, on what the youth is exposed to and how that youth is treated. When mistreated, a youth's development can be disrupted. The child's brain is affected by both negative and positive experiences. The positive allows for optimal development, resilience and recovery.



(Perry, Bruce [2002]. Figure 2: These images illustrate the impact of neglect on the developing brain.[1])

3. CHILD TRAUMA

The National Institute of Mental Health (NIMH) defines Childhood Trauma "as the emotionally painful or distressful experience of an event by a child that may result in lasting mental and physical effects." While there are other definitions, all seem to include three essential factors: the Event, the Experience and the Effects.

There is not a finite list of *events* that can cause trauma. There is consensus that, to cause trauma, an event must be extreme. There is an assumption that children can cope with day to day problems and stresses. In fact, learning to cope with daily stressors can actually make a child stronger and more resilient. There is also a growing consensus, that the event can be either one extreme incident or a series of intense, but less extreme, incidents. For example, nearly being killed in a car accident can be traumatizing. But so can growing up in an extremely violent neighborhood where a child repeatedly witnesses violence, even if that child is never directly attacked. Extreme physical or emotional neglect by a parent, while not a single event, is the sort of chronic negative experience that can affect a child's brain development and be part of an intense, traumatizing process.

The second essential factor, the *experience* of the event, is a subjective factor. The person must have an intense experience for it to be traumatizing. A young child might nearly be hit by a car but not appreciate the danger he/she was in, though seeing it might be a traumatizing experience for the mother. Conversely, a young child might be frightened by a shadow and calmed by the parent. Younger children can be much more responsive to the reactions of their parents than they are to objective dangers.

The final factor, the *effect* of the event and its experience, is also not a finite list. There are powerful effects that may be obvious within a short time of the event. Some of these are transitory and will dissipate over time (and, therefore, not result in 'trauma'). There are also effects that can take longer to manifest but will be sustained. Current research is just beginning to document some of the long-term effects of childhood trauma. These long-term effects can range from an early death of the traumatized youth all the way to intergenerational trauma issues, with families repeating cycles of unhealthy behaviors (such as children who cycle through child protection courts to juvenile justice courts to criminal courts and then have their own children who start over in child protection courts).

A. Short Term Effects

Immediately after a disaster, it is common for victims to be shocked, fearful, angry or confused. They may be withdrawn and isolative. They may develop a number of physical complaints, such as fatigue, headaches, or sleep difficulties. Younger children's behavior may regress, becoming more clinging or returning to earlier habits such as thumbsucking. Older youth may have more sleep difficulties and generally be angrier.

It is normal to grieve one's losses. In most cases, these are temporary states that will pass. Additionally, there are things other people can do to support disaster victims. The National Child Traumatic Stress Network (NCTSN) publishes a manual on Psychological First Aid (PFA) which "is designed to reduce the initial distress caused by traumatic events and to foster short- and long-term adaptive functioning and coping." Most people are resilient and will recover, returning to their normal (pre-disaster) functioning.

During the first month after a disaster it is too early to determine whether someone is traumatized. Of course, the issues become more complicated when the problem is not a one-time disaster that has passed but rather is an ongoing problem, such as domestic or community violence, where the child does not recover a feeling of safety.

B. Post Traumatic Stress Disorder and Other Terms

Post Traumatic Stress Disorder (PTSD) is the classic trauma diagnosis and is listed in the American Psychiatric Association's (APA) Diagnostic and Statistical Manual (DSM, currently in its fourth edition), the official book of diagnoses used by clinicians and third party payers. This diagnosis requires that, after the traumatic event and traumatic experience, the person demonstrate three types of effects: Re-experiencing, Avoidance and Increased Arousal. Re-experiencing might include nightmares and flashbacks. Avoidance might include refusing to attend activities that trigger reminders of the event or feeling detached from significant others. Increased Arousal might include the person having difficulty concentrating, being easily agitated or remaining hypervigilant.

PTSD was developed to describe what happened to soldiers who survived war and the use of the diagnosis has seen a resurgence with soldiers now returning from Iraq and Afghanistan. However, as noted in the 2010 American Academy of Child and Adolescent Psychiatry's practice parameter for the assessment and treatment of children and adolescents with posttraumatic stress disorder, "there is clinical consensus that children with severe PTSD may present with extreme dysregulation of physical, affective, behavioral, cognition, and/or interpersonal functioning that is not adequately captured in current descriptions of PTSD diagnostic criteria. Some of these children may be misdiagnosed… (pp.415 – 416)"

There is also a wide range of possibilities between the initial NIMH definition of childhood trauma (where there "may" be effects) and the definition of PTSD (that requires multiple, specific effects). Researchers are exploring child trauma terms that address aspects of this range. For example, youth may be dealing with "complex trauma" that includes multiple, chronic experiences involving a caregiver that can result in emotional dysregulation and the loss of the ability to detect or respond to danger cues. Other youth might be responding to "early childhood trauma" which focuses on young children who are at particular risk because of their rapidly developing brains. Early childhood trauma has been associated with reduced size of the brain cortex, an area of the brain responsible for many complex functions including memory, attention, perceptual awareness, thinking, language, and consciousness. There is even a new diagnostic term, "developmental trauma disorder," that other researchers are proposing for inclusion in the DSM-5 that is due out in 2013.

C. Disruption in Brain Development

Our brains have a very effective alarm system. When we perceive a threat, our brain's alarm system triggers a series of reactions designed to allow us to survive. Adrenalin is pumped into our blood stream which, for a short time, allows us to run faster, be stronger, feel less pain and get out of danger. At the same time, cortisol flows through our brain triggering a number of physical, emotional and cognitive reactions. Our hearts race and our palms sweat. Feelings become more intense. Our minds concentrate on possible solutions to the danger and, when the perceived danger has passed our brain turns off its alarm system. Post crisis we experience a let-down. We have been tapping into our energy reserves and we are exhausted. But we have survived.

The new brain research is finding that extreme or chronic traumatic events interfere with the development of a child's alarm system. Early findings indicate that the 'on switch' for the brain's alarm system grows larger and the 'off switch' becomes smaller. This results in an oversensitive warning system. The youth's alarm is constantly going off, leaving the child hyperaroused and overreactive. That youth is not concerned with daily activities, learning or

long-term planning. When a child feels constantly threatened, he or she remains focused on survival.

D. Developmental Response Styles

Children who are abused or neglected by caretakers learn that the world is not a safe place. Everyone is a potential threat. No one can be completely trusted. Their perception of the world is different than children with healthy attachments to adult figures. With healthy attachments, children can be taught how to regulate their emotions and reactions. Traumatized children may not learn this. Depending on when the mistreatment occurred, traumatized children may not have developed the ability to form healthy relationships. These children may not have learned how to regulate their emotions. They remain subject to misperceiving signs of threat and overreacting to these perceived threats. Unable to soothe themselves, they are more likely to engage in high risk behaviors.

Clinicians have identified three response styles that traumatized youth employ. The first two are the more active responses of "fight or flight." When a youth's alarm goes off and survival mode kicks in the youth wants to end the threat. The youth may attack the perceived perpetrator. Given the traumatized youth is prone to overinterpret signs of danger; this reaction will often be out of proportion to the reality of the situation. For example, in a school hallway, one youth may bump into another as they are going to their classes. Many children would disregard such minimal contact and focus on getting to class. A traumatized child might perceive the bump as an assault and respond violently in "self-defense." If the traumatized youth believes that he or she can escape from a threatening situation then the child might react to the perceived threat by flight, avoiding or quickly leaving the situation. This response can include actual runaway behavior.

The third response style is more passive or internalized and is often referred to as 'dissociation.' When the traumatized youth feels threatened and cannot cope with the threat, the child can become overwhelmed and simply shut down. The child may become totally nonresponsive to external cues and, in some circumstances, may actually lose consciousness. These youth are also at high risk for cutting and self-destructive behavior. Self-mutilators will explain that they are not trying to kill themselves. Instead, the cutting actually relieves some of their anxiety and, for a brief period, helps lower their arousal levels. They also may use drugs to self-medicate and temporarily block out their pain or general feelings of apprehension. They are attempting to temporarily shut off their aversive world.

Developmental research has found that children are particularly sensitive to the facial cues of adults and authority figures. Babies naturally learn to make eye contact and respond to the facial cues that a mother is sending. With normal development, the children go on to distinguish various facial expressions and identify the emotions that they reflect. Traumatized children are not as good at reading facial cues and they tend to overinterpret adult facial cues as showing distress and anger. This means that the traumatized youth are likely to misperceive authority figures as being more threatening and the youth will react in ways they feel will help them survive even when, in reality, there is no threat.

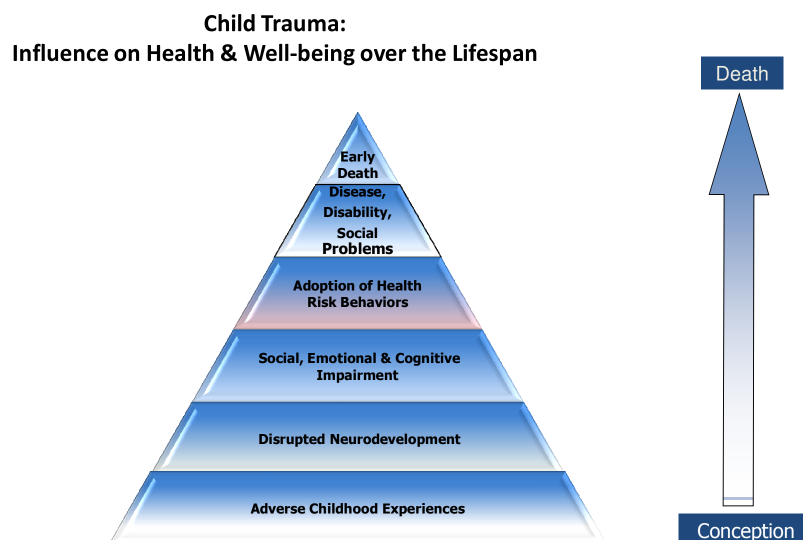
Research also indicates that children who are mistreated and traumatized at a young age are less ready to start pre-school than non-traumatized children. These same traumatized children are less likely to do as well as other children in school. They are more likely to act out when they are not doing well. As they get older, they are more likely to drop out of school.

All these response styles can develop from early childhood experiences. These styles describe the behaviors of the youth. Current research strongly suggests that, if untreated, these problematic responses will not resolve themselves and will result in long-term complications.

E. Long Term Impact of Adverse Childhood Experiences

The most striking research regarding the long term effects of early childhood mistreatment involves the Adverse Childhood Experiences Study (ACES). What began as a retrospective study of health care has become an ongoing longitudinal study supported by the Centers for Disease Control. ACES focuses on ten categories of early maltreatment: emotional abuse, physical abuse, sexual abuse, emotional neglect, or physical neglect or household dysfunctions such as a household member being imprisoned, doing drugs, being mentally ill, being absent or engaging in domestic violence. (The authors of the study point out that this is not an exhaustive list of adverse experiences or traumatic events. Other researchers have included adverse events such as living in a violent neighborhood, living in extreme poverty, being confined in juvenile detention centers or being taken into the custody of child welfare and then moved to multiple foster homes.)

The ACES research demonstrates that the number of categories a child experiences directly relates to clinical problems that the child will develop in later life including psychiatric disorders (such as depression or suicide), high risk health behaviors (smoking, alcoholism, drug use or multiple sexual partners), medical diseases (heart disease, liver disease or sexually transmitted diseases), and a shortened lifespan. The untreated traumatized child is likely to grow into a traumatized adult.



Drawn as a pyramid, the basic ACES model shows how these adverse experiences make it more likely that a child will develop social, emotional and cognitive impairments; that these impairments will lead to the adoption of high risk health behaviors; that these behaviors will lead to disease, disability and social problems; which, in turn, will lead to the likelihood of early death.

F. Prevalence Rates

Prevalence rates of child trauma vary depending on how the researchers define “trauma.” Estimates of the percentage of children who experience traumatic “*events*” will be much higher than those who experience traumatic “*effects*” since not all children who are exposed to events

become traumatized. Even within the categories a list of qualifying "*events*" can be defined more broadly or narrowly and "*effects*" can be defined as the percentage of youth who show some symptoms of child trauma (more broadly) to those who are diagnosed PTSD (more narrowly). For example, in Illinois, studying those children taken into state custody by the Illinois Department of Children and Family Services (DCFS) due to abuse or neglect, 97% of the youth experienced a potentially traumatic *event* (and would, therefore, qualify for the NIMH definition of childhood trauma), approximately 25% had identifiable trauma symptoms (*effects*) but fewer than 5% would qualify for a full diagnosis of PTSD (having the correct combination of multiple *effects*).

A longitudinal general population study of children and adolescents (9-to-16-year-old youth) found that 25% experienced at least one potentially traumatic "event," 6% within the past three months. Research on specific at-risk groups includes the Fourth National Incidence Study of Child Abuse and Neglect's 2010 Report to Congress, which found 1,256,600 children received harmful maltreatment in the one year studied (2005-2006). A National Child Traumatic Stress Network (NCTSN) study found that over 75% of the youth in the juvenile justice system have experienced traumatic victimization. A federal study of a juvenile detention center in Chicago found that 84% of the youth reported multiple exposures to trauma, with a majority exposed to six or more events. General population studies also found that anywhere from 0.5% to 10.4% of youth developed PTSD, with females having a higher rate than males. The NCTSN reports that over 50% of the youth in the juvenile justice system have some trauma symptoms. National studies have not yet been done to assess the prevalence of the new terminology, such as "developmental trauma disorder" in children.

G. Costs

Cost estimates of child trauma are even more speculative than prevalence rates. Authors of the ACE Study merely note that "[A]nalyses of the relationships of ACE Score to doctor office visits, Emergency Department visits, hospitalization, and death are in progress. (2009)" In 2002, the U.S. General Accounting Office published a report on the "Effectiveness of Insurance Coverage and Federal Programs for Children Who Have Experienced Trauma" but concluded that the answer was "Largely Unknown." In 1996, the Third National Incidence Study of Child Abuse and Neglect estimated that direct annual costs of child maltreatment were approximately $24 billion dollars (including health, mental health, child welfare, law enforcement and court costs) and the indirect annual costs were an additional $69 billion dollars (including special education, juvenile justice, and adult services costs).

H. Clinical Response to Trauma

Child trauma theory offers some reasons for hope. First, not all children exposed to traumatic events become traumatized. Some children are resilient and can tolerate higher levels of stress and adversity. Further, in terms of prevention, a child's strengths can be developed to increase resilience prior to traumatic events. Next, even when a child has been negatively impacted by trauma, removing a child from the adverse situation and putting him or her in a safe setting will allow for positive neurological changes to begin, due to the plasticity of the brain. Finally, when a child has been exposed to traumatic events and is showing clinical symptoms, there are some effective treatments available. These various responses can be viewed through the public health, three-tiered model of universal, selected and indicated interventions.

At a universal level, all adults and families could benefit from education about the impact of adverse experiences on children. It might help prevent some future abuse. Within education

programs, certain groups might receive more focused training. For example, all mandated reporters for child abuse and neglect should understand signs of childhood trauma. First responders, such as police, firefighters and the Red Cross could benefit from training in Psychological First Aid. Staff that work with youth in institutional settings, such as schools and juvenile justice institutions, might benefit from training on how to deal with traumatized children that are acting out, reviving the punitive/paternalistic dilemma.

At the selected level, children who have been exposed to potentially traumatizing *events* should receive support and assessment. Dr. Carl Bell, a psychiatrist based in Chicago and a pioneer in warning about the impact of violence on children in the public sector, likes to say that "Risk factors are not predictive factors because of protective factors." That is, just because a child is exposed to adverse experiences does not mean that the youth is doomed to be traumatized and have a lifetime of problems. Protective factors help a youth become resilient and survive despite those adverse experiences. Therefore, those children who are exposed to adverse *events* should receive the support that will help them develop resilience. While the research on protective factors is not as well developed as the research on the risk factors, there are, nonetheless, a number of skills that can be taught at the child, family, caregiving and community levels.

For all those youth who have experienced adverse *events*, another selected intervention should include assessment for possible trauma symptoms or *effects*. Some assessment tools, such as the Trauma Symptom Checklist for Children, focus primarily on trauma. Other assessment tools, such as the Child and Adolescent Needs and Strengths (CANS), are mental health assessments that include specific sections assessing trauma experiences and trauma symptoms. Many trauma tools are available and could be incorporated into existing child assessments used by different public sector programs. For example, in Illinois DCFS and some mental health and juvenile justice programs already use the CANS.

When an assessment identifies possible trauma symptoms, those youth reach the indicated level where they should receive treatment. Evidence-based practices are being developed to treat traumatized children. Depending on the age and ability of the child, there are individual, group and family therapies available. All of the therapies involve helping the youth to better regulate his or her physical, emotional and cognitive reactions to trauma triggers. Some therapies do this by exposure to and exploration of the traumatic event. Other therapies do not use exposure, focusing only on the present and moving forward. Some therapies are manualized. Several of the therapies offer certifications where the developer trains the therapists in the specialized treatment and then supervises the therapists through a series of actual clinical cases. NCTSN keeps a list of Empirically Supported Treatments and Promising Practices on its website.

Healing requires more than evidence-based practices provided by trained professionals. Healing is a family issue and the child needs family and other natural supports. If a child is living in a situation involving domestic violence or living in a violent community, one hour a week of professional outpatient therapy will have limited effect. Therapeutic interventions need to be part of a plan of coordinated care. If adults are not on the same page in responding to the traumatized youth, recovery can take considerably longer. A traumatized youth needs an overall plan for *safety, support, self-regulation and strengths*. First, a traumatized child needs a place to feel safe. If that youth does not feel safe, his or her internal alarm system will continue to go off and that youth will not be able to calm down enough to change. As part of feeling safe, that child needs a supportive adult, preferably a supportive family. It is not easy for a youth who has been mistreated by a caretaker to trust any adult but this is an essential part of the healing process. When a child has a place to feel safe and an adult he or she can trust, then the youth can begin to learn better self-regulation skills. Youth can learn to deal with feelings of alarm and to

calm down rather than act out. They can learn positive alternative responses to dealing with threats. Structured, evidence-based therapy can be very effective in helping a child to develop these self-regulation skills. Part of this skill set should include developing positive behaviors and strengths as well as learning to control the negative behaviors. These various aspects of care (*safety, support, self-regulation and strengths*) require working with the youth, the family and significant others in the child's life. Coordinating the efforts of the caring adults will optimize the healing of the trauma.

Though there is not adequate space to develop the concept in this paper, culture can play a major role in child trauma and recovery. What is considered normal and acceptable behavior in one culture may be seen as offensive or extreme in another. The role of females and acceptable ways for males to treat them varies by culture. Every religion has some framework for understanding why good people must suffer. Some families may prefer to work with healers from their own culture rather than with therapists using evidence-based practices. As an example of a cultural issue related to trauma, one of the authors was approached by a teacher and asked to speak with an upset student who was seeing visions of her dead father appearing to her during the school day. The teacher was concerned that the youth might be psychotic and hallucinating. The author considered the possibility of traumatic flashbacks and re-experiencing. In fact, the student spent her early childhood in another country and, in her village, it was considered an honor to be visited by one's ancestor. Clearly, trauma "symptoms" and therapeutic responses are intertwined with culture. Thus, trauma assessment and services need to be culturally sensitive. The NCTSN has published a summary of its Trauma-Informed Interventions: Clinical and Research Evidence and Culture-Specific Information Project.

4. SYSTEMIC RESPONSES

A. National Organizations

Both the public and private sectors have organizations that address child trauma. The primary public sector organization is the National Child Traumatic Stress Network. Created in 2001, NCTSN is funded by Substance Abuse Mental Health Services Administration (SAMHSA) within the U.S. Department of Health and Human Services (HHS). It consists of three levels of organization. Category I, the National Center for Child Traumatic Stress (currently based at UCLA and Duke), coordinates collaborative activity and oversees resource development. Category II consists of the Treatment and Services Adaptation Centers (research), which study specific types of traumatic events, population groups, and service systems as well as the adaptation of effective treatment. Category III consists of the Community Treatment and Services Centers (direct service), which implement treatment and services in community settings and service systems. Category II and III providers typically receive three years of SAMHSA funding. NCTSN maintains the best website (www.nctsn.org) for general materials on child trauma, including training, assessment and treatment materials.

The Child Trauma Academy (www.childtrauma.org), a major non-NCTSN child trauma group, is a private, not-for-profit organization, based in Houston, Texas and was founded by Bruce Perry, M.D., Ph.D. Dr. Perry began his work in Chicago and has become an internationally recognized expert on child trauma. The CTA also has an excellent website with training, assessment and treatment materials.

There are many other important private and governmental organizations that deal with child issues that are relevant to trauma (though these organizations may not have specific trauma programs), such as Voices for America's Children, Zero to Three (early childhood) and the Administration for Children, Youth and Families (ACYF is part of the U.S. Dept. of Health and

Human Services (HHS) and oversees funding of child welfare and homeless and runaway youth). Some agencies take a focus that occasionally overlaps with child trauma concerns, such as the U.S. Department of Justice (DOJ) recently awarding grants to address the high incidence of children's exposure to violence (CEV).

B. Illinois Organizations

Illinois has multiple organizations that address child trauma and many have received federal funding to start this work. Though it is not possible to describe every relevant program, some of the early and larger projects are worth noting. In 2000, the Chicago Department of Public Health initiated Chicago Safe Start and the Illinois Violence Prevention Authority (IVPA) initiated the Safe From the Start Grants Program to provide funds to selected sites to develop, implement and evaluate community-based models for identifying and providing services to young children (0-5) who have been exposed to and traumatized by violence in the home and community, and their families/caregivers. Program activities also include public education and systems advocacy related to preventing children's exposure to violence and intervening early when necessary. Currently, IVPA funds twelve sites statewide including four Safe Start sites in Chicago.

The National Child Traumatic Stress Network is currently funding several Category II and III Centers in Illinois. Two Category II providers in Illinois are the University of Illinois at Chicago/Institute for Juvenile Research and Northwestern University Feinberg School of Medicine's Center for Child Trauma Assessment and Service Planning. There are currently five Category III providers in Illinois: Chaddock (Quincy and West-Central Illinois), Children's Research Triangle (Chicago and Belleville), Heartland Alliance (Chicago), LaRabida Hospital (Chicago), and Youth Network Council (Carbondale, Granite City, Ottawa, Palatine, Rockford, and Springfield).

The Illinois Department of Children and Family Services (DCFS) began to use a trauma-informed approach to the provision of child welfare services in 2004 after federal reviewers from ACYF found that DCFS did not have an adequate system to address the mental health needs of its wards In response, DCFS contacted NCTSN, Dr. Frank Putnam, Dr. Bruce Perry, and several developers of evidence-based child trauma therapies, and local University partners who assisted DCFS in developing a trauma-informed program for wards. This resulted in a paradigm shift away from referring to DCFS youth as mentally ill and towards referring to them as reacting to traumatic events. DCFS implemented a three tiered trauma program of training, assessment, and service and treatment planning. Currently the department utilizes a learning collaborative model to support the ongoing training and support for over 3500 child welfare professionals.

Chicago Metropolis 2020 (CM2020) collaborated with the early CEV grants and DCFS. In 2006, CM2020 helped convene the Illinois Childhood Trauma Coalition (ICTC) with the initial Board of Directors consisting of leaders from the Chicago Department of Children & Youth Services (Tony Raden), CM2020 (Paula Wolff), DCFS (Andrea Ingram), IVPA (Barbara Shaw) and Voices for Illinois Children (Gaylord Gieseke). Paula Wolff served as chair until 2010, when Kathy Ryg from Voices assumed that role.

ICTC is a voluntary organization that provides a forum for leadership from multiple disciplines and service areas to work on child trauma-related issues. "The goal of the Coalition is to take a public health approach to the evolving understanding of the nature and impact of childhood trauma and to expedite the integration of this wisdom into public awareness and the array of systems that serve children and families in Illinois." It currently has approximately 50 member organizations. Each of these organizations has its own concerns about trauma and

extensive history of dealing with traumatized youth. ICTC has established an ongoing relationship with NCTSN. In 2008, ICTC convened a meeting of several NCTSN experts regarding support for the new developmental trauma disorder diagnosis. ICTC meets quarterly and its members serve on relevant local, state and national committees.

ICTC has worked on several projects through its own committees. One committee focuses on statewide system issues, exploring the child and family serving systems in Illinois that have a role in preventing or treating childhood trauma. Other committees focus on training and education issues, with the Pre-Service Committee addressing programs at institutions of higher learning and the In-Service committee addressing programs for the work force. Through an additional work group, ICTC collaborated with several other organizations in developing and distributing the animated DVD series "Stories for Children that Grownups Can Watch." These Stories for Children include several animated stories involving children and families that have had traumatic experiences. Each DVD also includes a separate segment for adults, with various experts discussing the relevant trauma concepts. The DVDs are available in English and Spanish and are accompanied by coloring books illustrating the stories. Several thousand have already been distributed. More information can be obtained through the ICTC website at www.illinoischildhoodtrauma.org.

5. Systemic Issues

In Illinois, integrating trauma informed practices into public sector children's services is an enormous challenge. Given current state finances, there is not enough funding to assure adequate trauma services for all Illinois children. In addition, other obstacles remain, including:

A. Healthcare reimbursement for mental health requires a DSM diagnosis

The American health care system usually requires that a diagnosis be included with reimbursement requests. For mental health services, the diagnosis must come from the AP A's Diagnostic and Statistical Manual (DSM, currently in its fourth edition). As noted above, there is no current diagnosis in DSM that adequately captures the range of child trauma *effects*. Only PTSD is a DSM diagnosis but it just applies to the most severely traumatized youth. Often, in Illinois, traumatized youth are diagnosed with a DSM mental illness (such as bipolar disorder or attention deficit disorder) when receiving therapy, even if the therapist believes the underliying issue is child trauma. This not only adds additional labels and stigma onto a child, it can also drive treatment in a different direction. For example, diagnosing a child as bipolar or attention deficit can result in doctors or managed care reviewers recommending trials of medications that would not be used to treat child trauma. Even DCFS, which recognizes child trauma, pays for therapy through public aid and, therefore, DCFS providers must list DSM diagnoses when getting reimbursed for family, individual or group therapy. One possible solution could involve public sector agencies pursuing direct funding of healthcare for child trauma issues. For example, states are allowed some limited flexibility in their Medicaid billing. Another solution would be to get a child trauma diagnosis in the next edition of DSM.

B. APA has not accepted the proposed Developmental Trauma Disorder for DSM-5.

Illinois advocates (including Dr. Carl Bell from UIC/IJR, Dr. Brad Stolbach from LaRabida and Drs. Cassie Kisiel and Tracy Fehrenbach from Northwestern) have worked with NCTSN experts to provide data that would support a new child trauma diagnosis in DSM-5, scheduled to be published in 2013. The NCTSN experts presented this data to the APA's DSM-

5 committee. However, the committee felt that the data was not yet sufficient to justify the developmental trauma disorder (DTD) diagnosis. In early 2010, the APA allowed public comment on the proposed diagnoses and it received over a hundred comments regarding the need for a child trauma diagnosis. The DSM-5 committee is in discussions with NCTSN experts about DTD and possible alternative diagnoses. The Illinois advocates continue to work with the NCTSN experts in collecting additional data.

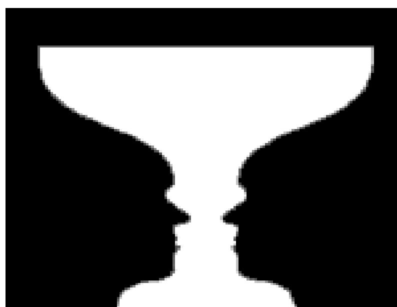
C. Lack of definitions and credentialing for trauma-informed treatment.

Just as anyone in Illinois can call themselves a "therapist" so any therapist can claim to be doing trauma treatment. When DCFS began its trauma program, many community providers explained that they were already doing trauma-informed treatment, though very few were using evidence-based practices. Just as there are many definitions of 'trauma' there are many ways for therapists to claim to be 'trauma-informed.' Does reading one article make a therapist trauma informed? What about attending one conference on trauma? Must trauma-informed treatment be limited to evidence-based practices? Must the therapist using an evidence-based practice be supervised by an expert for a certain period of time? DCFS is studying the merits of credentialing and the ICTC has recently formed a professional development committee that will be looking at standards and curricula for both people preparing to work with children and for current professionals.

D. The public sector agencies that serve children in Illinois do not share a common view of the child.

There are multiple child-serving agencies in Illinois. Each agency has a different focus and mandate. Each views the child from its own perspective and intervenes accordingly. The tension between youth as predator and youth as victim, as framed by our forefathers, continues. Unfortunately, a youth can be both a victim and a perpetrator. This means that various public sector approaches to children are not consistent and may directly conflict.

Imagine a youth who is not sitting still, not paying attention, over-reacting to slights and getting into fights. An adult must decide how to intervene. If the adult views that youth as a troublemaker, the adult might use a criminal justice approach, increasing punishments or having the youth arrested. If the adult views that youth as having attention deficit disorder, the adult might make a referral for a mental health and medication consultation. If the adult views that youth as traumatized, the adult might work with the youth on safety and self-regulation skills. These are three very different approaches. Yet, in each case, the child is exhibiting the same behaviors. It is the interpretation of the adult that varies. Given the many adults in a youth's life, it is possible for multiple interpretations to be made at the same time with conflicting responses to the youth. The key is how to coordinate these interpretations.



6. Action Steps for Illinois' Future

A. What not to do

Let's start with what is not called for: There is not a need for a new department of child trauma in Illinois. The issue is not how to create another agency in the public sector. Rather, it is how to get the current agencies to work with private providers, children, families and communities in ways that are consistent and coordinated. Toward this end, there are at least a dozen things that Illinois can start to do.

B. Suggested Steps

1. **Recognition by the child serving public sector agencies of the latest research on normal development and trauma:** Though child serving agencies have different mandates, they can all benefit from the common recognition of children's normal brain development and the recognition of trauma as a disruption in this development. This is not to say that all children in the public sector have been traumatized but it is probably fair to say that all child serving agencies in the public sector have to deal with traumatized youth. This means all public sector providers can share some common understanding of children and some common language in talking about youth. They can all share the goal of helping a child achieve normal development.

2. **Training of staff, families and youth:** Each public sector agency already has training programs for its staff. Brain development and trauma should be added to the training. Further, each department should see that the families and youth they serve get this information. Additionally, certain groups can receive advanced training. For example, all mandated reporters for child abuse and neglect could have training in how to recognize signs of childhood trauma. First responders, such as police, firefighters and the Red Cross could benefit from training in techniques such as Psychological First Aid.

3. **Prevention programs:** Those providers working with early childhood or prevention programs can incorporate concepts of building strengths and resilience in children and stopping cycles of intergenerational trauma.

4. **Early intervention programs:** For those providers working with children who have already been exposed to traumatic events, it is important for them to recognize the need for early screening, assessment and support. It is not sufficient to simply remove a child from a negative situation. Active intervention is required.

5. **Common assessment tools:** Public sector agencies should assess a child's positive, normal development as well as possible trauma. The use of common assessment tools or at least common items across provider assessments would allow for better communication and coordination of care.

6. **Trauma-informed treatment:** All public sector providers should be able to provide appropriate trauma-informed treatment for children and families. Evidence-based practices are available for clinicians to use in treating youth. Further, the broader

constructs of safety, supportive adult relationships, self-regulation and strengths can provide a role for families and natural supports in a wraparound service plan.

7. **Funding:** There is always a need for more public sector funding of services for youth and families. If agencies agreed as to what types of trauma assessments and treatments to use for which trauma symptoms, there might be some economy of scale savings. Further funding issues relate to diagnostic and Medicaid rules.

8. **Diagnosis:** Currently, DSM does not adequately address issues of child trauma. ICTC and several NCTSN funded Illinois providers are working on this issue.

9. **Medicaid:** Independent of the DSM decision, Illinois public sector agencies could pursue getting HFS to fund treatment for child trauma issues. States are allowed some limited flexibility in their Medicaid billing. This would still require Illinois providers to reach a consensus on the diagnostic issues but it would not require national consensus.

10. **Development of professional credentials for trauma-informed care:** Agencies can reach a consensus as to what qualifies a therapist as providing trauma-informed care. These criteria can be applied not only to current professionals but can also be adopted by clinical training programs.

11. **System coordination and shared services:** If child-serving agencies could contract with the same trauma-treatment providers (similar to the joint contracts which DCFS, Dept. of Human Services/ Division of Mental Health and the Dept. of Healthcare and Family Services offered to community providers for children's Screening, Assessment and Support Services) there could be a much more coherent, community-based system of care developed for traumatized children. A recent law authorizing shared services between the Illinois Department of Juvenile Justice and other state agencies offers a new opportunity for such system coordination.

12. **Universal child trauma awareness:** Moving beyond the public sector, ICTC is exploring the possibility of a universal approach to help the general public understand child trauma. This universal training could be developed to help people recognize basic emotional and behavioral indicators of child trauma and offer some very basic responses. In effect, it would be teaching an emotional and behavioral First Aid.

Such efforts would continue Illinois' movement beyond the orphanages and penal institutions, beyond the punitive/paternalistic debate and, instead, take a trauma-informed approach to working with children and families. This would be a challenging journey but could literally result in longer and happier lives for children. This, in turn, would benefit the entire Illinois community.

FOOTNOTE 1 Perry, Bruce (2002). Childhood Experience and the Expression of Genetic Potential: What Childhood Neglect Tells Us About Nature and Nurture. *Brain and Mind* 3**:** 79–100. "*Figure 1:* Abnormal brain development following sensory neglect in early childhood. These images illustrate the negative impact of neglect on the developing brain. In the CT scan on the left is an image from a healthy three year old with an average head size (50th percentile). The image on the right is from a three year old child suffering from severe sensory-deprivation neglect. This child's brain is significantly smaller than average (3rd percentile) and has enlarged ventricles and cortical atrophy. (p.93)"

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