

Inside this issue...

- 2 Juvenile Justice Roundtable
- 3 Upcoming: Secondary Traumatic Stress Series
- 3 Affiliate Corner Debuts: Chicago Child Trauma Center
- 4 Cultural Competence: the Organization Engages
- 7 Historical Trauma Explored, Part One

A QUARTERLY PUBLICATION OF THE NATIONAL CHILD TRAUMATIC STRESS NETWORK

New Members Join NCTSN Advisory Board

As the Network's new and returning grantees launch into the start of the funding cycle, the National Center for Child Traumatic Stress (NCCTS) has been busy assembling its new Advisory Board.

"Since 2004, the NCTSN Advisory Board has been a source of wisdom, support, and expertise, guiding the priorities and activities of the National Center and the NCTSN," said Ellen Gerrity, PhD, Associate Director and Senior Policy Advisor for the NCCTS. Of the 15 members of the 2013 Advisory Board, nine are returning and six are new appointees, Gerrity said.

One of the new members is Christine James-Brown, President and CEO of the Child Welfare League of America (CWLA), headquartered in Washington, DC. The CWLA and NCTSN have been strategic partners since 2005, collaborating on Learning Center Speaker series, training institutes, and related projects. For the recent Special Issue of CWLA's journal *Child Welfare* (Vol. 89, No. 6, 2012), titled "Effectively Addressing the Impact of Child Traumatic Stress in Child Welfare," James-Brown co-wrote the foreword with NCCTS Co-Directors Dr. Robert S. Pynoos and Dr. John A. Fairbank.

>>> *cont'd on pg. 6*

Grantees Enrich Network Mission, Part One: CAT II Centers

As a new four-year grant cycle begins, the NCTSN continues to expand its national reach and collaborative work and partnerships. The Network's centers and members are geographically and culturally diverse, and represent a wide variety of programs, populations, service systems, and professional disciplines. One glance at a national site map (see page 5) confirms the Network's scope.



The Network currently includes 79 funded centers and 90 Affiliate members, according to Dr. Robert Pynoos and Dr. John Fairbank, Co-Directors of the UCLA-Duke University National Center for Child Traumatic Stress (NCCTS). The NCCTS, a Category I center, coordinates the collaborative activities of the Network's 22 Category II grantees, 56 Category III grantees, and 90 Affiliate members.

This issue of *IMPACT* highlights four CAT II grantees as examples of hospital- or university-based centers involved primarily in the development of trauma-informed interventions. Next issue, a second feature will highlight several CAT III sites as examples of community-based organizations providing direct services to children and families within child-serving systems.

>>> *cont'd on pg. 5*

Giving a Voice to the Child

Steve Avalos has a clear goal: "To make sure no child has to go through the same things I did, thinking that failure is the only option and that gangs are the only avenue where we can find love and acceptance."



Silkscreen image of the Homeboy Industries motto, "Jobs not Jails," made by youth employed at the reentry program in Los Angeles.

His goal motivated Avalos to participate in a recent Juvenile Justice Roundtable held in Marina del Rey, CA, in February. Just four months earlier, Avalos had been paroled from prison; he currently serves as a mentor for high-risk and juvenile justice-involved youth through Homeboy Industries, a reentry program. Although speaking before an audience was stressful for him, Avalos believed he could bring something important to the roundtable. He wanted, he said, "to put a voice behind the child."

Avalos, 34, was raised in Los Angeles in a family with multigenerational ties to gang culture. His father was murdered before Avalos was born, and he saw his stepfather only during family prison visits. "I hated gangs and what that lifestyle did to my family," he said. But he had no models for any other path.

>>> *cont'd on pg. 2*

This project was funded by the Substance Abuse and Mental Health Services Administration (SAMHSA), U.S. Department of Health and Human Services (HHS). The views, policies, and opinions expressed are those of the authors and do not necessarily reflect those of SAMHSA or HHS.

Giving a Voice to the Child *cont'd from pg. 1*

When Avalos was 11, his older brother was killed in a gang shooting. "I became angry and hateful. That was the day I shaved my head," he recalled. Adopting the gang lifestyle he had so detested, Avalos was in and out of the juvenile justice system until the age of 17. In 1996 he was convicted and sentenced to life in prison for involvement in a gang shooting.

"Before my brother was murdered, I was already going down a negative path," Avalos said. "When I was nine years old, my mom had to take me to the police station, because I had assaulted another kid with a rock. From that point on, I always had a probation officer." He now asks, "Why, instead of a probation officer, didn't I have a counselor, a therapist, or somebody I could talk to? Why didn't someone say, 'This kid is being violent at nine years old: what's going on at home that he's like this?'"

Finding Other Choices

Two life-altering events helped Avalos change his beliefs and direction. The first was an encounter with his victim's mother. In her tearful speech at Avalos's sentencing, she described her dead son as someone who loved baseball, who grew up without a father, and who joined a gang because he wanted acceptance. At first Avalos resisted her message, seeing it as an attempt to manipulate the jury. Later, he realized that his victim, someone he had seen as an enemy, was "more like me than anyone—we just lived on two different sides of the street." After he was transferred to an adult facility, Avalos encountered his own stepfather, who, as he was dying, helped Avalos see the futility of revenge for its own sake.



Father Greg Boyle, founder of Homeboy Industries, on Thanksgiving Day, 2012, celebrating with Homeboy employees.

From those two encounters, and with advances in his reading ability and education (he attained his GED), Avalos began to build his self-esteem. "The more I learned, the more confident I became about myself, that I could do anything I put my mind to...There is a difference between just living and learning."

Making a Difference

Now that Avalos has transformed his own life, he wants to make a difference for others. "Looking back," he said, "I see that the ones who were saved are the ones whose mothers and family never gave up on them. I think it's a failure when we think that we can do no more. Absolutely not: we can always do more, and I think it starts with consistency."

Avalos is taking up the challenge of providing that consistency for his younger mentees. He recently accepted an internship position as a case manager at Homeboy, and he plans to work toward a college degree. "It all started with education and believing in myself," he said. "And it took someone else to believe in me for me to believe in myself." ■

Unique Format, Motivating Content at Juvenile Justice Roundtable

Using a roundtable format that encouraged small group discussion and brainstorming, the National Center for Child Traumatic Stress recently hosted a meeting focused on the priority initiatives of the Network's Juvenile Justice Consortium. Thirty-eight participants gathered for "Current Issues and New Directions in Creating Trauma-Informed Juvenile Justice Systems" on February 11-12 in Marina del Rey, CA. They represented frontline juvenile justice staff, system administrators, researchers, and mental health clinicians, as well as the National Council of Juvenile and Family Court Judges and the Center for Juvenile Justice Reform.

Carly Dierkhising, MA, Special Projects Manager for the NCCTS, described the meeting's unique format: five experts were invited to present briefs on one aspect of the juvenile justice system; each topic and how it might be addressed in trauma-informed systems were then discussed in a round-robin format, with participants rotating through small group sessions with each expert. For example, Sue Burrell, a staff attorney with the Youth Law Center in San Francisco, who advocates and litigates for the rights of incarcerated youth, submitted a brief on reducing re-traumatization of youth in the juvenile justice system. The discussions that followed helped pinpoint a gap in the Network's current seven-element definition of a trauma-informed service system. "Although

the *Think Trauma* curriculum [for frontline staff] speaks to the environment of care for youth," Dierkhising said, "our trauma-informed service system definition does not specifically address that."

Other topics dealt with challenges in implementing trauma-informed practices, and the importance of professional self-care. One of the most compelling presentations, according to participants' feedback, came from a young man and young woman who had been involved in the juvenile justice system as adolescents and who now work for Homeboy Industries, the reentry program founded by Father Greg Boyle (see our related story, [Giving a Voice to the Child](#), page 1.)

The Juvenile Justice Consortium has already accomplished many projects to advance a trauma-informed juvenile justice system. Dierkhising said that the motivation for the recent roundtable was to "move the discussion forward on what a trauma-informed juvenile justice system is." The energy and excitement generated at the gathering attested to the importance of the concept and the determination to fulfill it. Even though meeting participants represented a wide swath of national juvenile justice stakeholders, they expressed the desire to engage an even wider group of community, clergy, and law enforcement voices who could further enhance trauma-informed practices. ■

Summer 2013 *IMPACT* to Debut New Series on STS

Interaction with traumatized children and their families can take an emotional toll on child- and family-serving professionals, and may result in indirect trauma exposure, often called secondary traumatic stress (STS). The prevention of STS and promotion of worker resilience require not just individual but organizational awareness and strategies.

In the Summer 2013 issue of *IMPACT*, the Secondary Traumatic Stress Committee will launch a series titled “Creating Secondary Traumatic Stress-Informed Organizations.” The three-part series will highlight the pioneering work of Network members and other leaders in the field of STS, said committee co-chair Ginny Sprang, PhD, University of Kentucky.

- Part One will explore the essential elements of STS-informed approaches to workforce development, with an eye toward supporting worker resilience and creating organizational environments that are physically and psychologically safe.
- Part Two, featuring a discussion among experts from child welfare, mental health, and other child-serving systems, will review programmatic strategies for preparing professionals and protecting them from STS.
- Part Three will focus on formal and informal organizational policies and procedures related to self-care practices, training, and personnel management.

AFFILIATE CORNER

Strong Collaborations Continue to Thrive Between Chicago Child Trauma Center and Network Partners

In this issue, IMPACT introduces a quarterly column that highlights continuing collaborations between the Network and its Affiliate members.

For seven years, funding for the Chicago Child Trauma Center (CCTC) as an NCTSN community treatment services (CAT III) center allowed it to enhance and expand its services for children and families. At the same time, the center’s leadership and active collaboration with Network partners helped propel key Network initiatives. For example, during its first four years of NCTSN funding, the CCTC worked with the Trauma Center at Justice Resource Institute to develop the Attachment, Self-Regulation and Competency (ARC) Framework. That work, along with collaboration on Developmental Trauma Disorder, led to the inclusion of the CCTC in the CAT II Complex Trauma Treatment Network when it was created in 2009. Put simply by CCTC Director Brad Stolbach, PhD, “Our mission is completely intertwined with the mission of the Network.”

The CCTC now faces major challenges in maintaining that mission because its CAT III grant was not renewed in the recent funding cycle. Nevertheless, the CCTC intends to continue its current collaborations, staying on as part of the Network’s growing roster of Affiliate members.

Located at La Rabida Children’s Hospital on Chicago’s South Side, the CCTC serves urban African American children and families. As staff members have augmented their clinical skills and capabilities—accessing NCTSN training in Child-Parent Psychotherapy, Child and Family Traumatic Stress Intervention, and other approaches—their clients have been the direct beneficiaries. But CCTC staff members haven’t stopped there. For example, Carole Graybill, LCSW, participated in a Train-the-Trainer Child-Parent Psychotherapy Learning Collaborative in 2008-2009, and has since led the training of 16 other CCTC clinicians. After staff received training in Strengthening Family Coping Resources, the center adapted the model to include consumer co-facilitators. Today, CCTC consumer advocates not only sit on the center’s advisory boards; some have also become staff members and are working with the Urban Youth Trauma Center at the University of Illinois at Chicago.



Finale of “Fabulous Females,” a production of Storycatchers Theatre in collaboration with the Chicago Child Trauma Center, in which incarcerated teenage girls create musicals from their own stories.

The CCTC has been active with many committees, Learning Collaboratives, and special-interest consortia. Stolbach has been involved with the push to include Developmental Trauma Disorder in the DSM-5 since he attended his first All Network Conference. He is a member of many committees and workgroups, including the Complex Trauma Treatment Network. He will be presenting two workshops at this year’s All Network Conference.

Collaborations with CAT II centers continue to thrive. The CCTC is involved in research initiated by the Early Trauma Treatment Network at the University of California, San Francisco, that is focused on trauma in children aged 0-5 in the core dataset. Collaboration with Northwestern University’s Center for Child Trauma Assessment and Service Planning (CCTASP) and the Trauma Center at Justice Resource Institute have yielded three forthcoming publications.

The CCTC has subcontracts with several CAT II members that allow work to go forward. Stolbach is currently the lead technical advisor for the Midwest Region Complex Trauma Training and Technical Assistance Center in the Complex Trauma Treatment Network; he is also a member of the CCTASP’s Dissociation Expert Workgroup. Additional funding is accruing for other projects, so that, for example, collaboration with Storycatchers Theatre can continue. Stolbach’s position as a faculty member for a Chicago ARC Learning Collaborative is being supported by the Illinois Children’s Healthcare Foundation.

These myriad projects attest to the CCTC’s robust Network collaborations despite funding challenges. From Stolbach’s perspective, “We never considered leaving the Network; so many aspects of what we do are central to the Network that you cannot really separate the work.” ■

The Organizational Journey toward Cultural and Linguistic Competence

Part Four: Engagement with Community and Collaborators

This is the last of a four-part series on culturally and linguistically competent organizational services. Network members from the Refugee Trauma and Resilience Center (RTRC) at Children's Hospital Boston, and the Center for Trauma Recovery and Juvenile Justice at the University of Connecticut School of Medicine in Farmington, offer examples of the ongoing and reciprocal dialogue required for organizations to engage effectively with diverse communities and collaborators.

A Shared Language about Trauma

"One of the great difficulties when we work cross-culturally is the expectation that everything will fall into place once we perceive the need of a community," said Saida Abdi, MSW, LICSW, Director of Community Relations at the RTRC. "You see there is a need, and you have the answer. But there is a lot in between the need and the answer."

Ten years ago, B. Heidi Ellis, PhD, now Director at the RTRC, perceived that refugee children and their families from war-torn Somalia could benefit from trauma-informed mental health services. Some Somali children were being referred to the clinic because of their disruptive behavior, and were mandated to receive mental health evaluation and treatment before they could return to school. With funds from the National Institute of Mental Health, Ellis and colleagues conducted research that showed trauma and PTSD to be significant problems among these children. "Typically, mental health services were grossly under-accessed," Ellis said. "Based on this information and qualitative information that suggested schools were trusted institutions, we decided to develop and implement a school-based program."

Before offering their school-based intervention program to the community, the developers attended a series of seminars given by a Wellesley College professor versed in the Somali culture. Ellis simultaneously began outreach with community members and agencies already working within the Somali community. The aim was to identify community leaders and to understand how the community saw its own concerns. "The appropriate way to begin trauma work with any community is to start by listening," Ellis emphasized. Early on, the RTRC partnered with the Refugee and Immigrant Assistance Center (RIAC), directed by Mariam Gas.

The school-based intervention program, Trauma Systems Therapy for Refugees, begins with a community education process built upon an evolving relationship with families and community. In initial phases of offering services to parents, Ellis and her colleagues discovered an important obstacle: "In our culture," explained Abdi, who is Somali, "we do not have language for mental health. A person is either mad or sane. So we needed to do community groundwork to sensitize people to understand the complexity of what can happen in the mind."

At RIAC, staff member Naima Agalab helped with some of that groundwork. She invited community members to tea gatherings and began a dialogue with parents, soliciting their thoughts about the possibility that their children might need

help with mental health issues. "She kept raising this point," said Ellis, "that in her services as an interpreter she was asked to tell mothers that their children needed a mental health evaluation. And even though the concept of mental health was unfamiliar to Somali parents, she suggested that parents should be involved in the discussions, since their children were getting involved in the system anyway."

That was five years ago. By partnering effectively with the cultural brokers of the community, such as RIAC, the RTRC clinicians began to develop a common language about trauma and its effects. "It's been exciting to see how the community leaders have developed a deeper understanding of trauma and mental health," Ellis observed. "We can now have a different conversation because we have a shared understanding of these terms." Today, the RIAC has its own freestanding mental health clinic offering services to the community. The RTRC, a Category II site, is training Maine schools and mental health providers in their treatment model. RTRC staff are also working with the National Child Traumatic Stress Initiative, a Category III site at the University of Louisville, KY; and will begin working with Bhutanese and Iraqi refugee children through a partnership with agencies in West Springfield, MA.

Focus on Collaborators

Last March, as part of the NCTSN Category II Complex Trauma Treatment Network grant, Julian Ford, PhD, and Rocío Chang-Angulo, PsyD, from the University of Connecticut Health Center, arrived in Bayamón, Puerto Rico, to conduct an initial training for the Caribbean Basin & Hispanic ATTC (Addiction Technology Transfer Centers) Network. The topic was how to develop trauma-informed services in marginalized communities, and the host was the Universidad Central del Caribe.



Rocío Chang-Angulo, PsyD, of the University of Connecticut Health Center, who co-led training at the Universidad Central del Caribe in Puerto Rico.

Chang-Angulo and Ford expected to train only the members of the ATTC department. In the training room, however, they encountered more than 50 participants. Trainees came from seven agencies, including a feminist grassroots agency Taller Salud ("Health Workshop"), located in a high-risk, violence-prone community; El Buen Pastor ("the Good Shepherd"), a Catholic-run rural agency; and the Juvenile Institutions, which oversees all juvenile justice facilities on the island. That's when Chang-

Angulo and Ford realized that organizer María del Mar García, MSW, MHS, Education Coordinator at the ATTC, "had a larger vision in mind," Chang-Angulo said.

>>> *cont'd on pg. 6*



NCTSN Category II Centers: Snapshots

The Family-Informed Trauma Treatment (FITT) Center, University of Maryland, Baltimore

The driving belief behind the FITT Center, a Network member since 2007, is that families are the foundation through which children comprehend and cope with their traumatic experiences. The center has developed and disseminated family trauma interventions to help optimize healing using a family systems approach. In the new grant cycle, the center will continue work on disseminating and evaluating these interventions (Strengthening Family Coping Resources, Trauma Adapted Family Connections, FamilyLive, and Families Assessment of Needs and Strengths-Trauma). The center will also collaborate with Network, national and local partners on developing trauma-informed tools, resources, and curricula (such as the FITT toolkit and Trauma Education Connections Initiative), that strengthen access to and delivery of family-informed trauma care.

Principal Investigator Laurel J. Kiser, PhD, MBA, who is also Associate Professor in the Department of Psychiatry at the University of Maryland School of Medicine, said that, in addition to disseminating FITT interventions in 15 NCTSN centers and affiliates and five other programs across the country, the FITT center has planned Learning Collaboratives with the Center for Child Trauma Assessment and Service Planning at Northwestern University Medical School in Chicago (another CAT II site).

The Center for Pediatric Traumatic Stress (CPTS), co-located at Children's Hospital of Philadelphia, PA, and Nemours Children's Health System in Wilmington, DE

As a Network member since 2002, the CPTS has been active with the Medical Traumatic Stress Work Group and other Network partners to advance its mission of reducing medical traumatic stress. The center's Web sites offer resources

to healthcare providers (www.HealthCareToolbox.org) and parents (www.AfterTheInjury.org), providing these groups with practical steps for helping children avoid traumatic stress related to illness or injuries. During the new grant cycle, Co-Directors Anne Kazak, PhD (Nemours in Wilmington), and Nancy Kassam-Adams, PhD (Children's Hospital of Philadelphia), expect to reach more than 20,000 providers per year through their active Web presence. "The healthcare system is not monolithic," Kassam-Adams pointed out. "Kids get healthcare in a variety of settings, and our mission is to equip professionals to recognize the potential for medical traumatic stress by supporting the implementation of effective assessment and intervention for medical trauma."

The Urban Youth Trauma Center's Treatment Collaborative for Trauma and Violence, University of Illinois, Chicago

Network involvement has helped the Urban Youth Trauma Center connect its services to a trauma-informed framework, while tailoring best practices to the individual youth and families it serves. The center, which joined the Network in 2009, takes an ecological approach to addressing trauma and violence in high-risk youth populations. Thus its current thrust will be collaborative. Co-directed by Jaleel Abdul-Adil, PhD, and Liza Suarez, PhD, the center plans to expand its YOUTH-CAN (Youth Overcoming Urban Trauma and Healing through Community Action Network) program and extend its reach to juvenile-justice and crossover-youth populations. Aligning with the construct that "it takes a village to raise a child," the YOUTH-CAN program holds that everyone, from family members to first responders to clergy and street patrols, has a role to play.

Creating and Sustaining the Next Generation of Trauma-Informed Practitioners, Fordham University and Hunter College, NY

In the estimation of co-directors Virginia Strand, DSW, at Fordham's Graduate School of Social Service (at Westchester), and Robert Abramovitz, MD, Silberman School of Social Work at Hunter, the development of the Network's Core Curriculum on Childhood Trauma was a watershed moment in this center's 10-year involvement with the Network. The curriculum uses highly interactive, problem-based learning to enhance clinical reasoning, applying 12 core concepts of trauma's impact to in-depth case studies. "We looked at each other and said, students should not graduate without exposure to this state of the art curriculum," Abramovitz recalled. Seven schools of social work (at Hunter, Fordham, Simmons College, and Western Michigan, Maryland, Houston, and Michigan State universities) field-tested the curriculum during the previous funding cycle. Abramovitz and Lisa Amaya-Jackson, MD, Duke University Medical Center, co-led a Breakthrough Series Learning Collaborative to field-test the curriculum at nine community-based agencies. Going forward, said Principal Investigator Strand, the goals "are to help our partner schools' field agencies enhance their organizational readiness and capacity to deliver evidence-based trauma treatments;" and to co-lead (with the NCCTS) curriculum training for new CAT III members of the Network. ■

The Organizational Journey toward Cultural and Linguistic Competence *cont'd from pg. 4*

García explained that she had firsthand knowledge of the need for addressing trauma in Puerto Rico. Many of the students trained in her department work in the community organizations she had invited; none had received training in delivering trauma-informed services. The needs of each organization were diverse, but their responses to Ford and Chang-Angulo's trauma training sessions were uniformly positive. Attendees were especially enthusiastic about the Spanish language trauma tools available, some from the NCTSN and some from Carlos Albizu University in San Juan. They quickly organized into a learning community: Comunidad de Aprendizaje



Somali refugee girls participating in a group activity at the Refugee Trauma and Resilience Center, Boston.

Sobre Trauma de Puerto Rico. The first sessions were so successful that the agencies asked for the trainers to return.

Chang-Angulo said that she and Ford were surprised by the variety of training needs. Eager to continue the momentum, they secured funding, again through the Justice Resource Institute in Needham, MA, to

conduct a second session last September. This time, though, they needed to adapt their approach to deliver training that was culturally specific to each organization. For example, staff from Taller Salud had not spoken about vicarious trauma before the initial training and now wanted tools to incorporate that element into staff work in the future.

The trainers proposed a unique format for their sessions, dictated by the agencies' requests. Instead of didactic presentations, they offered to work one-on-one in three-hour sessions with each of the agencies. It was an intense two days, Chang-Angulo recalled. "The second time, we were very aware, as clinicians, of creating a safe network and really listening to their concerns. It was a growth experience on both ends."

"The appropriate way to begin trauma work with any community is to start by listening."

B. HEIDI ELLIS, PHD, Director, Refugee Trauma and Resilience Center, Children's Hospital Boston

These scenarios demonstrate that partnering with existing organizations is always a good first step when reaching out to culturally diverse communities in need. No matter how effective the established interventions might be, careful listening to community members enables agencies to assess and retool their approaches to make them culturally specific. Whether at the community or service systems level, said Abdi, "If you go into communities with the same level of commitment to learn as to teach, you will be so much more successful." ■

The NCCTS extends a special thank you to Vivian H. Jackson, PhD, for her conceptualization of and major contributions to this series.

New Members Join NCTSN Advisory Board

cont'd from pg. 1

"The journal's Special Issue was a perfect example of bringing together two organizations with complementary strengths and missions," James-Brown said. She added that CWLA is "moving much more in the direction of connecting research to practice," and that the Network's collaboration in this effort "will continue to be of great value." On a personal level, James-Brown said she looks forward to connecting with child-serving professionals on the Advisory Board who have similar interests, but who approach their mission through different lenses.

Teresa Huizar, Executive Director of the National Children's Alliance, also based in Washington, DC, is a returning board member, having served in that capacity since 2010. "Our Children's Advocacy Centers have benefitted dramatically from our close relationship with the NCTSN," Huizar said. For example, the *CAC Directors' Guide to Mental Health Services for Abused Children* has been a valuable resource for helping nonclinical directors at the advocacy centers to evaluate the effectiveness of their programs, and it is now serving as a platform for Webinars and other projects. Huizar said that serving on the Board "is a wonderful opportunity to collaborate with talented professionals and innovative thinkers. Whenever I attend Advisory Board meetings or the All Network Conference, I find myself gathering much information that I can bring back to my own work."

Traditionally, the Advisory Board convenes twice yearly; a summary report of the 2013 in-person meeting will appear in an upcoming issue of *IMPACT*. "It has been an honor to work with these outstanding professionals and consumers, who have contributed so much to the NCTSN mission," observed Gerrity, who leads the Advisory Board meetings. "We are looking forward to many exciting collaborations and discussions with our new Board." ■

For the full roster of Advisory Board members and their professional associations and accomplishments, visit <http://www.nctsn.org/about-us/national-advisory-board>

Conversations about Historical Trauma, Part One

Responses to trauma are often mediated by culture and history, a reality that should inform the delivery of mental health services for all culturally diverse groups. Clinicians working with American Indian children and families must be especially aware not just of multigenerational trauma but the ways in which each family and tribal community frames the narrative of their losses, said Maria Yellow Horse Brave Heart, PhD (Hunkpapa/Oglala Lakota), Associate Professor of Psychiatry and Director of Native American and Disparities Research at the Center for Rural and Community Behavioral Health, University of New Mexico, Albuquerque.

Brave Heart defines historical trauma as: “cumulative and psychological wounding over the life span and across generations, emanating from massive group trauma experience.” In American Indian communities, the responses to those traumas—survivor guilt, depression and psychic numbing, fixation to trauma, low self-esteem, and anger—often lead to self-destructive behavior, substance abuse, and domestic violence.

American Indian tribes have also been deterred from resolving their grief by federal prohibitions against their ceremonial practices and takeover of their sacred spaces. Thus historical traumatic grief becomes interwoven with historical trauma. To address these complex factors, Brave Heart developed the historical trauma intervention model. The intervention has been offered to tribal communities through the Takini Network, founded by Brave Heart and colleagues in 1992. At the invitation of tribal leaders, Takini Institute trainers collaborate with tribal community members to deliver tribal-specific interventions.

Complexity and Heterogeneity

With 583 federally recognized American Indian tribes, “there is a lot of diversity across and within tribal communities,” Brave Heart noted. That diversity extends to each tribe’s history and culture. For example, many American Indians consider the boarding-school experience, which for most tribes began in the 19th century and lasted into the 20th, as an exceptionally dark period. American Indian children were taken from their homes and forced to attend federal and Christian-run boarding schools. There they were punished for speaking their tribal language and forced to assimilate white cultural values; many were physically and sexually abused. However, Brave Heart has found some regional and individual differences: boarding schools are not necessarily perceived as universally traumatic. “For those [children] who came from a family where everyone was drinking,” she explained, “the boarding school functioned as a safe haven.”

Trauma responses also vary across cultures, Brave Heart pointed out. For example, Beals, Manson, and colleagues have found that American Indian adolescents reporting multiple traumas did not meet the DSM-IV criteria for PTSD. “It is possible that we might have a higher trauma threshold before we become symptomatic,” Brave Heart said. On the other hand, clinicians working with American Indian people

should be careful not to over-diagnose PTSD, and to respect the possibility that denial of trauma is serving as a coping mechanism. “Sometimes what people see as psychosis is really a spiritual phenomenon or is culturally grounded,” she pointed out.

Tapping into Community Resilience

A SAMHSA Circles of Care grant in 2008 allowed the Mashantucket Pequot Tribal Nation (MPTN) to explore ways of incorporating tribal wisdom to destigmatize mental health issues, reported Michele Scott, MSOL, an enrolled member of the MPTN and Executive Project Director of the MPTN Circles of Care Project. Gretchen Chase Vaughn, PhD, a



Children learn of tribal traditions at the annual Mental Health Awareness Fair, a SAMHSA Circles of Care project developed by the Mashantucket Pequot Tribal Nation in Connecticut.

clinical psychologist and principal of Vaughn Associates, a New Haven, CT, consulting firm, used a community participatory model to evaluate the project. The planning committee, comprised of tribal community members, providers, parents, youth, and elders, began bimonthly meetings six months before the chosen

event, designated the Mental Health Awareness Fair in conjunction with National Children’s Mental Health Awareness Day. On the day of the event, traditional tribal foods, family tree exercises, storytelling, and art booths were among the activities offered to inform the 400 participants about mental health and cultural healing practices. Scott said the Tribal Council has endorsed the event each year since 2008. “It’s become a way for us to help heal the community through intergenerational connection,” she said.



Maria Yellow Horse Brave Heart, PhD, University of New Mexico, Albuquerque.

Brave Heart closed by saying that “historical trauma response is not a diagnosis; nor is it about dredging up and staying stuck in the past.” “It’s about starting a healing process to let go of that past collective trauma, and moving forward.” ■

For more information, visit the Native American Center for Excellence at nace.samhsa.gov/HistoricalTrauma.aspx and the Takini Network at www.historicaltrauma.com

The NCCTS extends a special thank you to Vivian H. Jackson, PhD, and the NCTSN Culture Consortium for their conceptualization of and major contributions to this series.

Have You Heard?

Nancy Kassam-Adams, PhD, has been chosen President-Elect of the **International Society for Traumatic Stress Studies**. Kassam-Adams is Associate Director for Behavioral Research at the Center for Injury Research and Prevention and co-directs the **Center for Pediatric Traumatic Stress**, co-located at Children's Hospital of Philadelphia, PA, and Nemours Children's Health System in Wilmington, DE. She is also Research Associate Professor at the University of Pennsylvania School of Medicine. Her research focuses on the impacts of injury, illness, and other acute events on children and parents; and the development of effective screening and secondary prevention tools for use in pediatric healthcare settings and via the Web. Congratulations, Dr. Adams!

The Substance Abuse and Mental Health Services Administration (SAMHSA) has awarded 30 new Primary and Behavioral Health Care Integration program grants. The grantee organizations will receive intensive support from the **SAMHSA-Health Resources and Services Administration Center for Integrated Health Solutions** as they work to improve the whole health of individuals with behavioral health issues. Four Network members were among the grantees: **Aurora Comprehensive Community Mental Health Center**, Aurora, CO; **Didi Hirsch Community Mental Health Center**, Los Angeles, CA; **Family and Children's Service, Inc.**, Tulsa, OK; and **Native American Health Center, Inc.**, Oakland, CA.

Judith A. Cohen, MD, Medical Director of the **Center for Traumatic Stress in Children and Adolescents** at Allegheny General Hospital, received the Sarah Haley Memorial Award for Clinical Excellence at the 2012 annual conference of the International Society for Traumatic Stress Studies. The award is given to a clinician or group of clinicians in direct service to traumatized individuals, and recognizes written or verbal communication that exemplifies the work of Sarah Haley, a pioneer in defining and treating PTSD in combat veterans.

Lisa Amaya-Jackson, MD, MPH, Co-Director, **North Carolina Child Treatment Program of the Center for Child & Family Health** at Duke University Medical Center, is the recipient of the 2012 Norbert and Charlotte Rieger Service Program Award for Excellence. Presented by the American Academy of Child and Adolescent Psychiatry, the award is supported by the Norbert and Charlotte Rieger Foundation, which was established in 1996 to recognize innovative programs that address prevention, diagnosis, or treatment of mental illnesses in children and adolescents.

Did You Know?

The **Center for Trauma Recovery and Juvenile Justice** at the University of Connecticut Health Center is sponsoring a Learning Collaborative in Puerto Rico, an initiative funded by the **Complex Trauma Treatment Network** (an NCTSN center). Beginning last March, seven organizations became recipients of a year of technical assistance on integrating trauma-informed services. Although this was their first collaboration, the organizations have formed a local network, *Comunidad de Aprendizaje Sobre Trauma de Puerto Rico*. Led by the Behavioral Community Clinical Center from the Universidad Central del Caribe, the organizations include the SAMHSA-associated Community Mental Health Center; the Community Mental Health Clinic from Carlos Albizu University; El Buen Pastor ("the Good Shepherd"); Juvenile Institutions (Instituciones Juveniles); Taller Salud ("Health Workshop"); and the Puerto Rico Bureau of Rehabilitation and Treatment and the Correctional and Rehabilitation Department. Among its continuing projects, the Puerto Rico learning group is working with the NCTSN to translate the *Think Trauma* toolkit into Spanish, as part of a project of the Center for Trauma Recovery and Juvenile Justice.



About IMPACT

IMPACT is a publication of the National Child Traumatic Stress Network (NCTSN). It is produced quarterly by the National Center for Child Traumatic Stress (NCCTS), co-located at UCLA and Duke University. The NCCTS serves as the coordinating body for NCTSN member sites, providing ongoing technical assistance and support.

Managing Editor: Gretchen Henkel

Consulting Editor: Melissa Culverwell

Design & Layout: Sue Oh Design

Established by Congress in 2000, the National Child Traumatic Stress Network (NCTSN) brings a singular and comprehensive focus to childhood trauma. NCTSN's collaboration of frontline providers, researchers, and families is committed to raising the standard of care while increasing access to services. Combining knowledge of child development, expertise in the full range of child traumatic experiences, and dedication to evidence-based practices, the NCTSN changes the course of children's lives by changing the course of their care.

**Do you want to receive future
IMPACT newsletters?**

Email: newsletter@nctsn.org