Exposure to IPV, Adverse Childhood Experiences, Attachment, Trauma, and the Brain: Current Research and Practical Suggestions for Assessment and Treatment

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Presentation Outline:

- Effects of Family Violence & Trauma on Children
- Attachment and Developmental Issues
- Post Traumatic Stress Disorder (PTSD)
- The Brain: How It All Fits Together
- Attention Deficit Disorder/ADHD
- Adverse Childhood Experiences (ACE) – The Link
- Healthcare and Neuropsychological Issues
- Long-Term Effects of Childhood Victimization
- Intimate Partner Violence
- Prevention: Promoting Positive Youth Development
- Family Strengths and Promoting Resiliency
  - 12 Key Steps and 4 Strategies

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Definitions of Trauma

- *Physical Abuse and Neglect*
- *Sexual Abuse*
- *Traumatic Grief*
- *Domestic Violence*
- *Community and School Violence*
- *Complex Trauma (multiple trauma)*
- *Medical Trauma*
- *Refugee and War Zone Trauma*
- *Natural Disasters*
- *Terrorism*

Public Health issues

National Child Traumatic Stress Network, 2006

Recent research has shown a connection between brain development, childhood maltreatment, family violence and trauma. Our understanding of the effects of these types of adverse childhood experiences on the brain has expanded. This presentation will discuss brain development and the various types of multiple victimization experienced by children that often leads to later aggressive behavior and impulsivity due to the interaction of the brain and psychosocial factors. The influence of trauma on the brain and development makes it much more difficult to focus on just one issue when assessing or treating these children or victims of various forms of intimate partner violence.

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It is Estimated...

In about 40-60% of the homes where a parent is being maltreated, the child is also a victim of abuse,

and vice versa.

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Children are Affected

Emotional Effects

- Feelings of helplessness, worthlessness
- Constant fear of: abandonment, expressing emotions, the unknown, and personal injury
- Shame – "I caused it", or "I should have been able to stop it"
- Grief for family and personal losses
- Lack of good attachment bonds

Children are Affected

Cognitive Effects

- Lack of sense of consistency and predictability;
- Feeling of incompetence;
- Difficulty encoding new information;
- Cause and effect relationships ill-defined;
- Difficulty concentrating;
- Poor school functioning.

Children are Affected

Social Effects

- Isolation from friends and relatives
- Difficulty in trusting, especially adults
- Poor anger management and problem-solving skills
- Passivity with peers or bullying towards peers; play with peers gets exceedingly rough

Children are Affected

Behavioral Effects

- **Stress disorders and psychosomatic complaints**
- **Increased social isolation and withdrawal**
- **Aggressiveness and/or poor impulse control**
- **School problems (refusal to go, truancy, poor performance) or perfectionism and overachievement**

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Post-Traumatic Stress Disorder: Risk Factors

	Event	Individual	Family & Social
Increased Risk (Prolong the intensity or duration of the acute stress response)	· Multiple or repeated event (e.g., IPV or child abuse) · Physical injury to child · Involves physical injury or death to loved one, particularly mother · Dismembered or disfigured bodies seen · Destroys home, school or community · Disrupts community infrastructure · Offender is family member · Long duration	· Female · Age (Younger more vulnerable) · Subjective perception of physical harm · History of previous exposure to trauma · No cultural or religious anchors · No shared experience with peers (experiential isolation) · Low IQ · Pre-existing neuro-psychological disorder (especially anxiety related)	· Trauma directly impacts caregivers · Anxiety in primary caregivers · Continuing threat and disruption to family · Chaotic, overwhelmed family · Physical isolation · Distant or absent caregivers

Post-Traumatic Stress Disorder: Attenuating Factors

	Event	Individual	Family & Social
Decreased Risk (Decreased intensity or duration of the acute stress response)	· Single event · Perpetrator is stranger · No disruption of family or community structure · Short duration (e.g., tornado)	· Cognitively capable of understanding abstract concepts · Healthy coping skills · Educated about normative post-traumatic interventions · Strong ties to cultural or religious belief system	· Intact, nurturing family supports · Non-traumatized caregivers · Caregivers educated about normative post-traumatic responses · Strong family beliefs · Mature, attuned parenting skills

From Perry, 2001

CHILDHOOD TRAUMA

BEHAVIORAL/ DEVELOPMENTAL EFFECTS

PHYSIOLOGICAL/ BIOLOGICAL STRESS SYSTEMS EFFECTS

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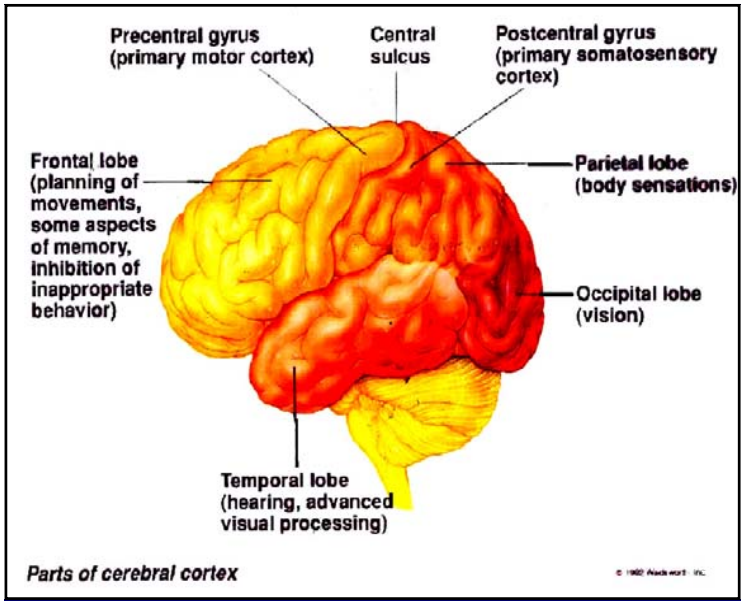

Shifting Developmental Activity Across Brain Regions

Brain Region	Age of Greatest Developmental Activity	Age of Functional Maturity	Key Functions
Neocortex	Childhood	Adult	Reasoning, problem solving, abstraction, secondary sensory integration
Limbic	Early Childhood	Puberty	Memory, emotional regulation, attachment, affect regulation, primary sensory integration
Diencephalon	Infancy	Childhood	Motor control, secondary sensory processing
Brainstem	In utero	Infancy	Core physiological state regulation, primary sensory processing

From Perry, 2001

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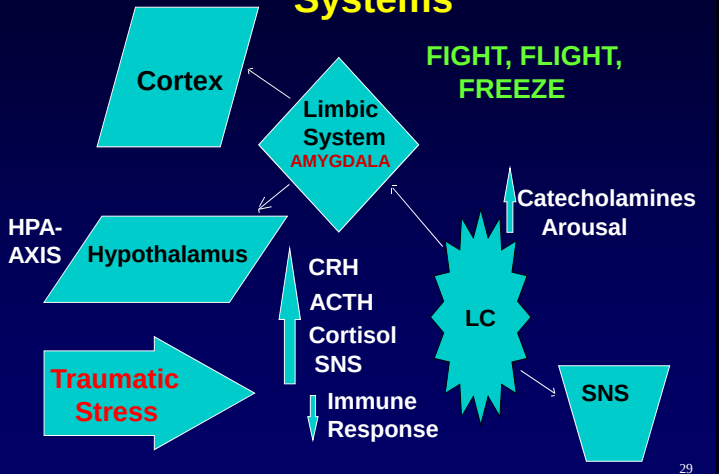
Trauma and Biological Stress Systems



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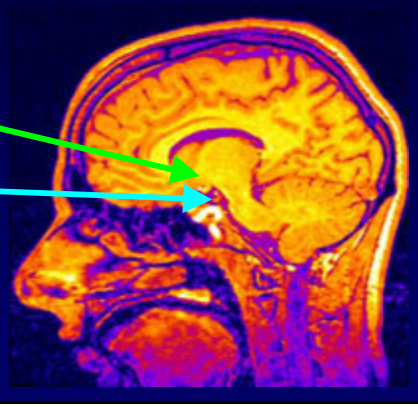
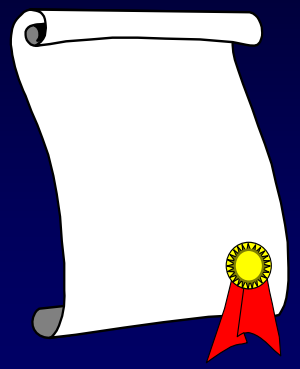
Brain activity of children exposed to IPV on fMRI Scans same as soldiers exposed to violent combat – increase in Amygdala and Anterior Insula when viewing pictures of angry faces.



E. J. McCrory, et al (2011), *Current Biology*, 21 (23) – University College London

Executive Function

- General organization and planning
- Ability to solve problems
- Regulation of activity
- Regulation of mood



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ADHD

What is the Disorder?

- Psychoneurological Disorder
  - Affects the Central Nervous System
  - Affects Self-Regulatory Center
  - Affects Attention Center

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ADHD

Impairment In Attention Center

- Impairment in Selective Attention
- Focus on Too Much Information
- Focus on Irrelevant Information

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ADHD

Impairment in Self Regulatory Center

- Impairment of Organizational Skills
- Impairment in Self Control
- Impulsive Behaviors
  - *Difficulty Delaying Gratification, Poor Listening Ability*
  - *Hyperactivity - Unproductive Activity*

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Common Principles Linking Children Exposed to Family Violence or Other Traumas

- Affect and impulse dysregulation – Aggression
- High levels of anxiety
- Rapid shifts in psychological state
- Disturbances in sense of self: low self-esteem, body image distortion, identity diffusion/fragmentation, attachment issues
- Attention, concentration, memory issues
- Self-destructive behaviors

Key #1- Need Early Intervention for Trauma Negative Behaviors/Aggression

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Categories of Adverse Childhood (ACE) Experiences

V. J. Felitti, M.D., & R. F. Anda. M.D., 2003 – CDC & Kaiser Study

	Category Prevalence (%)
Abuse, by Category	
Psychological (by parents)	11%
Physical (by parents)	28%
Sexual (anyone)	21%
Emotional Neglect	15%
Household Dysfunction, by Category	
Substance Abuse	27%
Mental Illness	19%
Mother Treated Violently	13%
Imprisoned Household Member	5%

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Adverse Childhood Experiences Score

Number of categories of adverse childhood experiences

ACE score	*Prevalence*
0	36%
1	26%
2	16%
3	10%
4 or more	12%

- More than *60% have at least one ACE, and almost ¼ have 3 or more ACEs*

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Evidence from ACE Study Suggests:

Adverse childhood experiences are the most basic cause of health risk behaviors, morbidity, disability, mortality, and healthcare costs.

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Adverse Childhood Experiences determine the likelihood of the 10 most common causes of death in the United States.

Top 10 Risk Factors: smoking, severe obesity, physical inactivity, depression, suicide attempt, alcoholism, illicit drug use, injected drug use, 50+ sexual partners, h/o STD.

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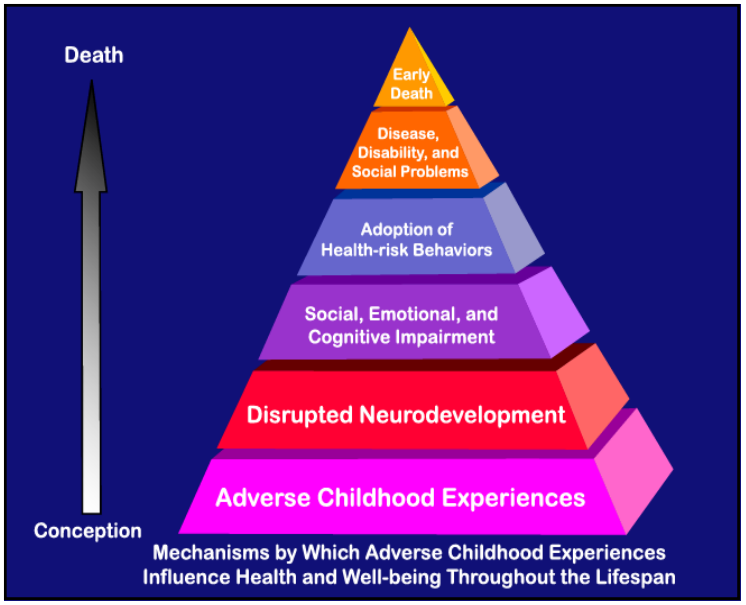

Mechanisms by Which Adverse Childhood Experiences Influence Health and Well-being Throughout the Lifespan

Summary of Means for Heart Rate throughout Protocol

Abuse Type	HR1	HR2	Recovery
Exposure to DV	87.4	94.4	84.3
Physical/Sexual Ab.	84.7	85.9	81.7
None	80.5	80.2	79.1

HR1 = heart rate 1, taken during baseline; no stressor.
HR2 = heart rate 2, taken during the stressor.
Recovery = heart rate, taken after relaxation again.

From Stride & Geffner, 2005

Key #2 - Violence Prevention/Anti-Bullying in Schools

Jane E. Brody

Breaking bullying habit is crucial

Studies of younger bullies have repeatedly shown that bullying can have disastrous effects not only on the victims but also on the bullies themselves, who often grow increasingly violent and antisocial.

The rash of school shootings in recent years, including the massacre at Columbine, has renewed attention to the extent and potential consequences of bullying for both bully and victim.

In a videotape, the young gunmen attributed their acts to retaliation for years of taunting that they said friends and relatives had inflicted on them because of an unwillingness to dress and act as others wanted.

ried weapons to school, 38.7 percent fought frequently, and 45.7 percent reported being injured in fights. The comparable statistics for boys who had never bullied others in school were 13.4 percent, 7.9 percent, 8.3 percent and 16.2 percent.

The greatest risk for engaging in violence-related acts was found among boys who bullied others when they were away from school: 70.2 percent of them had carried weapons.

Nor were girls exempt from potentially violent behavior. About 30 percent of girls who had bullied others in school at least once a week reported carrying weapons.

names, refusing to invite particular classmates to birthday parties or excluding certain children from games.

In a study published in November in the journal *Child Development*, Dr. James Snyder of Wichita State University and colleagues reported that many kindergarten children found themselves verbally and physically abused by their playground peers. By the time the children reached first grade, an increasing amount of harassment had focused on a smaller group of perpetual victims.

In Summary .....

- Abused children need to be carefully diagnosed to R/O disorders such as PTSD.
- Abuse and maltreatment, even without PTSD, may be associated with chemical and structural brain changes in children.
- While these changes are still under investigation, they appear to have real-life consequences for affect regulation, etc.
- Assessment can assist with diagnosis, prognosis, and educational recommendations.

Beers, S. R., & De Bellis, M. D. (2002). Neuropsychological function in children with maltreatment-related Posttraumatic Stress Disorder. *American Journal of Psychiatry*, *159*, 483-486.

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Multiple Victimization of Children - Factors

- Social Learning
- Trauma Effects
- Genetic Predisposition (Genes)
- Head Injuries
- Substance Abuse
- Neuropsychological Factors (Structural, Neurotransmitters)

Interactional – Biopsychosocial/Bioecological

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Do You Address/Ask About Trauma and Attachment Issues During Intake or Assessment With The Offender or the Victim?

- How?

- Do You Address Attachment and Trauma Issues in Your Treatment of IPV Offenders or Victims?

Co-Occurrence of IPV and Child Abuse

- 30 studies find correlation.
- As number of incidence of DV against partner increase so does likelihood of child abuse.
- Daughters of batterers are 6.5 times more likely than other girls to be victims of incest.

Emotional/Psychological Maltreatment in Spouse Abuse

A pattern of acts or omissions, such as violent acts that may not cause observable injury, that adversely affects the psychological well-being of the victim. Arguments alone are not sufficient to substantiate emotional maltreatment.

Psychological violence is a pattern of behavior involving one or more of the following behaviors: explicit or implicit threats of violence, extremely controlling types of behavior, extreme jealousy, mental degradation (name calling, etc.), and isolating behavior.

Property violence by one spouse may constitute emotional abuse if intended as a means to intimidate the other spouse. Property violence includes, but is not limited to: damaging or destroying the other spouse's property, hitting/kicking a door or wall, throwing food, breaking dishes, and intentionally or recklessly damaging automobiles. Threatening injury to or injuring children, threatening or actually kidnapping the children, and threatening or actually injuring pets, are all included in this category.

EMOTIONAL/PSYCHOLOGICAL ABUSE

Psychological/emotional abuse always accompanies and, in many cases, precedes physical battering or marital rape. Like hitting, targeted and repeated emotional abuses can have severe effects on the victim's and children's sense of self and reality. Being exposed to or experiencing the below, including spouse abuse, is abuse.

- **Jokes about habits/faults**
- **Withholding approval as punishment**
- **Repeated yelling and name calling**
- **Repeated insults/targeted insults**
- **Repeated humiliation (public)**
- **Repeated humiliation (private)**
- **Labeling as "crazy," "bitch," whore," "animal," etc.**
- **Threatens violence/retaliation**
- **Hurts animals and pets to show power & control**
- **Puts down abilities**
- **Demands all of the attention (resents children)**
- **Ignoring feelings**
- **Threatens with getting custody**

Adapted From Geffner & Mantooth, 2000 76

SEXUAL ABUSE AND VIOLENCE

This is the most difficult aspect of family abuse to identify and discuss, whether in a group or individually. Sexual abuse in the home is, however, more common than many would like to believe.

RAPE in Marriage:

- **Jokes about women said in their presence**
- **Sexual "put-down" jokes**
- **Women/men as a sex object (leering)**
- **Minimizing feelings and needs regarding sex**
- **Criticizing sexual "performance"**
- **Sexual labels; "whore" may alternate with "frigid"**

- **Unwanted touch**
- **Uncomfortable touch (or forced to touch/ watch others)**
- **Withholding sex and affection**
- **Always wanting sex**
- **Demanding sex with threats (e.g., withholding child support; custody battle; disclosure)**
- **Forced to strip - humiliation (maybe in front of kids)**
- **Promiscuity with others**
- **Forcing sex with him or others**
- **Forcing uncomfortable sex (e.g., after surgery, etc.)**
- **Forcing sex after beatings**
- **Forcing sex with animals**
- **Sex for the purpose of hurting (use of objects/weapons)**
- **Sexual torture**

From Geffner & Mantooth, 2000

Abused Victim with PTSD

Screening - Assess:

- Safety Concerns
- Coping Strategies
- Social Support (real and perceived)
- Stressors
- Need for Referrals

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ISSUES/QUESTIONS

1. Who is the primary/dominant aggressor in the relationship?
2. Past victimization/trauma/abuse?
3. Depression history?
4. Relationship history?
5. Emotional expressiveness?
6. Issues of child abuse and parenting?
7. Conflict management styles?
8. Neuropsychological impairment?
9. Substance abuse/dependence history?
10. Attachment issues?
11. Motivation to change/accept responsibility?

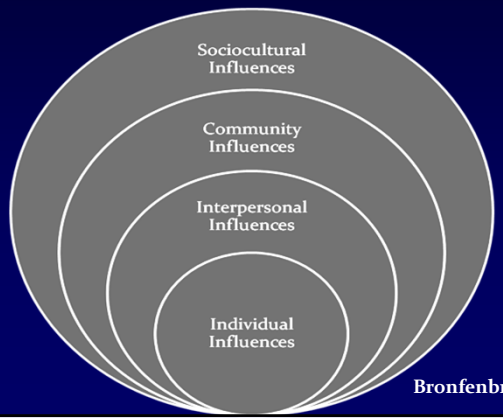
ALCOHOL/DRUG USE ABUSE AND DOMESTIC VIOLENCE

Treatment for alcohol or drug problems must occur prior to or currently with the treatment for domestic violence. There is no evidence that alcohol treatment by itself will be effective in changing abusive behaviors - however alcohol and drug problems most likely seriously interfere with the process of change and must be addressed.

Executive Function Issues/Deficits for Offenders and Victims of Family Violence: A Biopsychosocial Approach

- General organization and planning
- Ability to solve problems
- Regulation of activity/Impulsivity
- Learned aggression, power and control
- Low threshold for frustration/stress
- Closed head injuries or other neuropsychological impairments

Bioecological/ Biopsychosocial Model of Human Behavior



Bronfenbrenner (1979)

3 Key Approaches

Differential Diagnosis

Assessment-Based Intervention

One Size Does Not Fit All

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IDENTIFICATION OF VICTIMS OF WIFE/PARTNER ABUSE*

Robert Geffner, Ph.D. & Mildred Pagelow, Ph.D.

Bearing in mind that both victims and their abusers are likely to minimize or deny the occurrence of spouse abuse, professionals need to draw upon their training, experience, and their observation skills to make accurate assessments. The first clues may not be visible in the appearance or outward behavior of the clients. The initial interviews are very important in the process of identifying victims of spouse abuse. At least one interview with each spouse should be conducted in private. It is very important to determine the level of intimidation that may be occurring and how free the abused spouse may be to express feelings and opinions openly.

The interviewer can learn much by watching and listening during joint interviews. For example, pay attention to body language, and watch for eye contact, reactions indicating possible fear rather than ordinary nervousness, and avoidant posture. Listen for "permission" words between them. Does either party talk about men and women exclusively in terms of traditional stereotypes? Are these terms about the other sex negative? Be alert for indicators of jealousy pointing to possessiveness, immaturity, or low self-esteem.

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Trained interviewers should be able to discover how important decisions are reached in the family, especially concerning financial matters. Yet they should be aware that the person who writes the checks does not necessarily have decision making powers; sometimes the controlling spouse merely delegates the check-writing and accounting duties to the other. The roles of each spouse should also be explored to determine domination and subservience. Details concerning how each spouse spends time at home, their chores, responsibilities, and decision making power provide indications of possible rigid role restrictions suggestive of potential abuse. The history of the individual or couple should include items about both their present relationship and their families or origin. Finally, if there are any children, the interviewer should seek information about them.

Physical abuse often is preceded by psychological abuse, and it usually is a gradual conditioning process. An abuser may begin by intimidation, such as verbal abuse, degrading the spouse, punching holes in walls with his first, or by destroying or disposing of possessions owned by, or at least valued by, the partner.

When clients come to a professional for intervention, legal help, medical services, individual, marriage or family counseling, it is relatively easy to include some of the questions presented below. It is important to identify any abuse in relationships since this information is rarely volunteered by the victims or offenders unless specific questions are asked.

* The ideas for the original version of this questionnaire originated in a subcommittee of the Domestic Violence/Family Court System Committee of the Los Angeles, Calif., Conciliation Court.

SPOUSE ABUSE IDENTIFICATION QUESTIONNAIRE

(Robert Geffner, Ph.D., ABPN & Mildred Pagelow, Ph.D.)

- ____Were either you or your spouse physically abused in childhood? If so, in what way?
- ____Was there a history of violence in either of your families?
- ____If so, was the violence directed at the children, or was it directed at one parent by the other?
- ____Does either your spouse or his/her parents abuse alcohol? Do you? Do your parents?
- ____Has your spouse ever threatened to harm you?
- ____Are your spouse's problems usually blamed on you or others?

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SPOUSE ABUSE IDENTIFICATION QUESTIONNAIRE

- ____Have you been attacked or blamed when your spouse got angry?
- ____Are you afraid of your spouse's temper?
- ____When drinking, does your spouse get rough or violent?
- ____Has your spouse ever hurt you? When? What happened?
- ____Has your spouse ever deliberately hurt or killed a pet?
- ____Does your spouse have a Dr. Jekyll and Mr. Hyde personality?
- ____Are your children afraid when your spouse is angry?
- ____Have you felt free to invite family or friends to visit you?

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SPOUSE ABUSE IDENTIFICATION QUESTIONNAIRE

- ____ Is your spouse an extremely jealous person?
- ____ Has your spouse ever forced you to have sex even though you did not want to?
- ____ Have you ever called, or thought of calling, the police because an argument was getting out of control?
- ____ Have your neighbors or friends ever called the police because of your situation?
- ____ If the police were called, was your spouse arrested or given a citation?
- ____ Does your spouse ever threaten to take the children where you could not find them?
- Did this ever occur?
- ____ Do you feel safer when I talk with you alone?

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Stages of Change (Transtheoretical Model)

- Precontemplation
- Contemplation
- Preparation
- Action
- Maintenance
- Termination

- From Prochaska, J.O., DiClemente, C.C., & Norcross, C.C. (1992). In search of how people change: Applications to addictive behaviors. *American Psychologist, 47*, 102-1127.

In the first stage, ***precontemplation***, individuals with violent behaviors have no intention of changing and are likely in strong denial. ***Contemplators*** accept or realize that they have a problem with violence/abuse and begin to think seriously about changing it, but they have not made a commitment to take action in the near future. Individuals who are in the ***preparation*** stage are planning to take action within a short time period. They think more about the future than about the past, and more about the benefits of being non-violent than about the losses. ***Action*** is when the client is overtly expressing a genuine belief that violence/abuse is unacceptable and is actively utilizing the therapeutic interventions to change him/herself and the relationship. ***Maintenance***, often far more difficult to achieve than action, can last a lifetime. Maintenance is a long, ongoing process. Three common internal challenges to maintenance are overconfidence, daily temptation, and self-blame for lapses.

Life is not always a matter of holding good cards, but sometimes of playing a poor hand well.

Robert Louis Stevenson

RESILIENCY

Despite the increased risk, not all children exposed to domestic violence are traumatized, or become batterers or victims. Children react to their environment in many different ways. Additionally, children's responses differ with age and gender.

Adapted from *The Violence and the Family* report of the American Psychological Association, 1996.

Resiliency

"The Chinese symbol for the word 'crisis' is a composite of two pictographs: The symbols for 'danger' and 'opportunity'" (Walsh, 1998, p. 7). Resilience is a process that encapsulates these two symbols (Walsh, 1998). These individuals overcome adversities in their lives by tapping into their strengths and utilizing effective coping mechanisms (Rutter, 1993). The ability to rise above stressors and/or trauma does not necessarily mean that the person is not affected by adversity. Resiliency is the ability to find meaning and live productively in spite of the negative experiences (Werner, 1990).

Models of Resiliency

Person Focused Model (Werner & Smith, 2001)

Variable Focused Model (Masten, 2001)

Family Focused Model (Walsh, 1998)

Protective Factors to Moderate the Stress and Trauma of the Risk Factors

(Internal Factors/Individual Characteristics, External Factors, and Family Factors)

Changing the Odds

- Resilience: Strength under adversity
- Multiple risk exposure: Limits of emotional endurance
- Positive outlook, perseverance, en-*courage*-ment, reframing, hope, success mentality, humor, values/purpose/spirituality,

(Adapted by Geffner, 2005, from Katz, 1997; Walsh, 1998, 2006)

Kauai 40-Year Resiliency Study

Resilient adults were mostly:

(a) satisfied with their achievements in different aspects of their lives, including work, school, and family,

(b) felt that they had mainly positive relationships with others, and

(c) were free of any mental illness.

From Werner & Smith, 2001

Key #3 - Positive Power of Peers

Good peer relationships
Development of self-esteem and strong social skills
A sense of hope
High maternal empathy and support
Opportunities to help others
Respect for others, and empathy
Hobbies and other creative pursuits in which to find refuge
Development of some sense of control of one's life.

To Help Children Feel They are Making a Contribution:

Required Helpfulness

- Positive peer relationship, especially when they can help or mentor another child
- Increasing Behavioral Successes

Fostering a Sense of Mastery

- The child gets to answer questions or solve problems correctly in front of age mates.
- The parents/caregivers get a call at home letting them know the special thing that their child did that day, followed by a written note that can be saved.
- At least 1x per week, a picture is taken of a special accomplishment. It's put in a photo album and either a story is written about it, or a tape recording is made. Memories of successful experiences.

Fostering a Sense of Mastery

- Helping to define one's identity around strengths and talent; success experiences are to mastery as repeated failure is to learned helplessness
- Caregivers and teachers can determine # of success experiences children/students have and in what areas
- Highlighting, nurturing and expressing strengths and talents, and things you feel passionate about

From Katz, 2003

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Mentoring Relationships

You ask me can I do it, Well don't you understand.

You're the one to answer, Because I can if you think I can. I have the courage and the skill, But these alone won't do. I must be sure that you believe I can do what you ask me to. So whether or not I reach my goals,

In your hand I place the key. Before I can ever reach heights, I must know you believe in me.

I Can If You Think I Can

Ivan Fitzwater

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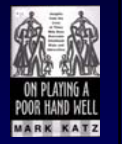

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Key #4 - Connecting Emotionally

Protective Processes That Can Offset the Effects of Multiple Childhood Risks

(Rutter, 1990, Werner & Smith, 1992, Werner, 1993)

1. Experiences That Reduce the Impact of Prevailing Risks:
   - A. Learning to see adversities in a new light
   - B. Reducing the amount of exposure to the risks of adverse conditions; buffers
2. Preventing a Chain Reaction of Negative Life Events; Creating Safety Nets
3. Experiences That Promote a Sense of Mastery
4. Opening the Door to Turning Point Experiences or Second Chance Opportunities

Personal and Social Assets That Facilitate Positive Youth Development

- **Physical Development**
  - Good health habits
  - Good health risk management skills
- **Intellectual Development**
  - Knowledge of essential life skills
  - Knowledge of essential vocational skills
  - School success
  - Rational habits of mind- critical thinking and reasoning skills
  - In-depth knowledge of more than one culture
  - Good decision-making skills
  - Knowledge of skills needed to navigate through multiple cultural contexts

Social Development

Connectedness - perceived good relationships and trust with parents, peers, and some other adults

Sense of social place/integration - being connected and valued by larger social networks

Attachment to pro-social/conventional institutions, such as schools, church, non-school youth programs

Ability to navigate in multiple cultural contexts

Commitment to civic engagement

Community Programs to Promote Youth Development, 2002, National Research Council, Institute of Medicine, National Academy of Sciences, Washington, DC

Psychological and Emotional Development

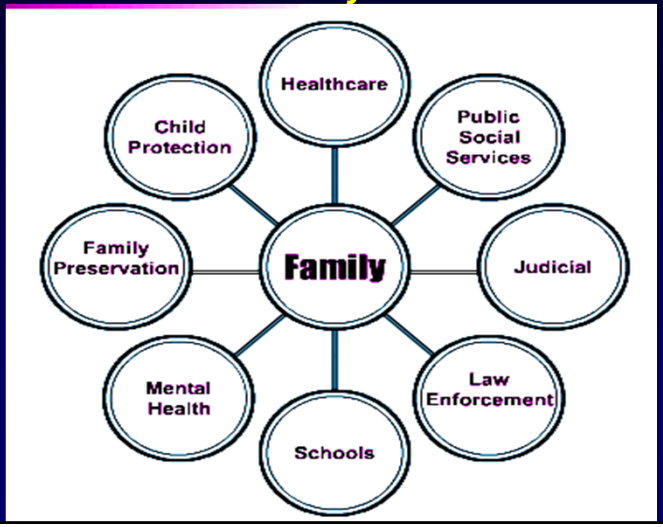
Good mental health including positive self-regard
Good emotional self-regulation skills
Good coping skills
Good conflict resolution skills
Mastery motivation/positive achievement orientation
Confidence in one's personal efficacy
"Planfulness"- planning for the future life events
Sense of personal autonomy/responsibility for self
Optimism coupled with realism
Coherent and positive personal and social identity
Prosocial and culturally sensitive values
Spirituality or a sense of a "larger" purpose in life
Strong moral character
A commitment to good use of time

System of Care Principles

(from Lenore Behar, 2006)

- *Child centered, individualized*
- *Family focused*
- *Community based*
- *Comprehensive*
- *Culturally competent*
- *Accountable/evidence based*
- *Coordinated across agencies*
- *Requires care management*

Key #5 - Recidivism Prevention
Trauma-Informed Systems of Care



Children Exposed to Family Violence

- WORK TOGETHER
- BEGIN EARLIER
- THINK DEVELOPMENTALLY
- MAKE MOTHERS SAFE TO KEEP CHILDREN SAFE
- ENFORCE THE LAW
- MAKE ADEQUATE RESOURCES AVAILABLE
- WORK FROM A SOUND KNOWLEDGE BASE
- CREATE A CULTURE OF NONVIOLENCE

Blueprint for Action, NIJ, OCJP, 2000

Practice Applications

- Integrate Approaches
  - Child and spouse/partner maltreatment
  - Mental health, social services, criminal justice/law enforcement, advocacy, health care - - multidisciplinary
- Broader Definition of Intervention
- Assessment of All Family Members (Multimodal)
- Systematic Approach
- Follow Over Time and Monitor/Re-Evaluate

Phase-Oriented Treatment

- Safety and Stabilization.
- Symptom Reduction
  - Regulating emotion
  - Processing trauma.
- Developmental skills.

Key #6 - Treating Trauma, Shame, etc. Treatment Goals

Regulating emotion:

- Help the child learn healthy ways to regulate emotions
- Help the child to reduce and eliminate self destructive behaviors
- Promote acceptance of painful feelings.
- Promote the direct expression of feelings in healthy attachments and relationships

Building positive relationships

Correcting cognitive distortions

Desensitizing and processing traumatic experiences

Building developmental/life skills

Adapted from the ISSD Guidelines for treatment (2000).

#7 - Calming & Nurturing Environment Family Goals

Change patterns of communication that maintain/reinforce symptoms.

Reinforce responsibility and accountability of all behavior.

Enhance attachment, emotional closeness, as well as autonomy.

Stay in charge through use of empathic limit setting.

Use communication that does not deny, distort, and disconfirm.

Encourage the child/family to accept all emotions

Discourage emotional contagion by enhancing personal boundaries.

#8 - Positive Attachment Relationships

Goals for Parents or Foster Parents:

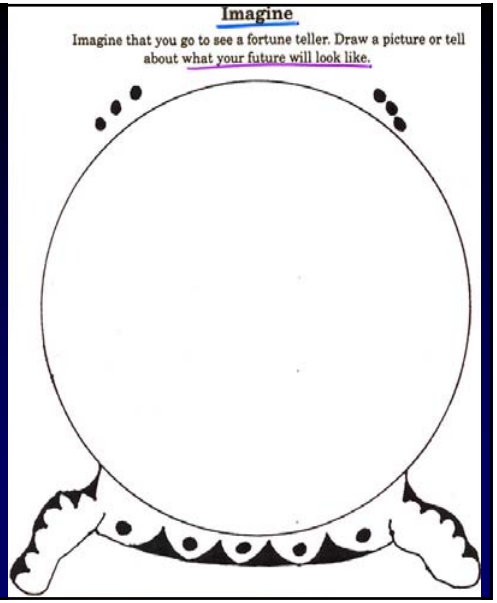
Change family patterns of communication that maintain and reinforce symptomatic behavior.
Reinforce responsibility & accountability for *all* behavior.
Accept responsibility for abuse, express repentance, apologize for lack of protection, and offer reparation (this goal assumes that the child continues to live with his family of origin where maltreatment occurred).
Enhance attachment--closeness and connection--as well as autonomy.
Encourage the child/family to accept *all* emotions.
Enhancing personal boundaries.

#9 – Positive Parenting

Working with and Engaging the Parent(s)

Parent Programs
(Responsible Parenting Curriculum and game - RESPECTT)

#10 – Future Orient-ation



#11 – Promoting Empathy

Roots of Empathy Video

4 min

Pres 2 - #1

4 Strategies to Reduce and then End Interpersonal Violence and Abuse

1) Public Awareness – Getting People Involved and Educating Them on Creating Safe Environments for Themselves and the People They Love
2) Providing Easy Access to Intervention and Advocacy for All Victims and Survivors Who Need It
3) Ensuring All Violence and Abuse Are Reported
4) Effective Systems of Care with Trained Professionals

Institute on Violence, Abuse & Trauma (IVAT) at Alliant International University, San Diego

Family Violence & Sexual Assault Institute (FVSAI)

National Partnership to End Interpersonal Violence Across the Lifespan (NPEIV)

International Conference on Violence, Abuse & Trauma, Including the *National Summit on Interpersonal Violence and Abuse Across the Lifespan* – Sept., San Diego, CA

Assessing, Treating & Preventing Child, Adolescent & Adult Trauma - March, Honolulu, HI