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Editor's Note—Winter 2007-2008

This issue of the *Michigan Child Welfare Law Journal* focuses on issues related to Michigan's foster care system. In "How does Michigan Fare in the Fight to Improve Outcomes for Youth Aging Out of Foster Care? A Response from the State and One of its Communities" (Day, Watson), the authors note that approximately 20,000 children age out of the nation's foster care system each year. Many of these youths find themselves making an abrupt transition to adulthood and independence with little or no assistance from their caregivers, biological families, or the child welfare system. Unlike their same-age peers in the general population, they have no safety net if they fail to succeed at navigating the adult world. The authors examine how the State of Michigan is seeking to improve outcomes for those children aging out of the Michigan system.

In "Procedural Injustice: How the Practices and Procedures of the Child Welfare System Disempower Parents and Why it Matters" (Sankaran), the author notes that over 60 percent of children removed by Michigan DHS do not return home within one year. Soon after the child protective case is initiated, many parents become disengaged in the process, fail to complete services, and drop out of their child's life. In many cases, this failure occurs, in part, due to the ways in which the procedures used by the child protective system disconnect and alienate parents from the decision making process involving their children. To the extent that the child protective system is serious about reunifying children with their parents, many of its practices and procedures undermine that objective. Sankaran explores this dissonance, which has significant repercussions for child welfare policy.

In "Circumstances and Suggestions of Youth Who Run from Out of Home Care" (Day, Riebschleger), the authors present the results of a study examining the circumstances of youth that ran away from out-of-home care. Data was drawn from 111 case records of three county courts in southeast Lower Michigan. Data was also drawn from four focus groups of youth living in out-of-home care. Circumstances that preceded youth running included female gender, African-American ethnicity, more restrictive placements, prior running episodes, and separations from siblings and children. Focus group youth expressed concerns about placement disruptions, rules, chores, differential treatment, loss of control, safety, and especially, feeling that "no one cares about me." The authors present specific suggestions to help prevent these children from running away from their placements.

Finally, this issue also includes an interview with Vicki Thompson-Sandi, director of Lutheran Foster Care Services, and Kari Mascar, director of Lutheran Adoption Service. For over a century, Lutheran Social Services of Michigan has sought to provide creative services to meet a variety of human needs. Services to families and children encompass a large portion of Lutheran's work today. Today, Lutheran is the largest private foster care and adoption agency in the state, serving over 800 children in different capacities. Lutheran maintains offices throughout the state of Michigan to serve this population. This article provides an overview of Lutheran's services and also discusses the challenges that the agency faces working in this most difficult field.

I hope you find this issue interesting and useful. As always, the editorial board welcomes your feedback on this and future issues to ensure that the *Child Welfare Law Journal* is of value to you. ◎

Editorial and Review Board

Message from the Chair

It is with great pleasure that I welcome you to this issue of *The Michigan Child Welfare Law Journal*. I would like to express my appreciation for the work and words of wisdom of the previous Chairs.

I have worked in the Prosecutor's Office for over 25 years. Along with the variety of cases you work on in a small county office, I've certainly lived with many child protection cases. During that time, I have met so many wonderful social workers, doctors, psychologists and police officers who have worked very hard for children in need, who they came into contact with, and for what they believed in.

In my work handling children's abuse and neglect cases, it also became apparent to me that we needed homes, good homes, for children removed from their homes in emergencies, or removed from their parents when they were not able to care for them. Frequently, substitute homes were full, difficult to find, didn't have sufficient space, or didn't or couldn't accept something about the children needing to be placed. Certainly, there was no point in removing a child from a home if we were not able to provide a better home for the child or the kind of home their parents would have wanted to provide. It became apparent to me that I needed to be one of those homes. So I began the journey of being a foster parent for the next 20 years.

There was not a child whom I met on this journey, as a foster parent, no matter what age, no matter what their limitations, no matter how short or long they stayed, that I did not learn something from. They may be appreciative of simple things we take for granted. They may steal when you least expect it. They may want to go back to a home when there is no home to go back to. They may cry that parents love them when they were terribly abused. But I loved what each child had to offer of themselves, their food and their traditions.

We have all heard it; children are our future. Really consider what that means. I'm sure you would not be reading this if you did not already work in the area of child welfare and already know that what you do is important. You must realize what you are doing makes a difference. However, think about the cases you've worked on and how they have changed the future. Where would those children be, had there not been intervention?

Even though our county is relatively small, some memories of certain children are very clear. I won't forget the little boy left at the rest area in his underwear, his mom in jail, the two little girls riding their bikes on US-27 in the snow, searching for their mother at a drug house. I won't forget the many sexual abuse cases I handled, some of the girls later speaking out at a sentencing or going onto college. I won't forget the little girl covered with bruises everywhere under her clothing or the brother and sister starving with distended stomachs.

So many children need our intervention and assistance. And with it, their lives may be changed forever, and, hopefully, for the better. I say hopefully, because, we all know, there are frustrations. Frustrations with caseworkers, foster parents, supervisors, service providers, separate even from the parties and system itself. Therefore, we all need to do the best we can and offer the best we can. We need to work together for our clients, whether those clients are parents, children or caseworkers.

We all need to work together to prepare the best home, environment and education for these children, whether they are returned home or find a new home, because they are our future. They will be the next social workers, police officers, therapists and attorneys or they will be the next generation of struggling parents, unable to adequately care for their children, too early, repeating what they never learned. Once children have been removed and had their lives changed, we must not fail them.

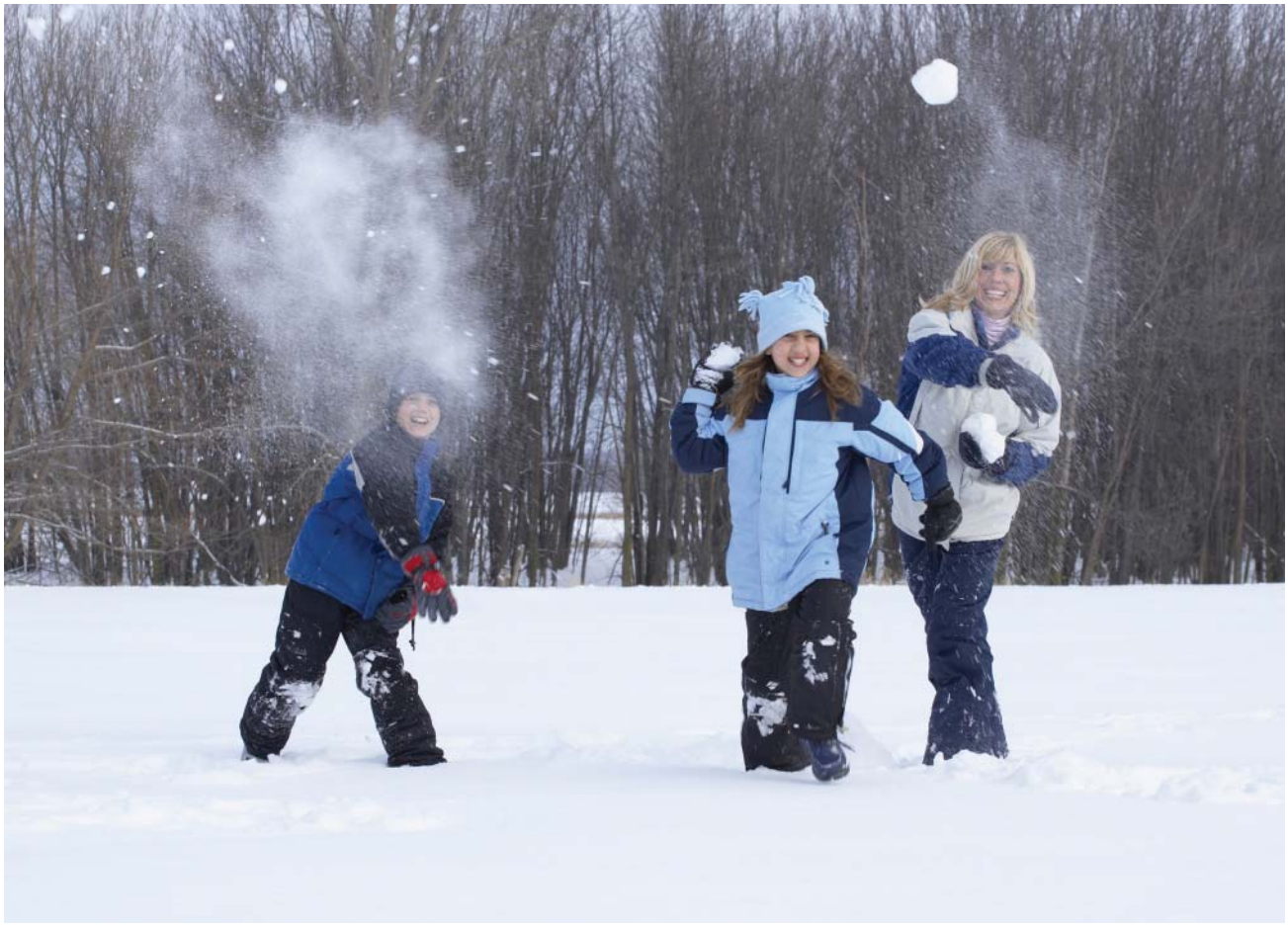
These children remember their past, how people explained it to them, and helped them or failed to help them grow. They know so much and want to be heard. They want their attorneys to come talk to them, even if they don't act like it. They want the same advantages and benefits in life as any other

child. And they will remember those people who reached out and offered them an opportunity where there wasn't one before.

This year, I would love to expand our Section's membership and participation. Please feel free to call in or attend our meetings held every month. More importantly, I would like to see our Section take a strong role in supporting opportunities for youth currently, or previously, in the foster care system, in anyway we can. We owe it to our clients and to our future.

Mary C. Pino, Chair
State Bar of Michigan Children's Law Section

Correction: In our last issue we listed Itzhak Lander as a co-author of "Procedural Injustice: How the Practices and Procedures of the Child Welfare System Disempower Parents and Why it Matters" when in fact the article was written soley by Vivek Sankarin. We apologize for this error.



Collaborative and Empowering Practices with African American Families in Child Welfare

by Asha Barber, M.A., Kathleen Jager, Ph.D., Michigan State University

Abstract

African-American children are disproportionally represented in their rate of entry, duration, and exit from the child welfare system (AFCARS, 2006). Understanding how the complexities of child maltreatment, mental health, and trauma inherently intersect with race and class experiences for African-American families in the child welfare system is a necessary component of comprehensive services. To adequately address the needs of black families and children, child welfare professionals must begin to understand and acknowledge how cultural values and experiences shape and structure interactions and inform parenting (Abney, 2002; Hill, 2008). This article addresses the role that culture plays in devising and implementing a family-centered treatment plan that meets the individualized needs of black families. In addition, practice implications, including the use of family-based services, are explored as a means of working collaboratively with African American families.

African Americans and Their Current Involvement in the Child Welfare System

Recent government reports illustrate that minority populations disproportionally populate the child welfare systems (AFCARS, 2006). Specifically, although African Americans comprise 15 percent of the total U.S. population, within the child welfare system, African-American children comprise 38 percent of the children in care. Studies have examined contextual reasons for the disproportionate numbers of minority children in care and found that no racial group differences in terms of the rate of child abuse/neglect exist (Green, 2002; Sedlak, 1991; Sedlak & Broadhurst, 1996). Institutional structural inequality (USACYF, 2005; USDHHS, 2002) and poverty-related challenges (Bartholet, 1999; Benson & Michael, 1997; Seccombe, 2007) are among some of the hypothesized explanations for the disproportionate number of minority children in care.

Once in care, African-American children continue to face a myriad of difficulties related to successful familial reunification. United States Department of Health and Human Services (2002) records confirm that black children remain in care longer, have significantly lower rates of exits compared to their Latino and European American counterparts, and are less likely to be reunified or adopted (Courtney & Wong, 1996). Moreover, the criteria used to discern the receipt of in-home services is counterintuitive to the struggles related to poverty. According to the U.S Children's Bureau (1997), children that are older, come from a two-parent family in which one parent is employed, reside in low crime areas, come from a family with no evidence of parental drug abuse or prior child welfare case openings, and do not rely on government financial assistance programs are more likely to receive in-home services while matriculating through the child welfare system. Unsurprisingly, these struggles are representative of the very same difficulties that increase a minority family's original entry into the child welfare system and subsequently the minority children's entry into the foster care setting.

Considerations Related to Child Maltreatment and Out-of-Home Placement

Children in foster care represent high risk for maladaptive outcomes including socioemotional, behavioral, and psychiatric problems. Main risk factors leading to maladaptive outcomes include the maltreatment experiences leading to child welfare involvement, the processes of children's protective services investigation and judicial decision-making, and the stress of removal from the home (Landsverk, Garland, & Leslie, 2002). There is also evidence that children's emotional and behavioral profiles influence the likeli-

hood of family reunification, meaning that children with greater externalized behavioral difficulties are less likely to be reunified (Lau, Litrownik, Newton & Landsverk, 2003).

Mental health providers must be cognizant of variable stressors and problems that exist for families in relation to child maltreatment in addition to the acute stressors that coincide with entry and participation in the child welfare system itself. The proportion of children in foster care that meet clinical criteria for behavioral problems or psychiatric diagnoses is very high (Lau, Litrownik, Newton & Landsverk, 2003). Up to 75 percent of children in foster care exhibit behavior or social competency problems warranting mental health treatment (Landsverk, Garland & Leslie, 2002). Additionally, maltreating family systems are often characterized as "multistressed" (Lindblad-Goldberg, Dore & Stern, 1998), disorganized, chaotic, and less able to cope with stressful circumstances. Such characteristics are linked to risk for further maltreatment and negative impacts on child psychosocial functioning (Lau, Litrownik, Newton & Landsverk, 2003).

Though the words "abuse" and "trauma" are often used interchangeably in child welfare, Gil (2006) believes that it is necessary to distinguish between children who suffer from long-term traumatic impact and those who have experienced acute stress. Though child sexual abuse may pose higher risk for post traumatic stress disorder (PTSD) and depression, overall general functioning problems are comparable for all forms of child maltreatment (Chaffin, 2006). Though it is clear that traumatized children are a subset of abused children and that children's responses to abuse are extremely heterogeneous, all forms of child maltreatment have the potential to be traumatic and are dangerous to children's development and survival (Gil, 2006). When engaging maltreated children and their families into mental health services, it is important to understand that the core experiences of trauma are disempowerment and disconnection from others. Additionally, these same factors that make it difficult for maltreating parents to emotionally engage with their children probably also make it difficult for families to connect with service providers (Erickson & Egeland, 2002). Effects of trauma elicit feelings of guilt and inferiority, a sense of disconnection between individuals and their communities, and a struggle between isolation and clinging to others (Herman, 1997). Maltreating families share similar stresses such as poverty, multigenerational abuse, multiple stresses (Lindblad-Goldberg, Dore & Stern, 1998), perceived inattention to children's needs, and multigenerational experiences of inadequate parenting (Friedrich, 2002).

Recovery from maltreatment and trauma is based upon empowerment and the creation of new connections within the context of relationships (Herman, 1997). All people mature and thrive in a social context that has profound effects on how they cope with stresses (van der Kolk, 1996). Because traumatic life events damage relationships, persons who are social supports for others have the power to influence the outcome of trauma (Herman, 1997). Black families, however, face additional obstacles when child welfare and mental health professionals fail to deliver culturally competent services (Abney, 2002) in the wake of trauma. Racial and ethnic culture impacts and informs family skills, beliefs, and values, including behavior and interaction in family systems (Hill, 2008). Culture has a crucial impact on individual response to trauma and stress. Culture informs individuals' organization, perception, disclosure, expression of symptoms, and attitude toward treatment and recovery (Abney, 2002).

Practice Implications

Despite the child welfare system's efforts to decrease overrepresentation of African-American families, it appears that more innovative strategies must be examined as a means of positively impacting black families and decreasing their overall continued involvement in the child welfare system. In particular, there is a need for increasing the scope of cultural knowledge pertaining to working with African-American families. Reputable texts exist that examine core concepts and components related to working with African-American families, covering such topics as working from a multicultural perspective (Hepworth, Rooney, & Larsen, 1997; Locke, 1992; McGoldrick, 1998), general practices related to working with black families (Boyd-Franklin, 2003; McGoldrick, 1998), and home-based services (Boyd-Franklin & Bry, 2000). Beyond increasing child welfare workers' cultural knowledge pertaining to the overall functioning of black families, workers should be challenged to use family-centered planning as a means of rigorously

trying to provide in-home social services to African-American families instead of foster care services.

Social programs aiming to prevent child maltreatment through intervention with the family system must implement a diversified balance of responsiveness and protocol (Daro & Donnelly, 2002). Best practices for foster care can emerge through the collaboration of therapists, social services, and the courts (Britner & Mosler, 2002). A primary step toward informing collaborative processes between family therapists, social workers, and the foster care system involves developing a clear understanding of the issues that affect maltreating families (McWey, Henderson & Tice, 2006). A framework of cultural competence must be integrated into the collaborative processes that inform child welfare and mental health practices (Abney, 2002).

Child abuse and neglect are experienced and organized from the subjective viewpoint of the individual, which inherently includes cultural identification. Creating spaces in which the cultural viewpoints of both client and professional can be recognized, appreciated, and valued in an interaction that holds the potential for meaning and change is critical, as cultural identification informs how all persons organize life experience (Abney, 2002).

Additionally, understanding the manner in which black families receive and utilize support services is critical in devising reunification plans that will decrease long-term involvement of African American families in the child welfare system. Help-seeking behaviors of African Americans can inform practice efforts of service professionals. For instance, although studies have shown that African Americans use informal supports to cope with life difficulties (Neighbors & Jackson, 1996; Broman, 1996), compared to European-American counterparts, African Americans are more likely to pair informal supports with formal supports (Snowden, 1998). Moreover, the work of Snowden (1998) has shown that African Americans typically address emotional and mental health-related concerns by formal supports as opposed to informal supports. Knowing that formal supports are used to address emotional and mental health concerns and that African Americans in general use a balance of formal and informal supports, child welfare caseworkers can work to establish a connection with other mental health practioners to further assist black families to develop informal supports that remain in place after a family's involvement in the child welfare system terminates (Ferguson, 2007).

Due to the patterns associated with African Americans seeking formal supports to help cope with emotional and mental health-related problems, mental health practitioners that are selected to work with these families must work from a strength-based perspective that seeks to build upon and increase the strengths of the black family. Clinicians must be sensitive to the historical trauma that African Americans have endured as a result of centuries of marginalized treatment. Clinicians can normalize and reframe cultural mistrust and paranoia as appropriate reactions to racist practices that have led to an overall mistrust of the mental health and child welfare systems. Recognizing the likeliness that some level of cultural mistrust will be present, clinicians should be prepared to work hard in order to gain the trust of African-American families and to provide a collaborative therapeutic environment (Boyd-Franklin & Bry, 2000; Combs, Penn & Fenigstein, 2002). Once families begin to feel safe with mental health practitioners, the family's ability to function in multiple environments (Bry, 1994), the manner in which the family advocates for itself (Berg, 1994), and the cultural strengths and resources the family already possesses (Boyd-Franklin & Bry, 2000) can be accurately evaluated and expanded upon. A positive working relationship between clinicians and African-American clients can have a positive impact on the overall outcome of child welfare cases.

Mental health clinicians already working with African-American families who have gained trust and are knowledgeable about help seeking behaviors of blacks can work to mend fractured relationships that African Americans might have with other service professionals. Because blacks use formal supports to address emotional and mental health concerns, it is vital that African-American families have a reputable working relationship with child welfare professionals, especially caseworkers. An amicable working relationship with caseworkers can increase the likelihood that African-American families will obtain the services needed for long-term mental health care and stability. Mental health practitioners can work to address and mend communication difficulties between caseworkers and black families that ultimately hinder African Americans from attaining the services needed. In addition,

mental health clinicians should be working closely with caseworkers in order to assist in the development of a reunification plan that specifically addresses the needs of the family and seeks to further promote and build upon the strength of the family.

It is important that mental health practitioners and child welfare caseworkers integrate their resources and knowledge base in order to provide the most family-centered services to African Americans. Clinicians can help expand caseworkers' knowledge pertaining to the struggles related to biculturalism (McGoldrick, Giordano, & Pearce, 1996) in addition to highlighting the strengths that the family already possesses. Caseworkers should be encouraged to work collaboratively with clinicians and black families in order to devise a plan that is individualized for the particular needs of the family (DHS, 2006). Declining the utilization of a "one-size-fits-all" approach to working with African-American families will inevitably decrease reentry into the child welfare system.

Family-Based Services with African-American Families

Family-based services focus on expanding the family's available internal and external resources to nurture and care for a child who has experienced threats to development such as trauma, maltreatment, and emotional or behavioral disability (Heflinger & Bickman, 1996, Lindblad-Goldberg, Dore & Stern, 1998). Family-based service professionals recognize and address dysfunction in the family system that likely interferes with the family's ability to maintain and nurture a child who has experienced trauma. Attention is also focused on establishing relationships between the family and community services, organizations, and institutions that can support and enhance their efforts. Simultaneously, value is placed on forming a collaborative partnership between the therapist and the family, and meeting the needs of the family in its natural settings (e.g., home, community). Since the 1980s, the treatment trend for families at risk has been to enlarge the treatment context by including all essential informal helpers (e.g., natural supports) and formal systems in collaborative treatment processes (Linblad-Goldberg, Dore & Stern, 1998). Positive outcomes of family treatment, especially home based, include the clinician's increased likelihood of meeting and engaging key and peripheral family members who might not otherwise be included in treatment, ability to experience the family's living arrangements (e.g., household structure, neighborhood, economic condition,, increased exposure to the family's culture, and firsthand witnessing of parenting practices [Boyd-Franklin & Bry, 2000]). In addition to providing the clinician with a firsthand account of the family's environment and functioning, these family treatment outcomes seek to better inform the overall work of clinicians.

Family empowerment is a specific goal toward which the collaborative treatment processes of family-based services should aspire. In the context of human service delivery systems, family empowerment is defined as a process by which families access knowledge, skills, and resources that enable them to gain positive control of their lives and improve the quality of their lifestyles (Koren, DeChillo & Friesen, 1992; Singh, Curtis, Ellis, Nicholson, Villani & Wechsler, 1995). Helping African Americans increase their internal locus of control is particularly important since research has found that marginalized individuals generally adhere to the belief of an external locus of control (Sue & Sue, 1990).

As marginalized individuals are forced to confront societal structures that have been established as a means of deliberately stifling their progress toward goals, feelings of individual powerlessness are increased (Abney, 2002). Institutionalized and structural inequality helps to support the use of an external locus of control and inevitably increases the needed for individualized empowerment. To the extent that individuals are left feeling powerless about having the individual ability to work toward and accomplish goals, external locus of control appears to be a justifiable means of coping.

Work with African-American clients can seek to expand their understanding surrounding the systemic context of their marginalization. Service professionals should empower African-American clients and increase their ability to locate and utilize an internal locus of control that will help to increase their ability to advocate for themselves and their families within the established social structure. It is through the work with professionals that African-American clients can begin to gain an increased sense of individual power, bear witness to ways in which they can advocate for themselves and their family, recognize their individual

and collective strengths, increase their ability to work collaboratively with professionals, and gain a sense of mastery and belonging (Abney, 2002; Heger & Hunzeker, 1998).

Implications for Legal Practitioners

Effective practices of family empowerment include direct and collaborative planning efforts with all involved professionals (Lindblad-Goldberg, Dore & Stern, 1998). The process of creating an accessible and collaborative environment with clients can be particularly difficult for attorneys and other legal practitioners working within the child welfare profession. Inherent power discrepancies, accompanied by social hierarchies, present complexities at the onset of relationship development between legal practitioners and clients involved in the child welfare system. Qualitative and quantitative data examining the viewpoints that children hold related to the legal process, particularly the role of child advocates, have been severely understudied (Hughes, 2006). Gaps in the legal literature hinder legal practitioners' ability to understand child welfare clients' viewpoints, thereby reinforcing power differentials.

Legal practitioners are uniquely responsible for understanding the extent and role that culture plays into clients' understanding of their situation. Deficits in practitioners' understanding of the role of culture can further disempower child welfare clients. Legal practitioners who are committed to working from a culturally competent perspective ensure that their work is parallel to the beliefs, behaviors, and expectations of a particular culture's members (Green, 1995). It is particularly important that attorneys and judges recognize and acknowledge the power they hold over the policy establishment and reinforcement process (Mathis, 2007; McPhatter & Ganaway, 2003). Legal practitioners' comprehension of decision-making processes significantly impacts policies related to child welfare program appropriateness (Ferguson, 2007). Practitioners have an obligation to thoroughly understand the impact that cultural competency plays into the distribution of equality and justice within the policy formation and reinforcement process. On a larger scale, legal practitioners can partner with individuals and families involved with child welfare and advocate for system reforms that seek to provide better services for those involved in child welfare (Mathis, 2007).

Conclusion

Undoubtedly, the experiences of child maltreatment impact the lives of not only children but all members of a family. Statistics demonstrate that African-American families are particularly vulnerable to suspicions of and substantiated incidences of maltreatment. As it stands currently, entry into the child welfare system speaks of a grim prospect that "treatment" will positively change the lives of black families. Understanding the ways in which abuse and trauma impacts African Americans and the manner in which African Americans cope with such an experience ultimately impacts the way that service professionals approach their work with black families.

Collaboration between all service professionals involved in the family's treatment in addition to the family itself will provide family-based services that seek to address the family's individualized needs. Child welfare workers must work to thoroughly understand the unique life stressors that African-American families endure as a result of their marginalized status. Additionally, the manner in which disempowerment and disconnection from others is further impacted by experiences of trauma should be carefully and extensively explored in order to adequately address those feelings.

Ignoring the unique experiences that African American face is no longer an acceptable practice for child welfare service professionals. Mental health clinicians who work closely with African Americans and have gained the trust of black families have an added responsibility of educating other professionals about the family's unique experiences and strengths. Treatment should be from a strength-based empowerment approach and address obstacles related to eliciting positive natural supports and an increasing sense of internal control and advocacy. Ultimately, there is a need to honor and respect the experiences and the voices of African-American families as a means of adapting treatment to meet the unique needs of the black family.

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A Trauma-Informed Child Welfare System Practice: The Essential Elements

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Historically, key professional groups within the child welfare system (legal, social services, and mental health) have attempted to define best practices for maltreated children and their families. However, professionals frequently do not operate from similar perspectives, which can result in system fragmentation and alienation. Professionals bring their personal values, unique professional educations (perspectives specific to profession), and different experiences to decision-making and interventions with maltreated children. All verbalize the necessity for collaboration, but forging partnerships is extremely challenging. Criticism, turf protection, and blame of other professionals surface, compromising the system's ability to meet children's needs and achieve goals of child safety and family support.

Over the past 15 years, family preservation has been the primary philosophy and set of values guiding the child welfare system. Driven by federal policy, child welfare systems across the country have had to integrate new language into legal proceedings, create new family centered programming, and set goals to reduce the number of children in foster care and the duration of out-of-home placements. Opponents, usually child advocacy proponents, argue that the philosophy is parent-centered and places children at undue risk of harm (Gelles, 2007). Extensive research has produced mixed results on the potential benefit and harm of family preservation to maltreated children (Kirk & Griffith, 2004).

Concomitant with the infusion of family preservation philosophy and practices, research on the deleterious impact of trauma to children was burgeoning (Taylor, Wilson & Igelman, 2006). Child advocates heralded the new trauma research as essential in protecting children and protecting families. The findings from brain research on the physiological changes within the structures of the brain from childhood trauma has informed professionals that children's brains are extremely vulnerable to long term damage (Perry, 1997; DeBellis, 2005; Teicher, 2002; van der Kolk, 2005). Consequently, efforts to procure the physical and psychological safety of children have taken on increased significance.

The research consistently reveals that multiple chronic traumatic events including abuse, neglect, and sexual abuse, often result in relational disturbances, deficits with language and cognition, emotional and behavioral impairments, and social/emotional disturbances (Cohn, Miller & Tickle-Degnen, 2000; Dunn, 2001; Dunn & Westman, 1997; Ingelman, Conradi, Ryan, 2007; Miller, Reisman, McIntosh & Simon, 2001; Parham & Mallioux, 1995; van der Kolk, 2005; van der Kolk, Roth, Pelcovitz, Sunday & Spinazzola, 2005). The experience of trauma increases vulnerability to stress, affects the capacity to problem solve, and may manifest as over compliance, resistance to change (Crittenden & DiLalla, 1988), or aggression and oppositional defiant disorder (Ford, Taylor & Warner-Rogers, 2000). Children and youth who have experienced maltreatment suffer from post traumatic stress disorder at a higher rate than war veterans (Seita, 2006). All of these impairments often translate into poor academic performance, poor social relationships, risk-taking, delinquent behavior in adolescence, and adult problems with health, intimate relationships, mental health, and employment success (Dube, Anda, Felitti, Chapman, et al., 2001; Dube, Anda, Felitti, Croft, et al., 2001; Felitti, et al., 1998; Goodyer, et al, 2000a, 2000b, 1985; Herman, Perry & van der Kolk, 1989; Simpson & Miller, 2002; Yehuda, Spertus & Golier, 2001).

New federal child well-being initiatives demand that states refocus and redesign their programming to

include efforts to not only physically protect children, but to develop assessment and intervention protocols that recognize the potentially harmful effects of traumatization. Michigan, consistent with most other states, failed its federal child family services review in 2002 by not achieving substantial conformity to each of seven safety, permanency, and well-being outcomes for children in the child welfare system.

Balancing parents' rights in regard to their children with the physical and emotional well being of children has always been an inherent debate within child welfare. With new trauma research, the debate has become more intensified because of potential irreparable harm to children.

Child Welfare Curriculum

The National Child Traumatic Stress Network, recognizing the importance of institutionalizing child trauma research, developed a trauma-informed child welfare model of practice. The model, based on trauma-informed "Essential Elements," transcends individual professional practices, providing a framework for professionals and resource parents to intervene with traumatized maltreatment children. The Essential Elements address and provide a framework for responding to the needs of children who have been maltreated and traumatized. "The Essential Elements are the province of all professionals who work in and with the child welfare system and span investigation, service provision and coordination, court decision- making, and permanency" (National Child Traumatic Stress Network, Accelerated Child Welfare Committee, 2007).

Essential Elements

1. Support and promote positive and stable relationships in the life of the child.
2. Maximize the child's sense of safety.
3. Services to the child should be guided by a thorough assessment of the child's trauma experiences and their impact on the child's development and behavior.
4. Assist children in reducing overwhelming emotion.
5. Help children make new meaning of their trauma history and current experiences.
6. Address the impact of trauma and subsequent changes in the child's behavior, development, and relationships.
7. Provide support and guidance to the child's family and caregivers.
8. Coordinate services with other agencies.
9. Manage professional and personal stress.

(Accelerated Child Welfare Committee, 2007)

Implementation of each Essential Element must take into consideration the child's developmental level and be sensitive to the child's family, culture, and language. While the Essential Elements were initially designed for the training and fostering of trauma-informed child welfare practices for caseworkers managing the care and treatment plans for children under the jurisdiction of family and probate courts (Igelman, Conradi, Ryan, 2007), the Essential Elements have the potential to provide diverse professionals and resource parents a unifying set of maxims that recognize the impact of child trauma due to maltreatment. The elements are consistent with family preservation, but expand the focus to include the psychological needs of traumatized children. The elements actually strengthen family preservation because they add a critical dimension, a framework that considers the well-being of the child, while simultaneously supporting the child's family. Each element, as discussed below, creates a common language for child welfare professionals to utilize.. The elements become unifying principles that guide decision-making and intervention. The professional disciplines are likely to interpret the elements in the context of their specific trainings, experiences, and role expectations. Finding common ground to derive similar meanings within each element amongst diverse professionals is likely to be problematic, at times. Varied professional interpretations of the elements are expected, but mutual efforts to operationalize and achieve each Essential Element create opportunities for discussion and collaborative problem solving to better respond to maltreated children.

Practical Implications for a Trauma-informed Child Welfare System

For children entering child welfare, service provision and comprehensive treatment planning are often marked by the fragmented and "siloed" response systems (Lieberman, 2007). While each primary system, including child welfare case management, mental health, and the legal system strives to provide remedial services to families, differing missions and funding

directives often interfere in a uniform provision of care. Additional systems serving traumatized children including the educational system and advocacy services, and especially caregiver groups (biological, foster, and kinship care providers) further contribute to the potential benefit or negative impact on children exposed to maltreatment.

Case Example

The case of Micala:

Eight-year-old Micala resided with her mother and two siblings, her four-yea- old brother and her two-year-old sister. Her father had been incarcerated for domestic violence, which Micala had witnessed on several occasions. He had a previous record of assault. During the previous month, Micala came home from school and saw her father pushing her mother to the floor and kick her, resulting in a cut to her face and substantial bleeding. Micala's siblings were in their bedrooms. Micala called her grandmother, who called the police. Children's protective services (CPS) was called, at which time the children were left in their mother's care, and her father was jailed. Home-based intensive services were initiated to ensure safety, identify the family's needs, and support their adjustment to changes in the home.

Previously, Micala's mother had taken the children to shelters, but had returned to their father when he promised to stop the domestic violence. On one occasion, her mother had gone to the shelter when her father spanked her brother with a cord and would not let her mother care for him afterwards. Micala has taken care of her brother and sister often, and when her mother stays in bed some days, she cares for them all day, sometimes missing school. When Micala was five, and when the family lived with a paternal uncle, Micala was sexually abused by her uncle for a period of four months. She did not tell anyone until they moved, at which time her father said she was making it up and told her never to talk about that again.

Micala is described as very quiet, has friends at school, but does not have children over to her house to play. She seldom goes to anyone else's house, and does not participate in any activities outside of school. She has a close relationship with her 17-year-old cousin who also had been sexually abused, and they talked frequently on the phone.

Micala can do well in school, but misses assignments and is behind other children in her classroom. She has a hard time paying attention, and her teachers have questioned whether or not she has ADHD. She talked to a counselor at school and described occasional nightmares. She sometimes "blows up" at other kids, but is not aggressive.

When Micala's father was released from jail three weeks following his arrest, her mother resumed contact. She first had phone contact, then allowed him to come home on the weekend after he was released. CPS was contacted, and Micala and her siblings were placed together in foster care after exploring relative options. Her grandmother's health issues prohibited placement in her care, and other relative/kinship care placements were either not appropriate or unavailable. After a week in foster care, her foster mother described her as cooperative, smart, but emotionally disengaged. Her biggest concern for Micala is that she masturbates a lot, and sometimes she is observed masturbating while watching TV. Her brother exhibited aggressive play with peers and had significant difficulty following directions. Her two-year-old sister exhibited highly clingy behaviors, often sought out Micala, yet was not easily comforted, sometimes tantruming suddenly and for long periods of time.

Traditionally, the child welfare system would likely intervene following removal of Micala and her siblings with a parent agency treatment plan. This plan, presented to the court, would require that mother and father perform a series of mandated tasks to retain custody. These tasks are likely to include:

- The mother separating from the father and establishing her own residence
- The mother and father both undergoing a psychological evaluation
- The parents visiting the children weekly
- Counseling for the mother

- Anger management class for the father
- Counseling for Micala

These tasks, overseen by the caseworker, would be initiated by referral and monitored by phone contacts and written reports. Parent agency plan implementation, rooted in family preservation philosophy, would outline the steps necessary for the children's return home to mother. Operationalizing the plan would not be guided by trauma elements but rather task achievement and management of Micala's and the other children's behaviors. Little to no consideration would be given to how visits with mother may trigger past traumas and precipitate old harmful coping mechanisms. Contacts with foster parents would be limited to monitoring and not address the internalizing (disengagement) and externalizing (masturbating) behaviors that Micala is exhibiting. The foster parents would likely have minimal understanding that Micala's hypersexualized behaviors were trauma reenactments. Professionals and resource parents would likely respond with moralistic lectures and significant consequences.

Operationalizing a trauma-informed response for Micala utilizing the Essential Elements

In a trauma-informed system, the child and biological family benefit from the knowledge, acknowledgment, and proactive response that provides for their complex needs. Promising or evidence-based practices are prioritized as methods of intervention. Further, cross training in the Essential Elements promotes collaboration and planning based on the needs of the children and family. A trauma-informed multi-system approach that is driven by the Essential Elements can create opportunities for meeting the needs of traumatized children and their families, while reducing the risk of retraumatization (due to chronic disruption and uncertainty).

Biological parents, who may themselves have traumatic histories and stress responses, are able to benefit from the perspective of understanding their children's behavior, as well as their own. Interventions that foster family skill building in the context of safety, self regulation, "meaning making," and family support are more likely to support change that has long term benefits.

In the case of Micala, the following represents a trauma-informed response.

Trauma-informed Protective Services Intervention

CPS initially made attempts to support Micala's family in the home, building on the safety achieved when her father was incarcerated. CPS petitioned the family court to obtain jurisdiction to strengthen their efforts to provide services and outcomes. CPS and the family court began the process of identifying the needs of the children and their mother. Families First (an intensive home-based intervention) provided initial support and referrals to therapists known to utilize culturally sensitive and trauma-informed assessment and treatment protocols. A trauma assessment for all of the children and their mother was initiated to understand the impact of their direct and indirect exposure to abuse and violence in the home. Prior to the father's release from jail, a restraining order was obtained to aid in providing safety in the home. However, when her mother was unable to maintain no contact, CPS explored family and kinship options, especially with Micala's grandmother, who had been a protector in the past. When placement in foster care occurred, the judge overseeing Micala's case ordered trauma therapy, reiterating the need to use a therapist known to have expertise in trauma-informed practices. The judge also ordered supervised visits with the therapist present until assessments were complete, while allowing Micala to have phone contact with her grandmother and cousin. Micala and her siblings were placed in the same home, minimizing their loss of significant others. A placement with a foster family that had completed training about the impact of trauma on children, including the emotional and behavioral manifestations of maltreatment, was important for Micala and her siblings to prevent further disruption in their placement. Her foster mother was provided historical information related to the children's experienced abuse (physical and sexual) as well as their exposure to domestic violence. Micala was shown pictures of the foster home and given informa-

tion about the foster parents before she and her siblings arrived, and she was allowed phone contact with her cousin and grandmother that evening, as these relationships were significant supports to her.

Trauma-informed Foster Care Intervention

Micala and her siblings were assigned a foster care worker. He had previous training in the impact of maltreatment and exposure to violence on children, as well as methods of implementing trauma-informed child welfare practices into case management responsibilities. He met with Micala and her siblings in the foster home, at first introducing himself at an age-appropriate level, telling them that he would be working with Micala and her family. Her foster mother, Micala's therapist, and the worker discussed behaviors often demonstrated by children exposed to violence, and in Micala's case, those related to sexual abuse. An initial safety plan was developed that identified stress behaviors and strategies to provide calming that minimized the likelihood of exposure to Micala's masturbating to others in the home, and that minimized the impact of the loss of their mother. This safety plan included continued contact with her cousin and grandmother and regular supervised visitations with her mother, to be supervised by the therapist. Contact with their father was initially suspended until his risk of physical and emotional harm to the children and their mother was evaluated. Her foster mother and foster care worker made contact with Micala's teacher to inform him of her move, and to coordinate a safety plan based on Micala's known anxiety and difficulty with attention/memory. Information related to other behaviors frequently seen in traumatized children at school and with peers was provided.

Micala's, her sister's and brother's trauma evaluation was conducted the week following their placement in care. Micala was identified as having primarily age appropriate development, although deficits in attention, memory, and comprehension were identified. Trauma specific self rating scales also revealed significant post traumatic stress symptoms and sexual distress, and her foster mother's observations revealed withdrawal behaviors and clinically significant internalization. Micala communicated that she worried about her mother because her dad "always came back and hurt her." She also disclosed her previous sexual abuse which had never been investigated. Her brother was also found to have developmental lags in language development, and attachment concerns for both him and the two-year-old sister were identified.

A report to CPS related to Micala's sexual abuse was made, and an interview was scheduled at the local child advocacy center, minimizing the number of forensic interviews. She also began treatment with her therapist, who was trained in trauma-informed practices, including trauma focused cognitive behavioral therapy. Her brother and sister were also referred to the same therapist, and their foster mother participated in their therapy to understand ways to foster calming strategies for Micala and her brother and ways to enhance attachment and emotional safety in her home. Her mother was referred to a trauma-informed therapist with goals of increasing skills of developing safety, recognizing stress reactions, and helping her children understand their experiences. Micala, her foster mother, her biological mother, and her therapist also created a book where Micala could put pictures of her family, her memories, thoughts, and feelings as part of a mutual plan to assist her in understanding her experiences. Assessment of her parents was initiated that addressed their ability to provide safety and care, while also developing a treatment plan that included her mother in helping Micala make meaning of (understand) events that she had experienced.

In the case of Micala, several trauma-informed responses, operationalizing the Essential Elements, are evident. These included initial steps to consider the children's needs and minimize the loss of significant others when placement was deemed necessary. Placement preparation included communication with potential caregivers and other professionals about what is normal for children who have gone through similar experiences and developing a trauma framework to better understand the children's needs and reactions. In Micala's case, the trauma assessment also revealed different domains of functioning impacting

how she and her siblings were able to think. Traumatic stress reactions, including sexual behaviors, were addressed through a 'safety plan' that reduced the impact of ongoing, day-to-day stressors and built on existing relationships and supports. Micala was referred for a multidisciplinary forensic interview, minimizing re-traumatization. Of particular importance is the integration of interventions that fostered her caregiver's and other professionals' trauma framework, including the impact of trauma on children and their need for safety and support.

Integration of the Essential Elements into day-to-day practice

The challenge of integrating new practices into day-to-day operations is not new or unique to child welfare. Adult learning theory has explored the distinctive needs of adult learners and adapted training methodology to foster the integration of new information and skills into practice. (Knowles, 1970) Professionals in the child welfare system have the additional challenge of attempting to care for children with limited resources, including budget restraints, high turnover of child welfare workers (U.S. General Accounting Office, 2003), and competing priorities of differing professionals. Integration of the Essential Elements into the unique roles of professionals and caregivers may appear initially forbidding, especially when each professional entity (case management, legal, mental health, foster parents, etc.) are often overloaded and overwhelmed. However, operating from a "trauma lens" that incorporates a paradigm shift that understands traumatized children through the Essential Elements only reprioritizes the use of time rather than demanding more time. Used as a guide for child welfare practices across a multidisciplinary perspective, the Essential Elements provide a framework for assessment, planning, and decision-making that minimizes crisis, builds collaboration, and provides unified goals across professions. Specific explanations and examples of trauma-informed actions for the Essential Elements and specific child welfare system roles are included below. The described implementations of the elements are suggestions and not meant to be exhaustive, as there are innumerable possibilities for each.

Support and promote positive and stable relationships in the life of the child

The significance of attachment and bonding to children's development, including the development of essential pathways in the brain necessary for learning and social/emotional development, is prevalent in the literature (Perry, 1999; Schore, 2003; Teicher, 2002). Traumatized children may have difficulty trusting that their needs will be met by caregivers, especially if the children have experienced betrayal in primary relationships. However, protective factors contributing to resiliency in children emphasize that even one caring person in a child's life who accepts him and his behavior, provides a positive role model for identification, and is available as a confidant can support a child's development and learning (Werner and Smith, 1989). When children are in the child welfare system, they often experience separation or loss of significant others. Disruptions to their relationships due to moves and change of schools contributes to stress reactions. Professionals and caregivers intervening with children have the capacity to promote children's relationships through efforts that maintain relationships and build new relationships that are positive and fulfilling to a child.

Box 1

Role	**Trauma-Informed Activity**
Child Welfare Worker	Frequent contact with child. Willingness to listen. Inform without making promises
Court	Provide orders to support contacts with important people in child's life
Resource Parents	Respect child's distrust. Build relationship through predictability
Mental Health	Relationship building as foundation to therapy
Medical	Provide continuity in care. Obtain medical and trauma history.
Schools	Develop relationships with children that provide safety and predictability

Maximize the child's sense of safety

Safety for traumatized children includes both physical and emotional safety. Traumatic stress responses in children reveal and further foster a lack of perceived safety even when the child is in a "safe" environment. Professionals in child welfare settings, including child welfare, mental health, and other child care systems have the potential to provide comprehensive assessment and interventions addressing those risk factors known to be traumatizing. The *Technical Assistance Brief* published by the National Council of Juvenile and Family Court Judges in December 2002 is one such document that provides guidelines addressing physical health, developmental health, mental health, educational/childcare settings, and placement considerations (Osofsky, Maze, Lederman, Grace, and Dicker, 2002).

Box 2

Role	Trauma-Informed Activity
Child Welfare Worker	Recognize that the impact of professional actions can undermine child's feelings of safety.
Court	Decision-making that creates physical safety while also prioritizing psychological safety.
Resource Parents	Acknowledging child's fears. Soliciting child's perception of safety.
Mental Health	Therapy becomes a safe place to recover from trauma.
Medical	Examinations and procedures are explained, especially surrounding touch.
Schools	Primary goal is to create classroom as a safe place.

Trauma-Informed assessment

Children who have experienced traumatic exposure may exhibit a range of outcomes that impact their functioning across multiple domains of functioning. Chronic stress and repeated experiencing of overwhelming events have the potential to alter brain function (Perry, 1999; DeBellis, 2005;Teicher, 2002), as well as to significantly impact neurodevelopmental functioning, especially when compounded by prenatal exposure to alcohol (Henry, Sloane, Black-Pond, 2007). Children may be experiencing symptomology associated with traumatic stress responses, and their difficulty self regulating may be misinterpreted as "willfully disobedient" behavior. A trauma-informed assessment that utilizes standardized measurements for traumatic stress responses and fosters an understanding of children's survival strategies has the potential to minimize secondary trauma due to failed placements, misdiagnosis, and interventions that fail to consider traumatic reminders.

Box 3

Role	Trauma-Informed Activity
Child Welfare Worker	Obtain trauma history. Make referral for trauma-informed assessment.
Court	Order trauma-informed assessments on all children entering foster care.
Resource Parents	Participate in assessment, providing observations and support. Obtain results through consultation with evaluator/therapist.
Mental Health	Conduct or refer for comprehensive trauma assessments.
Medical	Coordinate with the assessment process and consider treatment options that maximize a child's functioning.
Schools	Provide input including classroom observations. Utilize findings to support safety plans, academic support, and social support in the child's plan.

Assist children in reducing overwhelming emotion

Children with experienced trauma, especially complex trauma and/or poly-victimization are prone to react immediately and in extreme ways to signals of threats, and in ways that are not always appropriate for the social environment (Finkelhor, Ormrod, Turner, 2006). Their information processing of environmental, social, and cognitive stimuli may

become disorganized and manifested in emotional and behavioral responses that are confusing to those around them. Their inability to self-regulate these intense emotions is a core feature of traumatic stress and is directly related to brain system reactivity rather than willfulness (Saxe, Ellis, et al; 2005). When children have been traumatized, their repertoire of self-regulation strategies may be limited to those that further interfere in their ability to process their experiences or utilize others as supports. These strategies might include anticipatory strategies, avoidance, emotional numbing, or dissociative coping and accommodation.

Box 4

Role	Trauma-Informed Activity
Child Welfare Worker	Frame externalizing/internalizing child behaviors as survival strategies.
Resource Parents	Respond to behaviors through attunement.
Mental Health	Teach child affective management skills such as those incorporated in TARGET (Ford, 2007) and SPARCS (DeRosa, Habib & Pelcovitz, 2006).
Court	Address children's difficulty with mood and behavior as stress reactions as opposed to delinquency issues (conduct or oppositional disorders).
Medical	Consideration of medication for traumatic stress reactions.
Schools	Create safety plans for children rather than total reliance on behavior plans.

Help children make new meaning of their trauma history and current experiences

Traumatized children often are unable to understand their experiences and have the propensity towards cognitive distortions surrounding traumatic events. Trauma focused interventions, especially those that are evidence based such as Trauma Focused Cognitive Behavioral Therapy (Cohen, Mannerino, Deblinger, 2003) and Real Life Heroes (Kagan, 2006), strive to create avenues to desensitize children to traumatic reminders, resulting in decreasing avoidance and hyperarousal. Children are then better able to integrate their traumatic experiences into their entire experience, rather than traumatic events defining their self concept and their world view.

Box 5

Role	Trauma-Informed Activity
Child Welfare Worker	Refer children to evidence supportive trauma therapy
Court	Provide answers to children's questions about why the court is involved and what the court intends to do.
Resource Parents	Address children's perception of being "bad" or "responsible" for their abuse.
Mental Health	Receive training and utilize evidence supportive therapies.
Medical	Support trauma-informed perspective and interpretation of child's functioning.
Schools	Support development of self efficacy by recognizing children's achievements and not interpreting attention deficits and inconsistent performances as "laziness."

Address the impact of trauma and subsequent changes in the child's behavior, development, and relationships

Traumatized children may experience ongoing, and sometimes very persistent, difficulties as a result of traumatic events. Long after the initial reaction, the "ripple effects" of traumatic exposure might include difficulty trusting others, difficulty with learning, stress states that impact their relationships with others, and other impairments in their functioning. Environmental stressors may be chronic that are a result of new environments, separation from family, visitation demands, and the introduction of strangers into their lives who make big decisions that impact their family.

Box 6

Role	Trauma-Informed Activity
Child Welfare Worker	Respond to placement crisis with a reframing of children's behaviors as traumatic reenactment to resource parents
Court	Specifically address children's progress in court hearings and address children when they are present
Resource Parents	Frame children's behavioral and developmental progress in the placement on a continuum of time rather than limiting evaluation to the immediate moment
Mental Health	Utilize trauma focused therapies that recognize and respond to the developmental, not chronological, age of the child.
Medical	Verbalize to child what will happen in exams, especially when physical contact is required. Provide reassurance.
Schools	Provide classroom safety plans that recognize deficits as real and not willful or laziness

Provide support and guidance to the child's family and caregivers.

Children's identity and their working model of the world are first shaped within the context of their family, both immediate and extended. Their primary relationships are often perceived as essential for survival, and they need their parents' love and acceptance even in the presence of maltreatment. Children, more often than not, perceive their parent's or other family member's stress reactions as meaningful to their sense of safety and security. When parents are supported and included in planning and skill development, children have a greater opportunity to experience themselves as cared for and view their parents as empowered.

Box 7

Roles	Trauma-Informed Activity
Child Welfare Worker	Provide trauma education to biological parents to explain how children's behaviors are slow to change despite parental change efforts
Court	Specifically address children's needs with parents during the court hearing by inquiring as to how parents expect they will meet their children's needs.
Resource Parents	Communicate with biological parents about children's progress and challenges requesting input on how parents have responded to the children's behaviors in the past.
Mental Health	Have biological parents participate in therapy regularly. Utilize a model of change (i.e., transtheoretical model of change) to evaluate parental progress and readiness for child's return to the home.
Medical	Provide medical consultation related to options for treating mood and behavioral dysregulation. Refer to specialist when appropriate.
Schools	Invite resource parents and birth parents (when appropriate) to the classroom for participation and discussion.

Coordinate services with other agencies

Maltreated children and their families are likely to experience multiple and new professionals and complex systems. They may have contact with a child welfare worker, the courts, mental health providers, advocates, and other entities that communicate their goal to assist both children and families to prevent maltreatment and secure safety. When service providers have a common perspective and minimize duplication or contradictory messages, children and their

families are more likely to experience the system in a positive manner. When multiple systems operate as "silos," each with its separate priorities and perspectives, families are less likely to benefit and may fall through the cracks (Lieberman, 2007). Utilizing common language, prioritizing similar goals, and minimizing duplication of interviews and assessment/planning tools are likely to reduce stress to families, decrease time involvement, and lower costs associated with duplication of efforts.

Box 8

Role	Trauma-Informed Activity
Child Welfare Worker	Refer children for services based on trauma needs and therapist trauma expertise. Do not assume that all therapists are trained in trauma therapy.
Court	Communicate and collaborate with other service providers in decision-making. Ask the complex questions of agencies regarding their ability to meet the needs of traumatized children.
Resource Parents	Be a team member of the child welfare team and participate in team meetings.
Mental Health	Educate professionals and resource parents on how trauma alters psychological development. Reframe challenging behaviors as trauma-induced.
Medical	Refer children for services based on trauma needs and therapist trauma expertise. Do not assume that all therapists are trained in trauma therapy.
Schools	Invite resource parents and birth parents, when appropriate, to the classroom for participation and discussion

Manage professional and personal stress

Professionals working with traumatized children are faced with multiple challenges. The risks associated with both direct and indirect exposure to threats to them or the children they are serving include immediate and long term distress. Workers, judges, therapists, and other interventionists are confronted daily as to the significant traumatic events that children experience and, many times, their own helplessness in effecting change. Professionals may experience secondary traumatization, including intrusive thoughts, intense anxiety, depression, and other mental health issues. The impact of their own distress may impact their relationships, work performance, and self esteem. Some professionals struggle with their own histories of maltreatment that may be triggered when interacting with children, their families, or other professionals. Many professionals feel unable to talk about their own distress and possible grief out of fears of being judged and potentially deemed unable to perform competently. Identifying ways to identify and address professional and personal stress is, therefore, critical to the welfare of both the professional and the children he serves.

Box 9

Role	Trauma-Informed Activity
Child Welfare Worker Court Mental health Medical Schools	Be willing to communicate grief within safe environment following difficult child welfare events including (i.e. disclosure of maltreatment, removal, placement disruption, school change, or termination).
Resource Parents	Participate in resource parent groups that honor the challenges, appreciate resource parent commitment, and grieve the loss of childhood innocence.

Conclusions and Implications for System Change

Few studies have been conducted to determine the impact of coordinated child welfare services on child outcomes (Hoagwood, 1997; Glisson & Hemmelgarn, 1998). Glisson & Hemmelgarn (1998), found a relationship between improved psychosocial functioning in children served by child welfare and positive organizational climates. Another study of the effectiveness of trauma systems therapy, a model for integrating and coordinating a system of care guided by trauma knowledge, found significant improvement in children's psychiatric symptoms as well as measur-

able changes in children's social environments (Saxe, 2005). In most communities, however, the systems responding to children coordinate their overlapping responsibilities and communication to, at best, foster fundamental decision-making requiring multiple sources of input (i.e., case worker, therapist, etc).

The Essential Elements of child welfare practice provide a trauma-focused framework for intervening with children in the child welfare system. These principals of understanding and responding to children and their families, in addition to the self care necessary when exposed to children's maltreatment and system demands, allows professionals an opportunity to reduce the risk of children's retraumatization by systems that intend to protect them. These principals easily extend to caregivers and other professionals, creating a potential for a unified framework for interventions, both formal and informal, and impact decision-making.

Large caseloads and budget reductions have the potential to inhibit and compromise the quality of child welfare system interventions. However, a framework that guides perceptions, interactions, and interventions with maltreated children and their families does not require additional funding. Rather, professional agreement that a trauma-informed system of care best serves children, their families, and professionals will promote and support system change. Operationalizing the Essential Elements, through a unified response by collaborating professionals and caregivers, has the potential to protect children from compounded mental health and relational disturbances. Therefore, the benefit of training multiple systems on the impact of trauma on children's emotional and behavioral functioning, as well as the potential to minimize system retraumatization (Henry, 1997) is compelling. Decision-making within federal guideline timeframes becomes more feasible when interventions address the needs of traumatized children and their families. Professionals confident in their ability to understand the children they serve are more likely to develop treatment plans that serve to provide safety and skill building, both necessary for successful reunification, child well-being, and permanency planning.

Further research that measures the effectiveness and outcomes for children impacted by a trauma-informed system is important to the development of new training practices and changing child welfare policies to be more trauma-sensitive. The first step, however, is the willingness of professionals and resource parents to examine and expand their practices to integrate trauma theory and interventions. This paradigm shift has the greatest potential to create momentum for change, yet may be the greatest challenge to systems. If and when this occurs, then future research can provide the child welfare system with the quantitative feedback necessary to hone trauma-informed child welfare practices.

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Using Family Attachment Narrative Therapy to Heal Childhood Trauma: A Case Study of a Twelve-Year-Old Boy

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Abstract

This paper describes the utilization of Family Attachment Narrative Therapy with a twelve-year-old boy experiencing significant developmental and behavioral problems emerging from paternal physical abuse and neglect. This innovative treatment model is demonstrated to be a useful tool for changing the child's faulty self-narrative, resulting in improved functioning. The critical element of the reworked schema is the perception of self as adequate, worthy, and cherished. Family Attachment Narrative Therapy is also shown to facilitate parental attunement to the child's inner state and repair of the parent-child bond. This paper highlights the multigenerational transmission of child maltreatment within the family, cultural, and societal contexts.

Family Attachment Narrative Therapy was developed in 1995 to address the adjustment difficulties of maltreated children within adoptive and foster families. It challenged the prevailing view that these children would respond positively once no longer directly exposed to abuse and neglect. Family Attachment Narrative Therapy acknowledged the complexity of childhood experience of maltreatment and posited the need for a corresponding change in a child's inner world, in particular how the child views him or herself, in order to continue forward on the developmental path (May 2005).

This paper presents a case study of a twelve-year-old boy with significant developmental and behavioral difficulties closely associated with his experience of paternal physical abuse and abandonment. (Some identifying information has been changed in this case study). The potential efficacy of Family Attachment Narrative Therapy with maltreated children and their biological parents is explored. Specifically, the paper examines how this relatively new treatment modality may contribute to the reconstruction of the internal working model of a boy whose sense of self has been significantly compromised in early childhood, leading to improved functioning in his living environment, school, and community. Family Attachment Narrative Therapy may also promote healing of the bond between children and their parents who have abused or neglected them or collaborated in such maltreatment. This suggests a role for Family Attachment Narrative Therapy in facilitating reunification post-apprehension. In addition to making a contribution to the practice literature on the healing of childhood trauma through its focus on a family systemic approach, this paper highlights the utilization of such a model in tandem with individual child psychotherapy.

The Case of Sergey

Sergey is a twelve-year-old boy who was placed in a residential facility after his emergency removal by a Wayne County court. He disclosed severe corporal punishment on the part of his father to his teacher after she inquired about his scratched and bruised face. Sergey was previously unknown to child welfare authorities. Prior to his removal, he had been living at home with his father, Uri, age 38, a computer technician, and his mother, Victoria, age 35, a graphic artist.

Sergey was born in the Ukraine and at age three relocated with his mother to Detroit. His father adamantly refused to leave his homeland and joined his wife and son five years later. According to the Children's Protective Services (CPS) worker, Uri's corporal punishment of his son began soon after immigration. The CPS worker's report cites significant problems in Uri's occupational and social adjustment as well as great difficulty finding a niche for him in the fam-

ily home. Uri did not succeed in building a positive relationship with Sergey. During the father and son's lengthy physical separation, the father's contact with Sergey was nonexistent.

Sergey presented as being of normal intelligence and with no significant health problems. He was a high achiever in school, especially in mathematics. The father constantly pressured Sergey to excel in his studies and spent large sums of money on private tutors. He was totally isolated from his peers. During the three years prior to his apprehension, Sergey, at the insistence of his athletic father, swam competitively, practicing twice daily. He rarely exchanged a word with his teammates.

Since the third grade, Sergey has displayed frequent violent behavior towards small children and animals. In such instances, his mother would be livid and punish him by confining him to the apartment storeroom for relatively lengthy periods of time. In addition, about every three months, Sergey would forcefully bash his head against the living room wall chanting repeatedly that he was a very bad boy and a piece of garbage. According to his mother, her strenuous efforts to convince him otherwise were totally rebuffed. Sergey would stop when he noticed blood dripping down his face.

Sergey was referred to the author to undergo post-apprehension assessment and treatment. One of the author's primary goals in such cases is to assess the dynamics and effects of the abuse and neglect and begin a therapeutic process towards healing the trauma of maltreatment. On the basis of this initial therapeutic involvement, recommendations are made regarding either permanent placement or, alternatively, family reunification. Once a decision has been made and initial implementation in progress, the child is discharged (Feigelson & Lander, 2000).

Overview of Therapy

Assessment of the dynamics and effects of Sergey's maltreatment quickly became focused on his violent behavior and associated feelings of hurt and anger. He had beaten several of the younger children in the residence. The childcare staff was very concerned. The initial substantive treatment goal of the author's individual meetings with Sergey became defined as eradicating his violent behavior. A related process goal was enabling Sergey to more effectively engage in self-reflection and self-expression, especially with regard to his negative feelings. These goals were largely accomplished through a combination of traditional talk therapy, art, and play therapy—primarily around the medium of the sand tray. Topics which emerged most consistently and intensely centered on Sergey in his current relationships, especially with his father. There was considerable reference to his early childhood, especially with respect to his physical separation from his father, and Uri's corporal punishment. Entrenched negative self-narratives of unworthiness and inadequacy became increasingly evident. By the conclusion of the first stage of therapeutic involvement, Sergey's violent behavior had almost totally abated.

The second phase of therapy, consisting of 20 sessions (and the focus of this paper), was the application of Family Attachment Narrative Therapy to transform Sergey's internal working model and also to improve parent-child bonding to facilitate eventual family reunification. The therapeutic vision was of markedly improved child-functioning in the living environment, school, and community.

By the conclusion of the narrative therapy sessions, Sergey had constructed a significantly more positive internal working model, which highlighted his adequacy and worthiness as well as parental valuing of his "self." The parent-child relationship, especially with his father, had greatly strengthened, and the parents were substantially more aware of the inner world of their son. Important behavioral referents of Sergey's renewed self-narrative included the total cessation of his self-destructive head banging and markedly improved social functioning. He talked to children in his immediate environment and built friendships with peers. Sergey organized social events and volunteered to become the treasurer of the children's council.

During the final phase of therapeutic involvement, the author assisted the parents and son to prepare for anticipated family reunification. Significant therapeutic achievement led to the recommendation that Sergey return to the family home and treatment continue in the community. In addition to Family Attachment Narrative Therapy, Uri participated in a cognitive-behavioral treatment group for perpetrators of physical abuse, and the mother participated in a short-term spouse group.

Description of Therapy

The first phase of Sergey's assessment and treatment lasted four months and consisted of weekly

meetings with the author in the residence play therapy room. The concept of primary and secondary emotions was introduced to help Sergey understand and manage feelings of hurt and anger toward his father as revealed in the "color your world" exercise.

In Sergey's drawings of instances when his feelings were most hurt by others, he highlighted his separation from his father in the Ukraine, adjustment difficulties with teachers and classmates in Detroit, and his father's beating of him. In focused discussion of these pictures, the author introduced Sergey to information on the causes and effects of physical abuse and child abandonment with an emphasis on how the causality of child maltreatment may be related to the family background and immigration experience of the perpetrator, as well as cultural and societal norms. At this juncture, the author introduced Sergey to the notion of internal working models and their relation to parent-child attachment. He identified and highlighted for Sergey his perception of the boy's deep and persistent sense of unworthiness and inadequacy and the manner in which this may have strongly influenced his life and development. Sergey began to understand his experiences, thoughts, and feelings within a new conceptual context.

Next, Sergey did substantial work with sand tray figures representing his father's beating of him, his mother's pact of silence, and Sergey's eventual conquest of his father.

The second phase of Sergey's treatment consisted of the application of Family Attachment Narrative Therapy to transform Sergey's negative self-narrative of unworthiness and inadequacy. This faulty motivating internal working model, and its genesis in his experience of paternal abandonment and physical abuse, had emerged strongly during the second half of the first stage of Sergey's therapeutic involvement with the author. The author perceived the boy's self-narrative as reflecting Sergey's impeded growth and functioning in his living environment, school, and community.

Twenty sessions devoted to Family Attachment Narrative Therapy were conducted. According to the model, the author's first task was to "activate" Uri and Victoria's innate desire to participate in the healing of Sergey's childhood wounds. This initial phase was lengthy, lasting 10 sessions, and complex because of the difficulty in activating his father. A major obstacle was Uri's anger at his son for his disclosure at school of the physical abuse. He blamed Sergey for the apprehension and child welfare involvement with the family.

The author dedicated several meetings to joining and building a therapeutic alliance with Uri (Thomas, Werner-Wilson & Murphy, 2005). Prominent here was the author's ability to identify with the father's Ukrainian background and empathize with his difficult immigration experience (Lu, Dane & Gellman, 2005). The author engaged in appropriate self-disclosure of his extended family's geographic roots and his own problematic post-immigration adjustment in Detroit (Dewane, 2006). Uri became open to accepting the author's positive connotation of the chain of events that started with Sergey's disclosure and which led to his apprehension and out-of-home placement (Porter, 1993).

Another very significant obstacle to the father's activation was the father's contention that his son's suffering was insubstantial, especially as compared with his own, and would not have major lasting detrimental effects. Uri perceived his own development as uncompromised by his childhood experience of very severe abuse.

Several meetings focused on dispelling Uri's distorted beliefs. First, the author provided Uri with substantial theoretical and empirical information about the dynamics and effects of intra-familial child neglect and abuse, particularly within his own cultural community (Kinard, 1982; Sidebotham & Heron, 2006). The author discussed with Uri normative child emotional development utilizing Erik Erickson's model (Eilberg, 1984). A number of sessions were dedicated wholly to hearing Uri's own story of extremely severe psychological and physical abuse as a boy.

After succeeding in recruiting Uri into the therapeutic process, the author could begin the actual activation. He began by reviewing Sergey's drawings with his parents. In the ensuing discussion, the parents offered beginning insights into Sergey's internal working model.

Next, the author presented a series of questions to more systematically uncover Uri and Victoria's latent understanding of Sergey's motivating thoughts and emotions:

"How would Sergey have behaved if he had received the love and attention of children who have two parents present throughout their childhood? How would Sergey have behaved if he had received from his father only love and not also severe corporal punishment? How did Sergey think and feel when his own father rejected and punished him severely? What conclusions did Sergey form in response to his parents' failure to protect and care for him? How does Sergey think and feel about being a newcomer in a strange land? What is Sergey thinking and feeling when he violently attacks children and small, defenseless animals?"

Towards the end of the initial activation phase and according to the model, the author prepared Uri and Victoria for their actual role as narrative therapists with Sergey. "Claiming," "developmental," "trauma," and "successful" child narratives were crafted and their delivery practiced through role-play.

Eight regular narrative sessions were held. Two sessions were dedicated to each of the four narrative types. An extra narrative session, not part of the original model, was orchestrated by the author in order to present a claiming narrative to Uri. The goal was to begin to heal father's own childhood trauma to further solidify father's recruitment into his son's healing. In the concluding session, Sergey's new internal working model and renewed bond with parents, in particular with his father, were highlighted and celebrated with certificate, speeches, refreshments, and presents.

The final stage of treatment began concurrently with a decision by child welfare authorities to attempt family reunification (Maluccio, Pine & Warsh, 1996). The decision to reunify the family was supported by the author. Highly prominent in the decision making process were inroads gained in the Family Attachment Narrative Therapy with respect to parental attunement to the inner world of Sergey and improved father-child bond. The focus in preparing the parents and Sergey was identifying possible obstacles to the maintenance of therapeutic achievements, especially those made in stage two, and brainstorming possible strategies. The major difficulty identified was the father's close connection with friends and family within the immigrant group who tend to support authoritarian parenting and use of corporal punishment to motivate children. The author shared with Uri the idea that every culture and society has its own dominant emotional processes. The author and the father compared the major emotional processes in Uri's immigrant community that support use of force in child rearing with the emotional processes of American society that support an alternate vision of parent-child relations.

Outline of the Therapy Sessions

The core of Family Attachment Narrative Therapy is the delivery of healing narratives by the parents, scripted and practiced in the activation phase. A number of Uri and Victoria's narratives are demonstrated by means of select verbatim examples.

Claiming Narrative #1

(Uri and Victoria sitting side by side, Sergey sitting in far corner of room silent and face down to chest. The author signals to the father to begin the first of two claiming narratives).

Father: Sergey, you need to know, with God and Itzhak as my witness, that Mother and I, really mostly me, made terrible mistakes raising you. You deserved to be protected and not hurt by me. More than that, you deserved to be appreciated, and even cherished and celebrated. You had a right to my uninterrupted love and attention. If I had succeeded in giving you all this, many very unfortunate things that did happen could have been prevented. First, I would have gone with you and Mother to Detroit; I would have been there to comfort you when you felt so strange. I would have talked to you lots. I would have taken you to the beach and to the forest, maybe evening skiing in the North. I would have read with you and played soccer with you. I would have told you how much I loved you and shown you with hugs and kisses. If I must have stayed back in Kiev temporarily, I would have stayed in close contact with you until the moment I could rejoin you. And when I finally did come to live in America, I would not have begun to hit you.

(Sergey looks at father momentarily).

Mother: If I had considered your well-being as seriously as you deserved, I would have not moved to America without your father. You deserved to have your need to be near your father placed above my desire for financial betterment in Detroit. I would have seen you as a person in your own right who still needed to develop emotionally and psychologically and certainly had to do this close to his father. And if I still decided to leave, if I saw you as first prior-

ity as I should have, I would not have put you in the middle of my battle with your father to let me leave the Ukraine without him. And when he didn't come with us, I would have been able to put your development before my pride and done all that I could to ensure he was in contact with you. If I had been able to see you as important enough, I would have garnered the strength to apologize to him for leaving in such a hurry. This probably would have worked as far as him staying in touch with you. But my big mistake was that I thought of myself more than I considered you. And once Dad did arrive in Detroit and start hitting you, I would have put your interest before mine and gone to the police to complain. But I thought, in a wrong way, that he had finally come to America, and we were getting along, and I didn't want to rock the boat. But if I would have put you first and your healthy development as number one priority, that is what I would have done. You deserved to be protected above all else, like every other child. And I also would have been a better mother to you. I would have greeted you at the start of every new day with enthusiasm and pep. I would have danced around the house with you. I would have told you that you are the one and only for me and the love of my life. I would have showered you with compliments about the great child you are—smart, strong willed, handsome.

(The mother walks over and puts her hand on Sergey's leg and whimpers softly. Sergey touches her hand very lightly, then quickly removes his hand. Sergey makes sustained eye contact with his father for the first time in the session).

Developmental Narrative #1

(The parents are sitting with Sergey between them, legs touching. Sergey is grinning and leaning slightly forward. The father begins to deliver the first of four developmental narratives).

Father: It would have been my greatest pleasure when you were a baby to take you to the relatives to show you off. You were a beautiful baby. Your smile could melt hearts. You had long, wavy hair even when you were born and the cutest little feet. And you were a very friendly and playful baby. Everyone would sit around in a circle and fight over who would hold you next, and I would be full of pride inside. Everyone would fall in love with you at first sight and tickle you all over. They would cover you in kisses, from head to toe, and they would not be able to stop looking at you. You would coo and grin back softly. The folks would notice me bursting with happiness—everyone wanting to hold my own son. And when you would let out a sound, even a burp, it would be as if an entire orchestra was playing Tchaikovsky. We would take in every note like music to our ears. You would smile without stopping as we listened attentively to you.

Mother: I would be with my camera every moment trying to get our visit all on film. I would not want to lose any of this beautiful time. I would be the kind of mother who was always taking pictures of her baby and then putting them up everywhere in the house and showing them to anyone I would meet on the bus, in the street, at work. But like your father, I would be most proud to show them to all the family. They would love putting up your pictures in their houses. You would adorn all our living rooms. Granny would make a wall just with photos of you—probably 10 or more. This would be her favorite place in the house. To her, your picture was the biggest present anyone could give her. She would always say that your wavy brown hair reminded her exactly of mine when I was a baby girl. You loved Gran. You would play in her lap and smile and make sweet faces at her. If she had aches and pains, you would massage her arms and hands just right.

(Sergey is giggling in the direction of parents. He remarks that it is good to know he was such a lovable baby and that maybe he should be a television star when he grows up).

Trauma Narrative #1

(Sergey is sitting on the sofa close in between his parents. He has his arm on his father's shoulder. The therapist signals to the father to begin to deliver the first of two trauma narratives developed in the activation sessions. The narrative focuses on Sergey's experience of physical abuse by his father and Victoria's associated parental failure with respect to protecting her son. The child protagonist is named "Vova").

Father: Every night at 8:00, Vova would be commanded by his mother to go to sleep. Vova did everything he could to force himself to sleep, even though he believed strongly this was too early to sleep, as he wasn't at all tired and his classmates went to sleep at 9:30. Vova counted black and white dairy cows, imagined stars high up in the sky, repeatedly rubbed his eyebrow with his forefinger, and recited the national anthem over and over. Inside, however, he was

growing more and more frustrated because though he was trying with all his might, none of this worked. After about an hour, Vova couldn't think of anything else to do, so he called out to his mother, once, then twice, then three times, to ask if she could read him a bedtime story. He knew that other children had stories read to them before bed by their mothers and that this helped them sleep. Mother did respond to Vova, but Vova was getting frightened by how quickly she was walking towards his bed.

Mother: Being a child, Vova didn't know how (sic) what to do when he was made to go to bed so early and all that he tried failed to put him to sleep. At his age, he wasn't supposed to know how to get his parents to reconsider the wisdom of their bedtime decision or how to get them to help find him find a way to fall asleep when all that he genuinely tried to comply with their request did not work. It was mother's job to find out when other children Vova's age went to sleep and how much sleep Vova needed each night in order to grow. Mothers are supposed to know when their children are sleepy and when they are too alert to sleep. Children are not supposed to know what to do when they begin to fill up with a negative feeling. Mothers need to notice all the time how their children are feeling, even when they are in bed and trying to fall asleep. It is mother's responsibility to teach their children what they can do when they become frustrated or hurt and then eventually become angry.

Father: Vova's mother reached his bedside in a split second. "You can't do anything right, can you? Well, answer me! All of a sudden you don't know how to talk? You have been bothering me all evening with your whining. Bedtime story? I never had a bedtime story, and I always went to bed like a good girl when I was told to do so." Mother's voice was loud, her eyes were wide open, and her nostrils spread. She was shaking her arms up and down, side to side. Vova was becoming more and more frightened of her.

Mother: Being a child, Vova didn't know how to answer his mother's accusations or how he could act so she would not behave so roughly and loudly. He also didn't know what to do with his growing feeling of fear, which made him feel increasingly uncomfortable. He was like frozen on the spot. It was mother's responsibility to know how to calmly and quietly explain to him the reasons she was not telling him a bedtime story and provide him other ways she and Vova could work together to help him fall asleep. It was her place to realize her son was becoming scared of her, to understand why this was happening and to control her behavior.

Father: Vova's mother yelled at him to go into the yard and collect a branch from a tree. Vova was in his pajamas, it was cold outside, and he was afraid he would get sick. But he was even more afraid of not doing what mother ordered, so he went outside. It was pitch dark, he was all alone, and he was really afraid. As fast as he could, he found a long willow branch and brought it into the house. Mother grabbed it from his hand, lifted up Vova's shirt, and began to hit him across the back over and over again, telling him that this is what he will get every night if he continues to bother her when he should be falling asleep. Father heard crying and peeked in to see what was happening. He quickly went back to listen to the radio. A flood of thoughts rushed through Vova's mind, and they made him feel sad and hurt. "If I didn't exist everyone would be better off. Why was I even born? What is wrong with me that I can't even fall asleep like I am asked? What kind of a lousy child am I to make my own mother have to hit me?"

Mother: No one ever taught Vova that good enough parents do not hit their children, and if they choose to occasionally spank their child, they do so with an open hand on the child's clothed bottom. Vova was also too small to fully realize that requiring a child about to be punished to fetch the branch he would get whipped with was extremely cruel. Nor could Vova know for certain that making a child go out into the cold and dark night without proper clothing was totally unacceptable.

(Sergey stares into the air and says that he is sure this is a story about himself and his father. He starts to cry loudly, sobbing. His father hugs him strongly, and he himself begins to cry. Uri wipes some of Sergey's tears and asks him to forgive him. Sergey replies that it will be really hard to forgive him and that he will try, but that his father must never hit him ever again).

Discussion

Sergey's therapeutic involvement with the author began upon apprehension and short-term placement in a residence where he underwent a combined assessment and treatment process. It quickly became apparent that emergent out of Sergey's maltreatment were intense feelings of hurt and anger and associ-

ated violent behavior. Relationship, and in particular attachment, surfaced as important thematic material in preliminary referral information and early sessions where Sergey frequently sought out proximity to the author. An attachment theory perspective highlights the client-therapist relationship as a most important prerequisite for effective therapy (Berlin, 1997).

In the first stage of their therapeutic involvement, the author met with Sergey individually. The primary goal was the cessation of Sergey's violent behavior. An important early process goal was the facilitation of increased awareness, understanding, and more appropriate expression of feelings. Central here was the notion of primary and secondary emotions and Sergey's transformation of hurt into anger (Johnson, 1994).

Sergey's violent behavior towards the smaller children in the residence was largely eliminated by the end of the first stage of treatment. A combination of techniques was employed, including artwork, discussion, and play therapy (Morales, 2001; O'Connor, 2005). Sergey related especially well to sand play (Hunter, 1998). It was in his initial drawings that Sergey explored incidents in which he experienced intense hurtful feelings within the family. In the sand tray, he actively recreated major family dynamics. Prominent here was his experience of threat from his father. It was at this juncture that the author clearly made the connection for Sergey that his own behavioral problems were inherently related to his father's physical abuse and abandonment. The author highlighted central elements of Sergey's early childhood development, including the five-year separation from his father and his virtual disappearance from Sergey's life, and his father's severe corporal punishment of his son and his mother's relative inability to provide protection. The author proceeded to point out to Sergey the linkage between this neglect and abuse and the family's cultural and societal background as well as its immigration experience. Sergey himself witnessed the author's innovative claiming narrative delivered to Uri. This narrative underscored the multigenerational transmission of child maltreatment in Sergey's family and assisted Sergey to more fully understand the complex causality underlying his father's maltreatment, providing additional groundwork for repair of the father-child bond. Sergey was given a new lens through which he might make sense of self and others to promote some measure of normalization of his and parents' problematic behavior (Kim Berg, 1994).

Most importantly, the author highlighted for Sergey the elements of his internal working model that evolved during early childhood. His experience of abuse and abandonment was presented as an essential tool for understanding his damaged sense of self -- inadequate, unworthy, and uncherished. The author perceived Sergey's faulty self-narrative as substantially impeding Sergey's growth. The author's therapeutic vision was of a reparative renewal of Sergey's internal working model and subsequent improved functioning in all realms of life.

The author served as information provider to Sergey during the first stage of therapy. The psychoeducational aspect of the therapeutic process is well acknowledged (Brownell & Heiser, 2006). New information was necessary for Sergey to see his difficulties as emergent from his complex life situation - paternal abandonment and severe physical abuse reinforced by culture and immigration related factors. Sergey was no longer simply another male child throwing boulders at kittens. The second phase of Sergey's therapy was the central focus of this study and demonstrated the application of Family Attachment Narrative Therapy. The combination of family psychotherapy with more traditional child therapy, as seen with Sergey, is complex and acknowledges the rich interplay of individual and systemic causal factors related to the difficulties of children and youth (Glazer &Clark, 1999; Wachtel, 1994; Wilson & Ryan, 2001). Moreover, Family Attachment Narrative Therapy represents an innovative approach to family treatment as yet not applied to a wide variety of clinical populations, including biological families where such therapy may aid in facilitating reunification after apprehension and brief out-of-home placement.

Above all, Family Attachment Narrative Therapy emphasizes the transformation of negative self-narratives that have evolved out of childhood abuse and neglect. The approach also stresses the facilitation of parent-child attachment through increased parental sensitivity to the child's inner world. The need for modification of Sergey's internal working model, as well as for the building of parent-child attachment, especially with respect to his father, became glaringly evident as stage one of the therapy unfolded. With Sergey's violent behavior essentially eradicated and no longer a major focus, Victoria could be recruited into a process that would heal their son through re-narration.

Discussion of his treatment of his son triggered in

the father recollections of his own childhood experience of physical and psychological abuse. Substantial attention had to be allotted to his own childhood experience to allow Uri's full recruitment into Sergey's healing. Parents' own maltreatment as a potential obstacle to activation is not discussed in the original Family Attachment Narrative Therapy model. The author's self disclosure with respect to his nationality and own difficult immigration experience was also important in recruiting Uri into the healing process.

Four types of narratives were developed by Uri and Victoria and delivered to Sergey, with his father playing a lead role. The practicing of the narratives through role-play in the initial activation stage was seen as helpful by the parents.

The first trauma narrative appeared especially effective in terms of achieving parental attunement and attachment with Sergey as well as challenging elements of his faulty internal working model. Here the child protagonist experienced parental physical abuse. Immediately upon completion of delivery, Sergey noted how the story was probably about him and not fictional. His open sobbing was highly uncharacteristic of him. Sergey was able to express his primary emotion of hurt instead of expressing his usual anger. His father was capable of relating to his son's hurt and began to show his own by crying. His father asked for forgiveness, which appeared to be a new experience for him. Sergey appropriately acknowledged his father's sincere request and replied that he would forgive him if his father could make real, and not only symbolic, behavioral change towards him. The narrative begins to generalize to the realm of actual parenting skills and behavior. Family Attachment Narrative Therapy has a ripple effect (Kim Berg, 1994) on the actual parenting of Uri and Victoria. Symbolic "good enough" parenting leads to the improvement of actual parenting. The entire therapeutic process in stage two provides parents with an increased sense of confidence and even empowerment as it relies almost exclusively on parents as narrative therapists. The therapeutic work in stage two seems to have also made a valuable contribution to the father's healing of his own childhood wounds. This is a previously unrecognized by-product of Family Attachment Narrative Therapy (May, 2005). Throughout the treatment process, the author emphasized both for Sergey and Uri the familial, cultural, and societal wellsprings of child maltreatment and how immigration may also contribute. This new information would help the father deconstruct messages supportive of abuse and neglect he would likely receive from family and friends within his ethno-cultural community.

Most important, Sergey's faulty childhood-generated self-narrative was repaired and reconstructed by means of Family Attachment Narrative Therapy. This was associated with significant personal and interpersonal growth demonstrated during Sergey's residential placement. Parental capacity for attunement and attachment to Sergey improved substantially. It was these therapeutic gains that largely facilitated the reunification of the family.

Implications for Treatment

Clinical practice with children and adolescents may tend to focus heavily on the modification of specific problematic behavior that generates sufficient concern for parents to initiate treatment. However, an untoward emphasis on behavior change may exclude other important treatment goals. Of particular prominence here is the renewal of those unsatisfactory internal working models forged in early childhood that has stifled growth and functioning. Still other potentially important treatment goals that can be overlooked are the building of parental capacity to understand the inner world of their child as well as the creation of connection between parent and child.

Family Attachment Narrative Therapy appears to have an important contribution to make with respect to these important treatment goals of child and adolescent therapy. Moreover, it may be applicable to a wide range of presenting problems and populations where there has been a substantial wounding of the sense of self and need for renewal and healing, such as with children of divorce and remarriage, children of substance abusers, and child witnesses of parental violence. Its application in this study to the unique behavioral and development challenges of a young boy who experienced physical abuse and abandonment related to his cultural background and family immigration, points to its potential contribution to clinical practice with a numerically significant population of youngsters. Family Attachment Narrative Therapy appeared in this study to be particularly effective in combination with individual child therapy. This highlights the overall need for practitioners to integrate individual therapy with wider systemic approaches when working with the difficulties of children and

adolescents who are integral and vital parts of their families and communities.

The study also points to the potentially important contribution of Family Attachment Narrative Therapy to family reunification where repair of the parent-child bond after parental maltreatment or collaboration is an important prerequisite. ◎

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Could Dialectical Behavior Therapy Help Young Children in Foster Care Circumvent the Long-Term Effects of Early Trauma?

by Diana Theiss, MSW, LSW

Exposure to trauma during the prenatal stages through the first three years of life can have significant effects on the developing brains of young children, influencing their capacities for trust, empathy, self-regulation, and attachment. Even if the child is removed from the maltreating environment, the early damage can lead to later problems with social-emotional functioning, cognitive processes and school achievement, peer and family relationships, impulsivity, and aggression. Frequently, the child is not seen in a therapeutic setting until these problems become severe. If the child has been removed from the maltreating environment by Children's Protective Services (CPS) and placed in foster care, the trauma of separation from the biological family and loss of the familiar environment is likely to be an exacerbating factor to the original trauma, and mask its origins and effects.

Currently, there are thousands of children in foster care who have been referred to counseling because their behavior is defiant, unruly, and aggressive. The outlook for these children can be grim; they are unsuccessful in school, experience multiple placement changes because foster parents become unable or unwilling to manage the increasing disruption they bring into the home, and they lack permanency because their behavior limits their adoptability. Many of these children with the most severe behaviors are teenagers between the ages of thirteen and eighteen years old, thus, it can be postulated that the problems in functioning seen so often in this age group have been developing for some time and have caused them considerable loss in educational, social, and permanency opportunities.

If identified earlier and provided with effective intervention, it is conceivable, if not likely that these children would have been more amenable to treatment and the prognosis for positive well-being outcomes would be significantly enhanced. Therefore, children in foster care with early trauma who are between the ages of six and twelve years old will be the population examined in this paper as potential candidates for dialetctical behavior therapy (DBT).

Therapeutic treatment can pose great challenges to therapists as they search for effective strategies to ameliorate the early damage and help young children develop healthy coping mechanisms and positive daily functioning. Child clients (and adults, such as caseworkers, who may have come into contact with the child only recently) will be most likely unable to provide a great deal of information about the nature or scope of the child's early maltreating environment and emotional deprivations. They will provide history about the chronic aspects of the more recent abuse and the disruption caused by removal from the biological family. The application of DBT techniques would not be inhibited by this deficit of specific historical background, and is in fact, consistent with it because of its focus on change in the context of acceptance.

Overview of Dialectical Behavior Therapy (DBT)

DBT as a treatment strategy was first seen in peer-reviewed journals in 1986 and is associated with Marsha Linehan. In her treatment of patients with borderline personality disorder (BPD), Linehan found that typical change-oriented treatment strategies were not effective. The American Psychiatric Association defines BPD as, "a pervasive pattern of affective instability and identity disturbance characterized by frantic efforts to avoid loss and diminish chronic feelings of emptiness that often take the form of impulsivity and recurrent suicidal or self-mutilating behaviors" (Sneed, Balestri, & Belfi, 2003). Linehan observed that her

patients had difficulties both in tolerating distress and with accepting themselves and others as they were (Robbins & Chapman, 2004). DBT counters these barriers by teaching and promoting acceptance of self, personal histories, and current situations while simultaneously actively helping the client work toward changing unhealthy or problematic thoughts, emotions, or behaviors. This dialectic relationship between acceptance and change is the theoretical basis of DBT (Baer, 2003). DBT draws on research on the psychology of learning and emotions, as well as social influence, persuasion, and other areas of human behavior (Robbins & Chapman, 2004).

Core elements of DBT as described by Robbins and Chapman include:

(a) a biosocial theory of the disorder (in Lineham's work, BPD).

(b) a conceptual framework of stages of treatment.

(c) a clear prioritizing of treatment targets within each stage.

(d) delineation of the functions treatment must serve.

(e) treatment modes that fulfill those functions.

(e) several sets of acceptance strategies, change strategies, and treatment strategies.

Foster Care

Currently, there are approximately 500, 000 children in foster care in the United States (AACAP/CWLA, 2003). These children face numerous barriers to healthy and positive functioning later in life. First, they have been abused and or neglected, resulting in removal from their home and family of origin in order to provide them with a safe environment. The abuse or neglect to which they were exposed may have been isolated yet severe, or, as is more frequently the case, chronic and long-lived, resulting in cumulative effects that can be more damaging to the developing child than the rare or isolated act of physical harm perpetrated by a parent or adult who is primarily loving and attentive, but used poor judgment or lost control due to other stresses or influences (Crozier & Barth, 2005).

Second, children in foster care often have lives that are unstable and unpredictable. They may move from foster placement to foster placement, leading to a cycle of interrupted attachments as they change homes, caregivers, and schools (Christian, 2003). Their futures can be uncertain for long periods of time, during which they have little or no control of the outcome.

Considering the above scenarios, it is not surprising that an estimated 85% of children in foster have an emotional disorder or substance abuse problem (AACAP/CWLA, 2003). The severe behavioral and emotional problems seen in this population are further evidenced by their over-representation in special education programs in school and high percentages of serious mental health diagnoses, including depression, post-traumatic stress disorder (PTSD), conduct disorder (CD), oppositional defiant disorder (ODD), and severe emotional disturbance (SED) (Zetlin, Weinberg, & Kimm, 2003; Clark, Boyd, Lee, Prange, Barrett, & Stewart,1996, Kortenkamp & Ehrele, 2002). Consequently, former foster children are statistically at a higher risk of failure to graduate from high school, early pregnancy, welfare dependence, homelessness, and incarceration (McMillen, Auslander, Elze, White, & Thompson, 2003; Blome, 1997; Ayasse, 1995).

Besides the obvious and recognized harm to healthy development caused by abuse and neglect, some point to the problems within the foster care system itself and the child welfare system in general as contributing to negative outcomes for children in the system (Zetlin, et.al., 2003; Ashtuler, 2003). Child protection agencies often take too long to provide parents with the assistance and services they need, leading to a prolonged lack of permanence for the children involved. Children move too often in care, and may be abused or neglected by the foster parent charged with caring for them (Wells, 2003). Routine medical or health care needs may go unmet, and educational and mental health needs may not be attended to in timeframes necessary to prevent existing problems from exacerbating.

Others argue that the majority of children in foster care come from families characterized by poverty, minority status, neighborhoods filled with substance abuse and violence, and a lack of value for education. Therefore children enter foster care academically behind and without the social skills necessary to be successful in school (Zetlin, et.al., 2003; Ashtuler, 2003). Faced with the intrusion by the child protection system into their families, denial and angry responses of their parents (whom they often defend) to accusations of abuse and neglect, placement in the

homes of strangers, and enrollment in a new school with new peer relationships to form, they use non-compliance, defiance, and aggression as coping skills (skills that may be necessary for survival in their home environments but are seen as maladaptive behavioral problems by the system).

Early Trauma

The above experiences are certainly contributors to problems in the healthy social-emotional and psychological functioning of children in the foster care system. Still, many children in the system cope fairly well, while others with similar histories lack the resilience necessary to avoid serious impairment of their development and functioning. One possible explanation may lie in the degree of early trauma to which these children were exposed. Early influences on the brain program the ways in which children respond to later stimuli (Perry, 1997). Prenatal drug exposure can change the way synapses are connected, making children more impulsive and impacting the ability to securely attach with a caregiver; early abuse can result in a level of vigilance to the environment that detracts from other developmental tasks; early neglect can leave children unable to trust that the world is a safe place to explore and develop (Perry, 1997, Schore, 2002).

There are many causes and contributors to poor social-emotional outcomes for abused and neglected children in general and for those children in foster care in particular. The purpose here is not an attempt to argue for a single cause, rather to add to the understanding of how the earliest influences set the stage for the older child's ability to be resilient to later challenges and stressors and to form and follow a path to healthy adjustment and adult functioning.

Prior to the 1950's it was largely believed that the fetus was safe from most negative influences by the protective environment of the womb. Later, scientists began to document the link between exposure to drugs such as alcohol or thalidomide to physical deformities and mental defects (Karr-Morse & Wiley, 1997). Only in the last ten years has research emerged that shows the link between teratogens, such as alcohol, nicotine, lead, and cocaine and later behavioral problems, including impulsiveness and aggression. As with drugs that produce physical malformation, the type and extent of damage to the fetal brain is related to the timing, degree of exposure, and sensitivity of the developing brain functions to the teratogen. By inhibiting the healthy development of physical, cognitive, or emotional capacities, the teratogen renders the child more vulnerable to environmental risks later. For example, school failure, low self-esteem, and difficulty in forming positive peer relationships, in combination with other environmental risk factors, may leave the child alienated, angry, and without sufficient coping skills (Karr-Morse & Wiley, 1997; Perry, 1997).

Alcohol is probably the teratogen most widely used during pregnancy (Karr-Morse & Wiley, 1997). Prenatal exposure to alcohol can cause a continuum of effects, ranging from mild to severe, and may be hard to recognize in the newborn. The most severely affected children are those with fetal alcohol syndrome (FAS), who comprise an estimated 2.2 of every 1,000 live births. The leading cause of mental retardation in the Western world, FAS leaves afflicted children with a variety of social deficits. Parents rated FAS children in the ninety-first percentile on a mean ranking of social problems in one longitudinal study. The children were described as hard to discipline, overly tactile with others and inappropriately demanding of attention, and had difficulty with boundaries, both those of their own and those of others. Fetal alcohol effect (FAE) is less severe than FAS, but is approximately three times as common (Karr-Morse & Wiley, 1997).

Because alcohol crosses the placenta it can alter the development of the fetal nervous system. An estimated 85% of FAS children have attention deficit disorder with hyperactivity (ADHD). The production of neurotransmitters and brain growth can be slowed or impaired by alcohol exposure. Prenatally-exposed children have been found to exhibit problems with short-term memory, information processing, and mathematical comprehension. They have also been found to be inflexible in their approach to everyday problems, hampering their ability to successfully resolve common dilemmas (Karr-Morse & Wiley, 1997).

As children mature, the effects of prenatal alcohol exposure may become more noticeable. Longitudinal studies have found an increase in distractibility, impulsivity, disorganization, restlessness, and agitation. Alcohol-exposed children are at increased risk of deficits in judgment, difficulty dealing with frustration, and difficulty perceiving and interpreting social cues (Karr-Morse & Wiley, 1997). Infants prenatally exposed to cocaine often experience severe symptoms of withdrawal after birth. These infants may have shrill, piercing cries, tremble and shake, exhibit erratic

sleep/wake cycles, and be difficult to comfort.

The longer term effects of prenatal cocaine exposure are less clear. A series of longitudinal studies conducted in the 1980's and 1990's did not find significant differences between exposed and non-exposed infants in motor skills or intelligence (Karr-Morse & Wiley, 1997). Cocaine exposed infants are at increased risk of low birth weight and smaller than average head circumference. Other researchers have found that exposed infants have a reduced ability to modulate their arousal and a more difficult time focusing, variables not measured in the earlier studies. Researchers believe that cocaine exposure produces the most serious damage to fetal development during the first trimester of gestation, by interfering with the migration of embryonic cells to the proper place in the cortex, a process which is completed during the first 120 to 125 days of life. As a result, synaptic development, which begins during the third trimester and continues in the infant and very young child, may be impaired or changed, resulting in subtle defects in the way the brain is "wired". Children may be less persistent, more agitated, and more distractible in later childhood (Karr-Morse & Wiley, 1997).

Children prenatally exposed to a teratogen, then, may be biologically very vulnerable at birth (Karr-Morse & Wiley, 1997; Perry, 1997). When the infant's early caregiving experiences are abusive or neglectful, the risks are greatly compounded. Polydrug use is common in cocaine-addicted mothers, so it is likely that the prenatally cocaine-exposed infant was exposed to nicotine or alcohol as well. If the drug-addicted mother is the primary caregiver for the infant in the first two years of life, risks factors multiply exponentially (Perry, 1997).

Addicted mothers are likely to be neglectful, leaving the child in the care of multiple, often inappropriate, caregivers. The child finds an environment that is unpredictable, without a consistent caregiver with whom to attach (Hecht & Hansen, 2001). If the drug-exposed infant is difficult to care for, cries inconsolably, or is agitated and irritable, the risk of physical abuse increases. The perpetrator may be someone with whom the child has been leftwho has no emotional attachment to the child and is therefore less tolerant of the child's difficult temperament, or it may be the mother. Drug-addicted mothers themselves are more agitated, stressed, and less able to cope with an infant's needs (Hecht & Hansen, 2001).

The drug-exposed child may be less responsive to the mother, while the mother is less able to read the child's cues (Pollack, Cicchetti, Hornung, & Reed, 2000). What is put in play is a dyadic interaction between the mother and young infant or child where the healthy interplay between mother and child necessary to foster attachment, trust, exploration, and cognitive development is derailed. In this scenario, the child's social-emotional development becomes seriously compromised (Hecht & Hansen, 2001; Pollack, et.al., 2000; Schore, 2002; Karr-Morse & Wiley, 1997; Perry, 1997). The child becomes more impulsive, less able to attend to cues and norms, and engages in more hyperactive behavior that is difficult for the caregiver to manage. If the mother or caregiver is living in an environment is already compromised by other risk factors, such as poverty, chaos, violence, stress, and substance abuse, the risk of physical abuse or neglect is high (Hecht & Hansen, 2001; Pollack, et.al., 2000; Schore, 2002; Karr-Morse & Wiley, 1997).

Abusive and Neglectful Parenting

Impulsive and over-reactive children are at risk for poor social-emotional development and aggressive behavior, but child-rearing conditions can determine whether or not they develop in a healthy manner. Love withdrawal, power assertion, negative comments and emotions, physical punishment, and inconsistent discipline are linked to anti-social behavior. Chronic anger and a punitive parenting style can create a conflict-ridden family atmosphere and an out-of-control child. Cycles in which the parent threatens, criticizes, and punishes, and the child whines, yells, and refuses until the parent gives in tend to repeat and escalate. The cycle generates anxiety and irritability within the family. The result is a child with poor impulse control and antisocial behavior. Parents can encourage aggression directly through conflict and inconsistency, or indirectly through poor supervision and lack of limit-setting (Berk, 2006).

But young children often are not provided with intervention and services needed to promote healthy development and mitigate the impact of abuse, neglect, and separation from parents. Many children are the subjects of repeated referrals to CPS before any substantive action is taken. Sometimes the reason is that infants or very young children are non-verbal, making substantiation of an allegation difficult in the absence of clear medical evidence. The result is that

by the time children enter foster care, they may bring with them the cumulative effects of years of abuse and neglect. They may also bring with them coping and survival skills that the foster care, mental health, and educational systems do not understand and therefore misinterpret, and are ill-equipped to manage.

The foster care system, while meant to provide children with a safe haven from the abuse and neglect they have suffered, also can bring disruption, instability, fear, and uncertainty about the future. Children with neurodevelopmental vulnerabilities, in combination with the effects of chronic abuse and neglect, are less likely to have the resilience necessary to modify their adaptive behavior, which would allow them to adjust and cope with the non-abusive environment. If they cannot adjust and continue to respond to the world through the more primitive brain responses, they find that the environment confirms their belief that it is hostile (Perry, 1997). They enter a cycle of school suspensions and expulsions, placement disruptions, physical restraints, and alienation.

It is not surprising, therefore, that the social-emotional outcomes of foster youth, as a population, emancipating from the system are dismal. Research examining the well-being outcomes of youth emancipating from foster care illustrate that these young adults are ill-equipped to function as self-sufficient, contributing members of society (Courtney, et.al., 2004). In 1988, only 48% of emancipating youth had graduated from high school. The study also found that two years after leaving foster care, only 38% had stayed employed. Only 48% had ever held a full time job (Aron & Zweig, 2003).

Still, some youth emancipate from foster care and do well. This is not surprising either. Research on resiliency indicates that protective internal and external factors, such as good self-esteem, a strong support system, and positive social skills can help children survive adversity and be strengthened by it (Berk, 2006). These children not only survive the foster care system, they thrive in it. These children are likely to externalize blame for their abuse and neglect, and subsequent removal from their homes appropriately to the parent responsible, rather than feel responsible themselves. These are the children who remain stable in foster care, form bonds and attachments to foster parents, and, if they cannot return home, are more quickly adopted.

Why DBT?

Although it was developed as a treatment for parasuicidal women with borderline personality disorder, DBT has been adapted for use with other populations. Robbins & Chapman (2004) described outcomes of their use of DBT with borderline persons with substance abuse disorders, suicidal adolescents, patients with eating disorders, inmates in correctional facility settings, depressed elderly, and adults with ADHD. In a study of the use of a modified DBT skills training component in a group therapy setting with thirty-two non-suicidal adolescents who met the criteria for oppositional-defiant disorder (ODD), researchers found that the treatment was effective in reducing externalizing and internalizing of symptoms for youths completing the sixteen week program, along with decreases in depression (Nelson-Gray, Keane, Hurst, Mitchell, Warburton, & Chock, 2006). In addition, caregivers reported increased positive behaviors and decreased negative behaviors, suggesting that the treatment was effective with this population. ODD is characterized as, "a recurrent and developmentally inappropriate pattern of negativistic, defiant, disobedient, and hostile behaviors toward authority figures that persists for at least 6 months and leads to significant impairment in social, academic, or occupational functioning (American Psychiatric Association, 2000-DSM IV-TR). In their report, Nelson-Gray, et. al describe ODD as "a developmental antecedent to an adverse outcome of conduct disorder (CD)." CD, a diagnosis of childhood, has been associated with later diagnosis of borderline personality disorder, the adult diagnosis most commonly associated with DBT.

Although acknowledging that the empirical support for the treatment of ODD is largely behind parent-training, the authors of this particular study point out that involvement of parents of ODD adolescents in therapy is often difficult because the parents are either unwilling or unable to be constructively active in the therapy. For this reason, a therapy was sought that would promote individual change in the adolescents, rather than rely on family change (Nelson-Gray, et. al., 2006). The authors noted the similarity in dysfunction characterized by the ODD youths and adults with borderline personality disorder(BPD); specifically emotional dysregulation, difficulties with interpersonal relationships, and poor response to stress.

Mindfulness

Although it is a cognitive-behavioral therapy that teaches and promotes the identification of maladaptive thinking styles and automatic thoughts, a central component of DBT is known as "mindfulness" (Sneed, et.al. 2003). It is the focus on mindfulness, dialectical philosophy, and the importance of the therapeutic relationship that delineate DBT from other cognitive-behavioral therapies (Sneed, et. al., 2003). An examination of mindfulness techniques helps to illustrate the potential compatibility with the treatment needs of our population of young children with trauma-effects. By teaching patients to focus on different stimulate, including sensations and emotions non-judgmentally, mindfulness helps them to move toward a stronger sense of self-acceptance and self-awareness. Through increased acceptance and understanding of their feelings and thoughts, patients are able to reduce the reactivity to the emotions they are feeling, leading to enhanced ability to cope with problematic and difficult situations (Huss & Baer, 2007).

Mindfulness has its origins in Middle Eastern meditation practices, and complements DBT's emphasis on acceptance of current reality with awareness of cognitions, emotions, and sensations (Baer, 2003). Empirical findings suggest that mindfulness interventions may lead to reduced emotional difficulties such as stress, anxiety, and depressive symptoms. Maintenance of effective interpersonal relationships, emotional regulation, and tolerance of distress are also taught through mindfulness skills training (Baer, 2003). These are the very challenges faced by children in foster care, particularly as they move into adolescence. Mindfulness training shows the potential to provide them with the skills they will need to continue to cope.

When considering DBT as a potential treatment modality for young children in foster care impacted by early trauma, the emphasis Linehan placed on a biosocial theoretical perspective that incorporates both biological and social-environmental influences seems particularly relevant. In her work with BPD patients, Linehan theorized that the disorder may have a biological component; specifically a dysfunction of the way the central nervous system experiences and regulates emotions. The origins of this biological aspect of BPD may lie in genetics, prenatal development, or early trauma (Robbins & Chapman, 2004). The biological component then interacted with and was intensified by an environmental component that invalidated the patient's feelings. The result is a pattern of extreme emotional dysregulation, inability to identify feelings, and overly intense inhibition or expression of emotions (Robbins & Chapman, 2004).

Linehan recognized emotional vulnerability versus self-invalidation as a dimension of BPD that reflects the characteristic high level emotional arousal and sensitivity along with the tendency to invalidate those strong feelings. This tendency to invalidate feelings has been associated developmentally with strong emotions tied to shame and guilt (Sneed, et. al., 2003). Although Lineham's patients were adults, it is relevant here to remember Erikson's psychosocial stages of development: autonomy versus shame and doubt (1-3 yrs) and initiative versus guilt (3-6 yrs) (Berk, 2006). This is associated with the developmental task of shame versus guilt.

DBT theory views extreme emotional dysregulation as an artifact of the interaction between biological vulnerability and an invalidating environment. Sneed, et. al. (2003) list as typical features of an invalidating environment exposure to caregivers who:

(a) respond erratically and inappropriately to emotional experiences.

(b) are insensitive to others' emotional states.

(c) have a tendency to over or under-react to emotional experiences.

(d) emphasize control over negative emotions.

(e) have a tendency to trivialize painful experiences or attribute the painful experiences to negative traits, such as lack of motivation or discipline.

In combination with biological vulnerability, the invalidating environment results in an individual who has difficulty labeling and modulating emotions, tolerating emotional or interpersonal distress, and trusting in the validity of his or her private experiences. Thus, validation is a primary aspect of DBT methods (Sneed, et.al., 2003). In contrast, therapies that focus on teaching strategies to change thoughts or behaviors with the goal of suppressing problematic symptoms may lead to temporary stability, sometimes referred to as first order change (Fraser & Solovey, 2007). Second order change requires acceptance of the underlying symptoms and, at a developmentally appropriate level, an understanding of why the symptoms exist. Second order change signals a resolution of the problem,

rather than simply replacement of the symptoms with the appearance of stability (Fraser & Solovey, 2007).

The strategies identified by Sneed, et. al. (2003) in their examination of the use of DBT with adult patients in the psychiatric emergency room have potential as adaptations in DBT for children. For example, a therapist might move a child toward second order change through a dialectical technique often used by parents to help their children see the illogical aspects of typical childish arguments. In DBT, this technique is called the "Devil's Advocate". It involves the therapist endorsing an extreme position, which the patient, in this case a child, can recognize as extreme and nonproductive. This forces the child to take a position at the opposite extreme. The hope is that the therapist will be able to move the two positions toward a more moderate and reasonable position somewhere in the center. In this way the therapist models integrative thinking for the child (Sneed, et. al., 2003). It is critical to adapt any use of the "Devil's Advocate" or other DBT technique to the child's developmental level and unique situation and circumstances.

The use of metaphors is another DBT technique that can be easily adapted to children. Metaphors are more interesting than simple explanations and, if consistent with the child's cognitive developmental level, can be easily understood and remembered, even when children are emotionally overwhelmed. In addition, metaphors can reduce the sense of powerlessness (Sneed, et. al., 2003), a feeling common to children who have been separated from their families and placed in out-of-home care.

Although mindfulness is a component of DBT, Huss and Baer (2007) see it as serving different purposes for patients based on different assumptions inherent in the treatment. They point out that Lineham's DBT biosocial modality assumes that patients had grown up in dysfunctional environments and had not learned the skills necessary for self-regulation of emotional responses, interpersonal effectiveness, tolerance of distress, and problem solving. Therefore, DBT taught those skills. Mindfulness, on the other hand, assumes that individuals already have those skills but need to bring them out in order to cope effectively with current difficulties (Huss & Baer, 2007). Children in foster care who are having difficulty are likely to fit both groups.

Adaptation of DBT for children might best be viewed in the context of healthy and successful developmental stage resolution. Psychosocial theorist Erik Erikson described human development as movement through a series of developmental stages, each with corresponding psychosocial conflicts. These conflicts may be resolved or be left unresolved; creating a continuum that determines healthy or unhealthy adaptation of the individual (Berk, 2006). Infants from birth to one year of age need to learn that the world is a safe place in which caregivers can be trusted to respond to them lovingly and meet their needs. During the toddler stage, from one to three years, children learn that they can exercise some control over their own bodies (as in potty training) and their environments, as in expressing themselves verbally for example. If children are not excessively punished and shamed as they move through this stage, they develop a sense of autonomy and will that is internalized. They believe that they can control their impulses because the control comes from within, and not from external powers. As children move into Erikson's third stage, from three to six years of age, children learn to develop and pursue their own goals, thus leading to a sense of purpose and initiative. Successful resolution of the first three developmental stages positions the young school-aged child, now six to eleven years old, to believe that they can master new skills, such as academic and social challenges. They develop a sense of competence unimpeded by distrust of others and the environment, shame and self-doubt, and reliance on external controls (Crane, 2000).

Children who have been victims of abuse or neglect resulting in early trauma are unlikely to have positively resolved the early psychosocial tasks upon which the foundation of healthy cognitive and social functioning rest. If mindfulness and DBT were to be used to treat children from six to eleven years of age, it may be that the explicit instruction characteristic of DBT is utilized more for the younger children, who are developmentally wrestling with shame and guilt, and as they successfully move toward autonomy and initiative, mindfulness can be introduced as they struggle with the psychosocial tasks of latency (industry vs. inferiority).

Summary

Because alcohol and drug abuse is related to parents who abuse or neglect their children (Berk, 2006), even if maltreated children were not exposed to drugs in-utero, many were subjected to the drug-abusing lifestyle of their parents in their early develop-

ment, which can include chaos, unpredictability, and violence. Maltreated children are also more likely to live in poverty, have a single parent, and have a parent with mental health issues (Hecht & Hansen, 2001).

The effects of neglect are cumulative, while the effects of physical or sexual abuse may be interactive. Foster children's histories of having been abused or neglected are known to have high potential to impact their cognitive, physical, and social-emotional development, leaving them less ready to learn than other children (Berk, 2006, Christian, 2003). Many children who begin school developmentally behind will never catch up to their peers. In addition, many studies confirm that the more harsh threats, angry physical control, and physical punishment children experience, the more likely they are to develop serious, lasting mental health problems. Besides poor academic performance, these include weak internalization of moral rules, depression, aggression, and anti-social behavior (Berk, 2006).

Parents who themselves have mental health problems, who are emotionally reactive, depressed, or aggressive, are more likely to have children who are hard to manage, placing the children at risk of abuse and neglect. Research indicates that parental harshness predicts emotional and behavior problems in children of diverse temperaments (Berk, 2006). When these children enter school, they often struggle. Nationally, abused and neglected children placed in out-of-home care typically perform one to two years behind their peers in school (Courtney,et.al., 2004). A study of 239 third through eighth grade Chicago public school students who entered care during 2002 and 2003 found that almost 66% were either old for their grade or scored in the bottom quartile in reading. The same study found children in sixth through eighth grade who were in care to be at least three times more likely to be classified as learning disabled than their peers in the same school system who were not in care (Courtney, et. al., 2004). Children in foster care are also over-represented among students classified as having emotionally disturbance (ED) (Smithgall, et. al., 2005).

In light of these presenting deficits, it is critical that the developmental and mental health needs of children be addressed quickly upon entering care and at an age when children are less damaged and more compliant and amenable to treatment. Social-cognitive interventions such as DBT, along with the changes in brain chemistry that mindfulness can bring, may help young children in foster care learn to focus on improving information processing, attend to relevant, non-hostile social cues, seek additional information before acting, and evaluate potential responses in terms of effectiveness . Before behavioral problems become too severe, these interventions can increase social problem-solving skills, decrease endorsement of beliefs supporting aggression, reduce hostile behaviors, and improve interpersonal relationships, providing children with skills and resiliency to move them toward healthy and positive outcomes that will last them into adulthood. ◎

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The Impact of Traumatic Stress and Alcohol Exposure on Youth: Implications for Lawyers, Judges, and Courts

by Frank E. Vandervort, JD*

Since its inception in the late nineteenth century, the juvenile court has been concerned with the legal problems of children and their families. From the court's earliest days, it has sought to address child abuse and neglect and juvenile delinquency as social problems that result from familial and community breakdown. Over the decades, researchers from various disciplines have provided varying explanations of how and why family systems break down, why some parents fail to nurture their children, why some physically or sexually abuse their children, and why some children become delinquent.[1]

Research conducted over the past two decades demonstrates that exposure to traumatic events can have devastating consequences for children's development. Whether that trauma is experienced in the prenatal period in the form of alcohol or drug exposure, is the result of exposure to violence directed at the child, or is the result of witnessing violence between others in the environment (e.g., domestic violence or community violence), traumatic stress can change both the chemistry and physical architecture of a developing child's brain. Exposure to traumatic events can impair a child's physical and emotional development, and provides poor models for the child to imitate. Exposure to abuse and neglect as a young child is correlated with subsequent delinquent behavior.[2]

Efforts to help children who have been traumatized by family violence can themselves be traumatic for children: repetitive interviewing about traumatic events; dislocation from immediate and extended family; removal from their community and disruption of significant relationships with friends, schools, and places of worship; changes in placements; and participation in the legal system have all been identified as sources of trauma for children in the child protection system.[3] So, when addressing individual cases, courts and lawyers must carefully balance the harm children experience in their homes and the risk to the community against the harm that can result from our efforts to respond to child maltreatment and delinquency. In the delinquency context, maltreatment by law enforcement officers and inappropriate handling and supervision by authorities while in confinement can exacerbate preexisting effects of trauma. At a systemic level, we seek to increase the resources available to address the needs of children and families and to push the various systems—legal, social services, mental health, and educational—to work more closely together and with greater cooperation to ensure the needs of traumatized children are addressed.

Scope of the Impact on Legal Practice

In their article in this issue of the *Michigan Child Welfare Law Journal*, Connie Black-Pond and James Henry detail numerous impacts of traumatic stress on children and discuss from a systemic level some steps that may be taken to make Michigan's legal system more sensitive and responsive to the needs of traumatized children. In virtually every child protection case, and in most juvenile justice cases, lawyers and judges encounter a child who is before the court who has been impacted by the effects of trauma, including prenatal exposure to alcohol.

Researchers have found that as many as half of all cases reported to children's protective services involve parental substance abuse.[4] One study published in 1999 found that in 79 percent of the cases in which the court removed a child from the parental home, the parent had a substance abuse problem.[5] Similar findings have been noted in juvenile justice cases. In a study of 287 youth remanded for an inpatient assessment, 23 percent (67) had an alcohol related diagnosis.[6] Each of the 67 "had a history of significant prenatal exposure to alcohol."[7]

This article will address some of the practical implications for representing clients in child welfare and juvenile justice cases given our knowledge of the impact of childhood trauma on children's functioning.

Communicating With and Counseling Clients

Children who have experienced fetal exposure to alcohol[8] or drugs,[9] and those who have experienced complex trauma[10] may have difficulty communicating.[11] At a physical level, prenatal exposure to alcohol damages the central nervous system and is a leading cause of developmental delay.[12] Such exposure has been shown to significantly impact the physical development of the brain in ways that impair communication skills. For example, both receptive and expressive language skills are impacted by prenatal exposure to alcohol.[13] Even if they do not have physical damage to their brains as a result, children who have experienced trauma may have developmental emotional delays which have no physiological basis but that cause them to function at levels below their chronological ages, sometimes significantly so.

Youth with receptive language deficits have difficulty processing information that they hear, such as when their rights are explained to them. These youth may say that they understand things they have heard when in fact they do not.[14] In part, these kids have learned to do this as a mechanism of social adaptation to overcome the neurological deficits with which they must cope. As Timothy Moore, a psychologist, and Melvyn Green, a lawyer, have observed,

> These language impairments interfere with academic progress because FASD children have difficulty understanding their teachers and other adults. They learn to exploit nonverbal cues to maintain conversational flow, but their degree of comprehension may be much lower than it appears. They develop a glibness that belies their actual competence. Subtleties of language use are beyond them.[15]

Obviously, children and youth with these difficulties in communication present real challenges for lawyers and courts. Children with these sorts of communication problems will need to be interviewed carefully and will require evaluation by medical and mental health professionals to understand their level of functioning and how to best communicate with them effectively. One easy and effective technique for gauging the youth's level of understanding is to ask him or her to reflect back what you have said. After the court has explained to a child his or her rights when taking a plea and the child indicates an understanding, ask the child to repeat to you in his or her own words what you have just explained. If the youth cannot do so in a way that manifests at least a basic understanding, then you will need to explain the concept again. Similarly, a youth should be asked about and able to explain the consequences of what the lawyer or judge has explained.

In addition to developmental delays that may impair traumatized children's capacity to communicate, some abused and neglected children will have developed inhibitions that have a negative impact on communication. Children who have experienced abuse or neglect are sometimes threatened that if they disclose information about their abuse or abuser they will experience some additional harm; this is perhaps especially true of children who have experienced sexual abuse.[16] In these cases, it is important to consult with the protective services worker, the foster care worker, the child's custodian, and any mental health provider working with the child before you begin interviewing the child. Speaking with these people who know the child may assist you in developing an interview strategy. It will typically be the case that eliciting information from and conveying information to these children will take more time and effort than communicating with children who have been less severely traumatized.[17]

Investigation

Whether representing a child in a protective proceeding or in a delinquency matter, careful investigation of the case is crucially important. Michigan's Juvenile Code requires that a child's lawyer-guardian ad litem (L-GAL) conduct an independent investigation of the case.[18] The law requires that the L-GAL interview family members, case workers, and "others as necessary." The L-GAL should also review "relevant reports and other information." To carry out this responsibility, MCL 712A.17d(1)(b) broadly grants the L-GAL access to "all relevant information regarding the child." Similarly, effective representation of a minor charged with delinquency requires the attor-

ney to conduct a thorough investigation of both the circumstances of the alleged delinquent act and the child-client's background in order to properly prepare a defense strategy.[19]

Counsel should pursue medical, educational, mental health, law enforcement, and any other records that may shed light on a child's history of trauma. A birth record, for example, may contain evidence of prenatal exposure to drugs or alcohol, or other environmental stressors such as domestic violence or mental illness on the part of the child's mother. Medical records may contain information about injuries the child may have suffered as a result of abuse, neglect, or other causes (e.g., injuries sustained in accidents[20]) that may be helpful to understanding alleged delinquent behavior.[21] Similarly, school records may contain a wealth of information regarding a child's intellectual and emotional functioning over time since the school is in a good position to observe cognitive capabilities. For example, fetal alcohol spectrum disorder (FASD) is very often not diagnosed until after a child begins school and shows academic and social delay. Similarly, intellectual limitations as a result of intrauterine drug exposure often will not manifest until the child is seen in the educational setting.

Addressing System Trauma

As noted in the introduction to this article, the child welfare system's efforts to help children and families can be traumatic for youth. [22] Dislocation from a primary attachment figure, even one who is less than optimal, is traumatic for children, and repeated moves while in the foster care system cause tremendous stress, which in turn causes alterations in brain chemistry and architecture. Similarly, repeatedly interviewing young people about their traumatic experiences, which causes them to relive these experiences at an emotional level, may cause additional trauma, as can multiple court appearances to testify, and vigorous cross-examination. There are a number of steps a child's L-GAL can take to address these issues. Of course, the child's experienced trauma and its ramifications are important considerations regarding many, if not all of, these efforts.

First, preparing the child if he or she will need to testify is important. There are a number of educational materials available to help kids understand what will happen in court and what they can expect to happen if and when they must testify.[23] Children will be better able to testify if they have had the opportunity to see the courtroom in which they will need to testify, and have discussed where the judge will sit, where the jurors will be if there is a jury trial, and where their parents and the various lawyers will sit. Your local victim-witness program may be of assistance in regard to helping your child-clients with this.

The law provides two helpful means by which a child's hearsay statements may be admitted. First, for children under 10 years of age, the court rules provide a specific exception for statements regarding child abuse or neglect.[24] For children's statements that do not fit within the court rule exception, due to age or some other circumstance, MRE 803(24), the residual hearsay exception, may provide a means of admitting the statements, thereby obviating the need for the child to have to testify.[25] Each of these options has a notice requirement.

Next, as part of your routine case preparation, you should decide whether to use the child witness protections established in the Juvenile Code and related court rules. For example, MCL 712A.17b provides for a support person to accompany a child who must testify. It also provides for the taking and use of a "videorecorded statement" at all phases of a child protective proceeding except the trial. Thus, the CPS agency could make a videorecording of a forensic interview with the child, and this could be used, if necessary, at the preliminary hearing and in the dispositional phase of a proceeding. The statute also provides that a child's testimony may be taken by way of a videorecorded deposition, which will then be played at trial in lieu of the child's live testimony.[26] Some of these methods of witness protection require a showing that the child would likely experience psychological harm if the protective measures are not taken.[27] Similarly, the court rules provide for several other measures intended to protect child witnesses (e.g., closed circuit TV, speaker phone, impartial questioner).[28]

Assessments and Pre-Trial Motions

Evaluations by medical and mental health professionals are extremely helpful in both the child protection and, in some cases, delinquency context.

Child Protection

The child's L-GAL may need to seek a court order for additional evaluations of the child if doing so would, in the lawyer's judgment, assist the lawyer in understanding the child's history of trauma or preparing the case for trial. The Juvenile Code expressly provides the court the authority to order that a child receive medical and mental health evaluations once a petition has been filed.[29] This authority is expanded upon in the court rules to include evaluations of parents as well as children.[30]

Early comprehensive and interdisciplinary evaluations of children and parents are essential to a complete understanding of the case history and to ensure that the proper services are utilized for both the child and the parent. First, there is some research evidence that early multidisciplinary assessment—before court involvement—can keep families together, improve child functioning, and obviate the need to remove children from parental custody.[31] One reason for this seems to be that an early and comprehensive assessment more precisely identifies the needs of the child, the parent, and the family, which leads to the provision of services more likely to meet those needs. Lawyers and courts should press their local children's protective services agency to adopt a practice of seeking such a comprehensive assessment in each case that they open for services.[32]

Even if a petition has been filed and the child removed from the home, an early and comprehensive assessment can promptly identify the need for services. For example, the author recently became involved in a case that had been pending for five months. After reviewing the file and meeting briefly with the children and observing the mother, the author requested and the court ordered such an evaluation. The results of the evaluation were telling. The mother had an IQ of 70, which placed her on the borderline of intellectual impairment. (Some parents with an IQ of 70 can parent effectively while others cannot.) A functional assessment of her abilities (assessed in part through a parent-child interaction) revealed that she actually functioned as a parent at a level lower than her IQ itself would have suggested. With this assessment, it became clear that the services the agency had been providing were inadequate to meet the mother's needs—they were not of the correct intensity or duration to provide her a fair opportunity to regain custody of her child and did not meet the agency's obligations established in *In re Terry*[33] to comply with the Americans with Disabilities Act. As this example illustrates, we very often do not recognize problems that parents and their children have until months into a case. Given the exacting timelines under which child welfare cases must be handled, it is essential that we do a better job of identifying problems with functioning early in the court's involvement of the case if families are to have a fair opportunity to reunify.

A comprehensive evaluation at the beginning of the case also establishes a baseline against which to measure the parents' progress toward resolving the issues that brought the family to the court's attention. Too often, we require parents to attend "counseling" without any real idea of what the issues are they should be working on or what exactly we expect the counselors and parents to accomplish.

Delinquency

A child's history of trauma and its neurological, psychological, and behavioral sequela is important to understand when representing a child in a delinquency case. As has been noted, children who are exposed to trauma may have communication, intellectual, and functional deficits. These may have a negative impact on the child's functioning in relation to the ability to understand and waive rights, competency to stand trial, whether the client may have a cognizable mental health defense, and the appropriate disposition in such a case.

Even developmentally normal youth very often lack competence to understand and assert or knowingly and intentionally waive *Miranda* warnings. This fact was recognized by the United States Supreme Court more than 40 years ago in *Gallegos v Colorado*, when the court said that "A 14-year-old boy, no matter how sophisticated . . . is not equal to the police in knowledge and understanding . . . and is unable to know how to protect his own interests or how to get the benefits of his constitutional rights."[34] True as the court's observation was, it is even truer when the child has the sort of developmental and language delays that many allegedly delinquent children have as a result of experienced trauma. Social science researchers have articulated a very clear link between childhood abuse

and victimization and subsequent delinquency.[35] Unfortunately, the juvenile justice system makes no reasoned accommodation for this fact. As a Yale University professor of psychiatry has observed,

> Today our justice system wrestles with the question of whether normal adolescents, with as yet immature, poorly insulated frontal lobes, should be held as accountable for their violent acts as normal adults.[36] Psychiatrically ill, neurologically impaired, and abused adolescents are even more handicapped than their normal peers. The question of ethics that their conditions pose is to what extent these impaired juveniles should be held accountable for their violent acts.[37]

Plainly the client's history of maltreatment and resultant impairment is a crucial part of the totality of the circumstances that must be considered when determining whether a juvenile understood and provided a knowing and intelligent waiver of his or her *Miranda* rights.[38] Moreover, aggressive questioning techniques that police routinely use in questioning suspects can easily overwhelm such a youth.[39] Youths who have the sort of developmental delays that result from a history of trauma may confess to being involved in crimes in which they simply were not involved or having committed specific acts that even the complaining witness has not alleged happened.[40] These considerations should be accounted for in determining whether to file motions to suppress statements, and what strategies should be used to do so.

A child's developmental impairments that grow out of a history of trauma are also relevant to the determination of the minor's competency to stand trial. In *In re Carey,*[41] the Michigan Court of Appeals held that the Due Process Clause requires that, if raised, a juvenile's competency to stand trial must be evaluated. The court noted that a child might be incompetent based solely on age and immaturity.[42] While no Michigan case has squarely addressed whether a child may be developmentally incompetent, courts in other states have addressed this issue.[43] It is crucial to understand that children who have experienced trauma that has resulted in neurological impairments and developmental delays may function at levels substantially below their chronological age. These developmental delays should be taken into account when determining whether a juvenile is competent to stand trial.

Limiting Cross

A trial is said to be a search for the truth.[44] How witnesses are questioned is directly related to whether the court is able to ascertain the truth in a given case. Michigan Rule of Evidence 611(A) provides that "the court shall exercise reasonable control over the mode . . . of interrogating witnesses and presenting evidence so as to (1) make the interrogation and presentation effective for the ascertainment of the truth. . . ." Generally, of course, direct examination is to be conducted using open ended questions, while cross-examination is "ordinarily" conducted by leading question.[45] Rule 611 makes clear that the court has the authority to exercise reasonable control over the questioning of witnesses to maximize the truth seeking function of hearings at which the rules of evidence apply.

A great deal of social science research demonstrates that children are susceptible to suggestion if they are questioned in a leading manner.[46] While susceptibility to suggestion is especially problematic with young children, even older children can be influenced by aggressive questioners.[47] This is the major reason why a decade ago Michigan adopted a forensic interviewing protocol to be used by children's protective services workers and staff members of child advocacy centers who interview children.[48]

Children charged with law violations who have experienced trauma are young and, as a general proposition, are susceptible to suggestion just as are their counterparts in child protection cases. These children also may suffer the effects of trauma-inflicted developmental delays in language and cognition. Developmentally, they may lag years behind their chronological age. Children's capacity to handle courtroom testimony, and especially cross-examination, should be gauged not by their chronological age but by their developmental age. Determining the youth's developmental age, of course, requires careful expert evaluation.

Cross-examination, it has been said, is the "greatest engine ever invented for the discovery of the truth."[49] To keep it so, in both child protection and delinquency cases, counsel for the child should consider whether to file a motion requesting that the court exercise its authority to prohibit the use of leading questions when the child or the delinquency respondent testifies. Such a motion should contain a description of the factual basis on which the request is made, such as the child's IQ, developmental age in relation

to chronological age, sources of the delay, and known history of traumatic experience. It should also detail the medical and social science research that substantiates the claims that children who have experienced various forms of trauma are susceptible to improper suggestion that may result from vigorous cross-examination. Successfully pursuing such a motion will likely enhance the truth-seeking function of the legal proceeding.

Developing a Litigation Strategy

The child's experience of trauma and its effects on the child's development also will influence the litigation strategy. Trauma history and developmental status should be carefully considered in terms of the theory of the case. A theory of the case is a succinct statement of what the case is about and which takes into account both the good and bad facts presented. In a child sexual abuse case, for instance, the child may suffer from post traumatic stress disorder, a psychological condition that is prevalent in these cases. This may explain some peculiar behaviors exhibited by the child which would otherwise seem counterintuitive. Similarly, in a delinquency case, information about the child's developmental delays secondary to traumatic experiences may suggest a defense based upon an inability to formulate a specific intent or may provide the foundational evidence to assert a mental health defense. As these examples illustrate, understanding the child-client's history of trauma is essential in developing a strategy for handling the case.

Child Protection

Sadly, many of the parents of the children who populate the child welfare system are living with the consequences of their own traumatic victimization in childhood. Maltreated children are at heightened risk for mental illness, substance abuse, domestic violence, criminality, and similar problems as adults.[50] In some of these cases, the parents' problems may be of such a magnitude that there is simply no reason to believe that they will be able to overcome their parenting deficits in a timeframe that would be conducive to reunifying the family. As Dr. Steven Ondersma of the Merrill-Palmer Institute and his colleagues have observed, "In addition to the risks to children presented by drug use alone, the many factors associated with substance use are also important to consider. Depression, criminality, poverty, prior abuse, and family violence are all more common in homes where illicit substances are used."[51] He goes on to observe that "chemical dependency can easily require years of treatment and is characterized by repeated relapses."[52] Obviously, with limited time and resources to address the problems presented by parental substance abuse, it is clear that in some cases the interests of the children would be best served by an early move in the direction of a permanency plan that excludes consideration of reunification.

Both federal and Michigan law permit the court to terminate parental rights or to make other permanent plans for a child without the need to expend limited resources or time that is crucial to a child's development on efforts to rehabilitate a parent who is unlikely to benefit from services. Two underutilized provisions of the federal Adoption and Safe Families Act (ASFA) speak directly to movement in the direction of early permanency. First, one provision of ASFA provides that the state child welfare agency may seek an early termination of parental rights in any case if doing so would serve the interests of the child. It provides:

> Nothing in this section or in part E of Title IV of the Social Security Act [42 U.S.C. § 670 et seq.] shall be construed as precluding State courts or State agencies from initiating the termination of parental rights for reasons other than, or for timelines earlier than those specified in Part E of Title IV of such Act, when such actions are determined to be in the best interests of the child, including cases where the child has experienced multiple foster care placements of varying durations.[53]

Similarly, 42 U.S.C. § 678 directly addresses the court's ability to make decisions in children's best interests in any case other than one in which the federal law requires termination of parental rights:

> Nothing in this part [42 U.S.C. §670 et seq.] shall be construed as precluding State courts from exercising their discretion to protect the health and safety of children in individual cases, including cases other than those described in section 471(a)(15)(D) [42 U.S.C. §671(a)(15)(D)].

Michigan law, too, permits the court to terminate parental rights at the first dispositional hearing in any case in which such an outcome is requested.[54] In cases

in which the parent is unlikely to be able to regain custody in a timeframe that is conducive to the child's needs, the child's L-GAL should consider whether to seek early termination of parental rights or some other permanent resolution to the case.

Delinquency

Some children who exhibit aggression and violent behavior, many of whom may be assigned the labels such as "oppositional defiant disorder" or "conduct disorder," have been shown to have abnormally high levels of certain neurotransmitters (i.e., chemicals in the brain) and stress hormones.[55] These abnormalities may provide a biological basis to explain their aggressive, impulsive behavior. In some cases, these biological indicators may provide a legal excuse, diminish responsibility for the child's acts, or provide evidence that the youth was incapable of forming or as a factual matter did not form a specific intent in a particular situation.

Services

When considering the services to be provided to the children and families that come before the court, we must be both soft hearted and hard headed. We must exhibit the compassion to provide services aimed at rehabilitating the neglectful or abusive parent and remember that youth who commit violent acts are doing their best to cope with a world that has been hostile and violent to them and overwhelms their capacity to cope, that they are not simply "bad" kids. But we must also be hard headed. We must recognize that some parents' capacity to parent is so impaired by substance abuse, mental illness, developmental delay, and the like that no amount of services we can provide can change their course in the timeframe necessary to meet the needs of their children. Similarly, we must recognize that some young people, because of their own brutalization, present a very real danger to the community and must be very closely monitored, or, in some rare instances, removed from the community altogether.

As noted earlier in this article, early and comprehensive evaluations of parents and children are essential to understand the variety and complexity of a parent's and child's needs encountered by our juvenile courts. But evaluation is only the beginning of the process. After the evaluation has been completed, children's L-GALs and parents' attorneys must advocate for services for both the child and the parent (if reunification is the goal) that will actually address the needs of the *particular* child, the *particular* parent, and the *particular* family. Boilerplate, cookie-cutter treatment plans do not take into consideration the unique needs of the individuals involved and provide neither hope to the child to return home nor fair opportunity to a parent to regain custody of his or her child. In advocating for or ordering services, it is essential that they accomplish the following:

(1) Maximize the child's sense of psychological safety. Many of the chemical and architectural changes that take place in the brain as a result of abuse and neglect result from the brain's reaction to flight or fight states, that is, a lack of psychological safety.

(2) Ensure that services are coordinated and trauma informed.

(3) Connect children with professionals who can help them develop a coherent understanding of their traumatic experiences and help them integrate and gain mastery over their experiences.

(4) Address the ripple effects on the child's behavior that result from the traumatic experiences. This includes the ability to form and maintain healthy attachments, aggressive behavior, and academic/learning problems.

(5) Provide support and guidance to the child's family.

It is essential that lawyers advocating for children or parents and courts become informed consumers of the services being provided to the families with whom we work.

Child Protection

After the evaluation has been concluded, the L-GAL and the parent's attorney should seek evidence based treatments to address the identified needs. A research team at Duke University Medical School has outlined several treatment programs that have been tested empirically and have shown promise in addressing the needs of children and families in the child welfare system.[56] They recommend the following approaches to treatment:

(1) **Trauma Focused Cognitive Behavior Therapy (TF-CBT)**: TF-CBT, which is used with both the child and the parents, "addresses behavioral and negative thought patterns associated with childhood trauma."[57] In this form of treatment, the therapist teaches the child how to cope with the emotional impact of the trauma he or she experienced and teaches the parent how to encourage and support the child's use of these skills. Research has demonstrated that TF-CBT is "linked to improvements in PTSD symptoms, depression, anxiety, behavioral problems, and feelings of shame and mistrust."[58]

(2) **TF-CBT for Childhood Traumatic Grief** is a form of treatment "designed specifically to help children suffering from traumatic grief after experiencing the loss of a loved one in traumatic circumstances."[59] Some of the children who enter the foster care system have lost loved ones to violent death—a mother is killed by a father; a sibling is beaten to death. Sometimes children will directly witness these horrific incidents[60] and will be severely traumatized as a result. TF-CBT for Traumatic Grief is a fairly new approach, but two studies have shown positive outcomes for the children who have participated in this form of treatment.

(3) **Abuse-Focused Cognitive Behavior Therapy (AF-CBT)** is a short term approach to therapy that lasts 12-18 hours and has proven effective at reducing the risk of parental anger spilling over into physical abuse. It does this by reducing the use of physical discipline and physical force to get children to comply with parental directives. In this form of treatment, children are taught positive social skills and to reduce their aggressive behavior at the same time parents are taught anger management and relaxation skills. This form of treatment can be provided in the family's home and should be considered for use in those cases that children's protective services (CPS) has categorized Category III or Category II.[61]

(4) **Parent Child Interaction Therapy (PCIT)** lasts between 12 and 20 sessions and can be used with children from 4 to 12-years of age. In this approach, parents learn to use positive discipline techniques while children learn to be more compliant with parents' directions. The goal of this treatment modality "is to change negative parent-child interaction patterns."[62] This form of treatment has been shown to reduce the number of incidents of physical abuse, reduce child behavior problems, reduce parental stress, and to increase positive interactions between parents and their children.

(5) **Child-Parent Psychotherapy for Family Violence (CPP-FV)** is a method of providing individual treatment to pre-school-aged children who have witnessed domestic violence and exhibit trauma symptoms related to their exposure to violence in their homes. This form of treatment is typically provided once per week for about a year. Research has shown it to be more effective than other forms of treatment at reducing symptoms of traumatic stress, behavior problems, and maternal avoidance of the child.

(6) **Project 12-Ways/Safe Care for Child Neglect**: as the name suggests, is aimed at addressing neglect rather than abuse or exposure to violence. This approach specifically addresses issues such as environmental safety, bonding between the parent and the child, and responding to the child's medical needs. Project 12-Ways has been shown to improve both interpersonal skills and functional skills (i.e., home management, job training) of the parents who have participated in the program.

Delinquency

As with child protection cases, attorneys for children in delinquency cases should also be aware of the need for and availability of evidence-based approaches to treatment, and should insist that they be ordered by the court and utilized when children are on probation or in placement. Historically, the juvenile justice system has over-relied on the use of secure detention before trial and secure confinement post-adjudication, which has resulted in overcrowding of detention facilities.[63] The excessive use of secure confinement can be

dangerous for both youth and for the staff members who work in facilities.[64] In addition to being expensive, secure detention and confinement have a proven track record of failure, exemplified by high recidivism rates.[65] Children are routinely brutalized in many of these programs.[66] Since at least the 1960s, research has consistently demonstrated that properly designed, well-run, community-based juvenile correctional programs are more effective at reducing recidivism and enhancing community adjustment of adjudicated juvenile offenders.[67]

There are a number of alternatives to secure detention and confinement that have proven effective at both providing community safety and providing effective supervision and treatment of juvenile offenders in the community. Massachusetts has long rejected the large-scale confinement of juvenile offenders, instead relying on intensive, community-based programs to monitor and treat juveniles in both the pre-trial and post-adjudication phases of delinquency proceedings. These programs "have shown powerful effects in reducing subsequent involvement in delinquency."[68] Below are several programs that have proven effective in the pre-trial and the post-adjudication phases of the process.

Pre-Trial Detention or Monitoring

Pre-trial detention or monitoring of allegedly delinquent children has two legitimate goals: 1) to ensure that the minor appears for court hearings; and 2) to maintain community safety by guarding against recidivism. In order to achieve these goals, communities across the nation have developed alternative programs to monitor youth.

(1) **Home detention** demands that youth be home at certain periods. For some youth, this means at all times; for others, when not in school or at work. It also applies to curfew hours as established by the community generally or as established for the individual youth by the court. Contact with these youth is often made daily. Home detention has proven to be both cost effective and effective at meeting the two objectives of pre-trial detention or monitoring.

(2) **Electronic monitoring** monitors the youth's whereabouts by way of an electronic monitoring device and random phone calls to the youth's home. It is often used in conjunction with home detention. Electronic monitoring has shown success. For example, in a study done in Lake County, Indiana, youth involved in electronic monitoring completed their programs 90 percent of the time, as compared with 75 percent for youth who were not monitored, and had recidivism rates 9 percent lower than unmonitored youth.

(3) **Day and evening reporting centers** require that youth report to a given place on a daily basis. These programs vary, but a number of them provide an array of services in addition to merely requiring that youth report. These services may include job skills training, counseling, recreation, and independent living skills. Cook County (Chicago), Illinois is a national leader in implementing day and evening reporting, and they claim a 92% success rate.

Post-Adjudication

Broadly speaking, the purpose of the disposition in a delinquency case is to provide rehabilitative services to the youth and to protect the community from further delinquent conduct. A recent publication by the Office of Juvenile Justice and Delinquency Prevention noted that, "Youth's behavior problems are deeply embedded in their psychosocial systems (e.g., family and community); to be effective, therefore, interventions should treat youth while addressing their complex multidimensional problems."[69] A number of programs have proven successful in addressing the challenges presented by delinquent youth:

(1) **Intensive supervision programs (ISP)** provide increased monitoring for some higher risk youth in order to maintain them in their home. While research has shown mixed results, ISPs, when properly structured and implemented, have show promise in reducing recidivism. In general, those programs that provided more services (e.g., individual and family therapy, job training, and educational supports) are more successful than those that simply provided an increased level of monitoring.[70]

(2) **Multi-Systemic Therapy (MST)** provides family-based, intensive therapeutic intervention with delinquent youth at risk for place-

ment in out-of-home care. "The overriding purpose of MST is to help parents deal effectively with their youth's behavioral problems; help youth cope with family, peer, school, and neighborhood problems; and reduce or eliminate the need for out-of-home placements."[71] Research studies have demonstrated that MST is one of our most successful programs at rehabilitating delinquent youth, preventing recidivism.[72] MST has been shown to reduce the need for out-of-home placement from 47 to 64 percent.[73] In studies in which MST was used with "violent and chronic" juvenile offenders, re-arrest rates dropped 25 to 70 percent, and there were decreases in the youths' mental health problems and improved family functioning.[74] The benefits of MST have been shown to last at least four years, and it has proven to be a cost effective alternative to out-of-home placement.[75]

(3) **Functional Family Therapy (FFT)** is a short-term program which typically consists of between 12 and 30 one-hour therapeutic sessions over a three-month period of time. Research has shown FFT to be successful in engaging youth and their families (80% of the families that participate in the program complete it), effective at reducing recidivism, and highly cost effective ($700–$1000 per case as compared to $6,000–$13,000 for detention or residential placement). FFT has the attendant benefit that it has been shown to prevent siblings of the delinquent youth from entering into delinquency.[76]

(4) **Multidimensional Treatment Foster Care (MTFC)** is a program for those youth who cannot be maintained in their family home. In this program, youth are placed into a foster home rather than in a group care setting. The foster parents receive specialized training in addressing the needs of delinquent youth, including close supervision and emotional support. Youth in MTFC assist in developing a schedule of activities and behavioral expectations, and are intensively monitored by both their foster parents and by a case manager. The youth's family of origin is provided family therapy with a focus on assisting the family to develop the structure the youth needs to be successful. When compared with youth who were placed in residential programs for delinquents, youth who participated in MTFC programs had "significantly fewer arrests" after one year.[77]

As the programs briefly described here demonstrate, there are viable community-based programs which can address the needs of youth and their families, maintain community safety, and save money. But many, if not most, Michigan communities lack sufficient programming of the type described here, requiring that lawyers, and especially judges, be involved in system reform and demanding that these programs be made available. This will take considerable cross-systemic work.

Reforming the System

Understanding the impact of complex trauma on children demands that we be engaged in reforming the system to better respond to their needs. Judges especially play a crucial role. They are in a position to convene a community's leadership to marshal its resources—the court itself, the Department of Human Services, community mental health, and the school system—to address the needs of these children, their families, and their communities. Judges should seek to bring together representatives of various community agencies to ensure that the programs discussed earlier are available in the community. Judges should order the evaluations that children and families need, not merely those that are available. When the demand is made, the programming will follow. In short, judges must take a leadership role at the systemic and community level in responding to the effects of trauma on children.

But lawyers play an important role, too. When lawyers representing children in individual cases begin to educate courts about the need for early assessment and evidence-based programming aimed at addressing the child's history of experienced trauma, the system will begin to respond. When lawyers demand that every child and family coming before the court be evaluated at the beginning of the proceedings rather than after months have passed, the system will begin to provide these services as a routine rather than as the exception to the rule. When lawyers insist that courts reject boilerplate treatment plans for children and families in favor of services that are tailored to the needs of that child and that family, then courts will

understand why they so insist and will act with this in mind. Also, lawyers—through individual effort as well as local and statewide bar committees—must also be involved in systemic reform. Lawyers should press courts and agencies to address the issues at a systemic level to ensure that trauma sensitive services are available in their communities. To do this, lawyers must increase their level of sophistication regarding clinical matters and must be knowledgeable about resources available in the community.

Further Reading

Whether a lawyer or a judge, legal professionals working in child protection and juvenile justice must develop a working knowledge of the impact of child maltreatment and other forms of traumatic experience on the children with whom they work. A good place to start is the winter 2007 issue of *Focal Point*, which is published by the Regional Research Institute for Human Services at Portland State University and available free online.[78] This publication contains several short articles that provide a helpful introduction to the issue of traumatic stress in the child welfare context. These articles provide an overview of the impact of traumatic stress on children, ways in which we as advocates can work to make the child welfare system more sensitive to child traumatic stress, and information about evidence-based practices that have been shown to work for children and families.

Another helpful introductory source of information is Bruce Perry's recently published book *The Boy Who Was Raised As a Dog*.[79] In this book, Dr. Perry, one of the nation's leading researchers on the impact of traumatic stress on children, provides an introduction to the numerous ways that exposure to traumatic stress early in childhood can impact upon development. Using case vignettes from his practice, Perry illustrates how trauma can contribute to emotional and behavioral problems from depression and withdrawal to aggression and violence.

For a more detailed treatment of the importance of relationships in early childhood to neurodevelopment, Louis Cozolino's *The Neuroscience of Human Relationships* is invaluable.[80] Cozolino discusses in depth—and in understandable terms—the science of how human relationships, particularly those in the early years of life, shape the human brain and the human being that one becomes.

Conclusion

Over the past decade or so, we have learned a great deal about the impacts of traumatic stress on children. Whether in the form of prenatal exposure to alcohol, abuse, neglect, or witnessing violence at home or in the community, traumatic stress can cause changes in brain chemistry and the physical architecture of the child's developing brain. These changes in brain functioning, in turn, have impacts on children's intellectual and emotional development as well as their behavior. Some children may become passive and self-destructive while others may become aggressive and violent. Lawyers and judges handling child welfare cases should educate themselves about the causes and impacts of traumatic stress on children—and the adults that they become—and should begin to use this knowledge in both their day-to-day handling of child protection and juvenile justice cases and to institute systemic change in our child protection and juvenile justice systems. ◎

Endnotes

* The author wishes to thank Joshua Kay, Ph.D., J.D. (expected 2008) for his helpful comments on an earlier draft of this article.

1 See, e.g., Clifford R. Shaw, "The Jack-Roller: A Delinquent Boy's Own Story" (1930); "Juvenile Delinquency"; Vernon L. Qunsey, et al., "Juvenile Delinquency: Understanding The Origins of Individual Difference" (2004); Katharine D. Kelly & Mark Totten, "When Children Kill: A Social-Psychological Study of Youth Homicide 1-20" (2002); Jascha Hoffman, "Criminal Element: Was Getting Lead Out of Gasoline a Factor in the Drop in Crime?", *New York Times Magazine*, October 21, 2007 at 32 (describing several research studies that link juvenile delinquency and crime rates to levels of lead in the human body; exposure to high levels of lead has been shown to lower IQ and is linked with increased impulsiveness and aggression).

2 The August 2007 issue of the social journal *Child Maltreatment* is dedicated to articles exploring the connection between child maltreatment and subsequent delinquent behavior and contains a number of interesting articles.

3 See Robyn Igelman, Lisa Conradi & Barbara Ryan, "Creating a Trauma-Informed Child System," *24 Focal Point 23* (Winter 2007); Jim Henry, "System Intervention Trauma to Child Sexual Abuse Victims Following Disclosure," 12 J. *Interpersonal Violence 499* (1997).

4 See Steven J. Ondersma, et al., "Prenatal Drug Exposure and Social Policy: The Search for an Appropriate

Response," *5 Child Maltreatment 91*, 96 (2000) (internal citations omitted).

5 Id., citing Besinger, et al, "Caregiver Substance Abuse Among Maltreated Children Placed in Out-of-Home Care," *78 Child Welfare 221* (1999).

6 Diane K. Fast, Julianne Contry & Christine A. Loock, "Identifying Fetal Alcohol Syndrome Among Youth in the Criminal Justice System," *20 Developmental and Behavioral Pediatrics 370* (1999).

7 Id at 371.

8 Id. (2000) (noting that alcohol exposure in the prenatal period may have irreversible negative effects on children's development).

9 Id. at 95 (citing research findings that intrauterine cocaine exposure lowers IQ).

10 See Generally, Jim Henry, Mark Sloane & Connie Black-Pond, "Neurobiology and Neurodevelopmental Impact of Childhood Traumatic Stress and Prenatal Alcohol Exposure," *38 Language, Speech, and Hearing Services in Schools 99* (2007).

11 See generally, Timothy E. Moore & Melvyn Green, "Fetal Alcohol Spectrum Disorder (FASD): A Need for Closer Examination by the Criminal Justice System," *19 Criminal Reports 99, 100* (2004) (noting that "The CNS [central nervous system] dysfunctions associated with FASD manifest in various cognitive deficits including problems with memory, language and social skills") (hereinafter, "A Need for Closer Examination").

12 Diane V. Malbin, "Fetal Alcohol Spectrum Disorder (FASD) and the Role of Family Court Judges in Improving Outcomes for Children and Families," *55 Juvenile and Family Court Journal 53, 54* (Spring 2004).

13 See "A Need for Closer Examination," supra, note 11 at 100, citing; L.A. Jazen, J.L. Nanson & G.W. Block, "Neuropsychological Evaluation of Preschoolers with Fetal Alcohol Syndrome," *17 Neurotoxicology & Teratology 273* (2000).

14 See "A Need for Closer Examination," supra, note 11 at 100.

15 Id. (internal citation omitted).

16 Kathleen Coulborn Faller, "Interviewing Children About Sexual Abuse: Controversies and Best Practice 184" (2007) (citing research findings that one half of the children studied did not disclose sexual abuse in part because they were told by their abuser not to tell); Charles Felzen Johnson, "Sexual Abuse in Children," *27 Pediatrics in Review 17* (2006) (discussing the role of threats by the perpetrator of sexual abuse).

17 See Ann Tobey, Thomas Grisso & Robert G. Schwartz, "Youths' Trial Preparation as Seen by Youths and Their Attorneys: An Exploration of Competence-Based Issues," in *Youth on Trial: A Developmental Perspective on Juvenile Justice 225-242* (Thomas Grisso & Robert G. Schwartz, eds. 2000)(noting that communicating complex legal concepts to developmentally normal youth requires a good deal of time and effort).

18 MCL 712A.17d(1)(C).

19 See Frank E. Vandervort, "When Minors Face Major Consequences," *80 Mich. B. J. 36* (September 2001).

20 Research studies have found that many delinquent youth have sustained brain injuries as a result of accidents which impair their ability to control violent impulses. See, e.g., Dorothy Otnow Lewis, et al., "Ethics Questions Raised by the Neuropsychiatric, Neuropsychological, Educational, Developmental, and Family characteristics of 18 Juveniles Awaiting Execution in Texas," *32 J. Am. Acad. Psychiatry & Law 408, 414-417* (2004).

21 See generally, Pavlos Hatzitaskos et al., "The Documentation of Central Nervous System Insults in Violent Offenders," *45 Juvenile and Family Court Journal 29* (1994); Dorothy Otnow Lewis, Shelley S. Shanok & David A. Balla, "Perinatal Difficulties, Head and Face Trauma, and Child Abuse in the Medical Histories of Seriously Delinquent Children," *136 Am. J. Psychiatry 419* (1979); Dorothy Otnow Lewis & Shelley S. Shanok, "Medical Histories of Delinquent and Nondelinquent Children: An Epidemiological Study," *134 Am. J. Psychiatry 1020* (1977);

22 See, e.g., James Henry, "System Intervention Trauma to Child Sexual Abuse Victims Following Disclosure," *12 J. Interpersonal Violence 499* (1997).

23 There are many resources available to help prepare children to testify in court. For instance, the National Center for Missing and Exploited Children publishes *Just In Case: Guidelines in Case Your Child is Testifying in Court*; *B.J. Learns About Federal and Tribal Court* (video) is a production of the U.S. Attorney's Office in Arizona; *Me In Court* is a coloring book developed by Sex Offender Services in St. Paul, Minnesota. Your local victim witness assistance program may be of help in locating additional or jurisdiction specific materials.

24 MCR 3.972(C)(2).

25 See *People v Katt*, 468 Mich. 272 (2003).

26 MCL 712A.17b(13).

27 MCL 712A.17b(12) and (13); see *In re Hensley*, 220 Mich. App. 331 (1996).

28 MCR 3.923(E) and (F).

29 MCL 712A.12.

30 MCR 3.923(B).

31 Kathleen Coulborn Faller, Mary B. Ortega & Elaine Pomeranz, "Can Early Assessment Make a Difference in Child Protection? Results From a Pilot Study," *J. Public Child Welfare* (forthcoming).

32 See MCL 722.628d. Such a policy would ensure that in each case in which the agency has determined that

child abuse or neglect has taken place, the family is comprehensively evaluated.

33 240 Mich. App. 14 (2000) (holding that the Americans with Disabilities Act applies to child protection cases; the agency must provide services that meet the ADA's requirement for reasonable accommodations).

34 370 U.S. 49, 54 (1962).

35 Special Issue, "Child Maltreatment and Adolescent Violence: Understanding Complex Connections," *12 Child Maltreatment 203-298*; James Garbarino, *Lost Boys: Why Our Sons Turn Violent and How We Can Save Them* (1999).

36 See generally *Roper v Simmons*, 543 U.S. 551 (2005) (QUOTE).

37 Dorothy Otnow Lewis, et al., "Ethics Questions Raised by the Neuropsychiatric, Neuropsychological, Educational, Developmental, and Family Characteristics of 18 Juveniles Awaiting Execution in Texas," *32 J. Am. Acad. Psychiatry and the Law 408, 427* (2004); see generally *Roper v Simmons*, 543 U.S. 551 (2005) (holding unconstitutional the death penalty as applied to juveniles in part because the developmental differences between adults and minors render minors less culpable for their crimes).

38 See *In re SLL*, 246 Mich. App. 204 (2001) (holding that the totality of the circumstances test applies to the taking of a juvenile's confession).

39 As the Central Park jogger case aptly illustrates, even developmentally normal youth may confess under intense questioning to crimes they did not commit. In that case, several teenagers admitted, in videotaped confessions, that they had physically and sexually assaulted a woman who was jogging in the park. Years later, when DNA linked the assault to an adult, he confessed that he, and only he, had been responsible for the assault. See generally, Steven A. Drizin & Beth A. Colgan, *Tales From the Juvenile Confession Front: A Guide to How Standard Police Interrogation Tactics Can Produce Coerced and False Confessions From Juvenile Suspects, in Interrogations, Confessions, and Entrapment* (G. Daniel Lassiter ed., 2004).

40 See, e.g., *In re Rueckert* (Unpublished Michigan Court of Appeals case, n. 250829) (16-year-old defendant who suffered from fetal alcohol syndrome, had been neglected and abandoned by his parents, and was sexually abused admitted to having committed a CSC in the first degree involving penetration when the complaining witness stated that he had committed only a CSC involving no penetration; although medical exam indicated no physical evidence of penetration in circumstances where there likely would have been had penetration taken place, defendant charged as an adult with CSC first degree).

41 *In re Carey*, 241 Mich. App. 222 (2000).

42 Id. at 234 ("we . . . note that it is possible that a juvenile, merely because of youthfulness, would be unable to understand the proceedings with the same degree of comprehension an adult would.")

43 See, e.g., *In re Timothy J.*, 150 Cal. App. 4th 847; 58 Cal. Rptr. 3d 746 (2007) (holding that a juvenile who is allegedly delinquent need not suffer from a mental disorder or a developmental delay in order to be incompetent to stand trial) .

44 *People v Shipp*, 175 Mich. App. 332, 340 (1989).

45 MRE 611(C)(2).

46 Stephen J. Ceci & Maggie Bruck, *Jeopardy in the Courtroom: A Scientific Analysis of Children's Testimony* (1995).

47 See *Tales From the Juvenile Confession Front*, supra note 39.

48 Governor's Task Force on Children's Justice, Forensic Interviewing Protocol (Revised Ed. 2005); MCL 722.628(6).

49 James Carey, Charles Laughton, Marlene Dietrich and the Prior Inconsistent Statement, 36 Loyola of Chicago L. J. 433 (2005) (internal citation omitted).

50 See "When Children Kill," supra, note 1 at 12.

51 "Prenatal Drug Exposure and Social Policy," supra, note 4 at 97 (citation omitted).

52 Id. at 100.

53 P.L. 105-89 § 103(d); 42 U.S.C. § 675 note.

54 MCL 712A.19b(4).

55 Bruce D. Perry & Maia Szalavitz, *The Boy Who Was Raised as a Dog and Other Stories From A Child Psychiatrist's Notebook: What Traumatized Children Can Teach Us About Loss, Love, and Healing 117* (2006).

56 See Leyla Stambaugh, et al., "Evidence-Based Treatment for Children in Child Welfare," *21 Focal Point 12* (2007). The information in this section is adapted from this article.

57 Id.

58 Id. at 13.

59 Id.

60 In his book *The Boy Who Was Raised as a Dog*, Bruce Perry describes one such case in which a little girl's mother was murdered while she was present and the emotional impact upon the child.

61 MCL 722.628d(c), (d).

62 See *Evidence-Based Treatment for Children in Child Welfare*, et al., supra, note 56 at 13.

63 Office of Juvenile Justice and Delinquency Prevention, *Juvenile Justice Bulletin*, "Alternatives to Secure

Detention and Confinement of Juvenile Offenders 2" (September 2005).

64 See, e.g., Solomon Moore, "Troubles Mount Within Texas Youth Detention Agency," *New York Times*, Tuesday, October 16, 2007.

65 *Alternatives to Secure Detention*, supra, note 63 at 3.

66 See, e.g., Kenneth Wooten, "Weeping in the Playtime of Others: America's Incarcerated Children" (1976) (discussing the abuse and neglect of youth in various delinquency programs); "Lost Boys," supra, note 35 at 232-233 (discussing juvenile bootcamp programs); "Troubles Mount Within Texas Youth Detention Agency," supra, note 64.

67 Id.

68 Id. at 3 (internal citations omitted).

69 Office of Juvenile Justice and Delinquency Prevention, *Juvenile Justice Bulletin*, "Blueprints for Violence Prevention 10" (July 2001).

70 Office of Juvenile Justice and Delinquency Prevention, *Juvenile Justice Bulletin*, "Alternatives to the Secure Detention and Confinement of Juvenile Offenders 18-19" (September 2005).

71 "Blueprints for Violence Prevention," supra, note 69 at 10.

72 See "Alternatives to Secure Detention," supra, note 63 at 19.

73 See "Blueprints for Violence Prevention," supra, note 69 at 10.

74 Id.

75 Id.

76 Id. at 9.

77 Id. at 11.

78 Go to: www.rtc.pdx.edu/pgFocalPoint.shtml

79 Bruce D. Perry & Maia Szalavitz, The Boy Who Was Raised as a Dog: and Other Stories From a Child Psychiatrist's Notebook: What Traumatized Children Can Teach Us About Loss, Love, and Healing (2006).

80 Louis Cozolino, *The Neuroscience of Human Relationships: Attachment and the Developing Brain* (2006).

The Michigan Child Welfare Law Journal
Call for Papers

The editorial board of *The Michigan Child Welfare Journal* invites manuscripts for an issue regarding current issues/developments in child welfare practice. *The Journal* takes an interdisciplinary approach to child welfare, as broadly defined to encompass those areas of law that directly affect the interests of children. The editorial board's goal is to ensure that the Journal is of interest and value to all professionals working in the field of child welfare, including social workers, attorneys, psychologists, and medical professionals. The Journal's content focuses on practice issues and the editorial board especially encourages contributions from active practitioners in the field of child welfare. All submissions must include a discussion of practice implications for legal practitioners.

The main text of the manuscripts must not exceed 20 double-spaced pages (approximately 5000 words). The deadline for submission is July 15, 2008. Manuscripts should be submitted electronically to to *kozakiew@msu.edu*. Inquiries should be directed to:

Joseph Kozakiewicz, Editor
The Michigan Child Welfare Law Journal
School of Social Work
238 Baker Hall
Michigan State University
East Lansing, MI 48823
(517) 432-8406

Upcoming Training and Conferences

SCAO Family Services Child Welfare Services Training Schedule 2007-2009—as of 10/10/07

2008 TRAININGS				
Training Date	**Title** (Bold font indicates that Child Welfare Services [CWS] is the administrator of the training)	**Location**	**Sponsor/contact**	**Eligible Participants**
Thursday Luncheon Webcast Series:				
January 24	**Children Missing From Care: AWOLP Update**	Webcast only, no on-site audience Registration: MJI webcast website at: *http://webcast.you-niversity.com/youtools/companies/default.asp?affiliateId=43*	Sponsor: SCAO Family Services Division—CWS professionals For questions contact: Joy Thelen 517-373-5322 Identified cosponsors: DHS	Judges; referees and other court staff; attorneys; children's protective services, DHS, and private agency foster care and adoptions workers; tribes; CASAs; legislators and policy-makers; and related child welfare
February 21	**CFSR Issues for Courts**			
March 27	**Youth Self-Injurious Behaviors**			
April 24	**Reducing Trauma to Children During Removal and Placement**			
May 29	**Working with Lesbian, Gay, Bisexual, Transgender, Questioning Youth**			
June 19	**Title IV-E update**			
TBA	Effective Petition Drafting	TBA	Sponsor: DHS- Office of Training & Staff Development - Child Welfare Institute Contact: Dawn Brown 517-335-6216 *Identified co-sponsors: SCAO Family Services Division—CWS; University of Michigan Child Advocacy Law Clinic*	DHS and tribal children's protective services workers; DHS, private agency, and tribal foster care and adoptions workers

Training Date	Title (Bold font indicates that Child Welfare Services [CWS] is the administrator of the training)	Location	Sponsor/contact	Eligible Participants
February 12-13	Michigan Association of Drug Court Professionals: 8th Annual Conference Continuing to Change the Face of Michigan Justice	Lansing Center Lansing	Sponsor: Michigan Association of Drug Court Professionals; SCAO; Michigan Judicial Institute Contact: Cathy Weitzel, MJI 517-373-7510 *Identified co-sponsors: SCAO- Family Services Division—CWS*	
Yellow Book Regional Trainings:				
Guidelines for Achieving Permanency in Child Protective Proceedings: Regional Trainings on the "Yellow Book"			Sponsor: SCAO Family Services—CWS Contact: Rose Homa, Michigan Federation for Children and Families 517-485-8552 *Identified co-sponsors: Michigan Federation for Children and Families, Children's Charter of the Courts, MSU School of Social Work, and Chance at Childhood Program*	DHS and private agency workers
Date	*Location*			
March 13	Bethany Christian Services-Grand Rapids			
April 17	Lansing—Hall of Justice			
May 2	University Center-Gaylord			
May 27	Schoolcraft VisTaTech Center—Livonia			
April 9-10	**Addressing Domestic Violence Issues in Child Welfare Conference**	**Kellogg Center East Lansing**	**Sponsor: SCAO Family Services Division—CWS Contact: Deborah Jensen, Children's Charter of the Courts 517-482-7533** *Identified co-sponsors: DHS, GTF, OCO, Children's Charter of the Courts; Prosecuting Attorneys Association of Michigan*	**Judges and referees; attorneys; children's protective services, DHS, and private agency foster care and adoptions workers; tribes; CASAs; legislators and policy makers; DV treatment providers; and related child welfare professionals**

Training Date	Title (Bold font indicates that Child Welfare Services [CWS] is the administrator of the training)	Location	Sponsor/contact	Eligible Participants
May 14	**Protective Proceedings**	Lansing	Division—CWS Contact: Joy Thelen517-373-5322Identified co-sponsors: University of Michigan (U of M) Child Advocacy Law Clinic	
Summer Series on Enhancing Parental Involvement in Child Protective Proceedings:				
June 3	**Legal Issues Regarding Fathers' Involvement**	**Holiday Inn-South Lansing**	**Sponsor: SCAO Family Services Division—CWS Contact: Joy Thelen 517-373-5322** *Identified co-sponsors: DHS, GTF*	Judges; referees and other court staff; attorneys; children's protective services, DHS, and private agency foster care and adoptions workers; tribes; CASAs; legislators and policy makers; and related child welfare professionals
July 15	**Dealing with Absent Parents: Implementing the Absent Parent Protocol and What to do About Incarcerated Parents**			
August 12	**Engaging Fathers: Resources and Programs for Full Engagement**			
Sept. 10	**Post-Termination Proceedings: Post-Termination Reviews and Adoption Proceedings (Specialized Legal Training)**	**Hall of Justice Lansing**	**Sponsor: SCAO Family Services—CWS Contact: Joy Thelen 517-373-5322** *Identified co-sponsors: DHS, GTF,OCO*	Judges, referees, and other court staff; attorneys
October TBA	Indian Child Welfare Act (ICWA) Training	TBA	Sponsor: SCAO Family Services Division—CWS Contact: Jennifer Doer at Prosecuting Attorneys Association of Michigan (PAAM) 517-334-6060 *Identified cosponsors: Tribal/State Partnership; Prosecuting Attorneys Association of Michigan*	TBA

Training Date	**Title** (Bold font indicates that Child Welfare Services [CWS] is the administrator of the training)	**Location**	**Sponsor/contact**	**Eligible Participants**
Oct. 20-21	U of M Medical School Child Abuse and Neglect Conference	TBA	Sponsor: University of Michigan Medical School Contact: Registrar 800-800-0666 or 734-763-1400 *Identified co-sponsors: SCAO Family Services Division—CWS*	Doctors and other medical personnel; law enforcement; judges; attorneys; children's protective services, DHS, tribal, and private agency foster care and adoptions workers; CASAs; and related child welfare professionals
Nov. 6 & 7	Foster Care Review Board Annual Training	Four Points by Sheraton Ann Arbor	Sponsor: SCAO Family Services—FCRB Contact: Kathy Falconello 313-972-3288	TBA
Handling the Child Welfare Case: "Applying the Law to Practice"				
TBA 2008	2 trainings annually for L-GALs and parents' attorneys	TBA	Sponsor: SCAO Family Services—CWS Contact: Deborah Jensen, Children's Charter of the Courts 517-482-7533 *Identified co-sponsors: DHS, GTF, Children's Charter of the Courts of Michigan*	Judges, referees and attorneys
TBA 2008	1 training annually for prosecutors and assistant attorneys general			
		TBA	Sponsor: SCAO- Family Services- CWS Contact: Jennifer Doer at Prosecuting Attorneys Association of Michigan (PAAM) 517-334-6060 *Identified co-sponsors: DHS, GTF, PAAM*	Prosecutors and assistant attorneys general

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