Summer 2013

MENTAL HEALTH CONNECTIONS

A Newsletter for CAC Staff who do not have a mental health background!

TF-CBT IN A NUTSHELL

By one of the developers...

Cym Doggett, Project Director
Southern Regional Children's Advocacy Center

While thinking about what to include in this newsletter, I ran across this snippet of an interview with Judith Cohen, PhD. on the National Child Traumatic Stress Network web site. Dr. Cohen is a co-developer of Trauma Focused Cognitive Behavioral Therapy and this piece gives an elegant overview of TF-CBT.

Q: What are the elements of effective therapy?
A: Trauma-Focused Cognitive Behavioral Therapy is a structured treatment that takes place over as short a period as twelve weeks. A child and (whenever possible) the child's parent or supportive caregiver participate. The treatment begins with ***education.*** The therapist shares information with the child and caregiver about common reactions and symptoms that may result from sexual abuse. This helps children understand that their reactions and feelings are normal and that treatment can help them. It helps non-abusing parents to accept that the abuse wasn't their fault or the child's fault. It's common for parents to react to their child's abuse by becoming either too permissive or too protective. The therapist helps them maintain normal routines, household rules, and expectations. If the perpetrator has been one of the parents, the whole structure of the family may have changed, and the remaining parent needs support to be consistent and keep family life as secure as possible.

Another step in the treatment, called ***affect regulation and relaxation***, helps the child to identify his or her negative feelings such as anxiety, jumpiness, and sadness that can occur after a trauma. The therapist gives the child techniques to modulate these feelings and to soothe him or herself. This is important so that the child does not begin to withdraw from life to avoid having these feelings. Another part of the treatment helps children to analyze the connections between their thoughts, feelings, and behaviors. Children who've been sexually abused often feel bad about themselves.

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TRANSITIONING AND SUSTAINING THERAPISTS AT CHILD ADVOCACY CENTERS

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NATIONAL CHILDREN'S ADVOCACY CENTER

The Executive Director (ED) of a Child Advocacy Center (CAC) is responsible for leading a staff of professionals from diverse backgrounds to accomplish the mission of the CAC. While expected to understand the perspective of each discipline represented on the staff, the ED very likely has a college degree(s) and experience in a completely different field. This scenario is made even more complicated when therapists come from a "generalist" background (differentiated from a "specialist" training) or when therapists are contracted with the CAC but employed elsewhere. Further, if the CAC is accredited by the National Children's Alliance (NCA), compliance with mental health standards will bring unique demands which do not necessarily coincide with the practices or expectations of the newly hired or contracted therapist. Compared to typical community-based mental health service providers, CAC therapists have a significantly more narrow and specialized scope of practice. Therapists who are new to the CAC world may not be accustomed to working only with childhood trauma, polyvictimization or child sexual abuse. Moreover, the implementation of an evidence-based treatment model could be foreign to their professional experience. How then does the ED, who may know very little about therapy services, ensure the provision of quality s***pecialized services*** which require ***specialized training*** and ***specialized supervision***? This article provides a suggested framework to help ensure that therapists make an effective transition to the CAC world and find ongoing sustenance for their work.

Compared to typical community-based mental health service providers, CAC therapists have a significantly more narrow and specialized scope of practice.

The first step is finding the right therapist. Not every therapist is suited to serving an exclusive client population. A ***deliberate hiring process*** is required, one that is both proactive in communication of agency priorities and preferences and also careful in determining the candidate's commitment to these priorities and preferences. At the National Children's Advocacy Center (NCAC), discussion about "specialized practice" begins at the start of the hiring process. The job posting is written with specific mention of specialized practice in the field of child maltreatment, and the initial phone interview includes conversation about the population served as well as the treatment approach utilized. Next, NCAC staff candidates are provided an online link to access more in-depth information about the treatment model prior to a face to face interview. That face-to-face interview then provides an opportunity to explore the candidate's commitment to the structured, directive and short-term approach to therapy which is employed at the NCAC.

Clinicians who are well-seasoned in other therapeutic approaches, however, may be less interested in changing certain counseling techniques that work well for them. Interview questions therefore must be deliberately crafted to determine the candidate's theoretical framework and openness to change. These early conversations with the therapist candidate help to assess a readiness for a narrower scope of practice. The consequence of overlooking these early steps in the process is an increased potential for hiring a therapist who has great difficulty with, or resistance to the agency's chosen therapy model. It can be very easy for experienced clinicians to "default" to old habits and practices rather than implement the agency's preferred approach with fidelity.

After hiring come several crucial steps:

- Prepare the therapist for the level of specialization needed to do the job,
- Ensure the therapist has the support needed to maintain specialized knowledge and skills,
- Maintain quality of service past the initial orientation.

The following ***four essential provisions for a CAC therapist*** will help accomplish these tasks.

1. **Specialized child abuse orientation** is often provided "on the job" and not necessarily in a systematic way. Con-

tracted therapists have a more difficult time receiving all that is needed because their time in the CAC is limited at best, or even non-existent depending upon where the service is provided. The initial orientation is an important part of a new therapist's integration with the CAC model. Consider the following two ways to systematically "orient" new therapists:

- Develop an orientation binder or electronic folder containing such information as an orientation checklist specific to your CAC, policies and procedures, the MDT Interagency Agreement, NCA Standards for CACs, key research articles about each disciplinary practice, and links to websites in the child abuse field (NCTSN, for example). This ensures consistency of information shared while providing a structure for covering all essential topics.
- Arrange individual meetings between the therapist and a representative from each MDT professional discipline. These meetings could include shadowing some of the investigative tasks. For the contracted therapist who spends the majority of time away from the CAC campus, such meetings will help with the development of mutually trusting relationships with MDT members.

An ED can lay the proper foundation for high quality specialized mental health services by a genuine commitment to a deliberate hiring process and implementation of the four essential provisions for a CAC therapist.

2. **Training in a trauma-focused, evidence-based treatment model** can happen only after your CAC choses a model. Like many other CACs across the nation, NCAC chose Trauma-Focused Cognitive Behavior Therapy because it is a highly researched model of treatment shown to be effective in reducing PTSD symptoms of traumatized youth. The free online training (http://tfcbt.musc.edu) provides a great start for someone new to the model. Keep in mind that the online training is truly just a beginning and must be supplemented with ongoing training and clinical supervision.
3. **Continuing education in the field of child abuse and also the specified treatment model** is necessary to maintain therapists' specialized knowledge and skills in child abuse intervention as well as clinical licensure. Be aware that, unlike the contracted therapist's employer, the ED has a vested interest in the specialization of that therapist and must take the lead in providing necessary training for CAC work. The degree to which the ED values this way of supporting therapists will be demonstrated by the inclusion of a budget line item for the provision of ongoing specialized training of staff.

The ED has a vested interest in the specialization of therapists and must take the lead in providing necessary training for CAC work.

4. **Clinical supervision related to the specialized treatment model** for the contracted therapist will also likely be the responsibility of the CAC. This is by virtue of the fact that the CAC has strong interest in supporting the specialized practice of working with traumatized children. If a particular CAC is small with only one or two therapists, none of whom is experienced in the chosen model of treatment, seeking supervision outside the agency is recommended. There are several possible ways to achieve this:
   - Some treatment models offer monthly supervision calls by an expert trainer, for a fee. Perhaps your therapist(s) could join with others at nearby CACs for peer supervision.
   - If distance and travel costs pose a barrier, peer group supervision can be accomplished effectively through Skype, conference calls, or other means of audio and video conferencing. Using Skype for three or more participants requires coordination but is free and easy to use.
   - An important ingredient to effective collaborative clinical supervision is having at least one "model-specific" experienced therapist who has additional training in the treatment model beyond an online course, preferably an expert trainer.

Transitioning and sustaining therapists at Child Advocacy Centers can be challenging. To quote Forrest Gump, "Life is like a box of chocolates. You never know what you'll get." There are no guarantees when it comes to hiring therapists. However, an ED can lay the proper foundation for high quality specialized mental health services through a genuine commitment to a ***deliberate hiring process*** and implementation of the ***four essential provisions for a CAC therapist.***

National Children's Advocacy Center

JUSTICE FOR VICTIMS
JUSTICE FOR ALL

Office for Victims of Crime
OVC

Poly-victimization: Childhood Exposure to Multiple Forms of Victimization

Summary of Key Points

Far too many children are exposed to abuse, violence, and crime. A new emphasis on what is being called "poly-victimization" can help professionals identify the most endangered children and youth, provide the most appropriate interventions, and protect them from additional harm.

Poly-victimization refers to the experience of multiple victimizations of *different kinds*, such as sexual abuse, physical abuse, bullying, witnessing family violence, and exposure to community violence (versus experiencing a single form of victimization).

Evidence indicates that:

- Many children routinely identified as victims of child abuse or bullying or other single forms of violence are in fact poly-victims who have experienced many different types of victimization.
- Half of sexually victimized youth are also poly-victims.
- Poly-victimization is more highly related to trauma symptoms than experiencing repeated victimizations of a single type
- Poly-victimization explains most of the psychological consequences of victimization. Surprisingly, this is true even in comparison to commonly considered more severe forms of violence such as sexual and physical abuse.

Why the powerful effect of poly-victimization? Poly-victimization:

- Represents a life condition of victimization rather than a set of events.
- Creates threats to safety, stability, and nurturance in multiple life domains (home, school, community).
- Damages resources (e.g. social support, coping, self-esteem, social competence) that would normally help buffer the impact of victimization.

Implications for practitioners:

- All providers, no matter their focus, should inquire about victimization experiences in all the major settings of a child's life: home, school, and neighborhood.
- Practitioners can use poly-victimization assessments to better understand and promote treatment effectiveness. To learn how to assess poly-victimization see the NCAC White Paper titled "Poly-victimization: Childhood Exposure to Multiple Forms of Victimization".
- Interventions that focus on only one form of victimization, such as sexual abuse, without attention to other types of violence exposure, may fail to identify the contexts placing children at greatest risk.
- Poly-victimization points to the importance of moving towards a more holistic and child-centered approach to evaluating and responding to victimized youth which is completely consistent with the Children's Advocacy Center model's core philosophy.

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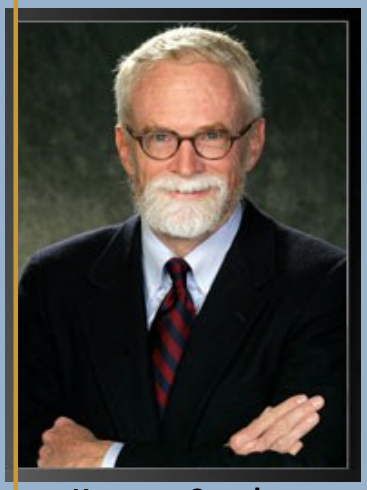
the 30th
IT'S ALL ABOUT THE CHILDREN
NATIONAL SYMPOSIUM ON CHILD ABUSE
The Profession You Chose. The Work You Do. The Training We Offer.
Huntsville • Alabama
National Children's Advocacy Center
march 24-27
2014

Mark Your Calendar!
March 24-27, 2014
30th National Symposium
on Child Abuse



Keynote Speaker
John E.B. Myers, JD
Professor of Law
University of the Pacific
McGeorge School of Law
Sacramento, CA

Poly-victimization

What is it? What does it mean for CACs?

Karen Hangartner, Outreach Coordinator
Southern Regional Children's Advocacy

Poly-victims are significantly more distressed than children who are victims of one type of chronic victimization.

Working in the CAC world provides a glimpse of the many different types of violence to which children are exposed. Seldom are we working with a child who has experienced a singular type of abuse or maltreatment. The National Survey of Children's Exposure to Violence (NatSCEV) was the first national study to comprehensively examine children's exposure to violence across ages, settings and timeframes. Developed by the Office of Juvenile Justice and Delinquency Prevention (OJJDP) and conducted by the University of New Hampshire's Crimes Against Children Research Center, researchers measured the past-year and lifetime exposure to violence for 4,549 children age 17 and younger through phone interviews. The major categories included: conventional crime, child maltreatment, victimization by peers and siblings, sexual victimization, witnessing and indirect victimization (including exposure to community violence), school violence and threats and internet victimization.

This research reveals what many professionals working in the CACs across the country already know; our kids see a lot of bad stuff in their lives. Here are some of the findings as published in the October, 2011 OJJDP Juvenile Justice Bulletin **(*retrieved from: https://www.ncjrs.gov/pdffiles1/ojjdp/235504.pdf*):**

- **38.7%** of this nationally represented sample of the US population reported more than one type of direct victimization (victimization directed toward the child, as opposed to an incident that the child witnessed, heard or was otherwise exposed to) in the past year.
- Of those who reported any direct victimization, **64.5%** reported more than one type of direct victimization.
- **10.9%** reported 5 or more direct exposure to different types of violence.
- **1.4%** reported 10 or more direct victimizations.
- Children exposed to even one type of violence were at far greater risk of experiencing other types of violence.
- **8%** of all youth in the NatSCEV sample reported 7 or more different kinds of victimizations or exposure to violence, crime, and abuse in the past year, qualifying them as poly-victims.

Victimization is a condition for these kids rather than a series of events.

What do poly-victimized kids look like?

50 % of child sexual abuse victims are poly-victims

- Somewhat more likely to be boys (54%) than girls (46%).
- Tend to be older with 10% of youth in the 14-17 age range.
- Higher rates among kids of middle socio-economic status.
- No difference in rates among urban and rural populations.
- Higher rates among African American children and lower rates among Hispanic children.
- Higher rates among children from single-parent and stepparent families.
- Have more severe victimizations.
- More likely to have other lifetime adversities such as illnesses, accidents, family unemployment, parental substance abuse, and mental illness.
- These children are significantly more distressed than the children who are victims of one type of chronic victimization but did not have additional different kinds of victimization.
- Victimization is a condition for these kids rather than a set of events.
- These kids are not safe anywhere – at home, school, or in their community.
- The resources that help buffer the impact of victimization (social support, coping, self concept) are damaged.

What does this information mean for the CACs?

What does this information mean for the CAC world?

1. We must look beyond the presenting allegation and get a more comprehensive understanding of the different types of violence to which our clients might have been exposed. In a webinar presented by the National Children's Advocacy Center, researchers Dr. Heather Turner and Dr. Sherry Hamby stated that **50%** of child sexual abuse victims are poly-victims.
2. We must help our multidisciplinary partners understand the unique reactions and needs of these children and accurately assess client safety at home, school and in their communities.
3. We must ensure that our Mental Health providers complete a comprehensive trauma history and use appropriate assessments to gain an accurate understanding of the level of distress of our clients.
4. We must require our mental health providers to use evidence based interventions in order to provide these youth with the best possible care.

For more information about poly-victimization including an Annotated Bibliography, a free Webinar by the researchers and community resources visit the

Child Abuse Library Online (CALiO).

http://www.nationalcac.org/calio-library/polyvictimization.html

TF-CBT In a Nutshell. . .

Cym Doggett, Project Director
Southern Regional Children's Advocacy Center

Continued from page 1

They may blame themselves or believe that nothing good will ever happen to them again. We begin by helping children examine their thoughts about everyday events. We then move into exploring their thoughts, beliefs, and feelings about the abuse.

Another part of the therapy is overcoming ***learned fears***. This means unlearning the connection a child has made between the abuse, her negative feelings about it, and ***trauma reminders***, other things and events she's associated with the experience. Desensitization may be necessary when a child continues to have intense reactions to particular things, places, people, or situations that remind him or her of the trauma. To avoid reactions to these trauma reminders, a child may limit his or her experiences. For example, a child may avoid going into the basement of the house where the abuse occurred because she associates the basement with negative feelings about the abuse. Reactions to trauma reminders may also generalize. A child may begin by being afraid to go into the particular basement where the abuse took place, and gradually become afraid of going into any basement, and then into any room that is downstairs or that in any way resembles a basement. In the case of a child afraid to go into any basement, our treatment would help the child overcome the fear of basements by having the child gradually imagine being in a basement without feeling upset. In some cases, the therapist might actually go into the basement with the child to be sure she can tolerate the experience.

The clinician helps the child to tell a coherent account of what happened, how it felt, and what it meant. By putting her memories in order, the child no longer feels haunted by them.

One of the most significant parts of the treatment is the ***trauma narrative***. The clinician helps the child to tell a coherent account of what happened, how it felt, and what it meant. By putting her memories in order, the child no longer feels haunted by them. The therapist helps identify and correct the child's distorted ideas and beliefs about the abuse. For example, an adolescent was in treatment for abuse that had occurred when she was five years old and the perpetrator was fifteen. She was still blaming herself for "letting," the abuse occur. By creating the trauma narrative she realized she had been blaming herself for something she hadn't had the power to prevent. By telling the story to her therapist, she corrected her own false understanding. The mother had also felt confused about who was to blame. By sharing this story with her mother in a joint therapy session, the daughter helped her mother to understand what had really happened. The therapy healed not only the young woman but the mother-daughter relationship as well.

For more information about TF-CBT, see the complete interview with Dr. Cohen.

Retrieved from:
Questions and Answers about Child Sexual Abuse Treatment
National Child Traumatic Stress Network
http://www.nctsn.org/nctsn_assets/pdfs/Q&AChildSexualAbuseTreatmentJC103007.pdf

Southern Regional Children's Advocacy Center
2013 TRAINING DATES

Medical Training Academy
November 14—16

This training is specifically designed for medical professionals who have the responsibility for providing the medical evaluation for children who are suspected victims of child abuse. Topics to be covered include: role of the medical provider; evaluation and diagnostic approach of child physical and sexual abuse; documentation and interpretation of findings; diagnostic dilemmas; testifying as the medical expert; Participants are required to submit case presentation(s). ***Fee: $199***

Visit www.srcac.org for more information.
And watch for our 2014 Training Dates to be released soon!

National Children's Advocacy Center
2013 TRAINING DATES

Extended Forensic Interview Training - This training introduces a model for a multi-session forensic interview of a child who is potentially a victim or witness of child abuse or other violent behaviors.
September 17-19, 2013 St. Louis, MO

Forensic Interviewing of Children Training - This comprehensive training teaches the nationally recognized NCAC Child Forensic Interview Structure, which is designed to gather the greatest amount of reliable information in a child-sensitive, developmentally-appropriate and legally-defensible manner. The NCAC Forensic Interviewing of Children Training immerses the participant in the most current research and evidence-based information in the field.
September 23-17
December 9-13

Advanced Victim Advocacy Training - The Advanced Victim Advocacy Training will be an opportunity for participants to gain a better understanding of the roles and relationships of the Victim Advocate and the Multidisciplinary Team, and improve communication and collaboration that ultimately benefits the child victims and their caregivers.
October 9-10

Advanced Forensic Interviewing Training - The 2013 training will focus on challenging interviews. Challenges may arise from child factors (young age, developmental issues, cultural issues, impact of neglect or trauma on the child's abilities, and motivation to participate in the interview.) Additionally or alternatively, challenges may arise from case complications (trafficking, sexualized behaviors without verbal statements, multiple forms of victimization, or long-standing and violent abuse). Thorough case planning and investigation, as well as accommodations to the standard interview process are necessary. Attendees will be encouraged to bring recordings of challenging interviews or complicated case histories to share throughout the training.
November 5-7

Visit http://www.nationalcac.org/ncac-training/ntc.html for more information.

WHO WE ARE....

The U.S. Department of Justice established four Regional Children's Advocacy Centers in 1995 to provide information, consultation, training and technical assistance, helping to establish child-focused programs that facilitate and support coordination among agencies responding to child abuse.

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OJJDP

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WHO WE SERVE. . .

SRCAC proudly serves:

Alabama, Arkansas, Delaware, District of Columbia, Florida, Georgia, Kentucky, Louisiana, Maryland, Mississippi, North Carolina, Oklahoma, South Carolina, Tennessee, Texas, Virginia, and West Virginia.