CLAIMING CHILDREN

FEDERATION OF FAMILIES FOR CHILDREN'S MENTAL HEALTH • SPECIAL ISSUE • FALL 2003

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Trauma

Layer Upon Layer

Shannon CrossBear

Shannon is a family member from the Lake Superior Ojibwe Nation. She is a daughter, mother, grandmother, sister and aunt. A long time advocate, storyteller, and strong spiritual woman, she focuses her work through writing, training family members, serving as a peer mentor, and working as an interagency liaison. Shannon's middle son Brian died of suicide.

The specific traumatic and tragic events that have happened to my family over the past years occurred against a backdrop of historic, multi-generational trauma. One cannot escape the lineage of loss that accompanies being a Native American. Historical trauma is not an abstraction; it is trauma handed down from one generation to the next; it is trauma rippling through a people.

There are early deaths, widespread poverty and deprivation, alcoholism, suicides, a high incidence of physical and sexual abuse; crises all the time, all around you. As children, our ancestors were forcibly removed from their homes, taken to boarding schools run by the Military where their hair was cut, their Native clothing torn from them. They were abused if they attempted to speak their own language, if they tried to practice their own rituals. Now we have generations of parents who were never parented. It's impossible to separate the historical trauma that happened to our people as a whole, from the family trauma that marks each family's history.

Five years ago, my son, Brian, nineteen, was living in Omaha, Nebraska with his older brother. He had just gotten out of school and was in between jobs, struggling to

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LAYER UPON LAYER

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"Layer upon layer is how trauma arrives.

Layer upon layer is how we learn to heal."

make a life for himself. We were in constant contact, talking to each other at least two or three times a week. Then over the course of about two weeks — it happened so rapidly — he started to change. He became obsessed with strange ideations; he couldn't sleep or eat. He started to have auditory hallucinations. He was having suicidal ideations. His family encouraged and supported his decision to seek help. We were confident that with help we could find the answers to his imbalance. Accessing services was a challenge since insurance was an issue. Brian went to a Crisis Center. They sent him to an adult psychiatric mental health unit in a hospital.

I was so relieved. I was so proud of him for having the courage to self-admit; I had always taught him that mental health problems were no different than physical health problems.

He went into the unit on a Thursday. He kept telling the doctors and nurses that he was suicidal and they placed him on suicide watch. I've learned since that the standards for suicide watch vary from institution to institution. They were checking on him every fifteen minutes but that wasn't enough. He completed his suicide while on "suicide watch."

His dad and his younger brother arrived at the hospital for visiting hours, just after Brian completed his suicide. The hospital didn't offer us help in processing the trauma; they offered no services to the family; they didn't even say we're really sorry this happened. Nothing. Nothing. That's what we were left with as a family to deal with.

His family and community were devastated. We turned to our community, we used our traditions and sought to release his spirit in a good way. His family and friends chose to both grieve the loss and honor Brian's brief life in this way.

Our family is grieving, each in our individual ways and collectively. We are learning to travel in this lifetime without Brian's physical presence. That continued journey is not without challenges. Recently we were confronted with another consequence of trauma.

My youngest son was living in another state, experiencing his independence and pursuing his dreams. All of that became interrupted when he was abducted and assaulted. As a strong young male, the police did not recognize the trauma and fear. No victim services were offered. He began taking methamphetamines to stay awake to protect himself. After a couple of weeks his behavior and communication changed. He spoke in a way that triggered our own experiences with his brother. Friends and family member recognized that something was wrong. I was scared for him. How much of it was the drug and how much of it was something else? Trauma revisited; terror in every heartbeat. We had to get him into the hospital, and yet, how could we trust a system that had already failed us so horribly? He was on the brink of his nineteenth birthday, the same age that Brian had been when he died. "How can you put me in the hospital?" he asked. "Don't you know what happened to my brother?" He was angry, frightened, confused.

This time, I had others willing to join me in the battle to reclaim my son. I called upon the resources from the Federation of Families, other family members and the network knowledge. I called

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Layer Upon Layer

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for the practical and the prayerful. This time, we never left the hospital. In the nine days he was there, he had seven different doctors. The doctor who admitted him went on vacation; the other doctors were on-call. We tried to tell the doctors the history — that his brother had suffered from an undetermined psychosis, that he had killed himself in the hospital, that it was within a month of the anniversary of his brother's death — but they didn't seem prepared to deal with it. We made them listen. Slowly, as the drugs left his system, the psychosis cleared. We brought my son home and began the process of healing.

How does one heal from trauma? I don't know a singular, definitive answer. I do everything I can to contribute to my own healing and the healing of others. Sometimes that takes concrete form such as working to prevent others going through what I have gone through by systems change. Accessing services should not require such a monumental effort. Cultural competency should not require petitions and pleas but should be integrated and readily available.

Sometimes my healing takes the form of sitting on a mountain in my homeland and allowing the spirit of the lake to take my heartache, the spirit of the rain to wash away my pain, the spirit of the shore to teach me more about the ebb and flow. Healing is a continuous process. I have learned that my people may never be free of crises but that we can learn to move within life in such a way as to honor our own experience, to carry what we need forward and leave behind what we need to leave behind.

Layer upon layer is how trauma arrives. Layer upon layer is how we learn to heal. ◆

Breathe In

Shannon CrossBear

Breathe in.
Breathe out.
Make it to the next moment.

My son Brian would have been twenty in September.
He and his girlfriend Melanie were coming home for his birthday.
Brian wanted to climb the mountain, to look down upon the lands and waters he called home.
Brian was like that.
In one of his poems he wrote,
"Someday, I am going to know what it means to be a human being, someday I won't hate wearing shoes."

In August, Brian couldn't make it to the next moment
and my son took his life.
People are afraid to look into my eyes for fear of witnessing the loss.
I feel that loss in the depths of my womb.
I feel that loss in my fingers, in the way his fingers would intertwine with mine when we held hands.
I feel that loss with every beat of my heart.

So, I wrapped my sons' ashes in the elk skin bundle
and I carried him up the mountain.
The thing is, that bundle, felt the same as when he was a newborn.
On top of the mountain I released my son to a new journey, one without shoes.

They say to lose a child is the hardest thing. I could not have imagined.
And so, I breathe in
and I breathe out,
and in some moments I can feel him in the wind ,
hear him in the trees
and in those moments,
if you look into my eyes,
you will see the love of Brian
reflected within me.

A Message from our President Barbara Sample

Barbara Sample

Barbara Sample is President of the national Federation of Families for Children's Mental Health and mother of four children. Living in Montana, she is also the founder and director of the Montana Family Support Network, the Montana State Organization of the Federation of Families for Children's Mental Health. She has a Master's Degree in special education.

Trauma. A single word should not have so much power standing alone, yet it does. For everyone trauma is a powerful word used in a variety of circumstances, none good. For parents of children with an emotional illness, trauma has an equally powerful presence in our everyday world. But imagine for a moment the exponential power of trauma when in addition to a mental illness, your child has the trauma of sexual abuse, or domestic violence. The explosion of the trauma can unravel the family, destroy the only safe haven the child knows, and break the hearts of parents just like you and me.

The Federation of Families for Children's Mental Health presents this issue to our members and friends to begin to open the door of discussion about the effects of trauma on our children and to engage parents and professionals in a common discussion. Too often the response to trauma is blame and help is bogged down while people blame each other. The child is momentarily pushed aside (though everyone would deny this), while guilt and responsibility is determined.

We write today to ask for change. Let us, parents of children who have experienced the challenges of mental illness and trauma, begin the dialogue with the professional community with a spirit of commitment to address the needs of our children first. Let us address the need to research the best services and response to these children. Let us combine our energy to make a difference.

Isn't that the way of the parent anyway, making a difference one child at a time?

From the Editor of this Special Issue

Trauma. Life, for many of us, seems full of trauma. How does it impact our children and our families in the long run? How can we protect our children from its effects? The Federation of Families for Children's Mental Health is pleased to bring you this special issue of *Claiming Children* focused on trauma. There are many voices and many perspectives represented in the articles collected for this issue. They include different definitions of trauma and a variety of recommendations for taking care of your child and family. You will find clinical viewpoints, family experiences, and practical information. Above all, we hope you find this helpful.

This special issue of *Claiming Children* has been developed in collaboration and with funding from the National Child Traumatic Stress Network (NCTSN.) NCTSN works to improve services for children impacted by trauma, their families and communities. The network includes more than 50 university and community based treatment centers nationwide. It is funded by the federal Center for Mental Health Services, Substance Abuse and Mental Health Services Administration.

Shannon CrossBear
Family member
Lake Superior Ojibwe Nation

What Is Child Traumatic Stress?

Robert P. Franks

What is child traumatic stress, how does it develop, and what are the symptoms? To answer these questions, we first have to understand what trauma is.

From a psychological perspective, trauma occurs when a child experiences an intense event that threatens or causes harm to his or her emotional and physical well-being.

Trauma can be the result of exposure to a natural disaster such as a hurricane or flood or to events such as war and terrorism. Witnessing or being the victim of violence, serious injury, or physical or sexual abuse can be traumatic. Accidents or medical procedures can result in trauma, too. Sadly, about one of every four children will experience a traumatic event before the age of sixteen.

When children have a traumatic experience, they react in both physiological and psychological ways. Their heart rate may increase, and they may begin to sweat, to feel agitated and hyper alert, to feel "butterflies" in their stomach, and to become emotionally upset. These reactions are distressing, but in fact they're normal — they're our bodies' way of protecting us and preparing us to confront danger. However, some children who have experienced a traumatic event will have longer lasting reactions that can interfere with their physical and emotional health.

Children who suffer from child traumatic stress are those children who have been exposed to one or more traumas over the course of their lives and develop reactions that persist and affect their daily lives after the traumatic events have ended. Traumatic reactions can include a variety of responses, including intense and ongoing emotional upset, depressive symptoms, anxiety, behavioral changes, difficulties with attention, academic difficulties, nightmares, physical symptoms such as difficulty sleeping and eating, and aches and pains, among others. Children who suffer from traumatic stress often have these types of symptoms when reminded in some way of the traumatic event. Although many of us may experience these reactions from time to time, when a child is experiencing child traumatic stress, they interfere with the child's daily life and ability to function and interact with others.

Some of these children may develop ongoing symptoms that are diagnosed as post-traumatic stress disorder (PTSD). When we talk about child traumatic stress, we're talking about the stress of any child who's had a traumatic experience and is having difficulties moving forward with his or her life. When we talk about PTSD, we're talking about a disorder defined by the American Psychiatric Association as having specific symptoms: the child continues to re-experience the event through nightmares, flashbacks, or other symptoms for more than a month after the original experience; the child has what we call avoidance or numbing symptoms—he or she won't think about the event, has memory lapses, or maybe feels numb in connection with the events—and the child has feelings

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Robert P. Franks, Ph.D. is a child psychologist specializing in the treatment of childhood traumatic stress and is the director of the National Resource Center for Child Traumatic Stress, which supports the National Center for Child Traumatic Stress and the National Child Traumatic Stress Network.

What Is Child Traumatic Stress?

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of arousal, such as increased irritability, difficulty sleeping, or others. Every child diagnosed with PTSD is experiencing child traumatic stress, but not every child-experiencing child traumatic stress has all the symptoms for a PTSD diagnosis.

And not every child who experiences a traumatic event will develop symptoms of child traumatic stress. Whether or not your child does depends on a range of factors. These include his or her history of previous trauma exposure, because children who have experienced prior traumas are more likely to develop symptoms after a recent event. They also include an individual child's mental and emotional strengths and weaknesses and what kind of support he or she has at home and elsewhere. In some instances, when two children encounter the same situation, one will develop ongoing difficulties and the other will not. Children are unique individuals, and it's unwise to make sweeping assumptions about whether they will or will not experience ongoing troubles following a traumatic event.

For children who do experience traumatic stress, there are a wide variety of potential consequences. In addition to causing the symptoms listed earlier, the experience can have a direct impact on the development of children's brains and bodies. Traumatic stress can interfere with children's ability to concentrate, learn, and perform in school. It can change how children view the world and their futures, and can lead to future employment problems. It can also take a tremendous toll on the entire family.

The way that traumatic stress appears will vary from child to child and will depend on the child's age and developmental level. To understand more about how traumatic stress appears in various stages of child development, see the accompanying article *Age-Related Reactions to a Traumatic Event*.

The good news is that over the past decade the mental health community has developed treatments that can help children suffering from traumatic stress. You can learn more about these in the article *Effective Treatments for Youth Trauma*. If you don't know where to go for help for your child, you can find suggestions in *Tips for Finding Help: Recommendations from the NCTSN*. It's important to seek help from someone who has experience working with children and knows how to access resources in your community.

Although not every child will experience traumatic stress, it's unlikely that any of us are immune from exposure to trauma. To learn more about child traumatic stress, please visit the National Center for Child Traumatic Stress website at www.nctsnet.org. ◆

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Effective Treatments for Youth Trauma

Lisa Amaya-Jackson and Charlene Allred

Dealing with a child's traumatic experience is confusing and stressful for parents as well as for the child. They wisely seek help, but the search for help can itself be confusing. How do parents know whether a proposed treatment has a good chance of working? Does their child really need to talk about the traumatic experience as much as some experts say?

For several years, clinicians have been helping children with treatments that have been practiced widely and accepted among mental health professionals, but only recently have some of these been tested scientifically to document how well they work. We now know that there are clinically sound treatments for trauma that are indeed helpful for children and adolescents.

Cognitive-Behavioral Therapies

Several studies have shown the effectiveness of treatments for traumatic stress that are based on what psychologists call *cognitive-behavioral* approaches. These approaches include:

Teaching children stress management and relaxation skills to help them cope with unpleasant feelings and physical sensations about the trauma.

- Using what therapists call "exposure strategies," or talking about the traumatic event and feelings about it at a speed that doesn't distress the child.
- Creating a coherent "narrative" or story of what happened. It is often a difficult process for children to reach the point where they are able to tell the story of a traumatic event, but when they are ready, the telling enables them to master painful feelings about the event and to resolve the impact the event has on their life.
- Correcting untrue or distorted ideas about what happened and why. Children sometimes think something they did or didn't do may have caused the trauma, or that if only they had acted a certain way a traumatic experience might have turned out differently. This is rarely true, and getting the story right helps a child stop prolonging the traumatic stress by punishing him- or herself.
- Changing unhealthy and wrong views that have resulted from the trauma. Children often need help to overcome such ideas as "if he did that bad thing to me it must be because I'm bad" or "children like me can never have a normal life again."
- Involving parents. No one has more influence in a child's life than a parent. Parents can play an important role in treatment, sometimes by participating in interventions with the therapist and by helping the child "practice" new therapeutic strategies at home. Parents have key information about their child that therapists need in developing and implementing treatment. Most importantly, parents can create the stable, consistent, and caring environment in which the child can learn that a traumatic experience doesn't have to dominate life.

Does Medication Help?

Because people respond to stress biologically as well as psychologically,

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Charlene A. Allred, Ph.D. is a registered nurse specializing in the dissemination of trauma-focused treatments for children and families and is the director of the Learning from Research and Practice Core at the National Center for Child Traumatic Stress.

Effective Treatments for Youth Trauma

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Each child's treatment depends on the nature, timing, and amount of exposure to a trauma. Some children may not be ready immediately to talk about their trauma, and therapists must move at a speed that a child can tolerate. But talking about the trauma with a skilled therapist has been a critical ingredient in treatments that have been studied scientifically and shown to be effective.

medications are sometimes prescribed to help dampen down symptoms such as nightmares, difficulty sleeping, and anxiety. But it's important for parents to understand that the research on using these medications with young people lags behind the research on adults. Medications may be helpful for treating specific symptoms, but there is no definitive medication treatment to "cure" children's traumatic stress.

Does It Help to Talk?

While many parents seeking help for their child say, "My child needs someone to talk to about what happened," others have asked, "How necessary is it to talk about the experience? Shouldn't you help the child move past this, stay away from stirring it up?"

Each child's treatment depends on the nature, timing, and amount of exposure to a trauma. Some children may not be ready immediately to talk about their trauma, and therapists must move at a speed that a child can tolerate. But talking about the trauma with a skilled therapist has been a critical ingredient in treatments that have been studied scientifically and shown to be effective. In fact, studies with adult rape victims have noted that not only is learning to tell the story of the trauma a critical piece to treatment, but that how well the story is organized and how emotionally engaged the client is when telling the story often predict the success of a treatment.

When Trauma Is Combined with Other, Ongoing Challenges

For some children, the experience of a specific traumatic event such as an act of community violence, domestic violence, or abuse and neglect are, sadly, combined with other ongoing psychological or social adversity. A therapist and community agencies involved in the child's life must take into account conditions like depression, grief, behavior problems, poverty, academic problems, or substance use when treating the trauma.

Many children and youth living with ongoing adversity, especially adolescents, have trouble regulating their emotions, which makes it difficult to begin trauma therapy. Many of these youth benefit from individual or group therapy that psychologists call *dialectic behavior therapy* designed to help youth learn how to deal with their feelings effectively and make wiser choices about their behaviors. Numerous studies have shown it to be effective, and it can be a useful precursor to the cognitive-behavioral treatment described earlier.

Interventions that are tailored to individuals, that involve families, and that take place in communities rather than separate settings have also been shown to be effective with children and families who suffer from ongoing exposure to trauma and life stress. These interventions might include case management and intensive in-home services, components of a system-of-care or wrap-around approach used by local mental health centers and others to coordinate community services for children. ◆

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It Takes a Community

Delilah Ramirez as told to Carolyn Nava

My mother could not take care of me. She didn't know how to deal with a sick child and she got no help. I was different from my brother, Daniel, who was a year younger and healthy. She was overwhelmed by my needs. Her escape was alcohol. She told me she needed it "to calm (her) nerves." It all fell apart and I had to be flown from Montana to a hospital in Denver, Colorado, where there were specialists for children with renal failure. My mother had no money to travel that far. A friend later brought her to Denver. Daniel and I were going to live with her there so I could get treatment. Her drinking only got worse. One day, the mobility driver found me hiding under my bed. At the hospital the nurse saw bruises on me and called Social Services. I knew my mother was in trouble and knew I was the reason. The loss of my mother was hard, but the loss of my brother was the biggest loss of my life. I was four years old.

Today, I am 27 years old. I live with my partner in a small house in a Hispanic neighborhood where we feel at home. I visit my mom and my brothers in Wyoming once in a while. I have four brothers now in my birth family. My mom still needs help and she still doesn't have any. I didn't know my father; each of my brothers has a different father. Daniel's father committed suicide. I know now what it is like to feel like an outcast. I know because I felt that, just like my mother. She was terrified of my condition and in foster care, I learned that Nana, my first foster mother, was also scared. She was a loving African American woman but I scared her. When her other foster and grandchildren played rough, I had to sit on her porch and watch. She said if the kids played with me, I'd get peritonitis and have to go to the hospital. Physically, I got sicker everyday. I wasn't active and depression took me down. Everyday the depression got worse. I quit eating and I lost weight.

Then, one day, Nana told me that Carolyn wanted to take me to live with

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Carolyn Nava, the Sr. Family Advisor at the Federation of Families for Children's Mental Health and the Technical Assistance Partnership, is a daughter, mother, and grandmother with intergenerational family experience with mental illness.

Delilah Ramirez is a 27-year-old survivor of the child welfare system and other traumas. Part of her life story is told in this article. She resides in Denver, Colorado.

Effective Treatments for Youth Trauma

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her. Nana had diabetes and her illness was getting worse. I got more scared. I didn't want to move. Carolyn lived alone. I knew who she was because she worked at the day psychiatric hospital where I was. Her kids were adults. I'd have no friends. Those were my thoughts. I was wrong,

"I was about to learn how to live in a community. Carolyn and her friends built a community we called Golden Buckets and she went to the hospitals in Denver looking for kids like me who needed machines to live. They called the community Golden Buckets and for the first time in my life I wasn't different from everyone else."

I was about to learn how to live in a community. Carolyn and her friends built a community we called Golden Buckets and she went to the hospitals in Denver looking for kids like me who needed machines to live. They called the community Golden Buckets and for the first time in my life I wasn't different from everyone else. Some of the kids had mental illness that no one could see. Some of the kids needed a ventilator. I needed a dialysis machine. For the first time in my life, no one teased me. Before, I was teased all the time and today I am still sensitive when someone teases me. It took a load off of me, knowing there were other kids who were like me. I wished my family could be in the community with me. My mother hid everything in a closet – her drinking, my sickness, the men she picked up all the time. In her generation, kids were seen and not heard. We were to be quiet all the time. We were poor, so poor that my mother had to put me on Medicaid to save my live. My first home away from her was the hospital where I lived for two years.

Carolyn ended that. I came to her mad, sad, depressed, confused. I didn't know what was going to happen to me. And she said, "What do you want for your life?" I raged and raged for the first time and she didn't get scared, I got a new machine and she learned how to make it work. I had surgeries, 27 in the end, and she didn't drink to get drunk. And then, when I turned 13, she said, "Now you will learn how to take care of yourself. You will load and start your own machine and you will hook on without my help." I said I couldn't and she said, "You told me you wanted to be normal. Well, prove it. You are a teenager. Act like one."

Years later, when I was 25 years old, Carolyn, who had become my mom, dragged me crying one more time to adulthood. She had moved to Washington, DC, but every time I needed her, she was only a phone call away. I was having another surgery and she flew into Denver. The first night in rehab, she stood up and said she was going to leave for her hotel to spend the night. I just stared at her. She had always spent every night with me in the hospital. She had never left me alone. I thought, 'I'm not going to be able to do this.' I felt like I didn't have the knowledge to get what I needed. I'll tell you I was pretty impressed with what happened. I did it. I asked questions I always heard her ask.

"What is that medication? Why am I getting it?"

"How does this work?"

If I didn't understand, I would say what I thought and ask, "Do I understand?"

The staff would say, "Yes. You do."

When she came back the next morning to visit me, I was very angry with her but she knew it was time. When I

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snapped at her, she told me I was a woman now and that when I was very young, I told her what I wanted most in life was to live like my brother and sister, have a partner and live in my own home. She said I had taken the first step toward being the way I wanted to be — independent.

My mom asked me, when I was asked to do this article, what it is like to live with thinking about when I am going to die?

Real independence doesn't come from 'going it alone.' It comes from knowing when and how to offer — and accept — help.

I no longer think about that. I take care of myself. If I think something is wrong, I ask questions. I live my life one day at a time, one step at a time. I have come this far. I was to be dead at 5. I know God has a plan for me. I have friends. Angel is one. She doesn't have a family and sometimes she is mouthy and aggressive with other people, but around me and my partner, she is respectful. She has no money for therapy so we talk. I am her respite. I tell her things are going to be OK. I know that when my therapist asks me if things are OK, it relieves me. I'm lucky and I know it. A lot of people on dialysis feel really sick all the time. My therapist asks me to talk with them because I have been on dialysis so long and I stay so upbeat. I'm grateful for these friends, for the knowledge about my condition. I know enough to stay healthy.

My partner and I visit my birth mom and my brothers in Wyoming occasionally. Sometimes I fight with my birth mother about what happened in my childhood. She is still drinking. It has been very hard for me to accept that she has mental illness. She still needs help and she still is not getting any.

The most important thing that has happened to me is Carolyn and Golden Buckets. I got self-esteem and self-esteem made me feel good about myself and it made me feel grateful for all I have. It made me think I could help other kids and in helping them, I have learned how to help myself. And believe it, trauma has helped me, too. It has helped me to live my life more carefully. Trauma makes everyday problems seem a little smaller to me. I now see my surgeries as a nuisance to me instead of a threat to my life. They are just a treatment to boost me up, you know? When I think about how far I have come, I am amazed. When the time comes that I get really sick, I know I can deal with it, and so can those around me. Everything that happens today is preparing for the future.

Trauma? A chance to stop and sit in silence. To turn off the phone. To cry. Then, to make some tea. A chance to make some choices and find some solutions. Until the next time, when it happens again. What do you think? ◆

"...she told me I was a woman now and that when I was very young, I told her what I wanted most in life was to live like my brother and sister, have a partner and live in my own home. She said I had taken the first step toward being the way I wanted to be – independent."

Challenging Race

Shari D. Morris

Shari D. Morris, is the Training, Technical Assistance, Social Marketing & Communications Coordinator for Community Connections for Families and Partnerships for Youth Transition, two SAMHSA funded system of care initiatives in Allegheny County Pennsylvania. She is also a student at the University of Pittsburgh's Graduate School of Public Health in the Behavioral and Community Health Sciences Program. Her area of focus is minority health disparities

Note: This is a condensed version of an eloquent essay that may be read in full at the Federation of Families website at ffcmh@ffcmh.org. The full essay includes strategies for adults who interact with children and youth to open healthy dialogues addressing xenophobia — the fear or intense dislike of difference.

Racism and violence often traumatize children in the United States. The systemic impact of social injustice and its predictable outcomes such as poverty, family and community violence, and the escalating socioeconomic and cultural gap between people jeopardize our society as a whole. These environmental stressors make significant impressions upon many areas of a child's development and can impact the behavior and well-being of all children.[1]

Racism is deeply embedded in the life and history of the nation, and all Americans have suffered from its consequences, although some more directly than others:

"Perceived discrimination was linked to symptoms of depression in a large sample of 5,000 children of Asian, Latin American, and Caribbean immigrants (Rumbaut, 1994). Two recent studies found that perceived discrimination was highly related to depressive symptoms among adults of Mexican origin (Finch et al., 2000) and among Asians (Noh et al., 1999).

"In summary, the findings indicate that racism and discrimination are clearly stressful events (see also Clark et al., 1999). Racism and discrimination adversely affect health and mental health, and they place minorities at risk for mental disorders such as depression and anxiety.[2"]

Still, all of us are labeled by so-called racial classification. These categorizations are assigned at birth. Personally, I don't remember the first time I was called "Colored," "Negro," or "Black," but the incremental changes in terms created to describe my African heritage during my lifetime made no difference in how I was or am treated outside of friends and family. They are as much a part of others' perception of me as "girl" or "female." My presumed intelligence and beauty was determined by these labels, because the reason for the classification was for me to know my place in society's hierarchy. In spite of my protests or quests for individual distinction, my everyday social encounters are often impacted by this position in life as a dark complexioned person of African descent. The inability to affect my position in life in this way created a low level of frustration and resentment.

I could not count on assimilation or any self-promotional strategies to differentiate myself from the expectation of who I was presumed to be. Nor could I count on individual strengths or talents I had to make myself the exception, and therefore acceptable. Like many African Americans, I became resilient in coping strategies to deal with the everyday encounters based upon a socially constructed concept called race. When

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Challenging Race

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I think of children growing up today, I think they are at least fortunate enough that the argument is being made to eliminate categorization by something which in reality does not exist. The term *African American* at least reflects a cultural heritage, although it does not protect one from the previously mentioned presumptions or experiences in life. The naive illusions of so-called "racial harmony" are often systematically shattered by what is experienced, witnessed, and heard.

I am reminded of my own naivety, having grown up in a Catholic school system, expecting to be treated as I would have others treat me. On more than one occasion, I was punished for "acting like a boy" or being a "roughneck." I was also told by a nun, who was supposed to be my guidance counselor, that I was trying to be more than I was, although I was less affected than some, considering that she had told most of the other African American students that they "weren't college material."

As I grew older, there were several instances when I was stopped by the police while driving in my car. This phenomenon is so common that it has a name — "Driving While Black." Appeals to local magistrates often produce more frustration in the quest for justice. With each experience, I speak in less detail about what transpired until later. Bitter and angry, I don't know *how* to talk about it at times, except in angry bursts of fury, which I presume most who do not share my ethnic background or experiences of discrimination will not understand, or even worse, will justify and rationalize. I talk to my mother, sister, and sometimes other friends and family long distance. They are my personal wraparound team when it comes to dealing with the issues of everyday racism. I want to put these incidents behind me — to move on, to start forgetting — but I can't. Each time I require more time to recover my dignity.

There is still a tendency for much of mainstream America to equate the expressed or repressed anger of African Americans with pathology and impulsive behavior rather than seeing it as a justifiable feeling or emotional state given our experiences. The fury and passion of people like me, smarting by repeated instances of the everyday trauma of racism, sometimes find in that rage a source of strength and a channel for productive change. The challenge is to eliminate or at least reduce the incidents that produce this rage—especially among our youth. ◆

(Footnotes)

[1] PUBLIC FORUM on Color and Trauma presented at the 1997 Fall meeting of The American Psychoanalytic Association co-sponsored by The American Psychoanalytic Foundation, from the Discussion Guide for a video presentation of the Forum by Leon Hoffman, M.D., Chair, and Sandra C. Walker, M.D., Co-Chair, Committee on Public Information, American Psychoanalytic Association.

[2] Supplement to Report of the Surgeon General 1999 Inventory Number: SMA-01-3613. Mental Health: Culture, Race and Ethnicity, Chapter 2,Culture Counts: The Influence of Culture and Society on Mental Health, Mental Illness, Racism, Discrimination, and Mental Health.

"There is still a tendency for much of mainstream America to equate the expressed or repressed anger of African Americans with pathology and impulsive behavior rather than seeing it as a justifiable feeling or emotional state given our experiences. The fury and passion of people like me, smarting by repeated instances of the everyday trauma of racism, sometimes find in that rage a source of strength and a channel for productive change. The challenge is to eliminate or at least reduce the incidents that produce this rage—especially among our youth."

Adopting and Parenting a Child with a History of Trauma

Joycee Kennedy and Frank Bennett

Joycee Kennedy, LCSW, and Frank Bennett, PhD, are the clinical coordinator and the project director for the Aurora Mental Health Center site of the National Child Traumatic Stress Network. They have been foster or adoptive parents to children with histories of trauma and have served as therapists for many more.

Raising a child changes your life, whether the child comes through birth, adoption, or the foster care system. Adopting a child with a history of trauma is particularly challenging. While we don't believe that we have answers to every problem of every family, we believe that the following principles will improve the lives of many families embarking on this journey.

Make the Child's Sense of Safety Your Priority

Provide consistent love and safety. You want to help your child feel safe regardless of his or her behavior at the moment. Once, Joycee's son announced that he was going to run away. Shortly thereafter, Joycee showed up in his room with a suitcase and started packing. He looked at her and asked, "What are you doing?" She said, "I'm going with you." This unexpected maneuver showed him that she was willing to do whatever it took to keep him safe. He didn't run.

Understand the Child's View

Children who've been adopted or brought to a family through the foster care system, especially those who have experienced trauma, may not share certain basic beliefs that other children share with their parents. They may have been moved from home to home, been physically or sexually abused, or repeatedly been lied to and may not trust adults. More fundamentally, trauma may interfere with children's learning. When a situation reminds them of a traumatic situation, these children may become so anxious that they can't organize their thinking, can't take in new information, or may not even be able to remain in a situation to see how it develops. And they may not be able to describe in words what they are experiencing.

What Works for Other Children May Not Work for Your Child

Joycee's son told her once how important it was that she never let him down. On the other hand, when Frank's daughter by birth took tennis lessons, her parents frequently forgot to pick her up on time. This earned them some glares, which they felt they deserved, but the relationship was not threatened. Children with histories of trauma may not have the confidence in the relationship that other children do, and the experience of being let down may make them so anxious that they cannot perceive an event as simply annoying rather than life threatening.

Understand What Discipline Means

The threat of a parent's displeasure is probably the major factor inhibiting inappropriate behavior in children who are securely attached to their parents. That factor may not exist for a child with a trauma history who's been adopted. Physical discipline may recall memories of abuse and set off a chain of fear and anger. Deprivation of privileges may set off a power struggle that doesn't end.

Much of the misbehavior of children

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Adopting and Parenting a Child with a History of Trauma

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who've been traumatized is due to their lack of self-control, self-calming abilities, and everyday positive coping strategies. These skills need to be taught to the children before they will let go of troubling behaviors. For these children, rules must be crystal clear and consistent. As the children's sense of safety and ability to care for themselves increases, the rules can become more flexible, but patience and repeated practice are needed before a child can feel safe with self-control.

Adjust Your Expectations

What other children can do, children with histories of trauma may not be able to do or may take much longer to learn. One young boy, when first placed in the new home, would retreat to a corner of the room when he met new people. With two years of coaching and practice, the boy learned to shake hands and introduce himself when he met new people. Without a caring relationship and extreme patience, this new pattern could not have been built.

Get Support

Parenting children with trauma histories is hard work. It may be possible to do it alone, but it isn't a good idea. Support can come from support groups, a therapist, family members, friends, colleagues, books and other materials, or a combination of all of these. Spending time with other parents who have had similar experiences will help you realize that you are not alone.

There are apt to be times when other children in the family are stressed and tested by their siblings. They will need support and help. The other children in the family may not greet the suggestion to enter therapy with enthusiasm, but persist. They need to have some understanding of what their sibling is going through and what the family can do to work better together.

Recognize That You Will Not Be Perfect

You will never be able to follow all the helpful advice you get. You will undoubtedly lose your temper at times or do other things that you later wish you hadn't. Relax, forgive yourself, and get ready to face another day.

Never, Ever Give Up

Your children may not do things in the time frame you have imagined for them. Children with histories of trauma in particular may take more time than other children to finish school, find work, establish relationships with family and friends, and learn to adapt to society's expectations. When Frank's son was 21, he was homeless and heavily involved in alcohol and drugs. Four years later, he had held down the same job for three years, owned a car, and was paying his rent on time. You never know when the love and concern you give a child may bear fruit. ◆

Further Reading

Two books we have found helpful are:

Delaney, Richard (2003) *Small feats: Unsung accomplishments & everyday heroics of foster and adoptive parents*. Oklahoma City, Oklahoma: Wood 'N' Barnes.

Loux, Ann Kimble (1997) *The limits of hope: An adoptive mother's story*. Charlottesville, Virginia: University of Virginia Press.

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Age-Related Reactions to a Traumatic Event

Alessia de Paola Gottlieb

Alessia de Paola Gottlieb, M.D., is a child and adolescent psychiatrist. She is the Associate Medical Director of the UCLA Child Psychiatry Trauma Service and is a member of the National Center for Child Traumatic Stress and the National Child Traumatic Stress Network.

A fundamental goal of parenting is to help children grow and thrive to the best of their potential. Parents anticipate protecting their children from danger whenever possible, but sometimes serious danger threatens, whether it is man-made, such as a school shooting or domestic violence, or natural, such as a flood or earthquake. And when a danger is life-threatening or poses a threat of serious injury, it becomes a potentially traumatic event for children.

By understanding how children experience traumatic events and how these children express their lingering distress over the experience, parents, communities, and schools can respond to their children and help them through this challenging time. The goal is to restore balance to these children's lives and the lives of their families.

How Children May React

How children experience traumatic events and how they express their lingering distress depends, in large part, on the children's age and level of development.

Preschool and young school-age children exposed to a traumatic event may experience a feeling of helplessness, uncertainty about whether there is continued danger, a general fear which extends beyond the traumatic event and into other aspects of their lives, and difficulty describing in words what is bothering them or what they are experiencing emotionally.

This feeling of helplessness and anxiety is often expressed as a loss of previously acquired developmental skills. Children who experience traumatic events might not be able to fall asleep on their own or might not be able to separate from parents at school. Children who might have ventured out to play in the yard prior to a traumatic event now might not be willing to play in the absence of a family member. Often, children lose some speech and toileting skills, or their sleep is disturbed by nightmares, night terrors, or fear of going to sleep. In many cases, children may engage in traumatic play — a repetitive and less imaginative form of play that may represent children's continued focus on the traumatic event or an attempt to change a negative outcome of a traumatic event.

For school-age children, a traumatic experience may elicit feelings of persistent concern over their own safety and the safety of others in their school or family. These children may be preoccupied with their own actions during the event. Often they experience guilt or shame over what they did or did not do during a traumatic event. School-age children might engage in constant retelling of the traumatic event, or they may describe being overwhelmed by their feelings of fear or sadness.

A traumatic experience may compromise the developmental tasks of school-age children as well. Children of this

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Age-Related Reactions to a Traumatic Event

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age may display sleep disturbances, which might include difficulty falling asleep, fear of sleeping alone, or frequent nightmares. Teachers often comment that these children are having greater difficulties concentrating and learning at school. Children of this age, following a traumatic event, may complain of headaches and stomach aches without obvious cause, and some children engage in unusually reckless or aggressive behavior.

Adolescents exposed to a traumatic event feel self-conscious about their emotional responses to the event. Feelings of fear, vulnerability, and concern over being labeled "abnormal" or different from their peers may cause adolescents to withdraw from family and friends. Adolescents often experience feelings of shame and guilt about the traumatic event and may express fantasies about revenge and retribution. A traumatic event for adolescents may foster a radical shift in the way these children think about the world. Some adolescents engage in self-destructive or accident-prone behaviors.

How to Help

The involvement of family, school, and community is critical in supporting children through the emotional and physical challenges they face after exposure to a traumatic event.

For young children, parents can offer invaluable support, by providing comfort, rest, and an opportunity to play or draw. Parents can be available to provide reassurance that the traumatic event is over and that the children are safe. It is helpful for parents, family, and teachers to help children verbalize their feelings so that they don't feel alone with their emotions. Providing consistent caretaking by ensuring that children are picked up from school at the anticipated time and by informing children of parents' whereabouts can provide a sense of security for children who have recently experienced a traumatic event. Parents, family, caregivers, and teachers may need to tolerate regression in developmental tasks for a period of time following a traumatic event.

Older children will also need encouragement to express fears, sadness, and anger in the supportive environment of the family. These school-age children may need to be encouraged to discuss their worries with family members. It is important to acknowledge the normality of their feelings and to correct any distortions of the traumatic events that they express. Parents can be invaluable in supporting their children in reporting to teachers when their thoughts and feelings are getting in the way of their concentrating and learning.

For adolescents who have experienced a traumatic event, the family can encourage discussion of the event and feelings about it and expectations of what could have been done to prevent the event. Parents can discuss the expectable strain on relationships with family and peers, and offer support in these challenges. It may be important to help adolescents understand "acting out" behavior as an effort to voice anger about traumatic events. It may also be important to discuss thoughts of revenge following an act of violence, ad-

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"The involvement of family, school, and community is critical in supporting children through the emotional and physical challenges they face after exposure to a traumatic event."

"Recognizing each others experience of the event, and helping each other cope . . . is an important component of a family's emotional recovery."

Age-Related Reactions to a Traumatic Event

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dress realistic consequences of actions, and help formulate constructive alternatives that lessen the sense of helplessness the adolescents may be experiencing.

When children experience a traumatic event, the entire family is affected. Often, family members have different experiences around the event and different emotional responses to the traumatic event. Recognizing each others experience of the event, and helping each other cope with possible feelings of fear, helplessness, anger, or even guilt in not being able to protect children from a traumatic experience, is an important component of a family's emotional recovery. ◆

Tips for Finding Help:

Recommendations from the National Child Traumatic Stress Network

Information

Because children and adolescents go through many normal changes as they mature into young adults, it is not always easy to tell whether they are bothered by posttraumatic stress, grief, or depressive reactions. Families can be most helpful if they learn as much as they can about child traumatic stress. Helpful sources of information include:

www.nctsnet.org	The National Child Traumatic Stress Network
www.aboutourkids.org	The New York Child Study Center
www.nccev.org	The National Center for Children Exposed to Violence at the Yale Child Study Center
www.ncptsd.org	The National Center for PTSD
www.ojp.usdoj.gov/ovc	The Office for Victims of Crime — U.S. Dept. of Justice
www.istss.org	The International Society for Traumatic Stress Studies
www.ncvc.org	National Center for Victims of Crime

Professional Help

There are many routes to finding a qualified mental health professional. Families can:

- Look on the website of the National Child Traumatic Stress Network to see if one of its member centers exists in your city or state.
- Ask a pediatrician, family physician, school counselor, or clergy member for a referral to a professional with expertise in traumatic stress.
- Talk to close family members and friends for their recommendations, especially if their child or adolescent had a good experience with psychotherapy.
- Contact a community hospital, state or county medical society, state or county psychological association, or the division of child and adolescent psychiatry or department of psychology in any medical school or university.
- Contact agencies in the community that specialize in trauma and/or victimization. These might include sexual assault or rape programs, victims' advocacy agencies, the local crime victims' compensation program, the children's advocacy center, or local domestic violence programs.
- Contact local community mental health centers, mental health associations, and support groups such as chapters of the Federation for Families (http://www.ffcmh.org/) and NAMI (National Alliance for the Mentally Ill, http://www.nami.org/), which often keep lists of mental health professionals willing to see new clients or patients.
- Call the American Psychological Association (http://www.apa.org/) toll free number that will connect you to the state or local referral service for your area. The number is 1-800-964-2000.

Stress, Stress, Stress Everywhere

Jerome H. Hanley

The drip, drip, drip of negative events takes its toll, as rain on rocks created the Grand Canyon. Trauma is usually thought of as a major negative event in which a child personally experiences or witnesses a significant event like unexpected or violent death; threaten death, serious injury, a natural or created disaster. *But stress and trauma can be the result of everyday occurrences that over time accumulate and have a negative impact on the child.*

Those children who are, or at risk of being, system involved often times experience stress while in the care of the very child-serving agencies mandated to help. The child welfare, education and juvenile justice systems are replete with policies and practices, which albeit unintentional, produce stress and in some cases trauma in children.

Children who experience foster care and child protective services, as part of the child welfare system, are often stressed and traumatized because of some guilt and loss of having been removed from their homes. It is for this reason that every child that is removed from his/her home should have an opportunity to debrief and be a part of any subsequent investigation. In addition children removed from their homes and placed in foster care should be screened to determine the degree and magnitude of stress they are experiencing and appropriate services should then be implemented.

In most schools the teacher's work plan focuses upon material they hope will be on the standardized test. This may work well for the majority of students, but for far too many, especially for those who are academically challenged, the result is fear, anxiety and depression. In addition there are other students who simply give up and resign themselves to failure.

The juvenile/criminal justice system is yet another that creates problems for children. Unfortunately being incarcerated has become a badge of, or right of passage to, manhood or womanhood for some children in varied communities. But for those children in these communities who do not want to commit crimes the pressure to do so causes stress. Many feel pressure to commit crimes, and many pretend to go along with the program, so they will be not be ostracized by their peers. For these children especially being involved in or witnessing criminal activity and post event experiences can leave their mark. Post- traumatic stress is common when children witness or experience: a crime gone wrong that results in injury or death; police brutality; false arrest; and the fear of potential police violence (The Rodney King effect).

But "stress, stress everywhere" is really the mantra of many children living in some very scary neighborhoods. These children and their families experience stress 24 hours a day seven days a week. These neighborhoods have no way out and positives are hard to find, there is a general feeling of doom. Everyday experiences, like playing safely outside, walking unharmed to the grocery store, getting good grades and not being ridiculed or ostracized,

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"But 'stress, stress everywhere' is really the mantra of many children living in some very scary neighborhoods. These children and their families experience stress 24 hours a day seven days a week. These neighborhoods have no way out and positives are hard to find, there is a general feeling of doom. Everyday experiences, like playing safely outside, walking unharmed to the grocery store, getting good grades and not being ridiculed or ostracized, enjoying new toys or clothing without the threats of theft and/or personal injury, are challenges for these children."

enjoying new toys or clothing without the threats of theft and/or personal injury, are challenges for these children.

The young people and situations presented are few but their demonstration of the cumulative and pervasive effects of a stressful environment, whether "system imposed" or neighborhood specific, are real. And while the following suggestions are not sure fire or effective for all children experiencing stress and/or trauma in these circumstances, they are worth consideration:

Twenty-four hours a day, seven days a week, the neighborhoods of many children and their families contribute to feelings of stress. Everyday experiences, such as playing safely outside, can be a challenge.

1. Recognize your child's level of resilience and reinforce it starting from infancy. Provide contact comfort as much as possible. An infant or small child cannot be spoiled with love. At the same time older children also crave to be touched and held.

2. Visit your child's school on a regular basis. Make the visits non-problem ones. If visiting is too problematic, then phone the school on a regular basis. In either case do so unannounced and maintain contact with your child's teachers, principal and counselor.

3. Read to your child from conception. If for some reason you cannot, take your child to the public library. Develop reading circles in your community with 2 or 3 other families.

4. No matter how isolated you as the family member may feel work hard at developing a support system for your child(ren). Children may not feel comfortable talking with you, but with a support system comprised of church members, school personnel/activities, neighbors (I know this is rare now, but it is worth the effort), and youth programs.

5. Beware of what is happening within your community and the best source maybe your child. Open the lines of communication early and work hard at keeping them open.

Understanding it in the context of its demonstrated and potential cumulative effects is critical to identifying significant stress early thereby giving better chances for successful outcomes for children and their families. ◆

Parenting and Advocating for Children with Severe Mental Health Needs: An Intimate Traumatic Experience

Eloise Boterf and Elaine Slaton

Raising a child with severe mental health issues can leave one raw, stressed, even traumatized. Sleepless nights of worry, of self-doubt, of strategizing ways to get support eat away at our personal resilience. Stigma and isolation strip us of social and emotional support and make us more vulnerable to the effects of trauma. Too many of us, as parents, encounter family and friends who don't want to talk about mental health, who don't believe in mental health disorders, or as time goes on, just don't want to hear about it anymore. Our grief can become overwhelming, as others do not see our heartbreak over lost expectations and fears about the future. Layers and layers of deep vulnerability, grief, isolation, and stress can accumulate into significant trauma. Each new traumatizing event or emotion often shows up before we've been able to stabilize ourselves from the last. Sometimes, especially during yet another crisis situation, the effects of the trauma snowball out of control even as we desperately try to care for the needs of our children.

Trauma continues to layer as our financial resources erode with the cost of services needed by our children. Many of us find we are unable to work because our child needs supervision and support around the clock. We feel more loss and completely powerless to avoid yet another disaster – bankruptcy or loss of custody. So, with our child's loss of mental health, our loss of support, and loss of any level of financial security – or worse yet, our loss of custody – our self-confidence about parenting collapses. More layers of trauma build one upon the other. And, still we struggle to care for the needs of our child.

It is gut wrenching to watch one's own child slip away into deeper depression or to watch her lose more and more control over her behavior. Hopelessness and helplessness become the reality of our day-to-day life as no matter what we do, we are powerless to change what is happening to our child. For some of us the ultimate horror is realized when our child is lost to suicide. More grief. Deeper grief. Unspeakable grief. No support. More blame directed at us. We can begin to feel like victims.

For some of us, there may finally come a time and place when our child's needs ebb and he or she begins a path of healing and recovery. In spite of our relief and deep gratitude, how do we find our own recovery?

How do we climb out of debt? How do we recreate lost social connections? More importantly, how do we heal from the agony of our own child's pain? How do we go forward? For some we are lucky and find other parents who have journeyed down a similar path. In those people we find comrades who

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Elaine Slaton is the parent of two now-adult sons. She works for the national Federation of Families for Children's Mental Health as a trainer and project manager. She, too, brings the perspective of having raised a child with serious mental health needs.

Parenting and Advocating for Children with Severe Mental Health Needs

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"...'The music is about my feelings and no one can challenge what I feel. They can only challenge what I do with my life.' This has become my mantra as I continue my own path of healing."

do not judge, do not blame, and do not desert. Finally, we find a safe haven from the chaos, the rejections, the blame and the isolation.

And, for some of us, we chose to continue that journey of healing through the family movement. Working diligently to support other families, to change policies, to improve systems. But, with that work comes the risk of adding to our layers of trauma. Those of us in the family movement can feel naked revealing our own family's stories and the pain that has become part of our very being. Then, comes the anger. I **AM** right. I **DO KNOW** what we experienced and I **DO KNOW** what we needed. That is the beginning of taking one's soul back.

Parents, as well, must seek a path of recovery, even as we fight for our children's recovery.

The work we do in the family movement too frequently means that when we enter a room, we are the nemesis. Any sense of security and safety we may have had long before children entered our lives continues to elude us. We speak when people do not want to hear us. We show up when people do not want to see us. We — our children and our families — expose our society's underbelly. We represent the failure of our country to care for its own children. So, the stigma and isolation continues — even in the company of our newfound comrades.

Sometimes it makes my very skin hurt. Then I must remember what my now-grown son shared with me. He is one of the truly lucky ones who found his way to safety and recovery. He is, among other things, a musician. He plays a new genre of music called "Noise." He explained it to me as a communal and spontaneous expression of emotion as the musicians respond to one another. I asked, "What does it feel like when your audience doesn't like your music?" He responded with a grin, "It doesn't matter. The music is about my feelings and no one can challenge what I feel. They can only challenge what I do with my life." This has become my mantra as I continue my own path of healing.

Layer upon layer of stress, grief, rejection, pain have built up within too many of us. As we go forth in the family movement, we parents must be cognizant of the cumulative effects of these stresses. We must beware of getting stuck in our victim-ness, our anger, or our hopelessness. We, too, must follow a path of recovery even as we continue to fight for our children, expose the underbelly of our country and advocate for systems change. Our children, our families, our lives depend on it! ◆

Families, Juvenile Justice, and Trauma

National Child Traumatic Stress Network

Note: A full essay on this subject, including references and recommendations, can be read on the NCTSN website at www.nctsnet.org.

Each year, over two million young people come into contact with the juvenile justice system, and hundreds of thousands of them are sent to correctional facilities. Many of these youth faced emotional, behavioral, or mental challenges before entering the justice system, and the challenges remain when the system becomes part of their lives. Entering and living in the system can be a traumatic event for a young person. In these difficult circumstances, family involvement in the justice system and the life of their child becomes essential to their eventual well-being.

A growing number of juvenile and mental health systems are recruiting and training family members as case managers, advocates, service brokers, and mentors. One such program is Project Hope, which is affiliated with the Rhode Island Training School. You can learn more about this program, which was featured on a National Public Radio series on youth in detention, at http://www.brown.edu/Departments/IESE/Projects/RITS/.

Numerous studies have documented the prevalence of trauma among youth in detention and several of these are cited in the full version of this essay. Such scientific evidence can be crucial for the efforts of families, advocates, and juvenile justice officials who understand the need to address mental health issues among these young people. ◆

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