Center for Child and Family Traumatic Stress
at Kennedy Krieger Institute

SUMMER 2019

TRAUMATIC STRESS CHRONICLES

GROWTH THROUGH TREATMENT, TRAINING, AND RESEARCH

INSIDE
THIS EDITION...

TRAINING FRONT

7TH BIENNIAL TRAUMA CONFERENCE: A SOCIAL JUSTICE LENS

In just a few months, on October 3 and 4, the Center for Child and Family Traumatic Stress will sponsor its 7th Biennial Trauma Conference: Addressing Trauma Across the Lifespan. Our theme of social justice will be the focus of more than 20 workshops offering education, resources, and trauma-informed conversations about compelling social justice concerns. Among the many events addressing interventions for traumatized families, Day 1 offers a 4-hour intensive workshop entitled *Cultural Considerations in the Implementation of Strengthening Family Coping Resources (SFCR) with Latino Immigrant Families* (for more on SFCR, see page 3 of this newsletter); Day 2 includes a 2-part workshop and panel entitled *One River Two Streams: Family Partnerships and Community Change*. Keynote speaker Wizdom A. Powell, PhD, MPH, will open Day 2 with her talk entitled *Speak to the Wounds: Unpacking Racial Trauma and Developing Healing-Centered Responses for Boys & Men of Color*.

At each Trauma Conference since 2013 we have featured a trauma-themed performance. The 7th Biennial Conference will highlight the voices of youth through the literary and performance-based art of DewMore Baltimore Youth Poetry Team aka BCYPT (Baltimore City Youth Poetry Team). BCYPT is made up of youth ages 13 to 19 who live in or around Baltimore City and are passionate about writing, performing, and advocating for change in their communities. The team, led by published and award-winning writers, uses spoken word as a tool to increase civic engagement among marginalized communities across Baltimore.

DewMore Baltimore Youth Poetry Team aka BCYPT are featured performers at the 7th Biennial Trauma Conference, Center for Child and Family Traumatic Stress.

Our keynote speaker is the Director of the Health Disparities Institute and Associate Professor of Psychiatry at UConn Health, Farmington. Dr. Powell's community-based research focuses on the effects of modern racism and gender norms on the health outcomes and health care inequities of African American males. Formerly,

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DIRECTOR'S CORNER

What we know to be true in our efforts to lessen the negative impact of traumatic stress on children is that service delivery must include interventions targeted at the contexts in which we hope healing can occur. Among the most critical of these contexts are the families in which children live. It was against this backdrop that we decided to spotlight the family in this edition of *Traumatic Stress Chronicles*. Two family-focused interventions are featured: Strengthening Family Coping Resources (SFCR), which reconnects families to rituals, routines, and supports in an effort to facilitate the trauma recovery process; and FamilyLive, designed to enhance the capacity of caregivers to become active, engaged participants in the healing process of their children. A new column, *At the Center*, describes some of the services we employ to address access issues, caregiver stress, and other social determinants important to a family's recovery. Our *Community Spotlight* turns to the Harriet Lane Clinic, another agency with which we have a longstanding relationship. In addition to high-quality medical care, Harriet Lane provides a range of non-medical resources and services to children and families.

To continue our commitment to providing information centered on our tripartite mission of treatment, training, and research, we've retained those column heads from our inaugural edition. In *Training Front*, for example, you'll read that the agenda for our October 2019 Biennial Trauma Conference is set, with all workshops focused on the theme of trauma viewed through a social justice lens. We are excited to introduce you to our distinguished keynote speaker, Dr. Wizdom A. Powell, and featured performance by *DewMore Baltimore*, a local and national award-winning youth poetry team. Under *Research Update* you'll see that our research team is gearing up for a pilot study designed to determine the feasibility of integrating two well-researched interventions as a model for treating maltreated children with severe emotional and behavioral issues. We welcome three new contributors in this edition: Anjelica Jackson, PsyD, Sara Davis, LCSW-C, and Danielle Gregg, MA. Our newest staff psychologist, Anjelica values working with clients to process racial trauma and spiritual issues, strengthen their social support networks, and emphasize their strengths. A clinical social worker, Sara has provided direct clinical care for the past 10 years and has expertise in incorporating the expressive arts into treatment. Danielle is co-director of our Trauma Training Academy and, as an advocate and peer mentor for people with disabilities, has been working with children with special needs and their families for more than 20 years. We are also pleased to share some pictures from a summertime event celebrating our 35th anniversary!

We appreciate the very positive response to our first edition and look forward to expanding our reach and sharing our work through this medium. Please e-mail us at TSChronicles@KennedyKrieger.org with your thoughts and suggestions.

Sincerely,

■ ***Elizabeth A. Thompson, PhD***

We invite you to join us for the **7th Biennial Trauma Conference on October 3-4, 2019**, in Towson, MD. For more information on workshops, registration, and the mobile app, visit www.KennedyKrieger.org/TraumaConference2019 or call us at 443-923-5971.

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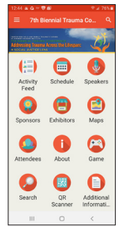
...7TH BIENNIAL TRAUMA CONFERENCE

she spent more than a decade at the UNC Gillings School of Global Public Health, Chapel Hill. In 2010 she testified before the President's Cancer Panel, addressing cancer care disparities and the impacts of physician communication with minority patients. In 2011-2012, she was appointed by President Obama to serve as a White House Fellow to Secretary of Defense Leon Panetta. In this role she provided subject matter expertise on military mental health issues such as PTSD, suicide, and sexual trauma.

Wizdom A. Powell, PhD, MPH, is keynote speaker at the upcoming 7th Biennial Trauma Conference, Center for Child and Family Traumatic Stress.



This year we are also very excited to introduce a conference mobile app! This free interactive tool will be available for download for all registered attendees beginning in September. They can use it to stay up to date via push notifications; gain instant access to workshop and speaker handouts; and increase networking opportunities via app messaging.

■ ***Danielle Gregg, MA***

INTERVENTION INSIGHTS

SFCR RECONNECTS FAMILIES TO RITUAL, ROUTINE, AND SUPPORTS

Every Wednesday night for the past nine years, our team at the Center for Child and Family Traumatic Stress has transformed the conference room with tablecloths and flowers, and the inviting smell of a hot meal, to create a welcoming space for seven families attending Strengthening Family Coping Resources (SFCR). We begin by eating dinner together, a routine that can be hard to manage daily for many of our families, all of whom have experienced trauma, and many of whom continue to live in stressful environments. The team of seven SFCR-trained therapists and paraprofessionals provides cards to family members with prompts to get the conversation flowing during dinner. As team members circulate to offer support, they might overhear a young child reading a question from the card such as, "If you could be any animal, what would you be?", and then sharing excitedly what it would be like to be a dolphin.

After dinner, we begin with the same routines every week, including an opening ritual designed by the group members. They may pray, say a few words about their day, or share a moment of mindfulness. The families then begin creative therapeutic activities that they complete and share with one another; as well as breakout groups for youth and adults. The supportive atmosphere of the adult breakout group helps caregivers to realize they are not alone; it counteracts the isolating nature of trauma.

SFCR is a 15-week, manualized, multifamily group developed by Laurel Kiser, PhD, Associate Professor of Psychiatry at the University of Maryland School of Medicine. It brings together families living in traumatic contexts, in order to help both children and caregivers reduce post-traumatic stress symptoms. Rooted in an awareness of how trauma disconnects families from the routines, rituals, and supports that are within the family's history and tradition, SFCR works to reconnect families to these foundations. SFCR places value on cultural contexts and unique family strengths, and encourages families to support one another in developing protective coping resources in ways that fit each family. Families work through three SFCR modules: Module I introduces skills related to family rituals, routines, and storytelling; Module II focuses on developing coping resources around safety and crisis management, connectedness, co-regulation, resource seeking, deliberateness, and spirituality; and Module III helps families deal with specific traumatic events, make meaning out of their trauma exposure, and reconnect with a focus on the future.

We brought SFCR to the Traumatic Stress Center in 2010 in an effort to help families who appeared "stuck" in other treatment models. Although these families were seeking to create change, they continued to experience ongoing stress, such as exposure to community violence and housing instability. Thus far, we have offered 23 rounds of SFCR (18 in English and 5 in Spanish) with more than 120 families. Our team is repeatedly reminded of the power of this group to not only bring individual families closer, but to help families create support networks with one another.

A "spirituality word flower" allows families in SFCR to identify and share words connected to their ideas about spirituality as a source of strength and resilience. Visit https://www.sfcresources.org/ for more on SFCR.

SFCR incorporates beautiful symbolism to help illustrate skills and concepts. In week 2, for example, families plant individual and group gardens and are invited to reflect on how the roots of the plants will grow together and influence each other, just like families and groups. Families are encouraged to take their plants home as a reminder that plants, also like family members, need care and nurturing. As a way for them to maintain their skills and reconnect with one another, we developed booster sessions for the families, which are held each summer. At the first booster, a family member was excited to tell how the entire family had been keeping its plant alive for the three years since completion of SFCR. When our most recent SFCR group graduated, a mother also drew upon this symbolism, saying,

"... At first I was apprehensive, but I am so glad we came. It has been so nice to meet other families like us, with various backgrounds, striving to raise their children in love. Progress takes time, but the seeds have been planted."

Families who have struggled to acknowledge the impact of their trauma in individual sessions often break through that avoidance in SFCR, perhaps because they know that other families are working through the same process simultaneously. A grandmother said,

"It brought my heart joy listening to my grandson speak on his feelings. He has grown and is developing the right attitude and mind frame for a beginning of forgiveness and moving on."

■ ***Sara R. Davis, LCSW-C***

SFCR Strengthening Family Coping Resources

COMMUNITY SPOTLIGHT

HARRIET LANE CLINIC AS "HOME BASE" FOR FAMILY HEALTH

The Harriet Lane Clinic is a pediatric and adolescent outpatient medical clinic at Johns Hopkins Hospital in East Baltimore. Formerly known as the Harriet Lane Home, the clinic has been a source of high-quality and compassionate care for the Baltimore community for nearly 100 years. Today the clinic offers medical and behavioral services, access to resources, and education to children from birth through age 25 and their families.

Harriet Lane serves approximately 8,000 patients and provides a multitude of services in addition to general and preventive health care, such as comprehensive dental care, pediatric and adolescent HIV services, adolescent family planning, nutrition, breastfeeding support, and parenting support. The clinic also assists patients in accessing needed resources in the community. The Center for Child and Family Traumatic Stress has enjoyed a long and fruitful relationship with Harriet Lane. Although the clinic provides mental health and behavioral health services, staff members often reach out to the Traumatic Stress Center when their children and families with trauma exposures would benefit from the evidenced-based trauma-informed treatments that we offer.

LaToya Mobley, MSW, LCSW-C, is a pediatric clinical social worker at the Harriet Lane Clinic, who provides mental health consultation and assessments. She pointed out that one of the guiding philosophies at Harriet Lane is that patients and families cannot fully benefit from clinic services if they are experiencing chronic stress and a lack of resources. Accordingly, Harriet Lane gives its families access to a Community Resource Desk, which links them to the resources they need to improve their stability. Staff members assist families in completing needs assessments, and walk them through the process of accessing services. The clinic is even able to provide families with necessities like formula, diapers, clothing, and in some cases cribs and car seats. Harriet Lane recognizes that when families know they have access

The Johns Hopkins Hospital as depicted in a mosaic at the Harriet Lane Clinic.

to the things they need, they are more likely to follow through with their medical and mental health needs. Because of this, LaToya calls Harriet Lane a "home base" for many families in our community.

LaToya described a young woman who benefitted from the comprehensive services available at the Harriet Lane Clinic. She was a teenage mother with a history of mental illness and exposure to intergenerational trauma. She also lacked access to basic resources for herself and her baby. By addressing her needs for mental health treatment, educational services, and housing, the clinic improved the teen's ability to meet her baby's needs on a more

LaToya Mobley, MSW, LCSW-C, pediatric clinical social worker at the Harriet Lane Clinic.

stable footing. Although it was not always easy to work with her, staff members at the clinic were able to engage the young mother, nurture her, and provide the crucial "home base" she needed.

Another invaluable service at Harriet Lane is health and mental health screening for newborns, which also involves maternal mental health screening. The maternal portion screens for postpartum depression as well as potential stressors including trauma that may be affecting the mother and therefore the infant. Depending on their specific needs, mothers can access mental health services at Harriett Lane or can be referred by staff to other mental health programs.

LaToya said that staff members at the clinic have recently been seeing more instances of toddlers and very young children (ages 3-5) demonstrating significant trauma symptoms. Parents express concern about their children's intense anger, aggression, and difficulty soothing. These little ones show behaviors that cannot be managed in their usual day care and preschool programs. LaToya explained that often the children are responding to trauma the parents themselves have experienced, or to a parent's response to trauma. In either situation, the children and families may experience intense stress and isolation due to lack of access to supportive services. The Traumatic Stress Center can be a crucial resource to these families by offering evidenced-based treatments developed for toddlers and young children, such as Parent-Child Interaction Therapy (PCIT) and Child-Parent Psychotherapy (CPP).

Harriet Lane Clinic and the Center for Child and Family Traumatic Stress embody the same values of compassion and high-quality care for children and families in our community. We at the Traumatic Stress Center greatly appreciate the work of the clinic, and we feel privileged to serve as a resource for clinic patients who have experienced trauma.

■ ***Emily Driscoll-Roe, LCSW-C***

RESEARCH UPDATE

A PILOT STUDY OF DBT-C FOR YOUTH WITH DISRUPTIVE BEHAVIOR AND TRAUMA HISTORY

Severe emotional and behavioral regulation problems are highly prevalent among children with histories of maltreatment, and are associated with a host of negative short- and long-term outcomes including increased rates of special education services, continuing mental health care needs, and involvement with child welfare, juvenile justice, and criminal justice systems. There are no effective treatment approaches for targeting severe aggressive and disruptive behaviors in school-aged children with trauma histories such as maltreatment. While Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) has an extensive evidence base, including 12 randomized controlled clinical trials that support it as a treatment for children with post-traumatic stress symptoms, two large-scale randomized trials that also assessed disruptive behavior of the participating youth found that TF-CBT did not significantly improve these symptoms.

Dialectical Behavior Therapy (DBT) was initially developed for adults with borderline personality disorder and severe emotional and behavioral regulation problems. This intervention was recently adapted for children (DBT-C) and studied in a cohort of children without significant trauma histories. In a randomized controlled trial, DBT-C was more effective than treatment as usual (e.g., individual therapy, parent-management training, adjunctive pharmacotherapy) at reducing severe irritability and aggressive and disruptive behavior in 7- to 12-year-old children. Improvements were maintained at the 3-month follow-up (see Perepletchikova and colleagues, below). DBT-C was also associated with lower rates of treatment drop-out, higher rates of treatment attendance, and enhanced parent and child treatment satisfaction. The children in the published study, however, were from middle to high socioeconomic backgrounds and did not have significant trauma histories.

What is the effectiveness of integrated DBT-C and TF-CBT intervention for children with traumatic stress symptoms and disruptive behavior?

At the Center for Child and Family Traumatic Stress, we are gearing up for a pilot study to obtain feasibility data on the delivery of an integrated intervention that combines DBT-C and TF-CBT, a novel approach to treating co-occurring disruptive behavior and trauma-related symptoms in maltreated children. As a history of child maltreatment is associated with a less favorable response to evidence-based treatments across a range of psychiatric disorders, it is important to study the efficacy of established interventions with patients with significant trauma histories.

Research in adults with co-occurring trauma and severe emotional and behavioral regulation problems suggests the value of combining DBT with a trauma-specific treatment. In adults with these co-occurring problems, trauma symptoms did not improve until the trauma-focused intervention was initiated, and addressing the trauma symptoms led to significantly greater improvements in the core symptoms targeted with DBT.

For the planned study we will be recruiting children in collaboration with both the Baltimore City and Baltimore County Departments of Social Services. Also working with us on this project are Francheska Perepletchikova, PhD, the developer of DBT-C; and Judith Cohen, MD, co-developer (with Anthony P. Mannarino and Esther Deblinger) of TF-CBT.

CORE SKILLS TAUGHT IN DBT FOR CHILDREN INCLUDE:

Mindfulness – Children are taught to observe and describe their behavior and emotions, focus on one thing in the moment, and concentrate on doing what works.

Distress Tolerance – Children learn how to distract, self-sooth, use imagery and relaxation techniques, consider pros and cons, and practice radical acceptance.

Emotion Regulation – Children are taught steps to increase positive emotions, enhance mindfulness of positive experiences, and reduce worries.

Interpersonal Effectiveness – Children learn strategies for making requests in a respectful and confident manner, and how to build and maintain relationships.

DBT = Dialectical Behavior Therapy

■ ***Joan Kaufman, PhD***

For further reading, see:

Perepletchikova, F., Nathanson, D., Axelrod, S. R., Merrill, C., Walker, A., Grossman, M., et al. (2017) Randomized Clinical Trial of Dialectical Behavior Therapy for Preadolescent Children With Disruptive Mood Dysregulation Disorder: Feasibility and Outcomes. *Journal of the American Academy of Child & Adolescent Psychiatry, 56*, 832-840. https://www.ncbi.nlm.nih.gov/pubmed/28942805

INTERVENTION INSIGHTS

FAMILYLIVE, A MODEL FOR ENGAGEMENT AND CHANGE

Trauma-focused mental health services for children teach management of strong emotions, reactions, and behaviors connected to extremely difficult experiences. Parents and caregivers can be an invaluable part of the healing journey for children. Unfortunately, there are many barriers to positive parent/caregiver participation, including but not limited to unremitting daily stress, difficult living situations, lack of confidence in systems due to previous negative experiences, and unresolved past trauma. FamilyLive, a caregiver-focused family therapy model, addresses some of these barriers by carefully establishing and maintaining therapeutic engagement with caregiving adults. The roots of the model date back to the early 1990s when our clinicians combined structural family therapy and object relations principles to work with highly stressed families involved with the child welfare system. Over time, the model incorporated specialized engagement strategies, a narrative approach to producing change, a non-pathologizing stance, and strict adherence to strengths-based and skills-oriented interventions.

MODEL ESSENTIALS

FamilyLive incorporates the following elements (Figure 1): two rooms connected by a one-way mirror; a system for transmitting sound from one room to the other; a telephone in each of the rooms; an "in-room clinician;" a specially trained "team lead;" and additional team members. During sessions, the family meets with the in-room clinician while the team lead observes from behind the mirror. The team lead is responsible for providing telephone "call-ins," which the in-room clinician relays word for word to the family. These "verbalizations" are the model's primary intervention, and take the form of comments, thoughtful questions, observations, and offers of validation and support.

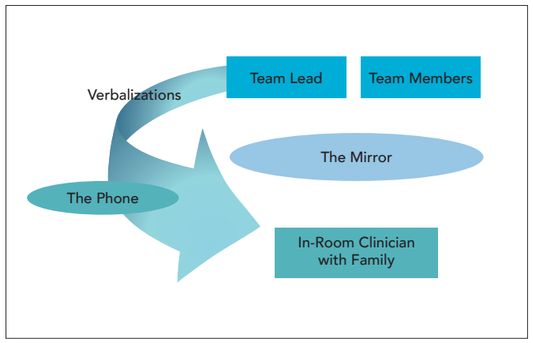


Figure 1. Key components of FamilyLive.

Families quickly adapt to the telephone calls, and generally experience the team as a helpful and reliable presence. The family consents to the FamilyLive experience and meets the team lead and any team members. The caregiver is treated as the authority and decision maker, which is part of a "shared power" approach to practice. The model's predictable session routine keeps anxiety down and helps with strong emotions and difficult content.

PROGRESS IN THE MODEL

Using the FamilyLive developmental ladder (Figure 2), caregivers develop skills in the following areas: Awareness of Self (essential self-care); Affect Management (expressing a full range of emotions in safe ways); Emotional Perspective Taking (considering multiple points of view with more clarity and detachment); Interpersonal Skills (on boundaries, expectations, and addressing conflicts); Personal Reflective Function (understanding the interplay of relationships); and Parental Reflective Function (on the caregiver's own role in interactions with the child).

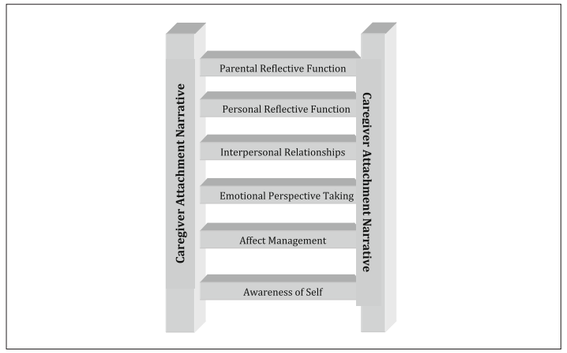


Figure 2. FamilyLive developmental ladder.

FAMILYLIVE IN PRACTICE

"Ms. Green" has a history of early sexual and physical abuse, being bullied, abandonment, and foster care. Now she is raising her own two young children locally, and has older children living out of state with a relative. She and the younger children are seen at our Unity Clinic (for the deaf or hard-of-hearing community) because Ms. Green is deaf and requires an ASL interpreter. Her Unity therapist referred her to FamilyLive because she was having trouble managing her children, who were demonstrating risky behavior. School personnel, pediatricians, and protective services staff were concerned about the children's mental health symptoms and whether their needs were being adequately met.

In initial FamilyLive sessions, Ms. Green engaged the team, the in-room clinician, and the ASL interpreter through humor that was animated but out of sync with her family's serious situation. Her humor would alternate with periods of extreme frustration, and she did not differentiate her children's occasional bad behavior from their more serious outbursts. However, as she began to make progress on the first two ladder rungs of FamilyLive, Ms. Green

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...FAMILYLIVE FOR ENGAGEMENT AND CHANGE

A TEAM LEAD REFLECTS ON THE FAMILYLIVE MODEL

From the moment the parent steps into the therapy space, the model "models" that they are the key to the well-being and recovery of their child. It actively helps the parent to discover what they need and want for themselves, and to recognize that the work is necessary before they can provide what their child may need or want. The model does this by fostering parental curiosity about how their own trauma history has played a role in who they are today, as a person as well as a parent. It provides an opportunity for parents who have experienced lifelong trauma, which includes being failed by systems and individuals who should have been sources of protection, to participate in a service that predictably and continuously provides containment, support, and shared power.

– Cindy Rollo, LCSW-C

developed skills for participating constructively in sessions, such as reporting coherently on recent events and with reference to her own thoughts and feelings. She has increased her supervision of the children and now varies her use of discipline strategies. She recognizes her own sad feelings separate from her children, and that the feelings relate to her own difficult and extremely invalidating childhood. She is starting to report a clearer understanding that the kids have their own reactions to events and that she can express concern for their feelings while starting to hold them more accountable for their behavior.

Regarding her family's progress in FamilyLive, Ms. Green said, "As parents, we are old dolls and broken dolls [a reference to the movie "Toy Story"]. My family growing up was fractured and I never fit in. I felt I was in the dark in a closet. I have some wounds I can't fix but my children are the new dolls. I am giving them opportunities to not be like me. When I started in these sessions, I was a broken doll and now I am a new doll with my children and partner." According to in-room clinician Casey Anderson, LCPC, Ms. Green "has distilled the connections between her personal trauma history, development as a parent, and value as an individual. She has developed a new way of staying true to herself while also balancing the needs of her children. She is taking more risks in service of her children's and family's needs, including advocating that she receive appropriate ASL interpretation services. She has benefitted from compassion, empowerment, persistent validation, and rigorous tracking and organization. The sessions use careful pacing in a way that allows her to synthesize and reflect before taking action."

When caregivers participate in their children's therapy, the whole family benefits. Pictured are Kandi Robinson (2nd from R), her sons Kwon Robinson (L) and Quis Whitaker (R), and FamilyLive in-room therapist Shahla Adam (at desk). Photo courtesy of Sarah A. Gardner.

FAMILYLIVE TRAINING

There are three team leads practicing FamilyLive at the Traumatic Stress Center: model developer and trainer Sarah Gardner, and leads Teresa Loya and Cindy Rollo. The model is in demand at the Center but it is difficult to introduce to other settings because mastery in the model requires didactic training, observation of the model in action over time, coached sessions, and then solo sessions. Current training and dissemination efforts focus on spreading practical strategies and tools (see below) to support working with families led by caregivers with difficult histories, who benefit from learning new skills in a highly supportive environment.

■ ***Sarah A. Gardner, LCSW-C***

For further reading, see:

Gardner, S., Loya, T., Hyman, C. (2014). FamilyLive: Parental Skill Building for Caregivers with Interpersonal Trauma Exposures. *Clinical Social Work Journal, 42*, 81-89. DOI: 10.1007/s10615-012-0428-8

"Working with Parents/Caregivers in Trauma-Focused Therapy: A conversation guide." A new resource based on FamilyLive. https://www.fittcentertoolkit.org/

"Getting Help After Trauma: Is My Family Ready?" For families considering their readiness for help. https://www.kennedykrieger.org/sites/default/files/library/documents/patient-care/centers-and-programs/traumatic-stress-center/Family%20Readiness%20Worksheet.pdf

"What's Sharing Power Got to Do With Trauma-Informed Practice? Sharing Power Tip Sheet and Reflection Tool." Assists providers in building skills for engaging with families using a shared power approach. https://www.nctsn.org/sites/default/files/resources/fact-sheet/whats_sharing_power_got_to_do_with_trauma-informed_practice_2.pdf

AT THE CENTER

WE ARE A FAMILY AFFAIR, TAILORING SUPPORT AND OVERCOMING BARRIERS

The Center for Child and Family Traumatic Stress has been serving children and their families for more than three decades. While the center's name (formerly the Family Center) and locations in Baltimore have changed, its focus on helping families access effective mental heath services has remained the same. For many of the families we serve, substantial obstacles in daily life – housing and food instability, inactive insurance, and caregiver stress, to name a few – often stand in the way of their ability to consistently attend and benefit from therapy. In an effort to eliminate these barriers and make treatment more accessible, the Traumatic Stress Center provides a unique combination of therapeutic and ancillary services for our clients.

Research has indicated that parental stress is associated with higher levels of behavioral and emotional problems in children (see Neece, Green, & Baker, below). Traumatic Stress Center social worker Gloria Seo, LCSW, and psychologist Jen Serico, PhD, recognize these findings and are aware of the relationship between caregivers' well-being and the ability to positively engage in their children's treatment. They are co-leading the Caregiver Support Group at the Center this summer. An annual offering, this group is comprised of caregivers referred by their child's individual therapist. It is designed to allow the caregivers to support one another while discussing everyday stressors and the impact of trauma on their families. Group activities are selected based on the interests and needs of the caregivers in the group; they often focus on self-care and problem-solving. For Seo and Serico, family support is the ultimate focus. "Caregiver Group provides an additional level of support," Seo stated, "so that caregivers can more actively participate in their children's trauma treatment."

Bilingual case manager Leslie Hoegg described the work she does to support the Center's Spanish-speaking families as an opportunity to partner with them and "open up more space" for them to focus on their children's mental health care. Hoegg's ancillary support can look different for each family, depending on the needs at hand. She may help parents apply for insurance, or go with them to the Department of Social Services to apply for services. She recalled accompanying a mother and her children on the bus in an effort to reduce the mother's anxiety about navigating the bus system. In the end, the family was able to overcome this barrier to obtaining mental health services.

Leslie Hoegg, case manager at the Center for Child and Family Traumatic Stress.

Through both therapeutic and ancillary services, the Center's staff continue to demonstrate their commitment to our children and families on their paths to improved mental health.

■ ***Anjelica Jackson, PsyD***

For further reading, see:

Neece, C. L., Green, S. A., & Baker, B. L. (2012). Parenting stress and child behavior problems: a transactional relationship across time. *American Journal of Intellectual and Developmental Disabilities, 117*, 48–66. https://www.aaiddjournals.org/doi/abs/10.1352/1944-7558-117.1.48

OUR 35 YEARS OF SERVICE AND GROWTH

In 1984, the Department of Family and Community Interventions (DFCI) began as a grant-funded project to better meet the treatment and evaluation needs of kids in foster care. Now the department is made up of three service programs at Kennedy Krieger Institute: The Center for Child and Family Traumatic Stress, Southeast Baltimore Early Head Start, and Therapeutic Foster Care. Representatives from each program gathered for a 35th anniversary celebration this summer – including guests of honor (pictured, L to R) Helen Kimmel, former department director; Margaret Bowler, former recreational therapist; and Elaine Harmel, former Care Center manager. At the reception, the celebrants shared cards, mementos, and pictures of past and current colleagues.

(Photos courtesy of Sarah A. Gardner)

This newsletter is a new endeavor for us! We'd like to hear your thoughts and suggestions, and about relevant happenings in your own work spaces. Please e-mail us at *TSChronicles@KennedyKrieger.org*