Center for Child and Family Traumatic Stress
at Kennedy Krieger Institute

INAUGURAL EDITION
SPRING 2019

# TRAUMATIC STRESS CHRONICLES

GROWTH THROUGH TREATMENT, TRAINING, AND RESEARCH

## INSIDE THIS EDITION...



INTERVENTION INSIGHTS

## CPP: OUR EXPERIENCE AS TRAINEES AND PROVIDERS

Child-Parent Psychotherapy (CPP), based on the seminal work of Selma Fraiburg, integrates attachment, psychodynamic, developmental, trauma, social learning, and cognitive behavioral theories. It is an evidence-based practice whose primary goal is to bolster the relationship between the caregiver and young child. The decision to bring CPP to the Center for Child and Family Traumatic Stress stemmed from a long-held recognition of the need for specialized mental health services for very young children. Since the Center's inception, our training and service development have included: Greenspan's Developmental, Individual-Difference, Relationship-Based (DIR) model; a grant-funded crisis nursery program; the Birth to Five Clinic; Southeast Early Head Start (SEEHS); the Chicago Parenting Program; and Parent-Child Interaction Therapy (PCIT). In 2015, the Center's leadership made the commitment to join the Mid Atlantic CPP Learning Collaborative offered through the Taghi Modarressi Center for Infant Study, Division of Child and Adolescent Psychiatry at the University of Maryland School of Medicine, in collaboration with CPP model developer Alicia Lieberman.

CPP is designed to address the needs of children exposed to a variety of traumatic experiences including maltreatment, witnessing domestic violence, and traumatic losses.

*cont'd on page 6*

## WE MOVED, AGAIN! A PERMANENT HOME TAKES SHAPE


ART WITH A HEART

Journeys have beginnings, endings, and sometimes a few side trips along the way. The Center for Child and Family Traumatic Stress, formerly known as the Family Center, has had an unusually eventful journey when it comes to our physical locations. Since we began providing services in 1984, we have resided for brief or extended periods in multiple sites in Baltimore, some of them quite tight on space. At one point, we had to run our clinics in two separate locations at the same time.

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**This design for a mosaic mural will come to life in Summer 2019 at the hands of staff and families at the new home of the Center for Child and Family Traumatic Stress.**

# DIRECTOR'S CORNER

Welcome to the inaugural edition of *Traumatic Stress Chronicles*, a quarterly newsletter from the Center for Child and Family Traumatic Stress at Kennedy Krieger Institute in Baltimore, Maryland. Each year our multidisciplinary staff provide evidence-supported mental health treatment and assessment services to more than 1000 youth in the community who have experienced neglect, abuse, violence, and loss. Our Training Academy provides trauma-informed training, education, and consultation to mental health and other helping professionals. Our research initiatives center on the causes, consequences, and treatment of child and family trauma.

Now in our 35th year but having recently moved, this "fresh start" seemed like the right time to share our story in a medium we haven't tried before, and with a wider audience of current stakeholders, our current and potential collaborative partners, and the local and national communities we are part of. We're happy to include pictures of the Traumatic Stress Center's new location, as we are now settled in and getting used to a newly constructed building that offers, among many benefits, more space and closer proximity to other departments at Kennedy Krieger. The goal of this inaugural newsletter is to introduce you to the Center by highlighting current examples of our work in each area of our tripartite mission: treatment, training, and research. With a treatment focus on trauma in young children for this edition, we hope you'll find takeaways in reading about the importance of anchoring clinical care with a trauma lens, and about our experience implementing Child-Parent Psychotherapy, one of several evidenced-based treatments our clinical staff have been trained in. As we gear up for our 7th Biennial Trauma Conference, to be held October 3-4, 2019, we take a look back on how the format of this conference has changed over the years. The focus of this year's conference will be on integrating social justice in trauma work at the individual, community, and organizational levels. The current newsletter also reports on studies conducted by our research director in the exciting field of epigenetics, which holds some promise for helping us understand the relationship between adverse childhood experiences and negative health outcomes.

Critical to the Center's success over the years are partnerships with organizations and institutions in Baltimore City whose mission, service delivery, or academic endeavors are synergistic with ours. The first such organization we are featuring is Health Care for the Homeless, which provides medical care, support, and advocacy to clients significantly challenged by housing instability, and with whom we've collaborated for 10 years.

It is my hope that as you read this newsletter and editions to come, you get to know us and our commitment to increasing the quality of and access to care for traumatized children and families and the communities in which they live.

Sincerely,

■ ***Elizabeth A. Thompson, PhD***

We invite you to join us for the **7th Biennial Trauma Conference on October 3-4, 2019.** For more information on current trainings, conference updates, and registration information, visit www.kennedykrieger.org/traumatraining or call us at 443-923-5971.

TRAINING FRONT

# 7TH BIENNIAL TRAUMA CONFERENCE:
## A SOCIAL JUSTICE LENS

The 7th Biennial Trauma Conference at the Center for Child and Family Traumatic Stress will take place October 3-4 of this year with a focus on social justice. We will bring together mental health providers to examine how we conceptualize social justice within clinical practice; how we can foster confidence-building and advocacy skills; and how we can employ practice approaches that support social equity and cultural democracy for children and families across the lifespan.

Over the past 12 years, the Trauma Conference has grown in popularity and built a reputation for offering relevant workshops and tackling tougher conversations and topics. In 2007, the first conference featured Vincent Felitti, author of the landmark ACE study, as the keynote speaker. In 2011, we expanded the conference to two days and introduced pre-conference intensives. In 2013, we adopted the tagline *Addressing Trauma Across the Lifespan* in order to reach a broader range of trauma professionals. We also introduced trauma-themed performances. (The award-winning artists who have filled this role include Maria Broom, Judith Sloan, and Stacy Jewell.) The focus of our 6th Biennial Conference was *Modern Day Threats and Social Discord*.

From our first trauma conference to now, the ACE research has remained highly relevant, and has prompted us to reexamine social policies that affect the most vulnerable, oppressed, and impoverished members of our communities. The Traumatic Stress Center has defined social justice as: Advocating for the needs of marginalized people (sexual, racial, linguistic, neurological, and economic disparities) in the context of individual and cultural diversity. The complexity of social justice makes it imperative for us to think of more creative and collaborative ways to address the social justice problems of our day – a goal we will pursue at the 7th Biennial Conference.

■ ***Betsy Offermann, LCSW-C***

*cont'd from page 1*

# ...A PERMANENT HOME TAKES SHAPE

Begun in 2016, the new building on Ashland Avenue in Baltimore is now home to the Center for Child and Family Traumatic Stress.

Center staff members Sarah Gardner and Sheryl Jefferson (L and R) joined family member Norene Hammack at the building's groundbreaking ceremony.

Our spacious new Community Room was not empty for long. (All photos this page and page 6 courtesy of Sarah A. Gardner.)

Looking west to our Baltimore neighbors from our new fourth floor space. We also fill the third floor.

We always hoped that that part of our journey would have an end point, and it did. In late 2018, the Center moved to a brand new, permanent space on the campus of the Kennedy Krieger Institute.

We first learned in 2014 about the exciting plans to erect a new Kennedy Krieger building dedicated to outpatient care, into which our center would move along with several other mental health programs. By this point, we were settling into our new name, the Center for Child and Family Traumatic Stress at Kennedy Krieger Institute. Plans for construction continued to take shape, and in October 2016, staff members from the Center took part in a groundbreaking ceremony for the building. Although we had been planning and fundraising for this major transition for many months, it only began to seem real on that blustery October day. A particular highlight was the touching speech delivered by Norene Hammack, a family member from our program, in which she described the help and support she received for her son at the Center. It was hard to imagine during the ceremony what would spring from that plot of land. But in the months that followed, we were able to watch the construction via live feed!

> IT ONLY BEGAN TO SEEM REAL ON THAT BLUSTERY OCTOBER DAY AT THE GROUNDBREAKING CEREMONY.

In mid-2018, the building was accelerating towards completion and we prepared for relocating. On the first Friday in December, we moved to two expansive floors in the new space. Moves are always stressful, but we gave as much organization and planning to the task as we could muster. As a result, we were able to bring in clients for their appointments with minimal disruption to the process of care.

To be sure, the children and families demonstrated a lot of flexibility in the early weeks of settling into the new space. They were also excited – about the newness, the size, and the thoughtful touches in the space. Every day we appreciate being able spread out a little bit, and make use of a lovely Community Room. We have beautiful light and views, a large kitchen, and great storage. We have easier access to each other and our Kennedy Krieger Institute colleagues.

One of the fundraising events for the move took place in April 2016, when our staff members participated in Kennedy Krieger's ROAR for Kids, an annual run-walk at Oregon Ridge Park. Our team, ROARing for Art, raised money to hire Art With a Heart to design and help us create a mosaic mural for the space (see the final design on page 1). The completion of the mural is slated for Summer 2019 with the help of staff, kids, and families.

■ ***Sarah A. Gardner, LCSW-C***

RESEARCH UPDATE

# ADVERSE CHILDHOOD EXPERIENCES, EPIGENETICS, AND THE OBESITY EPIDEMIC

Over the past two decades, since the seminal study published by Felitti and Anda, there has been a growing appreciation of the role of adverse childhood experiences (ACE) in the development of a range of negative health outcomes (Figure 1). Child maltreatment and other ACEs are risk factors for multiple psychiatric disorders, and several health risk behaviors, including smoking, overeating, and excessive alcohol and drug use. Above and beyond the effects of these health risk behaviors, ACEs have been found to predict a multitude of medical problems later in life, including ischemic heart disease, stroke, respiratory problems, diabetes, and even cancer.

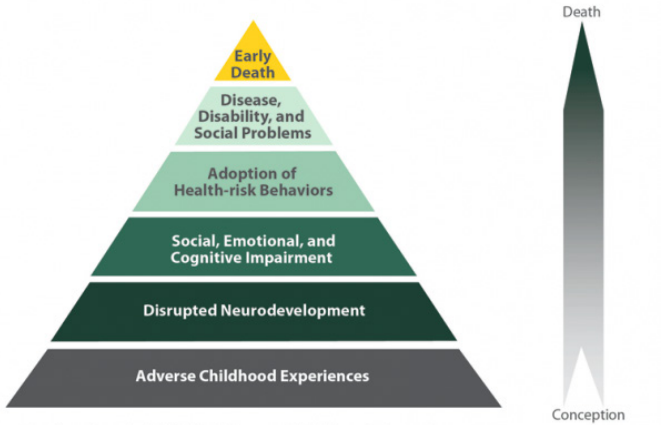


**Figure 1. Potential consequences of adverse childhood experiences on health and well-being across a lifetime.**

The exact mechanism by which ACEs predict this broad range of negative health outcomes is currently unknown, but there is preliminary evidence that childhood adversity may increase risk through epigenetic mechanisms. Epigenetics refers to chemical modifications to genes that do not involve mutations or changes in DNA nucleotide sequence. These chemical modifications can alter gene activity and may contribute to disease risk, with DNA methylation one of the most studied epigenetic mechanisms.

In a prior investigation we found that experiences of child maltreatment were associated with differential methylation at 2,868 sites along the genome. The methylation differences were found in genes involved in biological processes relevant to psychiatric and substance use disorders, heart disease, stroke, respiratory disease, diabetes, and cancer – as noted above, all medical illnesses that have been linked to adversity in youth. Although this study found differential methylation in genes related to ACE-associated health problems, it did not include any health assessments.

My colleagues and I then conducted a follow-up study in which we investigated measures of ACEs, DNA methylation, and obesity in school-aged children. We selected obesity as the health outcome (Figure 2) because it is the medical problem associated with childhood adversity that is most apt to manifest in youth. The results of this study, published recently in *The Journal of Pediatrics*, included identification of 10 methylation sites that

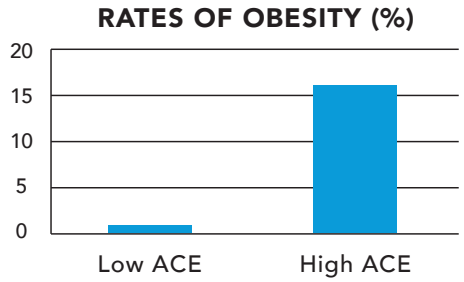


**Figure 2. Among children in our study of ACEs and obesity, the children who experienced high numbers of ACEs were 16 times more likely to be obese than those who experienced low numbers of ACEs.**

interacted with ACEs to predict obesity in the youth. Eight of these methylation sites were in genes previously associated with obesity risk or related to metabolism or fat tissue development. To the best of our knowledge, this is the first study to report childhood adversity-by-methylation predictors of obesity – or any health outcome associated with ACEs.

We are currently continuing our research with a prospective longitudinal study of 470 mothers recruited in their third trimester of pregnancy and followed until their child's second birthday. This new study may allow for a replication and extension of our prior findings. Exposure to ACEs and other forms of chronic psychosocial stress often accompanies the experience of poverty and racial or ethnic minority status, and may be causally related to health disparities. The ultimate goals of this line of research are to unravel the mechanisms by which adversity exerts risk for negative health outcomes, to learn how to best modify disease risk, and to reduce health disparities.

■ ***Joan Kaufman, PhD***

For further reading, see:

Felitti, V. J., Anda, R. F., Nordenberg, D., Williamson, D. F., Spitz, A. M., Edwards, V., Koss, M. P., Marks, J. S. (1998). Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults: The Adverse Childhood Experiences (ACE) Study. *American Journal of Preventive Medicine, 14*, 245-258. https://www.sciencedirect.com/science/article/pii/S0749379798000178

Kaufman, J., Montalvo-Ortiz, J. L., Holbrook H., O'Loughlin, K., Orr, C., Kearney, C., Yang, B-Z., et al. (2018). Adverse childhood experiences, epigenetic measures, and obesity in youth. *The Journal of Pediatrics, 202*, 150-156.e3. https://www.jpeds.com/article/S0022-3476(18)30876-X/pdf

Yang, B-Z., Zhang H., Ge W., Weder N., Douglas-Palumberi, H., Perepletchikova, F., Gelernter J., & Kaufman, J. (2013). Child abuse and epigenetic mechanisms of disease risk. *American Journal of Preventive Medicine, 44*, 101-107. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3758252/

COMMUNITY SPOTLIGHT

# HOW WE PARTNER WITH HEALTH CARE FOR THE HOMELESS

The Center for Child and Family Traumatic Stress has had the privilege of partnering with Health Care for the Homeless for more than a decade. This Baltimore-based organization is the largest provider of medical and behavioral health services for homeless persons and families in the state of Maryland. Its offices, mobile clinic, and outreach teams serve approximately 12,000 homeless individuals per year throughout the state. It also provides advocacy and case management services including referral of patients for other needed services – among these are mental health services for children, teens, and families who receive care through the organization's pediatric clinic. Staff members frequently refer their young patients for evidenced-based mental health services at the Traumatic Stress Center. In turn, case managers at the Center connect our families experiencing housing insecurity with Health Care for the Homeless for the best possible medical services they can receive.

The Center's relationship with the organization is based on mutual respect and the common mission of serving our community's most vulnerable families. We also share an understanding of the impact of trauma on families and family functioning. Homelessness is a trauma. It has a significant impact on the mental health of children and families. Many children in our communities experience multiple stressors associated with homelessness, such as witnessing caregiver stress, witnessing or experiencing domestic or community violence, and food insecurity. Moreover, as a result of either homelessness or involvement in the child welfare system, these children are at exceptional risk for bullying, poor academic performance, and separation from parents and siblings.

Social worker Debbie Wilcox, LCSW-C, based at the Baltimore office of Health Care for the Homeless, says that the children and teens served at the office's pediatric clinic present with a range of mental health issues related to trauma: anxiety, hypervigilance, sleep issues, and behavioral issues such as aggression, hyperactivity, and lack of focus. She has also observed separation anxiety and intense emotional responses to common medical procedures from youth with trauma history. Living in shelters with no personal space, few opportunities for play, and frequent interactions with other traumatized children can compound trauma symptoms.

Debbie spoke recently about a family she referred to the Traumatic Stress Center. She had recognized at the pediatric clinic that the mother and children were under intense stress from experiencing homelessness, domestic violence, and a tragic death in the family. The little girls in the family were anxious and unfocused, and they had difficulties separating from their mother. The youngest girl was having tantrums that seemed to come from nowhere and last for a long time. Upon Debbie's referral, we completed an assessment of the family members at the Center. They are now in treatment to help them process their experiences; and to support the mother's efforts to respond to stressors, increase the family's stability, and develop a plan to predict and reduce trauma symptoms.

We share a mission of serving our community's most vulnerable families.

Health Care for the Homeless is also responding to an increasingly vulnerable population in our community: Spanish-speaking immigrants, who now comprise about 50% of the patients seen by the organization. Debbie Wilcox pointed out that many children and families in this population demonstrate intense anxiety related to trauma experienced in their countries of origin, compounded by trauma related to the immigration process, family separation, and ongoing fears for their safety in the United States. The children often elope from school, and they worry that their parents won't be home when they get there. Staff members have worked diligently to address the cultural stigma associated with mental health issues, and to get these families the treatment they need at the Traumatic Stress Center – whether or not they are insured.

Each year since 1994, the Traumatic Stress Center has been the fortunate recipient of grants under the Victims of Crime Act (VOCA), administered by the US Department of Justice. Grant funds have enabled us to provide mental health services free of charge to many uninsured children and families who have experienced trauma. Now this grant is allowing us to expand our reach to children and families who are Spanish-speaking, uninsured, or undocumented (a particularly vulnerable group at this moment). Wilcox noted that in many cases, the Center is "really our only resource to serve these families."

The Traumatic Stress Center is committed to our partnership with Health Care for the Homeless. As a small token of our appreciation for its work, our staff members made hygiene kits for the families and donated toys at the holidays. We look forward to many more years of working together to recognize and support the needs of our community's most vulnerable families as well as responding to social justice issues that negatively impact families' functioning.

■ ***Emily Driscoll-Roe, LCSW-C***

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# ...OUR EXPERIENCE AS CPP TRAINEES AND PROVIDERS

Across an average of 50 sessions, all of which involve the child and parent or caregiver, the CPP work focuses on restoring the child's sense of safety and regulation of affect; normalizing trauma responses; improving the caregiver-child relationship; and jointly constructing a trauma narrative. CPP's evidence base includes three randomized controlled studies of trauma-exposed children from a range of cultural groups – including Central and South American, Caucasian, African American, Native American, and Cambodian – based in mostly urban settings and from lower income backgrounds.

## THE TRAINING PROCESS

The Mid Atlantic CPP Learning Collaborative consisted of three learning sessions separated by six-month intervals during which trainees engaged in consultation calls. This approach supports skills development through direct practice, and recognizes that practice improvement must be embedded in strong institutional practices and a commitment to change.

In a recent interview, CPP trainer Kay Connors, LCSW-C, Program Director at the Taghi Modarressi Center, said that her experience training our team was "fun and incredibly rewarding." She described the Traumatic Stress Center as a "good holding-environment for the model" because of our numerous strengths – including "dedicated and expert administrators who understand the work at a deep level." Referencing the term "organizational fidelity," Kay noted that the Center prioritizes the needs of staff members through protected time for learning and clinical discussion. The use of "reflective supervision" helps sustain CPP's emphasis on the impact of emotional content in key therapeutic relationships: practitioner and supervisor, practitioner and caregiver, and parent and infant or toddler. Connors also pointed out that the Center's training team (see photo above) was already grounded in trauma-informed assessment and treatment practices, early childhood clinical competencies, family-centered practice, and choosing, prioritizing, and implementing evidence-based practices.

> THE PREMISE OF CPP IS SMART. I LIKE BEING INVOLVED AND PART OF THE HEALING PROCESS. I THINK THAT MAKES IT MORE EFFECTIVE.
>
> A CAREGIVER PARTICIPATING IN CPP

Sheryl Jefferson, LCSW-C, CPP Coordinator at the Traumatic Stress Center, spoke about the rigors of the CPP training experience, which, in addition to didactic sessions, included weekly meetings, consultation calls, and completion of fidelity forms. "We were already addressing trauma directly, which put us ahead of the game," Sheryl recalled. Still, Jefferson and our other CPP team members – including Marilyn Camacho, LCPC, Beth Campbell, LCPC, Teresa Loya, LCSW-C, and Jasmine Grant, LCPC – have encountered challenges in CPP implementation. For example,

**Child-Parent Psychotherapy team at the Center for Child and Family Traumatic Stress. L-R: Sheryl Jefferson, Teresa Loya, Jasmine Grant, Marilyn Camacho, and Beth Campbell. Each member received CPP certification through the Mid Atlantic CPP Learning Collaborative. Grant, Jefferson, and Loya are certified as CPP supervisors.**

## CPP IN PRACTICE

Sheryl Jefferson's first application of CPP was with a family in which the foster parent, who had never raised children, was caring for toddler twins, a boy and girl. The boy had extreme and unusual behaviors, while the girl elicited more favorable responses from adults. Both kids had difficulty with bath time and a strong preoccupation with food.

Jefferson had no clear information about the kids' past experiences, so it was difficult to make connections between their behaviors and their histories. However, in following the CPP model and incorporating play therapy methods, the team and foster parent gradually understood the kids' behaviors and difficulties as stemming from early and severe neglect. The foster parent modified her management of the twins and relied less on punishment. With her greater understanding of the children, she became more patient and confident. She also reflected on her own history; being the parent of these children had brought up difficult parts of her early life that she hadn't fully examined. These gains produced shifts in the relationships, allowing both of the children, but especially the boy, to feel better.

"I love this model," Jefferson volunteered. Among her reasons: the model uses a lot of play and focuses on the relationship between parent and child; it helps parents gain a better understanding of behavior and increase their competence and creativity; it gets at the roots of children's behavior through an expanded understanding of trauma exposures; and it helps parents consider important and possibly painful connections to their own histories.

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# ...OUR EXPERIENCE AS CPP TRAINEES AND PROVIDERS

although our system was set up to manage young children, our Community Room is not staffed for the presence of kids under age four without caregivers. The staff came up with creative solutions for meeting with families with multiple young children. Another challenge was making sure that clinical pathways clearly differentiated which clients should be followed in CPP, and which in PCIT. All in all, "there was a lot of support for a new model," Sheryl said.

CPP has a train-the-trainer model called the CPP Agency Mentorship Program (CAMP), an 18-month process. Discussions are underway at the Traumatic Stress Center about the participation of our CPP team in this experience.

■ ***Sarah A. Gardner, LCSW-C***

For further reading, see:

Child-Parent Psychotherapy.
http://childparentpsychotherapy.com/about/contact/

Lieberman, A. F., Van Horn, P., & Ghosh Ippen, C. (2005). Toward evidence-based treatment: child-parent psychotherapy with preschoolers exposed to marital violence. *Journal of the American Academy of Child and Adolescent Psychiatry, 44*, 1241-1248. https://www.ncbi.nlm.nih.gov/pubmed/16292115

California Evidence-Based Clearinghouse for Child Welfare.
http://www.cebc4cw.org/

TRAUMA IN FOCUS

# THE IMPORTANCE OF TRAUMA-INFORMED CARE ACROSS PROVIDERS

Understanding traumatic stress and the impact it has on children is essential to effective intervention by the individual providers and child-serving systems in our communities. This understanding allows professionals in all capacities to intervene and provide services and support that are meaningful and protective. It also allows a deeper picture of the unique needs of each child and how to meet them successfully.

### HOW DOES TRAUMA AFFECT A YOUNG CHILD'S DEVELOPMENT?

Early childhood trauma can alter how children's brains function and change the trajectories of children's development. The first years of life are critical to brain development across all domains of cognitive function; this includes areas that play key roles in executive cognitive functions such as memory, attention, language, problem-solving, and perceptual awareness. Trauma-related alterations in these and other areas may negatively affect development. They may, for example, impact the child's readiness to learn and ability to function in school. They may be expressed in the form of emotional dysregulation, behavioral challenges, adverse health effects, disrupted social attachments, and regression of developmental skills. When these trauma-related symptoms persist beyond early childhood, they may further affect children's performance in school and their ability to maintain meaningful social supports.

### WHAT IS TRAUMA-INFORMED CARE?

Trauma-informed care begins with provider knowledge and recognition of traumatic stress and its potential effects on children. It is the response of caregivers and providers who are using this trauma lens to guide their interactions with children. It is the collaboration of providers, programs, and agencies to promote children's physical and psychological safety. It is the promotion of recovery and resilience through the use of trauma-informed, evidence-based interventions.

### HOW DO WE CREATE TRAUMA-INFORMED SYSTEMS?

Trauma-informed systems are empathy-based systems. On this foundation, providers can build strong partnerships and relationships with children and families. They can meet each child and family "where they are" and identify their strengths as well as needs.

Trauma-informed systems screen for trauma exposure and trauma-related symptoms. They use evidence-based, culturally responsive assessments and interventions. Trauma-informed systems provide resources to children and families designed to promote their own understanding of what trauma is and the impact it can have on functioning and development. Trauma-informed systems identify protective factors in children and families and work to promote resilience and well-being. These systems also address intergenerational trauma and its impact on family systems.

Trauma-informed systems further emphasize continuity of care and collaboration across services and providers. Of course, the creation, maintenance, and growth of trauma-informed systems rely on adequate professional training and support.

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# ...TRAUMA-INFORMED CARE ACROSS PROVIDERS

*cont'd from page 7*

**WHAT ARE THE CONSEQUENCES OF PROVIDING CARE WITHIN SYSTEMS THAT ARE NOT TRAUMA-INFORMED?**

Systems and professionals operating without a comprehensive understanding of traumatic stress may make misdiagnoses leading to incorrect treatment and medications, adverse educational outcomes, negative family system outcomes, and continued exposure of the child to traumatic stress. Children may remain vulnerable to the compounding effects of untreated traumatic stress.

## A YOUNG GIRL WITH TRAUMA-INFORMED PROVIDERS

Joy, age three, was removed from her parents' care at age two due to neglect. Before her placement in foster care, she had witnessed her parents' drug abuse and domestic violence and experienced homelessness and food insecurity. Joy had delays in language development. She was often irritable and withdrawn, and she had sleep problems, significant tantrum behavior, and delayed toilet training. Her foster parents sought therapy to address these issues.

Joy's situation and challenges were formidable. Yet she was eventually, and successfully, reunited with her biological family. The child-serving systems around her had responded to her with an understanding of trauma, and she encountered adults and professionals who interacted with her through a trauma lens – who recognized and took account of the impact of her trauma experiences. Without this lens, Joy's foster parents may have interpreted her behaviors as strictly oppositional and exacerbated her symptoms with inappropriate interventions. With this lens, her case manager was able to connect Joy's history of homelessness with her difficulty adjusting to a foster home. Her lawyer was able to make due note of her trauma history while advocating on her behalf. Her preschool teachers could recognize and address her challenging behaviors as symptoms of trauma. Ultimately, her parents' own growing insights on traumatic stress helped them successfully reunite with their daughter and support her well-being and resilience.

■ ***Kendall Patterson, LCPC***

# *Meet the Contributors*

*from the Center for Child and Family Traumatic Stress*

***Emily Driscoll-Roe, LCSW-C, Social Work Manager***
Emily received her undergraduate degree from Fordham University in 1993, and her master's degree in Social Work from New York University in 1996. She has provided therapeutic services to children, adolescents, and their families since 1996, and has practiced in New York City; Dayton, Ohio; and Baltimore. At the Center she has received extensive training in providing mental health services to survivors of sexual abuse.

***Sarah A. Gardner, LCSW-C, Director of Clinical Services***
With 30-plus years of service at Kennedy Krieger Institute, Sarah is an experienced administrator, supervisor, trainer, and clinician. She developed FamilyLive, an innovative family therapy model that helps caregivers with unresolved trauma histories to improve their parenting skills. She has also participated in national efforts to improve access to trauma services for families affected by cultural, racial, and economic barriers to care.

***Joan Kaufman, PhD, Director of Research***
Dr. Kaufman received her PhD in Clinical Psychology from Yale University, where she served on faculty from 1998 to 2015. In 2015 she moved to Baltimore to direct research at the Center. She is also a Professor of Psychiatry at Johns Hopkins. Her research in the area of child abuse and neglect spans from neurobiology to social policy, and uses tools from psychology, genetics, and neuroscience to understand mechanisms of risk and resilience.

***Betsy Offermann, LCSW-C, Co-Director of Training***
Betsy received her master's degree from the University of Maryland at Baltimore in 1985. She has more than 34 years of clinical experience in the area of child sexual abuse and trauma. She developed and directs a sexual abuse treatment program and co-directs the Training Academy at the Center.

***Kendall Patterson, LCPC, Therapist***
Kendall obtained her undergraduate degree in Psychology from Davidson College and her master's in Counseling Psychology from Towson University. She has experience providing trauma-informed treatment to adults, children, and families. Evidenced-based treatments including Trauma-Focused Cognitive Behavior Therapy, Cognitive Behavior Therapy, and play therapy inform her practice. She also has experience with program and grant management.

***Elizabeth A. Thompson, PhD, Vice President and Director***
Dr. Thompson is a mental health executive with an established track record of optimizing service delivery to traumatized children and families through organizational leadership, policy and program development, grants management, regulatory compliance, and community relations. She holds a faculty appointment in the Department of Psychiatry and Behavioral Sciences at Johns Hopkins.

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