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Trauma Adapted Family Connections: Reducing Developmental and Complex Trauma Symptomatology to Prevent Child Abuse and Neglect

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Families living in urban poverty, enduring chronic and complex traumatic stress, and having difficulty meeting their children's basic needs have significant child maltreatment risk factors. There is a paucity of family focused, trauma-informed evidence-based interventions aimed to alleviate trauma symptomatology, strengthen family functioning, and prevent child abuse and neglect. Trauma Adapted Family Connections (TA-FC) is a manualized trauma-focused practice rooted in the principles of Family Connections (FC), an evidence supported preventive intervention developed to address the glaring gap in services for this specific, growing, and underserved population. This paper describes the science based development of TA-FC, its phases and essential components, which are based on theories of attachment, neglect, trauma, and family interaction within a comprehensive community-based family focused intervention framework.

Family functioning may be negatively impacted when children and adolescents living in poverty experience chronic exposure to trauma(s) and environmental stressors. Increased exposure to stressful life events and chronic traumas such as multigenerational family, school and community violence, victimization, and traumatic loss often leads to the development and escalation of trauma symptoms among parents and children (Santiago & DeCarlo, 2010; Wood, 2003), challenges in parenting (Kiser, Nurse, Lucksted, & Collins, 2008), and heightened risk for child maltreatment (Drake & Pandey, 1996). There is a dearth both of family-focused trauma treatments (Collins, Connors, Davis, Donohue, Gardner, Goldblatt, Hayward, Kiser, Strieder, & Thompson, 2010) and trauma-informed service providers skilled in evidence-based treatment for traumatic stress-related disorders (Chadwick Center for Children and Families, 2004; Chaffin & Friedrich, 2004). Nevertheless, treatment strategies that address the child's experience within the family while incorporating evidence-based interventions show promise for the treatment of youth and families who are traumatized (Igelman, Conradi, & Ryan, 2007).

Trauma Adapted Family Connections (TA-FC) is a manualized trauma-focused practice rooted in the principles and essential components of Family Connections (FC), an evidence supported preventive intervention for child abuse and neglect (DePanfilis & Dubowitz, 2005). Intervention research (Brekke, Phillips, Pancake, O, Lewis, & Duke, 2009; Fraser, Richman, Galinsky, & Day, 2009) and implementation science (Fixsen, Blase, Naoom, & Wallace, 2009; Fixsen, Naoom, Blase, Friedman, & Wallace, 2005) propose specific processes for developing and adapting interventions for new target populations In particular, challenges in implementation occur when existing evidence supported practices are not tailored and therefore may not be appropriate for specific populations (Proctor, Silmere, Raghavan, Hovmand, Aarons, Bunger, Griffey, & Hensley, 2011). Using science based principles regarding best processes for adapting and testing interventions for new target populations, this paper

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describes the process of developing TA-FC to respond to the needs of families exposed to multigenerational trauma and/or current trauma. TA-FC is being pilot tested within a National Child Traumatic Stress Network Substance Abuse and Mental Health Services Administration supported Category II Center. Its principles and essential components are based on theories of attachment, neglect, trauma, and family interaction within an in-depth community-based family focused intervention framework.

Stages of Intervention Development

Following intervention research (Fraser et al., 2009) and implementation science (Fixsen et al., 2005; Fixsen et al., 2009) guidelines, four stages of the implementation development model are useful in describing the resulting TA-FC program:

1. specification of the problem and development of a program theory;
2. creation and revision of program materials;
3. refinement and confirmation of program components; and
4. assessment of effectiveness in a variety of settings and circumstances.

Problem Specification and Program Development

TA-FC targets families at risk of child neglect and maltreatment living in impoverished urban neighborhoods. These families often experience a variety of stressful life events, including severe and multigenerational chronic traumas such as family violence, unemployment, drug activity, incarceration, gang violence, failing schools, and personal victimization in the school and/or community (Kaysen, Resick, & Wise, 2003; Wood, 2003). Researchers and clinicians have postulated that the culture of poverty is partially mediated through the contextual environmental deprivations and circumstances that families endure (Wood, 2003), and that this culture of poverty is one of the largest predictors of child abuse and neglect (Sedlak, Mettenburg, Basena, Petta, McPherson, Greene, & Li, 2010).

The development team identified the need for the trauma adaptation of FC based on secondary data analysis of FC client baseline data. Approximately 50% of youth receiving services from FC scored in the clinical range for posttraumatic stress on the CBCL. The social and environmental adversities confronting children and families have been described as being "filled with misery and hopelessness" (Heclo, 1997); therefore, families affected by trauma may be best served through the use of a trauma informed care lens that uses trauma specific strategies and interventions. Trauma-informed care (TIC) provides a new paradigm, transforming the basic premise for organizing services from "What is wrong with you?" to "What has happened to you?" (National Center for TIC, 2008).

FC is grounded in public health and social work perspectives, and builds on 15 years of community-based family intervention and research. Core components include family engagement and comprehensive family assessment, emergency assistance to meet basic needs, SMART (specific, measurable, achievable, realistic, and time limited) case planning (Cournoyer, 2000), advocacy and service coordination, and individual and family counseling. FC reduces risk factors for maltreatment (e.g., parental depressive symptoms, parenting stress, life stress), enhances protective factors (e.g., parenting attitudes, parental competence, social support), improves child safety (physical and psychological care of children), and reduces internalizing and externalizing child behavior (DePanfilis & Dubowitz, 2005). It has been recognized as a promising program for preventing child neglect (California Evidence Based Clearinghouse for Child Welfare, 2008/2011; Thomas, Leicht, Hughes, Madigan, & Dowell, 2003), and is currently being replicated and evaluated nationwide (DePanfilis, Filene, & Brodowski, 2009).

Program Theory

Several theories and perspectives informed the development of TA-FC modules and strategies. Trauma theory is evidence supported, practice informed, rooted in the sociopolitical context of human well-being, and helps to explicate families' responses to traumatizing events. Trauma may disrupt attachment schema in

children and adults; therefore, developmental aspects of survivor experiences must be considered (Bloom, 2004; Pine, Costello, & Masten, 2005; Urban, 2003). Uncovering trauma responses specific to the family of origin as well as other historical individual, family, and/or community factors allows workers to address caretaker symptomatology and other aspects of the caregiving relationship. Altering patterns of response can moderate the child's problematic behaviors/symptoms, thereby interrupting the cycle of trauma (Scheeringa & Zeanah, 2001).

TA-FC further applies concepts and tenets of an eco-structural model (Aponte, 1994); Bowen family therapy (Bowen, 1978/2004; Gilbert, 2004; Harris & Topham, 2004; Kerr & Bowen, 1988); narrative practice (Freeman, Epston, & Lobovitz, 1997; White, 1986; White, 2007; White & Epston, 1990); cognitive behavioral strategies (Cohen, Mannarino, & Deblinger, 2006); and attachment theory (Egeland, 2007; Erickson, Egeland, Simon, & Rose, 2002; Sroufe, Egeland, Carlson, & Collins, 2005) to develop comprehensive assessments as well as intervention components and modules. These theories and perspectives are related to family triggers, reciprocal patterns of family interaction, disassociation, safety planning, complex trauma, and trauma-induced growth. In addition, there are special considerations for practice as it relates to implementing community-based family strengthening interventions with those who have experienced complex trauma.

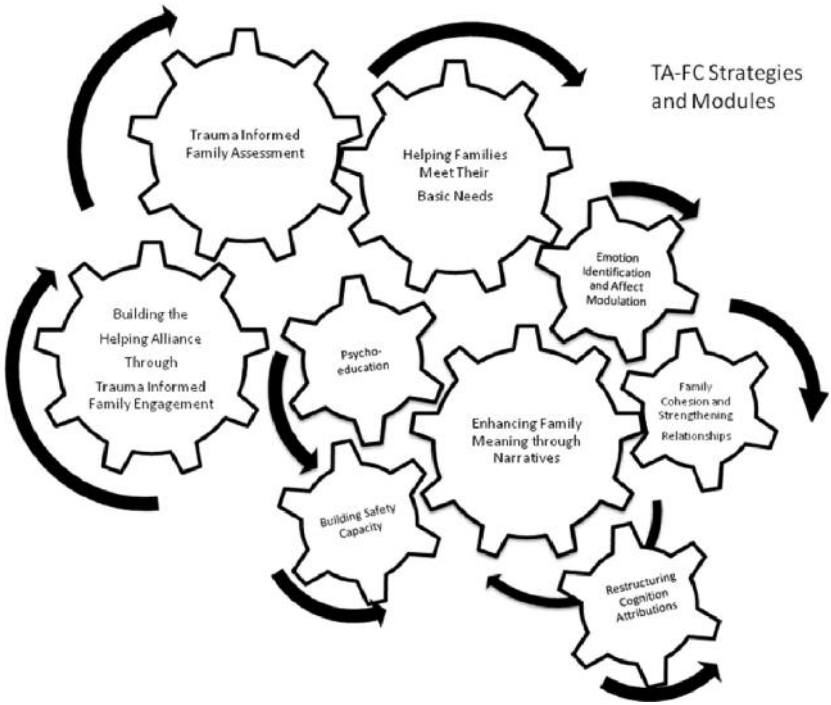
TA-FC Development Team

The TA-FC team consists of trauma clinicians, researchers, and community representatives. A family partnership group comprised of six families who completed FC services met quarterly to provide feedback on model development. The developers conducted an in-depth literature search using databases (e.g., MEDLINE, PILOTS, and PsycINFO) and identified core conceptual components of empirically based trauma informed family therapy strategies, consulting internationally recognized trauma clinicians, researchers and intervention developers throughout each stage of TA-FC development.

Theory of Change

TA-FC is designed to increase families' protective factors and decrease risk factors, with a particular focus on trauma. As depicted in Figure 1, TA-FC developers theorized that family and child well-being, permanency and safety can be achieved through (1) trauma-informed family assessment; (2) helping families meet their basic needs; (3) building the helping alliance through trauma-informed family engagement; (4) building safety capacity; (5) psychoeducation; (6) enhancing family meaning making through trauma narratives; (7) emotion identification and affect modulation; (8) family cohesion and strengthening relationships; and (9) restructuring cognitive attributions.

Figure 1
Theory of Change



Creating and Revising Program Materials

The developers augmented the original FC logic model (DePanfilis, 2002; DePanfilis, Dubowitz, & Kunz, 2008) to target trauma-focused risk and protective factors. TA-FC intervention supports families to promote well-being through (1) knowledge and normalization of trauma reactions; (2) family organization, cohesion, and adaptation to acute and chronic stress; (3) coping strategies/resilience enhancement/emotion regulation; (4) family-shared meaning of trauma and environment; and (5) social support including sibling support. Simultaneously, the model addresses reducing the following risk factors: (1) trauma symptoms of child and caregiver; (2) negative attributions related to traumatic events; and (3) child and caregiver trauma related mental health problems.

Program outcomes are focused on child/family safety and well-being and permanency and stability of the family system. Guided by the logic model, the development team established fidelity criteria for TA-FC, and revised the FC intervention manual to blend TA-FC concepts, phases, and essential components. Given the importance of clinicians' experience of secondary and vicarious trauma, supervision and staff development guidelines were modified using a trauma lens. The implementation plan also included pilot testing of the TA-FC protocol. After receiving IRB approval, TA-FC clinicians received training on the protocol and began providing program services. The development team continues to meet weekly to discuss implementation, adherence to fidelity, and enhancing model development.

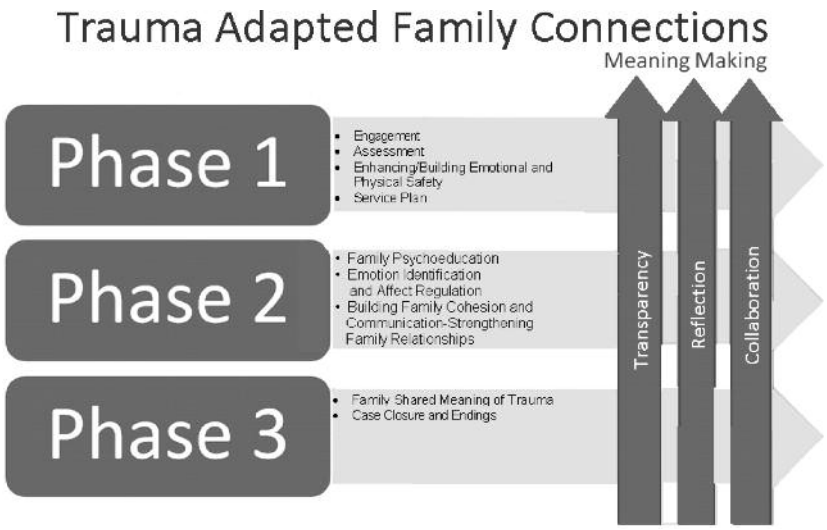
Refining and Confirming Program Components

The programmatic boundaries are defined through the eligibility criteria, which includes households with at least one child between the ages of 5 to 17 and the following conditions: (1) the child has lived with the primary caregiver for at least six months and is expected to remain with the primary caregiver; (2) at least two identified risk factors related to the child, caregiver, and/or family system; (3) a

child identified to be at risk for at least one type of neglect; (4) child and/or caregiver has a presence of trauma related symptoms; (5) no current CPS involvement; and (6) willingness to participate in trauma services.

Participants receive family assessment, emergency assistance, a service plan, advocacy, coordinated referrals to community agencies, and outcome-driven intervention over a period of up to six months. There are three treatment phases, with each phase lasting about two months. Most services are delivered weekly in the home or other community setting. As depicted in Figure 2, the themes of collaboration, reflection and transparency permeate the work conducted throughout the three phases. Partnering with families communicates that they are the "experts" about their lives, while collaboration strengthens the helping alliance. This allows them to examine their stories to develop an individual perspective about how trauma has impacted their functioning. Treating families with respect and as "experts" also counteracts feelings of disempowerment often associated with trauma and

Figure 2
Phases, Themes, Essential Components of Trauma Adapted Family Connections



helps create a positive, non-authoritarian relationship between TA-FC clinicians and families (Markoff, Reed, Fallot, Elliott, & Bjelajac, 2005). The three phases of TA-FC not only are complimentary, but also build on one another. Early stage components must be implemented to successfully engage those central in later phases. For example, meeting basic needs, agreeing on goals of service, establishing emotion identification and affect regulation, and cultivating/maintaining a sense of family cohesion lay the ground work for the development of a shared narrative of the meaning of trauma. The strategies accommodate the iterative nature of clinical work and practitioners are encouraged to revisit specific components of each phase, when applicable, as their work with each family progresses.

Phase One

Phase One incorporates trauma-informed intervention components including engagement, assessment and service planning, helping families connect to resources within their community that will allow them to meet their basic needs, and safety building and enhancement.

Trauma-Informed Engagement

Engaging with families and developing a strong helping alliance form the cornerstone of TA-FC and are integrated throughout the entire process. Trauma-informed engagement strategies specifically address the families' needs by uncovering triggers of emotional, cognitive, and behavioral trauma-related sequelae that are barriers to service engagement and delivery. Beginning with the intake phone contact and initial face-to-face meeting, such engagement strategies increase continued participation in services (McKay, Hibbert, Hoagwood, Rodriguez, Murray, Legerski, & Fernandez, 2004; McKay, Nudelman, & McCadam, 1996).

Trauma Focused Family Assessment and Service Planning

TA-FC uses a twofold model of comprehensive and individualized trauma-focused family assessment. First, empirically based standardized instruments measure risk and protective factors at the individual, family, neighborhood, and community levels. Further,

assessment elicits an understanding of general family functioning and processing of the trauma experiences (Harris & Topham, 2004). In addition, TA-FC gauges resilience through an examination of the family's beliefs, structure, and communication (Walsh, 2006). The comprehensive assessment culminates in the prioritization of needs that requires an initial understanding of how trauma experiences and family and individual dynamics all converge to influence capacity for functioning. Service plan goals may include referring family members to other trauma, substance abuse, health, or mental health services that can be administered concurrently.

Helping Families Meet Their Basic Needs

A crucial component of TA-FC is responding to the complex basic needs associated with living in poverty and experiencing violence, victimization, and loss. Assessments identify unmet basic needs for food, clothing, shelter, health care, nurturance, stimulation, and safety throughout the intervention. Clinicians in conjunction with other community organizations provide emergency and concrete services such as emergency food and clothing, financial assistance to prevent eviction or other family disruption, and household furniture and supplies.

Enhancing/Building Emotional and Physical Safety

Helping a family build capacity to create safety involves a variety of intervention strategies. For many families, achieving a feeling of safety is a daily struggle as they strive to maintain physical, psychological, social, spiritual, and financial safety in an often violent environment. TA-FC builds safety capacity by strengthening problem solving abilities, cognitive coping skills, stress management techniques, social support, and community connections, which are often diminished in TA-FC families due to the isolating and oppressive context of urban poverty (Aponte, 1994). Eliciting the family's narrative of what safety means—including what experiences threaten their feelings of psychological or environmental safety, the connection between trauma triggers and reminders and psychological and physical well-being, the impact of individual member's reactions on the entire family's safety

and ways they have sought to achieve safety in the past—is an important starting point for building capacity and achieving safety and is a necessary first step for TA-FC's in-depth trauma work.

Phase Two

Phase Two involves family psychoeducation, emotion identification and affect regulation, and building family cohesion, communication, and strengthening of family relationships.

Family Psychoeducation

Psychoeducation is introduced during the comprehensive assessment and is integrated throughout all phases of TA-FC. It includes sharing of information with families (both as a group and individually) about their specific strengths, symptoms, skills, and coping mechanisms that may affect functioning. Family psychoeducation and narrative practice principles emphasize that family members are not the "cause" of symptoms. Instead they help families better understand how symptoms impact them and how external forces contribute to patterns of negative communication and relationships. Sharing information about the link between current symptoms and past trauma strengthens the helping alliance and provides a framework for the cognitive behavioral portion of the intervention, easing anxiety about the treatment process (Briere & Scott, 2006).

Identifying, Expressing, and Regulating Feelings

TA-FC incorporates an eco-structural perspective that highlights environmental factors (e.g., poverty and community violence) that engender complex trauma and the suppression or disconnection from emotions. In many instances a limited emotional repertoire has developed over multiple generations as caregivers transmitted their emotional processes to the subsequent generation. Increasing identification, expression, and regulation of emotion heightens inter- and extrafamilial connectivity and may facilitate managing the impact of larger social problems. Families can learn to add a new layer to their narrative as they reauthor their story, attending to their emotional reactions to experiences (Freeman et al., 1997).

Building Family Cohesion and Communication; Strengthening Family Relationships

Family adjustment and functioning reflects how members perform necessary roles and tasks, adapt to problems, and communicate with one another, thereby promoting family well-being (Fobair & Zabora, 1995). The accumulation of violence in the lives of family members compounded by the traumatic experience of poverty directly affects natural reciprocal relationships, functioning, and adjustment. Family functioning may also be a moderator between traumatic events and the resulting impact on family members (Banyard, Rozelle, & Englund, 2001; Cohen & Mannarino, 1996, 2000; Pfefferbaum, 1997). Promoting cohesion and functioning in families is achieved through strategies that (1) increase closeness, flexibility, communication, and problem solving; (2) develop and establish family routines; (3) establish family member roles, responsibilities, and boundaries; (4) assist family members in developing mutual involvement, shared interests, and emotional support of one another; (5) teach skills in resolving value and problem based conflicts among family members through externalizing the problem; (6) help family members adapt to life changes, including adaptation to the family system; (7) increase positive parenting styles; and (8) repair or build on the strengths of sibling relationships.

Phase Three

Phase Three includes developing a family-shared meaning of trauma, and case closure and endings.

Building Family-Shared Meaning of Trauma

TA-FC uses an interlocking narrative family practice perspective that provides a framework and therapeutic stance to understand, examine, and apply strategies that are appropriate for families exposed to trauma (either historical or current), many of whom live in poverty and have poor connections to both informal and formal social and community networks. Using narrative techniques throughout treatment is a way to work with the family as a whole and create a shared meaning related to their traumatic experiences. This practice strengthens

family members' ability to challenge negative, unhelpful thoughts/stories of problems and events, and creates flexibility to consider positive and adaptive views of the context of their lives (Freeman et al., 1997; White, 1986). Narrative approaches and the strengths perspective (Saleebey, 1996) assume that family members have many skills, competencies, beliefs, values, and abilities that will assist them to reduce the influence of problems in their lives and within the family system. Therefore, the objectives of the narrative approach in family work are to create promotive and strengthening stories, define the relationships the family and individual members will have with the problems encountered, enhance interpersonal relationships, increase positive communication, and enrich functioning of the unit. The development of a shared meaning evolves throughout the course of work in TA-FC. In the final phase the family constructs a new storyline, reworking the roles of family members as they address the trauma experience and their relation to it. The family thus constructs a new identity and related capacity to understand themselves and their history.

Trauma-Informed Case Closure and Endings

Termination may be especially problematic for some families because of traumatic losses or endings that were previously experienced. TA-FC practitioners aim to mediate potentially triggering endings through a strengths-based, trauma-informed termination process. Practitioners and families identify and process specific stressors related to endings—memories of previous endings, issues related to grief and loss, and individual and family dynamics that focus on individuation and separation—that may be compounded by traumatic experiences. At the close of a TA-FC case, the family is encouraged to celebrate achievements while also taking initiative to seek resources to fulfill unmet needs.

Professional Development

Service providers may be affected and changed through their secondary exposure to traumatic events and engagement in a helping relationship. Monitoring providers' reactions and resilience safeguards

their well-being and decreases contamination of practice. Essential TA-FC clinician self-care strategies include a daily regimen of self-care practices, self-reflection, and professional consultation that bolster clinicians' tools to cope with traumatic material and stress. These strategies are informed by a "trauma lens" and a "family lens" to frame their work with clients, offering a dynamic perspective for those who encounter traumatic material in their professional work.

Supervisors and consultants play crucial roles in promoting worker self-care, aiding workers in the prevention of negative effects of trauma work through provision of professional feedback. As suggested by Pearlman and Saakvitne (1995), TA-FC clinical supervision for trauma therapists requires at least one hour per week for experienced clinicians, with additional time allotted for new or beginning therapists. Using a cognitive behavioral framework, TA-FC supervision includes (1) strong orientation in psychotherapy theory; (2) relational focus with emphasis on subconscious aspects of treatment; (3) respectful and collaborative interaction to explore countertransference; and (4) education on vicarious traumatization and its clinician impact (Azar, 2000). TA-FC professional development and supervision includes not only the clinician providing direct services, but also the organizational staff and environment as a whole.

Assessing Effectiveness

Funding sources and governmental agencies are increasingly emphasizing the need for evidence-based practices. Services provided to children who are maltreated and their families have infrequently been provided evidence based services, resulting in the implementation of interventions with unknown efficacy (Chaffin & Friedrich, 2004). TA-FC was built from the foundation of an evidence-supported intervention (i.e., FC), while responding sensitively to the specific and unique needs of families and children who experience complex and chronic trauma because of various familial and/or community-based factors. The TA-FC program is currently being pilot tested in two communities; one that serves African American families living in urban poverty and one that serves Latino families in rural poverty.

Summary

In response to the need for family-focused trauma interventions, using the principles of intervention research and implementation science, TA-FC employs a manualized, multiphased approach to increase the safety, well-being, stability, and health of children and families who have experienced multigenerational trauma and/or complex trauma. Each phase encompasses elements drawn from theories of attachment, neglect, trauma, family interaction, and community-based frameworks to uniquely respond to the needs of individual family members as well as the unit as a whole, promoting the development and support of trauma-informed service providers delivering an evidence-supported treatment strategy that is both safe and effective. Given the lack of trauma-informed service providers who are skilled in evidence-based treatment for traumatic stress disorders (Chadwick Center for Children and Families, 2004; Chaffin & Friedrich, 2004), TA-FC is a worthy and needed intervention to facilitate posttrauma recovery and the development of a trauma-informed system.

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