The Safe Horizon–Yale Child Study Center Partnership

Offering Hope for Abused Children

Yale Child Study Center

FROM GENERATION TO GENERATION

Authors

■ **Steven Marans, PhD**
Harris Professor of Child Psychiatry
Professor of Psychiatry
Childhood Violent Trauma Center
Child Study Center
Yale University School of Medicine

■ **Hilary Hahn, EdM, MPH**
Associate Research Scientist
Childhood Violent Trauma Center
Child Study Center
Yale University School of Medicine

■ **Carrie Epstein, LCSW-R**
Assistant Clinical Professor
Childhood Violent Trauma Center
Child Study Center
Yale University School of Medicine

■ **Nancy Arnow**
Senior Vice President
Child, Adolescent, Mental Health & Anti-Trafficking Programs
Safe Horizon

■ **Liz Roberts**
Chief Program Officer
Safe Horizon

With special thanks to:

■ **Matthew Oransky, PhD**
Trauma Fellow
Childhood Violent Trauma Center
Child Study Center
Yale University School of Medicine

■ **Clemente Luna**
Vice President, Institutional and Government Support
Safe Horizon

■ **Phillip Burgess**
Manager, Institutional and Government Support
Safe Horizon

moving victims of violence from crisis to confidence.

The Safe Horizon– Yale Child Study Center Partnership

Offering Hope for Abused Children

EXECUTIVE SUMMARY

Safe Horizon and the Childhood Violent Trauma Center at Yale Child Study Center have joined forces to address the needs of children traumatized by abuse. Working together, the two institutions have adapted and implemented a brief, evidence-based intervention for traumatized children developed by the Childhood Violent Trauma Center at the Yale Child Study Center for implementation at four Child Advocacy Centers (CACs) in New York City. The Child and Family Traumatic Stress Intervention (CFTSI) is a family strengthening intervention that aims to reduce early post-traumatic stress symptoms; to decrease the likelihood of traumatized children developing long-term post-traumatic psychiatric disorders; and to identify children who need longer-term mental health care. Intended for children 7 to 18 years old who have either recently experienced or disclosed traumatic events, CFTSI has demonstrated exciting results. In a randomized control trial conducted by the Yale Childhood Violent Trauma Center (CVTC), children who received CFTSI were 65% less likely than comparison youth to meet criteria for full Post-Traumatic Stress Disorder (PTSD) at three month follow-up and were 73% less likely than comparison youth to meet combined criteria for partial and full PTSD at the three month follow-up. These results are supported by recent findings among children seen at Safe Horizon's CACs. In addition, the CAC population demonstrates increased parent-child communication and high levels of satisfaction with treatment following CFTSI. Following on the successful results of implementation, Yale's CVTC has responded to Safe Horizon's request to adapt the CFTSI model for implementation with children placed in foster care. The collaboration between Safe Horizon and Yale's Childhood Violent Trauma Center has resulted in a model approach to abused children that can benefit children who have suffered abuse in New York City and throughout the country in order that that they may have the chance to recover from their traumatic experiences.

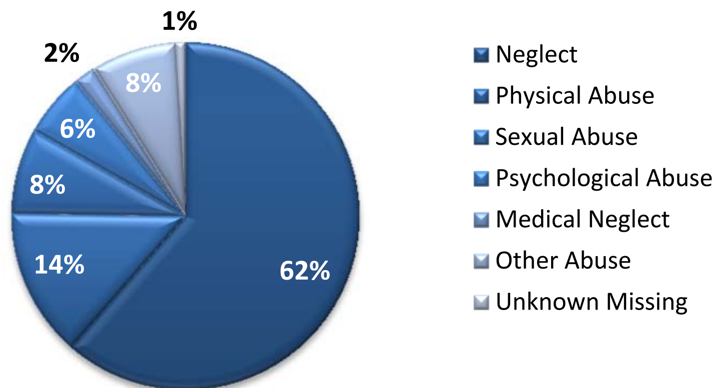
EXECUTIVE SUMMARY:

Safe Horizon and the Childhood Violent Trauma Center at Yale Child Study Center have joined forces to address the needs of children traumatized by abuse. Working together, the two institutions have adapted and implemented a brief, evidence-based intervention for traumatized children developed by the Childhood Violent Trauma Center at the Yale Child Study Center for implementation at four Child Advocacy Centers (CACs) in New York City. The Child and Family Traumatic Stress Intervention (CFTSI) is a family strengthening intervention that aims to reduce early post-traumatic stress symptoms; to decrease the likelihood of traumatized children developing long-term post-traumatic psychiatric disorders; and to identify children who need longer-term mental health care. Intended for children 7 to 18 years old who have either recently experienced or disclosed traumatic events, CFTSI has demonstrated exciting results. In a randomized control trial conducted by the Yale Childhood Violent Trauma Center (CVTC), children who received CFTSI were 65% less likely than comparison youth to meet criteria for full Post-Traumatic Stress Disorder (PTSD) at the three month follow-up and were 73% less likely than comparison youth to meet combined criteria for partial and full PTSD at the three month follow-up. These results are supported by recent findings among children seen at Safe Horizon's CACs. In addition, the CAC population demonstrates increased parent-child communication and high levels of satisfaction with treatment following CFTSI. Following on the successful results of implementation, Yale's CVTC has responded to Safe Horizon's request to adapt the CFTSI model for implementation with children placed in foster care. The collaboration between Safe Horizon and Yale's Childhood Violent Trauma Center has resulted in a model approach to abused children that can benefit children who have suffered abuse in New York City and throughout the country in order that that they may have the chance to recover from their traumatic experiences.

THE PERVASIVE PROBLEM OF CHILD ABUSE AND NEGLECT

Child abuse and neglect now represent a national epidemic in the United States. For far too many children, abuse at the hands of caregivers upon whom they rely is an unavoidable and central experience of life. Children of all ages are exposed to abuse and neglect at extraordinarily high rates:

- In 2010, an estimated 3.3 million allegations of child maltreatment were reported to child protective service agencies, involving approximately 6 million children[1]
- As of September 30, 2010, there were 408,425 children in the foster care system[2]
- In 2009, child protective services found approximately 763,000 children to be victims of maltreatment in the following categories:



- A 2009 national survey by David Finkelhor and colleagues[3] found that *in the past year*:
  - ✓ 60% of children and adolescents suffered *at least* 1 victimization;
  - ✓ 46.3% experienced a physical assault;
  - ✓ 25.3% witnessed violence;
  - ✓ 9.8% witnessed intra-family assault;
  - ✓ 10.2% were subjected to child maltreatment;
  - ✓ 10.2% experienced a victimization-related injury;
  - ✓ 6.1% experienced sexual victimization.

---

[1] U.S. Department of Health and Human Services in *Child Maltreatment,* 2010

[2] Adoption and Foster Care Analysis and Reporting System (AFCARS) FY 2010 data (October 1, 2009 through September 30, 2010) http://www.acf.hhs.gov/programs/cb/stats_research/afcars/tar/report18.htm.

[3] Finkelhor, D., Turner, H.A., Ormrod, R.K., & Hamby, S.L. (2009). Violence, abuse, & crime exposure in a national sample of children & youth. *Pediatrics 124(5): 1-14*

THE IMPACT OF CHILD ABUSE AND NEGLECT ON THE CHILD

Abused children and children who witness violence suffer devastating consequences, both short-term and over a lifetime. The scars of abuse and neglect are not only physical. Abuse and exposure to violence affects how children feel, how they act and how they learn. Children who are victims of and witnesses to violence—and whose trauma goes unaddressed—are at a higher risk of developing behavioral problems, school failure, substance abuse, repeat victimization, and violent criminal behavior. Tragically, victims often become perpetrators of violent behavior similar to that to which they were originally exposed. Not surprising, children with the most contributing risk factors are the ones at greatest risk of perpetuating the cycle of violence, and repetitive exposure to violence in childhood is associated with dramatically increased likelihood of involvement in physical aggression and violent behaviors:

- Children who experience child abuse and neglect are **59% more likely to be arrested as a juvenile, 28% more likely to be arrested as an adult, and 30% more likely to commit violent crime**[4]
- Substantiated cases of adolescent maltreatment (against children ages 12 to 17) increase the odds of **arrest, general and violent offending, and illicit drug use in young adulthood**[5]
- Abused children are **25% more likely to experience teen pregnancy**[6]
- As many as **two-thirds of the people in treatment for drug abuse** report being abused or neglected as children[7]
- About **30% of abused and neglected children will later abuse their own children**[8]

Over the past two decades, a wealth of research has borne out a direct connection between childhood abuse and poor developmental, psychiatric, physical health and behavioral health outcomes in victims. It is an accepted view that the long-term impact of childhood sexual abuse is exacerbated by additional stressors during the course of development. But even in the context of multiple other Adverse Childhood Events (ACEs—see Felitti, 1999; Anda, et.al., 2003;

---

[4] Long - Term Consequences of Child Abuse and Neglect. Child Welfare Information Gateway.Washington, D.C.: U.S. Department of Health and Human Services, 2006. Retrieved from http://www.childwelfare.gov/pubs/factsheets/long_term_consequences.cfm

[5] Smith, C.A., T.O. Ireland, and T.P. Thornberry, "Adolescent Maltreatment and Its Impact on Young Adult Antisocial Behavior" *Child Abuse & Neglect* 29(10) (2005): 1099–1119

[6] Ibid

[7] Swan, N. (1998). *Exploring the role of child abuse on later drug abuse: Researchers face broad gaps in information.* NIDA Notes, 13(2). Retrieved from the National Institute on Drug Abuse website: www.nida.nih.gov/NIDA_Notes/NNVol13N2/exploring.html

[8] Long - Term Consequences of Child Abuse and Neglect. Child Welfare Information Gateway.Washington, D.C.: U.S. Department of Health and Human Services, 2006. Retrieved from http://www.childwelfare.gov/pubs/factsheets/long_term_consequences.cfm

2006), **childhood sexual abuse is a powerful independent experience in the developing life of a child that is causally related to an increased risk for psychiatric disorders, substance abuse and psychopathology, one that can have profound consequences for adaptation or maladaptation throughout life.**

- Child Sexual Abuse has been demonstrated to lead to increased rates of:
    - Depressive and anxiety disorders
    - Suicidal risks
    - Anti-social behaviors and delinquent behavior
    - Substance abuse and dependence
    - Poor educational achievement
    - Physical health problems
    - Sexual risk taking and promiscuous behaviors
    - Unstable and poorly functioning relationships
    - Marital and family problems including intimate partner violence
    - Personality disorders

A comprehensive list of references related to Child Sexual Abuse follows this document.

THE ECONOMIC IMPACT OF CHILD ABUSE AND NEGLECT

Alongside the devastating short- and long-term impact of child abuse for victims and their families, the economic costs are also enormous. According to a *Prevent Childhood Abuse* 2007 report, **the estimated annual cost of child abuse and neglect is $103.8 billion** (Wang and Holton, 2007). This estimate includes the direct costs associated with maintaining a child welfare system to investigate and respond to reports of child abuse and neglect, as well as expenditures by the judicial, law enforcement, health, and mental health systems. These costs also include indirect costs associated with juvenile and adult criminal activity, mental illness, loss of productivity due to unemployment and underemployment, the cost of special education services, and increased use of the health care system.

Direct Costs:

- Over $25 billion in child welfare system costs
- Over $1 billion in mental health care system costs
- Over $6.6 billion in hospitalization costs
- Over $1 million in law enforcement costs

Indirect Costs:

- Over $7 billion in residential treatment facility costs for maltreated children
- Over $2 billion in special education costs for maltreated children
- Almost $68 million in mental health care and health care costs
- Almost $28 billion in costs associated with the adult criminal justice system response to violence specifically linked to earlier child maltreatment
- Over $33 billion in costs associated with lost productivity to society

SAFE HORIZON: THE NATION'S LEADING VICTIM ASSISTANCE ORGANIZATION

In the midst of maltreatment, victims of child abuse are not only helpless, isolated, and alone, but often remain isolated and alone until someone is able to step in and step up on their behalf. For the past 34 years Safe Horizon has been committed to assuming that critical role, ensuring that victims of crime and abuse receive the respect, the rights, and the services that they are entitled to, as well as the assistance they need to find safety and to recover.

Background

Safe Horizon was founded as Victim Services in 1978 and changed its name to Safe Horizon in 2000. Though the name has changed, the mission of Safe Horizon has remained constant: to provide support, prevent violence, and promote justice for victims of crime and abuse, their families and communities. Over the years, Safe Horizon has evolved from an organization serving people in crisis in the New York City courts by providing case management, advocacy, guidance, and support to victims of domestic violence, rape, and sexual assault, into a major, multi-service organization offering a holistic continuum of services to a highly diverse constituency. Today, Safe Horizon is the nation's leading victim assistance organization.

A dedicated, highly professional team of almost 700 full- and part-time staff, as well as 400 volunteers a year, enables Safe Horizon to provide an unparalleled level of client-centered service. Safe Horizon clients include victims of child abuse, domestic violence, rape and sexual assault, human trafficking, and other crimes. The organization also serves homeless and street-involved youth and operates the only mental health counseling center licensed by New York State that specializes exclusively in providing evidence-based, trauma-focused services to crime victims. Safe Horizon clients are as diverse as the general population of New York City in terms of age, race, gender, gender identity, sexual orientation, ethnicity, religion, socio-economic class, and place of birth.

During Fiscal Year 2011, through Safe Horizon's network of programs at more than 50 locations throughout New York City, Safe Horizon staff:

- received and responded to 137,500 calls on the Safe Horizon domestic violence, crime, and rape and sexual assault hotlines;
- provided safe refuge in seven emergency shelters and two transitional shelters to approximately 2,400 women, children, and families fleeing domestic violence;
- investigated more than 4,000 cases of child sexual and severe physical abuse in their Child Advocacy Centers (CACs);
- provided childcare for 17,270 children while their parents/caregivers attended to court business; and
- distributed 51,000 warm, home-cooked meals and provided practical services and counseling to more than 1,700 unduplicated homeless and street-involved youth through the Streetwork Project.

Safe Horizon pioneered the fully co-located Child Advocacy Center model in 1996 with the opening of the Jane Barker Brooklyn CAC. For the first time anywhere in the country, the

Brooklyn CAC brought together, under one roof, a multidisciplinary team comprised of detectives from the New York City Police Department, prosecutors from the District Attorney's office, child protective staff from the New York City Administration for Children's Services, a pediatrician with expertise in child abuse from the Brooklyn Hospital Center, and Safe Horizon administrators, case managers and counselors. Since then, Safe Horizon has opened fully co-located CACs in Manhattan, Queens, and Staten Island. Today Safe Horizon is the only organization in the country that operates four fully co-located, nationally accredited Child Advocacy Centers in an urban setting.

THE NEED FOR EFFECTIVE MENTAL HEALTH INTERVENTIONS IN CHILD ADVOCACY CENTERS

In January 2006, Nixzmary Brown, a seven-year-old child living in Brooklyn, died tragically as a result of child abuse. This horrific case resulted in intense and sustained media attention to the pervasive nature of the problem of child abuse. The widespread media coverage was a call to action for all citizens to become aware of signs of child abuse and to notify local authorities when they suspected abuse. Public and private agencies responded to the case by strengthening their policies and practices for identifying and responding to child abuse and neglect. As a result, the reporting of suspected child abuse in New York City skyrocketed, and Safe Horizon's CACs experienced a 148% increase in the volume of new child abuse allegations coming to the CACs for coordinated investigations and response to the victims and their families.

At the same time, Safe Horizon recognized a need to standardize client services throughout the organization and set out to implement evidence-based interventions whenever possible. In the face of an increased volume of referrals, without a concomitant increase in funding, Safe Horizon was committed to using its limited resources effectively to meet the most pressing needs presented by child victims and their families. Safe Horizon concluded that a brief, evidence-based intervention – one that was strengths-based, capitalized on protective factors, and focused on improving communication between a child victim and his/her non-offending caregiver – would be most effective in a CAC setting. The agency also concluded that this intervention needed to take into account the very real external stressors that the child victims and their families were confronting beyond the victimization itself, such as potential homelessness, court involvement, and medical care.

National search for an appropriate treatment model

Safe Horizon engaged the entire CAC program leadership in a national search for evidence-based treatments that were aligned with the agency's guiding principles and program needs. In 2007, Safe Horizon first learned of the Child and Family Traumatic Stress Intervention (CFTSI) and began discussions with CFTSI model developers at the Yale Child Study Center about the possibility of adapting and implementing CFTSI for CACs in a large urban setting. These early discussions formed the foundation for the remarkable partnership between Safe Horizon and the Childhood Violent Trauma Center at the Yale Child Study Center – a partnership that emerged out of genuine respect and admiration for the work being done by each entity, and that deepened over time through a shared vision and excitement regarding the impact that

CFTSI could have on child victims and their families, not only in New York City, but across the nation as well.

THE YALE CHILD STUDY CENTER: A NATIONAL LEADER IN RESEARCH, CLINICAL SERVICE, AND TRAINING

The Yale Child Study Center (YCSC) was founded in 1911 as part of the Yale University School of Medicine. The YCSC brings together multiple disciplines to further the understanding of the problems of children and families. Among the many disciplines are child psychiatry, pediatrics, genetics, neurobiology, epidemiology, psychology, nursing, social work, and social policy. The mission of the Center is to understand child development, social, behavioral, and emotional adjustment, and psychiatric disorders and to help children and families in need of care. The Center is unusual in its scope of research, clinical services, training programs, policy work, and much local, state, national, and international collaboration. The strengths of the Center are reflected in the breadth and integrative nature of research, clinical services, and training.

The YCSC offers comprehensive, multi-disciplinary evaluations and treatment for children with a wide range of emotional and psychological needs. In 1991, the Yale Child Study Center, in partnership with the City of New Haven and the New Haven Department of Police Service, launched the Child Development-Community Policing (CD-CP) Program, a unique partnership of mental health and law enforcement professionals who provide collaborative responses to children and families exposed to community violence. Under the direction of Dr. Steven Marans, the CD-CP Program has broadened the field of mental health interventions with traumatized children, families, communities, and nations. The CD-CP model has been replicated in numerous communities around the country and abroad. Lessons learned from this work have been applied in the Yale team's response to school shootings, the terrorist attacks of 9/11, Hurricanes Katrina and Rita, and other catastrophic events. In 1999, having worked closely with the US Department of Justice, the Trauma Section at the Yale Child Study Center was designated by the White House and Department of Justice as the National Center for Children Exposed to Violence. In 2001, as part of the Substance Abuse and Mental Health Service Administration's (SAMHSA's) National Child Traumatic Stress Network, the Trauma Section began receiving funding as the Childhood Violent Trauma Center and was tasked with the development and dissemination of early interventions and collaborative responses to childhood trauma.

THE CHILD AND FAMILY TRAUMATIC STRESS INTERVENTION (CFTSI): FILLING A GAP IN AVAILABLE SERVICES

While children may find the first genuine source of protection through involvement with Safe Horizon's CACs, they are especially vulnerable to post-traumatic symptoms that often follow disclosure of abuse, symptoms that may be heightened by the investigation that follows, and the out-of-home placement that may be necessary for a child's safety. When children are alone with and don't have words for their traumatic reactions, symptomatic behavior is their only means of expression. To heal, children need recognition and understanding from the most important source of support in their lives – their caregivers. The child victims in the CACs need

help in communicating their reactions and emotions more effectively, they need to learn coping skills to reduce those reactions, and they need to be able to count on family and social support. In addition, parents and caregivers are often unable to understand the connection between the potentially traumatic event and their children's symptoms and behaviors. Parents need education, support and practical skills to help manage their children's traumatic reactions following the disclosure of abuse. Children need to have a voice and appropriate help and support at these junctures to reduce their immediate suffering and their risk for long-term negative consequences.

In order to address these pressing issues, the Child and Family Traumatic Stress Intervention was developed at the Childhood Violent Trauma Center at the Child Study Center at the Yale University School of Medicine.

THE DEVELOPMENT OF CFTSI AT THE YALE CHILDHOOD VIOLENT TRAUMA CENTER

For over two decades, clinicians at the Yale Childhood Violent Trauma Center (CVTC) have collaborated with law enforcement and child protective service partners to respond to children and families exposed to violence, abuse and other potentially traumatic events. Under the leadership of Steven Marans, PhD, MSW, Harris Professor of Child Psychiatry and Professor of Psychiatry at the Yale University School of Medicine, and Director of the CVTC, clinicians have provided acute, on-scene interventions, as well as longer-term coordinated care to children and families impacted by traumatic events. As part of their work, CVTC clinicians saw first-hand how affected children were at greatest risk for long-term traumatic reactions and Post-Traumatic Stress Disorder (PTSD) when their experience/symptoms went unrecognized and when they failed to receive adequate support immediately following an overwhelming event. It became clear that there was a need for an evidence-based early intervention that could not only help to ameliorate distress in the immediate wake of traumatic events but could also help to prevent the onset of longer-term psychiatric disorders. Based on the CVTC's extensive experience working with children and families who had been exposed to a range of traumatic events—including abuse, domestic violence, murders, suicides, terrorist attacks, and other disasters—Dr. Marans and colleague Dr. Steve Berkowitz, now at the University of Pennsylvania School of Medicine, developed the Child and Family Traumatic Stress Intervention (CFTSI), an early intervention to fill this significant gap between acute responses/crisis intervention and evidence-based, longer-term treatments designed to address traumatic stress symptoms and disorders that have become established in the weeks and months following an event.

WHAT IS CFTSI?

CFTSI is a brief (4-6 sessions), evidence-based early intervention for children 7 to 18 years old that reduces traumatic stress reactions and PTSD. It is implemented immediately following a traumatic event (or events), such as physical or sexual abuse, or the disclosure of a traumatic event (or events). This intervention can be used successfully with children with extensive trauma histories. In addition, the approach can act as a seamless introduction to longer-term treatment and other mental health interventions when necessary.

GOALS OF CFTSI

- Improve screening and identification of children impacted by traumatic stress
- Reduce negative reactions or symptoms related to the traumatic event
- Strengthen communication between caregiver and child to enhance emotional support
- Teach and practice coping skills to help reduce trauma reactions
- Identify and address concrete external stressors and practical needs (such as safety, legal issues, or medical care)
- Assess child’s need for longer-term treatment

CFTSI FILLS A GAP IN SERVICES

As an evidence-based early intervention, CFTSI fills the gap between standardized acute interventions and evidence-based, longer-term treatments required to deal with enduring post-traumatic reactions.

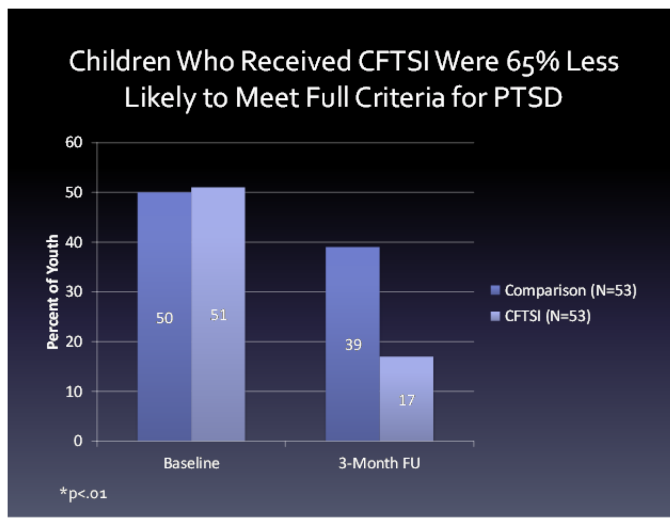
THE EVIDENCE BASE FOR CFTSI

A randomized controlled comparative effectiveness trial on CFTSI was completed in 2009. 106 youth were randomly assigned to the Intervention (n = 53) or a four-session supportive Comparison condition (N = 53). At baseline, youth in both groups had similar demographics, including the nature of their past traumatic experiences, the number of past trauma exposures, and symptom severity. The traumatic events that brought participants to the study were: 24% motor vehicle accident (MVA), 18% sexual abuse, 19% witnessing violence, 21% physical assaults, 8% injuries (e.g., sports, cycling), 5% animal bite, and 5% threats of violence (e.g., mugging). At follow-up, the Intervention group demonstrated significantly fewer full and partial PTSD diagnoses than the Comparison group on a standardized diagnostic measure of PTSD. Full results are published in the Journal of Child Psychiatry and Psychology.[9]

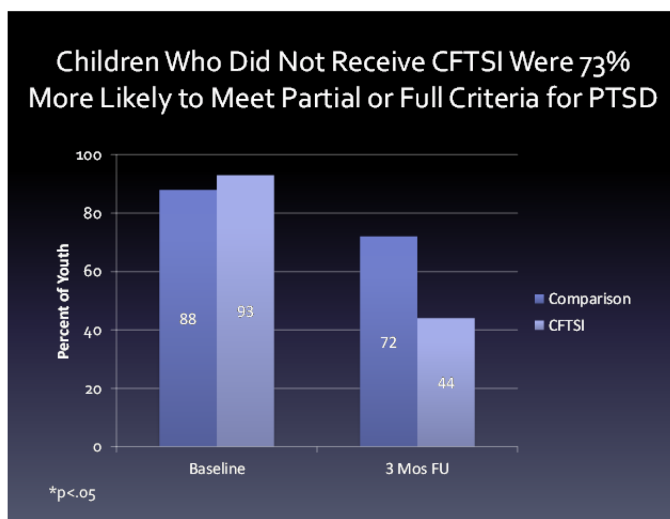
[9] Berkowitz, S., Stover, C.S. & Marans, S. (2010). The Child and Family Traumatic Stress Intervention: Secondary Prevention for Youth at Risk Youth of Developing PTSD. Journal of Child Psychology and Psychiatry.

The randomized controlled comparative effectiveness trial on CFTSI found that children receiving CFTSI:

- Were 65% less likely than comparison youth to meet criteria for full PTSD at three month follow-up



- Were 73% less likely than comparison youth to meet combined criteria for partial and full PTSD at the three month follow-up



THE SAFE HORIZON-YALE CHILDHOOD VIOLENT TRAUMA CENTER COLLABORATION: PUTTING IMPLEMENTATION SCIENCE INTO PRACTICE

For more than two decades, faculty in the Yale Child Study Center's Childhood Violent Trauma Center have translated direct clinical experience, in combination with advances in scientific and practical knowledge, into the development of groundbreaking interventions for traumatized children and families. This approach has led to collaborations that have, in turn, broadened the field of trauma interventions in both knowledge and practice. The Yale-Safe Horizon partnership is just such a collaboration.

The collaboration between Yale's Childhood Violent Trauma Center and Safe Horizon began in 2008 with the introduction and piloting of CFTSI in its three CAC's—Brooklyn, Queens, and Staten Island—and subsequently at the Manhattan CAC when it opened in January 2009. Since that time, the partnership has evolved to include the following mechanisms for communication, training, and ongoing development:

- a Learning Collaborative based on shared and skill-based training on the CFTSI model, which involved teams from each of the CACs
- regular case-consultation calls with providers and supervisors
- database for tracking clinical outcomes and efficacy, provider, and consumer satisfaction
- mechanisms for providing regular feedback of results to participants and Safe Horizon leadership
- regular feedback to Yale CFTSI developers informing adaptations and modification of the model

Initial and subsequent results indicated enormous benefits of CFTSI for children and caregivers seen in the CACs. Additionally, social work and case management staff reported growing confidence in their use of the model and described an increased sense of efficacy in their ability to help children immediately following the disclosure of overwhelming, traumatic experiences of abuse. Regular contact between the partners, the systematic review of model implementation and case discussions, and the sharing of analyzed data engendered a true collaborative, continuous improvement process. As a result, the CFTSI model was strengthened; children, caregivers, providers, and developers have been the beneficiaries. One specific example of this collaborative approach emerged as CAC staff pointed out the remaining gap in available early interventions for foster care children. The initial design and evaluation of CFTSI focused on children living with their long-term caregivers. Yet approximately 40% of all children seen in Safe Horizon's CACs who disclose abuse are placed in foster care, and were initially excluded from the intervention. It became clear to the partners that the CFTSI model would need significant modifications in order to respond to the special circumstances of abused children in out-of-home placements. Based on a wealth of shared clinical experience, and with extensive input from Safe Horizon colleagues, the Yale team recently developed the **CFTSI Adaptation for Children in Foster Care**. Training and beginning implementation has now begun in the four Safe Horizon CACs as well as in several trauma-informed clinical agencies around the

country.

SIGNIFICANT OUTCOMES OF THE SAFE HORIZON – YALE CHILDHOOD VIOLENT TRAUMA CENTER COLLABORATION

The Safe Horizon-Yale CVTC partnership has been enormously successful; this is evident in the overwhelmingly positive outcomes for children and families who have received CFTSI in the CAC setting. To date, close to 500 children have participated in the CFTSI intervention in a Safe Horizon CAC since 2008. The following results are from 124 CFTSI cases completed at Safe Horizon CACs between April 2010 and March 2011.

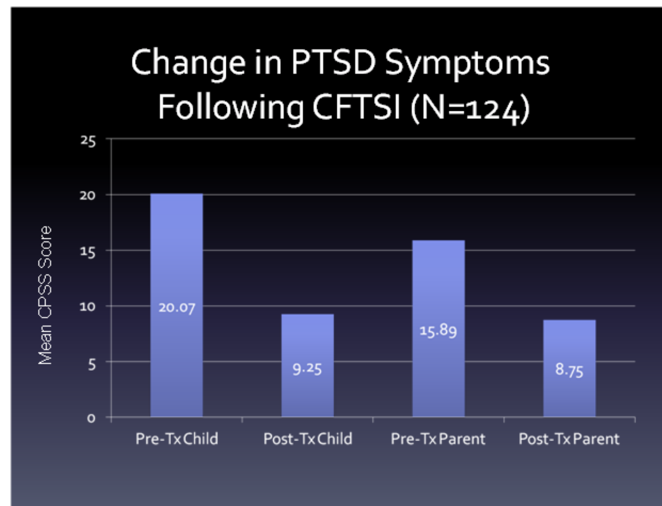
OUTCOME #1: DECREASE IN SYMPTOMS AS REPORTED BY CHILDREN AND THEIR CAREGIVERS

Children's trauma symptoms are measured by the children themselves and by their caregivers prior to the beginning of CFTSI and again at the end of the intervention using a standardized screening instrument for trauma symptoms, the Child PTSD Symptom Scale (CPSS). When completing the scale, children and their caregivers report on common symptoms like having bad dreams or nightmares, feeling scared, feeling worried, having trouble concentrating in school, feeling lonely, not wanting to play, and having upsetting thoughts or images of the abuse. Researchers and clinicians agree that scores of 11 or higher reflect significant distress, and indicate that a child may qualify for a diagnosis of Post-traumatic Stress Disorder upon further assessment. Children who score 15 or higher are almost certain to meet the full criteria for Post-traumatic Stress Disorder.

Children who completed the CPSS at Safe Horizon's CACs before receiving CFTSI reported an average score of 20.07. This indicates that children disclosing abuse at Safe Horizon's CACs have very high levels of trauma symptoms immediately following the disclosure. By participating in CFTSI, these children have a chance to heal more quickly from their symptoms and get the vital support they need. After completing CFTSI, children report feeling significantly better. On average, children's trauma symptoms decreased to a mean score of 9.25, a 54% reduction in symptoms, which is both statistically and clinically significant.

Caregivers also recognized high levels of trauma symptoms in their children prior to the beginning of CFTSI, a mean score of 15.89, and reported a significant reduction in their children's trauma symptoms, down to 8.75, at the conclusion of CFTSI.

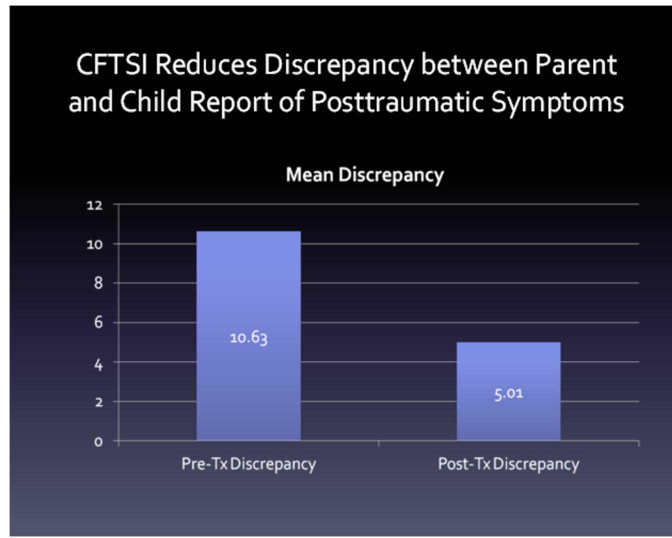
This graph represents the reduction in the children's symptoms after participating in CFTSI, as reported by both the child and the caregiver.



OUTCOME #2: INCREASED SYMPTOM RECOGNITION AND COMMUNICATION BETWEEN CHILDREN AND CAREGIVERS

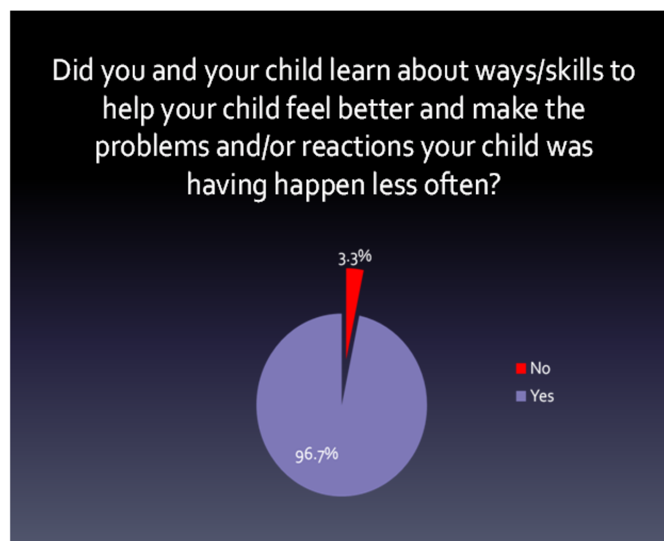
When children are alone with and do not have words to describe their traumatic reactions, symptoms and symptomatic behaviors are their only means of expression. Children need recognition and understanding from the most important source of support in their lives – their caregivers. Caregivers are often unable to understand the connection between the traumatic event and their children's symptoms and behaviors. CFTSI replaces the chaotic, post-traumatic experience with words, structure, and an opportunity to be heard and supported by the caregiver. The provider helps the child communicate about his or her reactions and feelings more effectively, while also increasing the caregiver's awareness and understanding of the child's experience.

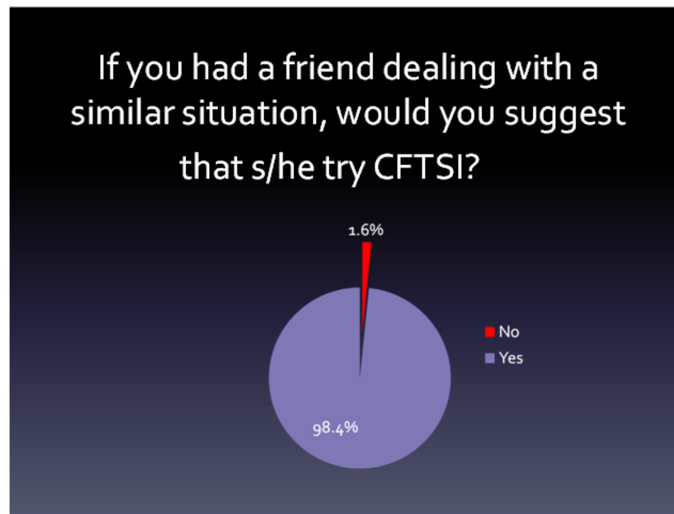
One of the ways we measure our success in improving this communication is by comparing the child's report of symptoms he/she is experiencing to the caregiver's report. Prior to CFTSI, children typically report symptoms of which their caregivers are not aware. By the end of the CFTSI process, we see a significant improvement in the agreement between the child and parent's reports on the CPSS. This graph shows that the discrepancy between child and caregiver reports of the child's traumatic symptoms was reduced by 53% following CFTSI.



OUTCOME #3: AN INTERVENTION THAT INSPIRES CONSUMER CONFIDENCE

CFTSI is an intervention that inspires hope and confidence in clients. In 2011, 64 caregivers who completed CFTSI at a Safe Horizon CAC completed a client satisfaction survey; these caregivers expressed an extraordinary level of satisfaction with the help they received. As shown below, 96.7% of respondents reported that they had learned new skills, and 98.4% said they would recommend CFTSI to a friend.





CONCLUSION

Together, Safe Horizon and the Childhood Violent Trauma Center at the Yale Child Study Center have demonstrated that a brief, early intervention can make an immediate and palpable difference in the daily lives of children who have suffered even the worst forms of abuse. In the years to come, we believe that CFTSI has the potential to be widely disseminated to Child Advocacy Centers around the country, as well as to other settings where abused children are often seen. And we believe that the collaboration between Safe Horizon and the Childhood Violent Trauma Center at the Yale Child Study Center offers a model for human service providers that seek to increase the efficacy of their interventions.

REFERENCES

Anda, R.F., Felitti, V.J., Bremner, D.J., Walker, J.D., Whitfield, C.L., Perry, B.D., Dube, S.R., & Giles, W.H. (2006). The enduring effects of abuse and related adverse experiences in childhood. *European Archives of Psychiatry and Clinical Neuroscience, 256,* 174-186.

Anderson, M.C., & Green, C. (2001). Suppressing unwanted memories by executive control. *Nature, 410*, 366-369.

Boden, J.M., Horwood, L.J., Fergusson, D.M., (2007b). Exposure to childhood sexual and physical abuse and subsequent educational achievement outcomes. *Child Abuse and Neglect, 31*, 1101-1114.

Dube, S.R., Anda, R.F., Whitfield, C.L., Brown, D.W., Felitti, V.J., Dong, M. & Giles, W.H. (2005). Long-term consequences of childhood sexual abuse by gender of victim. *American Journal of Preventive Medicine, 25*, 430-438.

Duncan, A.E., Sartor, C.E., Scherrer, J.F., Grant, J.D., Heath, A.C., Nelson, E.C., Jacob, T., & Bucholz, K.K. (2008). The association between cannabis abuse and dependence and childhood physical and sexual abuse: evidence from an offspring of twins design. *Addiction, 103*, 990-997.

Epstein, M.A., & Bottoms, B.L. (2002). Explaining the forgetting and recovery of abuse and trauma memories: Possible mechanisms. *Child Maltreatment, 7*, 210-225.

Fergusson, D.M., Lynskey, M.T., & Horwood, L.J. (1996). Childhood sexual abuse and psychiatric disorder in young adulthood: I. Prevalence of sexual abuse and factors associated with sexual abuse. *Journal of the American Academy of Child & Adolescent Psychiatry, 35*(10), 1355-1364

Fergusson, D.M., Horwood, J., & Lynskey, M.T. (1996). Childhood sexual abuse and psychiatric disorder in young adulthood: II. Psychiatric outcomes of childhood sexual abuse. *Journal of the American Academy of Child and Adolescent Psychiatry, 34*, 1365-1374.

Fergusson, D.M. & Mullen, P.E. (1999). *Childhood sexual abuse – An evidence based perspective.* Sage, CA: Thousand Oaks.

Fergusson, D.M., Boden, J.M., & Horwood, L.J. (2008). Exposure to childhood sexual and physical abuse and adjustment in early adulthood. *Child Abuse and Neglect, 32*, 607-619.

Finkelhor, D. (1990). Early and long-term effects of child sexual abuse: An update. *Professional Psychology: Research & Practice, 21*(5), 325-330

Friesen, M.D., Woodward, L.J., Horwood, L.J., & Fergusson, D.M. (2010). Childhood exposure to sexual abuse and partnership outcomes at age 30. *Pyschological Medicine, 40*, 679-688.

Garaerts, E., Lindsay, D.S., Merckelbach, H., Jelicic, M., Raymaekers, L., et al. (2009). Cognitive mechanisms underlying recovered-memory experiences of childhood sexual abuse. *Psychol. Sci., 20*, 92-98.

Gordon, H.M. & Connolly, D.A. (2010). Failing to report details of an event: a review of the directed forgetting procedure and applications to reports of childhood sexual abuse. *Memory, 18*(2), 115-128.
Holmes, W.C., & Slap, G.B. (1998). Sexual abuse of boys: Definition, prevalence, correlates, sequelae, and management. *JAMA: Journal of the American Medical Association, 280*(21), 1855-1862.

Koustaal, W., & Schacter, D.L. (1997). Intentional *forgetting and voluntary thought suppression: Two potential methods for coping with childhood trauma.* Washington, DC: American Psychiatric Association.

Lazarus, R.S., & Folkman, S. (1984). Stress*, Appraisal and Coping.* New York: Springer.

McNally, R.J., &Geraerts, E. (2009). A new solution to the recovered memory debate. *Perspect. Psychol. Sci., 4,* 126-134.

Mikulincer, M., & Shaver, P.R. (2008). Adult attachment and affect regulation. In *Handbook of Attachment,* ed. J. Cassicy, P.R. Shaver, pp. 503-531. New York: Guildford.

Mullen, P.E., Martin, J.L., Anderson, J.C., Romans, S.E., & Herbison, G.P. (1994). The effect of child sexual abuse on social, interpersonal and sexual function in adult life. *British Journal of Psychiatry 165*, 35–47.

Putnam, F.W. (2003). Ten-year research update review: Child sexual abuse. *Journal of the American Academy of Child & Adolescent Psychiatry, 42*(3), 269-278.

Richards, J.M., & Gross, J.M. (2006). Personality and emotional memory: how regulating emotion impairs memory for emotional events. *J. Res. Personal, 40,* 631-651.

Senn, T.E., Carey, M.P., & Vanable, P.A. (2008). Childhood and adolescent sexual abuse and subsequent sexual risk behavior : evidence from controlled studies, methodological critique, and suggestions for research. *Clinical Psychology Review. 28*, 711–735.

Terr, L. (1990). *Too Scared to Cry: Psychic Trauma in Childhood.* New York: Harper & Row.

Tyrka, A.R., Price, L.H., Kao, H., Porton, B., Marsella, S.A, & Carpenter, L.L. (2009). Childhood maltreatment and telomere shortening: Preliminary support for an effect of early stress on cellular aging. *Biological Psychology, 67*(6), 531-534.

Van Der Kolk, B.A. (1997). Traumatic memories. In *Trauma and Memory: Clinical and Legal Controversies,* ed. P.S. Appelbaum, L.A. Uyehara, M.R. Elin, pp. 243-260. New York: Oxford University Press.

Williams, J.M.G, Barnhofer, T., Crane, C., Herman, D., Raes F., et al. (2007). Autobiographical memory specificity and emotional disorder. *Psychol. Bull., 133*, 122-148.

Williams, J.M.G, Broadbent, K. (1986). Autobiographical memory in suicide attempters. *J. Abnorm. Psychol., 95,* 144-149.