"If You Brave Enough to Live It, the Least I Can Do Is Listen"1
Overcoming the Consequences of Complex Trauma

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Abstract
Too many parents who find themselves involved with child welfare agencies have had lives threaded with deeply traumatic events. As adults, their childhood histories manifest themselves in substance abuse, domestic violence, relational problems, risk-taking behaviors, emotional lability, self-harming, anxiety, and depression. To successfully overcome the worst of the disabilities associated with complex childhood trauma, the family support community must be able to distinguish the behavioral hallmarks—the symptoms—of complex trauma from the chronic underlying traumatic history that drives the parents’ behavior.

A vampire leans over the soft exposed neck of an innocent girl and sinks his fangs into her. As he sucks the blood from her, the bite fills her with his venom. From then on, she carries his mark. The vampire has polluted her; she is no longer pure and good. Young children who are sexually abused take on the responsibility for their victimization in exactly this way (Duran, 2006). They internalize the violence and degradation of their assault, believing that they are responsible for bringing it on. Their developmental trajectory is hijacked by the need to make sense of the failure of trusted adults to keep them safe. As they grow older, they may be victimized repeatedly and may initiate sexualized behaviors with others. They may engage in substance abuse and criminal behavior and enter into relationships in which they are victims of domestic violence. They are likely to experience psychiatric problems (Hindman, 1999; Trickett, Noll, & Putnam, 2011).

Child maltreatment forms the backdrop for the lives of many more adults than one would ever want to imagine. In all its forms it is far more common than the official statistics document. This truth was brought home through the work of Vince Felitti and Robert Anda and the Adverse Childhood Experiences (ACE) Study (Felitti, 2002). Dr. Felitti was a doctor of internal medicine at Kaiser Permanente in San Diego, California. He was troubled by the weight loss outcomes of patients who had participated in the Southern California Permanente Medical Group’s Positive Choice Weight Loss Program that he was running.

We slowly discovered that major weight loss is often sexually or physically threatening and that obesity, whatever its health risks, is protective emotionally. Ultimately, we saw that certain of our more intractable public health problems such as obesity are often also unconsciously attempted solutions to problems dating back to the earliest years but hidden by time, by shame, by secrecy, and by social taboos against exploring certain areas of life experience. (Felitti, Jakstis, Pepper, & Ray, 2010)

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1 This is a quote (page 298) from the novel, Ruby, by Cynthia Bond about a woman who was sexually assaulted from the time she was 6 years old until she reached her 40s. Near the book’s conclusion, someone who loves her asks her to tell him about her past.
This early discovery led to Dr. Felitti’s partnership with Dr. Robert Anda and the U.S. Centers for Disease Control and Prevention. With agreement from Kaiser Permanente in San Diego, they began asking patients about their adverse experiences as children, awarding an ACE score of 0 to 10 to each study participant based on the number of items to which the respondent said yes (Felitti, 2002). In this predominantly middle-class group of people, average age 57 years old, the prevalence of ACEs was surprisingly high (Redding, 2006):

- 28% were physically abused
- 27% grew up living with someone who was a problem drinker and/or used street drugs
- 21% were sexually abused
- 19% lived with a mentally ill person
- 13% witnessed domestic violence against their mothers

As an example of how these results exploded previous notions of the prevalence of maltreatment, consider physical abuse. In 2013, child welfare agencies across the U.S. substantiated the physical abuse of 122,159 children. These children represented fewer than one percent (0.16%) of the children in the U.S. (U.S. Department of Health and Human Services, 2015). Comparing this tiny fraction to the more than one quarter of the respondents (28%) to the ACE Survey who reported having experienced physical abuse as a child, it is clear that the public system for identifying maltreatment is not capturing even the tip of the iceberg.

Unfortunately, ACEs do not exist in isolation. This is especially true for children who have been the subject of maltreatment investigations—whether substantiated or not. They are likely to have experienced multiple ACEs. In an exploration of that relationship, the researchers responsible for the National Survey of Child and Adolescent Well-Being found that more than half the children investigated as victims of child maltreatment had four or more ACEs. This included children in every age range; 38% of children ages birth to 2 years old had four or more ACEs (Stambaugh et al., 2013).

More important than knowing that many more Americans live with a history of childhood trauma is learning what impact this has on them as they age. The ACE Study took the survey responses and matched them to each person’s medical record. Would they find a relationship between the number of ACEs the respondents listed and the quality of their health? Indeed they did. Felitti and Anda discovered that the more ACEs adults had, the more likely they were to have negative physical and mental health outcomes. At highest risk for chronic disease and early death were respondents who had four or more ACEs.

The original Kaiser Permanente sample was drawn from a predominantly white, middle-class, college-educated sample (Centers for Disease Control and Prevention, 2014). Subsequently the ACE Survey has been used with a wide range of populations (e.g., the state of Iowa, 7 tribes from the southwestern U.S.). In a study looking at adolescents presenting for trauma-focused assessment and treatment, the majority (61.3%) had been the victims of multiple ACEs. So-called poly-victimization, especially when it occurs in the first 5 years of life, lays the foundation for additional victimization during adolescence. Because each developmental stage builds on the competencies achieved (or missed) during previous stages, early childhood trauma “can interfere with the normative developmental process and set the stage for a variety of functional impairments and health issues that can persist and evolve across the lifespan” (Grasso, Dierkhising, Branson, & Ford, 2015).

Compounding the difficulty of assisting complex trauma victims is their distorted perception of themselves. They believe themselves responsible for whatever terrible things have happened to them. Their ACEs are so much the fabric of their lives that they think those experiences are normal. In her autobiographical book, Living With a Wild God, Barbara Ehrenreich described a childhood that included no fewer than five ACEs. But her memory of that period does not include an objective appreciation of her trauma:

But if you are thinking this is the usual story of dysfunction and abuse, then I’m doing a poor job of telling it, and projecting my own standards as a parent onto a time, and a class, when children were still regarded as miscreants rather than the artisanal projects that they have become today. (Ehrenreich, 2014, p.12)

Before we recount the stories that form the core of this article, a definition of complex trauma is in order.

The term complex trauma describes the dual problem of children’s exposure to traumatic events and the impact of this exposure on immediate and long-term outcomes. Complex traumatic exposure refers to children’s experi-

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Childhood trauma has a huge effect on how the various areas in the brain function.
ences of multiple traumatic events that occur within the caregiving system—the social environment that is supposed to be the source of safety and stability in a child’s life. Typically, complex trauma exposure refers to the simultaneous or sequential occurrences of child maltreatment—including emotional abuse and neglect, sexual abuse, physical abuse, and witnessing domestic violence—that are chronic and begin in early childhood. Moreover, the initial traumatic experiences (e.g., parental neglect and emotional abuse) and the resulting emotional dysregulation, loss of a safe base, loss of direction, and inability to detect or respond to danger cues, often lead to subsequent trauma exposure (e.g., physical and sexual abuse, or community violence). (Cook, Blaustein, Spinazzola, & van der Kolk, 2003, p. 5)

The Brain: What Fires Together Wires Together

Childhood trauma has a huge effect on how the various areas in the brain function. The brain builds itself on the basis of the child’s experiences. If those experiences predominantly create fear and uncertainty, the areas in the brain associated with the fight-flight-freeze response will build stronger connections than those associated with problem solving, emotional regulation, and higher cognitive thinking. During the first 3 years, the rate of brain development is phenomenally fast. A newborn’s brain weighs approximately 13 ounces or 28% of its adult weight; by 3 years old the brain weighs 42 ounces, which is approximately 90% of its adult weight (Chudler, 2015). With brain development this rapid, the child’s experiences are having a major influence on building productive, curious, likeable humans or insecure, angry, reactive ones.

Complex trauma co-exists with other factors that impair the brain’s ability to do its job. Alcohol and drugs numb the pain for the victim but they also reduce critical thinking capacity. More catastrophic is the concurrence of complex trauma and fetal alcohol spectrum disorders. As is often true for women whose children are in foster care, not only did they drink while pregnant with their children, they are themselves affected by prenatal alcohol exposure because their mothers used alcohol during pregnancy. Prenatal alcohol exposure has permanent deleterious effects on the brain which are made manifest in blighted executive functioning skills (see box Effects of Prenatal Alcohol Exposure).

The list in the box, although composed from documentation of fetal alcohol spectrum disorders, is similar to the effects seen in cases of complex trauma (Hudson, 2011).

The Impact of Complex Trauma on One Family

The introductory discussion of ACEs is made flesh and blood when we meet Elizabeth (Liz) Johnson.2 Her sons, James, 5 years old, and Daniel, 3 years old, were first brought to the attention of child protective services (CPS) after Liz was brutally beaten by her boyfriend of 2 months. When police and EMS responded to the scene, they found Liz in critical condition and immediately took her to the hospital. CPS was notified that James and Daniel had been present when the incident occurred and had no safe place to go. Upon their arrival, CPS found that James and Daniel’s father was deceased, and they had no known relatives. Liz’s only relative was her mother, who was contacted but stated that she could not take responsibility for the boys. Due to the absence of family, James and Daniel were taken into emergency custody and placed in a traditional foster home. James participated in a forensic interview which revealed that he had witnessed his mother being beaten in the most recent incident and had also witnessed episodes of domestic violence regularly over the last 2 months. Both boys were also seen by a medical provider who found that they had marks on their bodies consistent with physical abuse. Two days later an Emergency Shelter Hearing was held to determine whether James and Daniel should remain in state custody. Liz was released from the hospital just in time to attend this hearing, entering the court room on crutches due to a broken leg and with many visible injuries to her face, neck, and arms. It was determined that the boys would remain in the state’s custody and that the family would be referred to the local Safe Babies Court Team (SBCT; see box Safe Babies Court Teams). Charlotte Williams, SBCT community coordinator, met with Liz following the hearing to describe the SBCT approach. Liz con-

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2 The names and certain specific details have been modified to protect the privacy of the family described.
Safe Babies Court Teams

Safe Babies Court Teams (SBCT) focus on improving how the courts, child welfare agencies, and related child-serving organizations work together, share information, and expedite services for young children. This work increases knowledge among all those who work with maltreated children about the needs of infants and toddlers and how to meet the individual needs of each child and parent. Typically judges introduce the community to the SBCT approach. They collaborate with child development specialists to create teams of child welfare and health professionals, child advocates, and community leaders. Together the ever expanding SBCT provides tailored services to abused and neglected infants and toddlers and their parents.

If service providers can take the parent’s trauma history into account and view their actions through the lens of complex trauma, the reasons for their behaviors become clearer, and they can identify more effective ways to support parents.

When she was 13, she began a series of relationships with men, all of which involved domestic violence. She had her first child just after turning 15. Feeling that she had no other options, she left the child with his father, hoping that his violence toward her would not create danger for the baby. James and Daniel’s father left her when she was pregnant with Daniel. He died just after Daniel’s birth. Unable to support her family, she turned to prostitution. Reflecting on all her relationships with men, Liz told Charlotte that she felt like she deserved to be beaten. According to Liz, the man who sent her to the hospital had not been physically abusive to her before that incident, despite what James had disclosed to the forensic interviewer. Liz said the violence began after they started using heroin together. Charlotte responded to Liz’s life story by saying how hard it must have been as a child and young adult to face so many terrible events. Liz replied that it was just life and that others must have similar childhoods. For her, normal was life as she had experienced every single ACE on the 10-item survey. This survey asks, “During your first 18 year of life, did you experience:

1. Physical abuse?
2. Emotional abuse?
3. Contact sexual abuse?
4. Emotional neglect?
5. Physical neglect?
6. Your mother being physically abused?
7. Parental substance abuse?
8. Losing a parent to divorce or separation?
9. A household member going to prison?
10. A household member who was depressed, mentally ill, or attempted suicide?”

(The survey instrument is available at www.cdc.gov/violenceprevention/acestudy)

For as long as Liz could remember, her father was physically and emotionally abusive toward her mother, often restraining her in a chair and holding a knife to her neck while questioning her about things he believed she had lied to him about. Liz stated that on the few occasions she tried to help her mother, her father turned his aggression toward her, locking her in a closet or whipping her with a belt. When Liz was 7 years old, her father started to sexually abuse her. When she turned 10, a teacher reported the possibility that Liz was being abused to CPS and she was taken into custody. She was separated from her mother only for a short time, but her father’s parental rights were terminated.

Strategies for Supporting Parents With Histories of Complex Trauma

Many parents of children in the foster care system have themselves had histories of repeated trauma, often in the context of their own caregiving relationships with their parents. When working with these parents, it is essential that service providers understand the damage such experiences can cause to their ability to think ahead and plan, to manage their emotions and their actions, to relate in a healthy way with others, to talk coherently about their own experiences, to identify what they think and feel, and to take others’ perspectives (van der Kolk, 2014). There is often also damage to the parent’s self-concept: they may see themselves as “damaged goods,” as unworthy and unlovable. Paradoxically, these views of the self can manifest as demanding, entitled, and grandiose feelings and behaviors. They expect to fail and expect that others will let them down, or will
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actively work and conspire against them. They often put their trust in the least trustworthy of people; those who have abused them in the past, be they parents, lovers, friends, or siblings. And they may reject the help of those who genuinely want to help them, frustrating those team members and family who want to support them. These parents are often labeled as “noncompliant” and “self-destructive.” They often abuse substances because it is the most effective resource readily available to them to cope with flashbacks and other traumatic reminders and the strong emotions that accompany them.

If service providers can take parents’ trauma history into account and view their actions through the lens of complex trauma, the reasons for their behaviors become clearer, and they can identify more effective ways to support parents:

1. Begin with the understanding that their early childhood caregiving relationships (which are the model for all future expectations of others) were fraught with danger, and that normative childhood vulnerability and trust within those relationships were often met with rejection, abandonment, and betrayal. Therefore, do not expect that the parent will trust you simply because you express genuine concern for them. They have learned to be wary and do not trust others. You will have to earn their trust over time.

2. Cognitive function is often affected such that the parent is overwhelmed by the many demands presented by a case plan; by the formalized language of court proceedings; and by the barrage of advice, instructions, and orders coming from their caseworker, their family, their attorney, and from service providers. This does not mean they are not intelligent. They simply need more time to take in and process new information. These parents benefit when team members slow down their pace; speak in short, one-part sentences; then check for understanding. Giving multistep instructions can be overwhelming to the parent who then fails to do as instructed, or tries, becomes frustrated, and gives up. These parents may be unfairly judged as noncompliant and might do much better with a slight change in approach.

3. Their ability to recall events as a coherent story is impaired, and because of this they are often perceived as being deceptive. To get an accurate narrative of their history, team members should expect to gather information over many sessions, using the case documentation to help in organizing a coherent timeline of their life. In addition, because they are wary, they often will not share some parts of their story until they have developed some sense of the team member as trustworthy and reliable. They will need support and patience to tell their story.

4. Their ability to think ahead and to plan is often limited, thus they will miss or double-book appointments, over-extend themselves, or simply forget about an appointment despite the usual reminders. They lose calendars and appointment cards given to them. These parents tend to focus solely on the present moment and are often responding to one crisis after another due to their impaired ability to plan ahead. The constant activation of their fight or flight response weakens any capacity for thinking past the present moment. Safety planning, so crucial in child welfare cases, relies on the ability to think ahead to identify possible dangers and risks to the child so that these can be avoided or reduced. These parents have a very hard time thinking ahead. These parents can best be supported through transparency and coordination among service providers, or central coordination by the caseworker regarding all case-related appointments. These parents will benefit from frequent verbal reminders (especially the day before an appointment and the morning of an appointment) and by help with problem solving around any scheduling conflicts that arise. This assistance provides the parent with an experience of learning how to plan and schedule and how to address conflicting demands through a supportive relationship. Having supportive adults who mentor youth through this learning process is how these skills are usually developed through middle childhood and the teen years. These parents have not had this experience but rather were, to paraphrase Dr. Bruce Perry (Perry, 1997), incubated in crisis. Often they are not self-sabotaging but simply lack basic skills usually mastered at an earlier developmental stage.

5. Parents with histories of severe developmental trauma often have internalized powerfully negative self-attributions based on their early experiences. They may view themselves as inherently defective and fear that opening up to others will result in others realizing
they are damaged and then rejecting them. These powerful and painful cognitive distortions are highly resistant to reason. Such parents fear that if others see who they really are, it will confirm their defectiveness. This fear feeds their avoidance of vulnerability and honesty with team members. Paradoxically, they long for acceptance, validation, and inclusion, but at the same time do not trust those who mirror them in a positive way. For them, this can feel manipulative and they can respond with emotions ranging from skepticism to rage. Team members may come away from such an exchange feeling wounded, confused, and defensive. Parents who present this way can be supported when team members maintain a consistent positive regard for the parent, while resisting the temptation of attempting to connect primarily through empathic support, which some parents may experience as manipulative and dishonest. Initially the focus should be on communicating clearly and maintaining consistency with the parent. Praise should be given when the parent has successes but should be specific and brief so as not to overwhelm the parent. Constructive criticism should be brief and focused as well and should be balanced with recognition of any successes.

It should be noted that not all parents with such histories would present with these difficulties. Some may have benefited from prior treatment; some may have a natural resilience in the face of adversity. Yet others may have been affected more in one area of functioning than another, and thus may present with only one or two of the problems presented. It is essential that a thorough assessment of the parent’s developmental and trauma history is completed with the understanding that, given the interpersonal difficulties they may struggle with, such a history will likely be gathered over weeks, if not months. In our experience, parents need time to develop enough trust to share some of their story, and, as discussed above, may struggle with putting together a coherent narrative of their lives. In addition, the impact of the parents’ own prenatal alcohol exposure, current substance abuse, or both is often interwoven with their trauma history both as an underlying contributor to some of the deficits outlined above and to their attempt to cope with their history of trauma through numbing (Ayard, Berlin, Rosanbalm, & Dodge, 2011; Herrick, Hudson, & Burd, 2011). While it is beyond the scope of this article to address this factor meaningfully, both prenatal alcohol exposure and current substance abuse should be assessed and factored into treatment.

Preventing a Lifetime of Suffering

It is important to take a multigenerational approach with families involved in the child welfare system. In addition to working with parents through the lens of complex trauma, professionals working with vulnerable families need to be able to tell many more stories like Penny’s. Penny3 was a 3-year-old toddler referred for therapy following her verbal disclosure of sexual abuse by her stepfather, Martin. Martin had married Penny’s mother, Angela, when Penny was 5 months old. (Penny’s biological father denied she was his child when she was born and had never had any contact with Penny.) Thus Martin was Penny’s psychological father, the man she identified as “Daddy.” Penny told a preschool teacher that Martin had repeatedly touched her private parts and her disclosure indicated he had attempted penetration. Although these attempts were unsuccessful, Penny said they were painful and that she asked him to “wait until I’m bigger.” Penny talked about these incidents readily, indicating she perceived them as normal interactions between father and child. Penny’s disclosure to her preschool teacher was reported to CPS. When the CPS investigator interviewed Penny’s parents about the disclosure, they both denied the allegations vehemently and expressed dismay that Penny would say such a thing. Angela initially indicated she would cooperate with the investigation and have Martin move out of the home until it was completed, and so Penny went home with her. Later it was apparent that Angela had pressured Penny to recant, telling her that Martin would go to jail because of Penny’s disclosure. Two days later the CPS investigator was told by an anonymous source that Angela was allowing Martin to have unsupervised access to Penny, and that Angela was very angry with Penny for having made the disclosure. The investigator met with Angela at the home and confronted her about these allegations. Angela became agitated and stated that Penny was lying about the abuse. The investigator noted that Penny appeared frightened of Angela, who was visibly angry. Angela now refused to make Martin leave the home while the investigation was completed, stating that Martin had done nothing wrong and should not be punished. Therefore Penny was moved to a therapeutic foster home as Penny’s mother could not identify any appropriate family members. Shortly thereafter Angela and Martin surrendered their parental rights.

At her first assessment appointment with the mental health clinician, Penny was brought by her foster parents, the Smiths, with whom she had resided for approximately 3 weeks. Penny presented as a highly intelligent and verbal child. She was outgoing and curious. However, she showed no appropriate caution with the unknown therapist, readily leaving her foster parents to go to the playroom with the therapist. This indicated that Penny had not developed age-appropriate wariness of strangers and did not use her primary caregivers as a “secure base” (Bowlby, 1988) to help her identify people who were safe and those who were not safe. The absence of a self-protective caution with strangers made Penny markedly more vulnerable to other abusers.

3 Names and certain details of this story have been modified to protect the privacy of the families described.
Mr. and Mrs. Smith reported that Penny seldom talked about her parents, but had periodically made brief, disjointed disclosures about Martin’s abuse. For example, one day when at the park with Mrs. Smith, Penny noticed a red truck. She said: “Daddy took me for a ride in a red truck one time. It went really fast! It was fun.” Mrs. Smith said that it sounded like it was fun. Penny then became pensive and said, “I had sex with Daddy. I was bad.” Mrs. Smith was startled, but calmly reassured Penny that she was not bad, but that it was Martin who had acted badly. Penny thought about this, then smiled at Mrs. Smith and nodded. Penny also said one day that her parents were in jail “forever” because “I told a lie.” Penny’s belief that her parents were in jail made sense given their abrupt abandonment of her in their attempt to avoid further legal consequences for Martin’s abuse of Penny. Despite his abuse of her, Penny experienced Martin as the “loving” parent and grieved his absence. Angela was volatile and confrontational in her interactions with others, and Penny perceived her as frightening and dangerous. Martin was affectionate, soft-spoken, and reassuring by contrast, and Penny bore the guilt of feeling fully responsible for his fate.

During her assessment and treatment Penny demonstrated a warm relationship with both of the Smiths, who were loving and supportive and who were experienced in fostering children with histories of child sexual abuse. The Smiths quickly came to love Penny and began the process of adopting her within 2 months of her entering foster care. During treatment and between sessions, Penny’s play themes reinforced that she saw her father as affectionate and loving and she saw her mother as frightening and dangerous. For example, while playing during a session, Penny stopped and appeared “zoned out.” She then talked about a time when her mother was angry at her and said she would throw Penny out the second story window. Penny engaged in “magical thinking” so common in cases of child sexual abuse. She believed fully that she could reunite with her father and that he could simply stop abusing her. Penny’s therapy focused on using the healthy supportive caregiving relationship she had developed with the Smiths to help Penny work through her confusion, sadness, loss, and fears; to address her cognitive distortions; to integrate her experience of being sexually abused by a parent; and to anchor Penny in a healthy parent-child relationship and the normative physical, emotional, and social boundaries such a relationship provides. Penny was adopted by the Smiths approximately 14 months after coming into care. She responded well to the combination of effective therapeutic intervention and a supportive and engaged adoptive family.

Conclusion

Many of the parents whose children enter foster care have themselves experienced abuse, neglect, and other forms of serious trauma. They may well have been through the foster care system as children. When children are wounded by traumatic experiences within their family system, and when these traumas are not addressed, they can carry the scars for the rest of their lives. This damage can result in intergenerational trauma and abuse so familiar to experienced child welfare and Dependency Court staff. Substance abuse, domestic violence, relational problems, risk-taking behaviors, emotional lability, self-harming, anxiety, and depression are often the adult sequelae of significant untreated childhood trauma. In the past these were seen as standalone issues, contributing to the family dysfunction and were treated as such. Through the groundbreaking work of Bessel van der Kolk and many others, systems that work with these families have come to recognize that these diagnoses are secondary effects cascading from the primary experience of complex childhood trauma. In the past, these effects were identified and treated in isolation from the root cause, ignoring the deeper wounds from which they spring. With the source of dysfunction left unaddressed, secondary problems emerge as needed, albeit negative, coping and survival skills that insulate parents from the pain of the source trauma. This behavior is often perceived by CPS and other support services as “self-sabotage.” As long as these parents are caught in this cycle, they remain unable to develop the skills needed to be good enough caregivers for their children. It is essential to understand, assess, and treat these symptoms holistically: that is, to identify the parent’s trauma history and to understand the secondary effects’ functionality in relationship to their early traumatic experiences. By doing so, team members can more effectively support parents in their attempts to gain competencies needed to parent their children successfully. Focused attention on healing the parent’s childhood trauma history can be accomplished concurrently with dyadic work supporting the child-parent dyad in the process of healing their relationship. When parents are supported through breaking the cycle of complex trauma, they become working models for their children and the source of their children’s healing, rather than their pain.

Learn More

Don’t Hit My Mommy! A Manual for Child-Parent Psychotherapy With Young Children Exposed to Violence and Other Trauma (2nd ed.)
Washington, DC: ZERO TO THREE

Adverse Childhood Experiences Study
www.cdc.gov/violenceprevention/acestudy

National Child Traumatic Stress Network
www.nctsn.org/trauma-types/complex-trauma

Safe Babies Court Teams Project
www.zerotothree.org/maltreatment/safe-babies-court-team/

Child-Parent Psychotherapy
http://childtrauma.ucsf.edu/manuals-and-books
Lucy Hudson, MS, currently serves a dual role at ZERO TO THREE; she is the director for the Safe Babies Court Teams Project and the demonstration site implementation director for the Quality Improvement Center for Research-Based Infant-Toddler Court Teams (QIC-CT). She has been instrumental in the planning and development of the Court Teams Project and the QIC-CT and is responsible for the daily operation and oversight of all demonstration site activities, staff, and fiscal matters. She also produces training materials, including a series of DVDs about working with families involved in the child welfare system. She earned her bachelor’s degree from the University of Massachusetts Boston and her master of science degree from Wheelock College.

Sarah Beilke, MSW, is the community coordinator for the Tulsa Safe Babies Court Team in Tulsa, OK. She works closely with the Tulsa County Juvenile Court, the Oklahoma Department of Human Services, and other community stakeholders to ensure that foster children in the birth to 3 age group are on a fast track to safe, nurturing permanency. As a graduate student, Ms. Beilke had the opportunity to work as a part of the New York University Family Defense Clinic, thus sparking her interest in the relationship between child welfare practices and the courts. She received a bachelor’s degree in psychology from Drury University and her master’s in social work from New York University.

Michele Many, MSW, LCSW, BACS, is an assistant professor in Louisiana State University’s (LSU) Department of Psychiatry. She is a primary clinician in several of LSU’s multidisciplinary teams including the Orleans Parish Infant Team and the Orleans Parish Baby Court Team, working with infants and toddlers in the foster care system. Ms. Many has co-authored several chapters and articles on child sexual abuse, early childhood trauma, and vicarious trauma, and she has presented nationally on complex trauma and on working with infants and toddlers who have been sexually abused. Ms. Many also coordinates an outreach behavioral health clinic for youth in the Vietnamese community of New Orleans East and consults in public schools in Terrebonne and Lafourche Parishes.

References


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