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ORIGINAL PAPER

Helping Children Exposed to War and Violence: Perspectives from an International Work Group on Interventions for Youth and Families

Hilit Kletter · Rebecca A. Rialon · Nathaniel Laor · Daniel Brom · Ruth Pat-Horenczyk · Mohammed Shaheen · Daniel Hamiel · Claude Chemtob · Carl F. Weems · Carl Feinstein · Alicia Lieberman · Daryn Reicherter · Suzan Song · Victor G. Carrion

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Abstract
Background This paper outlines conclusions from a three-day workgroup hosting the eight authors as well as others with expertise in the evaluation and treatment of youth exposed to war and violence.
Objective The purpose of this meeting was to bring multiple perspectives together to identify components that comprise effective psychosocial interventions for child victims of war and community violence across cultures. The meeting also sought to identify gaps in the existing treatment approaches.
Method In the meeting, personal experiences and previous research were discussed to develop a wide-ranging intervention approach, determine a cohesive definition for "indirect" exposure, and identify successful methods of intervention delivery for youth exposed to acts of war and violence.
Results and Conclusions Key components of intervention for youth exposed to war/violence, important outcome measures, and cultural differences that may influence effective intervention were identified. A clearer definition of "indirect" exposure was also

H. Kletter · R. A. Rialon · C. Feinstein · D. Reicherter · V. G. Carrion
Department of Psychiatry and Behavioral Sciences, Stanford University, 401 Quarry Road, Stanford, CA 94305, USA

H. Kletter (✉)
Division of Child and Adolescent Psychiatry and Child Development, Stanford University, Stanford, CA 94305-5719, USA
e-mail: hkletter@stanford.edu

N. Laor
Tel Aviv-Brull Community Mental Health Center, Tel Aviv, Israel

N. Laor
Donald J. Cohen & Irving B. Harris Resilience Center for Trauma and Disaster Intervention by the Association for Children at Risk, Tel Aviv, Israel

N. Laor
Sackler Faculty of Medicine, Tel-Aviv University, Tel Aviv, Israel

developed. Finally, a nine-phase model was developed to provide guidelines for establishing partnerships between trauma teams and other organizations or schools to implement and disseminate treatment for this population.

Keywords War · Violence · Children · Developmental trauma · Treatment interventions

Introduction

Childhood exposure to traumatic acts of violence and war creates a significant public health problem across numerous countries worldwide. Youth exposed to terrorism, violence, and war are at a higher risk for developing posttraumatic stress symptoms, depression, aggression, functional impairment, substance use, suicidal ideation, and risk-taking behaviors than are youth not exposed to such events (Pat-Horenczyk et al. 2007a, 2009; Qouta et al. 2008; Sagi-Schwartz 2008). Further, the impact of indirect exposure to terrorism, defined as a "near miss" experience such as having been near the site of a terrorist attack or having been there just before or after an attack, leads to similar posttraumatic distress as direct or personal exposure (Pat-Horenczyk et al. 2007b). In addition to the impact on mental health, children exposed to violence are also at risk for severe physical health problems including obesity, heart disease, cancer, chronic lung disease, skeletal fractures, and liver disease (Felitti et al. 1998). Furthermore, during and after war or community violence, it is often challenging for mental health services to be implemented effectively, given the complexity of the multiple systems involved, fiscal limitations, competing service programs, and the overall limited availability of support and resources (Carrion et al. 2012). In this paper, we first review the effects of war and violence on youth, and describe existing psychotherapeutic interventions. We then identify gaps in these interventions and offer solutions to these gaps focusing on the key components of intervention, discuss effective outcome measures, and provide a clearer definition for "indirect" exposure and the treatment considerations for this population. Finally, we describe a nine phase model we developed for treatment implementation and dissemination.

N. Laor
Child Study Center, Yale University, New Haven, CT, USA

D. Brom · R. Pat-Horenczyk
Israel Center for Treatment of Psychotrauma, Herzog Hospital, PO Box 3900, Jerusalem 91035, Israel

D. Brom · R. Pat-Horenczyk
Paul Baerwald School of Social Work and Social Welfare Hebrew, University of Jerusalem, Mount Scopus, Jerusalem 91905, Israel

M. Shaheen
Center for Development in Primary Health Care, PO Box 4006, Albireh-West Bank, Palestine

D. Hamiel
Tel Aviv-Jaffa Academic College, Tel Aviv, Israel

C. Chemtob
Child Study Center, New York University, One Park Ave, New York, NY 10016, USA

Overview of the Impact of War and Violence

Prevalence estimates of war-related posttraumatic stress disorder (PTSD) among youth range from 8 to 75 % (Gurwitch et al. 2002; Saigh et al. 1999; Schiff et al. 2010). Furthermore, there is convincing evidence that, for youth who are exposed to traumatic conditions, the negative psychological impact may not be transient (Brom et al. 2011; Chemtob et al. 2011; Desivilya et al. 1996; Dyregrov et al. 2002; Klingman 1992; Laor et al. 1997; Rosenthal and Levy-Shiff 1993; Weisenberg et al. 1993). When studying the impact of ongoing violence on these children, Laufer (2003) found that 6.8 % of Israelis and 37.2 % of Palestinians met criteria for PTSD. A study of Palestinian children living in the Gaza strip found that 32.7 % developed PTSD symptoms requiring treatment and 49.2 % experienced moderate PTSD symptoms (Quota and El Sarraj 2004). A comparative study of posttraumatic symptoms among 1,016 Israeli and 1,235 Palestinian adolescents found that 6.8 % of the Israelis and 37.2 % of the Palestinians met criteria for PTSD (Pat-Horenczyk et al. 2009). Similar to Israeli and Palestinian youth, Lebanese children, reported experiencing an average of six war-related traumas in their lifetime and had a PTSD prevalence rate of 43 % (Macksoud and Aber 1996).

Exposure to violence is also a significant problem in the United States, with 50–96 % of urban youth being exposed to violence in their own neighborhoods (Stein et al. 2003b). Research studies have documented varying rates of PTSD in trauma-exposed youth. In terms of lifetime incidence, Kilpatrick et al. (2003) documented a PTSD prevalence rate of 4.8 % in a nationally representative probability sample of 3,161 participants ranging in age from 12 to 17 years. Significantly higher point prevalence estimates of PTSD have been found. For example, in a study of American children experiencing interpersonal violence, 57.5 % of youth in the sample met criteria for a diagnosis of PTSD and 42.5 % reached subthreshold symptoms (Kletter et al. 2009).

Effective interventions for PTSD exist. For example, Trauma-Focused Cognitive Behavioral Therapy (TF-CBT; Cohen and Mannarino 2008) has been proven useful in reducing symptoms of PTSD, as well as symptoms of depression and behavioral difficulties in children who have experienced sexual abuse, multiple traumas, and intimate partner violence (Cohen et al. 2004, 2011; Deblinger et al. 2001). Trauma Systems Therapy, another well-established treatment, is a comprehensive method for treating posttraumatic stress (PTS) in children and adolescents by specifically addressing social and environmental factors that are believed to be driving a child's PTS symptomatology (Saxe et al. 2005; Ellis et al. 2011). In addition to individually-based methods, family therapy approaches, such as Alternatives for Families CBT (Kolko and Swenson 2002), aim to activate the child's support system, improve family communication, foster understanding

C. F. Weems
Department of Psychology, University of New Orleans, New Orleans, LA 70148, USA

A. Lieberman
Child Trauma Research Program, UCSF Department of Psychiatry, San Francisco General Hospital, 1001 Potrero Street, Suite 2100, San Francisco, CA 94110, USA

S. Song
Asian Americans for Community Involvement/Center for Survivors of Torture, 2400 Moorpark Ave. #300, San Jose, CA 95128, USA

of the trauma, and develop healthy coping mechanisms within the family system. Despite the evidence for efficacy many youth go untreated due to reasons such as lack of accessibility to resources and stigma surrounding the trauma.

Schools as Context for Intervention

Given the potential negative impact of war and violence, there is a clear need to support youth who live under conditions of war, terrorism, and violence in order to reduce risk of developing long-term posttraumatic symptoms and enhance overall resiliency to adverse circumstances, but also there is a need to deliver intervention to those in need. Because of this, providing treatment for PTSD symptoms and co-occurring psychiatric problems associated with youth exposure to violence and war has often centered on school-based models. Implementation of treatment in schools increases accessibility and affordability while reducing stigma, thus reaching diverse socioeconomic and ethnic populations who otherwise would not receive services (Berger et al. 2007). Schools also offer a natural, built in support system for the children beyond the first line of support; the family (Wolmer et al. 2005). Providing classroom activities that help children understand the traumatic events, express their feelings, and engage in help-seeking behaviors can help restore a child's sense of security (Rolfsnes and Idsoe 2011).

Pat-Horenczyk et al. (2011) have described a model for comprehensive school-based interventions aiming to involve the various ecological circles of schools including teachers, school personnel, students and parents. The integrative school-based intervention combines universal resilience building in the community as well as screening for posttraumatic distress and providing clinical treatment for affected students. This ecological model is based on the conviction that effective implementation of long term programs is conditional upon building capacity within the local educational system. The effectiveness of school-based trauma interventions has also been demonstrated by Jaycox (2004), whose Cognitive Behavioral Intervention for Trauma in Schools (CBITS) is designed to reduce symptoms of posttraumatic stress disorder, depression, and behavioral problems, and to improve functioning, grades and attendance, peer and parent support, and coping skills through cognitive-behavioral techniques (e.g., psychoeducation, relaxation, social problem solving, cognitive restructuring, and exposure). CBITS has been used with students from 5th grade through 12th grade who have witnessed or experienced traumatic life events such as community and school violence, accidents and injuries, physical abuse and domestic violence, and natural and man-made disasters (Kataoka et al. 2003; Stein et al. 2003a).

Additionally, teacher-administered interventions have demonstrated effectiveness in reducing PTSD symptoms and somatic complaints in school children exposed to terror and war. From a public health systemic-ecological perspective, teacher-delivered interventions allow flexible access that replaces referral with outreach, a suitable setting that replaces office with school, proper format that replaces individual with group, efficient process that replaces direct care with clinical mediation, adapted technology that replaces pathology-based with a coping enhancement approach, and a platform to integrate the family (Wolmer et al. 2011a). For example, Wolmer et al. (2011a) implemented a teacher-delivered protocol focusing on enhancing personal resilience by strengthening adaptive coping and socioemotional competence to Israeli students during the Second Lebanon War in 2006. In another study, Wolmer et al. (2011b) implemented a universal, teacher-based, preventive intervention with Israeli students 3 months before the rocket attacks that occurred during Operation Cast Lead. Compared with a nonintervention but exposed

control group, those receiving the stress-inoculation-based treatment displayed significantly lower symptoms of posttraumatic stress, highlighting the potential effectiveness of the use of a psychosocial approach for preventing the development of PTSD in war-exposed children. Berger et al. (2007) also documented a significant symptomatic reduction in a controlled study of a different model of teacher-delivered intervention utilizing psychoeducational material, cognitive–behavioral skills, meditative practices, bioenergy exercises, art therapy and narrative techniques. A controlled study by Baum et al. (in press) evaluated the impact of a four-session resilience-building intervention for teachers on children affected by war. The results show that training of teachers alone can effectively lower posttraumatic stress and anxiety levels in their students.

Despite a substantial body of published research, researchers have often learned a great deal from initial mistakes or from discovering unforeseen paths leading to success and these insights are rarely documented in the literature. Treatment approaches developed for childhood trauma need to consider availability, feasibility, and methods of delivery. A three-day workshop, with eight experts in assessment and treatment of war and violence exposed youth, was held to bring together these researchers to explore the methodological issues and the limitations inherent in trauma research, to discuss the pitfalls and how to avoid or overcome them and thereby advance the next generation of research in interventions. For example, there is a need for treatments designed for children who have experienced multiple or repeated traumatic events within the context of adverse environments (i.e., those characterized by isolation, lack of stimulation and resource-poor support systems). There is a need for intervention models targeting children and adolescents who have experienced ongoing traumatic stressors, particularly in the midst of war and violence.

In order to address these crucial gaps, the eight authors (from Israel, Palestine, and the United States) as well as other developmental trauma researchers, psychologists, and psychiatrists with expertise in posttraumatic stress, psychosocial treatment development, and the effects of urban violence and exposure to war and terrorism, were invited to participate in a three-day workgroup entitled "*Interventions for Youth Exposed to War and Violence*" sponsored by the Stanford Early Life Stress Research Program and held at the Freeman Spogli Institute for International Studies at Stanford University. The workgroup examined the following broad aims: (1) treatment goals and core components of child trauma interventions; (2) gaps in existing interventions; (3) best practices for measurement of treatment outcomes; and (4) challenges to treatment implementation and dissemination. A professional writer, Dr. Dee Seligman, recorded the proceedings for each workgroup session and provided a comprehensive summary of the 3 days according to the meeting objectives. Each session was divided into general discussions, to allow open dialogue among group members to address the issues at hand, and work sessions to determine solutions to the challenges identified in the general discussions.

Workgroup Perspectives

Section 1: Treatment Goals and Core Components of Child Trauma Interventions

Identifying Those Youth in Need

This topic of discussion centered on the idea that while there are a number of psychosocial treatment approaches available for children exposed to trauma, given the heterogeneity of traumatized populations, it is unclear whether a standard set of treatment goals can be

applied across respective groups. There are critical factors that apply to all groups; early identification, need for prevention and early intervention, to name a few. All systems could improve in terms of increasing accessibility to all children who need resources while experiencing chronic or ongoing trauma. Although it is clear that sensitive screening needs to be conducted in those groups more at risk, it is important to highlight that proper screening should be followed by providing resources to those children in need. Multiple raters offer the advantage of combining subjective and objective data points. Of course, cultural and linguistic competence needs to be achieved within all assessments.

After appropriate assessment, an effective approach would include understanding of the context of the child's cultural environment. Understanding both the community and the cultural context surrounding the child's everyday life is critical when treating youth exposed to chronic or acute stress secondary to war or violence (Pynoos et al. 1995). Interventionists should implement necessary treatment adaptations. More specifically, it is imperative to recognize factors that constitute the child's cultural world, including social relationships, community support, ontogenic beliefs, as well as religious practices and beliefs (Barenbaum et al. 2004). The impact of these cultural components must be examined across the child's life span, not simply from the period surrounding the traumatic event. Taking these steps would help the feasibility of the treatment implementation and its sustainability within the community by promoting long-term effectiveness and generalization of treatment gains. It is also essential to recognize that mental health professionals, teachers, caregivers, and other individuals working with the child, as well as children themselves, often bring their own culturally-based ideas and perceptions into the treatment (U.S. Surgeon General 2001). Furthermore, certain therapeutic elements cannot be used in isolation of cultural context. For example, cognitive interventions that frame certain thoughts as "positive" or "negative" need to be used with caution, as certain beliefs may provide inherent strength in certain populations.

Interventions for youth exposed to complex traumas such as war and violence center upon the development of a strong therapeutic alliance (Ford and Cloitre 2009; Ford et al. 2005). Through the process of building a stable connection with the therapist, the child increases his or her capacity for trust, thereby enhancing his or her sense of security in knowing that there is someone who can provide protection or who will know what to do in times of crisis or uncertainty. In addition, assisting the child with self-regulation, thereby increasing the capacity for safety and building on resilience are critical aspects of the interventions regardless of cultural context (Ford and Cloitre 2009; Ford et al. 2005).

Another core component of childhood trauma interventions involves validation of the trauma as an event in need of attention. This education results in empowerment as well as the child's acknowledgement that the trauma was a significant event. Treatments must work to restore the child's capacity for safety, or forge a sense of control over his or her situation (Cook et al. 2005). Within the framework of a stable attachment, trust, and self-regulation, children can learn about the process in which their body responds with increased sensitivity to stress. This opens the scenario to explore relaxation techniques, including mindfulness, deep breathing, muscle relaxation, visual imagery and others (Cohen and Mannarino 2008; Gelkopf and Berger 2008; Layne et al. 2008). Lastly, through psychoeducation, children can understand, process, and accept their emotional experiences (Cohen and Mannarino 2008; Gelkopf and Berger 2008; Layne et al. 2008). This process can facilitate the development of cognitive flexibility and the development of adaptive responses for nonthreatening situations.

Given the widespread public health issue of childhood trauma following war and violence, it is also essential that a greater emphasis be given toward the development and

implementation of community-based prevention programs. Researchers should initially work to increase their familiarity with members of a community prior to the occurrence of acute trauma in order to foster a sense of trust in the intervention team later on. Furthermore, school-based prevention programs have served to significantly reduce the impact of PTSD symptoms in children experiencing traumatic events (Berger et al. 2007; Gelkopf and Berger 2008; Layne et al. 2008). Programs of this nature increase awareness and provide education to those often at high-risk for trauma exposure. In addition, such preventive efforts may serve to identify people in the school and community who can be mobilized for support in an actual event of acute trauma.

In developing treatment approaches, researchers and clinicians also need to consider the impact of traumatization on school personnel, such as teachers, principals, and guidance counselors, who are often susceptible to developing posttraumatic stress symptoms as a result of direct as well as vicarious exposure (Pat-Horenczyk et al. 2011). Providing support and trauma-related services to those adults within the community and school systems who have frequent contact with youth, may serve to promote the emotional and academic well-being of traumatized children and adolescents. Recognizing the need for both adult and child interventions will aid in the preparation and dissemination of treatment once a trauma has occurred (Pat-Horenczyk et al. 2011).

Incorporating Manualized Treatment Protocols in an Ongoing Therapeutic Relationship

Protocols can be defined as a step-by-step procedure on how to carry out a specific treatment, whereas a method is a more general guideline for how to reach certain objectives in treatment. The inherent flexibility that comes with most psychosocial interventions can be highly valuable as they allow for exploration and the tailoring of the intervention to a child's history, developmental level and cultural context. When using manualized protocols, there is often little room for consideration of the child's cultural background, as the therapist must often closely follow the treatment model. However, some protocols, such as TF-CBT and interpersonal psychotherapy, have been translated and adapted for different cultures (Eaton 2012). Protocols can prove to be a valuable tool for experts as it allows them to train other providers, such as teachers, more reliably. However, it is important for those trained to receive ongoing supervision to ensure proper adherence to the protocol so that the intervention does not veer away from being based on empirical evidence. Protocols can provide a starting point for more individualized treatment, as they are usually designed to reduce avoidance and confront the issue at hand, the traumatic history, by creating a narrative for the traumatic events and identifying traumatic reminders that may be impacting the individual.

Determining the Advantages of a Universal Approach Versus a Cultural Specific Approach

Children cannot be viewed in isolation of their culture, gender, or previous experiences, as these are all important aspects of what they bring to treatment and how they understand the trauma. Culturally-informed approaches need to be added to those universal approaches that are demonstrated to be effective (those listed above). Factors such as the child's access to resources, chronic threat of trauma, cultural definition of stress and mental health (including stigma), and community support must be taken into account during treatment. For example, Palestinian youth are much more likely to seek support within the family and community rather than from mental health professionals as is more commonly acceptable

in Israeli and American cultures (Al-Krenawi 2005; Al-Krenawi and Graham 1999; Savaya 1995).

Section 2: Gaps in Existing Interventions

Background

Children exposed to chronic threat of trauma may require different treatment components given the cognitive and physiological ramifications of living in constant fear. Oftentimes, interventions focus on targeting the immediate trauma and nothing beyond. However, the majority of youth exposed to war/violence experience ongoing threat that is of a more severe and enduring nature (Garbarino and Kostelny 1996). This places them at increased risk for derailment of their developmental trajectory and the chronicity of the trauma prevents them from being able to recover (Terr 1991). Thus, there is a need to develop interventions that will help these youth cope with their reality and increase their capacity for stress tolerance. This is an important consideration especially in countries or regions with little social infrastructure to provide mental health services. As mentioned previously, interpersonal connection is an important component of treatment for children exposed to trauma (Cook et al. 2005). Children under chronic threat of trauma can experience constant disruption in attachment, as their parents, teachers, and other caregivers are not invulnerable to ongoing threat. Children undergoing constant threat develop mistrust in people who have the power to make the threat disappear; they become disillusioned. Children being treated for chronic stress need to form strong interpersonal connections with adults given the uncertainty in their lives.

Young victims of chronic threat of trauma perceive the reality of the threat differently than those experiencing acute trauma. These children develop a steady belief that they are not safe and recognize the reality that no one can protect them. It must be accepted that the world is dangerous and uncertain, and psychosocial treatment can help the child cope with this reality. This can be done by teaching resilience skills and empowering these children. Two examples are Child–Parent Psychotherapy (CPP), a dyadic intervention in which play and other expressive methods are used to repair attachment and regulate traumatic stress and Cue-Centered Therapy (CCT), a hybrid intervention that emphasizes education on classical conditioning and trauma-related reminders (cues), focusing on how these are linked to current behaviors, emotions, thoughts, and physiological reactions (Carrion and Hull 2010; Lieberman et al. 2011).

Understanding Resilience and Its Relationship to Treatment Implementation and Outcomes

A better understanding of factors that promote resiliency fosters an awareness of how children respond differently to the same trauma, and informs treatment. What is it that helps one child continue functioning in the midst of adversity, while another does not? One important consideration is the context in which the child is being viewed. Different organizations consider resiliency indicators to be different things. For example, a school might determine resiliency through standardized test scores, while a mental health agency may consider resiliency to be the lack of psychiatric symptoms. The traditional definition of resiliency has simply been the ability to recover or not develop adverse symptoms (Masten 2009); however, resiliency must also be considered as the capacity to grow and respond to challenges while maintaining positive mental health and developmental outcomes (Luthar e al. 2000; Werner and Smith 1992). Maintaining supportive relationships

can also be a resilience indicator (Werner 1995). More research is needed in order to understand the difference between true resiliency and an individual who may be approaching the threshold to be impaired, but has not expressed this vulnerability yet. Interventions for these two groups may be different; while prevention should be emphasized for the first, increasing the threshold of vulnerability may be the goal for the second.

One suggestion to increase our understanding of resiliency may include asking the children what they consider "well-being" indicators. This fosters a more flexible definition of resilience with room for cultural and contextual factors, as well as individual differences. Protective factors for the development of resiliency include social support, exercise or physical fitness, respite for those with anxiety, and validation of personal experience. The definition of resilience can only be recognized in terms of trauma. It differs from strengths or developmental assets which are characteristic of an entire group, regardless of the level of adversity they face. When trauma is present, assets function differently; for example, a good school will have a lot more influence in the life of a child from a poor resource background than one from a wealthy background that has a lot more options for support (Annunziata et al. 2006).

Section 3: Perspectives on the Assessment of Treatment Outcomes

Balancing information acquired through qualitative and quantitative assessment measures when making clinical decisions can be a challenge in the field of childhood trauma. When working with traumatized youth, use of both assessment modalities is recommended to facilitate clinically significant or meaningful outcomes (Chadwick Center for Children and Families 2009). Regarding quantitative assessment, measures of social and emotional functioning allow professionals to assess youth functional impairment in terms of behavioral problems, interpersonal relationships, and personal distress. These measures also provide ways to evaluate symptoms of depression, anxiety, and posttraumatic stress across treatment (AACAP 2008). Gathering collateral information such as grades, absenteeism, and medical information helps supplement these measures, however it is always important to clarify how these are defined and acquired (Chadwick Center for Children and Families 2009; AACAP 2008). Providing norm-referenced rating forms to teachers or other adults is often an accurate way of evaluating the extent of youth functional impairment, as grades or absenteeism might require more time for significant improvement. Data from these sources also enables professionals to monitor progress and determine treatment effectiveness. Qualitative methods can be effective when determining the role of key therapeutic factors, such as therapeutic alliance and trust. Indirect exposure to trauma is particularly concerning given that, for many youth, the ongoing threat of experiencing a traumatic event represents an actual significant stressor (Evans and Kim 2012).

There are a wealth of measures for assessment of violence/war exposure, posttraumatic stress and associated symptoms, and functional impairment. While a full review of all existing measures is beyond the scope of this paper, some of the most common assessments will be presented below.

Violence/War Exposure

Traumatic Events Screening Inventory for Children (TESI-C)

The TESI-C is a 15 item clinician-administered interview that assesses children's past and current exposure to a variety of traumatic experiences (Ford and Rogers 1997). In addition,

it evaluates PTSD Criterion A and details for each specific traumatic event. The TESI-CRF-R (Ippen et al. 2002) is a revised 24-item version of the original TESI intended to be more developmentally sensitive to the traumatic experiences of children ages 0–6 years. It is available in both child (TESI-CRF-R) and parent (TESI-PRF-R) report forms. The TESI is available for free download from the U.S. Department of Veteran's Affairs website: http://www.ptsd.va.gov/professional/pages/assessments/tesi.asp. The TESI-CRF-R and PRF-R forms are available by contacting Chandra Ghosh Ippen: Chandra.ghosh@ucsf.edu.

Trauma Symptom Checklist for Children (TSCC)

The TSCC is a 54 item self-report measure for youth ages 8–16 that assesses exposure to a variety of traumas and posttraumatic symptoms, but is not intended for diagnosis (Briere 1996). It consists of two validity scales (over- and underreporting) and six clinical scales: anxiety, depression, posttraumatic stress, sexual concerns, dissociation, and anger. The Trauma Symptom Checklist for Young Children (TSCYC) is a 90 item caretaker report form intended for children ages 3–12 (Briere 2005). It is made up of two validity scales (over- and underreporting) and 8 clinical scales: Anxiety, Depression, Anger/Aggression, Posttraumatic Stress—Intrusion, Posttraumatic Stress—Avoidance, Posttraumatic Stress—Arousal, Dissociation, and Sexual Concerns. In addition, the TSCYC provides a summary PTSD scale (PTSD Total) and a possible PTSD diagnosis for children ages 5 and older. Both the TSCC and TSCYC are available for purchase at the Psychological Assessment Resources website: http://www3.parinc.com.

War Experience Questionnaire

The War Experience Questionnaire consists of 14 items assessing demographics, current living arrangements, and events experienced during war (Husain and Holcomb, unpublished, 1994). The measure can be obtained from Debora Bell-Dolan: BellDolanD@Missouri.edu.

Exposure, PTSD and Functional Impairment

Clinician Administered PTSD Scale for Children and Adolescents (CAPS-CA)

The CAPS-CA assesses PTSD and associated symptoms in youth ages 8–18 (Nader et al. 1996). The 36 item semi-structured diagnostic interview is based on a specific event that the child identifies as most distressing. The measure evaluates current and lifetime diagnosis; frequency and intensity of symptoms; and developmental, social, and academic functioning. The CAPS-CA can be obtained by completing the request form at the U.S. Department of Veteran Affairs website: http://www.ptsd.va.gov/professional/pages/assessments/caps-ca.asp.

UCLA PTSD Reaction Index for DSM-IV (PTSD-RI)

The PTSD-RI is a self-report measure with child (ages 7–12), adolescent (ages 13–18), and parent versions (Pynoos et al. 1998). It consists of 48 items that assess exposure to 26 types of traumatic events and evaluates DSM-IV PTSD criteria for the event that the child identifies as the most distressing. The PTSD-RI also evaluates associated symptoms of

guilt and fear of recurrence of the event. The measure is available by contacting the UCLA Trauma Psychiatry Service: HFinley@mednet.ucla.edu.

Children's PTSD Inventory (CPTSDI)

The Children's PTSD Inventory (CPTSDI) is a clinician-administered measure for children ages 6–18 based on the DSM-IV criteria for PTSD (Saigh et al. 2000). The child is first screened for exposure to various traumatic events by being asked if he or she ever experienced it or felt upset for not being able to stop it from happening. If an event meets the screening criteria, then symptoms are assessed in reference to the event. In addition to a PTSD total score, the CPTSDI also yields scores on five subscales: Situational Reactivity, Reexperiencing, Avoidance and Numbing, Increased Arousal, and Significant Impairment. The measure is available for purchase from the Psychological Corporation: www.PsychCorp.com.

Associated Symptoms

Revised Child Anxiety and Depression Scale (RCADS)

The RCADS is a 47 item self-report measure for youth in 3rd–12th grades (Chorpita et al. 2000). It consists of six subscales: separation anxiety disorder (SAD), social phobia (SP), generalized anxiety disorder (GAD), panic disorder (PD), obsessive compulsive disorder (OCD), and major depressive disorder (MDD). The RCADS also provides a total anxiety scale (sum of the 5 anxiety subscales) and a total internalizing scale (sum of all 6 subscales). There is also a parent version (RCADS-P) that assesses parent report of youth's symptoms across the same six subscales. Versions of the RCADS are available for free download at Child FIRST: http://www.childfirst.ucla.edu/Resources.html.

Anxiety Disorders Interview Schedule for DSM-IV (ADIS)

The ADIS is a semi-structured interview focusing on anxiety disorders with child (ADIS-C) and parent (ADIS-P) versions (Albano and Silverman 1996). The measure also provides assessment and diagnosis of other major childhood disorders, including externalizing and affective disorders. Diagnostic criteria of each disorder are assessed as well as an "interference" rating to evaluate the level of functional impairment. For each of the diagnoses met, a "Clinician Severity Rating" is also assigned. The ADIS child and parent versions can be purchased from Oxford University Press: http://www.oup.com/us/catalog/general/subject/Psychology/PractitionerClientGuides/?ci=9780195186741.

Anxiety Control Questionnaire-Child (ACQ-C)

The ACQ-C (Weems et al. 2003) is a developmentally adapted version of the Anxiety Control Questionnaire (Rapee et al. 1996), a measure of control in anxiety disorders used with adults. The ACQ-C assesses perceived lack of control over external threats (e.g., feared objects or situations) and control over negative, internal, emotional, and bodily reactions associated with anxiety (e.g., heart racing, trembling). The measure is available for free download from the University of New Orleans: http://psyc.uno.edu/weems%20lab%20page_files/Measures.html.

Section 4: Integrating Key Treatment Components, Identifying Best Methods of Delivery, and Innovative Approaches to Overcome the Challenges of Dissemination of Evidence-Based Interventions: A Nine-Phase Model of Intervention Implementation

The following model was intended to integrate key treatment components, identify best methods of delivery, implement, and disseminate evidence-based interventions. In order to achieve this end, the model is intended for creating partnerships between trauma experts and other leaders and organizations in the community. The components of this model were developed by the group members based on prior work by Laor et al. (2006) and Pat-Horenczyk et al. (2011). The model includes nine phases, with specific principles that are consistent throughout each phase. It is important to note that each phase should not be viewed discretely, but rather as overlapping one another. Consistent components across these phases include communication, continuous identification of partners, the partners' responsibility for financial resources, and supervision and leadership. When developing a partnership, it will be important to identify partners as they may change throughout the process depending on the phase. Lastly, providing clear guidelines permeates each phase of building a partnership. Considering the phases as a spiral, not a linear movement allows one to understand the flexibility and fluidity of these phases. The nine phases include:

1. Preparatory Phase
2. Introductory Phase
3. Design/Planning Phase
4. Implementation Phase
5. Evaluation Phase
6. Assimilation Phase
7. Dissemination Phase
8. Sustainability/Continued Evaluation Phase
9. Getting Out/Visiting Phase

Phases One and Two

The Preparatory and Introductory phases include workshops to engage and inform stakeholders interested in pursuing the partnership. Preparatory work is necessary in order to be accepted by the community. For example, teams must study who their likely partners are and the ecology of those groups before moving forward. The relationship between stakeholders, leadership, and implementers should be considered a mentoring relationship as this is a developing system with the goal of sustainability without constant supervision of the experts. A mentoring relationship sets the framework for the final "getting out" phase. These phases will help build a working alliance to facilitate the partnership's success. Horizontal integration, rather than vertical hierarchy, will aid in the cohesion between community leaders and trauma teams. Lastly, identifying preparedness skills as part of preparatory work will help inform future phases.

Phase Three

The Design Planning Phase includes identifying the common problems in the community as well as the more extreme problems. As mentioned previously, identification of preparedness skills the community already holds will guide design planning. It is important for the investigation team to have an understanding of the community's existing resources and

their needs in order to design an intervention plan. Enlisting the help of teachers, for example, in a school setting will help with the success of the application of different techniques. In this manner, partners are invited to be co-creators of the intervention plan. This will aid their sense of ownership and their investment in successful implementation.

Phase Four

The Implementation Phase's objectives include training, preparedness, activation of the program, and ongoing meetings with the entire agency or school staff. An actual pilot training to test the model should be a component of this phase to ensure its success before widespread implementation. There exists a need for flexibility of implementation; a prescribed pilot training might not be logical given the different cultural components at play with each partnership. It is important, however, to give teachers or other partners the structure of the intervention in the beginning and then be flexible on how the partners choose to implement while assuring reliable interpretation. This will allow implementation within the institution's structure in its entirety, thus leading to real cultural change.

Understanding and addressing the challenges to implementation requires a high level of administration and oversight. The level of personal experience and training impacts the ability to implement, and thus should dictate the structural needs of a particular protocol. The benefits to our associates, teachers or partners, need to be clear at the outset. It is necessary to have their buy-into the intervention in order to have effective implementation. If the investigation team communicates dedication and genuine care for the program, schools or agencies often feel more dedicated to it; they know that the team will come back to visit and evaluate how the program is progressing. While there are many challenges of implementation, empowering and engaging partners will definitely facilitate the process.

Phase Five

Particular emphasis on the generalizability of treatment programs within both the general population and across cultures needs to be noted; it is often argued that evidence-based programs are effective in investigation settings, but limited in their generalizability or applicability to real-world groups. To this end, delivering treatment through community-based sites may serve to improve the effectiveness of various psychosocial treatment interventions. Additionally, training partners, such as teachers and school personnel in the treatment model may enhance treatment outcomes and buffer the impact of trauma; however, during a mass trauma or disaster situation, school-based or other agency resources are often not readily available or accessible to those in need. Directly training providers in the intervention, shortens the time between training and implementation, and lessens the distance between the child's environment and where the intervention is delivered will likely enhance the effectiveness of the treatment.

Phases Six and Seven

The primary goal of the Assimilation and Dissemination phases involves reaching more children while making the organization more independent and effective. Assimilation, referred to herein as a process of restoration of previous worldviews or a return to pre-trauma baseline functioning (Payne et al. 2007), is also tightly linked with previous phases, as appropriate design, training, and implementation must be assimilated into the target

culture. Having the system adopt the program and integrating it into the organization's daily routine is an objective of dissemination. Both horizontal and vertical dissemination are important aspects of this phase. Horizontal dissemination includes ensuring that knowledge of the program has reached relevant parties within the environment, such as parents, principals, the medical system, the community center, and religious centers among others. These two phases lead to substantial social change in the communities.

Phase Eight

Phase eight ensures sustainability and includes continued evaluation of efficacy. Sustainability centers on the idea that once good results have been obtained, but before the trauma team leaves the site, it is ensured that the program can maintain itself and sustain its benefits. This allows the capacity to continue collaborative projects, such as training, if necessary.

Phase Nine

The trauma treatment team must gradually transfer oversight of an intervention program once a solid infrastructure of support networks responsible for sustaining the resources has been established within the impacted region. A primary duty of the treatment team, therefore, is to develop strong relationships with local providers and governing officials, if applicable, before withdrawing from the site so that the school or other agency can contact the team in the event of a future crisis.

Summary and Conclusions

In summary, the three-day workgroup aimed to foster a consensus amongst developmental trauma experts regarding factors that constitute a gold standard treatment approach for youth exposed to war and violence. Our primary area of concern involved children chronically exposed to traumatic events, as such interventions often vary largely in scope from treatments targeting youth exposed to single-incident events. The outcomes of this meeting included identification of the core components of treatment intervention for youth exposed to war/violence, determination of best outcome measures, addressing cultural differences, and definition of indirect exposure. Implications of this work include a plan to use the nine-phase model to build partnerships between trauma teams and other organizations or schools to implement and disseminate treatment for this population.

One area not discussed at length within this paper includes an examination of adult-focused trauma interventions. Therefore, this topic must be explored further by teams fostering partnerships in communities under chronic threat of violence or war. Research teams must assess whether these adults need psychological treatment themselves, before expecting them to administer interventions to children in the community.

Future work must be done to promote the development of scientifically sound outcome measures. There is a discrepancy between the need for quantitative data for donors and policymakers and expert preference for qualitative measurements. Developing more sound qualitative measurements or informing policymakers and donors on the value of qualitative data might help alleviate this disparity.

Unanswered questions about resiliency still remain, such as the role of genetics and how resiliency can be viewed outside of trauma. While resiliency is understood more easily in

the face of a trauma, attempting to identify resilient children without a trauma would foster preventive care. Detecting children, who are less resilient than others, would allow professionals to intervene prior to a trauma to develop more coping tools. Additionally, exploring the role of genetics in resiliency would help professionals identify those children who might be less resilient. This early identification would not only foster preventive care, but also quicken intervention after a trauma has occurred.

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