Questions and Answers from
"The Right Intervention: What Works for Children Exposed to Violence"
Live event held August 23, 2012
Responder: Betsy Groves, MSW, LICSW

	Questions Asked by Attendee	Response
1	Q: I would like to know if there any future webinar related to family violence or drug use among adolescents	We don't at this time, but those are great suggestions that we will consider for the future!
2	Q: What is the reason for aggression developing after stress exposure and how common is it?	Agression is a common response to a traumatic stressor in children--particularly young children. In fact, in our program it is the most frequently mentioned behavioral symptoms by parents. This response can be understood in connection with the impact of chronic stress on the stress-response system, and the resulting difficulties that children show with regulating their emotional responses. For many children, the alteration in the stress response system results in hyervigilance, hyerarousal and difficulties with emotion regulation.
3	Q: What if any are the different symptoms a child may exhibit when esposed to verbal violence?	This received a response during the Webinar
4	Q: What were the three criteria for exposure?	Symptoms related to re-experiencing the event, Symptoms associated with avoidance of trauma reminders and numbing of general responsiveness, Symptoms of arousal, Duration of symptoms > 1 month
5	Q: Advise for when the family does not have financial resources for treatment?	This is difficult to answer because it depends on what state you are in. I would suggest that you contact your state mental health department/agency, or the child's pediatrician to determine what resources might exist for families who are uninsured or cannot afford to pay.
6	Q: How do you recommend we increase the number of mental health professionals in our communities? Do you know of any scholarships available to assist person's who are interesed in the mental health feild?	Schools of social work and other graduate level mental health training programsoften offer scholarships. The specifics depend on the school. The larger issue of the shortage of child mental health professionals is a difficult and widespread problem. I would suggest contacting a consumer mental health advocacy group or your local child protection services to share your concern and find out what is being done to address this issue.
7	Q: If there are some signs of child suffering PTSD at what age can they start getting mental health asistance such as therapy?	Evidence-based treatments exist for children 0-6. Specific interventions include Child-Parent psychotherapy (ages 0-6); the Incredible Years (ages 2-12); Parent Child Interactional Therapy (ages 2-7); Trauma-Focused Cognitive Behavior Therapy (age 3-18). In many states, private insurers and Medicaid reimbursement guidelines now recognize that very young children (under the age of four) suffer from trauma-related mental health issues and provide coverage for these children.

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8	Q: What if the batterer is in prison, but the child will be seeing him again, and the mother plans on contiuning her relationship with him?	It would be important to know the age of the child, the specifics of the family history of violence, and the potential dangerousness of the batterer. That said, my suggestion would be to partner with the mother around a discussion of what this might mean to the child and to her, and to share your concerns about safety (if that is relevant). Depending on the age of the child, you could also have this discussion with him/her--either with or without the mother. The goal is to lay the groundwork for your availability if things do not go well. If you have strong reason to worry about the safety of the mother and child, I would suggest developing a safety plan with the mother if she is agreeable to that idea.
9	Q: in addition to using the PEDS, etc and making a referral, what can pediatric practice do in terms staff education to offer anticipatory guidance, etc?	Routinely asking about violence, scary or upsetting events in the life of a family or community is a form of anticipatory guidance in that the clinician has initiated the conversation, is communicating to the parent that this is a part of good health maintenance. Some of the providers I work with ask about how couples manage disagreements, or about violence in the community (particularly if the family lives in a high-risk area). Also, asking about media habits is a form of anticipatory guidance. The general goal here is to sensitize parents to the impact of violence exposure--even in the media and to encourage them to be pro-active in protecting their children. Please see the parent resources that I mentioned in the presentation. Please see the comment in Question # 13 below.
10	Q: Does a DV screening that is positive for mom automatically raise a red flag for screening a child using PEDS, etc?	Not necessarily. Rather than use the PEDS, I would prefer to ask the parent if the child was present, if she/he has concerns about the effects of the DV on children, if the parent has noticed changes in the child's behavior. This line of questioning will likely provide more information than the PEDS
11	Q: Given the lack of child mental health professionals and referral resources, what are a few of the options pediatricians can fall back on to assist trauma exposed children?	Obtain consultation from a local mental health provider; use resources from the American Academy of Pediatrics and National Child Traumatic Stress Network to educate yourself and to pass along to parents. The NCTSN has a section of helpful resources for medical providers.
12	Q: Observation re: prevention: if the pediatrician routinely asks "has anything really scary or upsetting happened to your child or anyone in your family?" this opens a path for discussion about prevention, making the connection about the role of parents in being pro-active, aware of protective factors.	Yes! Well stated!
13	Q: Are ther any evidence based programs showing the effect of home visitors for the parent?	I am not sure what specific outcomes you are asking about--whether you are thinking about child abuse, domestic violence, reducing or preventing maternal depression, etc. There has been extensive evaluation of home visiting programs for all of these outcomes. Please see the resources for evidence based interventions, particularly NREPP and the California Evidence-based Clearinghouse for Child Welfare

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14	Q: How do you suggest relating to parents who have been so desensitized by their own histories of abuse and violence that they don't recognize the detriment of the same exposure to their children?	This received a response during the Webinar
15	Q: What kind of treatment do you provide for children who are having contact with the batterer or if the child is continuing to be exposed to family violence?	This received a response during the Webinar
16	Q: When you talk about being careful working with the child who has contact with the batterer, what do you do or not do with the child in treatment? How do you know when to end treatment in this situation?	We are aware that the child might struggle with divided loylaties between his parents or that he/she must choose one parent over the other. We are aware of the fact that the child may be conflicted about sharing information out of fears for safety or a fear of betraying a parent. The question of ending treatment must be answered on a case-by-case basis. In general, the guidelines for ending treatment would include an assessment of safety, an assessment of the child's functioning, a decrease in trauma symptoms and the parent's agreement that the treatment contract has been met.
17	Q: Please comment about media exposure to violence and it's contributions to toxic stress	This received a response during the Webinar
18	Q: Are you aware of any large medical insitutions currently using the STEPP tool in the pediatric setting?	This received a response during the Webinar
19	Q: As you discussed treatment, you said that parental involvement is critical. However, often times these children are in foster care. How does that change you treatment approach?	In our program, we identify the adult who is the primary caregiver and ask that person to be involved. So, we would certainly ask foster parents to be involved. The focus may shift to assisting that foster parent to develop a consistent, nurturing and protective relationship with the child. That may involve helping the caregiver to understand the child's behavior, providing information about traumatic stressors, assisting her/him to devise strategies to comfort the child, and deal with behavior challenges.
20	Q: Are there any specific agencies/providers/researchers that you partner with on adolescent specific trauma related interventions?	This received a response during the Webinar