NCTSN The National Child Traumatic Stress Network

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A QUARTERLY PUBLICATION OF THE NATIONAL CHILD TRAUMATIC STRESS NETWORK

Special Issue: Culture and Trauma

An Introduction from the NCTSN Culture Consortium Leadership

This Special Issue of IMPACT is devoted entirely to the relationship between culture and trauma. In support of its mission to raise the standard of care for traumatized children and their families and communities, the National Child Traumatic Stress Network is committed to advancing and supporting trauma-informed education, training, service adaptation, and delivery that are developmentally and culturally appropriate. Our members are encouraged to collaborate within and beyond the Network with diverse communities and individuals, recognizing that their unique histories are influenced by ethnicity, language, race, gender, immigration status, spirituality, and identity. As professionals who walk alongside and provide services to survivors of trauma, our intent is to be ever mindful of the impact of cultural diversity as it is experienced and expressed by the children and families that we serve—taking into account not only historical cultural factors but the realities of our clients' current social, political, and interpersonal situations.

This issue of IMPACT describes the incredible work being done across the Network by members with informed perspectives on the cultural dimensions of trauma at multiple levels: the individual, including both the client and practitioner; the organization or system; and the broader community. While the issue highlights a wide spectrum of stories and topics, the common thread is appreciation of the intersection of culture and trauma and our commitment to embracing it.

We would like to acknowledge the National Center for Child Traumatic Stress for supporting the NCTSN Culture Consortium and providing the resources to make this Special Issue on culture a reality. We also thank our colleagues who contributed to this newsletter for sharing their work and wisdom.

Luis E. Flores, MA, LPC
Serving Children and Adolescents in Need, Inc. (SCAN)

Shawntae Jones, MS
La Rabida Children's Hospital Chicago Child Trauma Center (La Rabida CCTC)

Co-chairs, NCTSN Culture Consortium

Preventing Youth Suicide in Montana's Indian Country

Rocky Boy Reservation, MT, location of NNCTC's initial childhood trauma work. NNCTC's current suicide prevention projects are on other reservations in Montana.

In 2010, a small town on the Fort Peck reservation in northeastern Montana lost five kids from its middle-school community to suicide. Another 20 youth—some as young as age 10—attempted suicide in the course of the same year.

When youth suicides occur in a cluster, as happened in the town of Poplar, child-serving professionals like Marilyn J. Bruguier Zimmerman, MSW, Matt Taylor, MA, and their colleagues are called to help the community heal from their trauma and to prevent further tragedy. Bruguier Zimmerman is Director of the National Native Children's Trauma Center (NNCTC) and Taylor is Director of Montana Safe Schools Center, both housed at the University of Montana's Institute for Educational Research and Service in Missoula. >>> *cont'd on pg. 6*

For Immigrant Families, Language Opens Door to Healing from Trauma

A drawing by a young girl helped by the Child Witness to Violence Project, Boston, MA. Courtesy of CWVP.

When immigrant families come to the United States, they lose familiar references and routines, and communication is often difficult because of language barriers. For those families who have also experienced trauma, even the small details of everyday life add to the stress and confusion. "It is very frightening not to be able to articulate your needs, feelings, and ideas," said Carmen Rosa Noroña, MS Ed., who is from Ecuador and serves as both the Clinical Coordinator for the Child Witness to Violence Project (CWVP) at Boston Medical Center, and Associate Director for the Boston site of the Early Trauma Treatment Network.

Elena Muñoz encountered these stresses and barriers when she and her daughter Cielo came to Boston from Central America in 2007. "Immigration is a very big impact in the lives of adults and children," Muñoz said of her experience. "It is a 180-degree change: you don't know where to find food, you don't know where to find help. It is very disorienting." Elena and Cielo, then age five, had

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New Series: The Organizational Journey toward Cultural and Linguistic Competency

In this Special Issue of *IMPACT*, we debut a four-part series on the organizational domains that support the delivery of culturally and linguistically competent services to diverse groups of children and families who have experienced trauma. Our current topic focuses on how child-serving professionals can come to understand the cultural characteristics of those they are serving. Topics to follow address staffing and human resources issues; effective use of resources; and the collaborative process.

Part One: Who Do You Serve? Identifying Your Service Population

The delivery of culturally and linguistically competent services begins with knowledge of the characteristics of the population being served.

Whether an organization serves a specific, geographically-defined catchment area or is open to the public at large, it should periodically capture data about the children and families who come (and do not come) through its doors, said Vivian H. Jackson, PhD, a member of the NCTSN Advisory Board and a faculty member at the National Center for Cultural Competence at Georgetown University Center for Child and Human Development. Neighborhoods and communities are often in flux, Jackson noted, and strategies for helping a traumatized child who recently arrived from El Salvador, for example, are not interchangeable with strategies that may have been in use for years for helping African American children. "As populations move out and new populations come in," she said, "approaches to service delivery must be reevaluated."

External, Internal Sources of Information

There are many *external* data sources for assessing the characteristics of a service population. A quick scan of the addresses of current clients will help to identify their communities, the demographics of which can be researched through United States Census Bureau information or from enrollment data from local school systems. If the population is comprised of recipients of Medicaid or state mental-health funds, the state or local departments of these programs may supply additional demographic information. Some local jurisdictions furnish more detailed neighborhood profiles (for example, Citywide Vital Signs, compiled by the Baltimore Neighborhood Indicators Alliance). Online databases (see Additional Resources pg. 3) offer information about spoken languages, religious/faith adherents, and other key demographic data. With the information it collects, the agency can design services to better fit the social contexts of the people it serves and make appropriate decisions regarding outreach and collaboration.

Internal client data allow an organization to compare its own demographics with that of the community it serves. These data also serve as the baseline from which the organization can identify strengths and challenges in the provision of quality services. At minimum, the CLAS (National Standards on Culturally and Linguistically Appropriate Services) standards suggest that data on race, ethnicity, and language be collected. (A revision of the CLAS standards will be released later in 2012.)

In October of 2011, in compliance with the Affordable Care Act, Section 4302, the Department of Health and Human Services released guidelines that require collection of race and ethnicity data at a more specific, "granular" level. Collection of language, gender, and disability data is also required on all HHS-sponsored health surveys. Such granular-level data can make a difference. A study that used the terms Mexican-American/Chicano(a), Puerto Rican, and Cuban instead of the umbrella terms Latino or Hispanic was able to show that diabetes-related mortality was twice as high in Mexican-American and Puerto Rican patients as it was in Cubans (Smith & Barnett, 2005).

As electronic health records gain in use, data capture affects how organizations gather information and structure their services. Jackson pointed out that organizations working toward cultural and linguistic competency should actively encourage the inclusion of demographic fields that will allow them to uncover disparities in care in areas such as service utilization, diagnostic patterns, rates of participation and satisfaction, and clinical and functional outcomes.

Data on primary language and literacy levels, in both the mother tongue and English, are also important. (See www.lep.gov for federal guidance on language access.) An analysis of language needs can help guide the organization in developing a language access plan. The plan, in turn, will help the organization make decisions about multilingual staffing, interpreters, and telephone interpreting services; determine which materials require translation into which languages; and select facility signage to include in languages other than English. Assessing literacy levels will also guide decisions on the degree to which symbols and other plain language methods need to be incorporated in the organization's work.

Understanding Communities

Clinicians should be attuned to what is happening in their clients' worlds. Jackson offered examples from Washington, DC, where Haitians were deeply affected by the earthquakes in their homeland, and Trinidadians closely followed the elections in their home country. As they seek to help children and families heal from traumatic events, agencies can collaborate with key community partners, cultural brokers, and advocacy groups to help them stay apprised of these types of contextual family factors. "If you're not making connections about the level of tension in the household and how that is also influencing this child," Jackson said, "then you've missed a big opportunity to be helpful to the family."

Delivering culturally and linguistically competent services is a holistic process that takes place over time and evolves on a continuum (Cross, et al., 1989). The process may appropriately be led by organizational executives, board members, program managers, and others with the authority to make decisions about policies and resource allocation. However, "No one has to wait for the call from an organizational executive to begin to champion the issues of cultural and linguistic competence," Jackson said. Organizational change can start with leadership from any place within the organization. Any individual can begin to ask and answer these questions: Who do we serve? Who do we not serve, and why? How does the culture of our clients influence their experience of trauma? How does their sociocultural context contribute to their distress and to their

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Who Do You Serve? *cont'd from pg. 2*

healing? Who do we serve well? Who do we not serve well, and why? And finally, What organizational changes do we need in order to make a difference? ■

Additional Resources

- The Modern Language Association's Language Map Data Center offers a survey of spoken languages, broken out by state, county, or zip code. Visit http://www.mla.org/map_data&dcwindow=same
- The Migration Policy Institute offers estimates of foreign-born residents in a given geographic area, as well as current political and historical background and refugee information. Visit www.migrationinformation.org
- The Association of Religion Data Archives offers demographic maps of religious affiliation and identification, customized according to geographic area. Visit http://www.thearda.com/DemographicMap/
- The Health Research and Education Trust offers a free toolkit on how to collect race, ethnicity, and primary language information from clients. Visit www.hretdisparities.org
- The Institute of Medicine's report on Race, Ethnicity, and Language Data: Standardization for Health Care Quality Improvement can be accessed at http://www.iom.edu/Reports/2009/RaceEthnicityData.aspx
- The Office of Minority Health supplies templates for collection of language, race, gender and disability information. Visit http://minorityhealth.hhs.gov/templates/browse.aspx?lvl=2&lvlid=208

The NCCTS extends a special thank you to Vivian H. Jackson, PhD, for her conceptualization of this series and her major contribution to this article.

Chicago's Clergy Form Urban Dolorosa to Unite Against Violence in the "Sorrowing City"

"Chicago is the home of more youth homicides than any other American city." (The Chicago Reporter, January 25, 2012)

Like other first responders who provide services after disasters and emergencies, the Reverend Susan B. W. Johnson, Senior Minister at Hyde Park Union Church in Chicago, is familiar with sorrow in the community. Aware of its devastating impact, Rev. Johnson founded Urban Dolorosa to serve families who are grieving in the midst of escalating violence and deaths of young people in Chicago, the "sorrowing city."

Urban Dolorosa is a multicultural, ecumenical ministry of people of faith and conscience from churches, community groups, and the arts. It strives to give voice to grieving families who ask, "How could God let this violence happen?" and "Why did God let this child die?"—questions that Rev. Johnson hears frequently from members of her congregation. Urban Dolorosa's mission is to bring together diverse Chicago communities to memorialize the children killed by violence, to promote peace-making efforts in the city, and to motivate the public's commitment to end the violence. In Rev. Johnson's words, "We are an anti-violence fabric trying to cover our beloved city."

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Trust and Acceptance Can Encourage LGBTQ Youth to Disclose Abuse

Feelings of shame and embarrassment are common among youth who have been sexually violated or physically abused. In lesbian, gay, bisexual, transgender and questioning youth, those feelings may be magnified, to a degree that can impede their willingness to disclose the abuse. Al Killen-Harvey, LCSW, and Heidi Stern-Ellis, LCSW, who are both clinical supervisors at the Chadwick Center for Children and Families housed at Rady Children's Hospital and Health Center in San Diego, CA, have extensive experience training first responders and clinicians on issues of gender identification and development, including the common stereotypes around sexual identity. In their view, the dynamics of abuse disclosure require a nuanced response when the clinician is working with LGBTQ youth.

Suicide is the third leading cause of death among 15-to-24 year olds, and LGBTQ youth in general are up to four times more likely to attempt suicide than their heterosexual peers. The degree of risk may be associated with where the individual is in the process of coming out, and the reactions of family and friends. Messages of rejection from family and peers can lead to isolation and potential exploitation. An unwanted or unwelcome physical or sexual encounter can compound the multitude of developmental issues already faced by LGBTQ youth who are still coming to terms with their sexual orientation or gender identity.

Communicating Acceptance

LGBTQ youth intuitively screen their environment for cues that they are valued and respected, so clinicians who work with these youth must be sensitive to the messages that they and their agencies impart. "We know that the kids we work with are very reluctant to disclose and will only do it with someone with whom they feel safe and comfortable," said Killen-Harvey. Clinicians who demonstrate an attitude of acceptance about diversity will help start that conversation from a place of safety.

Killen-Harvey said that language used at the organizational level can also help convey acceptance. This includes language about sexual orientation or gender identity in an agency's nondiscrimination policy and published mission statements. More inclusive language on gender identity and family relationships can also be used in official forms. Because LGBTQ youth may feel excluded by traditional language used to connote gender identity and family relationships, organizations should consider revising intake and registration forms to be more inclusive—for example, replacing the terms "Mother/Father" with "Parent /Guardian."

The simple display of a symbol such as the rainbow flag also communicates inclusion. At one facility, clinicians wear name badges that include the words "Safe Space" (see example on pg. 4).

Stern-Ellis said that during initial interviews, clinicians can phrase their questions to LGBTQ youth in ways that encourage conversation. For example, instead of "Do you have a girlfriend/boyfriend?", the therapist can ask, "Is there someone special in your life?".

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Disclosure of Abuse in LGBTQ Youth

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An example of a staff identity badge that can be incorporated to communicate acceptance of LGBTQ youth issues. Courtesy of The Village Family Services.

Becoming the Safe Harbor

LGBTQ youth are most likely to disclose abuse to an adult they trust, such as a child welfare worker, a caring police officer or school officer, or a mental health clinician. However, Stern-Ellis and Killen-Harvey cautioned that having a lone ally in an organization can inadvertently put an LGBTQ youth in a riskier position. If the organizational culture has not embraced diversity, that ally could, due to an unplanned transfer or other outside situation, be forced to refer the youth to a coworker who is not as accepting or understanding.

The two trainers noted that it's imperative that organizational outreach to LGBTQ youth come from the top down, which is why they always insist that management personnel be included in training sessions requested by frontline providers.

Becoming advocates for abused youth does not require clinicians to abandon their own personal belief systems. Research conducted by Caitlin Ryan and colleagues at the Family Acceptance Project at San Francisco State University has established that accepting or non-rejecting reactions can foster health and emotional well-being. "One doesn't have to be accepting of diverse sexual orientation in order to mitigate harm," Killen-Harvey said. "One just has to stop being rejecting, and that's what we ask organizations and agencies to do."

For clinicians who feel that working with this population is beyond their clinical comfort zone, Killen-Harvey said "there is no shame" in admitting that referral of a youth to another clinician may be the most ethical course. Stern-Ellis added that the clinician must first be knowledgeable about the available referral programs and agencies, asking them specific questions such as, "What percentage of LGBTQ youth are represented in your client base?" and "Have staff undergone training in cultural competency and diversity, and specifically sexual orientation and gender diversity?"

Finally, clinicians working with abused LGBTQ youth and their families should not be afraid to address "the elephant in the room." Killen-Harvey said he is still astounded when parents voice the concern: "Will being abused by a person of the same sex make my child gay?" That's just one of the myths about sexual abuse that can be addressed with appropriate psychoeducation. "LGBTQ youth who have been traumatized need to know that we understand them, that we respect them, and that we value them," he said. ■

Language Opens Door to Healing

cont'd from pg. 1

fled their home country for their own safety--they had been physically assaulted by a gang—and to join Sr. Muñoz, who had immigrated to Boston a few years earlier. But soon after arriving, Cielo began to have difficulties. She had trouble remembering the names of people and places familiar to her in her home country, and she was becoming impulsive and hypervigilant. When Cielo started hitting her parents at home, Elena took her to a pediatrician at a community health center. When he learned of Cielo's past exposure to violence, the pediatrician referred Elena to the CWVP, which is housed in the pediatrics department at Boston Medical Center.

Elena didn't know what to expect when she walked through the door at the CWVP. "I was feeling lost," she said recently through an interpreter. "And I was not clear what this program was about." What she found in her intake worker was "someone who spoke Spanish and listened to me. Her sensitivity was very important because she understood my concern regarding what was happening to my daughter. That was comforting for me."

Language as the Portal

The Child Witness to Violence Project began in 1992 and currently provides therapy to more than 150 children and their families each year. According to Noroña, the majority of immigrant clients seeking services at CWVP are families from Central and South America and the Caribbean; more than half are Spanish-speaking.

The clinicians serving most of the Latin-American immigrant families are bilingual and bicultural. Sessions with Spanish-speaking families are conducted in Spanish using Child-Parent Psychotherapy, a relational child-parent treatment model of treatment for children up to age five. Noroña conducts supervision sessions with bilingual clinicians and trainees in Spanish, and encourages trainees to write their process recordings in Spanish as well. She noted that writing and analyzing content and process in Spanish enables trainees to reflect with families in Spanish and to translate

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A drawing by a young girl helped by the Child Witness to Violence Project, Boston, MA. Courtesy of CWVP.

Language Opens Door to Healing *cont'd from pg. 4*

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>
> *CARMEN ROSA NOROÑA, MS Ed., Clinical Coordinator for the Child Witness to Violence Project (CWVP) at Boston Medical Center*

what they have learned at a theoretical level to a clinical level. "It can be a challenge to provide developmental guidance in Spanish to a parent regarding how, for instance, a child is experiencing a trauma reminder," Noroña said. "If the clinician is too concerned about how well she or he is communicating in Spanish with the caregiver, child or family, this may become an obstacle to engagement. How then do you make meaning of the concepts you learned in class in English so that you can communicate with the parents?"

Trauma and Culture

Being bilingual and bicultural does not guarantee that clinicians will have an immediate rapport with their immigrant clients, said Marta Casas, MA, who is intake coordinator, clinician and trainer at CWVP. "There's always the assumption that belonging to similar cultures–or even the same culture–is going to be useful in therapy, and that is not necessarily true." Casas, who is Colombian and who also serves as a staff clinician at The Trauma Center at Justice Resource Institute (JRI) in Boston, does not assume that her clients will feel comfortable with her just because she comes from a Latin-American country and speaks Spanish.

Whereas clinicians need not belong to their client's culture in order to be helpful, they must be curious, respectful, and interested in knowing more about the client's culture, socioeconomic background, and home country's history. It is important to hear, in clients' own words, what their traumatic experience means for them. "Trauma is a subjective experience," said Casas. "It is when you explore the trauma in the light of the client's cultural identity that the trauma becomes a social experience." Clients' efforts to make meaning of what happened to them occur at the intersection between trauma and culture. "While trauma breaks meaning, culture makes meaning," Casas said.

Noroña added that clinicians must be able to view the child's traumatic experience with a culturally-responsive lens. "If we are focused on Eurocentric interventions," she said, "we may see pathology instead of something that is appropriate in a different cultural context." For example, a toddler who has experienced trauma may be thought to have regressed if he or she has stopped using the toilet after having been trained. But an understanding of how toilet training is handled in the client's native country may lead the clinician to a different conclusion. Particularities like these must be explored as part of engaging with clients.

"There is a lot of variation within a culture and we cannot assume that all individuals from a same culture perceive the world in the same way," Casas said. Clinicians must also be aware of and ask about geographic, social class, and historical influences in the family's country of origin. Noroña said that when she sees families from Central American and Caribbean countries, "I always have to understand the sociopolitical context of the country, depending on the client's generation. For example, many people in their 30s or older from El Salvador may have been affected by the massacre during the civil war, or by the ethnocide of 1932."

It also helps to understand each family's immigration history. This information was important when Cielo's family was beginning therapy at CWVP. Because Cielo's parents had been apart for four years, one of the initial goals of therapy was to help the couple work through feelings related to that period, which included not only the physical assault in the home country but dramatic changes in the family structure as a result of their sociocultural transplantation. "One of the important things that the program gave me," Elena recalled, "was learning how to communicate and relate again with Cielo's father, and helping him realize how important he was for us and Cielo."

Elena and her husband also learned how the traumatic events had affected them personally. This allowed them to help Cielo anticipate and understand traumatic reminders, and to cope with stressors and anxiety by expressing her feelings and practicing self-soothing strategies (such as breathing or progressive relaxation).

Through treatment at CWVP, Cielo and her family began their recovery from the trauma they had endured. And it all started with referral to a program where they could speak their native language. "Language provides meaning to everything," Noroña observed. "The possibility of conducting psychotherapy in the mother tongue of the person or family seeking help can be very powerful and therapeutic in itself." Elena added, "I would tell other parents that if they come to this program they will find comfort, hope, and a solution to their problem." ■

> ***"There's always the assumption that belonging to similar cultures is going to be useful in therapy, and that is not necessarily true."***
>
> *MARTA CASAS, intake coordinator, clinician and trainer at the Child Witness to Violence Project*

Urban Dolorosa Leads Anti-Violence Initiative *cont'd from pg. 3*

Role of Religious Leaders

Rev. Johnson said the central involvement of clergy in Urban Dolorosa reflects her belief that the community needs a commitment from religious leaders to "cross boundaries" that exist in Chicago. The chronic violence in the community can fuel feelings of despair, hopelessness, and helplessness to which religious leaders are not immune. Many clergy report feeling paralyzed and as a result become increasingly isolated from the neighborhoods they serve. They may turn away from important community engagement and outreach that is critical to sustaining a thriving congregation and disseminating a message of peace into the community.

In November 2011, over five nights, in five churches, across five neighborhoods in Chicago, Urban Dolorosa hosted its first annual Living Memorial pilgrimage in remembrance of the youth who have been lost or injured through violence. Concerts included poetry, music, photography, youth performances, and shared expressions of sacred remembrance from young local artists, choirs, and theatre troupes.

Rev. Johnson said she wants Urban Dolorosa to go well beyond an annual concert series. Her goal is that it will "mobilize our clergy to take responsibility for our kids, our neighborhoods and communities, and do something about the violence."

Strength through Collaboration

In an effort to increase awareness and educate her peers, Rev. Johnson reached out to Brad Stolbach, PhD, at the Chicago Child Trauma Center at La Rabida Children's Hospital. Johnson and Stolbach soon realized that a natural collaboration had been born. In October 2010, Stolbach lectured to a group of Urban Dolorosa's volunteer clergy and chaplains on traumatic grief and loss in the context of homicide. In January 2011, he coordinated a training on *Psychological First Aid for Community Religious Professionals* with Melissa Brymer, PhD, and Peter Kung, MDiv, MS from the National Center for Child Traumatic Stress. Reflecting on his collaboration with Urban Dolorosa, Stolbach said, "There's a lot that we as mental health clinicians have to offer clergy and a lot they have to offer us. In fact, as a field we tend to not get the best training in spiritual matters, so actually partnering with religious professionals has the potential to greatly enhance our practice and ability to serve our clients."

While religious leaders can directly touch people's lives during their darkest moments, these leaders often do not see themselves as first responders. Kung pointed out that "some clergy feel conflicted, like they have a dual role between providing religious or spiritual guidance and responding to the range of needs that arise in the immediate aftermath of a crisis." He noted that survivors of trauma "may not always be looking for an immediate theological answer. They often just want to be heard and have clergy practice a ministry of presence."

Through its partnership with La Rabida, Urban Dolorosa is spreading the message, one church, one neighborhood, one city at a time, that public awareness about community violence can begin the healing process for children and families. ■

Preventing American Indian Youth Suicide *cont'd from pg. 1*

The NNCTC recently received funding through SAMHSA for a Suicide Prevention Project, which the center just launched with the Fort Peck Assiniboine and Sioux Tribes, of which Bruguier Zimmerman is an enrolled member. The grant stems in part from the center's recovery efforts in response to the recent suicide cluster on the reservation.

Youth at Risk

Most people associate Montana with an idyllic lifestyle because of its stunning natural beauty. That's an understandable stereotype, said Bruguier Zimmerman. But if there's one lesson she and her colleagues at the NNCTC try to share with their government representatives and Network partners, it's that the state's rural impoverished communities have just the same, "if not worse," prevalence of violence, substance abuse, and loss as do some impoverished and underserved urban neighborhoods. And, when compared with other racial and ethnic groups, American Indian and Alaska Native youth as a group have more serious problems with anxiety, substance abuse, and depression, all associated with suicide risk. In Montana, just over 16% of the state's high school students living on or near a reservation attempted suicide in the past year, according to the Centers for Disease Control and Prevention's 2011 Youth Risk Behavior Survey. This is dramatically higher than the attempted suicide rate of 6.5% in the statewide high school population.

In partnership with tribal leadership, schools, and child-serving agencies, the NNCTC has worked for the past eight years with Alaska Native communities, the Ojibwe in the Midwest, and seven Montana reservation communities to raise awareness of and encourage active participation in suicide prevention. They have also conducted state and nationwide trainings for school administrators, teachers, certified staff, and school police officers on topics including secondary traumatic stress, bullying, Internet safety, emergency management, and suicide prevention. A number of these trainings have been offered in collaboration with the US Department of Education and the SAMHSA-funded Suicide Prevention Resource Center.

Becoming Authentic Partners

Both Bruguier Zimmerman and Taylor are certified to conduct the Applied Suicide Intervention Skills Training (ASIST), the widely regarded evidence-based training model developed by LivingWorks Education, Inc., based in Calgary, Alberta, Canada. The ASIST model consists of a two-day workshop in which participants learn to identify indicators and assess risk of suicide; intervene with youth at risk; and help to build resource networks for suicidal youth.

But this training is rarely the first step in intervention. Whenever the NNCTC staff are asked by tribal leaders to work among their people (services are not offered without an invitation from the tribal community), the staff's first action is to simply listen. Building a foundation of trust and respect is always the first order of business, Taylor said: "There is a great danger and disservice done when outside consultants and trainers drop in to native communities and presume to understand what the community

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Preventing American Indian Youth Suicide *cont'd from pg. 6*

Marilyn J. Bruguier Zimmerman, MSW, Director, National Native Children's Trauma Center at the University of Montana, Missoula

Matt Taylor, MA, Director, Montana Safe Schools Center, and Associate Director, Institute for Educational Research and Service

needs." Added Bruguier Zimmerman, "We spend a lot of our time, resources, and energy connecting with the community and becoming authentic partners with tribal health departments, law enforcement, and courts."

The team looks for guidance from tribal councils and community groups about their cultural perceptions of suicide, what communities see as their strengths, and how leaders believe the issue of suicide should be addressed.

For example, some tribal nations have taboos against talking about suicide. "Some hold the belief," Bruguier Zimmerman explained, "that if you start to talk about it [suicide] then you will call forth that spirit." So one of her first steps is to ask tribal elders and other community leaders, "How do you prefer to frame these events?". The pace of their suicide prevention and secondary traumatic stress training is also guided by sensitivity to the local norms.

Listen for Resiliency

Complex factors contribute to the mental health risks faced by American Indian youth. Chronic unemployment is endemic in many American Indian communities. Widespread poverty, historical trauma, isolation, and a lack of services can all put youth at higher risk for mental illness, substance abuse, and suicide. Youth are also exposed to family and interpersonal violence, and may have experienced multiple losses—of loved ones, of cultural and spiritual traditions, and of their tribal identity.

However, it is a mistake to assume that all American Indian youth experience and respond to risk factors in the same way. With more than 565 recognized tribes in the US, heterogeneity is the rule rather than the exception. "Risk factors in one area cannot be generalized to another," Taylor said.

Tribal cultures can also be resilient, and their sense of cultural identity and community cohesion, when accessed, can be extraordinarily protective for their youth. That's why NNCTC staff members assess a tribe's readiness before they proceed.

"We spend a lot of our time, resources, and energy connecting with the community and becoming authentic partners with tribal health departments, law enforcement, and courts."

MARILYN J. BRUGUIER ZIMMERMAN, MSW, Director of the National Native Children's Trauma Center in Missoula, MT

Currently, the Fort Peck Tribes Suicide Prevention Project is in the process of polling community leaders by means of the Community Readiness Model, a method for assessing a community's level of readiness to develop and implement community prevention or intervention programs. The model was developed by Colorado State University's Tri-Ethnic Center.

After immersing themselves in the norms of the tribal community, trainers then proceed with the suicide intervention training. "We make adaptations but we maintain great fidelity to the ASIST model," noted Bruguier Zimmerman. For example, the trainer might ask the tribe's ceremonial person to open the proceedings with a prayer; or, participants may choose not to participate in role-playing (a part of the intervention model) if it is too uncomfortable, perhaps because of recent loss or grief.

Few crises are more devastating for communities than youth suicide. And in Indian country, where tribes have experienced multigenerational trauma and loss, there is often distrust of conventional Western mental-health models and outside organizations. That's why the NNCTC proceeds from a community-based participatory research approach.

What does it take to work in Indian country? "Patience and openness," Taylor said without hesitation. Added Bruguier Zimmerman, "Intention is everything." ■

Resource List

For more information on the National Native Children's Trauma Center, visit http://iers.umt.edu/National_Native_Childrens_Trauma_Center/

For more information on the ASIST Suicide Intervention Model, visit http://www.yspp.org/training/asist.htm

For more information on the Tri-Ethnic Center's Community Readiness model, visit http://triethniccenter.colostate.edu/communityReadiness_home.htm

Have You Heard?

Alison Hendricks, LCSW, Operations Manager for the Chadwick Trauma Informed Systems Project, San Diego, is spearheading an effort to revise the **Child Welfare Trauma Training Toolkit**. Part of the effort involves the creation of supplements to the toolkit, including a supplement on working with American Indian and Alaska Native families, which is now in progress. Besides Hendricks, members of the workgroup for this supplement include **Dolores Subia BigFoot, PhD**, and **Susan Schmidt, PhD**, both from the Center on Child Abuse and Neglect of the University of Oklahoma Health Sciences Center; and **Marilyn J. Bruguier Zimmerman, MSW**, Director of the National Native Children's Trauma Center at the University of Montana, and a representative from the National Child Welfare Resource Center for Tribes.

The **Refugee Working Group** of the NCTSN is finalizing the **Refugee Services Toolkit**, a Web-based tool designed to help service system providers understand the experience and mental health needs of refugee children and families and ensure that these families receive the most appropriate available interventions. When the toolkit is launched (spring 2012), providers will be able to access information that helps them identify risk factors among the children and families in their care; develop individual risk assessments; and determine appropriate interventions and resources.

Since the inception of ***Psychological First Aid (PFA)*** in 2006, the developers, the NCTSN and the National Center for PTSD, and their partners have assisted dozens of communities around the world beset by disasters and crises. The PFA Field Manual has been adapted for community religious professionals, the medical reserve corps, and staff at facilities for families and youth experiencing homelessness. It has also been adapted for culturally diverse populations, with translations in six languages: Spanish, Japanese, Mandarin and Simplified Chinese, Norwegian, and Italian. To read or order PFA and its adaptations, visit http://www.nctsn.org/content/psychological-first-aid

The **Translations Review Committee** of the **NCTSN Culture Consortium** has prepared a **Spanish-language version** of ***Caring for Kids: What Parents Need to Know about Sexual Abuse***, a resource kit with information and fact sheets for parents, caregivers, and adolescents. For the parents and caregivers, the kit provides tools for supporting children who have experienced sexual abuse. It offers suggestions on how to talk to children and youth about body safety, and guidance on how to respond when children disclose sexual abuse. Also included is guidance on coping with the shock of intrafamilial abuse and the emotional impact of legal involvement in sexual abuse cases. For adolescents, *Caring for Kids* provides information about acquaintance rape and what to do in the event of it; key topics include disclosure, medical attention, and professional counseling. The Spanish-language *Caring for Kids* will be available in late spring 2012 on the NCTSN Web site (www.nctsn.org).

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Did You Know?

The goal of the Translations Review Committee (TRC) of the NCTSN Culture Consortium is to address the need for trauma-related information and products in languages other than English.

As the TRC works strategically to translate Network products, the Network has seen an increase in requests from other organizations for permission to translate Network materials. Recently, in the course of a single month, the National Center for Child Traumatic Stress (NCCTS) received requests for permission for translations into Russian, Hebrew, Arabic, Bulgarian, and Romanian. In response to the increased requests, the National Center and the TRC are preparing guidelines for the translation of Network materials completed outside of the committee. The procedures are meant to ensure that all translations are

- **Accurate**–the meaning of the original material has been fully transferred
- **Precise**–nuance, tone, intent, and style of the material have been preserved in the target language
- **Correct**–rules of grammar, syntax, and orthography (letters and symbols) have been observed
- **Complete**–no parts of the original material have been omitted (and no material added)
- **Consistent**–terms, stylistic elements, and language-specific norms have been used systematically throughout the translation

The overall translations effort and development of guidelines serve a greater goal of the NCTSN: to improve access to trauma-related services by disseminating NCTSN materials to non-English speaking communities.

About IMPACT

IMPACT is a publication of the National Child Traumatic Stress Network (NCTSN). It is produced quarterly by the National Center for Child Traumatic Stress (NCCTS), co-located at UCLA and Duke University. The NCCTS serves as the coordinating body for NCTSN member sites, providing ongoing technical assistance and support.

Managing Editor: Gretchen Henkel
Consulting Editor: Melissa Culverwell
Design & Layout: Sue Oh Design

Established by Congress in 2000, the NCTSN is a unique collaboration of academic and community-based service centers whose mission is to raise the standard of care and increase access to services for traumatized children and their families across the United States. Combining knowledge of child development, expertise in the full range of child traumatic experiences, and attention to cultural perspectives, the NCTSN serves as a national resource for developing and disseminating evidence-based interventions, trauma-informed services, and public and professional education.