Trauma Matters

SPECIAL EDITION: Children & Adolescents   WINTER 2019

A quarterly publication dedicated to the dissemination of information on trauma and best-practices in trauma-informed care.

The Impact of Childhood Trauma on Adult Homelessness
A Literature Review

Homelessness in America is a social issue; simply addressing lack of housing does not repair the on-going challenges that helped create the situations. There are deep, underlying problems that persons experiencing homelessness face, including many that started in childhood. Many individuals living in shelters or out of doors have deep seeded behavioral health needs that formed when they were children and victims of physical or sexual abuse.

Researchers believe that children who experience sexual, physical, or emotional abuse and/or neglect may not have resources or coping mechanisms to address them. Without the ability to address the abuse in childhood, these adults may develop behavioral health disorders. These disorders can negatively impact their income stability, relationships and ability to address problems in adulthood which could ultimately lead to homelessness (Roos, Mota Afifi, Kate, Distasio & Sareen, 2013; Herbers, Cutuli, Monn, Narayan & Masten, 2014).

Every January there is a national Point in Time (PIT) count of persons experiencing homelessness throughout the country. The latest data collated by the National Alliance to End Homelessness (2017) indicates that there were 553,742 individuals experiencing homelessness nationally at that time. Approximately two-thirds (369,081) of persons experiencing homelessness are single individuals, the remaining one-third are families (184,661), and an additional 7.4% were unaccompanied children and young adults (40,799). To assist in ending and preventing homelessness, service providers must look at the possible causes of homelessness. To that end, providers need to have many assessment tools to uncover these issues.

Some helpful assessment scales and surveys include:
• Adverse Childhood Experiences Scale (ACEs): a 4-page, yes/no questionnare;
• Childhood Trauma Questionnaire (CTQ): a 2-page liker scale questionnaire;
• and, Brief Betrayal Trauma Survey (BBTS): used to assess traumatic events, distinguishing between those perpetrated by persons close to the victim or someone not close to the victim.

Childhood adversity and traumatic events can have long lasting effects. The traumas have many ways of manifesting themselves, including substance use and abuse, obesity, difficulty parenting and physical illnesses, including chronic medical diseases. (Roos, et al., 2013); Herbers, et al., 2014). If the traumatic events are not addressed or the family lacks the resources to assist the child with coping (i.e.: counseling, medical care), there is an increased risk of on-going or additional re-victimization. Without interventions to break the cycle of abuse, children often grow up with the emotional wounds contributing to severe problems in adulthood (Herbers et al., 2014).

Philipps (2012) notes that childhood instability, disruption in the educational setting, physical and sexual abuse can negatively impact a person's ability to cope with stress, relationships, and self-worth. The inability to manage day to day stressors, self-esteem issues, and the need to feel a person is accepted can make someone more susceptible to substance use and abuse. Read and Bentall (2012) found that several childhood traumatic events are predictors for pervasive mental health disorders, including psychosis.

Roos, et al. (2013) found that persons experiencing homelessness had more prevalent ACE scores than the non-homeless population. The cluster of traumas most predominately experienced by the study cohort included physical abuse, neglect and general household dysfunction. This supports Mackelprang, Klest, Najmabadi, Valley-Gray, Gonzalez, and Cash's (2014) study which found high rates of multiple exposures (type and frequency) to trauma among persons experiencing homelessness. A known effect of childhood trauma and adversity is re-victimization, which can compound the consequences of the childhood trauma, causing persons experiencing homelessness to become even more vulnerable. Mar, Linden, Torchalla, Li, and Krausz (2014) state "…subsequently, the events and behaviors on the street (e.g., drug use, engaging in risky activities) amplify and exacerbate the effects of adverse childhood experiences and the resulting psychological distress and increase the risk of re-victimization and traumatization." Children who experience multiple forms of abuse are later found to experience multiple forms of abuse in adulthood as well. Women may be more susceptible to intimate partner violence, due to their traumatic and/or chaotic childhoods. Mackelprang, et al. (2014) believe that people may be less likely to recognize a relationship that is toxic, non-productive or abusive and thus, are less likely to be able to make the choice to end the relationship.

Roos, et al. (2014) found that half of the women in their study indicated that they had experienced some type of sexual abuse. Additionally, Ponce, Staeheli-Lawless, and Rowe (2012) found that 100% of women experiencing homelessness who were also diagnosed with co-occurring mental health disorders and chronic substance abuse disorders had experienced some type of physical or sexual assault. They theorize that women experiencing homelessness who are victims of intimate partner violence will have a greater need for clinical services and social supports, but may have more roadblocks to requesting or receiving them and may have greater difficulties in accepting them.

Herbers, et al. (2014) found that children experiencing homelessness have increased behavioral and social problems, including difficulty with self-regulation, post-traumatic stress symptoms, hyperactivity, cognitive control and/or executive function issues among others. Greater numbers of childhood traumas, including childhood homelessness, are associated with poorer physical and mental health in adulthood. Childhood abuse increases a person's use and abuse of illicit drugs and alcohol.

It has been well-established that childhood adversities and trauma are over-represented in population of people experiencing homelessness. It is also true that there are often poorer outcomes for persons experiencing homelessness, such as mortality, access and follow-up to services, including substance abuse and mental health treatment, medical and dental care and employment and income. Despite the many negative side effects of childhood trauma – behavioral and social problems, substance abuse, mental and physical illnesses, homelessness, and more – there are some promising findings through the work being done to prevent and ultimately, end homelessness. Herbers et al., (2014) have found that homeless children who experienced parenting characterized by positive structure, direction, and responsiveness had fewer trauma symptoms and fewer emotional/behavior problems.

If a child experiences trauma, the parental response could assist in decreasing any negative outcomes, potentially preventing homelessness. Prevention can help those not yet experiencing homelessness; however, in the meantime, there are many services in place to assist those without a home. Tsai, Edens, and Rosenheck (2011) found that once a permanent housing voucher and on-going supportive services are in place "childhood problems do not independently increase [their] risk for further homelessness."

Traumatic childhood experiences can have an effect on a person's adult life, including the person's ability to manage daily living responsibilities and can influence a person's mental health and substance abuse issues. The literature reviewed supports the ideas that early intervention may prevent homelessness for adults who experienced trauma and that stable housing and supportive services may help people to gain coping skills to prevent ongoing housing instability and homelessness.

Submitted by Alice Minervino
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The Deepest Well: Healing the Long-Term Effects of Childhood Adversity
A Book Review
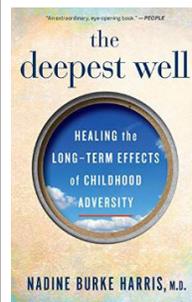
15 years into my career in addiction/mental health services, I was frustrated with "treatment as usual" but so well inculcated to never ask the trauma question that I could not see a way to effectively help those who were seeking services. When I first heard a talk about the impact of psychological trauma on the brain, my own brain cells exploded with fireworks of recognition and hope. In *The Deepest Well: Healing the Long-Term Effects of Childhood Adversity* (2018*)*, Dr. Burke Harris has a similar journey of discovery; she states "I lived in a state of not-quite-getting it for years because I was doing my job as I was trained to do it" (p. 7). Dr. Burke Harris further describes her astonishment (outrage?) that the initial Adverse Childhood Experiences (ACE) findings were published in 1998, and not only had she not heard about them until 2008, the impact of toxic stress was never mentioned in medical school.

While this is not a medical textbook, *The Deepest Well* is notable for its medical explanations of the impact of high ACE scores (the number of adverse experiences one encounters before age 18), including the role of epigenetics. Dr. Burke Harris tells story after story of children with failure to thrive, behavioral problems, and difficulties in learning. However, more than these troubling scores, she gives a message of hope by demonstrating that

early intervention can prevent ACE scores being written into biology for the rest of a child's life (p.142).

As the medical director of Bayview Child Health Center and then CEO of the Center for Youth Wellness, Dr. Burke Harris was on a quest to find the antidote to high ACE scores. As a result, she discovered many practices that made a remarkable difference in the lives of her patients including:

- Across the board ACE screening (including one developed by her clinic that a parent completes for the child);
- Providing mental health services in the clinic so that primary care physicians have easy access to mental health services for patients;
- And, using Child-Parent Psychotherapy with children and parents as team members.

In addition, other strategies that target the healing of a dysregulated stress response were implemented, including teaching families about toxic stress and encouraging the development of healthy relationships, exercise, nutrition, and culturally sensitive meditation (Mind Body Awareness Project).

If you are interested in deepening your understanding of the impact of psychological trauma on the body and the brain, I highly recommend adding *The Deepest Well* to your bookshelf. For those of you who would like primary care in your clinic or agency (or would like mental health services in your medical practice), this book will make the argument for you. And finally, for those of you who dream of a different future on the micro and macro level, buy *The Deepest Well*, immediately turn to page 223 and read the epilogue.

Submitted by Eileen M. Russo, MA, LADC

> ## Ask the Experts:
> ## An Interview with Gayle Dakof, PhD
> ### by Emily Aber, LCSW

Dr. Dakof is Director of MDFT-International, a 501(c)(3) public charity that facilitates the dissemination and implementation of Multidimensional Family Therapy (MDFT), an evidence-based treatment for adolescent substance abuse and other behavioral problems. She is also a Research Associate Professor of Public Health Sciences at the University of Miami Miller School of Medicine. She received her doctorate in psychology at University of California at Berkeley, and is a licensed clinical psychologist in the states of Florida and California. Dr. Dakof is a scientist-practitioner specializing in the development and testing of psychotherapeutic and systemic interventions directed toward preventing and treating substance abuse, child maltreatment, delinquency and criminality. Instrumental in the research and clinical development of MDFT, she is a Master Trainer of Multidimensional Family Therapy and the architect of the MDFT training and implementation approach. Dr. Dakof is the developer of a promising, research-supported intervention based on MDFT called Multidimensional Family Recovery, MDFR (formerly known as the Engaging Moms/Parent Program). MDFR addresses parental substance use and child maltreated. She has been a principal investigator or co-investigator on numerous NIH-funded research projects, and has authored over fifty publications.

1. **How did you become interested in trauma treatment?**
For Multidimensional Family Therapy (MDFT), the relevant question is not how did we become interested in trauma treatment but rather how could we not be interested in trauma treatment. Many, arguably most, of the youth and families we see in MDFT programs have experienced trauma including sexual abuse, abandonment, and witnessing violence just to name a few. It should be recognized, however, that MDFT is not a treatment for PTSD. Youth with a PTSD diagnosis should be referred to a PTSD specialized treatment such as Trauma Focused CBT (TF-CBT) or Eye Movement Desensitization and Reprocessing (EMDR). Certain youth might benefit from MDFT after completing TF-CBT or EMDR. Youth who have been exposed to traumatic experiences but do not currently meet criteria for PTSD can be treated successfully in MDFT.

2. **What is MDFT?**
Multidimensional Family Therapy is an evidence-based comprehensive family-centered treatment for teen and young adult problems and disorders. It addresses a range of youth problems including substance use, delinquency, aggressive behaviors, school and family problems and emotional difficulties. It can be implemented in various service delivery settings including outpatient, intensive outpatient, residential, and in-home. It is considered a strong evidence-based program because there have been over 9 randomized clinical trials of MDFT in the US and Europe, conducted by the developer as well as independent investigators. In every study MDFT was shown to be more effective than the comparison treatment including other evidence-based treatments such as Cognitive Behavioral Therapy (CBT) or residential treatment. MDFT intervenes in four connected areas of a youth's life: the self of the youth, the parents/caregivers, the family system, and the community. Addressing trauma and its consequences, and helping youth and parents process the events and find a healthy way of understanding the situation and coping with the consequences is essential in MDFT.

3. **Please tell us about the MDFT protocol for addressing trauma?**
The work we do alone, in individual sessions, with the youth is similar to evidence-based trauma or trauma informed treatments. What is distinctive about the MDFT approach to trauma is its focus on the family. Processing with the therapist and then sharing with parents all or part of their trauma story is a key intervention. A MDFT therapist prepares both youth and parents for the family sessions. The MDFT therapist may take time alone with the youth to practice and rehearse how to express him/herself to parents. On a parallel track we also help prepare the parents to have conversations with their teen about the trauma and its consequences. Parents of teens who have experienced trauma may need help in three critical areas: 1. Listening to and acknowledging their children's experience of the pain in the past and subsequent events. 2. Understanding and tolerating their children's reactions,

and 3. Managing their own emotional response. Parents are coached to not correct or argue with the teen while they are telling their version of the story but instead to listen, ask clarifying questions and try to deeply understand the teen's experience.

It is important to provide opportunities for family members to talk together about their feelings about the traumas. There may be feelings of regret, disappointment, anger, hurt, or loss. Teens may feel that their parents have been defensive, preachy or dismissive in the past. Once there is some understanding and acknowledgement in the family, the MDFT therapist helps the youth and parents together develop a healthy and functional trauma narrative and repair and rebuild the family relationships that are necessary for long-term recovery and well-being. Families are empowered to develop action plans to address reminders of the trauma that may come up in daily family life. Examples of action plans are that youth and parents agree (1) to keep talking to each other about the trauma, its consequences, and other important matters in their lives, (2) that when, and if, the youth is being reminded of the trauma, they will reach out to their parents for understanding, support, and encouragement. The mother of a teenager who had been referred to MDFT told us, "Before, we used to fight and [she would scream and go to her room]. And now we fight and she comes and she says, 'mom, please tell me that you love me.' And I say, 'yes, I love you. I love you more than you think. And we sit down and discuss our problems without screaming and saying bad things to each other."

Cyber Bullying and its Effects on Children and Adolescents

Bullying itself is not a new phenomenon among children, adolescents and adults. In all likelihood, all of us have had experiences with bullying either as a witness, a victim, or perhaps even as a perpetrator. For children and adolescents bullying itself is "unwanted, aggressive behavior among school aged children that involves a real or perceived power imbalance. The behavior is repeated, or has the potential to be repeated, over time. Both kids who are bullied and who bully others may have serious, lasting problems. Bullying includes actions such as making threats, spreading rumors, attacking someone physically or verbally, and excluding someone from a group on purpose."

Historically, bullying has tended to fall into three categories:1) *Verbal bullying* involves saying or writing mean (i.e., include teasing, name-calling, inappropriate sexual comments, taunting and/or threatening to cause harm); 2) *Social bullying* involves hurting someone's reputation or relationships and includes leaving someone out on purpose, telling other children not to be friends with someone, spreading rumors about someone and/or embarrassing someone in public; 3) *Physical bullying* involves hurting a person's body or possessions including hitting/kicking/pinching, spitting, tripping/pushing, taking or breaking someone's things, or making mean or rude hand gestures

Cyberbullying is bullying that takes place over digital devices like cell phones, computers, and tablets. Cyberbullying can occur through short message services, texting and apps, or online in social media, forums, or gaming sites where people can view, participate in, or share content. Cyberbullying includes sending, posting, or sharing negative, harmful, false, or mean content about someone else. It can include sharing personal or private information about someone else causing embarrassment or humiliation. *Some cyberbullying crosses the line into unlawful or criminal behavior.*

With the prevalence of social media and digital forums, comments, photos, posts, and content shared by individuals can often be viewed by strangers as well as acquaintances. The content an individual shares online – both their personal content as well as any negative, mean, or hurtful content – creates a permanent public record of their views, activities, and behavior. This public record can be thought of as an online reputation, which may be accessible to schools, employers, colleges, clubs, and others who may be researching an individual now or in the future. Cyberbullying can harm the online reputations of everyone involved – not just the person being bullied, but those doing the bullying or participating in it. Cyberbullying has unique concerns in that it can be:

- *Persistent* – Digital devices offer an ability to immediately and continuously communicate 24 hours a day, so it can be difficult for children experiencing cyberbullying to find relief.
- *Permanent* – Most information communicated electronically is permanent and public, if not reported and removed. A negative online reputation, including for those who bully, can impact college admissions, employment, and other areas of life.
- *Hard to Notice* – Because teachers and parents may not overhear or see cyberbullying taking place, it is harder to recognize.

So how frequent is cyberbullying and the experiences of young people?
- Nearly 43% of kids have been bullied online. 1 in 4 has had it happen more than once.
- 70% of students report seeing frequent bullying online. Over 80% of teens use a cell phone regularly, making it the most common medium for cyber bullying.
- 68% of teens agree that cyberbullying is a serious problem.
- 81% of young people think bullying online is easier to get away with than bullying in person.
- 90% of teens who have seen social-media bullying say they have ignored it. 84% have seen others tell cyber bullies to stop.
- Only 1 in 10 victims will inform a parent or trusted adult of their abuse.
- Girls are about twice as likely as boys to be victims and perpetrators of cyber bullying.
- About 58% of kids admit someone has said mean or hurtful things to them online. More than 4 out 10 say it has happened more than once.
- Bullying victims are 2 to 9 times more likely to consider committing suicide.

- About 75% of students admit they have visited a website bashing another student.

In a review of the literature, Vaillancourt, Faris, and Mishna (2017) note that being the victim of bullying, including cyberbullying, is associated with significant short- and long-term mental and physical health issues and academic achievement problems. Like traditionally bullied youth, cyberbullied youth report higher levels of depression and anxiety, emotional distress, suicidal ideation and attempts, somatic complaints, poorer physical health, and externalizing problems such as increased delinquency and substance abuse than their nonbullied peers. *These potential outcomes are not unlike characteristics observed in individuals who have experienced trauma-inducing events.* As one might expect youth who are bullied the most are the ones who suffer the most.

Vaillancourt, Faris, and Mishna (2017) also conclude *when cyberbullying is compared to traditional bullying, negative outcomes appear to be worse for the victims of cyberbullying;* for example, cyberbullied youth are reported to be 3.44 times more likely to have attempted suicide compared to nonbullied youth, whereas traditionally bullied youth were 1.63 times more likely to attempt suicide than nonbullied peers.

Summing up their review of the literature, Vaillancourt, Faris & Mishna (2017) raise the question about why cyberbullying seems to be more harmful to children and adolescents than traditional bullying: "It has been suggested that the effects of cyberbullying may be greater than the effects of traditional bullying because the attack can be viewed by a wider audience, who can access the material repeatedly and in turn share it to an untold number of people. Moreover, in the case of traditional bullying, the target typically knows who is bullying him or her, whereas with cyberbullying, the identity of the perpetrator(s) can remain anonymous, creating a greater sense of insecurity, lack of control, and hopelessness. Still, in some cases, cyberbullying is perpetrated by the target's own friends who may have more intimate and potentially damaging information about the target."

Continuing on, Vaillancourt, Faris, and Mishna (2017) suggest that "cyberbullying may be particularly detrimental to youth because individuals who cyberbully can access their victims more readily. In the case of traditional bullying, most aggression takes place at school whereas with cyberbullying, the aggression can be perpetrated at any time of the day or any day of the week and without the direct presence of the victim. Children and adolescents who are bullied through electronic means are also less likely to report their abuse or to seek help than victims of traditional bullying. Cyberbullied youth who suffer in silence perceive that they are supported less, which is related to adverse outcomes such as suicidality Finally, cyberbullied youth can be targeted by adult harassers, who can also exploit youth sexually."

Prevention is perhaps the preferred and best first step toward reducing the negative effects of cyberbullying. A child may be involved in cyberbullying (being bullied, bulling others, or witnessing bullying) and parents, teachers, and other adults need to be aware of all the digital media and apps that a child is using. *The more digital platforms that a child uses, the more opportunities there are for being exposed to potential cyberbullying.* Many of the warning signs that cyberbullying is occurring happen around a child's use of their device and may include:

- Noticeable increases or decreases in device use, including texting.
- A child exhibits emotional responses (laughter, anger, upset) to what is happening on their device.
- A child hides their screen or device when others are near, and avoids discussion about what they are doing on their device.
- Social media accounts are shut down or new ones appear.
- A child starts to avoid social situations, even those that were enjoyed in the past.
- A child becomes withdrawn or depressed, or loses interest in people and activities.

If a parent or teacher or other related adult notices any of these warning signs that a child may be involved in cyberbullying, it is imperative to take steps to investigate that child's digital behavior. *Cyberbullying is a form of bullying, and adults should take the same approach to address it*: support the child being bullied, address the bullying behavior of a participant, and show children that cyberbullying is taken seriously. Because cyberbullying happens online, responding to it requires different approaches. If you think that a child is involved in cyberbullying, there are several things you can do:

- **Notice –** Recognize if there has been a change in mood or behavior and explore what the cause might be. Try to determine if these changes happen around a child's use of their digital devices.

- **Talk –** Ask questions to learn what is happening, how it started, and who is involved.

- **Document –** Keep a record of what is happening and where. Take screenshots of harmful posts or content if possible. Most laws and policies note that bullying is a repeated behavior, so records help to document it.

- **Report –** Most social media platforms and schools have clear policies and reporting processes. If a classmate is cyberbullying, report it to the school. You can also contact app or social media platforms to report offensive content and have it removed. If a child has received physical threats, or if a potential crime or illegal behavior is occurring, report it to the police.

- **Support –** Peers, mentors, and trusted adults can sometimes intervene publicly to positively influence a situation where negative or hurtful content posts about a child. Public Intervention can include posting positive comments about the person targeted with bullying to try to shift the conversation in a positive direction. It can also help to reach out to the child who is bullying and the target of the bullying to express your concern. If possible, try to determine if more professional support is needed for those involved, such as speaking with a guidance counselor or mental health professional.

Submitted by Steve Bistran, MA

The ASSERT Treatment Model (ATM) provides youth up to age 21 years old and their families with six months of evidence-based intensive family treatment, medication assisted treatment (MAT), and recovery support services for up to 12 months. It is available to families in 121 Connecticut towns and has the capacity to serve as many as 94 youth and families at a time. It is not yet known how many of the youth will be struggling with opioid use and how many will be dealing with other substance use disorders.

The program is funding four agencies through a federal grant from the Substance Abuse and Mental Health Services Administration. DCF talked with advocates, young adults, and families about their treatment experiences. Then local and national experts in family therapy and recovery management collaborated with DCF to build the model. ATM combines several evidence-based treatments that are usually stand-alone services into a single, integrated program. The hope is this program will provide a "one-stop shop" for youth and their families, eliminating barriers to receiving multiple needed services to combat opioid addiction. DCF is optimistic that this new treatment program will stem the rise in opioid addiction among youth by blocking the pipeline from misuse to addiction, and prevent opioid overdose deaths. The ATM program is a critical piece of the Department's efforts to combat the opioid crisis, which also includes using private funding to provide in-home intensive substance use treatment services to parents at risk for having their child enter foster care.

For more information please visit https://health.uconn.edu/community-medicine/programs/health-services-research-unit/assert.

Who's Been Reading Trauma Matters?

Pictured at left is Jillian Gilchrest, MSW, who acted as a presenter, panelist and moderator at the April 2018 *Spotlight on Sexual and Domestic Violence* conference. Jillian was recently elected to the Connecticut state legislature, serving as state representative for house district 18. She is also the Director of Health and Professional Outreach for CT Coalition Against Domestic Violence and is a regular trainer at Connecticut Women's Consortium.

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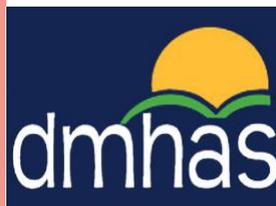
The Connecticut Women's Consortium

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The Deepest Well: Healing the Long-Term Effects of Childhood Adversity (A Book Review)

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Cyber Bullying and its Effects among Children and Adolescents

Much of the content of this paper is paraphrased or quoted from material located at https://www.stopbullying.gov/cyberbullying/what-is-it/index.html

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