Practice & Policy Focus
FAMILIES IN SOCIETY

2012

Healing Through Trauma-Informed Practice

Facing Trauma: The Power of Self-Healing

A man met with a practitioner to discuss chronic distress, ruminations, and mental strain which he believed, based on prior counseling, were caused by a parent's emotional abuse such as long-term criticism. While speaking about this parent, the client's mood deteriorated. It was clear that he was prepared to ventilate at length, believing that was how helping worked. Many clinicians seeing this person would have assigned one or more *DSM–IV–TR* diagnoses. But, after listening, building rapport, and discussing options, the practitioner asked permission to share another way of viewing stress. A discussion ensued about thought, belief, and how reality is constructed from inside out. The client was interested in the idea that once a belief is created, like his belief about a parent, a person tends only to see confirmatory evidence. In learning about this method, he recognized thoughts in order to reduce rumination and stress, access more free-flowing thinking, and experience more positive feeling. After a few sessions, the client made strong gains, expressing no need for further sessions.

The theory used is called psychology of mind/health realization (POM/HR). Practitioners who use this theory report achieving positive outcomes, mobilizing strengths, and catalyzing further growth. POM/HR focuses on assessing thought recognition, level of understanding, strengths, and resources. It goes beyond trying to change specific thoughts and beliefs, and focuses on the thinking process to promote second-order change. Building on cognitive and constructivist psychologies, POM/HR views thought as the foundation for feeling and behavior created through two modes of thinking: intuitive and analytic. Analytic thinking takes effort and can escalate through overuse and abuse, resulting in uncomfortable feelings, mental strain, and potentially poor actions. The more people trust the intuitive, the more effortless and productive the solution and the higher the likelihood of effective behavior. The POM/HR practice trusts in a person's ability to self-heal, empowering them to help themselves by providing tools that can be used throughout their lifetime. Helping is framed as educating and teaching, rather than counseling and therapy.

Application

In assisting trauma survivors, POM/HR improves solution-focused and cognitive–behavioral strategies. It dovetails well with other resilience and strengths-based models that recognize challenges rather than deficits. It supports helping people who have faced traumatic events to reduce their suffering, resume their lives, and grow. POM/HR-informed practice sees the memory of any event occurring in the past as a thought. Over time, even the most egregiously victimized people can be helped to recover and grow.

In addressing major mental illness, psychiatrists who use the POM/HR model prescribe psychoactive medications as needed, and after stabilization occurs and levels of understanding and thought recognition begin to increase, psychiatrists can monitor and reevaluate the need for medication, tapering doses.

POM/HR has also been successfully used to strengthen relationships and marriage. Because no two people can think alike, each marriage represents a wonderful microcosm of diversity. This challenges the mates to find richness in their differences, thereby vitalizing their relationship. This reframes their differences as enriching rather than conflicting.

A Strengths-Based Practice Model:
Psychology of Mind and Health Realization
S. G. Wartel

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Accessing and Addressing Trauma Memories

Trauma follows a specific pathway in the brain. Information is first received through the primary senses and body. This information is sent to the locus ceruleus, which evaluates the information for threat content, and then to the amygdala, where it is evaluated for emotional content. The amygdala sends the information to the hippocampus, which assigns cognitive meaning and routes it to the orbitofrontal cortex where hormones such as cortisol and adrenaline, that are essential in stress response, are secreted. The information is also sent to the cerebral cortex, which organizes survival behavior.

Two categories of memory play an important role in the development of trauma memory. Explicit or declarative memory is the memory of facts, ideas, concepts, and events individuals are consciously aware of which are closely linked to the language system. The hippocampus processes explicit memory. Because the hippocampus develops around the age of 2 or 3 years, people do not have explicit or declarative memories of their earliest childhood experiences. Implicit or nondeclarative memory is stored in the amygdala, which is present from birth. Implicit memory bypasses language, has no narrative, and is unconscious.

If the amygdala is overstimulated, the function of the hippocampus can be suppressed. The implicit and explicit memories then become disengaged, leading to the dissociation of the sensory and affective elements from any coherent narrative memories. This results in fragmented traumatic memory that is saved within the senses.

Recovery from trauma requires the integration of the explicit memories from the hippocampus with the implicit memories of the amygdala. This integration is the goal of Eye Movement Integration (EMI) therapy. Using 22 eye movements, EMI helps practitioners to access trauma material stored in a client's senses. The clinician can then retrain the client's senses so that the trauma memories are replaced with neutral or calming memories to aid in the resolution of childhood trauma symptoms.

An Exploratory Study on the Use of Eye Movement Integration Therapy in Overcoming Childhood Trauma
E. Struwig & A. D. van Breda

Look to Strengths in Family-Based Practice

Strength is intrinsic to the process of human development, and almost anything could be considered a strength. When strength is defined solely in terms of a particular human experience, such as resilience, restrictions are introduced that may limit the breadth and depth of what can be included as a strength.

The definition of strength adopted for the Strength, Assessment, and Treatment Model is that strength is a set of developed competencies and characteristics valued both by the individual and society and embedded in culture. The model is an approach to working with families that emphasizes four key foundational components: engagement, exploration, expansion, and evolution. These components are closely intertwined and each is emphasized at specific points in interactions with clients, although not strictly sequentially. The components are consistent with most approaches to clinical practice as well as other strengths approaches, but this approach differs in that it introduces a fuller spectrum of client strengths in conversations with clients; the model allows for the assessment of a broad array of strengths that are not strictly related to the problems that initiated the referral. It provides a mechanism for drawing upon the identified strengths to energize and galvanize the client toward the realization that strengths can be tools for self-development and problem resolution.

Engagement
The first step is to create a relationship that is positively oriented to resolving difficulties and conveys the idea that a focus on strengths will be woven throughout interactions and conversations. It is essential to communicate that strengths exist in all areas of everyday functioning, despite any difficulties experienced by a child or family, and that it is possible to identify numerous strengths reflected in daily life. This helps to establish positive expectations about the intervention process, which can contribute to improved therapeutic outcomes.

Exploration
Because the model emphasizes a comprehensive assessment of strengths in various environments a child encounters on a daily basis (e.g., home, school, community), the social worker should ask the child and significant others (e.g., parents, teachers, spiritual leaders) for observations and perspectives about the child's behaviors that could be considered strengths. A multi-source, multi-site assessment lends itself to the organization of strengths information according to naturally occurring structures in the environment, labeled domains of functioning—the areas of functioning that the child engages in on a regular basis that have been found to make intuitive and practical sense from both developmental and contextual perspectives.

Expansion
The social worker focuses on the assessed strengths of the client and encourages the client to recognize how these strengths can be expanded into a capacity for addressing difficulties. Expansion is aimed at helping the client recognize their potential.

Evolution
The final phase represents the implementation and evaluation of the treatment plan. The focus is to prioritize and maximize the possibilities emerging from the client's strengths and support the client in mobilizing, transferring, and implementing strengths to address outstanding issues or concerns. Engaging significant others to support the treatment plan is particularly important.

Making the Possible Probable: A Strength-Based Assessment and Intervention Framework for Clinical Work With Parents, Children, and Adolescents
E. Rawana & K. Brownlee

Insight Into Children's Survival Abilities

The survival abilities of children who have been sexually abused are often submerged beneath pain and discomfort and are difficult to elicit if the practitioner does not view these protective strategies as strengths. Although the strengths perspective and the resiliency literature in developmental psychopathology are grounded in different disciplines, both emphasize the children's ability to cope with traumatic situations; both recognize that a child's ability to live well in the present depends on the ability to recognize and uncover strengths; both understand that children are doing the best they can with available resources; and both recognize that children may lose sight of their strengths and abilities because the trauma and pain are too great, and the practitioner's role is to assist in recovering the submerged survival abilities.

Throughout the lives of sexually abused children, they may experience insight into the abuse; as they grow and learn from various life experiences, they begin to understand different aspects of the abuse. These insights can help children cope and develop resiliency.

Stages of Youth Insight Into Sexual Abuse

A family in which sexual abuse occurs may give messages blaming the young child for the abuse or deny it altogether, and although the child receives these distorted messages, they sense something is wrong. However, they are not mature enough to verbalize it. Insight continues to develop throughout adolescence, as children **identify** the reasons for family problems. Through changes emotionally and intellectually, and in social interactions with others, adolescents are able to grow from sensing what is wrong in the family to naming the problem. For example, incest victims figure out that the sexual activity is not an "expression of affection."

Independence refers to the child's ability to distance themself emotionally or physically from a troubled family. Such distancing is difficult to sustain in sexually abusing families because the tendency is to pull together to maintain the family secret. During childhood, independence and distancing are achieved by finding a protective place—psychologically through fantasizing or dissociating, or behaviorally by maintaining a low profile in the family (e.g., not seeking recognition from parents). Consequently, they immerse themselves in satisfying activities with others. School can be an important resource in that involvement in extracurricular activities allows the child to spend less time at home.

Initiative occurs through taking risks to gain control despite the abuse. Initiative takes the form of experimenting and learning what parts of a sexually abusing family environment are controllable and realizing which are not. They may figure out ways to protect themselves from the abuse (e.g., wearing extra clothes to bed, faking illness, or sharing a bed with a sibling). They may not always be successful in such attempts. Nevertheless, their actions show how active they are in trying to protect themselves and in trying to divert the abuse. In adolescence, initiative is shown through children's ability to take hold of their lives in the midst of family problems. These children maintain hope that the abuse will end and they find ways to persevere until then. Focusing on their future helps them separate from current trauma and allows them to begin planning for life after the abuse. Belief in God or a sense of spirituality can help.

Building relationships may involve searching for opportunities to connect with family members. Children may build on family relationships during periods of calm and distance themselves during chaos. Often their attempts are futile, which leads them to seek relationships outside the family, sometimes with parents of their friends. Dolls and pets can also serve as outlets for the need for nurturance. During adolescence, children are able to cultivate relationships over which they have a measure of control. These youth attempt to develop alternative families or seek out role models who can fulfill their needs.

Morality is the expression of an informed conscience and is demonstrated through empathy, compassion, and caring toward others. Throughout childhood, children feel they have been unlucky with their family but may channel their disappointment into trying to make a difference for others. Children may express their morality through their judgments of what is right and wrong in their own family. During adolescence, children's morality may be channeled into fighting for justice at home by protecting younger family members and standing up to their perpetrators. They may sacrifice their bodies to prevent their siblings from being molested. Or they may rebel against the rules and demands of the perpetrator, such as curfew or dating restrictions. These adolescents demonstrate compassion toward others even though they have received little compassion themselves.

Expressions of creativity and humor channel pain and discomfort in imaginative ways. A young child may manage adverse circumstances through play, using imaginative activities to cope with the real-life hardship of sexual abuse. Play helps children repair themselves emotionally and to endure trauma. They may imagine or fantasize about a life in which they have power and cannot be hurt. Children's play is refined during adolescence into creative works or a highly developed sense of humor. Their creative abilities help them process pain and grief. Emotional pain may be channeled through writing, drawing, music, etc. A well-developed sense of humor not only helps them disconnect from emotional pain, but helps them connect with others.

Practice Implications

Treatment with sexually abused children focuses predominantly on ameliorating presenting problems, which may include depression, anxiety, negative self-identity and self-blame, poor social skills, loneliness, self-destructiveness, and sexually acting out. Although addressing the sequelae of sexual abuse is an essential treatment concern, it should not obscure the need to honor and develop children's survival strategies. If children's survival abilities are ignored in favor of an exclusive focus on their problems it may be difficult for children to relinquish a view of themselves as being damaged.

The social work practitioner guides the process through uncovering and identifying themes of resilience in the survival stories of children who have been sexually abused. Although telling children they are not responsible for the sexual abuse is reassuring, often they continue to blame themselves. If the practitioner probes into the ways children tried to stop the sexual abuse (e.g., figuring out that sharing a bed with a sibling reduces the risk of being abused), they help the child uncover initiative and re-enforce the active role the child played in survival. Initiative becomes an important tool for change because it demonstrates the ability to problem solve in difficult situations and may be applied to other areas of the child's life. The psychological scars will never disappear completely, but focusing on the child's strengths and resiliency can help limit the power of sexual abuse over the child.

Uncovering Survival Abilities in Children
Who Have Been Sexually Abused
K. M. Anderson

Keywords
trauma, child abuse, ACE-informed practice, resiliency, resilient

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Personal Trauma Influences Professional Attitudes

Does exposure to domestic violence indicate a form of child maltreatment? Concern about the impact of domestic violence on children who witness the violence is not new. Advocates and researchers have called for collaboration between workers in the domestic violence and child welfare fields to ensure safety of the entire family. Most of the collaborative efforts in the United States focused on training child welfare workers to increase their knowledge of domestic violence, change attitudes and beliefs about domestic violence, revise screening procedures to identify families for domestic violence, and develop case plans that address safety and service needs of at-risk women.

An unintended outcome of these training efforts was that child welfare workers began removing children and charging mothers with failure to protect due to domestic violence in the home. This response is indicative of the clash between the worker's mandate to protect the child from harm and the knowledge gained through training about the potential violence occurring in the home. It is imperative that child welfare workers identify and use interventions that protect families from domestic violence and eliminate harm to children without further stigmatizing victimized women.

To understand how frontline workers intervene, the knowledge, attitudes, and beliefs of supervisors who oversee service delivery and the implementation of policies and direction for staff must be understood.

Personal Experiences

One out of every 2 women in the United States experiences violence during their lifetime. The chance that child welfare workers are victims, survivors, or have family or friends who have been or are victims of domestic violence is likely. Studies have found that between 11% and 32% of workers in the helping professions have experienced domestic violence. Do these experiences with violence influence the relationship between worker and client?

Of respondents in this study, 33% experienced domestic violence in their intimate relationships, 68% had family members who experienced domestic violence, and 85% had a friend who did. When respondents' parents experienced domestic violence, their beliefs about the causes centered on marital conflict and everyday stress. Variables measuring the experience of emotional abuse and physical abuse by an intimate partner were correlated with the belief that blames the victim for violence. Conversely, as professionals, the results indicated that workers with more professional experiences and tenure in human service fields believed that sexism in society led to domestic violence and victims were not to blame. The challenge, then, is to further explore how personal or professional experiences with domestic violence influences beliefs about the causes of domestic violence.

Serving Two Masters: When Domestic Violence and Child Abuse Overlap
J. L. Postmus & D. Ortega

Police–Social Work Teams Respond to Domestic Violence

For many family violence victims, law enforcement is the first point of contact. However, the many potential needs of the family victim may be beyond the scope of typical law enforcement tasks. Therefore, if social services are coordinated through the police department system, family violence victims are ensured a comprehensive range of services.

A domestic violence response team (DVRT) was created from the combined efforts of individuals from the victim assistance program and the domestic crimes unit. From a law enforcement perspective, the central goal of DVRT is to increase cooperation of victims of domestic violence with arrest and prosecution. A secondary goal is to increase the efficiency and effectiveness of domestic violence investigations. The central goal from the social work perspective is to provide crisis intervention services so the victim achieves continued safety and stability. DVRT members collaborate with shelters and resource centers on individual cases and follow-up via consultation with victims, community agencies, and police officers. Officers, because they are the first point of contact with a victim, are responsible for assessing the needs of the victim in terms of social services involvement and initiating such involvement. According to the police perspective, a coordinated response to the provision of comprehensive services, both law enforcement and social work, is effective.

Some of the most commonly identified services of DVRT involved counseling the victim while the officer questioned the suspect, helping victims complete emergency protective orders while officers took the suspects to jail, explaining the criminal justice system and giving referrals for counseling, and linking the victim with the battered women's shelter and providing transportation. By working cooperatively with the officer at the scene of domestic violence, the team is able to impact victims at the point of crisis when they may be most amenable to services and to change.

Survey responses on how the team could be made more effective also indicated the positive view of police officers to the crisis response team. Officers stated they wanted the team available more hours and to be able to handle calls other than family violence. Police also requested education about response team services. It is recommended that other victim assistance programs conduct similar surveys to discover police reception to such coordinated efforts. In this way, social work services can be effectively used and family violence victims can obtain a comprehensive range of services so they are more likely to remain safe and to achieve stable functioning for themselves and their children.

Perceptions and Utilization of a Police–Social Work Crisis Intervention Approach to Domestic Violence
J. Corcoran, M. Stephenson, D. Perryman, & S. Allen

Social Supports and Trauma Recovery

Mental health professionals in hospital- and community-based agencies should consider how informal social supports and self-care practices may contribute to trauma recovery. For survivors who do not have family, friends, or partners offering concrete support, helping professionals need to recognize the importance of this type of help and facilitate the provision of such support from other sources.

Psychosocial rehabilitation services for individuals suffering from PTSD may indeed be appropriate, such as with interventions that improve daily living skills, social interactions with family and friends, harm avoidance or health-promoting behaviors, housing needs, and educational needs. Social skills training, for example, is recommended to assist people dealing with severe symptoms of social avoidance associated with PTSD, although it was developed to meet the needs of individuals with other mental disorders.

Mental health professionals can work with abuse survivors to identify supportive friends and encourage the development of such relationships. Many survivors benefit from encouragement to reach out to potential friends, because this is often seen as a risk by the survivor. Furthermore, survivors can be encouraged to participate in activities that help them experience themselves as multifaceted human beings rather than solely as abuse survivors.

Couples therapy that is designed to help survivors and their partners understand the ways in which both can become caught in the reenactment of abuse in their relationships would be helpful in overcoming the stress in these relationships. Couples therapy could also be helpful in assisting survivors and their partners to better understand each other so they can be mutually supportive throughout the recovery process. Thorough assessments should be done to ensure that abuse is not presently occurring—if present, it may contraindicate couples therapy. Family therapy with survivors and family members willing to participate may help everyone to better understand feelings such as guilt, shame, and loyalty that often interfere with the abilities of family members, particularly mothers, to provide appropriate support. Again, a thorough assessment must be done to ensure there is not abuse present in the relationship.

Furthermore, abuse survivors are likely to benefit when mental health professionals encourage them to acquire self-care strategies that will assist them in developing a healthy sense of self and the strength required to navigate the long recovery process. Survivors can be assisted in distinguishing between the use of isolation as a maladaptive coping strategy and positive solitary self-care strategies that can enhance well-being. Survivors who are learning positive self-care strategies after years of self-neglect need support and reinforcement for new ways of thinking and behaving to withstand tendencies to return to more familiar and less adaptive behaviors. Regular, dependable contact with mental health professionals during this time can provide such reinforcement and support.

Experiences of Adults Abused as Children After Discharge From Inpatient Treatment: Informal Social Support and Self-Care Practices Related to Trauma Recovery
K. Harper, C. A. Stalker, S. Palmer, & S. Gadbois

Resiliency in Action

From Victim to Survivor

Monica, Ann, and Jean all experienced severe losses as children and felt hopeless about leading the lives they desired. They could have been seen primarily as victims of circumstance of their parents' abuse and neglect or of a culture and society that demanded they conform to norms for women. In therapeutic work, all of these factors should be acknowledged and validated.

Resilience is the remarkable capacity of individuals to withstand considerable hardship, bounce back in the face of adversity, and live functional lives with a sense of well-being. The premise is that everyone who has survived a trauma, or a neglectful or abusive childhood, has some strength that got them through it, and that this strength or capacity for mental health is innate and directly accessible. Clinicians working in a resilience framework assess how the person coped and work to strengthen those coping strategies. The case vignettes of these three women show how, in spite of having childhoods full of risk factors, stress, and inadequate bonding with their mothers, they developed behaviors that enhanced their resilience.

When they came into therapy, Monica and Jean did not consider themselves to be strong. Ann had always relied on her physical strength, but did not feel emotionally strong. A resilience-focused approach was used to help them name what they felt best about in themselves and their lives—their strengths. For Monica, the path to resilience was athletic ability and pride in her honesty and loyalty. As Monica gained pride in her physical strength, she became accepting of her body. For Ann, allowing herself to become a carpenter instead of an artist, as her father had wanted, was the opening for self-acceptance, a sense of self-efficacy, and rediscovery of her resilience. Jean accepted and found pride in her intelligence, sensitivity, and perception, which opened the door for her to reclaim her resilience.

To assess and support resiliency, people first need to be encouraged to acknowledge and talk about their pain. Second, clients need to discover and describe their assets and resilient traits. The three women had great difficulty describing their assets, but with coaching and reframing they were able to do so—therapists need to look for and tap into strengths that are unknown to clients. The third step is to support clients in naming and feeling entitled to their hopes and desires for their lives in terms of work, relationships, and community. The therapist must help the client match abilities and strengths with external and internal resources. Therapists can cultivate areas of comfort where women can feel it is safe to think, know, feel, and take action. Throughout the process, therapists who are able to form relationships of confidence with their clients in which there is mutual trust help build resilience. A therapeutic relationship that fosters mutuality and creates solidarity and a sense of connection can be the vehicle to transform casualties and deficits into victories and resilience.

Accessing and Supporting Resiliency

Step 1: Affirm the Experience
Step 2: Discover and Describe Assets
Step 3: Matching Strengths with External and Internal Resources

These three women learned in their childhoods to detach, mistrust, and isolate. Through therapy, they changed their views of themselves from victims to survivors. They affirmed their strengths; reframed insecurities as positive adaptations; found paths to forgiveness, separation, and success; and increased their self-esteem, thus becoming more resilient.

Resilience and Social Work Practice: Three Case Studies
S.G. Turner

Reframing Coping After Trauma

There is a critical need for clinicians to accept the pervasiveness of childhood physical, sexual, and emotional abuse and its power to affect subsequent adult psychopathology. Clinicians need to be sensitive to adult patients who were abused as children and whose adult lives have been profoundly affected by childhood experience. This population is large and has not been adequately recognized and treated. An open and accepting attitude helps create sufficient conditions of trust and safety and guides clinicians in empathically making the necessary initial inquiries. Patients who remember the abuse will feel more comfortable expressing their memories. Those who have only vague and partial memory fragments can begin to recover what they have forgotten. Even where full amnesia prevails, creating such conditions and actively asking questions can begin to spur recall.

In initial interviews of a routine assessment, any of the following presentations suggest the possibility of childhood abuse and deserve further inquiry: strong anxiety symptoms; hyperexcitability; overly high levels of activity, often alternating with withdrawal; dissociative symptoms, hallucinatory phenomena, or illusory experiences such as feeling a presence in a darkened room; difficulties with overstimulating affect; and compulsive, destructive, or self-destructive behaviors or addictions. A sincere and empathic clinician can find many ways to introduce direct questions related to childhood abuse into initial interviews. The clinician may start by introducing concepts of abuse and their sequelae in a gentle and educative fashion, following which they may simply ask if abuse was experienced. Because patients who do remember their abuse often experience denial and shame, the clinician should initially avoid using the term "abuse." Rather, the clinician might ask if as a child the patient was hit a lot, verbally attacked, criticized and shamed, locked in closets as punishment, overstimulated sexually by adults without contact, had contact with an adult that was perceived as sexual, and so forth. Minimized responses should be respected and gently and empathically worked with to enable elaboration.

Diagnoses require that organic factors be ruled out. Therefore, even though symptom presentations may be indicative of and consistent with a history of childhood abuse, clinicians are cautioned to consider organic determinants first because detection of these leads to appropriate diagnosis and treatment. However, organic and psychosocial causes often coexist and interact. In such instances, multimodal interventions are required.

If childhood abuse is confirmed, the abuse needs to be labeled and connected to the patient's symptoms within a cause-effect framework. Symptoms need to be reframed as normal (in the sense of normative) responses to abnormal events. Behaviors that were once self-protective need to be labeled, even though they are now unnecessary, may be quite destructive, and are not condoned. Adults who previously had been unable to understand their symptoms and behaviors can begin to see themselves more positively.

Case Study

A man in long-term psychotherapy had been physically and emotionally mistreated during childhood. As an adult he had difficulty with rage and self-hatred. In connecting his history to this difficulty, the man recognized that his hyper-alertness, which had survival value as a victimized and vulnerable child, had become destructive. Symbolic cues triggered overreactions proportionate to childhood hurt. During treatment, the various forms of expression his adult rage took were reframed as identifications with victimizer and victim roles. He began to see that he was driven to attempt to gain mastery, even by a need to maintain ties to the caregiver who had hurt him. He began to understand his self-loathing and to empathize with the hurt child within. Continuation of maladaptive behavior became dystonic and diminished significantly over time.

Clinical Considerations for Adults Abused as Children
S. G . Wartel

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