

## **“Scared Sick”: Poverty and Childhood Trauma Intervention**

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**Abstract:** Childhood trauma, which disrupts brain development, is disproportionately common in poor families. Current interventions focus on two main protective factors, parental attachment and creative expressiveness, which often are not accessible to poor families due to structural barriers inherent in their lifestyles. As I conclude, a Rawlsian argument demonstrates that society has an obligation to address the challenges faced by traumatized children and their families via innovative techniques and strategies.

## **Introduction**

"Mama was yelling, the bad guy was hurting her; I should have killed him. I came out of my room and mama was asleep - then he cut me - he said 'It's for your own good, dude.'...A three-year-old, throat-cut child, weeping, whimpering, comforting and seeking comfort from her naked mother's hog-tied, bloody, cold body...Sandy was alone - her world forever changed. Her entire being was altered - the way she thinks, the way she behaves, the way she feels, the way she grows. Her brain is etched with the memories of terror.<sup>1</sup>

Bruce D. Perry, M.D., Ph.D, is a leading figure in the field of research into the neurodevelopmental detriments caused by early childhood trauma. In one of his many publications surrounding the topic, Perry begins with this heart-wrenching story of three-year-old Sandy. Sandy is just one example of a large pool of children who experience a variety of traumatic incidents early on in life. Early childhood trauma, which is disproportionately frequent in low-income households, causes disruptions in brain development that are strongly associated with cognitive impairment later in life. This impairment is linked to negative outcomes that are detrimental to the individuals to whom they occur and to society as a whole. Although current efforts to mitigate the neurological repercussions of early childhood trauma are in place, these efforts are not appropriately tailored to support low-income and homeless families. The interventions focus on two main protective factors, parental attachment and creative expressiveness, which often are not accessible to poor families due to structural barriers inherent in their lifestyles. Given that these families are the most frequently traumatized portion of the population, the current state of childhood trauma interventions is largely 'missing the mark' in achieving its purpose by failing to reach the majority of children who need help.

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<sup>1</sup> Bruce D. Perry, "Traumatized Children: How Childhood Trauma Influences Brain Development," *Network of Care*, Accessed March 5, 2016, <http://ventura.networkofcare.org/mh/library/article.aspx?id=491>.

Because of this disconnect between active aid efforts and those needing aid, society's widely accepted obligation to reduce poverty and provide equal opportunity takes the form of reducing the negative outcomes of childhood trauma. A Rawlsian argument for justice dictates that fair equality of opportunity requires promoting resiliency against neurological disturbance for innocent children who are subjected to traumatic exposure through no fault of their own. Unfortunately, treatment currently focuses mainly on middle and upper income children, leaving out the most frequently traumatized children in low income and homeless families. As I conclude, society has an obligation to address the challenges faced by traumatized children and their families via innovative techniques and strategies.

## Traumatic Exposure and Poverty

Trauma is defined as a “deeply distressing or disturbing experience.”<sup>2</sup> Experiences or situations that cause emotional pain and overwhelm the ordinary human abilities to cope and adapt are considered traumatic and can come in a number of forms, all of which may cause severely undesirable reactions at any age. The pervasiveness of traumatic exposure and the threats it poses to wellbeing have made it a heavily discussed topic in research. The expanding abundance of evidence surrounding trauma has exhibited time and time again that traumatic distress occurs in low-income and homeless populations at disproportionately high rates, generally as a product of the lifestyles inherent to poverty, such as relational, social, violent, inconsistent, and familial complications often associated with low-income homes and homelessness.<sup>3</sup> Many publications have found data in accordance with this claim, finding the highest and most frequent incidence of traumatic experience in the poorest of the population.

Poor children specifically are vulnerable to this heightened risk of trauma exposure.<sup>4</sup> Between 29 and 50 percent of children and youth experience traumatic events, and these children are more often than not members of low-income families or living under other socially and financially compromised circumstances. Up to 50 percent of children and youth in child welfare, between 60 and 90 percent of youth in the juvenile justice system, and 83 to 91 percent of children in highly violent neighborhoods have had traumatic experiences.<sup>5</sup> Statistics like these demonstrate that childhood trauma pervasively cuts across class and race, but is experienced in

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<sup>2</sup> "Oxford Dictionaries - Dictionary, Thesaurus, & Grammar," Accessed April 14, 2016, <http://www.oxforddictionaries.com/us>.

<sup>3</sup> Collins et al., *Understanding the impact of trauma and urban poverty on family systems: Risks, resilience, and intervention*, Baltimore, MD: Family Informed Trauma Treatment Center, (Baltimore, MD: Family Informed Trauma Treatment Center), 11.

<sup>4</sup> Collins et al., *Understanding the impact of trauma and urban poverty on family systems: Risks, resilience, and interventions*, 11.

<sup>5</sup> Cooper, Janice L, “Facts about Trauma for Policymakers,” *NCCP* (2007), Accessed March 3, 2016, [http://www.nccp.org/publications/pub\\_746.html](http://www.nccp.org/publications/pub_746.html).

abnormally high concentrations among disadvantaged youth. 40% of Americans are homeless, and nearly all of this large homeless population has experienced trauma prior to or due to becoming homeless.<sup>6</sup> Furthermore, the conditions of homelessness can only serve to worsen traumatic symptoms or re-traumatize a child. So not only are people who become homeless more likely to have already been traumatized due to ongoing poverty and lack of social support, but the actual instance of poverty is more than likely to entail a considerable amount of trauma. “The experience of homelessness results in a loss of community, routines, possessions, privacy, and security,”<sup>7</sup> requiring significant adjustments which lead to traumatic relational and physical difficulties. Homeless families are additionally at higher risk for being victims of or witnesses to violence or family separation. Homeless children are sick two times more than other children, go hungry two times as often, and are twice as likely to repeat a grade, all events that could cause serious adaptive problems. More than a 20 percent of them have “emotional problems serious enough to require professional care.”<sup>8</sup> Less than one third of them do seek professional care. They have twice the rate of learning disabilities and three times the rate of emotional complications compared to non-homeless children, and one in three of them has a severe mental disorder by age eight.<sup>9</sup> Children are the primary victims of the trauma associated with homelessness, and they are the most vulnerable victims.

Poverty is moving its way into the spotlight of the abundance of literature on early childhood trauma because it is so strongly tied with this issue. Many scientific studies on

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<sup>6</sup> Bassuk et al., “Facts on Trauma and Homeless Children,” (Los Angeles, CA & Durham, NC: National Child Traumatic Stress Network, Homelessness and Extreme Poverty Working Group, 2005), 3.

<sup>7</sup> Bassuk et al., “Facts on Trauma and Homeless Children,” 3.

<sup>8</sup> Bassuk et al., “Facts on Trauma and Homeless Children,” 4.

<sup>9</sup> Bassuk et al., “Facts on Trauma and Homeless Children,” 3-5.

childhood trauma, including a few that are cited in the next section, have followed suit by including low-income status as a central variable in their experiments and observations.<sup>10</sup>

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<sup>10</sup> Koenen et al., “Early Childhood Factors Associated with the Development of Post-Traumatic Stress Disorder: Results from a Longitudinal Birth Cohort,” *Psychological Medicine* 37.02 (2006); Dutra et al., “Quality of Early Care and Childhood Trauma,” *The Journal of Nervous and Mental Disease* 197.6 (2009).

## **Trauma, the Brain, and Beyond**

“Human beings become a reflection of the world in which they develop.”<sup>11</sup> The human brain is 90% developed by the time a child reaches age four. This astounding fact makes the first four years of life an extremely critical window of time for neurological development that impacts the expanse of years following it. The brain develops in utero and in these first four years, what Bruce Perry calls a “time of great opportunity” and a “biological gift.” In these years, the brain develops and organizes itself in a way that reflects the environment it is exposed to, as its neurons, the cellular components of the brain and nervous system responsible for transmitting brain signals and coordinating reactions, form connections with each other. These neural connections, known as synapses, are formulated based on use, making 90% of human neurodevelopment a use-dependent process dictated by activity in just the first four years of life. Synapses utilized frequently in early childhood become strengthened, and unused or neglected synapses deteriorate. Due to these phenomena, early life experiences “determine how genetic potential is expressed, or not.”<sup>12</sup>

The environmental exposure and relational experiences within the first four years of life, therefore, can foster desirable outcomes, or pre-destine a child for later negative outcomes and cognitive disadvantages, depending on their qualities. Optimal development results in a child predisposed to reach ultimate cognitive potential, especially in terms of emotional processing and stress tolerance. Optimal development occurs under conditions of “predictable, enriched, and stimulating interactions in a context of attentive and nurturing relationships” with “moderate,

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<sup>11</sup> Perry, B. D., “Maltreatment and the Developing Child: How Early Childhood Experience Shapes Child and Culture,” *McCain Lecture Series*, (London, ON: The Centre for Children and Families in the Justice System, 2005), 1.

<sup>12</sup> Perry, B. D., “Maltreatment and the Developing Child: How Early Childhood Experience Shapes Child and Culture,” 1.

predictable stress” to foster cognitive and emotional resilience.<sup>13</sup> Disrupted development, on the other hand, causes disturbances in brain development, which can permanently impede cognitive processing long after the first four years of life. This can be caused by “inappropriate or abusive caregiving, a lack of nurturing, chaotic and cognitively or relationally impoverished environments, unpredictable stress, persisting fear, and persisting physical threat,” to name a few.<sup>14</sup> Episodic exposure to these mental toxins is risky, but chronic exposure is almost guaranteed to be problematic and cause undesirable downstream consequences because of the way trauma disrupts development.

To understand the psychology and neuroscience behind disrupted development at a cursory level, it is valuable to examine the human stress response. Every human’s normal psychological response to threat or stress takes on of two forms: hyperarousal or dissociation (or a combination of the two). Hyperarousal entails a “fight or flight” type reaction, while dissociation entails avoidance or “tuning out” of a threat. At a neurological level, these responses are regulated by the hypothalamic-pituitary-adrenal axis (HPA axis) and the dopaminergic system. The HPA axis is the brain’s stress regulation center, and dopamine is a major neurotransmitter, or chemical messenger of the nervous system, which is particularly associated with sending arousal signals to the frontal lobes and hippocampus of the brain; these two brain structures coordinate the fear response. A person whose brain has organized itself under an environment fostering disrupted development has a higher baseline stress arousal than normal; this is because neurologically, his HPA axis and dopaminergic system have become

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<sup>13</sup> Perry, B. D., “Maltreatment and the Developing Child: How Early Childhood Experience Shapes Child and Culture,” 2.

<sup>14</sup> Perry, B. D., “Maltreatment and the Developing Child: How Early Childhood Experience Shapes Child and Culture,” 2.



hyperactive from early overuse.<sup>15</sup> Thus, this person may constantly be in a state of subconscious fear because of the way his brain is organized. This person may constantly experience hyperarousal or dissociation or both, producing defiance displays, aggression, anxiety, panic, chronic avoidance, psychological flight, detachedness, numbness, or hypervigilance. Furthermore, this constant state of baseline fear changes the way that information is retrieved from the outside world. If a person's baseline stress level is heightened due to early life trauma, he or she is likely to be triggered into severe stress responses by stimuli considered minor to those who have experienced optimal development, because he or she starts out closer to the threshold for stress tolerance. "It is an unfortunate reality that the very adaptive responses that help the child survive and cope in a chaotic and unpredictable environment puts the child at a disadvantage when outside that context," such as in a playground or classroom.<sup>16</sup> When we are calm, we are able to use higher-level thinking, and our brains function to their full potential, utilizing upper-level cognitive synapses and cortices. When we are fearful, the lower, more primitive portions are activated. Thus, it follows that someone who is constantly fearful may in effect lose access to the upper-level capabilities of his brain. Instead, actions may strictly "be governed by emotional and reactive thinking styles."<sup>17</sup>

These disruptions in cognitive processing manifest themselves in various ways at the clinical diagnostic level. A number of studies support a strong positive correlation between

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<sup>15</sup> Read et al., "Traumagenic Neurodevelopmental Model of Psychosis Revisited," *Neuropsychiatry* 4.1 (2014): 65.

<sup>16</sup> Perry, B. D., "Maltreatment and the Developing Child: How Early Childhood Experience Shapes Child and Culture," 2-3.

<sup>17</sup> Perry, B. D., "Maltreatment and the Developing Child: How Early Childhood Experience Shapes Child and Culture," 2.

childhood trauma and adolescent or adult diagnosis of schizophrenia, ADHD, chronic dissociation, and PTSD.<sup>18</sup>

It is no wonder that complications such as ADHD occur so frequently among those who experience poverty early in life, given that they are so likely to have been traumatized.<sup>19</sup> It is clear that early life trauma is devastating to brain development in any population, but the fact that is so heavily concentrated in poor populations is especially troubling. The kind of problems that are associated with disrupted development and with poverty are similar, such as employment complications, mental illness, unstable relationships, and inadequate education. When the two are able to exacerbate and perpetuate each other, it is a dangerous combination, leading to significantly negative life outcomes overall. The poor are the most vulnerable to these dangers and simultaneously often the least equipped to cope with them.

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<sup>18</sup> Read et al., “Traumagenic Neurodevelopmental Model of Psychosis Revisited,” 65; Lewis et al., “The Association Between Youth Violence Exposure and Attention-Deficit/Hyperactivity Disorder (ADHD) Symptoms in a Sample of Fifth-Graders,” *American Journal of Orthopsychiatry* 85.5 (2015): 504; Dutra et al., “Quality of Early Care and Childhood Trauma,” 383; Koenen et al., “Early Childhood Factors Associated with the Development of Post-Traumatic Stress Disorder: Results from a Longitudinal Birth Cohort,” 181.

<sup>19</sup> Koenen et al., “Early Childhood Factors Associated with the Development of Post-Traumatic Stress Disorder: Results from a Longitudinal Birth Cohort,” 181.

## The Current State of Interventions: Progress and Problems

As aforementioned, the link between early life trauma and long-term negative cognitive consequences is robustly supported in literature, and therefore various institutions exist to attempt to support those who struggle in life because of prior trauma. The leading initiative in this respect is the institution of trauma sensitive schools, a widespread and growing effort spearheaded by the Trauma Learning Policy Initiative (TLPI). They have designed a method of tailoring schools toward fostering environments supportive of and therapeutic for students who have been traumatized, and may act out or otherwise fail to function optimally in school because of it. These efforts manifest themselves via a set of “core attributes” which TLPI uses to describe trauma sensitive schooling:

- A shared understanding among all staff/ a “whole school” approach
- The school supports all children to feel safe physically, socially, emotionally, and academically
- The school addresses students’ needs in holistic ways, taking into account their relationships, self-regulation, academic competence, and physical and emotional wellbeing
- The school explicitly connects students to the school community and provides multiple opportunities to practice newly developing skills
- The school embraces teamwork and staff share responsibility for all students
- Leadership and staff anticipate and adapt to the ever-changing needs of students<sup>20</sup>

The implementation of this framework in schools is spreading as data on trauma increases, and as success stories of established trauma sensitive schools are publicized. TLPI is additionally tackling the project at a policy level, seeking grant money, graduate level certification, and legislation in support of increasing trauma sensitivity in schools.

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<sup>20</sup> “Trauma Sensitive Schools: A Whole School Approach,” *Trauma Sensitive Schools*, Accessed April 2, 2016, <http://traumasensitiveschools.org/>.

Although interventions like trauma sensitive schooling are well intentioned, necessary, and undoubtedly have proven to have benefits, this type of mediation is arguably too late to actually solve the issue at hand, treating the downstream symptoms of traumatization as opposed to fixing the problem. TLPI is enacting these programs in grade schools, which generally cater to students aged six and older. There is a growing school of researchers who contend that since much of the damage done by disturbances in development is largely irreversible after age four, we must intervene before this critical window is over. To prevent the neurological consequences of early life trauma, it is paramount to intervene before a child ages out of the critical four year window of brain development, while the synapses are still somewhat elastic, or else disruption essentially becomes permanent. The first years of life are the most vulnerable to detriment by traumatic experience, and yet there is historically a very limited pool of resources for intervening within this critical period to circumvent the long-term damages that trauma can cause; however interventions have been moving in the right direction in recent years toward treating traumatized children earlier, before it's too late.<sup>21</sup>

The growing efforts to intervene early in life to prevent later negative outcomes caused by disrupted development mainly center around creating resiliency by harping on maximizing a number of protective factors. In adjusting the focus of childhood trauma interventions toward the period in which the trauma occurs, as opposed to later life support in response, the leading theoretical backdrop is resiliency theory. This theory “addresses the notion of adaptive behavior by acknowledging the capability of people to cope with adversity or risk particularly in the face of stress or trauma,” and that this capability is enhanced or weakened by the presence or absence

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<sup>21</sup> Ann T. Chu and Alicia F. Lieberman, “Clinical Implications of Traumatic Stress from Birth to Age Five,” *Annual Review of Clinical Psychology* 6.1 (2010): 470.

of certain protective factors.<sup>22</sup> The protective factors can buffer the blow of traumatic experience by increasing the capability to negotiate stressful scenarios, moderating the effects of risk, and enhancing adaptation, thus fostering overall resilience to permanent traumatization. Interventions that are formulated to treat early trauma rely on strengthening these protective factors.

Two protective factors in particular stand out in literature and intervention efforts for traumatized children. The first is supportive relationships, especially parental ones. Any healthy and trusting relationship, especially one with a guardian, has proven to be both protective and reparative in mitigating traumatization, by providing security and nurturing to an overwhelmed and distressed child.<sup>23</sup> Quality of parental attachment has been found in a number of studies to be positively correlated with childhood resilience.<sup>24</sup> For example, in one prospective study, children with secure maternal attachments were significantly less likely to develop problematic behavior trajectories, indicating that positive parenting was protective against disturbances in childhood that cause cognitive and behavioral disparities.<sup>25</sup> The second major protective factor is expressive art, such as theater, musical exploration, or other artistic activities. These creative outlets promote resiliency by providing emotional release, a sense of meaningfulness to others, and relief from the childhood home environment.<sup>26</sup> Expressive arts, like supportive

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<sup>22</sup> A. Meyers, "Trauma and Recovery: Factors Contributing to Resiliency of Survivors of Sibling Abuse," *The Family Journal* 24.2 (2016): 148.

<sup>23</sup> A. Meyers, "Trauma and Recovery: Factors Contributing to Resiliency of Survivors of Sibling Abuse," 151-152.

<sup>24</sup> Chu & Lieberman, "Clinical Implications of Traumatic Stress from Birth to Age Five," 480.

<sup>25</sup> Thomas E. Keller, Susan K. Spieker, and Lewayne Gilchrist, "Patterns of Risk and Trajectories of Preschool Problem Behaviors: A Person-Oriented Analysis of Attachment in Context," *Development and Psychopathology* 17.02 (2005): 349.

<sup>26</sup> A. Meyers, "Trauma and Recovery: Factors Contributing to Resiliency of Survivors of Sibling Abuse," 151.

relationships, have demonstrated their value in mediating traumatization in various publications.<sup>27</sup>

Besides merely general encouragement of strengthening these protective factors, a variety of institutionalized and formal therapeutic tools are specifically aimed on targeting them to prevent disrupted development. Trauma-Focused Cognitive Behavioral Therapy (TF-CBT), Child-Parent Psychotherapy (CPP), Infant-Parent Psychotherapy (IPP), play therapy, and Attachment and Behavioral Catchup (ABC) are a few examples of formalized techniques to rehabilitate traumatized children, created by various experts in the field by focusing heavily on operationalizing these two major protective factors.<sup>28</sup>

It is wonderful that the progression of research has led seemingly to the root of this widespread problem and provided a point of attack at which to try and prevent it, but in trying to mitigate the problem, it is important to keep in mind who it is that is suffering from it. Most of these interventions have been tested in clinical trials, and they work, and there is no discounting that. But the most important, and often neglected, question, is who are they working for? They are working for the children being put through these trials, children who have access to intervention and who are able to participate in this type of intervention. These children are probably not low income and homeless children, who are very unlikely to access these interventions, or furthermore to even have the opportunity to foster the two major protective factors at home due to systematic barriers inherent to poverty. As prior research demonstrates, the poor experience trauma, especially childhood trauma, occurs at the highest frequency, and thus are the most vulnerable to its detriments. Thus, aims to alleviate trauma-induced cognitive

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<sup>27</sup> Don Phelps, "Therapeutic Use of Expressive Arts with Children," Accessed April 2, 2016, [http://www.socialworktoday.com/archive/exc\\_020712.shtml](http://www.socialworktoday.com/archive/exc_020712.shtml); Catherine Cameron, *Resolving Childhood Trauma*, (Thousand Oaks, CA: Sage Publications, 2000), 276.

<sup>28</sup> Joann Grayson, "Evidence-Based Treatments for Childhood Trauma," *Virginia Child Protection Newsletter* 95 (2012): 2; Chu & Lieberman, "Clinical Implications of Traumatic Stress from Birth to Age Five," 484-487.

impairment should target this population and be tailored in a way that suits their lifestyles, or they will be largely ineffective in reducing the overall damage that trauma causes in a widespread scope.

As the research reveals, one of the most prominent protective factors active in promoting resilience of cognition against childhood trauma is relational richness, especially in a parental setting. There are unfortunately many facets that often come along with life in poverty that serve as barriers against parent-child relationships. Those earning the lowest wages are the most likely to work irregular schedules, often resulting in guardians working shifts at times that impede them from spending time with their children.<sup>29</sup> Additionally, the poor and low income are the most commonly incarcerated portion of the population, another factor which can hinder familial relationships.<sup>30</sup> Furthermore, poverty rates are higher in single parent or broken family households than in married couple families.<sup>31</sup> Finally, and perhaps most obviously, homelessness inherently provides its own barriers to upholding traditional family togetherness and secure attachment.

The other protective factor that appears frequently in literature about promoting resiliency is creative outlets and play opportunity, and aspects of poverty might serve as limitations against accessing this protective factor as well. Play and expressive art are often considered a luxury or “extracurricular” as compared to more basic needs and educational areas, so those living under restricted resources or in compromising situations are much less likely than

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<sup>29</sup> Lonnie Golden, “Irregular Work Scheduling and Its Consequences,” *Economic Policy Institute*, Accessed April 2, 2016, <http://www.epi.org/publication/irregular-work-scheduling-and-its-consequences/>.

<sup>30</sup> Karen Dolan and Jodi L. Carr, “The Poor Get Prison: The Alarming Spread of the Criminalization of Poverty,” *Institute for Policy Studies*, Accessed April 2, 2016, <http://www.ips-dc.org/wp-content/uploads/2015/03/IPS-The-Poor-Get-Prison-Final.pdf>, 7; Bernadette Rubay and Daniel Kopf, “Prisons of Poverty: Uncovering the Pre-Incarceration Incomes of the Imprisoned,” *Prison Policy Initiative*, Accessed April 1, 2016, <http://www.prisonpolicy.org/reports/income.html>.

<sup>31</sup> Carmen DeNavas-Walt and Bernadette D. Proctor, “Income and Poverty in the United States: 2014” in *Current Population Reports P60-252*, U.S. Census Bureau (Washington, D.C.: U.S. Government Printing Office, 2015), 44.

the general population as a whole to engage in such activity. In-home activities require supplies, supervision, and a home itself. Furthermore, creative outlets often take place via organized activities such as outside of school clubs, theater productions, or play groups, which usually demand additional transportation and financial support that those in poverty are not likely to be able to provide or prioritize. Statistics demonstrate that children from families at lower levels of income are considerably less involved in sports or athletic activities, volunteer work, religious instruction and youth groups, music, dance or art lessons, and scout-type organizations than higher-income families.<sup>32</sup> Yet again, here is a protective factor that, although undoubtedly supportive to resiliency against disrupted development, is being centralized in interventions while it rarely exists in poor families. In short, by focusing on improving parental attachment and creative outlets only, current interventions are fundamentally missing the target population altogether, since structural elements of their societal environments block them from accessing these very protective factors. An intervention meant to improve some construct cannot be effective if that construct does not exist in the first place for those who need intervention.

Clinically implementing formulated therapy such as CPP and ABC are great ways to compensate for a natural lack of these organic protective factors in low-income and homeless families, but they are of no use to the poor if they cannot be accessed. The population in general, especially the poor, lacks a convenient avenue to access aid for traumatized children in the current state of the healthcare and diagnostic system.<sup>33</sup> In sum, the glaring problem is as follows: not only are the poor statistically more likely to have traumatic experiences early in life

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<sup>32</sup> “5. Children’s Extracurricular Activities,” *Pew Research Center’s Social Demographic Trends Project RSS*, Pew Research Center (2015), Accessed April 7, 2016, <http://www.pewsocialtrends.org/2015/12/17/5-childrens-extracurricular-activities/>.

<sup>33</sup> Chu & Lieberman, “Clinical Implications of Traumatic Stress from Birth to Age Five,” 488.



than others due to the circumstances of their lives, they are furthermore more likely than others to be predisposed to have barriers blockading them from protective factors or institutional interventions which could mitigate the problematic consequences of this trauma.

## **Why Must Something Be Done?**

No child under the age of four years old chooses to partake in a lifestyle that predisposes him to traumatic experiences. Children this young do not have the agency to control the tragic loss of a loved one, the scarring experience of witnessing consistent domestic violence, the horror of sexual abuse, or the ever-distressing plight of homelessness. Poor children are truly born into lives that put them at higher risk to have these types of experiences, and thus at higher risk for cognitive impairment that can be lifelong if resiliency is not bolstered within the early critical window. If the wellbeing of the nation's children, the most innocent and faultless portion of the population, is of any societal priority, which it ought to be, then mediating this lack of efficient institutional support is necessary. The well-being of humans in general is paramount to the basal infrastructure of a prosperous society, and the well-being of children especially requires heightened attention and care. No individual has control over what life he is born into, and anyone could have been born to a household in poverty or other distress that fosters traumatic exposure early on in life. Given that any individual himself, or his loved ones, could be subjected to traumatizing life events and suffer lifelong consequences, it is only fair that something be done to stop this cycle. Even if I am fortunate enough to not have been born into an at risk household or have been traumatized when I was young, I could have been, and if I had been I would hope that there would be an effective way for me to cope and recover so that I could still have a chance at success later in life. Given that I would want this for myself, I feel inclined to believe that I should want it for others too, who were not as fortunate as I was through no fault of their own. Moreover, if merely the importance of protecting innocent children is not reason enough to merit putting resources toward this problem, the benefits that society as a whole would reap are. Mass incarceration carries a hefty national fiscal cost; trillions of dollars

go into the criminal justice system, which is also the second-fastest-growing category of state budgets.<sup>34</sup> Early life trauma increases the likelihood of later behavioral deviance and criminality, and thus improved resiliency against it would likely decrease the amount of criminal behavior, especially among the low income population, who are the most often incarcerated. The cognitive and behavioral deficits resulting from disrupted neurological development and constant hyperarousal of the stress system often make obtaining, and moreover maintaining, employment, difficult and in some cases impossible. Preventing disrupted development could increase the nation's viable workforce. Furthermore, given that early childhood trauma is strongly linked to a variety of later life mental disorders, the national medical resources put toward treating and rehabilitating those with these mental illnesses would decrease in the long term if the interventions were aimed at the source, by promoting early resiliency, rather than at the consequences, by treating lifetime mental illnesses.

Ethical theories on justice, namely those established by John Rawls and Norman Daniels, bolster the argument for helping low-income traumatized children. Disrupted development interferes with an individual's ability to function at his full potential later in life, due to cognitive deficits that interfere with emotional processing, behavioral control, and mental health. These complications can detract from the capability to participate fully in society, on the fronts of employment, education, social interaction, medical stability, and financial stability. Traumatized individuals therefore do not have equal opportunity to function and succeed in society as compared to the rest of the population. Justice calls for equal opportunity among other things, and thus principles of justice would prescribe that we find a way to effectively equalize life opportunities for this portion of the population.

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<sup>34</sup> "Fiscal Cost of Mass Incarceration," *American Civil Liberties Union*, Accessed March 29, 2016, <https://www.aclu.org/issues/mass-incarceration/fiscal-cost-mass-incarceration>.

John Rawls' theory of justice makes a convincing argument for why justice, which he considers the first and foremost virtue of social institutions, calls for equal opportunity. Rawls interprets justice as fairness in his social contract argument. He posits that principles of justice are any principles that free and rational contractors motivated by self-interest would agree to if they were to assume an initial position of equality in society. This hypothetical initial position entails that among the contractors, "no one knows his place in society, his class position or social status, nor does anyone know his fortune in the distribution of natural assets and abilities, his intelligence, strength, and the like."<sup>35</sup> Thus, the principles of justice are agreed upon behind a "veil of ignorance," to ensure that the choices made do not leave anyone at an advantage or disadvantage due to simply the natural chance of individual social circumstances; hence, justice as fairness. The principles theoretically chosen behind the veil should be considered the guidelines of justice and govern what institutions are and are not established and what is considered required by justice as fairness.<sup>36</sup>

Rawls derived two main principles of justice via his theoretical framework. The first is the liberty principle, which states that "each person is to have an equal right to the most extensive basic liberty compatible with a similar liberty for others."<sup>37</sup> Among these basic liberties are the freedoms of conscience, association, and expression, democratic rights, and rights to the respect of personal property. The second Rawlsian principle of justice is two-pronged, stating that "social and economic inequalities are to be arranged that they are both (a) reasonably expected to be to everyone's advantage, and (b) attached to positions and offices

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<sup>35</sup> John Rawls, *A Theory of Justice*, (Cambridge: Harvard University Press, 1971), in *Poverty and Economic Justice*, ed. Robert H. Hartman, (Ramsey, N.J.: Paulist Press, 1984), 110.

<sup>36</sup> Rawls, *A Theory of Justice*, in *Poverty and Economic Justice*, ed. Hartman, 108-120.

<sup>37</sup> Rawls, *A Theory of Justice*, in *Poverty and Economic Justice*, ed. Hartman, 115.

open to all.”<sup>38</sup> In elaborating, Rawls details that this principle can be split into two main concepts: fair equality of opportunity and the difference principle. Fair equality of opportunity dictates that all individuals in society have a fair and equal chance to function and succeed as well as anyone else. The difference principle, often a topic of controversy in ethics, dictates that in conjunction with equal opportunity, talents and motivation do in fact have something to do with life circumstances, as opposed to flat equity across all levels, and that those with similar talents and motivation should face similar life chances and achievements. Contractors behind the veil would choose this because the inequality outlined by the difference principle would work to the benefit of the least advantaged, ensuring that even the lowest in the hierarchy are as well off as possible, but allowing a gradient nonetheless as incentive to work hard and develop talents.<sup>39</sup>

The second principle of Rawls’ theory, particularly the fair equality of opportunity segment, is most relevant to the current discussion; but Rawls made a point to exclude health care and medical status from his theory, so how can it be applied here? Norman Daniels expands Rawls theory to include issues of health care delivery and social determinants of health, arguing that without intending to, Rawls’ theory “provided a defensible account of how to distribute the social determinants of health [and health care] fairly.”<sup>40</sup> Daniels calls for a broad view on justice in order to combine it with health care policy for the promotion of health and the provision of health care. He points out that this broad view cannot just focus on policy providing health care, because even in the presence of universal health care access, there are still inequalities at play which create a social gradient of health. Therefore, he argues the view of justice in health must be broadened to include social determinants of health, which are not equally distributed in

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<sup>38</sup> Rawls, *A Theory of Justice*, in *Poverty and Economic Justice*, ed. Hartman, 115.

<sup>39</sup> Rawls, *A Theory of Justice*, in *Poverty and Economic Justice*, ed. Hartman, 108-120.

<sup>40</sup> Norman Daniels, Bruce P. Kennedy, and Ichiro Kawachi, “Justice, Health, and Health Policy,” in *Ethical Dimensions of Health Policy*, eds. Marion Danis, Carolyn Clancy, and Larry R. Churchill, (New York, NY: Oxford University Press, 2002), 20.

society even if health care access is equalized. Data shows that the more socioeconomic inequity there is in a society, the steeper the health inequality gradient; thus even the middle class masses suffer from this inequality, as they, too are much worse off than those with higher status than them. As a result, Daniels' stance, in short, is that "justice requires that we ask whether these social determinants of health are fairly distributed, and where they are not, that we take steps to address these sources of health inequality."<sup>41</sup> This can be done by dampening negative social determinants of health where they are disproportionately at high concentration, and by promoting positive social determinants of health where they are disproportionately scarce. In Daniels' theory of "justice as fairness extended," he explains why these initiatives are in fact in line with Rawls' theory of justice despite their exclusion from its focus on social justice. He, along with Bruce Kennedy and Ichiro Kawachi, contend that in defining just principles as those of a social contract for free and equal people designed to guarantee equal opportunity, limit inequalities, and work to make the worst-off groups fare as well as possible, Rawls' account "turns out to provide principles for the just distribution of the social determinants of health, unexpectedly adding to its scope and power as a theory."<sup>42</sup> Rawls' emphasis on the value of equality of opportunity prohibits discriminatory barriers which confine individuals' opportunities, and requires "robust measures aimed at mitigating the effects of socioeconomic inequalities and other social contingencies on opportunity."<sup>43</sup> How could this principle not extend to the provision of health care and the mitigation of inequality of health determinants, which contribute to the opportunity to function and succeed in society? It can be argued that efforts to equalize the distribution of

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<sup>41</sup> Daniels, Kennedy, and Kawachi, "Justice, Health, and Health Policy," in *Ethical Dimensions of Health Policy*, eds. Danis, Clancy, and Churchill, 20.

<sup>42</sup> Daniels, Kennedy, and Kawachi, "Justice, Health, and Health Policy," in *Ethical Dimensions of Health Policy*, eds. Danis, Clancy, and Churchill, 29.

<sup>43</sup> Daniels, Kennedy, and Kawachi, "Justice, Health, and Health Policy," in *Ethical Dimensions of Health Policy*, eds. Danis, Clancy, and Churchill, 33.

social determinants of health, which often correspond with a wealth gradient, goes against the difference principle; however, Rawls suggests that equal opportunity is given priority over the difference principle. If adequate health is equated with opportunity, which in many ways it can be, then it should in turn hold greater weight than the difference principle. Moreover, Daniels briefly points out that the liberty principle, too, can be applied to health justice. Rawls includes basic liberties as their own principle based on the assumption that basic liberties would not be willingly traded for other goods; Daniels argues that the same could be said about trading health for other goods.<sup>44</sup>

Does justice call for restructuring childhood trauma interventions? According to Daniels' stance on Rawlsian justice, equal opportunity extends to equal health opportunity, which in a broad sense, includes equal distribution of social determinants of health. In abiding by this moral framework, justice requires both targeting early childhood trauma interventions toward low-income children to increase positive social determinants of health where they are lacking, and the prevention of trauma itself, especially in low-income families, to decrease negative social determinants of health where they are too highly concentrated. This paper focuses only on the former initiative.

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<sup>44</sup> Daniels, Kennedy, and Kawachi, "Justice, Health, and Health Policy," in *Ethical Dimensions of Health Policy*, eds. Danis, Clancy, and Churchill, 20-43.

## **What Can Be Done?**

In order to help the disadvantaged overcome the problems associated with early life trauma, we need to tailor policy interventions toward equalizing their capability to access protective factors. Evidently, secure parental attachment and engagement in expressive arts are two of the most valuable protective factors against disrupted brain development. Sensibly it follows that the best way to intervene in a way to prevent cognitive impairment would be to strengthen these factors. But if the structure of peoples' lives prevent them from being able to take the time and resources that developing familial relationships and utilizing creative outlets requires, these interventions are doomed to be highly insufficient and ineffective for them. Given that the majority of the people vulnerable to disrupted development, and thus in need of these intervention, are in fact in situations restricting their access to protective factors, this is a real problem. Societal structures currently in place largely shape the way that those in poverty are living, and thus tweaking these structures is an opportunity to remove systematic blockades between low income and homeless families and resiliency against traumatized brain development.

As aforementioned, as things are now, there are a number of institutional and structural barriers impeding poor families from fostering strong parental relationships and engaging in creative outlets. Low income parents are more likely to be in broken spousal relationships, to be incarcerated, to work irregular or excessive hours, or to live in quarters uncondusive to development. These restrictions limit the ability of these families to create secure parent-child attachment, due to lack of time together, lack of a stable environment, and lack of general safety in which to form these relationships. Thus, encouraging families of traumatized children to engage in therapeutic parent-child relationship strengthening is highly unrealistic and unhelpful



to the most frequently traumatized portion of the population, the poor. Encouraging families of traumatized children to promote resiliency via creative outlets is also of little utility to poor families, who are not likely to have the money, time, transportation, or space to generate expressive art opportunities or enroll in extracurricular creative activities. These structural and institutional barriers are what we need to attempt to remove in order to take a step toward allowing the poor a fair and equal chance at utilizing these protective factors to face the early life trauma which they are already more at risk for. There are a wide variety of ways to attack these issues from a policy standpoint, and this paper aims to point out a few, in the hopes to raise general awareness that this issue can be addressed politically.

### 1. Improving Parental Relations

#### 1A. Paid Family Leave

California, Rhode Island, Washington, New Jersey, and the District of Columbia have laws that provide some form of paid family leave (PFL). The eligibility requirements, restrictions, and provisions of these policies vary by state. The basal aim of PFL is to alleviate the pressure on employees to make the tough choice between spending time with family during important times and making money at work. By virtue, this type of pressure is especially strong on the lowest-paid workers. PFL policies mandate some amount of subsidized leave in situations where individuals should be at home with their families, such as in the case of serious illness or injury of a relative, a newborn baby, an adopted or foster child, a medical procedure of a relative, or victimhood of stalking, domestic violence.<sup>45</sup> More widespread enactment of PFL policy would help to remove the barrier between poor families and strong familial ties by allowing them to spend time together and build trusting relationships, especially in times of turmoil, without

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<sup>45</sup> Lisa Guerin, "Paid Family Leave in California, New Jersey, Washington, and the District of Columbia," *Nolo.com*, Accessed April 2, 2016, <http://www.nolo.com/legal-encyclopedia/paid-family-leave-states-29854.html>

compromising their incoming funds. Irregular and excessive shiftwork poses a major threat to parent-child relationships in poor families, and in the case where low income parents are faced with the tough choice between family time and working, financial constraints often make the decision for them. If they had the opportunity to spend time with their newborn children, or with their young children during or after a family tragedy, secure attachment would surely be supported and be much more likely to exist in disadvantaged households.

### 1B. Work Schedule Flexibility

Furthermore, policy to protect workers who ask for more flexible hours would additionally mediate this problem. There is a negative stigma attached to requesting job flexibility, and employees often find themselves being punished for doing so. It is no wonder that low income workers, who are the most desperate and in need of employment and wages, work the worst hours and shifts. If you know you could lose your job or hours by asking not to work nights, and you have no way of getting by without your wages, why would you ever ask for more flexible hours? More than 70% of low wage workers in the United States do not even get paid sick days, so you can imagine they would not dare ask for a shift change, if they can lose their jobs by even being too unwell to come into work.<sup>46</sup> Policies protecting employees from being punished by their employers for asking for more flexible schedules, and furthermore mandating some forgiveness for sick leave, would benefit low wage workers in a plethora of ways, including by giving them more time to be at home when their families are there. This would allow for parents to have more time to be at home with their children, increasing the likelihood of positive secure parental attachment considerably.

## 2. Increasing Creative Outlets

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<sup>46</sup> Anne-Marie Slaughter, "If You Ask for Job Flexibility, Will You Be Punished?," *CNN* (2015), Accessed April 1, 2016, <http://www.cnn.com/2015/09/29/opinions/slaughter-job-flexibility-punishment/index.html>

## 2A. Head Start Programs

An approach that is often utilized effectively in providing support for children in particular whose families are unable to provide it otherwise is to incorporate that support into school based systems. This is often an effective way to ensure that an intervention reaches all children equally, because in theory all children are able to and have to attend school. By this logic, there should definitely be increased efforts to incorporate expressive art activities in public schools, so that these creative outlets are built-in for at-risk children who attend government-funded preschools. However, this approach is not as all-encompassing in this scenario as it often is, since this problem deals with such young children. By age four, a large majority of children, especially low-income children, are likely not enrolled in school yet; the compulsory school age in most states ranges from 5 to 8 years old, so why spend time and money on school before it is required by law, if time and money are hard to come by?<sup>47</sup> This education lag for low-income families is a problem that has nationally been addressed by the Office of Head Start, which “promotes the school readiness of young children from low-income families through local programs... [by supporting] the mental, social, and emotional development of children from birth to age 5.”<sup>48</sup> Head Start serves children precisely when they are in the critical window this paper is concerned about; therefore, not only increasing the funding and operation of Head Start programs, but also incorporating specific trainings for Head Start educators to help them effectively provide creative outlets and support for traumatized children, is a prime target for policy intervention that could restructure the access of low-income children to resiliency.

## 2B. Other Subsidized Interventions

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<sup>47</sup> “Student Readiness and Progress through School,” *Institute of Education Sciences*, (National Center for Education Statistics, 2014), Table 5.3, Accessed April 10, 2016, [http://nces.ed.gov/programs/statereform/tab5\\_3.asp](http://nces.ed.gov/programs/statereform/tab5_3.asp).

<sup>48</sup> “About Head Start,” *Head Start: An Office of the Administration for Children and Families Early Childhood Learning and Knowledge Center*, Accessed April 9, 2016, <http://eclkc.ohs.acf.hhs.gov/hslc/hs>.

Apart from Head Start, there are other means by which to reach low-income and homeless children while they are still young and get them involved in creative interactions. There are subsidized programs in various states that provide for this need in diverse ways. They are funded by various sources and involved in various initiatives, but the main point is, we need more of them in order to reach the wide pool of children in need. The Kennedy Krieger Institute, an affiliate of Johns Hopkins University, funds the PACT therapeutic nurseries in Baltimore, which serve up to age three who come from disadvantaged and homeless families. PACT provides childcare and therapy for children and families with various physical and mental health problems (at low to no cost). The way PACT administers its services makes it a prime model for other programs to base themselves off of. The nursery bases all of its interactions on play therapy practices, and even incorporates parent-child attachment and clinical play therapy sessions. The activities during each day focus on creative outlets for the infants and creating a trust and calming environment.<sup>49</sup> Other therapeutic nurseries exist, such as the CCTC (Children's Crisis Treatment Center) Therapeutic Nursery in Philadelphia, with similar goals and curricula; however, these therapeutic nurseries are not as widespread as they should be considering the need for them, and are not always targeted at low-income children who need them the most. Therapeutic nurseries are just one model of subsidized programs that could be provided to low-income children to help them access creative outlets. Most extracurricular activities, such as theater, art groups, sports, and youth groups, require some form of resources and transportation to partake in, leaving low-income children out. If more of these activities are provided in a way that is not so taxing on low-income families, whether that be through therapeutic nurseries, or other expressive activity programs aimed at reaching disadvantaged

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<sup>49</sup> "PACT Overview," *PACT Helping Children with Special Needs*, Accessed April 5, 2016, <http://www.kennedykrieger.org/community/community-programs/pact/program-services/therapeutic-nursery>.

children, these children are less likely to be lacking the creative outlet component of resiliency. Furthermore, the previously mentioned interventions to improve parental attachment would probably also improve creative outlets in tandem, because expressive activity may be more likely to take place in the home if a secure parent-child relationship exists, and if there is more family time for such activities.

### 3. Further Changes

Finally, given that the poor are the most disadvantaged in terms of recovery in addition to being the most susceptible to experience the problem in the first place, we should be creating an avenue via which they can gain access to formalized therapeutic care as well. There is currently a lack of public policy systematically addressing the deficits in access to services for traumatized youth and their families, and this must be remedied by “a partnership between professionals working with young children, elected representatives, and public interest advocates.”<sup>50</sup> Possible entry points include pediatric care providers, mental health providers, schools, and childcare providers, to name a few. Each has its limitations, which is why a collaborative effort is necessary; for example, pediatric care visits are often too short to notice signs of traumatization, and mental health providers are often not specialized in children as young as two or three years old. Low income families already often have worse than average health care access options, so this lack of general access to clinical solutions is even more dangerous for them. General improved training of these individuals with the opportunity to diagnose and treat early childhood trauma is necessary, as well as development of more organized and coordinated efforts about how to identify and help traumatized children before it is too late. Establishing court mandates for child trauma therapy in cases of traumatic experiences involving young children would help

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<sup>50</sup> Chu & Lieberman, “Clinical Implications of Traumatic Stress from Birth to Age Five,” 488.

bridge the access gap in some scenarios, too.<sup>51</sup> These policy ideas are just a few examples of ways to attack the flaws in our societal structure that impede poor families' ability to access protective factors. The problem could be attacked from a large variety of angles beyond the scope of this paper, including reform of the criminal justice system to slow the mass incarceration of the poor, or increased familial support for homelessness, to name just a few. Moreover, restructuring policy isn't the only avenue that we can utilize to mitigate this disconnect. We can also investigate formulating different ways to promote resilience using protective factors that are more readily accessible to the poor, possibly via more in school intervention or other useful protective factors that are undiscovered as of yet, which would require further funded research into the subject matter.

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<sup>51</sup> Chu & Lieberman, "Clinical Implications of Traumatic Stress from Birth to Age Five," 488.

## **Conclusion**

Trauma in general, especially childhood trauma, is disproportionately common in poor families, as compared to the general population. Childhood trauma disrupts brain development, leading to lifelong consequences that impede individuals' ability to function in society to their full potentials. Current interventions focus on two main protective factors: parental attachment and creative expressiveness. These two factors hardly exist in the lives of many poor families due to barriers inherent to poverty, so interventions are barely any help to them, who need help the most. Society has a moral and social obligation to fix this discrepancy and help all traumatized children avoid permanent cognitive impairment, especially low income and homeless ones, and I believe that John Rawls and Norman Daniels, among others, would agree. This resolution could take many forms, in public policy, in social normative changes, and in healthcare-specific restructuring, and this paper only scratches the surface of that potential, with the hopes of increasing awareness for this problem and providing a jumping-off point from which to attack it.

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