

# Clinician's Corner

Uniting social work  
research & practice

A photograph of a family walking away from the camera in a field at sunset. A young girl in a white shirt and denim shorts is holding hands with a young boy in a white shirt and plaid shorts. They are holding hands with adults whose legs and arms are visible. The sun is low on the horizon, creating a warm, golden glow. The text 'SP 17' is overlaid on the right side of the image.

SP  
17

**The ACEs Issue**



The University of Texas at Austin  
**Texas Institute for  
Child & Family Wellbeing**  
*Steve Hicks School of Social Work*

# Welcome to Clinician's Corner

## A LETTER FROM OUR DIRECTOR

The ACEs Issue | Spring 2017

Dear Readers:

**W**elcome to our first issue of Clinician's Corner. Our team has unique experience as practitioners and researchers. We have worked in schools, foster care agencies, maternity homes, domestic violence shelters and private practice. While we love our role as researchers, we perceive a disconnect between research and practice. We want to know what practitioners think and we want practitioners to know what we are working on. We understand that many practitioners (despite sometimes vocal admonishments) do not have the time to sort through the many relevant journal articles and translate that information into their practice.

Clinician's Corner is our means to bring researchers and practitioners together to have a unique dialogue about current issues that will culminate in an annual digest co-created by social work researchers and practitioners. Our goal is to provide short-form reviews of research and implications for practice. We also want to provide a free and engaging professional development opportunity where practitioners co-create the final product through a series of Facebook Live sessions where attendees can earn Continuing Education Units (CEUs).

We chose to focus on Adverse Child Experiences (ACEs) in this first issue to address how information about ACEs can be incorporated into practice. We recognize that practitioners have long understood that trauma impacts a person's life trajectories, including health. However, we want to bring together discussions about neurobiology, ACEs, and trauma-informed care because ultimately these conversations are sending the same message to practitioners about the need to address trauma and toxic stress.

The following issue will provide an overview of ACEs, explore ACEs in our healthcare system and how social workers can begin to collaborate with physicians' to promote the use of a universal ACEs screening in doctor's offices. We will discuss how to implement an ACEs screening in practice and some of the things we should consider when using this tool. We also explore how organizations can become more ACEs and trauma-informed to prevent services and systems that may traumatize the people they aim to help. Finally, we discuss how to consider ACEs when working with special populations such as youth in foster care.

These articles are by no means a comprehensive investigation into all the ways social workers can use ACEs in their practice, but they serve as a start to the conversation. We want you to read these articles and bring your knowledge, experiences from your practice, and questions to the table. While every one of our authors are experts in their field, we believe you, the practitioners' out in the field have invaluable expertise and wisdom as well. We enthusiastically invite you to join us for our Facebook Live sessions as we discuss and expand upon articles in future issues and come together to build a bridge between social work research and practice.

Sincerely,

**Monica Faulkner, Ph.D., LMSW**  
Director, Texas Institute for Child & Family Wellbeing.



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# Adverse Childhood Experience (ACE) Study: The evidence behind what we know

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## The Ten Adverse Childhood Experiences

- Emotional abuse
- Physical abuse
- Sexual abuse
- Mother treated violently
- Substance abuse in the home
- Mental illness of a family member
- Parents divorced/separated
- Family member incarcerated
- Emotional neglect
- Physical neglect

Monica Faulkner, Ph.D., LMSW  
Director, Texas Institute for Child & Family Wellbeing



## IMPORTANT TO KNOW:

**T**he fact that trauma impacts motivation and behavior is not new or surprising to clinicians. Most of us know when there is something deeper driving a client's behaviors even when it is not articulated. Today, the knowledge clinicians have carried for decades about trauma has emerged in discussions in public health, medicine and education in the forms of trauma-informed practices and research on childhood trauma, toxic stress and ACEs. The impetus for these discussions lies with a study that, like our knowledge base, is not new.

In the late 1990s, researchers at the Center for Disease Control and Kaiser Permanente in Southern California[1] were able to provide very compelling evidence that childhood trauma and instability impact health outcomes. They surveyed 17,000 primarily white, middle-class adults. Each person indicated whether any of the ten adverse experiences occurred in his or her childhood. Over half of the people surveyed identified at least one of the negative experiences. A quarter of individuals reported experiencing two or more. The more adverse experiences a person reported, the more likely that person was to experience a host of serious illnesses as an adult.

The ACEs study continues to draw attention because of the high prevalence of adverse experiences. There are interesting caveats often discussed amongst those interested in the study. First, the study was conducted with a privileged population (white, middle-class individuals who had health insurance). The fact that ACEs occurred at such a high rate suggests that more disenfranchised populations will have higher ACEs scores. Second, the list of ACEs is not by any means, an exhaustive list. We know children in war zones, natural disasters, households with food instability and many other adverse experiences will have long-term health outcomes.

- ∞ In the late 1990s, researchers collected data from 17,000 Kaiser Permanente HMO patients. They linked childhood experiences of trauma and instability to adult health problems such as cancer and heart disease.
- ∞ Adverse Childhood Experiences (ACEs) include child abuse (emotional, physical and/or sexual abuse); household challenges (family violence, substance use, mental illness, divorce and/or incarceration of a family member); and neglect (emotional and/or physical).
- ∞ A higher ACE score correlates with later negative health outcomes, including early death, for some.

Two other strands of research have encouraged the discussion of ACEs. Along with the ACE studies in the 1990s, there is a continued focus in public health on social determinants of health[2]. In other words, a person's social and physical environments affect health just as biology does. While the field of social work and other helping professions have longed utilized the systems/ecological perspective to help clients, the concept of looking beyond biological causes for illness is innovative in the health field and it is an opportunity to bridge clinicians' knowledge with other professions. The second strand of research comes from the medical field, which has provided evidence that trauma impacts our physical bodies. For instance, we know that trauma impacts brain development.[3] Additional information is emerging that suggests that our exposure to traumatic events alters our DNA.[4]

The new attention and commitment to understanding and addressing ACEs comes from a greater awareness provided by research in multiple fields. ACEs, trauma and toxic stress are important to understand as potential driving factors behind client behaviors. However, more important to understand is that none of these things determines outcomes. While some clients may be at higher risk for negative outcomes, building resilience should remain at the core of any intervention.

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[1] Perry, B.D. Maltreatment and the developing child: How early childhood experience shapes child and culture. The Inaugural Margaret McCain lecture (abstracted); McCain Lecture series, The Centre for Children and Families in the Justice System, London, ON, 2005

[2] <https://www.theguardian.com/science/2015/aug/21/study-of-holocaust-survivors-finds-trauma-passed-on-to-childrens-genes>

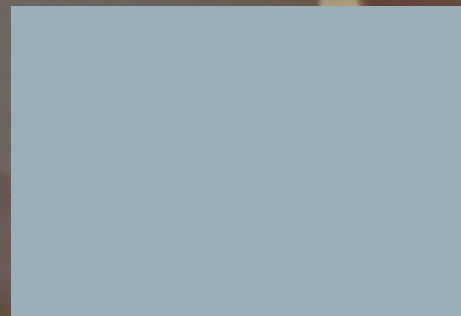
[3] [http://www.ajpmonline.org/article/S0749-3797\(98\)00017-8/abstract](http://www.ajpmonline.org/article/S0749-3797(98)00017-8/abstract)

[4] <https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-of-health>



A close-up photograph of two hands holding a small, white paper house. The house has several rectangular cutouts for windows and a door. The background is a warm, golden sunset sky with the sun visible in the lower left corner. The hands are positioned to support the house from below and the sides, with fingers gently gripping the edges. The overall mood is one of care and protection.

# **How to Create Trauma-informed Systems of Care within Organizations**



Seanna Crosbie, LCSW  
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Austin Child Guidance Center



## IMPORTANT TO KNOW:

- ∞ Adopt universal trauma screening for clients.
- ∞ Advocate for “no seclusion/no restraint” policies
- ∞ Use trauma-informed indicators that include safety, collaboration, cultural inclusivity, empowerment, and choice.

**W**hat is meant by “trauma-informed”? The term is often misunderstood, even within the clinical world. Some social workers believe that using evidence-based treatments with trauma survivors meets the criteria for being trauma-informed. However, if a social worker is employed within an organization, the provision of evidence-based treatments is only one small aspect of being truly trauma-informed.

Consider this: we have systems that were created to help children and adults at some of the most vulnerable times in their lives. But, some of these systems have policies and procedures that can cause harm in our efforts to help children and adults. In fact, some of these systems and organizations revictimize clients, often unintentionally, as well as increase the risk of secondary trauma in social workers. So, what does it mean, on an organizational level, to be trauma-informed? I encourage social workers to consider the definition provided by Substance Abuse and Mental Health Services Administration:

“...Every part of its organization, management, and service delivery system is assessed and potentially modified to include a basic understanding of how trauma affects the life of an individual seeking services. Trauma-informed organizations...are based on an understanding of the vulnerabilities or triggers of trauma survivors ...so that these services and programs can be more supportive and avoid re-traumatization. ”

Trauma-informed organizations utilize trauma screening for clients, ideally universal, to determine who may need trauma intervention. This means that organizations who are not focused on serving victims still need to ask about trauma and recognize the role trauma may have in driving thoughts and behaviors. For example, home visitors, doctors, and teachers are

not providing services specifically related to trauma, but they need to ensure that they recognize when a trauma survivor may need intervention.

Trauma-informed organizations adopt “no seclusion/no restraint” policies since physical restraints can be triggering and/or cause revictimization. Additionally, organizations evaluate clients and staff on trauma-informed indicators including safety, collaboration, cultural inclusivity, empowerment, and choice.

Everyone within the organization is trained on trauma, including clinical and administrative staff, volunteers and board members. In a trauma-informed organization, clients are greeted by staff who are knowledgeable about trauma and honor a survivor’s need for safety and trust when reaching out for services. Additionally, trauma-informed organizations are mindful of the impact of trauma work on staff and implement strategies to reduce the risk of secondary trauma.

When we, as social workers, think of trauma-informed care, it is important for us to include the system-level change within organizations. After all, social workers are trained not only to make micro-level interventions such as therapy but to also address systems in which we serve our clients. The ultimate goal is for our clients to heal from trauma in a compassionate system, and social workers are employed in organizations that intentionally support their work and wellbeing too.

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**Check out our Facebook Live Q&A Session  
with Seanna at [Facebook.com/TXICFW](https://www.facebook.com/TXICFW)!**





# Social Workers Can Collaborate with Physicians to Create ACEs-informed Healthcare

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## Additional Resources

- "To prevent childhood trauma pediatricians screen children and their parents" <https://acestoohigh.com/2014/07/29/to-prevent-childhood-trauma-pediatricians-screen-children-and-their-parentsand-sometimes-just-parents/>.
- "How childhood trauma affects health across a lifetime" TED Talk by Dr. Nadine Burke Harris [https://www.ted.com/talks/nadine\\_burke\\_harris\\_how\\_childhood\\_trauma\\_affects\\_health\\_across\\_a\\_lifetime](https://www.ted.com/talks/nadine_burke_harris_how_childhood_trauma_affects_health_across_a_lifetime)
- Shonkoff, J. (2016). Capitalizing on advances in science to reduce the health consequences of early childhood adversity. JAMA Pediatrics, 170(10), 1003-1007.
- "Addressing Adverse Childhood Experiences and Other Types of Trauma in the Primary Care Setting" American Academy of Pediatrics [https://www.aap.org/en-us/Documents/ttb\\_addressing\\_aces.pdf](https://www.aap.org/en-us/Documents/ttb_addressing_aces.pdf)



Beth Gerlach, Ph.D., LCSW  
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## IMPORTANT TO KNOW:

- ∞ We need to shift the focus from child to parent/caregiver to interrupt intergenerational transmission of trauma.
- ∞ Pediatricians should consider universally screening for ACEs.
- ∞ Social workers can support physicians through their expertise in treating trauma, including brief interventions, motivational interviewing, addressing shame, and in building resilience.

**R**esearch on Adverse Childhood Experiences (ACEs) has provided strong evidence for the negative effects of trauma on the developing brain and health across the lifespan. Advances in biology, psychology and human development have shown that reducing the exposure to trauma in prenatal and early childhood is crucial for protecting children from the long-term harm of adverse experiences. Thus, early interventions that limit exposure to adversity and build safe, stable and nurturing environments can have a substantial effect on children's long-term well-being. In fact, preventing and interrupting the exposure to trauma in childhood may well be one of the most important public health initiatives of our time.

With this in mind, one area of increasing attention is universal screening for adverse childhood experiences by healthcare providers serving expectant parents, children, and families. Physicians, nurses, social workers and other medical providers in obstetric, pediatric and family practices could be used as a front line in intervening in changing the long-term health trajectories of vulnerable children. This involves an important shift in focus from the child to the parent /caregiver to help them protect children from exposure to chronic adversity and build resilience. Understanding the caregiver's own trauma history is also crucial, to interrupt the intergenerational transmission of trauma. Supporting parents that experienced trauma as children can help them make the connection between their childhood experiences and current behavior, develop compassion for themselves and choose a more protected path for their own children. Also, including a parallel conversation about family strengths and resilience can help parents/caregivers heal and protect their children from further adversity.

The American Academy of Pediatrics (AAP) has strongly encouraged physicians to screen for ACEs as

part of their routine practice. The AAP is developing recommendations and strategies for best practices in addressing childhood trauma as part of a "medical home" model, including a whole child perspective and universal screening. However, there is some hesitation and doctors often express concerns about opening up a conversation with a patient that they can only be with for a short time frame, broaching subjects that they are not comfortable with and lacking appropriate support and resources for a patient who needs additional help. While these concerns are understandable, physicians can work with community partners to develop resources and referral networks. Growing evidence from clinics implementing universal screening for trauma, show an increase in trusting relationships with families without a substantial increase in time for patient visits.

Clinicians have long been aware of the impact of childhood trauma and cumulative risk factors over time, while healthcare providers have been exploring toxic stress and social determinants of health. The ACEs research creates a shared language and naturally brings together both fields in an interdisciplinary approach to addressing childhood trauma and its long-term impacts. Social workers and other clinicians can provide support, training and technical assistance to physicians interested in implementing screening and intervention through their expertise in treating trauma, including brief interventions, motivational interviewing, addressing shame, and in building resilience.

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**Check out our Facebook Live Q&A Session  
with Beth at [Facebook.com/TXICFW!](https://www.facebook.com/TXICFW/)**

# How to Administer a Trauma Screening Using The ACEs Questionnaire

**A**CEs may inform some or all of the reasons that a client is seeking treatment and can be clinically useful in treatment planning and provision. This article briefly reviews the importance of screening for trauma, how to do so using the ACEs questionnaire, factors to consider when implementing this screening, and how to best use data gathered through the screening.

## Why do it?:

A high proportion of the population has at least one ACE in their history. Clients entering mental health treatment are even more likely to have ACEs than the general population and the association between the presence of ACEs and negative psychological health outcomes follow a dose-response pattern (i.e., as the number of ACEs increases, psychological health decreases). It is also important to remember that, even if ACEs do not appear to be directly related to the primary presenting issue, they may complicate attempts to treat these “unrelated” issues. Given this, we should screen all clients for ACEs in the early phases of treatment.

## How to do it:

Clinicians often express trepidation at screening for trauma, but published research to date indicates that it is not only acceptable but actually quite important to do a thorough trauma screening with every client. Concerns over re-traumatizing clients are valid, but the risk can be mitigated through observance of several simple guidelines. For instance, though it is important to screen early in the treatment process, the clinician should always preference the client's safety by balancing the need for this information with the client's trust in and comfort with the clinician. The clinician should introduce questions on the trauma history carefully, stating the importance of these questions while also acknowledging that they may be distressing. It is also important to use a screening tool that

is sufficiently comprehensive and provides guidelines for determining the need for further assessment. Depending on client and contextual factors (e.g., the absence of space for a private conversation), it may be better to have clients complete the ACEs questionnaire on paper rather than verbally through an interview and doing so does not jeopardize the validity of the results. The client should understand that they are free to decline to answer any question and, whether conducted aloud or on paper, the clinician should non-judgmentally attend to client signals of distress. In addition to protecting the client from overwhelming emotions that they may not yet be equipped to handle, this can provide clinically useful information on the level of impairment related to the trauma. Finally, it is critically important that the clinician confirms that a client with trauma history feels safe and regulated before leaving the office. There are many “grounding techniques” that can be used to bring the client's awareness back to the safety of the present moment.

## What to do with the information:

Like all screenings, a trauma screening such as the ACEs questionnaire is meant to be used only to indicate the need (or lack thereof) for further assessment and does not constitute a thorough assessment in-and-of itself. It is also important to remember that no screening tool represents an exhaustive list of traumas that your client may have experienced and so it is essential to continue to explore the potential presence and impact of other traumas as your work with a client progresses. Similarly, the presence or absence of any particular experience is never “the whole story, largely” and each client's idiosyncratic responses must be considered. Said another way, completing the ACEs questionnaire with your client is a good place to start your trauma screening, but an insufficient place to stop.

At this point, some clinicians may wonder if a client's retrospective recall of childhood



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## IMPORTANT TO KNOW:

experiences is entirely accurate. There is some disagreement in the research literature on this topic, but the conclusion is generally that retrospective recall should be used and trusted by clinicians when higher quality data is not available (as it often will not be in outpatient treatment). This is because, while retrospective recall is not perfectly accurate when compared to prospective reports and may be shaped by the client's current disposition (e.g., neurotic clients may be more likely to recall adverse childhood experiences than highly agreeable clients), it is mostly accurate and is associated with a wide variety of co-morbidities. If the screening indicates that further assessment is needed, the clinician should warmly but directly investigate the client's trauma history (again, preferencing directness over avoidance, but allowing the client decide if/when the questions become too distressing) and formulate a trauma-informed treatment plan. It is critical that clinicians be aware of co-morbidities associated with the ACEs (especially the increased risk of suicidality and self-harm) and of the requirements of their mandated reporting status that may arise from assessing trauma history. Being prepared to offer (or offer referrals to) empirically supported trauma-informed treatments (i.e., Trauma-focused CBT, EMDR, or possibly exposure therapy) is also advisable. In the end, the great depth and breadth of research done on the ACEs and associated outcomes present clinicians with a major set of resources that are most accessible if the clinician conducts a screening using the ACEs questionnaire.

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- ∞ Ask all clients about trauma history using validated scales like the ACEs questionnaire
- ∞ Retrospective recall isn't ideal, but is still useful
- ∞ Be aware of link with co-morbidities (particularly suicidality) and be prepared to screen for risks
- ∞ Refer clients with trauma history to trauma-informed treatment using empirically supported protocol (i.e., Trauma-focused CBT or EMDR)

### Additional Reading

Briere, J. (2002). Treating adult survivors of severe childhood abuse and neglect: Further development of an integrative model. In J.E.B. Myers, L. Berliner, J. Briere, T. Reid, & C. Jenny (Eds.). *The APSAC handbook on child maltreatment*, 2nd Edition. Newbury Park, CA: Sage Publications.

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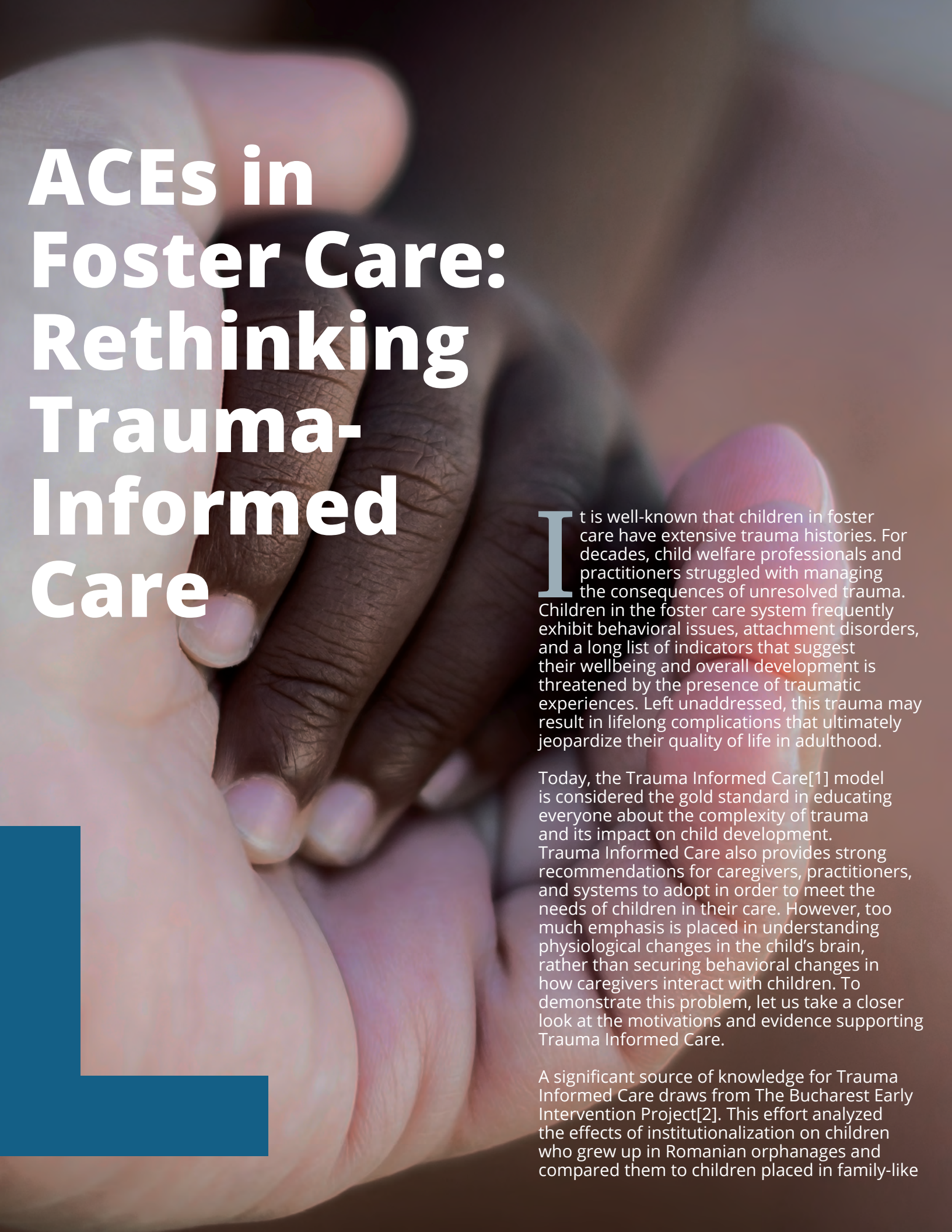
Edwards, V. J., Dube, S. R., Felitti, V. J., & Anda, R. F. (2007). It's ok to ask about past abuse. *The American psychologist*, 62(4), 327-8.

Reuben, A., Moffitt, T. E., Caspi, A., Belsky, D. W., Harrington, H., Schroeder, F., ... & Danese, A. (2016). Lest we forget: comparing retrospective and prospective assessments of adverse childhood experiences in the prediction of adult health. *Journal of Child Psychology and Psychiatry*, 57(10), 1103-1112.

Substance Abuse and Mental Health Services Administration. Trauma-Informed Care in Behavioral Health Services. Treatment Improvement Protocol (TIP) Series 57. HHS Publication No. (SMA) 13-4801. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2014

Watts, B. V., Schnurr, P. P., Mayo, L., Young-Xu, Y., Weeks, W. B., & Friedman, M. J. (2013). Meta-analysis of the efficacy of treatments for posttraumatic stress disorder. *The Journal of Clinical Psychiatry*, 74(6), 541-550.

Check out the original and revised version of The ACEs Questionnaire on our website.



# ACEs in Foster Care: Rethinking Trauma-Informed Care

It is well-known that children in foster care have extensive trauma histories. For decades, child welfare professionals and practitioners struggled with managing the consequences of unresolved trauma. Children in the foster care system frequently exhibit behavioral issues, attachment disorders, and a long list of indicators that suggest their wellbeing and overall development is threatened by the presence of traumatic experiences. Left unaddressed, this trauma may result in lifelong complications that ultimately jeopardize their quality of life in adulthood.

Today, the Trauma Informed Care[1] model is considered the gold standard in educating everyone about the complexity of trauma and its impact on child development. Trauma Informed Care also provides strong recommendations for caregivers, practitioners, and systems to adopt in order to meet the needs of children in their care. However, too much emphasis is placed in understanding physiological changes in the child's brain, rather than securing behavioral changes in how caregivers interact with children. To demonstrate this problem, let us take a closer look at the motivations and evidence supporting Trauma Informed Care.

A significant source of knowledge for Trauma Informed Care draws from The Bucharest Early Intervention Project[2]. This effort analyzed the effects of institutionalization on children who grew up in Romanian orphanages and compared them to children placed in family-like



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## IMPORTANT TO KNOW:

- ∞ Children in foster care have complex trauma histories and the system itself generates traumatic experiences.
- ∞ Trauma and neglect are proven to have significant repercussions on brain development, which leads to other issues.
- ∞ Trauma Informed Care is a viable strategy to help manage and overcome issues compounded by trauma, but child welfare professionals and caregivers need to also change the way they interact with children in foster care.

settings, similar to our conception of foster care. The results from this study were astounding. Children who spent more time in institutions were found to have abnormal neurological structures, reduced IQ, diminished language skills, and a number of other developmental issues. Whereas institutionalized children suffer significant consequences, children placed in foster care settings at early ages did not have the same problems. Therefore, it is clear that the dangers that compromise healthy human development in institutions are not present in family-like settings. What makes this so?

The differences in these arrangements is how caregivers interact with children. Staff working in the Romanian orphanages simply did not have enough time to provide each child with the attention, love, and compassion that they deserve. Infants in these institutions were left in their cribs all day, every day, only receiving attention when it was time to feed or clean them. To no surprise, the lack of stimulation resulted in diminished neurological development and invited a series of other developmental issues to manifest. On the other hand, children living with families received adequate attention and stimulation, which positively contributed to proper neurological and social development.

The real value in Trauma Informed Care is that it requires caregivers to change their approach in how they interact with the children in their care. While it is appropriate to educate child protection workers, caregivers, and clinicians

about the neuroscience underpinning Trauma Informed Care, it is imperative that they understand these changes can only occur if their interaction with children is sensitive and therapeutic. For foster children, placement instability, bureaucratic overreaction, and social isolation is unfortunately all too common. Consequently, these negative experiences have a powerful impact in shaping foster children's behavior. Youth who believe that the system is a threat to their interests will act according to that belief. Kids in foster care who act out and run away are not bad kids. Rather, they are children who have endured considerable hardship, loss, and trauma without adequate support to help them process these challenges. However, if we replace the cold, impersonal, and harsh elements found in our foster care system with policies and practices that promote compassion, dignity, and acceptance, we will witness growth and positive transformation for children.

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[1] <https://www.childwelfare.gov/topics/responding/trauma/>

[2] <http://www.bucharestearlyinterventionproject.org/>

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# Foundations to Thrive:

## Mapping assets in Travis County that Support Young Children and Their Families

**A**dverse Childhood Experiences (ACEs) can alter the brain development of children and contribute to poor health and social outcomes later in life. Universal prevention of children's exposure to trauma and supporting families should be a top priority in all communities. In addition to this, screening for and addressing trauma that has already occurred (through various multi-level, cross-sector approaches) is critical to the creation of healthy, resilient communities where all children and families have the opportunity to thrive.

While there are many excellent services, programs and approaches designed to help children and families thrive in Travis County, it is unclear where the strengths and gaps exist across all community sectors that impact children and families. Thus, St. David's Foundation has provided funds for Texas Institute for Child and Family Wellbeing to develop an asset map to explore efforts in Travis County for preventing adverse childhood experiences and building individual and community resilience.

Our specific goals for the project are to identify the presence or absence, and capacity, of multi-level, cross-sector assets within Travis County that:

- Promote the optimal brain development and overall health & wellbeing of children ages 0-5 and their families; and
- Promote resilience through trauma-informed efforts for children and families who are at risk for, or have experienced, trauma.

To guide this process we have developed a "Foundations to Thrive" framework that explores assets and gaps in universal, targeted and intensive approaches across the sectors

of physical and behavioral health, basic needs, school readiness and quality childcare, and neighborhood climate and community norms. The asset map will identify what Travis County is already doing well, and also where there are gaps that need to be addressed, at infrastructure, policy, and program and service levels. While it is not about identifying each specific service available to children and families, it will provide a "bird's eye" view of approaches across multiple sectors that impact children ages 0-5 and their families. Specific attention will be placed on universal approaches that could impact community resilience and reduce the exposure to childhood adversity. The final report will be completed at the end of the year and can be utilized by funders, program developers, policy makers and community stakeholders to explore strategic next steps for ensuring Travis County supports opportunities for all young children and their families to thrive.

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Written by: **Beth Gerlach, LCSW, Ph.D.**

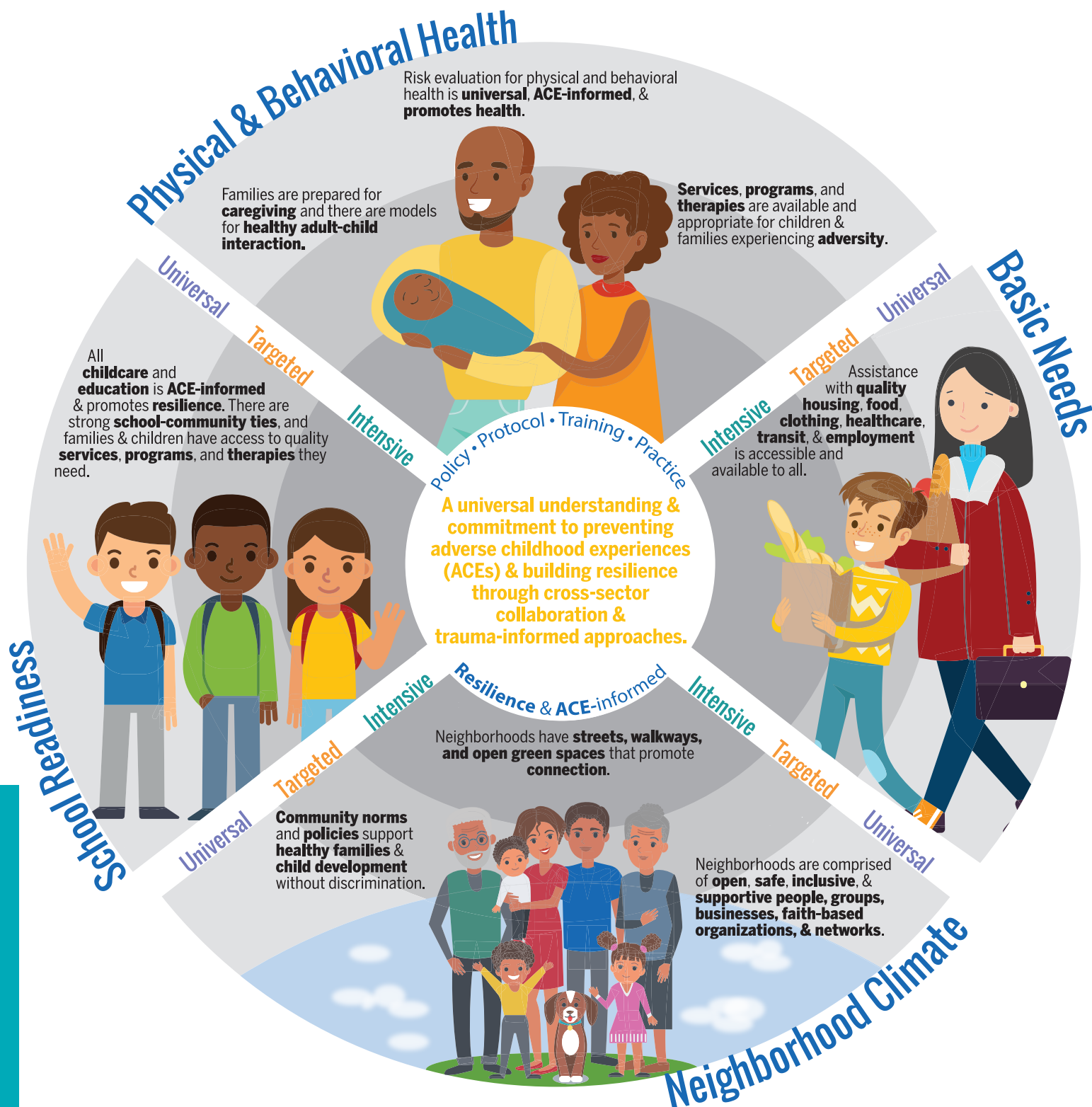
### Asset Mapping Research Team:

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# Foundations To Thrive

A framework of ideal conditions to promote **thriving children, supported caregivers** and **healthy, equitable & resilient** communities.



# Clinician's Corner



The University of Texas at Austin  
Texas Institute for  
Child & Family Wellbeing  
*Steve Hicks School of Social Work*

[txicfw.socialwork.utexas.edu/research/project/clinicians-corner/](https://txicfw.socialwork.utexas.edu/research/project/clinicians-corner/)