**Trauma-Informed PMTO: An Adaptation of the Oregon Model of Parent Management Training**

Laura A. Rains, MSW, LCSW, and Marion S. Forgatch, Ph.D.

Consistent effective parenting is a cornerstone for children’s healthy adjustment under normal circumstances; it is even more essential for families facing adversities. Providing effective treatment to families in the child welfare (CW) system who have experienced traumatic stress can promote recovery from adversity and a return to healthy balance. The Oregon model of Parent Management Training (PMTO™) is an evidence-based program (EBP) that increases effective parenting, which in turn promotes positive outcomes for children and parents (Forgatch & Patterson 2010). Recently PMTO has been tailored to address the needs of families in the CW system by strengthening a focus on emotion regulation and adding mindfulness, thereby yielding a trauma-informed version of PMTO.

Trauma and other adverse contexts can lead to emotional dysregulation. Parents may react with negative emotions, which in turn can interfere with effective parenting practices, and lead to negative outcomes for children and their families. Adversities such as transitions, unemployment, substance use, poverty, and discrimination can amplify caregivers’ negative emotions and interfere with social relationships outside the family (DeGarmo & Forgatch, 1999; Patterson & Forgatch, 1990). Additionally, maltreated children in foster care are burdened with challenges in social-emotional competence (Pears, Fisher, Bruce, Kim, & Yoerger, 2010) and psychosocial domains (Pears & Fisher, 2005).

The intervention empowers parents to serve as change agents for their families. Intervention studies consistently find that effective parenting mediates the harsh effects of high-risk contexts on children’s adjustment. For example, a short-term longitudinal study examining recovery in the close aftermath of traumatic events identified parenting practices as a key source of protection for children’s adjustment (Gewirtz, DeGarmo, & Medhanie, 2011). Findings from randomized controlled intervention trials in samples undergoing stressful family transitions have shown that improved parenting practices yield positive outcomes for children and for the parents themselves (Forgatch & Patterson, 2010; Patterson, Forgatch, & DeGarmo, 2010).

PMTO interventions decrease coercive parenting and increase positive parenting (i.e., skill encouragement, problem solving, limit setting, positive involvement, and monitoring). Improvements in parenting, in turn, buffer the effect of stressful contexts on youngsters and promote healthy adjustment. More than four decades of careful research with PMTO programs have shown benefits for youngsters in terms of reduced internalizing and externalizing behavior, deviant peer association, delinquency, police arrests, and increased academic functioning and positive peer relationships (Forgatch and Patterson, 2010). Several large-scale PMTO implementations have been conducted nationally and internationally. Adapted versions of PMTO are being tested with diverse populations, including English and non-English speaking Latinos, military personnel returning from the wars in Afghanistan and Iraq, Somali and Pakistani families in Minnesota and in Norway, and families in Mexico City.

Originally, PMTO focused on parenting interventions for child mental health issues. In the last decade, the intellectual contributions of Dr. Abigail Gewirtz contributed to tailoring PMTO programs to help families whose children have been removed for neglect and/or maltreatment. PMTO programs for CW include an intensive reunification project in Kansas and in Detroit, Michigan. Parents learn to integrate emotional regulation, mindfulness, communication, and problem solving skills to improve relationships at home and with adults in the community (e.g., other caregivers, CW, judicial, school, employer). As parents become more effective, new doors to healthy social environments open up for children and parents (Patterson et al., 2010).

PMTO clinicians deliver the intervention in parent groups or individual family sessions using non-blaming, strength-based, active-teaching strategies tailored to the specific needs of families. To broaden the range of emotional identification, practitioners use video and other media that elicit parents’ descriptions of attributes of emotions in terms of body posture, facial expression, and voice tone. To strengthen parent-child communication, families create an emotion collage or play games designed to provide practice in managing common family challenges. Clinicians engage families with theatrics and humor, thus promoting a comfortable environment for differentiating and expressing emotions.

Families in the CW system need evidence-based practices to ensure enduring positive outcomes. Intervention research must become standard practice to better understand the role of parenting in children’s post-trauma recovery and the relationship between trauma-informed parent training and child welfare.

---

**Continued on page 38**
Continued from page 19

Invisible Suitcase.” This exercise invites parents to examine what unseen beliefs and values children bring into their homes, including beliefs about self, caregivers, and the world.

Caring for Children Who Have Experienced Trauma was designed to meet a need within the child welfare community for a trauma-informed, application-focused training for resource parents. It is not, however, designed to stand alone. This curriculum is one piece of a broader effort to build a more trauma-informed child welfare system. The NCTSN also has a curriculum designed for child welfare staff, the Child Welfare Trauma Training Toolkit (CWTTT), as well as a set of “Essential Elements of a Trauma-Informed Child Welfare System.”

When all parties within the child welfare system use the trauma lens, we will, together, be more effective in our efforts to promote safety, permanency, and well-being in the lives of children who have experienced trauma.

“When I started foster parenting 14 years ago, I thought that a lot of love and cuddles was all the children needed. How I wish I would’ve had this in my tool chest at that time. But having it today, it only enhances the parenting skills that I had before.” –Donna, Foster and adoptive parent

Liz Sharda, LMSW is Program Coordinator for Project Return Home at Bethany Christian Services in Grand Rapids, MI. She can be reached at esharda@bethany.org

Continued from page 24

is to serve and advocate for these families must receive support and training in EBPs, which have been demonstrated to work. When programs are successful, families, clinicians and communities all reap the benefits.

“Children are not something you are entitled to but a gift. And in order to give them the best chance in life we as parents have to be able to talk to them and understand them. They are just like us, but in a smaller body – little people, with feelings, opinions, bad days and even days when they don’t know what they feel… I feel that every young parent should experience this class.”

– Father who completed parent group for reunification in Detroit

Laura A. Rains, MSW, LCSW is Director of Implementation and Training at Implementation Sciences International, Inc. She and Marion Forgatch can be reached at laurar@osfc.org.

Marion S. Forgatch, PhD is Executive Director and Senior Scientist Emerita of Implementation Sciences International, Inc.

Continued from page 25

DR services often include referral to cultural healers for those families who are traditional, as well as more western religious service providers.

Our goal at the National Native Children’s Trauma Center is to support and serve Native communities. As we continue to do so by utilizing the integration of traditional cultural activities in evidence based trauma treatments, we find the fusion greatly benefits Native peoples’ lives and the communities they impact while increasing access to mental health services in Native communities.

Wynette Whitegoat, AB, served as Research Intern with the National Native Children’s Trauma Center, University of Montana. She can be reached at wynettewhitegoat@gmail.com.

Richard van den Pohl, PhD is a Professor and Director at the Institute for Educational Research and Service and the Principle Investigator at the National Native Children’s Trauma Center, University of Montana, funded through the Department of Health and Human Services, Administration for Children and Families, Children’s Bureau, Grant #90C01056. He can be reached at VanDenPohl@mso.umt.edu

Integrated Bibliography


References


References


Agency Discussion Guide

*In order to assist busy supervisors and managers in thinking through how they might engage others around the information presented in this edition on trauma-informed practice, we offer several discussion questions to get the conversation started:*

**Between Supervisor/Workers**

1. What are some practice implications for child welfare workers working with very young children who have experienced trauma? How might early exposure to trauma impact a child [and his/her family] throughout his/her development? How can workers prepare families for the re-emergence of trauma responses throughout the developmental lifespan? See Pinna & Gewirtz, and McAlistier Groves.

2. How might trauma be experienced differently among children and families, based upon their diverse backgrounds [e.g. race, culture, socioeconomic status, education]? See Whitegoat & van den Pohl, and Zimmerman & Shannon.

3. The “Best Practices” section highlights some trauma-informed practice interventions. Which, if any, of these interventions seem applicable to our work? Do you think any should be implemented in our agency? What steps can you personally take?

4. Several of the articles in this issue focus on parents and their experience of trauma? How can we help parents and resource parents address their own trauma, as well as adopting a trauma-informed perspective in their parenting? See Tullberg, Sharda, Rains & Forgatch, Toohey, and Ake.

**Between Manager/Supervisor**

5. What does it mean to be a trauma-informed system or organization? What is agency already doing that is trauma-informed? What could we be doing that would move our agency closer to become trauma-informed in all aspects of our work? What resources would be needed to implement those changes? See Wilson, Leinfelder Grove, and Barto.

6. How can we make sure our workers are well-trained on trauma-informed practice strategies? See Wilson, Hendricks, and Wilcox & Petersen.

7. In thinking about the workers within your unit, as well as the agency as a whole, which interventions described in the “Best Practices” section seem to be interventions that could work here?