NCTSN The National Child Traumatic Stress Network

Child Welfare Trauma Training Toolkit

Comprehensive Guide

3rd Edition

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Established by Congress in 2000, the National Child Traumatic Stress Network (NCTSN) is a unique collaboration of academic and community-based service centers whose mission is to raise the standard of care and increase access to services for traumatized children and their families across the United States. Combining knowledge of child development, expertise in the full range of child traumatic experiences, and attention to cultural perspectives, the NCTSN serves as a national resource for developing and disseminating evidence-based interventions, trauma-informed services, and public and professional education.

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Introduction to the Comprehensive Guide

A significant majority of children in the child welfare system have been affected by trauma. Trauma can have a lasting impact on the well-being and functioning of these children and their families. For child welfare workers, the ability to understand the effects of trauma on the children and families whom they serve, and to identify and address the specific trauma-related needs of those children and families, is critical to effective case planning and improving the child's overall life trajectory.

This *Comprehensive Guide*, which is designed as a companion to the *Child Welfare Trauma Training Toolkit*'s *Trainer's Guide* and *Participant Manual*, includes:

- The definition of a trauma-informed child welfare system
- An overview of child traumatic stress and its varying impact on children
- *The Essential Elements of a Trauma-Informed Child Welfare System*
- Practical strategies that child welfare professionals can use with children and families in the system who have experienced trauma.

By understanding how trauma impacts children, and adopting a trauma-informed child welfare practice approach, child welfare workers can play a crucial role in mitigating both the short- and long-term effects of trauma and in ultimately improving the lives of the children they serve.

Definition of a Trauma-Informed Child and Family Service System

While the effects of trauma are often prevalent and far-reaching among children in the child welfare system and can impact casework practice at multiple levels, trauma and its effects have historically been overlooked or not well understood in day-to-day child welfare practice. As a result, many children who have experienced trauma may not receive the types of support and services that are necessary to help them achieve safety, permanency, and well-being. On the contrary, child welfare agencies may inadvertently participate in actions that exacerbate a child's trauma, such as multiple placements or removing a child from his/her community or school.

Researchers have identified the need to apply a trauma-informed approach across child-serving systems, such as child welfare, juvenile justice, education, and others. The forerunners of this movement have been members of the National Child Traumatic Stress Network (NCTSN). In 2008, in an article that reviewed how various systems approach trauma

services differently, NCTSN colleagues introduced the concept of addressing the needs of children who have experienced trauma across multiple systems. The article also provided recommendations for how to make each of these service systems more trauma-informed (Ko et al., 2008). Adopting a trauma-informed approach to child-serving systems provides benefits on multiple levels. It equips front-line workers, supervisors, and administrators with the tools and skills necessary to help children and families overcome trauma and manage their own secondary traumatic stress. It also provides a framework for educating the workforce and affiliated stakeholders on the impact of trauma, and provides them with strategies to manage children's difficult behaviors and overwhelming emotions and ensure that children receive the services they need.

The National Child Traumatic Stress Network's trauma-informed service system workgroup collaboratively developed the following definition of a trauma-informed child and family-service system.

A service system with a trauma-informed perspective is one in which programs, agencies, and service providers: (1) routinely screen for trauma exposure and related symptoms; (2) use culturally appropriate evidence-based assessment and treatment for traumatic stress and associated mental health symptoms; (3) make resources available to children, families, and providers on trauma exposure, its impact, and treatment; (4) engage in efforts to strengthen the resilience and protective factors of children and families impacted by and vulnerable to trauma; (5) address parent and caregiver trauma and its impact on the family system; (6) emphasize continuity of care and collaboration across child-service systems; and (7) maintain an environment of care for staff that addresses, minimizes, and treats secondary traumatic stress, and that increases staff resilience.

(NCTSN Trauma-Informed Service System Workgroup, 2012)

The Impact of Trauma on Children's Safety, Permanency, and Well-Being

Children who have experienced trauma present a unique challenge to child welfare professionals. As stated in the Adoption and Safe Families Act of 1997, the national goals for children in the child welfare system are safety, permanency, and well-being. For children with a history of trauma, such goals can be particularly difficult to achieve.

Safety: Trauma can adversely impact the child's ability to protect himself/herself from abuse, or for the agency to do so, in at least the following ways:

- The child's inability to regulate moods and behavior may overwhelm or anger caregivers to the point of increased risk of abuse or revictimization.

- The impact of trauma may impair a child's ability to describe traumatic events in the detail needed by investigators.
- The child's lack of trust may inhibit his or her ability to provide complete and accurate information to investigators or the courts about abuse experienced or witnessed.
- Traumatic reactions may dull the child's emotions in ways that make some investigators skeptical of the veracity of the child's statements.
- The child's altered world view may lead to behaviors that are self-destructive or dangerous, including premature sexual activities and substance abuse.

Permanency: Trauma reactions can adversely impact the child's stability at home or in out-of-home care.

- The child's inability to regulate his or her moods and behavior may lead to behaviors that endanger or threaten stable placements, reunification, and/or adoptive placement.
- The child's lack of trust in the motivations of caregivers may lead to rejection of possible caring adults or, conversely, to superficial attachments.
- The child's early experiences and attachment problems may reduce his or her natural empathy for others, including foster or adoptive family members.
- A new foster parent or adoptive parent, unaware of the child's trauma history or of which trauma reminders are linked to strong emotional reactions, may inadvertently trigger reminders of trauma for the child.

Well-being: Trauma may have both short- and long-term consequences for the child's mental health, physical health, relational capacity, functioning, and life trajectory.

- The child's traumatic exposure may have produced cognitive effects or deficits that interfere with the child's ability to learn, progress in school, and succeed in the classroom and the community (and later in the workplace).
- The child's inability to regulate emotions may interfere with his or her ability to function in a family, a traditional classroom, and/or with peers in the community.
- The child's mistaken feelings of guilt and self-blame for the negative events in his or her life may lead to a sense of hopelessness that impairs his or her ability and motivation to succeed in social and educational settings.

- A child's traumatic experiences may alter his or her worldview so that the child now sees the world as untrustworthy and isolates himself/herself from family, peers, as well as social and emotional support.

The Essential Elements of a Trauma-Informed Child Welfare System

Child welfare is charged with integrating multiple systems in the child's life in order to provide comprehensive and consistent services. The Essential Elements of a Trauma-Informed Child Welfare System described here were defined by the Child Welfare Committee of the NCTSN, and provide a framework for trauma-informed child welfare practice that addresses the various needs of children and families who have been impacted by trauma. While certain Essential Elements may be addressed by professionals in other systems, such as mental health or schools, it is the child welfare worker who coordinates with other systems to ensure that the child's and the family's trauma-related needs are being met.

These Essential Elements are the province of all professionals who work in and with the child welfare system. They span investigation, child protection, ongoing service provision and coordination, court decision-making, and permanency. Implementation of each Essential Element must take into consideration the child's developmental level and be responsive to the child's family, culture, and language.

The Essential Elements of a Trauma-Informed Child Welfare System:

1. Maximize physical and psychological safety for children and families
2. Identify trauma-related needs of children and families
3. Enhance child well-being and resilience
4. Enhance family well-being and resilience
5. Enhance the well-being and resilience of those working in the system
6. Partner with youth and families
7. Partner with agencies and systems that interact with children and families

Child Trauma and Child Traumatic Stress

Introduction

Child trauma refers to a child's witnessing or experiencing an event that poses a real or perceived threat to the life or well-being of the child or someone close to the child (such as a parent or sibling). The event overwhelms the child's ability to cope and causes feelings of fear, helplessness, or horror, which may be expressed by disorganized or agitated behavior. Situations that may be considered traumatic include the following:

- Physical or sexual abuse
- Abandonment, betrayal of trust (such as abuse by a caregiver), or neglect
- The death or loss of a loved one
- Life-threatening illness of a caregiver
- Witnessing domestic violence
- An automobile accident or other serious accidents
- Bullying
- Life-threatening health situations and/or painful medical procedures
- Witnessing or experiencing community violence (e.g., drive-by shooting, stabbing, robbery)
- Life-threatening natural disasters
- Acts or threats of terrorism

Types of Trauma

Acute trauma

A single traumatic event that is limited in time is called an acute trauma. An earthquake, dog bite, or motor vehicle accident are all examples of acute traumas. Other examples include:

- School shootings
- Gang-related incidents
- Terrorist attacks
- Natural disasters (e.g., wildfires, floods, hurricanes)

- Serious accidents
- Physical or sexual assault (e.g., being shot or raped)

Over the course of even a brief acute event, a child may go through a variety of complicated sensations, thoughts, feelings, and physical responses that rapidly shift as the child assesses and reassesses the danger faced and the prospects of safety. As the event unfolds, the child's increased heart rate, overwhelming emotions, and other physical reactions can add to his or her fright and sense of being overwhelmed.

Chronic trauma

When a child has experienced multiple traumatic events, the term chronic trauma is used. Chronic trauma may refer to multiple and varied events—such as a child who is exposed to domestic violence, is involved in a serious car accident, and then becomes a victim of community violence—or longstanding trauma such as physical abuse or war. The effects of chronic trauma are often cumulative, as each event serves to remind the child of prior trauma and reinforce its negative impact. A child exposed to a series of traumas may become more overwhelmed by each subsequent event and more convinced that the world is not a safe place. Over time, a child who has felt overwhelmed over and over again may become more vulnerable to and less able to tolerate ordinary everyday stress.

Complex trauma

Complex trauma is a term used to describe both exposure to chronic trauma—usually caused by adults entrusted with the child's care, such as parents or caregivers—and the immediate and long-term impact of such exposure on the child (Cook et al., 2005). Children who experience complex trauma have endured multiple interpersonal traumatic events (such as physical or sexual abuse, profound neglect, or community violence) from a very young age (typically younger than age five).

Children involved with the child welfare system are likely to have experienced chronic and complex trauma, in environments characterized by adversity and deprivation, and often without the mitigating influence of consistent and supportive caregivers. It is important for child welfare workers to recognize the complexity of a child's lifetime trauma history rather than focusing solely on the single event that might have precipitated a report. In general, children who have been exposed to repeated stressful events within an environment of abuse and neglect are more vulnerable to experiencing traumatic stress.

Historical trauma

Historical trauma is a personal or historical event or prolonged experience that continues to have an impact over several generations. It includes collective and cumulative emotional wounding across generations that results from massive cataclysmic events, known as Historically Traumatic

Events (HTE). The trauma is a psychological injury experienced personally and transmitted over generations. Thus, even family members who have not directly experienced the trauma can feel the effects of the event generations later. Examples include:

- Slavery
- Removal from homelands
- Relocation
- Massacres, genocides, or ethnocides
- Cultural, racial, or immigrant oppression
- Forced placement in boarding schools

Neglect as trauma

One prevalent form of chronic trauma is child neglect, defined as the failure to provide for a child's basic physical, medical, educational, and emotional needs. In spite of neglect being the most common type of maltreatment, much less is known about it than about other types of maltreatment (Mennen, Kim, Sang, & Trickett, 2010). Unlike physical and sexual abuse, where overt acts are committed against a child, neglect is most often the omission of caretaking behavior that a child needs for healthy development. Neglect can have serious and lifelong consequences. Experiencing neglect can feel acutely threatening, particularly for very young children who are completely dependent on caregivers for sustenance. Neglect often occurs in the context of other maltreatment, such as periods of abandonment and abuse, and is frequently associated with other psychosocial stressors and forms of adversity such as extreme poverty and parental substance abuse.

Child traumatic grief (CTG)

When someone important to the child dies in a sudden or violent manner that is perceived as traumatic to the child, the child's trauma symptoms interfere with his/her ability to grieve. Symptoms of CTG include:

- Being overly preoccupied with how the loved one died
- Reliving or re-enacting the traumatic death, which may include play that incorporates themes related to the death
- Showing signs of emotional and/or behavioral distress when reminded of the loss
- Attempting to avoid physical reminders of the traumatic death, such as activities, places, or people related to the death
- Withdrawing from others

- Showing signs of emotional constriction or numbing
- Showing signs of a lack of purpose and meaning to one's life

Child Traumatic Stress

Child traumatic stress refers to a child's physical and emotional responses to events that threaten the life or physical integrity of the child or of someone critically important to the child. Such events overwhelm a child's capacity to cope, and elicit intense physical and emotional reactions that can be as threatening to the child's sense of physical and psychological safety as the traumatic event itself. Immediate reactions to trauma can include:

- An overwhelming sense of terror, helplessness, and horror
- Physical sensations such as rapid heart rate, trembling, dizziness, or loss of bladder or bowel control
- Feeling hyperalert, agitated, and emotionally upset

After a traumatic event, some children experience intense and ongoing emotional upset. Persistent traumatic stress reactions in children can include nightmares, difficulties with attention, physical symptoms such as difficulty sleeping and eating, depressive symptoms, anxiety, and behavioral changes. These reactions often occur when children are reminded of the traumatic event, and they interfere with children's daily functioning and ability to interact with others.

Prevalence of Traumatic Events

Children in the United States are exposed to a wide range of traumatic events, from physical and sexual abuse to neglect or other forms of child maltreatment, to natural disasters, motor vehicle accidents, dog bites, or community violence.

Child maltreatment

The Child Abuse Prevention and Treatment Act, as amended by The CAPTA Reauthorization Act of 2010, defines child abuse and neglect as:

> …at a minimum, any recent act or failure to act on the part of a parent or caretaker which results in death, serious physical or emotional harm, sexual abuse or exploitation or an act or failure to act which presents an imminent risk of serious harm. (U.S. Department of Health and Human Services, 2010, p. 6)

In 2010, according to the U.S. Department of Health and Human Services (2011), 695,000 children were victims of substantiated child maltreatment. Of these:

- 78.3% experienced neglect
- 17.6% were physically abused
- 9.2% were sexually abused
- 8.1% endured emotional or psychological abuse
- 2.3% were subjected to medical neglect
- 10.3% experienced other forms of maltreatment (e.g., abandonment, threats of harm, congenital drug addiction)

In a national sample of children, over 60% were exposed to violence or abuse in their homes or communities during the past year (Finkelhor, Hamby, Ormrod, & Turner, 2009). In this national sample, it was also found that:

- One out of 10 children was a victim of violence five or more times
- More than 25% had been exposed to family violence
- 40% reported witnessing violence
- 8% had experienced sexual assault
- 17% had been physically assaulted

Juvenile justice system

The prevalence of trauma is even higher for youth in the juvenile justice system. More than 93% of juvenile offenders report at least one or more traumatic experiences, such as being a victim of or witness to violence (Abram, Teplin, Charles, Longworth, McClelland, & Dulcan, 2004). The mental health consequences of trauma, such as post-traumatic stress disorder (PTSD) or posttraumatic stress symptoms, are also documented in more than 65% of juvenile offenders (Abram, Washburn, Teplin, Emanuel, Romero, & McClelland, 2007; Arroyo, 2001; Burton, Foy, Bwanausi, Johnson, & Moore, 1994; Cauffman, Feldman, Waterman, Steiner, 1998).

Medical trauma

Medical trauma (related to ongoing or chronic illness or injury) is a special concern for children in foster care due to their higher rates of chronic health conditions:

- 40% of children in foster care have a chronic medical condition
- 10% have two or more chronic health problems (U.S. Department of Health and Human Services, 2007)

Further, medical illness, injury, and treatment can be traumatic. Post-traumatic stress has been noted in up to:

- 20% of children and adolescents with asthma (Kean, Kelsay, Wamboldt, & Wamboldt, 2006)
- 33% of those with HIV (Radcliffe et al., 2007)
- 53% of those with burns (Stoddard, Norman, Stroud, & Murphy, 1989)
- 48% of violently injured children and adolescents (Aaron, Zaglul, & Emery, 1999; Fein et al., 2002)

Medical exams can be invasive and may trigger past traumas or uncover conditions requiring painful or prolonged treatment (American Academy of Pediatrics District II, NY State, Task Force on Health Care for Children in Foster Care, 2005). For children who are in foster care, medical trauma may become layered onto previous traumatic experiences. For example, previous trauma not only contributes to health problems but also puts children at risk for additional traumatic stress reactions related to their healthcare experience.

The same risk factors for persistent traumatic stress in ill and injured children are particularly relevant for children in foster care:

- Experiencing severe levels of pain during illness or injury
- Exposed to scary sights and sounds in the hospital
- Separated from parents or caregivers during treatment
- Experiencing prior medical trauma or have had previous trauma reactions

Other Sources of Ongoing Stress Among Children in the Child Welfare System

By the time most children enter the child welfare system, they have already been exposed to a wide range of distressing experiences, many of which remain unknown and unreported during intake. Foster care placement often separates a child from what is familiar and beloved (e.g., primary caregivers, family members, friends, home, community, school). In addition, children in the child welfare system typically face many other sources of ongoing stress that can challenge child welfare workers' abilities to intervene. These include:

- Poverty
- Racism and other forms of discrimination
- Separations and frequent moves

- School problems
- Grief and loss
- Refugee or immigrant experiences

As a result of these experiences, significant numbers of children known to the child welfare system are likely to be suffering from child traumatic stress.

- Maltreated children are more likely than non-maltreated children to have depressive symptomatology, school behavior problems, difficulties with peer relationships resulting in more peer rejection and victimization, as well as difficulties with mood regulation. Chronic maltreatment is associated with greater emotional and behavioral difficulties (Ethier, Lemelin, & Lacharite, 2004).
- A study of the prevalence of mental health diagnoses in three groups of abused children found that PTSD generally co-occurs with other disorders, including depression, anxiety, or oppositional defiant disorder (Ackerman et al., 1998).
- A study of children in foster care revealed that PTSD was diagnosed in 60% of sexually abused children and 42% of physically abused children (Dubner & Motta, 1999). The study also found that 18% of foster children who had not experienced either type of abuse had PTSD, possibly as a result of exposure to domestic or community violence (Marsenich, 2002).

Potentially Traumatizing Events in Juvenile Detention and Other Residential Settings

Some practices in juvenile detention or other residential settings (e.g., group homes, residential treatment centers) have the potential to be traumatic for children and adolescents. These practices can act as trauma triggers and therefore impede the trauma recovery process. Caregivers and staff in these settings should be aware of this potential and try to use more trauma-informed practices with these adolescents. Practices that can be potentially traumatizing include:

- Seclusion (especially if the adolescent has been neglected)
- Restraint (especially if the adolescent has been physically abused)
- Routine room confinement (especially if the adolescent has been neglected)
- Strip searches and pat-downs (especially if the adolescent has been sexually abused or assaulted)
- Placement on suicide watch

- Witnessing physical altercations (especially if the adolescent has witnessed domestic or community violence)
- Fear of being attacked by other youth (especially if the adolescent has been physically abused)
- Separation from family and community

(Marrow, M., Benamati, J., Decker, K., Griffin, D., and Lott, D. A. (2012). *Think trauma: A training for staff in juvenile justice residential settings.* Los Angeles, CA, and Durham, NC: National Center for Child Traumatic Stress.)

What can a child welfare worker do?

- Remember that most children and families involved in the child welfare system have been exposed to multiple traumatic events.
- Consider that many children have a lifetime history of trauma, including acute, chronic, and complex situations, in addition to the event that precipitated the most recent report.
- Learn about the different types of trauma that can impact children and families.
- Seek information about the particular types of traumas and stressors that affect the families with whom you work.
- Do not underestimate the impact of witnessing violence, including witnessing the abuse of a sibling or caregiver.

The Impact of Trauma on Children in the Child Welfare System

How Does Trauma Affect Children?

The short- and long-term impact of potentially traumatic events is determined in part by the objective nature of the events, and in part by the child's subjective response to them. Not every distressing event results in traumatic stress; something that is traumatic for one child may not be traumatic for another. The ultimate impact of a potentially traumatic event depends on several factors, including:

- The child's age and developmental stage
- The child's perception of the danger faced
- Whether the child was the victim or a witness
- The child's relationship to the victim or perpetrator
- The child's past experience with trauma
- The adversities the child faces in the aftermath of the trauma
- The presence/availability of adults who can offer help and protection

Effects of trauma

When trauma is associated with the failure of those who are charged with protecting and nurturing the child, it can have profound, multifaceted, and far-reaching effects on multiple aspects of a child's development and functioning. Children who have experienced the types of trauma that precipitate entry into the child welfare system typically suffer impairments in many areas of development and functioning, including:

- ***Attachment:*** Children who have experienced trauma often feel that the world is uncertain and unpredictable. Their relationships can be characterized by problems with boundaries and trust. As a result, these children can become socially isolated and can have difficulty relating to and empathizing with others.
- ***Biology:*** Children impacted by trauma may experience changes in brain chemistry and structure as well as higher levels of stress hormones. They may show hypersensitivity to physical contact. Many of these children exhibit unexplained physical symptoms and increased medical problems.
- ***Mood regulation:*** Children exposed to trauma can have difficulty regulating their emotions, as well as difficulty understanding and describing their feelings and

internal states. They may struggle to communicate their wishes and desires to others. Irritability, mood swings, anger, anxiety, and depressed mood are common.

- ***Dissociation:*** Some children impacted by trauma experience a feeling of detachment or depersonalization, as if they are "observing" something happening to them that is unreal. They can also demonstrate an amnesia-like state.
- ***Behavioral control:*** Children exposed to trauma can demonstrate poor impulse control, self-destructive behavior, and aggression towards others. Sleep disturbances and eating disorders can also be manifestations of child traumatic stress.
- ***Cognition:*** Trauma can lead to problems focusing on and completing tasks in school, as well as difficulty planning for and anticipating future events. Children who have experienced complex trauma can have distorted beliefs about the trauma (e.g., blaming themselves or believing the world is no longer safe). Some of these children demonstrate learning difficulties and problems with language development.
- ***Self-concept:*** Children exposed to trauma may lack a continuous, predictable sense of self. They can suffer from disturbances of body image, low self-esteem, shame, and guilt.
- ***Development:*** Trauma can disrupt developmental processes and interfere with the mastery of age-appropriate tasks and skills.

Trauma and Overwhelming Emotion

Trauma can elicit such intense fear, anger, shame, and helplessness that the child feels overwhelmed. Overwhelming emotion may interfere with the development of age-appropriate self-regulation. Emotions experienced prior to language development may be very real for the child, but difficult to express or communicate verbally. Trauma may be "stored" in the body in the form of physical tension or health complaints.

Overwhelming emotion and behavior

Trauma-exposed children may also exhibit over-controlled behavior in an unconscious attempt to counteract feelings of helplessness, and impotence may manifest as difficulty transitioning and changing routines, rigid behavioral patterns, repetitive behaviors, etc. At the other extreme, due to cognitive delays or deficits, some children who have experienced trauma display under-controlled behavior in terms of planning, organizing, delaying gratification, and exerting control over their behavior. This may manifest as impulsivity, disorganization, aggression, or other acting-out behaviors.

Trauma-exposed children's maladaptive coping strategies can lead to behaviors that undermine healthy relationships and may disrupt foster placements, including:

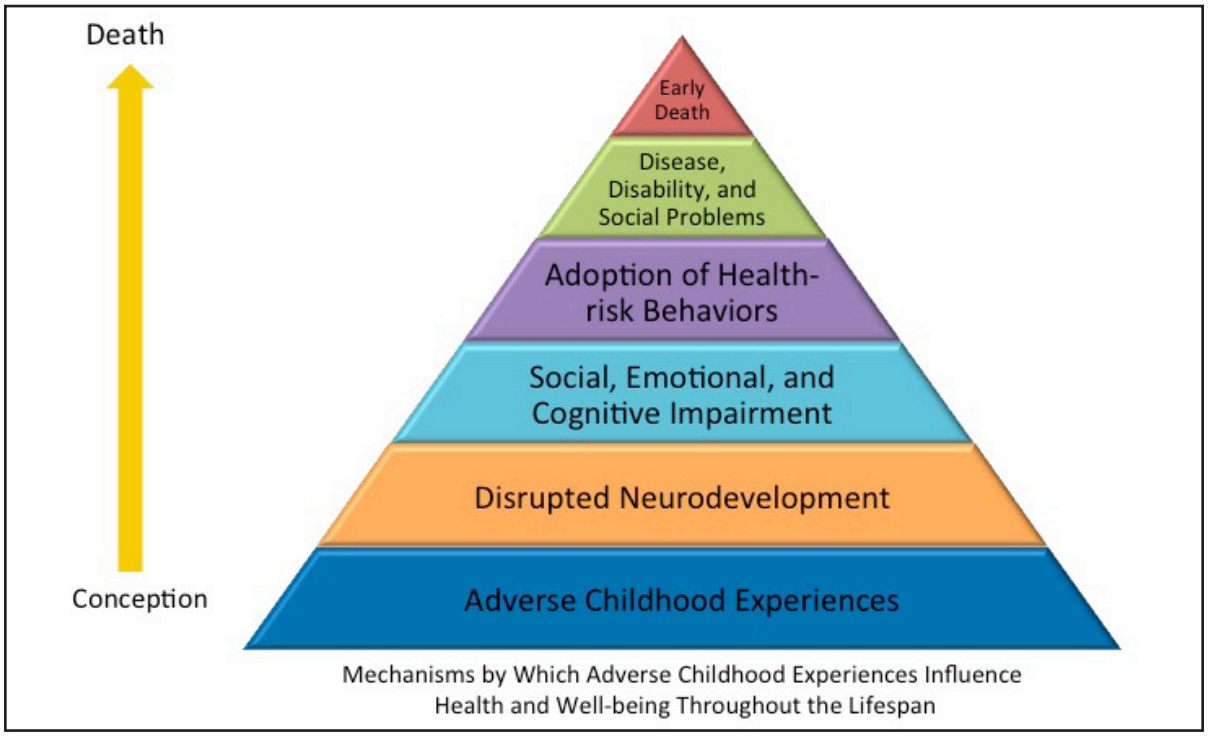
- Sleeping, eating, or elimination problems
- High activity levels, irritability, or acting out
- Emotional detachment, unresponsiveness, distance, or numbness
- Hypervigilance, or feeling that danger is present even when it is not
- Increased mental health issues (e.g., depression, anxiety)
- An unexpected and exaggerated response when told "no"

Long-term effects of trauma

In the absence of more positive coping strategies, these disruptions to the child's sense of safety, permanency, and well-being can foster a range of high-risk or destructive coping behaviors, ranging from reckless behavior to substance abuse, smoking, running away, eating disorders, sexual acting out, and self-mutilation. Not surprisingly, the experience of childhood trauma is also a known risk factor for many serious adult mental and physical health problems:

- A national study of adult "foster care alumni" found higher rates of post-traumatic stress disorder (PTSD) (21.5%) compared with the general population (4.5%). Interestingly, the foster care alumni group had higher rates of PTSD than American veterans of war (15% in Vietnam vets; 6% in Afghanistan vets; and 12% to 13% in Iraq vets). The foster care alumni group also had higher rates of major depressive episodes, social phobia, panic disorder, generalized anxiety, addiction, and bulimia (Pecora et al., 2003).
- By the age of 17, 62% of youth in foster care will exhibit both the symptoms of a mental health disorder and the symptoms of trauma (Griffin et al., 2012).
- **Adverse Childhood Experiences**, including abuse (emotional, physical, and sexual), neglect (emotional and physical) and household dysfunction (mother treated violently, household substance abuse, household mental illness, parental separation/divorce, and incarcerated household member), have been linked to high-risk health behaviors and a wide range of social problems and health disorders (Felitti et al., 1998). Adults who experienced multiple adverse childhood experiences (ACEs), are more likely to develop health risk behaviors such as alcoholism, drug abuse, depression, suicide attempts, smoking, physical inactivity, severe obesity, having over 50 sexual intercourse partners, and contracting sexually transmitted disease. The number of adverse childhood experiences

showed a graded relationship to the presence of adult diseases including heart disease, cancer, chronic lung disease, skeletal fractures, and liver disease (Felitti et al., 1998). More recent analyses of the ACEs data has suggested that ACEs may be an indicator of a chaotic family environment that results in an increased risk of premature death among family members (Anda et al., 2009). See the ACE Pyramid below for a visual depiction of the effects of adverse childhood experiences.



(*http://www.cdc.gov/ace*)

Childhood trauma and PTSD

Children who have experienced chronic or complex trauma may be diagnosed with post-traumatic stress disorder (PTSD). According to the American Psychiatric Association, PTSD may be diagnosed in children who have:

- Experienced, witnessed, or been confronted with one or more events that involved real or threatened death or serious injury to their own physical integrity or that of others
- Responded to these events by experiencing symptoms of PTSD

(American Psychiatric Association, 2013)

Key symptoms of PTSD include:

- Negative changes in thoughts and mood (e.g. inability to recall aspects of the trauma, feelings of fear, guilt, sadness, shame or confusion, loss of interest in activities)
- Intense psychological or physiological reactions to internal or external cues that symbolize or resemble some aspect of the original trauma
- Avoidance of thoughts, feelings, places, and people associated with the trauma
- Emotional numbing (e.g., detachment, estrangement, loss of interest in activities)
- Increased arousal (e.g., heightened startle response, sleep disorders, irritability)

(American Psychiatric Association, 2000)

Many children show signs of post-traumatic stress but do not meet the full diagnostic criteria for PTSD.

Childhood trauma and other diagnoses

Children in the child welfare system have been diagnosed with many different mental health diagnoses. The most common of these include attention deficit hyperactivity disorder, oppositional defiant disorder, conduct disorder, bipolar disorder, and reactive attachment disorder.

These diagnoses generally do not capture the full extent of the developmental impact of trauma. The symptoms leading to these diagnoses may in fact be a child's reaction to a trauma reminder, which can result in withdrawn, aggressive, reckless, or self-injurious behaviors.

Many children with these diagnoses have a complex trauma history. While some children who have experienced trauma may also have co-occurring mental disorders, it is important to consider trauma as a possible source for many symptoms and behaviors. For example, poor attention due to intrusive trauma-related thoughts may look like attention deficit hyperactivity behavior, and trauma-related mood regulation problems may look like bipolar disorder. Misdiagnosis can lead to inappropriate or ineffective treatment approaches, including misuse of psychotropic medications.

Trauma and psychotropic medication among children in the child welfare system

A psychotropic medication is one prescribed to help people who are experiencing a mental health disorder, such as depression, anxiety, conduct disorder, or attention-deficit hyperactivity disorder, as described in the *Diagnostic and Statistic Manual of Mental Health Disorders* (DSM-IV, American Psychiatric Association, 2000). Psychotropic medications serve to provide symptom relief for psychiatric conditions that have medication targets, improve functioning by relieving symptoms, and reduce high-risk symptoms (e.g., suicidality, psychosis). If the medication works, the individual is better able to engage in other interventions.

Psychotropic medication prescriptions for children and adolescents have risen two- to threefold in the past decade. There are increased rates of psychotropic use with young children, especially those in foster care (U.S. Government Accountability Office, 2011). As 40% to 60% of children in the child welfare system are reported to meet the criteria for at least one DSM-IV disorder, they are at higher risk for over-prescription of psychotropic medications (Landsverk, Garland, & Leslie, 2002). Rates of psychotropic medication use among children in the child welfare system are higher when compared to the general population, especially among older children, boys, those with behavior problems, and children in group homes (Raghavan et al., 2005). Because of their complex symptom presentations, children in child welfare may be at greater risk of using multiple concurrent psychotropic medications with the potential for adverse effects (side effects, drug interactions, alterations in metabolism and nervous system development), despite lack of evidence that polypharmacy is effective (Raghavan & McMillen, 2008). Traumatic events often cause or exacerbate symptoms leading to mental health diagnoses and psychopharmacology, and yet treatment frequently fails to address the underlying trauma. Other potential complications of medicating children and adolescents include compliance issues and substance abuse.

The impact of traumatic stress on behavior

Trauma-exposed children encountered in the child welfare system exhibit a range of complex emotional and behavioral responses to the events they have experienced. When working with a child in the child welfare system, it is important to be sensitive to the ways in which a child's trauma history affects his/her current behavior.

The behavior of a child exposed to trauma can be a reflection of his/her efforts to adapt to overwhelming stress. For example, a child may reenact aspects of his/her trauma (e.g., aggression, self-injurious behaviors, or sexualized behaviors) in response to a reminder of a previous traumatic event, or as an attempt to gain mastery or control over his/her experiences.

A trauma reminder is any person, place, situation, sensation, feeling, or thing that reminds a child of a previously experienced traumatic event. When faced with these reminders, a child may reexperience the intense and disturbing feelings tied to the original trauma. These trauma reminders can lead to behaviors that seem out of place in the current situation but were appropriate—and perhaps even helpful—at the time of the original traumatic event. For example:

- A seven-year-old boy who witnessed his father physically abusing his brother becomes frantic and tries to separate classmates who are playfully wrestling in the schoolyard.
- A three-year-old girl who witnessed her father beating her mother clings to her resource mother and cries hysterically when her resource parents have a mild dispute in front of her.

- An eight-year-old boy whose father physically abused him is tapped on the shoulder by a boy behind him in line and responds by turning and raising his fists.
- A teenager who was sexually abused by her stepfather refuses to go to gym class after meeting the new coach, who wears the same cologne as her stepfather.

When faced with a trauma reminder, a child with a history of trauma may feel frightened, angry, or shut down. The child's heart may pound or the child may freeze in his/her tracks, just as one might do when confronting an immediate danger.

Sometimes a child is aware of his/her reaction and its connection to the traumatic situation. Often the child is unaware of the root cause of his/her feelings and behaviors. The child may also exhibit increased behavioral problems as a way of coping with trauma and traumatic stress. For instance, in the absence of more adaptive coping strategies, a trauma-exposed child or adolescent may use drugs and/or alcohol in order to avoid experiencing overwhelming emotions. Similarly, in the absence of appropriate boundaries and interpersonal skills, a sexually abused child may revert to sexual behaviors with others because that is the only way he/she has ever experienced any degree of acceptance or intimacy.

Chronic childhood trauma is associated with two seemingly very different behavior patterns: over- and under-controlled behavior. Over-controlled behavior may counteract the feelings of helplessness and impotence that can pose a daily struggle for a chronically traumatized child. Such a child may be very resistant to changes in routine and display rigid behavioral patterns. Under-controlled or impulsive behaviors may be due in part to cognitive deficits including difficulty in planning and organizing, delaying gratification, and exerting control over behavior. These deficits can lead to an increase in impulsive responses, such as aggression.

Neglect, in particular, has been associated with the following emotional and behavioral responses:

- Lack of self-worth and efficacy
- Increased stress and anxiety
- Lower levels of emotional understanding and emotional regulation, which can impair the development of interpersonal relationships
- Increased risk for the development of anxiety, depression, PTSD, and physical symptoms
- Higher number of trauma exposures across the lifespan

(Hildyard & Wolfe, 2002)

A child who has been traumatized through maltreatment within his/her caregiving system can present a complicated array of behaviors. Some common responses reported by child welfare workers and resource parents include:

- Frequent sleeping, eating, and elimination problems
- High activity levels, irritability, and acting out, which can become problematic in a new foster home
- Regression in development and the need for more physical attention than expected among children their age
- Detachment, emotional distancing, numbness, and unresponsiveness to caregivers' attempts to develop a relationship
- Feeling that danger is present even when placed in a secure setting

(Kerker & Dore, 2006)

All of these factors may endanger a placement when the child's behavior overwhelms or confuses a resource parent to the point of feeling inadequate and hopeless.

Core Concepts for Understanding Traumatic Stress Responses in Childhood

In conclusion, the following 11 concepts should be kept in mind when trying to understand traumatic stress responses in childhood:

1. Traumatic experiences are inherently complex.
2. Trauma occurs within a broad context that includes children's personal characteristics, life experiences, and current circumstances.
3. Traumatic events often generate secondary adversities, life changes, and distressing reminders in children's daily lives.
4. Children can exhibit a wide range of reactions to trauma and loss.
5. Danger and safety are core concerns in the lives of traumatized children.
6. Traumatic experiences affect the family and broader caregiving systems.
7. Protective and promotive factors can reduce the adverse impact of trauma.
8. Trauma and post-trauma adversities can strongly influence development.
9. Developmental neurobiology underlies children's reactions to traumatic experiences.

10. Culture is closely interwoven with traumatic experiences, response, and recovery.
11. Challenges to the social contract, including legal and ethical issues, affect trauma response and recovery.

(Layne et al., 2011)

What can a child welfare worker do?

- Understand that children can react to trauma in different ways.
- View children's reactions and behaviors through a trauma lens and help other service providers and caregivers to do the same.
- Refer appropriate children for trauma treatment to reduce long-term impacts.
- Advocate for a second opinion if you are concerned that a child is being overly or unnecessarily medicated.
- Assure that medications are only used as part of a comprehensive treatment plan.

The Impact of Traumatic Stress on Brain Development

To understand how trauma affects a child's brain development, it is important to understand that the child's brain is always evolving and growing and is shaped by experience and stimulation. The prenatal brain has 2-3 times the number of neurons as the adult brain. The maximum number of neurons a person will have in a lifetime is present at birth. The brain's growth (size and weight) over the first years of life varies depending on myelination (the process that allows nerve impulses to move more quickly) and increases in synaptic connections (how nerve cells communicate with other cells). Growth is dependent on stimulation and experience. Humans have relatively few synapses present at birth. Learning requires forming new synapses as well as strengthening and discarding existing synapses. Early synapses are weak and need repeated exposure in order to strengthen. Therefore, the brain adapts to its environment, both positive and negative. Interactions with caregivers are critical to brain development.

Brain development happens from the bottom up. The most primitive part of the brain, the brainstem, develops first. This part of the brain governs basic survival functions, including breathing and eating. The prefrontal cortex, which is responsible for abstract thought, logic, factual memory, planning, and the ability to inhibit action, develops later. Exposure to trauma causes the brain to develop in a way that will help the child survive in a dangerous world: on constant alert for danger and quick to react to perceived threats (fight, flight, freeze responses). Past trauma causes the brain to interpret minor events as threatening, activating the trauma response cycle, which releases cortisol and adrenaline. These stress hormones can interfere with the development of higher brain functions (Teicher, 2002) and lead to impulsive reactions. Children and adolescents who have experienced trauma show changes in the levels of these stress hormones similar to changes found among combat veterans. A concern is that these changes may affect the way trauma-exposed children and adolescents respond to future stress in their lives, and influence long-term health (Pynoos, Steinberg, Ornitz, & Goenjian, 1997).

Early trauma may lead to atypical development of the hypothalamic-pituitary-adrenal (HPA) axis stress response, which predisposes the child to psychiatric vulnerability later in life (van Goozen & Fairchild, 2008). There are structural brain differences between children who have been maltreated and those who have not. For example, maltreated children present with a smaller corpus callosum (the brain structure that controls communication between hemispheres related to arousal, emotion, and higher cognitive abilities), and adults who were maltreated as children show reduced volume of the hippocampus, which plays a central role in learning and memory.

It is important to adopt a developmental perspective when understanding the impact of traumatic stress on brain development.

- In early childhood, trauma can be associated with reduced size of the cortex, the ability of brain hemispheres to connect (cross-talk), and the functioning of regions of the brain that govern emotions. These changes can affect IQ and the use of thinking to regulate emotions, and lead to increased fearfulness and a reduced sense of safety and protection. Young children can be impacted by trauma through implicit or explicit memory. For example, babies can perceive their environment and retain unconscious memories (e.g., recognizing mother's voice) prior to language development. Explicit, or conscious, memories can be created around age two, when toddlers are able to use language to encode their experiences. Children with early trauma often retain implicit memories of abuse; they carry memories of being distressed and dysregulated. Physical or emotional sensations can trigger these memories, causing flashbacks, nightmares, or other distressing reactions (Applegate & Shapiro, 2005).

- During the school-age years, the brain develops a greater ability to manage fears, anxieties, and aggression; to sustain attention for learning; to allow for better impulse control; and to manage physical responses to danger that allow a child to consider and take protective actions. Trauma that occurs during this period can undermine these developing capacities of the brain and result in major sleep disturbances, new difficulties in learning, impeded ability to control startle reactions, and behavior that alternates between overly fearful and aggressive.
- The brain continues to develop in adolescence and young adulthood, providing increased vulnerability but also a window of opportunity to make new connections based on experiences. Throughout adolescence, the maturing brain allows for improved consideration of the consequences of behavior, more realistic appraisals of danger and safety, enhanced ability to govern daily behavior to meet longer-term goals, and increased use of abstract thinking for academic learning and problem-solving. However, changes in dopamine levels during adolescence lead to risk-taking behavior (Spear, 2010). Trauma, by interfering in this stage of brain development, can result in reckless risk-taking behavior (including substance abuse and running away), underachievement and school failure, and making poor decisions (American Bar Association, January 2004). With adult support, adolescents can learn self-regulation, coping skills, and mastery by taking appropriate risks.

What can a child welfare worker do?

- Consider the impact of trauma on the child's developing brain based on the age of trauma exposure.
- Recognize that children's "bad" behavior is sometimes an adaptation to trauma and may be related to altered physiology.
- Remember that young children can store trauma memories in their bodies and can be highly impacted by trauma even when they cannot talk about the traumatic event.
- Due to neuroplasticity, the brain can change in response to repeated stimulation. This suggests that early intervention, treatment, and positive caregiving can help repair some of the negative impacts of trauma. Assure that all of these are a part of the child's plan.

Signs and Symptoms of Child Traumatic Stress by Developmental Stage

Young children

In response to trauma, young children may become passive, quiet, and easily alarmed. They can become more generally clingy and fearful, especially in regard to separations and new situations. Infants and toddlers may show changes in sleep, eating, and behavior patterns in reaction to trauma. In circumstances of abuse by a parent or caretaker, young children may act confused as to where to find protection and what constitutes threat. These children may overreact to very general reminders, like the sound of another child crying. The effects of fear can quickly get in the way of recent learning. For example, a child may start wetting the bed again or go back to baby-talk following a traumatic event or traumatic reminder. Preschool children may have very strong startle reactions, night terrors, and aggressive outbursts. It is important to remember that, although they may not be able to tell you about their traumatic experiences, children are affected by trauma even at a very young age.

Trauma and attachment

All development occurs in the context of attachment. Healthy or secure attachment supports affect regulation, provides a foundation for trust and safety, and increases a child's sense of self-worth and competence. The sensitive period for attachment is the first two years of life. There are four primary attachment classifications:

- Secure: The child uses the caregiver as a secure base for exploration, and the caregiver responds appropriately, promptly, and consistently to the child's needs.
- Insecure/Avoidant: The child shows little emotion or affection toward the caregiver, and the caregiver does not respond to the child when he/she is upset.
- Insecure/Resistant: The child is ambivalent toward the caregiver, seeking comfort but also pushing the caregiver away. The caregiver responds inconsistently to the child (sometimes attentive and sometimes neglectful).
- Disorganized: The child shows contradictory or disoriented behavior, and the caregiver displays frightening, frightened, intrusive, and or withdrawn behavior toward the child.

Trauma can inhibit secure attachment. Disorganized attachments occur when a child does not have a consistent pattern of interacting with a caregiver. Common signs of disorganized attachment include unusual behaviors that represent confused and/or fearful responses. In interacting with a caregiver, a child with disorganized attachment may display contradictory, fearful, or disoriented behaviors (Smyke & Potter, 2011). Attachment classification is relationship specific. A child's relationship with an attachment figure mediates the child's

response to a trauma. A young child with supportive, nurturing, and responsive caregivers is more likely to be resilient following a trauma. Oftentimes, the caregivers' responses to the trauma influence how the child perceives the trauma. A child has more positive outcomes when his/her caregivers have fewer symptoms and are able to be emotionally available (Laor, Wolmer, & Cohen, 2001; Kliewer et al., 2001). When there is interpersonal trauma, a child and his/her caregivers may serve as traumatic reminders for one another. Thus, treatment may be required, as the person the child previously experienced as a secure base now serves as a trauma reminder or even a source of threat.

There are multiple challenges to attachment formation in the child welfare system. Attachment may be disrupted when a young child is separated from a parent, especially when the separation is sudden and associated with major change and loss. Young children who are involved in the child welfare system often have multiple caregivers and numerous disruptions in caregiving, some of which may be sudden. These changes often disrupt the child's routines and schedules.

A child may have difficulty forming healthy attachment to a resource parent due to:

- Divided loyalties
- The child's behavior (e.g., rejecting, detached), which may confuse the resource parent
- The resource parent not encouraging attachment
- Disrupted placements where each disruption may make it harder for the child to attach to new caregiver

Trauma and developmental delays

Studies indicate that developmental delays are extremely common among children in out-of-home care, with 50% of children (according to the National Survey of Child and Adolescent Well-Being) exhibiting developmental delays in such areas as cognitive function, gross and fine motor skills, speech and language, sensory development, and emotional/behavioral regulation (Stahmer et al., 2005). Developmental screenings are therefore needed for all young children in the child welfare system.

School-age children

School-age children who are exposed to trauma often experience unwanted and intrusive thoughts and images related to the traumatic event. School-age children may be preoccupied with frightening memories of the trauma, thoughts of what they could have done to prevent the traumatic event from happening, and/or thoughts of revenge. School-age children may respond to stimuli that remind them of the trauma (e.g., someone with the same hairstyle

as an abuser, or the play structure on a playground where a child got shot), and may develop intense, specific new fears that link back to the original danger. These children can easily fear a recurrence of the trauma that results in avoiding previously pleasurable activities. More than at any other development age, school-age children may shift between shy or withdrawn behavior and unusually aggressive behavior. Normal sleep patterns can be disturbed, and lack of restful sleep can interfere with daytime concentration and attention.

Adolescents

Adolescents can be particularly challenged by their traumatic stress reactions. They may interpret these reactions as signs of "going crazy," being weak, or being different from everyone else. Adolescents may be embarrassed by bouts of fear and exaggerated physical responses. They may believe that they are unique in their pain and suffering, resulting in a sense of personal isolation. Adolescents may also be very sensitive to the failure of their family, school, or community to protect or carry out justice. After a traumatic event, they may turn even more to peers to evaluate risks and to support and protect them. Adolescent behavior in response to traumatic reminders can go to either of two extremes: reckless behavior that endangers themselves and others or extreme avoidant behavior that can derail the adolescents' teenage years. Adolescents may attempt to avoid overwhelming emotions and physical responses through the use of alcohol and drugs. Reminders of past trauma may elicit cravings for drugs or alcohol. Substance abuse further impairs their ability to cope with distressing and traumatic events and increases the risk of engaging in risky activities that could lead to additional trauma.

Specific adolescent groups

Homeless youth are at greater risk for experiencing trauma than other adolescents. Many have run away to escape recurrent physical, sexual, and/or emotional abuse. Female homeless teens are particularly at risk for sexual trauma (Whitbeck, Hoyt, & Yoder, 1999).

Special needs adolescents are two to 10 times more likely to be abused than their typically developing counterparts (Sullivan & Knutson, 2000).

Lesbian, gay, bisexual, transgender, or questioning (LGBTQ) adolescents contend with violence directed at them in response to suspicion about or declaration of their sexual orientation and gender identity (Kosciw, Greytak, Bartkiewicz, Boesen, & Palmer, 2012).

HIV-positive youth experience high rates of traumatic stress. Research indicates that receiving a positive HIV diagnosis is additionally traumatic for most of them (Radcliffe et al., 2007). This may impact participation in medical care.

Multi-system or crossover youth

Multi-system youth are involved in both the child welfare system and the juvenile justice system. Although there are several different pathways for multi-system involvement, most crossover youth start out in the child welfare system and then enter the juvenile justice system after engaging in delinquent behavior. Risk factors for delinquency include: physical abuse (Maas, Herrenkohl, & Sousa, 2008), neglect (Jonson-Reid & Barth, 2000; Smith, Ireland, & Thornberry, 2005), maltreatment starting or lasting into adolescence (Smith, Ireland, & Thornberry, 2005), group home placement (Ryan, Marshall, Herz, & Hernandez, 2008), and placement instability (Widom & Maxfield, 2001).

There are a disproportionate number of children of color in the crossover population compared to the general population, child welfare population, and juvenile justice population. There are a higher number of females in the crossover population compared to the general delinquency population. Crossover youth experience prevalent educational (including special education), mental health, and substance abuse problems (Herz et al., 2012). Many multi-system youth are in foster care for long periods of time, and are at risk of falling through the cracks due to lack of cross-system communication in case planning. Consequent outcomes include recidivism, adult criminal justice involvement, mental health and substance abuse problems, and need for public assistance (Culhane et al., 2011).

Protective factors that can prevent child welfare youth from crossing over to delinquency include positive attachments to others and safe school environments (Ryan, Testa, & Zhai, 2008; Crooks, Scott, Wolf, Chiodo, & Killip, 2007; Benda & Corwyn, 2002).

Transitional-aged youth

Transitional-aged youth are described as those aged 16-24 who are transitioning or aging out of foster care. These youth are often on their own; they have been in care for many years and lack stable, supportive families. As a result, many transitional-aged youth do not have the support and skills needed to succeed independently as adults. They experience high rates of mental health (including PTSD) and substance abuse problems, homelessness, unemployment, and crime (Courtney, Hook & Lee, 2010). Many foster care alumni (20%) still lack a high school diploma or GED by age 25. This is likely related to the fact that they have experienced multiple school changes while in care (Courtney et al., 2011). One-third are living below the poverty level and lack health insurance (Pecora et al., 2005). Many transitional-aged youth continue to suffer from trauma-related symptoms into adulthood, despite having received therapy while in care (Pecora et al., 2005). This suggests that the mental health services available to youth in foster care are not always effective in addressing their trauma issues.

What can a child welfare worker do?

- Recognize the signs and symptoms of child traumatic stress and how they vary in different age groups.
- Recognize that child welfare system interventions have the potential to either exacerbate or lessen the impact of previous traumas.
- Decrease the risk of system-induced secondary trauma by serving as a protective and stress-reducing buffer for children:
  - Develop trust with children through listening, frequent contacts, and honesty in order to mitigate previous traumatic stress.
  - Avoid repeated interviews, especially about experiences of sexual abuse.
  - Avoid making professional promises that, if unfulfilled, are likely to increase traumatization.
- Understand the impact of trauma on different developmental domains and attachment formation.
- Understand the cumulative effect of trauma.
- Ensure developmental screening for young children to identify potential trauma-related developmental challenges and need for further evaluation and/or services.
- Carefully consider the potential developmental risks to young children when making the decision to remove or change placement.
- Try to avoid placement changes for children between 6-24 months of age, when safely possible, since this is when attachment is being consolidated.
- Plan transitions well to allow young children to preserve memories and maintain routines.
- Gather and document psychosocial and medical information regarding all traumas in the child's life to make better-informed decisions.
- Educate resource parents about the impact of trauma on children of different ages and ask them about reactions and behaviors that could be trauma-related.

The Influence of Culture on Trauma

Culture is defined as a set of beliefs, attitudes, values, and standards of behavior passed from one generation to the next; this can include different notions about wellness, healing techniques, and child-rearing patterns (Abney, 1996). Cultural identity and cultural references can be influential in shaping the ways in which children identify the threat posed by traumatic events, interpret them, and manifest distress.

Some components of trauma response are common across diverse cultural backgrounds. Other components vary by culture. The necessity to respond to trauma is universal in terms of physiological (alterations in brain functioning) and social responses (universal tendency to seek healing or reparation after trauma). However, a child's experience of trauma may vary depending on his or her culture. For example, shame is a culturally universal response to child sexual abuse, but the victim's experience of shame and the way it is handled by others (including family and community members) varies in different cultures.

Rates of exposure to different types of trauma—including family, community, war, and political violence—vary across ethnic and cultural groups. Thus, people of different cultural, national, linguistic, spiritual, and ethnic backgrounds define trauma in many different ways and use different expressions to describe their experiences (e.g., visions, *ataque de nervios*, or spirit possession).

Many children who enter the child welfare system are from racial minority or cultural groups that experience prejudice, discrimination, negative stereotyping, poverty, and high rates of exposure to community violence. It is important to understand that such social and cultural realities can influence a child's risk for, and experience of, trauma. The responses and resilience of a child, his/her family, and his/her community to child traumatic stress are also affected by their respective socioeconomic and cultural realities. Strong cultural identity, and family and community connections, can contribute to strength and resilience in the face of trauma.

The cultural background of a child welfare worker can also influence his or her perceptions of child traumatic stress and how to intervene. Assessment of a child's trauma history should always take into account the cultural background and modes of communication of both the assessor and the family. When working with a family from a different cultural background, child welfare workers must understand that even speaking about child maltreatment or sexual issues is taboo in some cultures.

Psychological symptoms may also be expressed differently in different cultures. This becomes important when considering how to intervene with a trauma-exposed child, especially in determining whether individual or family therapy is appropriate.

Also, it is important to understand that if a child enters out-of-home placement and is a member of a racial or cultural group that experiences prejudice, discrimination, or negative stereotypes, he/she needs a foster or adoptive family that understands his/her culture and will help support the child's cultural identity. When kinship placement is not an option, a family with specialized knowledge, resources, skills, and capacities is needed to help the child address any losses of racial, cultural, and family-of-origin identity, and to cope with social and familial acceptance of birth status and racial origin. Whenever possible, the child's feelings and/or perceptions about living with a family (either temporarily or permanently) of a different race or culture should be considered along with the impact of those feelings on the understanding and experience of the traumatic event.

Racial disparity and disproportionality

Racial disparity refers to racial differences in children's or families' experiences with the child welfare system and their access to care, service utilization, or quality of care. Racial disproportionality refers to the over-representation of children of color in foster care, and differences in outcomes such as longer stays in out-of-home care and lower rates of reunification and adoption (American Public Human Services Association, 2010). For example:

- African-American and American Indian/Alaskan Native (AI/AN) children are three times more likely to be in foster care compared to Caucasian children.
- Latino/Hispanic children are overrepresented in the child welfare system in 10 states.
- African-American children stay in foster care for an average of nine months longer than their Caucasian counterparts.

(McRoy, 2008)

Child welfare professionals need to be aware of racial disparities and disproportionality and do their part to ensure that all families have access to needed services, including high-quality preventive services and family support services.

Trauma and immigration

Immigration is a process that includes the initial decision to migrate, the process of migration, and acclimatization to the new country (Pérez-Foster, 2005). A family may experience perimigration trauma (Pérez-Foster, 2005), which is psychological distress that can occur at four different points during the migration process: events before migration (e.g., extreme poverty, war exposure, torture); events during migration (e.g., parental separation, physical and sexual assault, theft of the money they saved to immigrate with, exploitation at the hands of human smugglers, hunger, death of traveling companions); continued rejection and suffering while seeking asylum (e.g., chronic deprivation of basic needs); and survival

as an immigrant (e.g., substandard living conditions, lack of sufficient income, racism). Therefore, many immigrant children and families are exposed to traumatic events due to migration and are at risk for PTSD. Sources of stress for immigrant families include:

- Traumatic and stressful events (including family separation) during the migration process
- Post-migration/resettlement stress
- Acculturation stress (the stress of adapting to a new culture, which can be accentuated in families when family members adapt at different rates)
- Deportation and fear of deportation
- Domestic violence
- Poverty
- Social marginalization/isolation
- Inadequate housing
- Changes in family structure and functioning

(Cohen, 2010)

Refugee families and trauma

The United States provides a safe haven to tens of thousands of refugees each year who are fleeing armed conflict, instability, and related risks such as hunger and deprivation. Refugee families face significant acculturation challenges, often compounded by traumatic stress associated with torture, rape, and other atrocities. Traumatic experiences in the country of origin may include:

- Violence (as witnesses, victims, and perpetrators)
- Ethnic cleansing
- Historical trauma
- War
- Lack of food, water, and shelter
- Physical injuries, infection, and disease
- Torture
- Forced labor
- Sexual assault

- Lack of medical care
- Loss of loved ones

(National Child Traumatic Stress Network, Refugee Collaborative Group, 2012)

During displacement, families may experience additional stressors, including: living in refugee camps, separation from family, loss of community, loss of language, loss of professional and socio-economic status, uncertainty about the future, harassment by local authorities, traveling long distances by foot, detention, or human trafficking for purposes of sexual or labor exploitation (NCTSN, Refugee Collaborative Group, 2012).

Cultural trauma

Cultural trauma is an attack on the fabric of a society, affecting the essence of the community and its members. The impact of this kind of trauma can be felt across generations; when trauma is not resolved, it is subsequently internalized and passed from one generation to the next (Brave Heart-Jordan, 1995; Brave Heart, 2000). Cultural trauma can create a legacy of poverty, poor mental and physical health, and a pervasive sense of hopelessness. This legacy can be perpetuated by ongoing racism, prejudice, discrimination, and health disparities.

Historical trauma

Historical trauma is a type of cultural trauma that can be defined as the collective and cumulative emotional wounding across generations that results from massive cataclysmic events—Historically Traumatic Events (HTE), including slavery, removal from homelands, ethnic cleansing, and genocide. Historical trauma involves cumulative exposure to traumatic events that not only affects an individual, but continues to affect subsequent generations. The trauma creates psychological injury that is held personally and transmitted over generations. Thus, even family members who have not directly experienced the trauma can feel the effects of the event generations later.

Historical trauma involves multiple losses, including loss of land, language, culture, traditional spiritual ways, and family ties. Emotional responses to these losses may include sadness, depression, anger, anxiety, shame, fear, and distrust (Whitbeck et al., 2004).

The Indian Child Welfare Act (ICWA)

The Indian Child Welfare Act is a federal law that was passed in 1978 to "protect the best interests of Indian children and to promote the stability and security of Indian tribes and families" (25 U.S.C. § 1902). It provides minimum federal standards for the removal and placement of American Indian children in foster or adoptive homes. It regulates states regarding the handling of child abuse and neglect, as well as adoption cases involving American

Indian children, and affirms and supports tribal jurisdiction in child welfare proceedings. It stipulates that foster care placements for American Indian children should be in this order of preference: with a member of the child's extended family; in a foster home that is licensed, approved or specified by the child's tribe; in an Indian foster home licensed or approved by an authorized non-Indian licensing authority (such as the state or a private licensing agency); or in an institution for children approved by an Indian tribe or operated by an Indian organization, and which has a program suitable to meet the child's needs. When parental rights have been terminated or relinquished, preferred adoptive placements are with a member of the child's extended family, with other members of the child's tribe, or with another Indian family.

What can a child welfare worker do regarding culture and trauma?

- Understand that social and cultural realities can influence a child's risk for, experience of, and recovery from trauma.
- Recognize that strong cultural identity can also contribute to the resilience of a child, his/her family, and his/her community.
- Assess for historical trauma: ask about traumas and losses experienced by family members and ancestors and their impact on the child and family.
- Assess for traumatic events that may have occurred in the family's country of origin and during the immigration process.
- Work with qualified interpreters, and allow the family to choose to have an in-person or telephone interpreter based on their preference.
- When working with a refugee family, assess for core stressors: traumatic stress, resettlement stress, acculturation stress, and isolation stress.
- Utilize the Refugee Services Toolkit: *http://learn.nctsn.org/course/view.php?id=62*.
- Seek information about different cultural and refugee populations:
  - *http://www.cal.org/*
  - *http://www.brycs.org/*
- Make a special effort to integrate cultural practices and culturally responsive mental health services.
- Ensure that referrals for therapy are made to therapists who are culturally and linguistically responsive.

- Promote protective factors from various cultures that prevent a family from needing out-of-home placement.
- When it is necessary to arrange out-of-home care, work to locate a resource family that embraces the child's cultural identity and has the knowledge, skills, and resources to help the child.
- Consider how your own knowledge, experience, and cultural frame may influence your perceptions of traumatic experiences, their impact, and your choices of intervention strategies.
- Be aware of how culturally-based parenting and intergenerational differences in acculturation impact family functioning and behavior.
- Utilize resources that the family trusts to supplement available services (e.g., bringing in a priest or healer).

Implications for Child Welfare Practice

Child welfare system interventions intended to protect children have the potential to either exacerbate or decrease the impact of previous traumatic experiences. Children who have been impacted by trauma can be extremely vulnerable to stress and may have difficulty coping with even minor everyday changes and stressors. In fact, a trauma-exposed child may have unexpected and exaggerated responses even when simply being told "no." Yet, a child in the child welfare system must not only face everyday minor stressors, but must also endure a wide range of ongoing and frequently significant stressors, such as:

- Separation from caregiver(s) and/or siblings
- Visitation
- Prolonged periods of instability
- New and changing environments
- Loss of friends
- System-related events, including forensic interviews and court testimony

The Northwest Foster Alumni Study (Pecora et al., 2003) found that child welfare agencies can help prevent child trauma and other negative mental health outcomes for a child in foster care by improving placement stability, by shortening the length of stay in care, and by reducing the number of placement moves the child experiences each year.

Developing trust with the child through listening, frequent contacts, and honesty can mitigate previous traumatic stress for him/her. As the child goes through the child welfare system, the child welfare worker has a unique opportunity to help serve as a protective and stress-reducing buffer for the child. It is important for child welfare professionals and agencies to recognize their role in helping children and families heal from trauma. The strategies included in this guide for each of the Essential Elements of a Trauma-Informed Child Welfare System suggest specific practices and policies that can be used to mitigate the impact of trauma for children and families.

The Essential Elements of a Trauma-Informed Child Welfare System

The seven Essential Elements of a Trauma-Informed Child Welfare System are designed to provide a framework for trauma-informed practice across the entire system. The Essential Elements are consistent with best practice in child welfare, and mirror well-established child welfare priorities, such as maximizing safety and enhancing child and family well-being. The following information provides a description of each of the Essential Elements and practical strategies that can be utilized by child welfare professionals and agencies to help them become more trauma-informed.

(Chadwick Trauma-Informed Systems Project, 2012, p. 12)

ESSENTIAL ELEMENT 1 – Maximize Physical and Psychological Safety for Children and Families

Why it's essential

Safety is one of the priorities of the child welfare system, but children and families who have experienced trauma may continue to feel unsafe even when they are no longer in a dangerous situation. Traumatic stress overwhelms a child's sense of safety and can lead to a variety of survival strategies for coping. After traumatic events are over, a child may continue to experience insecurity, both physically (e.g., have valid fears about their own safety or the safety of loved ones, be hyperaware of potential threats) and emotionally (e.g., have difficulty trusting adults to protect them, have problems controlling their reactions to perceived threats) (Grillo et al., 2010). Psychological safety (i.e., feeling safe, secure, and protected from danger or harm) is critical for physical and emotional growth and functioning.

Children and parents who have trauma histories may not feel safe due to trauma triggers, which elicit distress similar to what they experienced at the time of the trauma. Trauma-exposed children may engage in reenactment behaviors, including aggressive or sexualized behaviors, that are familiar and helped them survive in other relationships. These behaviors serve to prove the child's negative beliefs and expectations by evoking negative reactions in peers and caregivers, to vent frustration and anger, and to give the child a sense of mastery over the old traumas.

Parents who were maltreated as children may repeat their abuse experiences with their own children and/or may react in a defensive manner when they feel threatened. Children and parents who engage in reenactments are not consciously choosing to repeat painful relationships, but these reenactments can jeopardize their physical and emotional safety.

What you can do

Practice strategies

- Assess the child's perception of risk and develop a plan to ensure physical safety.
- Develop a safety plan contract with the child's parent(s).
- Establish protection orders (e.g., restraining order, personal protection order) to protect the child from witnessing or experiencing violence and/or abuse.
- Recommend out-of-home placement, if necessary, to establish safety.

- Help the child feel safe during key transition points (e.g., asking the birth parent to provide information about the child to the caseworker or resource parent at the time of removal, explaining to the child where he/she is going and with whom he/she will be staying).
- Recommend placement in a therapeutic setting, if necessary.
- Refer the parent(s)/family for parenting skills training, therapy, or domestic violence/substance abuse treatment as needed.
- Provide support and comfort—an island of safety—for the child.
- Listen to the child's worries and reassure the child with realistic information.
- When possible, work with caregivers and service providers to reduce the child's exposure to trauma triggers that are distressing to the child. Help the child and caregivers understand the links between trauma reminders and the overwhelming emotions the child may experience.
- Reestablish the child's sense that adults will be protective.
- Give repeated concrete clarifications about how the child will be kept safe.
- Avoid exposing the child and family to inaccurate or potentially re-traumatizing information.
- Describe in advance to the child and caregivers how the child will interact with child placement and/or legal systems.
- Promote safety by:
  - Letting children and families know what will happen next
  - Giving children control over some aspects of their lives
  - Helping children maintain connections
  - Giving a safety message

(Grillo et al., 2010)

- Help caregivers manage emotional "hot spots":
  - Food and mealtime
  - Sleep and bedtime
  - Physical boundaries

(Grillo et al., 2010)

Agency strategies

- Create policies and practices that emphasize the importance of maximizing psychological safety for children and families, especially during key transition points.
- Provide training for all staff on how to interact with children and families in a way that enhances their physical and psychological safety. This may include training on trauma triggers and reenactment behaviors to increase staff's understanding of children's and families' reactions.

2 ESSENTIAL ELEMENT 2 – Identify Trauma-Related Needs of Children and Families

Why it's essential

One of the first steps in helping individuals who have been affected by abuse, neglect, violence, and other trauma is to understand the impact of trauma on the particular child and family. **Trauma screening** is used to identify the types and duration of the traumatic events experienced by the child and family as well as the nature and severity of symptoms. It is brief, and widely administered by front-line workers such as child welfare workers. Trauma screening serves to assist workers in understanding the child's and family's history and potential triggers, to direct trauma-informed case planning, and to determine whether the child or parent may need a comprehensive trauma mental health assessment.

It is important to remember that not all children who have experienced trauma need trauma-specific treatment. Some children have amazing natural resilience and are able to overcome traumatic experiences with the help of their natural support systems such as parents, caregivers, teachers, and others.

Unfortunately, many children in the child welfare system do not have access to sufficient social support and have often been exposed to multiple traumas resulting in very complex problems. Many of these children have significant post-traumatic symptoms (e.g., intrusive thoughts about the event, hyperarousal to trauma reminders) that can have a dramatic, adverse impact on their behavior, judgment, educational performance, and ability to connect with caregivers and peers. Trauma screening helps child welfare workers identify which children and families are experiencing significant trauma reactions and need further assessment by a trauma-informed mental health provider.

Just as it is crucial to understand children's traumatic experiences and related reactions, it is also important to understand parents' trauma histories. Many parents in the child welfare system have significant histories of trauma (in childhood and adulthood) that impact their ability to protect and support their children. Conducting trauma screening with parents ensures that they are linked to services that best meet their needs, in order to enhance the safety, permanency, and well-being of the child.

A **trauma mental health assessment** is conducted by a mental health provider, and typically involves: a thorough trauma history that identifies all forms of traumatic events experienced directly or witnessed by the child, developmental history, and an assessment of potential risk behaviors (i.e., danger to self, danger to others), trauma-related emotional

and behavioral reactions, and general mental health symptoms. Proper assessment drives the development of treatment goals with measurable objectives designed to reduce the negative effects of trauma and helps determine the best treatment approach. Trauma mental health assessment should include the use of trauma-specific standardized clinical measures to assist in identifying the types and severity of symptoms the child is experiencing. Any therapist with whom the worker is contemplating a referral for a trauma-focused mental health assessment should be familiar with some common measures used in assessing trauma symptoms, such as the *UCLA PTSD Index for DSM-IV* (Steinberg, Brymer, Decker, & Pynoos, 2004) and the *Trauma Symptom Checklist for Children* (TSCC, Briere, 1996).

What you can do

Practice strategies

- Participate in training on the impact of traumatic events on individuals at different ages and in different cultural contexts.
- Identify the immediate needs and concerns of the child and family.
- Conduct a trauma screening that identifies the child's trauma history (e.g., child abuse, automobile accidents, exposure to family or community violence, painful medical procedures, or other types of traumatic experiences) and trauma reminders.
- Utilize other available resources to gain a full picture of the child's experiences and trauma symptoms. Review the child's records, conduct collateral interviews with other individuals in the child's life and, when appropriate, interview the child.
- Utilize tools such as the *Child Welfare Trauma Referral Tool* (Taylor, Steinberg & Wilson, 2006) to determine whether the child needs a referral for a trauma-specific mental health assessment and treatment, as needed.
- For children at risk of medical trauma due to developmental delays related to birth complications/prematurity, injury or illness causing severe pain or medical crisis, or life-threatening medical episodes, utilize the Medical Trauma Assessment & Action Form (Center for Pediatric Traumatic Stress, 2012; available at: *http://healthcaretoolbox.org/index.php/tools-and-resources/tools-you-can-use-assessment*).
- Conduct trauma screening with parents, using screening tools such as the Life Events Checklist (Gray, Litz, Hsu, & Lombardo, 2004; *http://www.ptsd.va.gov/PTSD/professional/pages/assessments/assessment-pdf/life-event-checklist-lec.pdf*) or the Trauma Recovery Scale (Gentry, 2006; *http://www.psychink.com/rfiles/CFScalesMeasures.pdf*).
- Communicate the results of the trauma screening (i.e., the child's trauma history and traumatic stress responses) to the team and other stakeholders. A plan

should be developed by the worker and team regarding how the results of the screening will guide decision making and planning for the safety, permanency, and well-being of the child and family.

- If a child with a history of trauma is exhibiting or reporting trauma-related reactions or difficulties, refer him or her to a trauma-informed therapist for a trauma mental health assessment.
- Interview therapists or agencies to determine which ones are best prepared to deliver therapy to children who have been impacted by trauma (see Appendix A, "Identifying Trauma-Informed Providers").
- Request assessments to evaluate the child's progress in therapy and trauma-related symptoms on a periodic basis, such as every three months.
- Gather enough additional information so that you can tailor and prioritize your interventions to match the identified needs and concerns of each individual child and family.
- Identify available resources in the community, including community agencies and providers with experience in assessing and treating trauma.

Agency strategies

- Child welfare agencies should also collect information about trauma experienced by children and their families and use this aggregate information to develop policies, supports, and other resources.
- Consider policies that promote universal trauma screening for children and families served by the child welfare system.

ESSENTIAL ELEMENT 3 – Enhance Child Well-Being and Resilience

Why it's essential

Trauma can elicit such intense fear, anger, shame, and helplessness that the child feels overwhelmed. Overwhelming emotion may delay the development of age-appropriate self-regulation. Emotions experienced prior to language development may be very real for the child, but difficult to express or communicate verbally. Trauma may be "stored" in the body in the form of physical tension or health complaints. Traumatic experience(s) may be difficult for a child to communicate, thereby undermining the child's confidence and ability to benefit from the social support he/she might receive from others. The child needs to feel safe enough to face distressing memories and associated emotions, begin to make sense out of what has happened to him/her, and express this to others. It is important for the child welfare system to recognize and build on a child's existing strengths, while also linking the child to trauma-informed services when needed.

Many children who have experienced trauma have coping abilities and social resources that can help to reduce the negative impact of traumatic events. Such protective factors include:

- Caregiver and social support
- Community involvement
- Others' belief in and validation of the child's experience
- Positive attachments and connections to emotionally supportive adults
- Positive relationships with peers
- Cognitive and emotional self-regulatory abilities
- Positive beliefs about themselves
- Positive disposition or temperament
- The ability to blame external factors, instead of internal factors or themselves, for problems
- Special talents and creativity
- Spiritual/religious beliefs
- Intelligence

(Benzies & Mychasiuk, 2009; Koball et al., 2011)

Many children are naturally resilient, and are able to get through the difficult experiences they have had and even flourish. Resilience is defined as the ability to overcome adversity and thrive in the face of risk. Neuroplasticity (i.e., the ability of the brain to rewire neural connections) allows for resilience to be developed through corrective relationships and experiences (Van der Kolk, 2006). Children who have experienced trauma can therefore develop resilience when supported by caring, safe, nurturing adults, and thrive when presented with positive new opportunities and learning experiences (Reed, 2006). Factors that can enhance resilience include:

- Supportive relationships
  - Family support
  - Having a strong relationship with at least one competent and caring adult
  - Feeling connected to a positive role model/mentor
- Peer support
- Competence
  - Having talents/abilities nurtured and appreciated
- Self-efficacy
- Self-esteem
- School and community connectedness
- Spiritual belief

(Masten, 2001; Marrow, M., Benamati, J., Decker, K., Griffin, D., and Lott, D. A. (2012). *Think trauma: A training for staff in juvenile justice residential settings.* Los Angeles, CA, and Durham, NC: National Center for Child Traumatic Stress.)

Being separated from an attachment figure, particularly under traumatic and uncertain circumstances, can be very stressful for a child. Maintaining connections to loved ones is essential for enhancing children's psychological safety and resilience. Child welfare workers can play a huge role in encouraging and promoting the positive relationships in a child's life by minimizing the extent to which these relationships are disrupted by multiple changes in placement. Therefore, both individual caseworkers and overall agency policies should support the continuity of children's relationships and minimize disruptions, so that familiar and positive figures, including parents, teachers, neighbors, siblings, and other relatives, remain involved in the child's life.

To promote well-being and resilience, all children in the child welfare system should have access to evidence-based, trauma-informed treatments and services. Ideally, children should be in a stable placement when receiving trauma-informed treatment. However, children should always be referred for necessary treatment regardless of their placement status.

Core components of trauma-focused, evidence-based treatment

The current research on treatment models for child traumatic stress suggests several common elements found in effective evidence-based trauma treatment. Child welfare staff should be able to identify these common elements in any proposed treatment plan for children presenting with primary trauma issues:

- **Building a strong therapeutic relationship:** The therapeutic relationship is considered to be core to any effective treatment modality. Research has shown that no matter which evidence-based practice a mental health provider utilizes with a client, it will not be effective if there is no therapeutic alliance established.
- **Providing psychoeducation (i.e., information on psychological principles that guide human behavior) to children and families:** Psychoeducation in trauma treatment focuses on providing information to children and their caregivers about the traumatic event experienced and common responses to trauma. This information helps to normalize children's reactions and reduce feelings of shame.
- **Parent support, conjoint therapy (when the parent and child meet together with a therapist), or parent training:** This may include incorporating the birth parent(s) and/or resource parents in treatment as appropriate. While the final decision regarding inclusion of the caregiver in treatment should be made by a well-trained mental health professional, it is helpful to include resource parents in the child's treatment, and it is often advantageous to incorporate the birth parent as well, particularly if there is an active plan for reunification.
- **Emotional expression and regulation skills:** This component includes helping children increase their ability to identify various feelings and develop coping skills for managing difficult feelings such as anger, sadness, or anxiety.
- **Anxiety management and relaxation skills:** The therapist will often work with the child to help the child develop relaxation skills to cope with trauma-related distress. This includes practices such as visualization, deep breathing exercises, progressive muscle relaxation, etc.
- **Trauma processing and integration:** A primary goal of trauma treatment is to help children integrate the trauma experience so that it is one of their many life experiences, not their defining life experience. In order to make sense of the trauma, the therapist will help the child find a way to gradually express

his/her traumatic experience and process related feelings about how the trauma has impacted the child's life. Through this process, children learn how to master the traumatic experience and trauma reminders.

- **Personal safety training and other important empowerment activities:** In order to prevent revictimization, the therapist works with the child to develop healthy boundaries and create a plan to enhance physical and psychological safety.
- **Resilience and closure:** At termination of treatment, the therapist focuses on helping the child to identify his/her strengths and areas of resilience that can be used to cope with future adversity. Treatment closure should also include helping the family prepare for and cope with reactions and trauma reminders that may occur in the future.

Unfortunately, many therapists who treat trauma-exposed children lack any specialized knowledge or training in trauma and its treatment. When a child welfare worker has a choice of providers, he or she should select a therapist who is most familiar with the available evidence and has the best training to evaluate and treat the child's symptoms. Child welfare workers can use the following questions to gauge how trauma-informed a mental health provider is:

- Do you provide trauma-specific or trauma-informed therapy? If so, how do you determine whether the child needs a trauma-specific therapy?
- How familiar are you with evidence-based treatment models designed and tested for treatment of child trauma-related symptoms?
- How do you approach therapy with children and families who have been impacted by trauma (regardless of whether they indicate or request trauma-informed treatment)?
- Describe a typical course of therapy (e.g., can you describe the core components of your treatment approach?).

For additional questions to ask mental health providers as well as information about appropriate responses, see Appendix A: Identifying Trauma-Informed Providers.

Examples of Evidence-Based Trauma Treatments

The four Evidence-Based Trauma Treatments described below were chosen because they have demonstrated the strongest research evidence to support their efficacy by the California Evidence-Based Clearinghouse for Child Welfare.

- ***Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)***

  TF-CBT (Cohen, Mannarino, & Deblinger, 2006) is short-term (12-20 sessions) therapy for children ages 3-18 who have been impacted by trauma. It is based on learning and cognitive theories. TF-CBT is designed to reduce children's negative emotional and behavioral responses and to correct maladaptive beliefs and attributions related to the abusive experiences. The intervention also aims to provide support and skills to help non-offending parents cope effectively with their own emotional distress and to respond optimally to their children.

  TF-CBT PRACTICE components

  Psychoeducation and parenting skills

  Relaxation

  Affective expression and modulation

  Cognitive coping and processing

  T rauma narrative development and processing

  I n vivo mastery of trauma reminders

  Conjoint child-parent sessions

  Enhancing future safety and development

- ***Eye Movement Desensitization Reprocessing (EMDR)***

  EMDR (Adler-Tapia & Settle, 2008) is a treatment for children (ages 2-17) based on Adaptive Information Processing (AIP) theory, which suggests that symptoms arise from maladaptively stored memories. This treatment approach helps children reprocess beliefs, emotions, and body sensations associated with the traumatic event in order to resolve trauma symptoms. The length of treatment varies, but symptom improvement is achieved in anywhere from three to 12 sessions. The EMDR therapist teaches the child self-soothing and calming skills prior to the trauma processing phase and has the child attend to traumatic material while focusing on an external stimulus (therapist directs child in bilateral eye movements, hand tapping, or audio bilateral stimulation) during the trauma processing phase.

- ***Child-Parent Psychotherapy (CPP)***

  CPP (Lieberman & Van Horn, 2005) is a dyadic (parent/caregiver and child together) attachment-based treatment for young children (0-6) exposed to interpersonal violence. CPP focuses on safety, affect regulation, improving the child-caregiver

relationship, normalization of trauma-related response, and the joint construction of a trauma narrative. This treatment approach aims to return the child to his/her normal developmental trajectory, and the average length of treatment is 50 sessions.

- ***Prolonged Exposure Therapy for Adolescents (PE-A)***

  PE-A (Foa, Chrestman, & Gilboa-Schechtman, 2009) is a therapy for adolescents (ages 12-18) in which they are encouraged to repeatedly approach situations or activities they are avoiding because the situations/activities remind them of their trauma. It includes psychoeducation about common trauma responses and relaxation training. PE-A helps teens emotionally process their traumatic memories through imaginal and in vivo exposure to resolve trauma-related symptoms. The average number of sessions is 8-15.

There are many different evidence-based trauma-focused treatments. The treatments listed here are supported by research, but the following practices have been identified by the California Evidence-Based Clearinghouse for Child Welfare as promising, and are among treatments that can also be beneficial for children and teens who have experienced trauma.

Promising Practices

- Alternative for Families: A Cognitive Behavioral Therapy
- Child and Family Traumatic Stress Intervention (CFTSI)
- Cognitive Behavioral intervention for Trauma in Schools (CBITS)
- Combined Parent-Child Cognitive Behavioral Therapy (CPC-CBT)
- Feel Better Now! Trauma Intervention Program
- Sanctuary Model
- Seeking Safety for Adolescents
- Structured Sensory Intervention for Traumatized Children, Adolescents and Parents, for At-Risk and Adjudicated Youth (SITCAP-ART)
- Trauma-Focused Coping (TFC)

A trauma-informed mental health professional should be able to determine which treatment is most appropriate for a given case. Refer to the California Evidence-Based Clearinghouse for Child Welfare (CEBC; *http://www.cebc4cw.org/*) for more information.

Children who have experienced trauma can also benefit from other services, such as sports and recreation, mentoring programs, community service, and wraparound programs.

What you can do

Practice strategies

- Nurture the child's strengths and interests by providing opportunities for sports and extracurricular activities.
- Listen to and acknowledge the child's traumatic experience(s).
- Let the child know that he/she is important and able to overcome trauma.
- Help the child identify and express his/her emotions in healthy ways.
- Let the child know that his/her emotions are normal and understandable.
- Offer the child a voice and choices in his/her services.
- Praise the child for his/her efforts and encourage parents and caregivers to do the same.
- Identify and build on parent and caregiver protective factors.
- Empower caregivers in their role in calming and reassuring children.
- Facilitate ongoing contact between the child and people who are important to the child (e.g., family, friends, teachers, etc.).
- Ensure that the child has at least one positive attachment relationship with an appropriate adult.
- Refer to mentoring programs as needed.
- As appropriate, provide the child with information about events that led to child welfare involvement in order to help the child correct distortions and reduce self-blame.
- Support the child in the development of a book of stories and memories about the child's life.
- If out-of-home placement is necessary, try to place children in their communities with familiar people, if out-of-home placement is necessary.
- Seek a placement appropriate to the child's level of distress and risk.
- Share the child's traumatic experiences and anticipated responses with substitute care, medical, and other service providers, as appropriate.
- Encourage resource parents to provide information if/when new revelations of past traumas emerge.
- Promote resilience through placement stability and timely permanency.
- Plan transitions carefully and prepare children as much as possible.

- Educate resource parents on the importance of promoting healthy attachment and the child's need for them to become a secure, even if temporary, base.
- Educate caregivers about the reasons for and techniques to manage children's emotional outbursts.
- Recommend trauma-informed parenting skills training to strengthen caregivers' ability to handle children's emotions and behaviors.
- Coach resource and biological parents to explore the child's fears and worries, provide reassurance, and learn what helps when the child is scared.
- Work with the child to normalize, identify, and label troubling emotions and reinforce positive coping skills.
- Make referrals to mental health providers when indicated (e.g., child is struggling with trauma-related or other emotional or behavioral concerns).
- Make a list of the mental health providers in your area who have training and experience in treating trauma and/or are trained in specific evidence-based trauma interventions.
- Refer the child to evidence-based trauma-focused therapies when appropriate and provide the therapist with a complete trauma history.
- Refer the child to appropriate skill-building (e.g., anger management, self-regulation) groups, if available and when indicated.
- Request that mental health providers include current caregivers in treatment, and educate them about the impact of trauma on child behaviors and behavior management.
- Establish a medical home for all children in care by maintaining the same primary care provider throughout the placement experience. (For more information on health care management and coordination for children in foster care, go to the American Academy of Pediatrics website: *http://www2.aap. org/fostercare/HC_management.html*.)

Agency strategies

- Promote policies that support continuity in children's relationships, such as placing them with kin and in their own communities.
- Understand the child welfare worker's role as a potential attachment figure and, when possible, try to minimize changes in caseworkers.
- Ensure that all children who have been traumatized have access to evidence-based trauma treatments and services.
- Partner with health, mental health, education, and other community providers to enhance child resilience and well-being in the aftermath of trauma.

ESSENTIAL ELEMENT 4 – Enhance Family Well-Being and Resilience

Why it's essential

Families are a critical part of both protecting children from harm and enhancing their natural resilience. However, family members may find it difficult to be protective if they have been affected by trauma, and they may need help and support in order to draw on their natural strengths. A child forms and maintains relationships with important figures in his/her life through bonding and attachment. Being separated from an attachment figure, particularly under traumatic and uncertain circumstances, can be very stressful for a child. Within the child welfare system, the risk of separation from parents, siblings, friends, and other important people in the child's life is common (i.e., removal from home, multiple foster home placements, changes in school and/or community). Maintaining positive connections enhances psychological safety and resilience. In order to form and support positive attachments, stability and permanency are critical. Providing support and guidance to the child's family and caregivers promotes permanency, safety, and well-being for the child.

Parents, kin, and other caregivers are the full-time and long-term supports for their children, and they will typically be involved in the children's lives longer than will the child welfare or mental health professionals. Research has demonstrated that support from their caregivers is a key factor influencing children's psychological recovery from traumatic events (Laor, Wolmer, & Cohen, 2001; Kliewer et al., 2001). However, in many cases, the family systems are experiencing traumatic stress along with the children. Promoting resilience and improving coping skills among family members helps them deal with traumatic events and support the children's recovery as well as preparing them for future challenges.

Parents whose children have experienced trauma often experience secondary traumatic stress reactions (distress related to caring for someone who has experienced trauma), which can interfere with their ability to provide support to their children and to follow through with services. Many birth parents who are involved in the child welfare system also have their own histories of trauma (recent and childhood trauma), which are often triggered by their children's traumas. Past and recent traumas can impact parents' ability to keep their children safe, to work effectively with child welfare staff, and to respond to child welfare system requirements. A personal history of trauma can:

- Compromise parents' ability to make appropriate decisions about their own and their children's safety
- Impair parents' ability to regulate their emotions

- Lead to maladaptive coping strategies including substance abuse
- Cause parents to become triggered by their children's traumas and/or systems' interventions

(National Child Traumatic Stress Network, Child Welfare Committee, 2011)

Trauma screening is important for identifying parents whose trauma histories impact their current parenting and functioning. Parents with unresolved traumas can benefit from referral to trauma treatment. There are several evidence-supported trauma-focused treatment approaches for adults, many of which address trauma and substance abuse issues simultaneously. For example, Seeking Safety (Najavits, 2002) teaches skills focused on coping, boundaries, grounding, and self-care for adults with trauma and substance abuse issues. The Trauma Recovery and Empowerment Model (TREM; Harris and Community Connections, 2008) emphasizes culturally relevant skill-building related to trauma, responses, and support, with gender-specific approaches. Trauma Affect Regulation: Guide for Education and Therapy (TARGET, Ford and Russo, 2006) is a strength-based model for self-regulation and managing PTSD symptoms.

For more information about trauma treatment models for adults, please visit the Substance Abuse and Mental Health Services Administration's (SAMHSA's) National Registry of Evidence-Based Programs and Practices: *http://www.nrepp.samhsa.gov/*.

In addition to enhancing the well-being and resilience of birth parents and families, it is also essential to enhance the resilience of resource families (including foster, kinship, and adoptive families). These families have some of the most challenging and emotionally draining roles in the entire child welfare system. They must be prepared to welcome a new child into their home at any hour of the day or night, manage a wide array of emotions and behaviors, and cope with agency regulations, policies, and demands. They are also expected to mentor and support the birth family while at the same time facilitating positive adjustment and healing for the child(ren) and youth in their care. Resource families must simultaneously prepare for the child's reunification with his/her family and for the possibility of making a lifelong commitment to the child through adoption or legal guardianship. Caring for children who have been through trauma can leave resource parents feeling confused, frustrated, unappreciated, angry, and helpless (Grillo et al., 2010).

Relatives caring for children and youth face many of the same challenges that other resource parents face, as well as several that are unique. Unlike foster parents who are not related to the child(ren) they care for, relatives may not have been seeking a full-time caregiving role at the time when they were called to do so. However, they have stepped up to the challenge in order to be there in a time of need or crisis in their family. Thus, they are often dealing

with their own conflicting emotions and experiences of trauma and crisis. Meeting the needs of the child(ren) they love, responding to the requirements of the agency and courts, and sorting out their own feelings about the child(ren)'s parents and the situation that brought the child(ren) into their home can be overwhelming at times.

Children bring their traumas with them into resource homes, as well as an *invisible suitcase* full of negative beliefs and expectations about themselves, caregivers, and the world, based on their past experiences of trauma and loss. These negative beliefs and expectations often lead to challenging behaviors, including reenactment behaviors. Caregivers can "repack" the suitcase by providing corrective experiences with positive replacement messages, consistency, and calm, supportive responses. However, altering children's belief systems is hard work, and resource families need training, support, and guidance to be able to do this successfully.

Providing trauma education, trauma-informed parenting skills training, and support to resource parents enhances placement stability, promotes permanency and well-being for children in care, and helps teach resource parents how to repack children's invisible suitcases. *Caring for Children Who Have Experienced Trauma: A Workshop for Resource Parents* (Grillo et al., 2010; http://www.nctsn.org/products/caring-for-children-who-have-experienced-trauma) is a helpful resource for educating foster, kinship, and adoptive parents on trauma and teaching them trauma-informed parenting skills. *Caring for Children* is based on nine *Essential Elements of Trauma-Informed Parenting*:

1. Recognize the impact trauma has had on your child.
2. Help your child to feel safe.
3. Help your child to understand and manage overwhelming emotions.
4. Help your child to understand and modify problem behaviors.
5. Respect and support positive, stable, and enduring relationships in the life of your child.
6. Help your child to develop a strength-based understanding of his or her life story.
7. Be an advocate for your child.
8. Promote and support trauma-focused assessment and treatment for your child.
9. Take care of yourself.

Child welfare professionals can promote these Essential Elements of Trauma-Informed Parenting with both resource and birth families as a way to enhance child and family resilience.

What you can do

Practice strategies

- Address concrete needs in the family.
- Identify and enhance family strengths and natural supports.
- Provide trauma-informed education and services to parents and other caregivers to enhance their protective capacity, thereby increasing the resilience, safety, permanency, and well-being of the child.
- Help reframe children's behaviors as trauma reactions to help parents and caregivers see that these behaviors are not about them.
- Recognize that caregivers themselves may have trauma histories or may experience secondary traumatic stress, and provide them with appropriate training and supports.
- Screen birth parents for trauma history and current trauma-related reactions and symptoms:
  - Assess the impact of trauma on their current functioning and parenting.
  - Examples of trauma screening tools for adults:
    - *Life Events Checklist* (Gray, Litz, Hsu, & Lombardo, 2004), which is available at: *http://www.ptsd.va.gov/PTSD/professional/pages/assessments/ assessment-pdf/life-event-checklist-lec.pdf*
    - *Trauma Recovery Scale* (Gentry, 2006), which is available at: *http://www.psychink.com/rfiles/CFScalesMeasures.pdf*
- Educate parents about trauma reminders and help them develop plans for managing reactions to triggers.
- Assess and integrate extended family, cultural, and community supports into a service plan for the family when appropriate.
- Utilize community-based family preservation services when available and appropriate.
- Recognize the influence of a family's culture, and incorporate culturally sensitive practices into their services.
- Ensure consistent contact with siblings and supportive adults, especially when a parent or caregiver is not available.

- Encourage familiar and supportive adults to provide respite care for the child. This allows time for caregivers to engage in self-care.
- Refer family for trauma-informed mental health services, substance abuse treatment, and parenting skills training as needed.
- Make referrals sequentially so that the family can access services as they are ready to receive them.
- Facilitate partnership between birth and resource parents.
- Provide trauma education and trauma-informed parenting skills to resource families.
- Give resource parents and caregivers information about the child's trauma history, enabling them to anticipate trauma reminders for the child and advocate for appropriate services.
- Take the time to listen to resource parents and ask them what they need.
- Link birth and resource parents to support groups, mentors, and other community services.

Agency strategies

- Work with the organizations that provide licensing training to resource parents and group home staff to ensure that initial and ongoing training includes education on trauma and its impact as well as trauma-informed parenting skills.
- Adopt and implement child welfare policies and procedures to address primary and secondary trauma among parents and caregivers.
- Work with partner agencies to ensure that support services for families are trauma-informed.
- Work to remove administrative barriers to communication and collaboration to ensure that parents and substitute care providers have the information they need to care for and meet the child's needs.

5 ESSENTIAL ELEMENT 5 – Enhance the Well-Being and Resilience of Those Working in the System

Why it's essential

Child welfare professionals need to have a thorough understanding of the impact of trauma not only on the children and families they serve, but also on themselves as helpers. Child welfare is a high-risk profession, and child welfare workers are confronted every day—both directly and indirectly—with danger and trauma. It is not uncommon for angry family members to make threats against workers. On top of this, hearing about the victimization and abuse of children can be very disturbing for the empathic child welfare worker and can result in feelings of helplessness, anger, and hopelessness. There have been multiple terms used to describe exposure to the trauma experienced in one's role as a helper. The most common terms are *compassion fatigue* (a gradual lessening of compassion over time, common in people who work directly with trauma survivors), *vicarious traumatization* (an internal transformation that occurs within trauma workers resulting from their empathic engagement with trauma survivors), and *secondary traumatic stress* (the stress of helping or wanting to help a person who has been traumatized. All of these terms describe the impact that exposure to trauma has for professionals. As children exposed to trauma are often profoundly impacted by the experience, professionals who work with them are also at risk of experiencing alterations in their worldview, feelings, relationships, and lives.

There are multiple sources of secondary trauma for child welfare professionals, including the death of a child or adult on the worker's caseload, investigating a vicious abuse or neglect report, frequent exposure to detailed emotional trauma accounts by children, photographic images of horrific injury or scenes of a recent serious injury or death, helping support grieving family members following a child abuse death, concerns about the continued funding and adequacy of resources for their agency, and concerns about being publicly scapegoated for a tragic outcome when they did not have the means or authority to intervene effectively (Osofsky, Putnam, & Lederman, 2008).

Child welfare professionals who are parents themselves or who have their own histories of trauma might be at particular risk for the negative effects of secondary traumatic stress. Some professionals struggle with maintaining appropriate boundaries and with a sense of overwhelming personal responsibility. These challenges can be intensified in resource-strapped agencies, where there is little professional or personal support available. The child welfare system itself can be a highly reactive, traumatizing system without enough services and supports to effectively assist the workforce in responding. Feeling frustrated when trying to deal with a complicated, often insensitive system, and experiencing a sense of

helplessness when trying to help children heal make staff vulnerable to developing their own emotional and physical problems (Perry, 2003).

It is critical to address professional or personal stress because, if left unaddressed, it can undermine work performance, to the detriment of the agency and the children and families served. Signs of secondary trauma include avoidance of certain clients, preoccupation with clients and/or their traumatic experiences, intrusive thoughts, hyperarousal/irritability, feeling detached or isolated, and feeling hopeless and depressed. Promoting system resiliency means implementing strategies and practices designed to assist those working within the child welfare system in building resilience and addressing the impact of secondary traumatic stress in a systematic way. Agencies must address secondary trauma on an organizational level in order to truly enhance staff well-being.

What you can do

Practice strategies

- Request and expect regular supervision and supportive consultation.
- Utilize peer support.
- Seek continuing education on the effects of trauma on child welfare professionals.
- Utilize agency resources such as Employee Assistance Programs for intermittent support if needed.
- Consider therapy for any unresolved trauma that the child welfare work may be activating.
- Set realistic goals and expectations.
- Practice stress management through meditation, prayer, conscious relaxation, deep breathing, and/or exercise.
- Develop a written plan focused on work-life balance.
- Work with teams within the child welfare agency and within the provider community.

Agency strategies

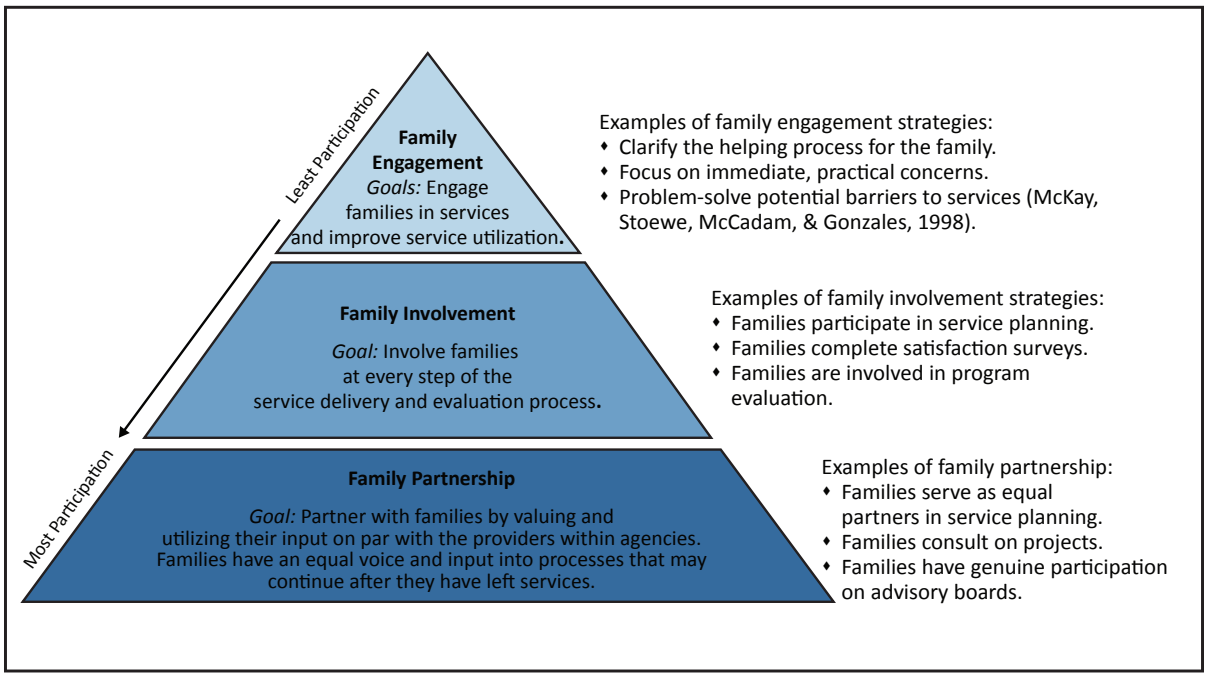
- Review recruitment and hiring practices with a focus on building resilience, professional training, and preparedness.
- Provide regular safety training for all workers.
- Have sufficient release time and a safe physical space for workers.

- Provide routine training, education, and support to all staff about secondary traumatic stress and how to recognize and manage their reactions.
- Acknowledge that secondary trauma is an occupational hazard, and promote open discussion of secondary traumatic stress among agency staff.
- Use self-assessment measures to evaluate the impact of secondary trauma exposure on child welfare workers.
  - Professional Quality of Life Scale: *http://www.proqol.org/*
  - Secondary Traumatic Stress Scale (Bride, Robinson, Yegidis, & Figley, 2004): *http://www.cehd.umn.edu/ssw/cascw/events/SecondaryTrauma/PDFs/SecondaryTraumaticStressScale.pdf*
- Consider agency policies that may exacerbate secondary trauma (e.g., agency response to high-stress events) and how policies can be amended to enhance staff resilience.
- Ensure that peer and professional counseling resources are available to staff at all times (not only after a crisis).
- Provide good mental health coverage and an Employee Assistance Program.
- Cultivate a workplace culture that normalizes (and does not stigmatize) getting help for work-related stress.
- Implement a comprehensive program to address secondary trauma, such as the Resilience Alliance (ACS-NYU Children's Trauma Institute, 2011).

6 ESSENTIAL ELEMENT 6 – Partner with Youth and Families

Why it's essential

Youth and family members who are or have been involved in the child welfare system have a unique perspective and can provide valuable feedback on how the system can better address trauma among children and families. In addition, forming a genuine partnership with youth and families on their caseload assists child welfare workers in better understanding the family's history and experience and therefore leads to more effective service delivery. Partnering with families also provides insight into how to better provide care and support to ALL families involved in the child welfare system. Some additional benefits of partnering with youth and families who are currently in services include: empowering families, building trust, enhancing the helping relationship, promoting youth and family buy-in, improving the quality of services and fit with families' needs, increasing placement stability and timely permanency, and building family decision-making skills (U.S. Department of Health and Human Services, 2010).



(Adapted from Chadwick Center for Children & Families, 2009, p. 3)

Greater family involvement in service delivery leads to increased collaboration among systems and professionals, greater understanding of challenges facing families, increased family satisfaction with services, and enhanced job satisfaction of providers (Koren et al., 2001; Worthington, Hernandez, Friedman, & Uzell, 2001). Partnering with youth and families in programming also leads to services that are more culturally relevant and competent, a sense of ownership and empowerment among youth and families, quality improvement, increased public awareness and advocacy regarding child trauma, and community outreach and mentorship (National Child Traumatic Stress Network, Partnering with Youth and Families Committee, 2009).

Despite the many benefits, there can be challenges to partnering with families, including logistics, confidentiality, stigma, cultural differences, lack of resources, role confusion, organizational capacity and culture, and consumer readiness (NCTSN, 2009). Some general strategies for overcoming these barriers include:

- Clear, honest, and respectful communication
- Commitment to strengths-based, family-centered, and youth-driven practice
- Shared decision making and participatory planning
- Praise and recognition of parents (birth, kinship, foster, and adoptive) as resources
- Seeking feedback from youth and families on a regular basis about their satisfaction with services and what would help them overcome trauma:
  - Focus groups
  - Confidential surveys
- Conducting exit interviews with families to:
  - Obtain feedback to improve services
  - Identify families who want to stay involved with agency as advocates or peer-to-peer support persons
  - Offer options for family participation
- Assessing the practice and conducting agency self-assessments to evaluate how well the agency partners with youth and families:
  - Include in the assessment team: board members, program administrators, clinicians, paraprofessionals, administrative staff, youth, and family members

(U.S. Department of Health and Human Services, 2010)

What you can do

Practice strategies

- Educate youth and families on their rights and options.
- Seek regular feedback from youth and families to assess the efficacy of services in addressing their trauma-related needs.
- Utilize peer-to-peer support programs, including parent partner programs, peer mentor programs, and support groups. These programs link new clients with families who have been through services in order to provide information, reduce stigma and isolation, and help families advocate for themselves.
- Provide training for youth and families to participate in mentoring, program development, advocacy, etc.
- Create incentives to encourage youth and family participation in programs (e.g., provide stipends or college/job references).
- Conduct exit interviews with families to elicit feedback as to how the agency can better meet the trauma-related needs of children and families.
- Offer a variety of options for family participation.

Agency strategies

- Actively involve youth and families in programming.
- Involve youth and family members in developing and delivering staff and community trainings.
- Invite youth and family members to participate on Advisory Committees and other types of committees as equal partners.
- Conduct focus groups with youth, alumni of care, resource parents, and birth parents to get a better idea of their perspectives on the system and to gather suggestions for how to become more trauma-informed.
- Administer confidential surveys to consumers to gain their input on services.
- Provide formal recognition for the accomplishments of youth and families in the organization.
- Assess your own practice and conduct agency self-assessments to evaluate how well you partner with youth and families.

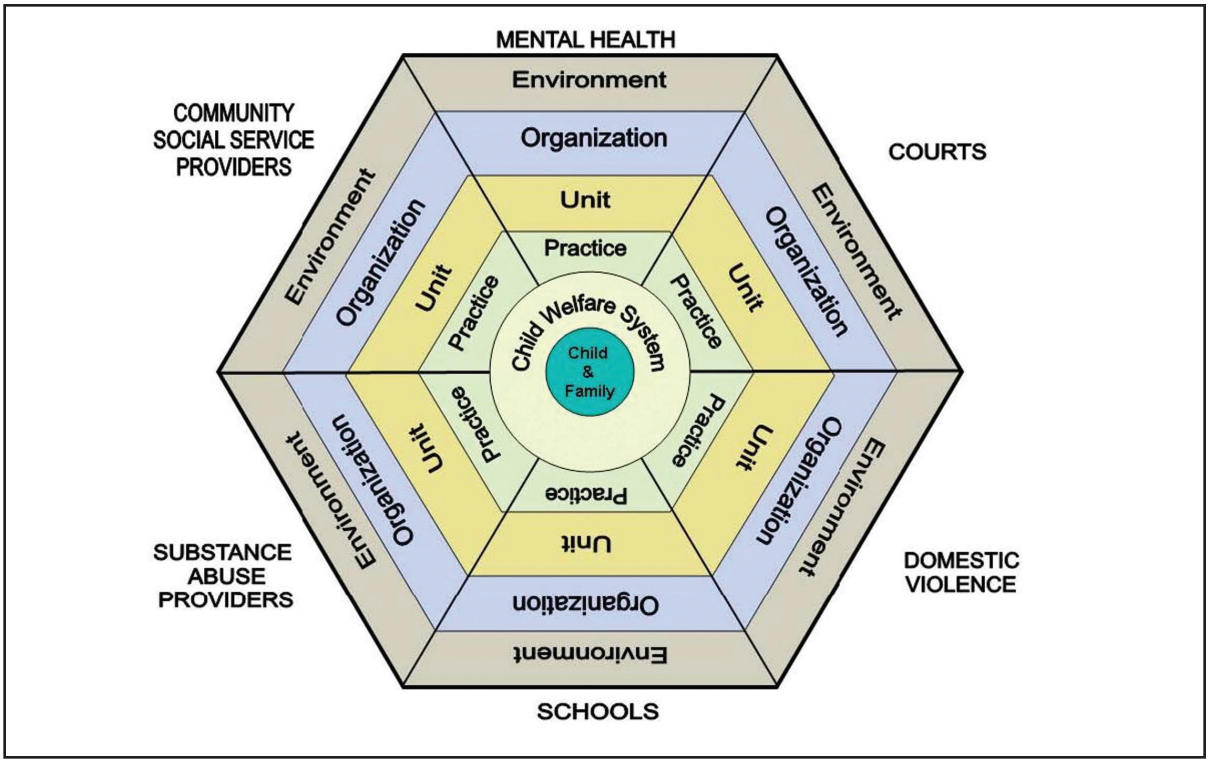
7 ESSENTIAL ELEMENT 7 – Partner with Agencies and Systems That Interact with Children and Families

Why it's essential

Children and families impacted by trauma are often involved with multiple service systems, including law enforcement, child welfare, the courts, schools, healthcare, and mental health. A typical child welfare system includes the following partners:

- Public Child Welfare Agency
- Department of Social Services (Child and Family Services)
- Public and Private Mental Health Agencies
- Non-Profit Social Service Agencies
- Specialty Programs (e.g., Substance Abuse and Domestic Violence)
- Juvenile and Family Courts
- Juvenile Justice
- Law Enforcement
- Attorneys and Advocates
- Child Advocacy Centers
- Foster Care and Adoption Agencies and Associations
- Schools
- Healthcare Providers
- Public Health Department
- Tribal, Community, and Faith-Based Organizations

The graphic on the next page shows six of the main systems that interact with child welfare and the different layers of each system. Children, families, and child welfare workers (who are responsible for service coordination) can easily feel overwhelmed and confused when dealing with all of these different systems, each of which has its own culture, goals, and perspective. This is why cross-system collaboration is so important.



Service providers working with children and families in the child welfare system should endeavor to develop common protocols and frameworks for documenting trauma history, exchanging information, coordinating screenings and assessments, and planning and delivering care. In contrast to a fragmented approach, cross-system collaboration facilitates a holistic view of the child and family. When different systems have many different and potentially competing priorities, there is a risk that children and their families will receive mixed or confusing messages—or simply fall through the cracks. Barriers to collaboration across service systems include:

- Issues of confidentiality
- History of lack of interagency collaboration
- Varying forms of complexity in each of the systems
- Lack of resources in time and money to support collaboration

Because trauma can impact many aspects of children's and families' lives, it is important for child welfare to partner with other service systems in identifying and addressing trauma. All systems must recognize the impact of trauma on behavior, and work to fully engage families in services.

General strategies for cross-system collaboration include:

- Cross-training on trauma and its impact: For example, hold a regional training on trauma and traumatic stress and invite professionals from all of the types of agencies listed above.
- Jointly developed protocols regarding child and family trauma and collaborative services that promote resiliency: This would include creating a multidisciplinary protocol for domestic violence cases, incorporating child welfare, law enforcement, the courts, and community providers.
- Multidisciplinary teams: These teams of child welfare system professionals coordinate child abuse investigations and meet regularly to coordinate services.
- Family team meetings: These meetings can include professionals from other systems (such as mental health and juvenile justice) as well as the family.
- Co-location of staff in community hubs: This would entail creating a one-stop shop where families can obtain needed services (such as a Family Justice Center) or creating a workplace combining professionals from different agencies and disciplines to work together to help children and families involved in the child welfare system.
- Cross-system assessment tools: These tools would include information pertinent to multiple systems/agencies needed to facilitate information sharing and reduce the number of parent and child interviews.
- Shared outcomes: Developing common goals to enhance cross-system collaboration.
- Technology for information exchange: Ensuring that all of the agencies have the ability to communicate and share information in a quick and secure way will make the exchange of information quicker and smoother and therefore enhance service coordination.
- Integrated information sharing systems: Databases or other file-sharing devices can be established that are accessible by multiple agencies and systems.

Service coordination is especially important for children who are involved in both the child welfare and the juvenile justice system, to improve outcomes for these children and ensure that they do not fall through the cracks. Child welfare can partner with the juvenile justice system to engage in prevention activities to identify at-risk youth; provide appropriate intervention in the least restrictive settings; create coordinated response protocols; coordinate engagement with the courts and legal system; overcome barriers to information

sharing; engage in coordinated case planning; and collaborate with education, mental health, and substance abuse systems (Herz et al., 2012).

What you can do

Practice strategies

- Educate other system providers about the impact of trauma, which will help guide collaboration and joint decision making.
- Participate in cross-training with other agencies and systems on issues related to child trauma and trauma-informed care.
- Ensure that service providers (e.g., family/dependency courts, multidisciplinary teams, and resource parents) have the necessary information regarding the child's and the family's trauma history and its impact, while respecting the child's and the family's confidentiality.
- Organize quarterly multidisciplinary team meetings to discuss common cases, develop a shared framework regarding trauma and its impact on the family, and coordinate services.
- Provide leadership to the team of care providers working with the child and the family to ensure integrated, trauma-informed care.
- Develop relationships with health and mental health providers and enlist them as trauma-informed team members in care plans for the child and his/her family.
- Provide continuous care coordination through communication with therapists and other service providers on a regular basis and invite them to attend case conferences.
- Advocate for the child and family to help ensure that partner agencies and systems are working to meet the child's and the family's trauma-related needs.

Agency strategies

- Establish strong partnerships with other child- and family-serving systems.
- Establish interagency coordination agreements.
- Partner with the mental health system to develop and support community capacity for trauma-informed mental health assessment and treatment.
- Engage in cross-training on trauma and its impact on other child-serving systems.
- Develop joint protocols regarding child and family trauma and collaborative services that promote resilience.
- Conduct multi-disciplinary team and family team meetings.
- Co-locate multi-disciplinary staff in community "hubs."
- Utilize cross-system assessment tools.
- Engage all systems in shared outcomes.
- Use technology for information exchange, including integrated information sharing systems.

Conclusion

Because so many children in the child welfare system have been impacted by traumatic experiences, it is imperative for child welfare professionals to understand the short- and long-term effects of trauma and practice strategies to help mitigate these effects. Recognizing and addressing the impact of trauma on children and families is critical to ensuring their safety, permanency, and well-being.

Child welfare professionals play an important role in helping children and families heal in the aftermath of trauma and can do so by incorporating the *Essential Elements of a Trauma-Informed Child Welfare System* into their daily work. When child welfare and allied professionals work together, in collaboration with youth and families, they have the power to help children and families overcome the impact of trauma and thrive.

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Appendix A: Identifying Trauma-Informed Providers

Many, if not most, therapists in the United States describe their approaches to treatment as *eclectic*. Unfortunately, many therapists also lack specialized training in trauma and its treatment and may even be unfamiliar with the basic trauma literature.

Child welfare workers and supervisors should interview therapists or agencies to whom the child welfare agency makes referrals and assess which ones have the best preparation to deliver therapy to children and families in the care of the agency who have been impacted by trauma. In the interview, the worker can ask the following types of questions. The agency may also send a questionnaire based on these questions to all therapists/agencies who receive child welfare referrals.

1. Do you provide trauma-specific or trauma-informed therapy? If yes, how do you determine whether the child needs a trauma-specific therapy?

   Providers should describe an assessment process that involves obtaining a detailed social history, including all forms of trauma, as well as the use of a standardized, trauma-specific measure.

2. How familiar are you with the evidence-based treatment models designed and tested for treatment of child trauma-related symptoms?

   Providers should mention specific interventions by name, such as Trauma-Focused Cognitive Behavioral Therapy (TF-CBT), Child Parent Psychotherapy (CPP), Eye Movement Desensitization Reprocessing (EMDR), or Prolonged Exposure Therapy for Adolescents (PE-A). A listing of evidence-based and promising intervention models for child trauma appears on the website of the National Child Traumatic Stress Network (NCTSN, www.nctsn.org). The California Evidence-Based Clearinghouse for Child Welfare (CEBC, www.cebc4cw.org) is another resource for learning more about various treatment models in child welfare, including trauma treatment for children and adolescents. If a provider cites a treatment model with which you are unfamiliar, look it up on one of the above websites or ask the provider for the research supporting its effectiveness.

3. How do you approach therapy with children and families who have been impacted by trauma? Ask this question of both those who indicate they use evidence-based models and those who assert they are otherwise qualified to treat child traumatic stress. Ask them to describe a typical course of therapy. What are the essential elements of their treatment approach?

Providers should describe approaches that incorporate some or all of the following elements:

- Building a strong therapeutic relationship.
- Psycho-education about normal responses to trauma.
- Parent support, conjoint therapy, or parent training.
- Emotional expression and regulation skills.
- Anxiety management and relaxation skills.
- Cognitive processing or reframing.
- Construction of a coherent trauma narrative.
- Strategies that allow exposure to traumatic memories and feelings in tolerable doses so that they can be mastered and integrated into the child's experience.
- Personal safety training and other empowerment activities. Trauma may leave a child feeling vulnerable and at risk. Trauma treatment often includes strategies that build upon the child's strengths. It teaches the child strategies that give him/her a sense of control over events and risks.
- Resilience and closure. The treatment often ends on a positive, empowering note, giving the child a sense of satisfaction and closure, as well as increased competency and hope for the future.

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