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In summarizing research, we try to give you new ideas for refining your practice. However, this publication is not intended to replace child welfare training, regular supervision, or peer consultation—only to enhance them.

Let us hear from you!

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TRAUMA-INFORMED CHILD WELFARE PRACTICE

Recent research has given us a richer understanding of just how maltreatment and other traumas hurt children. As Tullberg (2011) summarizes, studies have revealed trauma can negatively affect children's:

- Brain development
- Sense of personal safety
- Ability to trust others
- Sense of the future
- Behavior and social relationships
- Ability to navigate life changes, and
- Learning and school performance.

Trauma's footprint can be huge. Success or failure in these domains profoundly affects the trajectories of children's lives.

Children are also affected when parents are traumatized. Tullberg cites a study of child welfare-involved mothers in New York in which 92% had experienced at least one type of traumatic event (e.g., domestic violence); 35% of these mothers thought trauma symptoms affected their parenting or their relationship with their child. Trauma stress reactions—symptoms can in-

clude difficulty concentrating, detachment, anger, and others—can make it hard for parents to engage with the child welfare system.

If we want to be effective as child welfare professionals and make a lasting difference to families and children, we must ensure our work is guided by what we know about trauma and how to respond to it.

We'd like to support you and your agency as you seek to learn about and engage in trauma-informed child welfare practice. Therefore, this issue includes information about how trauma affects the developing brain, identifies trauma-informed concepts and practices that are already part of child welfare policy in North Carolina, describes the way trauma affects our work with birth parents, and offers concrete steps you can take to make your work with families more trauma-informed and therefore more effective. ♦

How we think about and respond to trauma matters a great deal.

BASICS ON CHILDREN AND TRAUMA

Traumatic Experience

- Threatens the life or physical integrity of a child or someone important to that child (parent, grandparent, sibling)
- Causes an overwhelming sense of terror, helplessness, and horror
- Produces intense physical effects such as pounding heart, rapid breathing, trembling, dizziness, or loss of bladder or bowel control

Three Types

Acute: a single event that lasts for a limited time

Chronic: multiple events, often over a long period

Complex: multiple events beginning at a very young age; caused by adults who should have been caring for/protecting child

Trauma Adds Up

It is cumulative—each new traumatic event compounds the last.

Neglect Counts

Failure to provide for basic needs is seen as a trauma by infants or young children, who depend on adults to survive. Neglect also opens door to other traumatic events, and may reduce a child's ability to recover from trauma.

Reactions Vary Widely

Based on the child's level of exposure to trauma, access to supportive caregivers, previous history of traumatic events, and other factors

HOW TRAUMA AFFECTS CHILD BRAIN DEVELOPMENT

The sheer volume of research on trauma, brain development, and outcomes for children can be daunting. Fortunately, understanding and applying key concepts to child welfare practice doesn't have to be complicated.

TRAUMA AND THE BRAIN

"The human brain is designed to sense, process, store, perceive, and act on information from the external and the internal environment. All of these complex systems and activities work together for one overarching purpose—survival" (Goldstein, 1995 cited in Perry, et al., 1995).

Neurons are the building blocks of the brain. During development, neurons create networks that link to create systems. These systems are how the brain regulates all functions. Brain functions are organized from the most simple to the most complex. The development of these functions is sequential, meaning prior events impact future development.

A key fact that child welfare professionals, judges, and others who work with child welfare-involved families should know is that there are critical developmental times when neural pathways are being formed that can be significantly altered by traumatic events (Perry, 1995, 2009).

EARLY CHILDHOOD

Brain development in infancy and early childhood lays the foundation for all future development. Neural pathways form at great speed and depend on the repetition of experiences. Experiences teach the brain what to expect and how to respond.

When experiences are traumatic, the pathways getting the most use are those in response to the trauma; this reduces the formation of other pathways needed for adaptive behavior. Trauma in early childhood can result in disrupted attachment, cognitive delays, and impaired emotional regulation. Also, the overdevelopment of certain pathways and the underdevelopment of others can lead to impairment later in life (Perry, 1995).

TRAUMA'S POTENTIAL IMPACT ON BRAIN DEVELOPMENT

Exposure to chronic, prolonged traumatic experiences has the potential to alter children's brains, which may cause longer-term effects in areas such as:

- **Attachment:** Trouble with relationships, boundaries, empathy, and social isolation
- **Physical Health:** Impaired sensorimotor development, coordination problems, increased medical problems, and somatic symptoms
- **Emotional Regulation:** Difficulty identifying or labeling feelings and communicating needs
- **Dissociation:** Altered states of consciousness, amnesia, impaired memory
- **Cognitive Ability:** Problems with focus, learning, processing new information, language development, planning and orientation to time and space
- **Self-Concept:** Lack of consistent sense of self, body image issues, low self-esteem, shame and guilt
- **Behavioral Control:** Difficulty controlling impulses, oppositional behavior, aggression, disrupted sleep and eating patterns, trauma re-enactment

Source: Cook, et al. 2005

By age three, the brain is almost 80% of its adult size; by age five it is 90% (zerotothree.org). Although this creates a sense of urgency regarding intervention, it is also important to know that the brain has the most plasticity in infancy and early childhood, meaning there is the most opportunity for change. This is both the reason that prolonged trauma in early childhood can be so devastating, but also a window of opportunity for interventions that can alter the brain in positive ways (CWIG, 2011).

CHILDREN AND TEENS

Brain development continues in the school-age years, but more slowly. During this stage neural pathways are pruned or eliminated to increase efficiency. In addition, the brain coats neural pathways to protect and strengthen them (Shonkoff & Phillips, 2000). This process allows the school-age child to master more complex skills, including impulse control, managing emotions, and sustaining attention. Trauma during this stage of development can have significant impact on learning, social relationships, and school success (NCTSN, 2008).

The impact of trauma at this age also depends on the onset. If trauma continues into the school-age years from early childhood, the impact is greater on overall functioning. There is some evidence that trauma that be-

gins during the school-age years will have a different impact than trauma that begins in early childhood. Specifically, school-age onset seems to result in more externalizing behaviors (acting out) whereas early childhood onset results in more internalizing behaviors (withdrawal, depression, self-blame) (Manly, 2001; Kaplow, 2007).

In adolescence the brain goes through another period of accelerated development. The pruning of unused pathways increases, similar to early childhood. This process makes the brain more efficient, especially the part of the brain that supports attention, concentration, reasoning, and advanced thinking. Trauma during adolescence disrupts both the development of this part of the brain and the strengthening of the systems that allow this part of the brain to effectively communicate with other systems. This can lead to increased risk taking, impulsivity, substance abuse, and criminal activity (NCTSN, 2008; Chamberlin, 2009; Wilson, 2011; CWIG, 2009).

WHAT YOU CAN DO

Addressing the impact of trauma requires a comprehensive and collaborative approach. Awareness and understanding of the issue is the first step towards trauma informed practice. For more practical applications see "Essential Trauma-Informed Activities for Child Welfare Staff in this issue." ♦

WHAT DOES A TRAUMA-INFORMED SYSTEM LOOK LIKE IN PRACTICE?

According to Tullberg (2011), a trauma-informed child welfare system should have the capacity to translate trauma-related knowledge into meaningful action, policy, and practice changes. Furthermore, this system and those who work in it should understand:

- the potential impact of traumatic stress on children served by the child welfare system;
- how the system can either help mitigate the impact of trauma or inadvertently add new trauma;
- the potential impact of current and past trauma on the families with whom we interact;
- how adult trauma may interfere with caregivers' ability to care for and support their children;

- how to promote factors related to child and family resilience;
- the impact of secondary trauma on the child-serving workforce;
- that trauma shapes the culture of child welfare the same way trauma shapes the world view of victims; and
- that a traumatized system will find it hard to identify clients' past trauma or mitigate/prevent future trauma.

The following case example illustrates what some of these principles might look like in practice as families, child welfare services, and related professionals address the effects of trauma on children's behavior and development. ♦

Billy's Story

Adapted from Supporting Brain Development in Traumatized Children and Youth (Child Welfare Information Gateway, 2011)

Billy is a 6-year-old boy placed with his maternal grandmother by the child welfare system. Although his mother stated that she never used drugs while she was pregnant, Billy was born prematurely. His mother did not have a home or regular income, and they moved from place to place for several years. Billy slept wherever he could find a spot, and he ate only sporadically. Billy did not cause much trouble because he rarely spoke.

After Billy was removed from his mother's care due to abandonment, he was placed in foster care until his grandmother could be located. Billy's grandmother became concerned about his behavior and development while caring for him over the last 6 months. Billy hid food in his pockets and in his room, and his teacher reported he was stealing food at school. Billy also slept on the floor. Because he was so quiet, it took some time for Billy's teacher to notice he had difficulty speaking and interacting in school.

Billy's grandmother asked for help from his caseworker, who referred him to a mental health therapist for evaluation. After letting Billy speak openly about his past experiences, the therapist determined Billy's tendencies to steal food and sleep on the floor were adaptive behaviors he developed while living with his mother—skills that helped him survive but are no longer appropriate given his current, more stable situation. Building on the therapist's advice and taking Billy's unique situation into consideration, the caseworker helped his grandmother establish regular routines, such as mealtimes and bedtimes, and gave her ideas for activities Billy and his grandmother could share to enhance the bond between them. The caseworker also connected the grandmother to a support group where she could meet other grandparents raising their grandchildren.

To address Billy's problems in school, his caseworker sought the help of the school's psychologist as well as a speech pathologist. Initial tests indicated Billy had attention-deficit/hyperactivity disorder (ADHD); with parental consent, Billy was prescribed medicine to address the issue. The speech

pathologist also began working with Billy and gave his grandmother exercises to do with him at home. Several months later, when Billy's grandmother and teacher felt the medicine was not "working," Billy's mental health therapist was consulted again. The therapist advised that Billy's problems are more likely caused by symptoms of posttraumatic stress disorder (PTSD) resulting from his earlier traumatic experiences. Under the therapist's supervision, Billy stopped taking the medicine, and his treatment plan was revised to include more trauma-focused therapies, to help Billy work through his feelings.

To improve communication and avoid overlapping efforts, Billy's caseworker scheduled a multidisciplinary team meeting for the adults in Billy's life. The long-term plan that resulted from the meeting included a number of action items:

- Billy's therapy sessions will continue; his grandmother will attend on occasion to support his progress and learn new activities and exercises to do with him at home.
- At school, Billy's teacher will follow the newly created individual education plan (IEP) to help him succeed academically and will create a weekly progress report. Billy's speech pathologist scheduled several more sessions to track his improvements.
- Billy's grandmother will continue to attend monthly grandparent support meetings to make connections and receive support from other community members.
- Billy's caseworker will help his grandmother become a foster parent and seek financial support while she cares for Billy. If Billy's father or mother is unwilling or unable to care for him, the grandmother will apply for subsidized guardianship to give Billy a more permanent home.



Source: Child Welfare Information Gateway. Available at <http://www.childwelfare.gov/pubs/braindevtrauma.cfm>

NINE TRAUMA-INFORMED ACTIVITIES FOR CHILD WELFARE

The National Child Traumatic Stress Network (2008) highlights nine essential activities in serving children who have experienced trauma. These activities form the core of a *Child Welfare Trauma Training Toolkit* and a two-day training developed by the Network. To move your agency forward with trauma-informed practice, visit the Network's website at <http://bit.ly/HWCkVq>.

Below are examples of ways you can engage in each of the essential activities, along with additional questions you might explore for each activity. To integrate a more trauma-informed perspective into your practice and case planning, start by asking questions. Some of the recommendations apply to the child's caregiver, whether that is a birth family member or foster care provider. Work in partnership with children, their families, and therapists to ensure that everyone is informed and taking a comprehensive approach.

1. Maximize safety.

- Children need to feel physically and psychologically safe. To feel psychologically safe, children need consistency and predictability. Remind parents that helping kids to know they are safe may take some time.
- Help caregivers provide predictable and consistent environments including routines, clear expectations, consistent feedback, and positive reinforcement.
- Listen to the child. Pay attention to possible triggers, which may be people, places, or things that make the child feel threatened.
- Increase awareness of behaviors that are reactions to triggers. It may not always be clear to you what the threat is, but the threat is real to the child.
- Reassure the child with specific information about how everyone is working to keep her safe.

KEY QUESTIONS: What are people, places, and activities that make this child feel safe and secure? What makes her feel unsafe or unsupported?

2. Help children manage overwhelming emotions.

- Frequent, intense and overwhelming emotions are triggered by reminders of traumatic events.
- Help the child label his emotions; make it clear these emotions are understandable.
- Teach relaxation skills; encourage the child to participate in activities that allow for positive expression of emotions (physical exercise, art, music, etc.).
- Identify and avoid reminders that trigger intense emotions. Help the child understand what is happening when reminders occur.

- Remember—and help caregivers remember—not to take it personally when children experience or express their emotions. Talking to other adults can help caregivers problem-solve and identify trauma-informed ways to respond.

KEY QUESTIONS: What are possible triggers that make this child feel threatened or remind him of traumatic events? What is being done in therapy and at home to help minimize or manage those triggers? Are there relaxation or stress management skills that the child is learning that I can remind him of and reinforce?

3. Help children make new meaning of their trauma history and current experiences.

- Listen to the child tell her story; acknowledge emotions.
- Support the child and caregiver in developing a Life Book.
- When appropriate, provide information about traumatic events to help the child gain a different perspective and reduce self-blame.

KEY QUESTIONS: What is the best way for me to respond to the child's comments or questions about her trauma history? Am I able to listen empathically without shifting to an investigative or problem-solving mode?

4. Address the impact of trauma and subsequent changes in the child's behavior, development, and relationships.

- Identify areas of concern as early as possible and take necessary steps to ensure the child is safe and that developmental needs are being met.
- Educate families about key developmental milestones and ways they can increase brain development through interactions with children.

THE NC CHILD TREATMENT PROGRAM

Effective Mental Health Treatment for Children and Families

Established in 2006, the NC Child Treatment Program serves children, adolescents, and families coping with serious psychological trauma or loss. Its faculty has trained a network of community-based mental health clinicians to provide effective, evidence-based treatments.



One such treatment, Trauma-Focused Cognitive Behavioral Therapy (TF-CBT), is designed to:

- Reduce negative emotions and behaviors especially those related to Post Traumatic Stress Disorder (PTSD), depression, and sexual reactivity
- Correct unhelpful thoughts that impede healing
- Provide caregivers with support and skills to help children move past the trauma and loss.

To learn more or to find a therapist in your area, go to www.ncchildtreatmentprogram.org.

- Remind parents to avoid saying to children that they are “bad” or their behavior is “bad.” This can reinforce negative behavior. What’s more, this might shame the child, which would be inappropriate, since the behavior is related to feelings of fear or anxiety.
- Work with schools and others to ensure the child has support in reaching academic, social, and behavioral goals.

KEY QUESTIONS: *What behaviors, symptoms, or situations is the child experiencing? How might they relate to his history of trauma? What support or information can we offer him and his caregivers to understand and respond appropriately?*

5. Coordinate services with other agencies.

- Share information with caregivers and service providers. General information about a child’s trauma history may legally be shared with foster parents and other members of the professional team when it is essential to providing quality services.
- With the family’s permission, invite service providers to child and family team meetings (CFTs).
- Be mindful of the family’s involvement with other agencies when developing Family Service Plans.
- Provide concrete support and encouragement for getting the child to the appointments that may be necessary for full assessment and treatment.

KEY QUESTIONS: *What other agencies or providers are serving this family? What expertise might they offer or what information might they need to ensure the entire team is helping the family heal from trauma?*

6. Use a comprehensive assessment of the child’s trauma experiences and their impact on the child to guide service provision.

- Gather trauma history from the child, family members, collaterals, and agency case records.
- Recognize that developmental delays and behavior problems may be related to trauma. A full developmental and medical assessment is needed to identify the appropriate treatment.
- Refer the child for further assessment and treatment as needed (health, mental health, education, etc.). Ask providers about their level of training and experience in trauma-focused treatment.

KEY QUESTIONS: *What can we do to individualize our services to this child and her caregivers, based on her specific history, developmental level, and strengths and needs? What are things that make this child and her situation unique, and how are we addressing that in our conversations and case planning?*

7. Support and promote positive and stable relationships in the child’s life.

- Use genograms, Life Books, and conversation to identify people who are important to the child.
- Review the case file; find people who have played a role in the child’s life in the past but have lost contact.
- Teach caregivers ways to develop healthy interactions and attachments with children of different ages.
- When considering placement and visitation recommendations, be sure to consider ways to maintain or strengthen the child’s current attachments.
- Remember that DSS workers may be an important attachment for the child. Minimize changes in case workers as much as possible.

Help caregivers provide predictable environments including routines, clear expectations, consistent feedback, and positive reinforcement.

KEY QUESTIONS: *Who is important to this child? What positive, stable relationships has he had in his life? What can I do to maintain, strengthen, or re-establish those connections?*

8. Provide support and guidance to the child’s family and caregivers.

- Provide training and information to caregivers about the effects of trauma.
- Encourage caregivers to participate in therapy, both to support the child’s recovery and to increase their own support network.
- Address respite needs of birth and foster families.
- Strengthening the family’s support system is critical. Include extended family, church, or neighborhood connections as much as possible. Consider ways to offer peer-to-peer support for families.

KEY QUESTIONS: *What connections, information, or resources will help this child and her family engage in trauma-informed treatment? What barriers exist to treatment, and how can I help the family to overcome them?*

9. Manage professional and personal stress.

- Take care of your own need for a healthy lifestyle and support system.
- Help create a supportive environment in your unit by recognizing the emotional toll of this work on your co-workers. Even small tokens of appreciation and understanding make a difference.
- Seek continuing education on the effects of trauma.

KEY QUESTIONS: *What symptoms of stress and secondary trauma am I experiencing? What can I do to add more healthy stress management to my daily life? What can we do on our team to take care of each other?*

TRAUMA-INFORMED PRACTICE AND NC CHILD WELFARE POLICY

The increasing emphasis on being trauma-informed can feel like pressure to add another complex dimension to child welfare practice. However, child welfare policy in North Carolina already emphasizes a number of practices that are in line with research recommendations about minimizing the effect of trauma. With the introduction of Multiple Response System (MRS), and with new federal laws passed in recent years, child welfare practice has increasingly emphasized partnering with families, listening to the voices of children and youth, and building and maintaining healthy connections. These are all trauma-informed activities and approaches. They're also already part of your everyday practice with families. The table below highlights North Carolina policies that align with key trauma-informed child welfare activities. ◆

| Activity | Related NC Policies* | Trauma-Informed Implementation |
|---|---|---|
| Maximize child's sense of safety | Safety Planning | Child welfare staff are strongly encouraged to involve parents and their children in safety planning, and to ask questions that help the child describe their concerns and fears as well as the things that help them feel safe. "Seeking first to understand" and taking the "not knowing stance" are also part of understanding the safety needs and protective factors in families. |
| Coordinate services with other agencies | Child and Family Team Meetings Permanency Planning Action Teams | CFTs are one of the most important techniques we have for coordinating services. Time spent preparing families, community partners, and others for CFTs is essential. Talk early and often about CFTs; have conversations about who will be helpful to have on the team. DSS agencies should be proactive about educating community partners about CFTs on an ongoing basis. This can help spread System of Care (SOC) values, which in turn ensure communities know what the needs are and can get them met. |
| Use comprehensive assessment of child's trauma history to guide services | CME/CFE Strengths/Needs Assessment Individualized case planning | NC policy requires us to engage children as part of assessments during the provision of CPS services and throughout their involvement with DSS. Particularly in family assessments, the focus should be on getting the big picture, which includes the child's history. One county DSS finds it helpful to consistently ask children a few simple questions to ensure that their trauma histories are fully explored and appropriate services are provided. Child Medical and Child/Family Evaluations also gather trauma history information to guide supportive interventions for children and families. |
| Support and promote positive, stable relationships | Placement priorities Visitation plans Sibling placement and visits Family notification Reunification efforts Shared Parenting LINKS goal Use of Life Books | Identifying and supporting positive, stable relationships for children is a theme that runs throughout NC policy, from looking diligently for absent parents, to placing priority on placements and frequent visitation with siblings and other kin, to the LINKS goal of ensuring that young people leaving foster care have a personal support system of at least five caring adults in addition to professional relationships. |
| Provide support and guidance to child's family/ caregiver | Involving family in case planning Individualized foster parent training and development | It is possible to do the Safety Assessment in the family's presence without doing it "with" them. The "to, for and with" frame taught in courses such as CPS Assessments effectively engages and empowers all family members to take part in the planning for their own safety and well-being. Involvement of foster parents and other substitute caregivers in CFTs and shared parenting is an excellent way to ensure they have the information they need to meet the needs of children in their care. Creating and actively supporting individualized foster parent training and development plans is another way to ensure they see children's behaviors through a "trauma lens" and have the skills they need to respond appropriately. |

*This is not a comprehensive list. NC's full child welfare policy can be found at <info.dhhs.state.nc.us/olm/manuals/>.

PROJECT BROADCAST

Disseminating Trauma-Informed Practices to Children in the NC Child Welfare System

The NC Division of Social Services (NCDSS) has been awarded grant funding for *Project Broadcast: Disseminating Trauma-Informed Practices to Children in the North Carolina Child Welfare System*. This project provides the state \$640,000 each year for five years (through September 2016). Its aim is to help provide children with services and practices to address the trauma caused by past abuse or neglect before that mistreatment leads to mental health problems or chronic disorders later in the child's life.

Pending approval from the US Children's Bureau, this project will have three broad areas of focus:

- (1) Providing training and professional development for resource parents (i.e., foster, adoptive, kinship) using the National Child Traumatic Stress Network's (NCTSN) *Resource Parent Curriculum*; child welfare professionals will also use the NCTSN's *Child Welfare Toolkit*;
- (2) Increasing access to trauma-informed, evidence-based treatments for children and youth by training more clinicians in these interventions:
 - Structured Psychotherapy for Adolescents Responding to Chronic Stress (SPARCS)
 - Attachment and Biobehavioral Catch-up (ABC)
 - Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)
 - Parent-Child Interaction Therapy (PCIT)
- (3) Creating systemic changes so that the training and interventions offered to the 9 demonstration counties can eventually be expanded to all 100 counties.

"This grant opportunity will help to provide tools that increase the capacity of the division and local departments of social services to serve children and families in our child welfare system," said Sherry Bradsher, director of NCDSS. "Incorporating trauma-informed practices into our child welfare services allows for a more holistic approach to meeting the needs of children."

In adopting trauma-informed, evidence-based practices, the child welfare system will take steps to adapt its service delivery system to include a better understanding of how trauma affects the lives of the children being served. Trauma-informed programs and services are based on an understanding of the vulnerabilities or triggers of trauma survivors so that these services and programs can be more supportive and meet the needs of the individual child. Trauma-specific interventions are designed specifically to address the consequences of trauma in the individual and to facilitate healing.

"Children who have been abused or neglected have been in and felt many negative experiences in their lives," said Bradsher. "We owe it to them and their futures to have a system in place that acknowledges those experiences,

New Law Requires Screening for Trauma

On September 30, 2011, Congress passed the Child and Family Services Improvement and Innovation Act (P.L. 112-34). Among other things, this new law requires states to describe in their health care oversight plans:

- How they will screen for and treat emotional trauma associated with maltreatment and removal for children in foster care;
- The protocols in place or planned to oversee and monitor the use of psychotropic medications among children in foster care.

North Carolina anticipates Project Broadcast will help it meet both these requirements. As the article on this page makes clear, there is a clear connection between trauma screening and this project.

The connection to psychotropic medication use is indirect but still strong. The hope is that if children in foster care receive trauma-informed, evidenced-based treatments, we will see a reduction in use of psychotropic medications in this population.



understand their traumas, deals with its impact, and prevents future occurrences."

This grant is funded through the U.S. Department of Health and Human Services, Administration for Children and Families, Children's Bureau (grant #90C01058/01). NCDSS is partnering on this project with the Center for Child and Family Health, a leader of the National Child Traumatic Stress Network, as well as the University of North Carolina at Chapel Hill—proven national leaders in developing effective programs and resources in this area.

The proposed goals of Project Broadcast are to:

- Coordinate system-level changes across the system of care in the nine demonstration counties (Buncombe, Craven, Cumberland, Hoke, Pender, Pitt, Scotland, Union, and Wilson);
- Develop trauma-informed child welfare workforces and systems across the nine demonstration counties, addressing service needs across the practice continuum from prevention to post-adoption care;
- Increase local capacity and access to trauma-specific evidence-based mental health treatments for children and youth in the nine demonstration counties; and
- Plan to incorporate these practices statewide.

For more information, contact Jeanne Preisler with the NC Division of Social Services (Jeanne.Preisler@dhhs.nc.gov; 336/209-5844). ♦

Trauma-Informed Practice

ENGAGING AND SUPPORTING FAMILIES WHO HAVE EXPERIENCED TRAUMA

Many parents involved with the child welfare system have trauma histories. Whether trauma is a past experience, a current reality, or both, it can shape a person's behaviors, feelings, and decisions. The more we learn about trauma, the more we can modify our practices and agency environments to support and engage birth parents.

As the information below from the National Child Traumatic Stress Network indicates, a history of traumatic experiences can impede parents' ability to keep their children safe and to work effectively with child welfare agencies and others. However, it's important to remember that each person is an individual. Any description of trauma's impact will not necessarily "fit" each person who has experienced trauma, but it can help develop general awareness for those who work with families.

At any point in an agency's involvement with a family, birth parents may experience trauma triggers. Consider the mother who, when asked about the child's absent father as a possible caregiver, feels overwhelming fear—her heart pounding fiercely as memories of spousal abuse race forward. Another birth parent, removed from his home as a youth, can't bear the thoughts that his own children are now in foster care, and therefore avoids visitation.

In these situations, a social worker knowledgeable about trauma responses might understand the intensity with which the mother demands the children's father not be contacted. She might set aside judgment of the father's avoidant behavior and seek to better understand his experiences and help him work through his pain toward a goal of re-

unification. Having empathy is important for building relationships, so that even when a social worker has to follow a course of action that is upsetting to parents but necessary in the best interest of the child, a genuine concern for the parent is evident. Understanding what a parent is dealing with won't necessarily change what you must do, but it can change how you do it.

In working with birth parents, trauma-informed child welfare workers ask themselves questions such as:

- How might trauma influence parents' current abilities to nurture and care for their child?
- How have parents managed all that's happened to them?
- How does the parent experience the agency or the work of the child welfare system?
- How can I minimize trauma triggers for parents and help them draw on their strengths to increase child and family safety and well-being?

Using these questions as a guideline can help reduce the extent to which parents re-experience trauma; it can also help parents find in the agency's interactions a source of hope and healing from the effects of trauma.

According to Pease (2012), "the **relationship** is the criti-

Resource Families

Resource families, too, may have trauma histories. In fact, they may have trauma reactions triggered by the struggles of the children in their homes. This, in turn, can have an impact on placement stability. We need to be sure to support resource families around trauma as well.

Trauma Can Affect Parents by...

- **Compromising their ability to make appropriate judgments about safety.** Some parents may be over-protective; others may not recognize situations that could be dangerous for the child.
- **Making it hard to form and maintain secure, trusting relationships.** This can lead to:
 - Disruptions in relationships with infants, children, and teens, and/or negative feelings about parenting; parents may personalize their children's negative behavior, resulting in ineffective or inappropriate discipline.
 - Challenges in relationships with caseworkers, foster parents, and service providers and difficulties supporting their child's therapy.
- **Impairing their capacity to regulate their emotions.**
- **Causing them to develop poor self-esteem and maladaptive coping strategies,** such as substance abuse or abusive intimate relationships that parents maintain because of a real or perceived lack of alternatives.
- **Making them vulnerable to trauma triggers,** which are extreme reactions to situations that seem benign to others. These responses are especially common when parents feel they have no control over the situation, such as facing the demands of the child welfare system. Moreover, a child's behaviors or trauma reactions may remind parents of their own past traumas or feelings of helplessness, which can cause impulsive or aggressive parent behaviors toward the child. Parents

also may seem disengaged or numb (in efforts to avoid trauma reminders), making engaging with parents and addressing the family's underlying issues difficult for caseworkers and others.



- **Impairing their ability to make decisions,** making future planning more challenging.
- **Making them more vulnerable to other life stressors,** including poverty, lack of education, and lack of social support. These stressors can worsen trauma reactions.

Reprinted from *Birth Parents with Trauma Histories and the Child Welfare System: A Guide for Child Welfare Staff*. National Child Traumatic Stress Network, 2011.

cal tool.” Social workers who are empathetic and form partnerships with parents lay the foundation for interactions that assist in trauma recovery. “Workers need to provide a psychologically safe setting for children and families while inquiring about emotionally painful and difficult experiences” (NCTSN, 2008). One way to let parents know a social worker cares about their emotional well-being is to acknowledge the physical environment. One could say, “If there are things here that make you feel unsafe or uncomfortable, let me know...we will try to make things comfortable and safe...” (Pease, 2012). Another way to assure parents and reduce triggers is to help them know what to expect throughout child welfare process; minimize surprises.

Acknowledging culture and language is another important aspect of engaging birth parents. Approach families with an understanding that some cultural groups have experienced trauma through involvement with child welfare or government systems. Based on that history, they have good reason to be wary of child welfare agencies. Appreciate their resilience.

Recognize the challenges that immigration presents to many families. “When immigrant families come to the United States, they lose familiar references and routines, and communication is often difficult because of language barriers. For those families who have also experienced trauma, even the small details of everyday life add to the stress and confusion” (NCTSN, 2012). Advocate for multilingual staffing that meets families’ language needs. Stay informed about world events and social/political situations in other countries and consider how these may impact the stress levels of families here who have loved ones or other ties in those countries.

Trauma-informed practice includes working alongside birth parents to find safe housing and living environments

if these are not already in place. Parenting one’s children while dealing with the effects of trauma is difficult enough;

RESOURCES FOR FAMILIES

Birth Parents with Trauma Histories in the Child Welfare System: A Guide for Birth Parents (2012)

www.nctsn.org/sites/default/files/assets/pdfs/birth_parents_trauma_history_birth_parents.pdf

Birth Parents with Trauma Histories and the Child Welfare System: A Guide for Resource Parents (2011)

www.nctsn.org/sites/default/files/assets/pdfs/birth_parents_trauma_resource_parent_final.pdf

worrying about personal safety compounds the stress.

Engage parents by providing them with opportunities to disclose information about their own or their children’s traumatic experiences. Strengthen parenting capacity by educating families about child and adult trauma.

In addition, focus on visitation for birth parents and their children. Ensuring “frequent and quality visits between parents and children is essential to reducing overwhelming emotions associated with trauma and minimizing disruptions in relationships” (CECMH, 2011). Through visitation parents have an opportunity to nurture their children and build on the skills they have for providing a safe, loving home. Referring parents to resources for trauma recovery can improve visitation as parents build on relationship and safety skills.

Ultimately, helping a birth parent who is hurting from traumatic experiences benefits both the parent and the child. Simply by reserving judgment, learning, asking and interacting positively with parents we communicate our desire to be trusted partners. ♦

Suggestions for Trauma-Informed Practice with Families

Child welfare professionals cannot undo parents’ traumatic experiences, but they can:

- Understand that parents’ anger, fear, or avoidance may be a reaction to their own past traumatic experiences, not to the caseworker him/herself.
- Assess parents’ history to understand how past traumas may inform current functioning and parenting.
- Motivate parents by approaching them in a non-judgmental, non-blaming, strengths-oriented way.
- Build on parents’ desire to keep their children safe and reduce children’s challenging behaviors.
- Help parents understand the impact of past trauma on current functioning and parenting, while still holding them accountable for maltreatment. Many parents are empowered and motivated when they learn there is a connection between their past experiences and their present reactions and behavior.
- Pay attention to how trauma plays out during CFTs, home visits, visits to children in foster care, and court hearings. Help parents anticipate their possible reactions and develop different ways to respond to stressors and trauma triggers.
- Refer parents to trauma-informed services whenever possible. Generic interventions that do not take into account parents’ underlying trauma issues may not be effective.
- Become knowledgeable about evidence-supported trauma interventions to include in service planning.
- Advocate for the development and use of trauma-informed services in your community.

Reprinted from *Birth Parents with Trauma Histories and the Child Welfare System: A Guide for Child Welfare Staff*. National Child Traumatic Stress Network, 2011. http://nctsn.org/sites/default/files/assets/pdfs/birth_parents_trauma_history_fact_sheet_final.pdf

A MEMO WORTH READING

In April the Administration for Children and Families (ACF) issued an information memorandum entitled “Promoting Social and Emotional Well-Being for Children and Youth Receiving Child Welfare Services” (ACYF-CB-IM-12-04). In this document, ACF urges child welfare systems nationwide to do more to attend to children’s behavioral, emotional, and social functioning—those skills, capacities, and characteristics that enable young people to understand and navigate their world in healthy, positive ways.

In explaining why this is such an important area of emphasis, this information memorandum presents ACF’s official framework for child well-being and describes in a very clear way trauma’s effects on children in six key areas:

- Neurological impact
- Traumatic impact

- Behavioral impact
- Relational competence
- Mental health, and
- Psychotropic medication.

A MUST READ

Reading this memo will give you a clearer sense of what the federal government is thinking about trauma-informed practice, the use of evidence-based practices, and much more. You can find it online at <http://1.usa.gov/J0zL1r>, or click on the image above. ♦



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