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For North Carolina's Child Welfare Workers
From the NC Division of Social Services and the Family and Children's Resource Program

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Children's Services Practice Notes is a publication for child welfare workers produced four times a year by the North Carolina Division of Social Services and the Family and Children's Resource Program, part of the Jordan Institute for Families and the School of Social Work at the University of North Carolina at Chapel Hill.

In summarizing recent 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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POSTTRAUMATIC STRESS DISORDER

Researchers recently examined outcomes for 659 young adults who had been placed in family foster care as children. One of the most remarkable things they discovered was that one in four (25.2%) of these foster care "alumni" had experienced posttraumatic stress disorder (PTSD) within the previous 12 months (Pecora et al., 2005). This rate of PTSD is nearly double that of US war veterans.

People who think of PTSD as something caused only by the trauma and terror of military combat will probably be shocked by this finding. However, if you work in child welfare, shock is probably not your reaction. You know all too well the effects abuse, neglect, and placement instability can have on children. And yet the implications of this finding for your work are huge.

As you will learn in this issue, PTSD significantly undermines a child's well-being. Left untreated, it can put children at risk for school difficulties, attachment problems, additional psychological disorders, substance abuse, and physical illness. When the children grow up, PTSD can interfere with economic self-sufficiency. The trauma experienced by children can also profoundly affect child welfare workers.


Photo Illustration

PTSD is one of the most common diagnoses of children in foster care.

Family support and child welfare workers and their agencies must be able to recognize the signs of PTSD and they must be prepared to respond in an appropriate and timely way when they come across it. The health and well-being of children—perhaps their very futures—depend on it. ◆

PTSD AND CHILDREN IN THE CHILD WELFARE SYSTEM

A trauma is a psychologically distressing event that is outside the range of usual human experience, one that induces an abnormally intense and prolonged stress response (Child Trauma Academy, 2002).

Despite the fact that they are outside the range of usual human experience, traumatic events are fairly common, even among children. In their study of children and adolescents (9-16 years old) in Western North Carolina, Costello et al. (2002) found that 25% had experienced at least one potentially traumatic event. In her review of the literature, Solomon (2005) found 90% of people surveyed experience at least one traumatic event during their lifetimes.

Events that can induce trauma include the sudden death of a loved one, assaultive violence (combat, domestic violence, rape, torture, mugging), serious accidents, natural disasters, witnessing someone being injured or killed, or discovering a dead body.

In child welfare, physical and sexual abuse are common sources of trauma in children. Other causes of childhood trauma can include animal attacks (dog bite), life-threatening illnesses, and prolonged separation from caretakers.

TYPICAL REACTIONS

Normal, immediate reactions to trauma cover a wide range and can include overwhelming feelings of helplessness, fear, withdrawal, depression, and anger. Reactions may last for weeks or months but *cont. p. 2*

PTSD AND CHILDREN IN THE CHILD WELFARE SYSTEM *continued from page 1*

more commonly show a swift decrease after the direct impact subsides (Goodman, 2002). Child welfare workers should look for and be able to spot the age-specific reactions to trauma described in the box below. Know that children are less likely to exhibit some of the well-known adult symptoms of PTSD (e.g., flashbacks).

With informal support, most trauma survivors recover on their own in a few weeks.

The intensity of a person's reaction immediately after a traumatic event is not predictive of that person's chances of developing PTSD. The most important indicator of subsequent risk of chronic PTSD seems to be the severity or number of posttrauma symptoms from about 1 to 2 weeks after the event onward (McNally et al., 2003). Adversities experienced for an extended period after the trauma (such as a series of different placements or separation from a caregiver) and the supports available to children also influence their risk for more serious posttraumatic stress reactions.

With informal support, the majority of trauma survivors recover on their own within a few weeks (NIMH, 2001), though some need longer to heal. For a small minority, however, traumatic events trigger various mental disorders, including PTSD.

PTSD

PTSD may arise weeks, months, or even years after the traumatic event (NIMH, 2001). Formal diagnosis of the disorder may be made only by a qualified professional. A person can be diagnosed with posttraumatic stress disorder only when all three of the following conditions are met: (1) the person has experienced, witnessed, or been confronted with an event or events that involve actual or threatened death or serious injury, or a threat to the physical integrity of oneself or others; (2) the person's response involved intense fear, helplessness, or horror (in children, this may be expressed by disorganized or agitated behavior); and (3) he or she exhibits at least one of the following symptoms for longer than one month:

- *Re-experiencing* the event through play or in trauma-specific nightmares or flashbacks, or distress over events that resemble or symbolize the trauma
- Routine *avoidance* of reminders of the event or a general lack of responsiveness (e.g., diminished interests or a sense of having a foreshortened future)
- Increased sleep disturbances, irritability, poor concentration, startle reaction and regressive behavior

The symptoms must cause distress or impair functioning (APA, 1994).

It is important to note that many children experience great distress from traumatic events but do not, for one reason or another, qualify for a diagnosis of PTSD. However, these children should also be screened and, if appropriate, treated by a qualified mental health professional.

Rates of PTSD are higher in children and adolescents recruited from at-risk samples than they are for the general population (Hamblen, 1999). In their study of PTSD in children in foster care, Dubner and Motta (1999) found PTSD was diagnosed for 60% of sexually abused children and 42% of physically abused children. Dubner and Motta also found 18% of the foster children who had experienced neither physical nor sexual abuse also had PTSD. These children may have developed PTSD due to exposure to domestic violence, community violence, or other events (Marsenich, 2002).

Another study examining children entering foster care aged six to eight found that one out of three met criteria for PTSD (Dale et al., 1999).

It has also been suggested that the incidence of PTSD may be higher in individuals with developmental disabilities (Pitonyak, 2005). This may have serious implications for child welfare work, since according to CWLA (1998) 20% of the children in foster care have some form of developmental disability. *cont. p. 3*

HOW CHILDREN AND ADOLESCENTS REACT TO TRAUMA

The following are typical reactions to a traumatic event and are not necessarily indicative of PTSD or another disorder. *Source of the following: NIMH, 2001*

Ages 5 and younger: may fear being separated from parent, crying, whimpering, screaming, immobility and/or aimless motion, trembling, frightened facial expressions, and excessive clinging. May regress—return to behaviors exhibited at earlier ages (e.g., bed-wetting, fear of darkness). Children of this age are strongly affected by the parents' reactions to the traumatic event.

Ages 6 to 11: may show extreme withdrawal, disruptive behavior, and/or inability to pay attention. Regressive behaviors, nightmares, sleep problems, irrational fears, irritability, refusal to attend school, outbursts of anger and fighting are common. Child may complain of stomachaches or other bodily symptoms that have no medical basis. Schoolwork often suffers. Depression, anxiety, feelings of guilt, and emotional numbing or "flatness" are often present as well.

Ages 12 to 17: may exhibit responses similar to those of adults, including flashbacks, nightmares, emotional numbing, avoidance of reminders of traumatic event, depression, substance abuse, problems with peers, and antisocial behavior. Also common are withdrawal and isolation, physical complaints, suicidal thoughts, school avoidance, academic decline, sleep disturbances, and confusion. May feel extreme guilt over his or her failure to prevent injury or loss of life, and may harbor revenge fantasies that interfere with recovery.

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About half of those with PTSD recover completely within three months, but others suffer chronically. If a person has symptoms for more than a year, it will usually be a lifelong condition if not treated (APA, 1994). Even if PTSD does become chronic, treatment can alleviate many symptoms.

It is important to have children assessed by mental health practitioners who have training and experience with PTSD and child trauma. A therapist we spoke to said she often sees traumatized children who have been misdiagnosed as having attention problems or oppositional defiant disorder (ODD). Misdiagnosis can subject children to inappropriate, ineffective interventions while depriving them of the treatment they need.

RISK AND PROTECTIVE FACTORS

PTSD can develop in individuals without any predisposing conditions, especially if the traumatic event is extreme. However, research has identified factors influencing an individual's likelihood of experiencing PTSD.

Goodman (2002) states that trauma-exposed children are most at risk if they have:

- Physical injuries as a result of the event (e.g., physical abuse)
- Personally witnessed the event (e.g., domestic violence, abuse of a sibling, community violence)
- Pre-existing mental health issues or learning difficulties
- A limited support network
- Someone close to them who is missing, hurt, or dead
- Caregivers who are experiencing emotional difficulty
- Pre-existing or consequent family life stressors (e.g., divorce, job loss)
- Previous loss or trauma experiences (may include multiple placements in foster care)

PTSD may be especially severe or long lasting when the stressor is of human design, as in cases of sexual abuse (Flick & Woodcock, 2002a).

WHAT DOES IT FEEL LIKE TO HAVE PTSD?

Photo Illustration

Symptoms vary. One person described it this way: "At first it didn't seem to bother me, but now I have terrifying dreams about it and can't seem to get it out of my mind. All I want is to be left alone. My family and friends want me to be the way I used to be, to forget it, but I'm not the same person . . . . If I don't have a couple of drinks I can't get to sleep, and now I'm drinking more. The kids bother me a lot, and I'm pretty irritable and snap at everybody for nothing." (Williams, 1995)

Gender also appears to be a risk factor. Several studies suggest girls are more likely than boys to develop PTSD (Hamblen, 1999).

Factors that reduce a person's chances of developing PTSD include: higher cognitive ability; strong social supports; having a happy, safe childhood in a stable family; and an overall positive outlook/personality (McNally et al., 2003).

IMPACT

Research has shown that if it goes untreated, PTSD affects children, teens, and adults in various ways:

Multiple Diagnoses. PTSD frequently occurs in conjunction with disorders such as depression, problems of memory and cognition (APA, 1994; Harney, 2000), anxiety disorders such as separation anxiety and panic disorder, and externalizing disorders such as attention-deficit/hyperactivity disorder, oppositional defiant disorder, and conduct disorder (Hamblen, 1999). Substance abuse is also a problem; the National Child Traumatic Stress Network (2003) cites a study that found 25% of children with PTSD became substance abusers, compared with 3.7% of non-traumatized children.

Relationships and Behavior. Children who have experienced traumas often have relationship problems with peers and family members and problems with acting out (Hamblen, 1999). Exposure to trauma, especially community violence, has been linked to aggressive and anti-social behavior (NIMH, 2001). Adults with posttraumatic stress symptoms are more likely to report marital problems (Solomon, 2005).

Physical Health. Solomon (2005) found in her research review that PTSD increases a person's risk for serious and chronic disease, including circulatory, digestive, musculoskeletal, endocrine, respiratory, and infectious diseases. She also notes that trauma victims are less likely than others to take steps to protect their health (e.g., fewer preventive healthcare visits, exercising and using seatbelts less). Child maltreatment in general is linked to a long list of later adult health problems (Felitti et al., 1998).

School Performance. Because it contributes to difficulties with behavior, relationships, mental health, attention, concentration, and memory tasks, PTSD has also been linked to school failure (Goodman, 2002).

Finances and Employment. Amaya-Jackson (cited in Solomon, 2005) found that adults with posttraumatic stress symptoms were much more likely to miss work, to experience insufficient income, and to be receiving public assistance (food stamps, Medicaid, TANF) than people without symptoms.

CONCLUSION

PTSD represents a special threat to children involved with the child welfare system. The potential costs of PTSD—for these children and for society—are significant.

The article on the next page suggest ways that workers and agencies can respond to children and families affected by traumatic events. ◆

A CHILD WELFARE RESPONSE TO TRAUMATIZED CHILDREN

To improve mental health outcomes for children and families, professionals in all service areas within departments of social services—including those in Work First and economic services—should have the following core knowledge and skills:

- Understand PTSD and traumatic stress
- Be able to identify events and experiences likely to cause trauma
- Be able to recognize the range of trauma reactions in children of different ages and cultural backgrounds, and in adults
- Know how and when to document and pass on to others in the agency information about a child or family struggling with traumatic stress
- Be able to obtain appropriate and timely mental health services for children and adults
- Understand the consequences of a child's lifetime trauma history for his or her current behavior

We hope the articles in this issue, including the discussion below, will help you develop some of this knowledge. For additional learning resources, consult *Training Matters*, v. 6, n. 3 (www.trainingmatters-nc.org).

Photo illustration

There is a need for more mental health screening of children involved with child welfare.

ENHANCING WORKER-CHILD INTERACTIONS

Interviewing. McNally and colleagues (2003) advise us to respect a trauma survivor's wishes about whether to talk about the trauma, and we know that most victims of child maltreatment, especially sexual abuse, can be retraumatized by interviews (Faller, 1993). Yet to ensure child safety and well-being—and do their jobs—child welfare workers must interview children, even those who have been traumatized.

To minimize the harm caused to traumatized children, professionals should reduce the number of interviews whenever possible by conducting joint interviews with law enforcement and by ensuring that interview practices are informed by policy, research, and practice guidelines (Faller, 1993). For example, proper use of the Stepwise Interview, a structured interview process, permits the child to state information in his or her own words as much as possible, which may reduce retraumatization (Flick & Woodcock, 2002b). To learn more about this interview process, attend the in-service training *Introduction to Child Sexual Abuse* (to register, go to www.ncswtrain.org). *Practice Notes* v. 8, n. 1 also discusses interviewing (www.practicenotes.org).

Using Trauma Assessment Tools. The National Child Traumatic Stress Network (NCTSN) encourages professionals to use tools such as the Trauma Symptom Checklist for Children and the Trauma Symptom Checklist for Young Children to help identify traumatic stress and PTSD in children (Taylor & Siegfried, 2005). The NCTSN explains that these tools, which are multiple item instruments that take approximately 20 minutes to administer, will help ensure workers have the information they need to meet children's needs. These tools are relatively inexpensive and available online at <www3.parinc.com>.

Collect Information on a Child's History. The NCTSN also believes that workers can support traumatized children by collecting more thorough information about a child's history. Children with a history of multiple foster placements often lack a sense of continuity about their lives. By gathering information about a child's history, relationships, strengths, and accomplishments, workers and foster parents can help organize the child's life and help the child structure his or her thoughts and memories into a coherent narrative. Therapists and caretakers can also benefit from more thorough information about a child's trauma history. Trauma history profiles help clinicians and caretakers form a more comprehensive and appropriate treatment plan and address underlying causes of emotional and behavioral problems. A trauma profile template is available online at <www.nctsnet.org>.

Promoting Recovery and Resiliency. The following may help traumatized children:

- Provide Information. Explain to children that it is very normal for people to have symptoms of PTSD after a traumatic event (McNally et al., 2003). *cont. p. 5*

PREVENTING PTSD IN CHILDREN

Adapted from Goodman, 2002

Parental support influences how well children cope after a traumatic event. Birth, foster, and adoptive parents, kin caregivers, and professionals can help children by:

- Providing a strong supportive presence
- Modeling and managing their own expression of feelings and coping
- Establishing routines with flexibility
- Accepting children's regressed behaviors while encouraging and supporting a return to age-appropriate activity
- Helping children use familiar coping strategies
- Helping children share in maintaining their safety
- Allowing children to tell their story in words, play, or pictures to acknowledge and normalize their experience
- Discussing what to do or what has been done to prevent the event from recurring
- Maintaining a stable, familiar environment

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Send the message that the emotions they are experiencing are normal, their reactions will not last forever, and that you accept what they are feeling. "Resist the temptation to talk a child out of fear, sadness, anger, embarrassment, guilt, or shame to avoid your own discomfort" (Levine & Kline, 2002).

- Maintain/Establish that One Key Relationship. Children do well, even under terrible conditions, when they have a relationship with at least one adult who is extremely supportive and accepting, who frequently spends time with them, is concerned about their welfare, and provides them with guidance, discipline, and information (Goodman, 2002).
- Teach Calming Techniques. "Give children the opportunity to relax through play, talk, art activities, music, or physical comforting. Exercise, muscle relaxation techniques, deep breathing exercises, and using calm mental images are techniques proven to reduce stress. Talk to a professional to learn more about these methods. Teenagers should be advised to avoid unhealthy means of stress reduction such as smoking or using alcohol or drugs" (Goodman, 2002).
- Monitor Environmental Stressors. In addition to being vulnerable to "triggers" that remind them of the specific traumatic event they experienced, children in the child welfare system are more vulnerable to the psychological effects of other traumatic events or potentially stressful incidents, such as school violence and terrorist attacks. Be prepared to support them (BPNP, 2002).
- See and Build Strengths. Though her behaviors may be difficult, see the child as a tough survivor whom you are helping to recover and thrive (Pitonyak, 2002). Remember these behaviors are not the child's fault, nor something she can control (Flick & Woodcock, 2002a).

IMPROVING PLACEMENT

The Northwest Foster Care Alumni Study (Pecora et al., 2005) found that child welfare agencies can help prevent PTSD and other negative mental health outcomes for foster children by improving placement stability—that is, by reducing the number of placements, shortening length of stay in care, reducing the number of placement moves a child experiences each year, etc. While this study validates the emphasis North Carolina already puts on placement stability, it should also inspire workers and agencies to redouble *cont. p. 8*

EFFECTIVE TREATMENT FOR PTSD

When a child or adolescent has PTSD, timely diagnosis and treatment are crucial (NIMH, 2001). Indeed, if a person has symptoms for more than a year, it will usually be a lifelong condition if left untreated (APA, 1994). Child welfare agencies should therefore sustain or develop strong collaborative ties with mental health providers.

Ideally agencies will have access to a mental health professional who has experience treating PTSD in children and adolescents. Many therapists with this experience are members of the International Society for Traumatic Stress Studies <www.istss.org>. The SIDRAN Institute <www.sidran.org> also has a directory of therapists who treat clients who have experienced psychological trauma, childhood abuse, or dissociation. SIDRAN is a national nonprofit organization devoted to helping people who have experienced traumatic life events.

Child welfare agencies should monitor the child's condition carefully to ensure he or she is receiving proven interventions, such as those described below.

Cognitive Behavioral Therapy (CBT). This treatment has been proven effective with PTSD and the other four most common mental health diagnoses among foster children—oppositional defiant disorder, mood disorders and depression, adjustment disorder, and conduct disorder (Marshall, 2004). According to several major reviews of the research literature, trauma-focused CBT is clearly best practice with children who have been sexually abused and have PTSD symptoms (Chadwick Center, 2004).

In CBT, cognitive training helps children restructure their thoughts and feelings so they can live without feeling threatened. Behavioral interventions teach children to face their fears so they no longer avoid people and places that remind them of the event. Children are taught relaxation techniques and then carefully guided in telling the story of the event. These strategies teach children to handle their fears and stress effectively. In CBT parents or caregivers are often trained to help the child with new coping strategies (Goodman, 2002).

To learn more about CBT consult *Closing the Quality Chasm in Child Abuse Treatment: Identifying and Disseminating Best Practices*, available online at <www.chadwickcenter.org/kauffman.htm>.

Medication. Various medications have proven useful in helping adults reduce the overwhelming symptoms of arousal that often accompany PTSD. However, "research is just beginning on the use of medications to treat PTSD in children and adolescents" (NIMH, 2001).

Treatment Duration. A common period of time for treatment of PTSD is 6 to 12 weeks with occasional follow-up sessions, though treatment may be longer depending on a patient's circumstances. For young children treatment may last a year or more. Research has shown that support from family and friends can be an important part of recovery (NIMH, 2001).

TRAUMATIC STRESS AND CHILD WELFARE WORKERS

Sarah (not her real name) began as a child protective services investigator. Though it was often hard, she enjoyed the work. She saw the stress as just a part of the job, a job she did well.

Years went by before she experienced her first trauma reaction.

At first she didn't know what was going on. She had a full-blown panic attack in the midst of a meeting. She began to shake and sweat. She felt dizzy. Her heart was pounding and she couldn't catch her breath. Sarah says: "I thought I was dying."

Something in the meeting—she's still not sure what—caused the attack.

She called her physician that day. After examining her, the doctor referred her to a mental health professional, who eventually diagnosed her with PTSD.

During treatment Sarah concluded her PTSD was caused by several traumatic incidents she experienced years before as an investigator. "I never processed those events," Sarah says. "I never dealt with those feelings."

With the help of her therapist and some time, she made a complete recovery, but the experience has made her a passionate advocate for worker self-care. For agencies and child welfare workers, she says, traumatic stress and the need for self-care are truly the "elephant in the room."

* * * * * * *

Everyone familiar with child welfare understands that exposure to trauma is an inherent part of working with maltreated children. Yet sometimes—as a system and as individuals—we choose to deny this fact.

When we do, it is often with the best intentions. We know that experiencing or hearing about trauma doesn't change the fact that there are families and children out there who need help right away. In the context of client needs and agency turnover it can be easy to convince ourselves that taking the time to step back and deal with our reactions is a luxury we simply cannot afford.

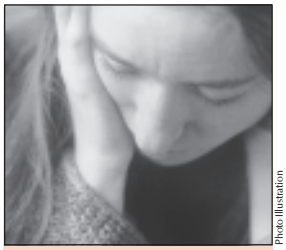

Photo illustration

Preventing and managing traumatic stress must be shared by the agency and workers—neither can do it alone.

Yet the costs of this choice can be high. Unresolved trauma reactions can hurt workers' physical and mental health. This impacts turnover, morale, and general agency function, which in turn affect an agency's ability to help clients achieve positive outcomes.

For agencies and individuals interested in helping staff deal with trauma in a healthy way, a good starting place is a basic knowledge of posttraumatic stress disorder (PTSD) and secondary traumatic stress.

PTSD

In the course of their work, child welfare professionals may be exposed to real or perceived threats to their lives and the lives of others. Threats may come in the form of violent family members, car accidents, drive-by shootings, or other street violence. Just like other people, most child welfare workers will have short-lived reactions to these threats, reactions similar to the teen reactions described in the box on page 2. With support from their colleagues and families, most of these workers will recover without formal assistance.

However, traumatic events will trigger various mental disorders, including PTSD, in a few child welfare workers. Agencies and supervisors must know that it is very normal for a worker to exhibit short-term problems (e.g. poor sleeping and eating, lack of enthusiasm) after a traumatic event.

However, if these symptoms persist for more than a month it is vital that the worker receive treatment from a mental health professional with training and experience in treating trauma (Child Trauma Academy, 2002). To ensure workers get the help they need, agencies must cultivate a work culture that normalizes (and does not stigmatize) the need for mental health services. Timely diagnosis and treatment of PTSD are crucial; one of the best treatments is Cognitive Behavioral Therapy (CBT).

Some organizations engage the services of professionals to offer **critical incident stress debriefing** (CISD) after traumatic events. CISD is a specific, structured group process that has been widely used with EMS providers, disaster relief workers, etc. However, most studies show individuals who receive this type of debriefing fare no better than those who do not (McNally et al., 2003).

This is not to say that voluntary one-on-one or small group *cont. p. 7*

INDIVIDUAL INDICATORS OF DISTRESS

According to the Child Trauma Academy (2002) there are indicators that can tell child welfare workers when they are at risk for secondary traumatic stress.

- **Emotional** indicators can include anger, sadness, prolonged grief, anxiety, depression
- **Physical** indicators can include headaches, stomachaches, lethargy, constipation
- **Personal** indicators can include self-isolation, cynicism, mood swings, irritability with spouse or family
- **Workplace** indicators can include avoidance of certain clients, missed appointments, tardiness, lack of motivation

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discussions with people who want to talk about their reactions to trauma are not helpful. At the very least, being open to talking about trauma can send the message that the agency cares about employee well-being.

Because it teaches them to recognize, avoid, and respond to work-related dangers, safety training may be another way for agencies to reduce workers' risk of developing PTSD. See <www.ilrinc.com> for well-developed worker safety training materials. See also *Practice Notes,* v. 3 n. 2., "A Look at Safety in Social Work."

STS

Due to the nature of their work, child welfare workers are perhaps even more at risk for secondary traumatic stress (STS). Secondary trauma, also referred to as *compassion fatigue* (Figley, 1995) and *vicarious traumatization* (Pearlman & Saakvitne, 1995), is defined as indirect exposure to trauma through a firsthand account of a traumatic event. The vivid recounting of trauma by the survivor causes trauma reactions in the helping person.

Symptoms of STS closely resemble those of PTSD, and can include increased fatigue or illness, emotional numbing, social withdrawal, reduced productivity, feelings of hopelessness, despair, re-experiencing, avoidance, and hyperarousal (Nelson-Gardell & Harris, 2003; Zimering et al., 2005).

Incidence. As with PTSD, most professionals will find that the reactions they have to clients' traumatic stories will decrease on their own after a short while. Only a small percentage of individuals will develop full-blown STS (Zimering et al., 2005).

The few studies that have been done on STS in child welfare workers suggest the incidence of the disorder in this population is relatively high. For example, a 1999 study of CPS workers in the South found that up to 37% of respondents were experiencing clinical levels of emotional distress associated with STS (BPNP, 2002).

Possible Risk Factors. Findings from Schauben and Frazier (1995) suggest that the more trauma survivors a helping professional has in her caseload, the more symptoms of STS she is likely to have herself.

Nelson-Gardell and Harris (2003) hypothesize that a worker's ability to empathize with clients may itself be a risk factor for STS. They suggest that although empathizing with a traumatized client helps the worker understand the client, the empathic connection may actually transmit the client's trauma to the worker.

A worker's personal history may put him at increased risk of developing STS. According to one study, having been abused or neglected as a child increases one's risk of STS. The study found a history of emotional abuse or neglect made individuals most vulnerable (Nelson-Gardell & Harris, 2003).

Other studies found no correlation between personal trauma history and STS symptoms in mental health providers (Zimering et al., 2005).

Impact. In addition to affecting workers, trauma reactions may interfere with the ability of helping professionals to serve their clients (Bride, et al., 2003; Zimering et al., 2005). Untreated trauma reactions can also damage a worker's personal relationships.

Identification and Treatment. If workers exhibit symptoms of PTSD or STS for more than one month they should consult a qualified mental health professional. To access tools that may help you determine whether you have STS, visit the online version of this issue <www.practicenotes.org>.

PREVENTING STS

Pearlman and Saakvitne (1995) identified four areas they say are important to the prevention of STS in mental health providers:

- Professional strategies (e.g., balanced caseloads, accessible supervision)
- Agency strategies (e.g., sufficient release time, safe physical space)
- Personal strategies (e.g., respecting your limits, taking time for self-care)
- General coping strategies (e.g., self-nurturing, seeking connection)

Thus far, no studies have evaluated the effectiveness of these prevention strategies (Zimering et al., 2005).

Additional strategies for addressing traumatic stress include:

- Administrators and staff developers should factor in STS and PTSD when thinking about developing and retaining staff (Nelson-Gardell & Harris, 2003).
- Agencies should ensure employee health plans cover mental health services.
- Supervisors must help workers establish boundaries between themselves and their clients, give them a chance to talk about how they've been affected by trauma, and help them recognize the need to find balance in their work and personal lives (Child Trauma Academy, 2002).
- Workers should know and use stress management techniques. For more on this, visit this issue at <www.practicenotes.org>.

CAVEAT

Direct and indirect exposure to trauma can negatively impact practitioners and the services they deliver. However, work with trauma survivors can also be immensely rewarding. Professionals who are vigilant about taking care of themselves and who receive consistent support from their supervisors and others often find that working with trauma victims enables them to grow personally and professionally (Zimering et al., 2005). ◆

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their efforts. To improve placement, child welfare and family support agencies and practitioners should consider the strategies in the box on this page.

CONCLUSION

Agencies do not have full control over what happens to children exposed to traumatic events, but they have an extremely important role to play. If they take appropriate action in the areas of training, policy, and practice, and if they have strong collaborative relationships with foster parents, mental health, the schools, and others, agencies will strengthen their ability to help trauma-exposed children recover and achieve positive life outcomes. ◆

STRATEGIES FOR AGENCIES AND WORKERS

Photo illustration

Agencies wishing to enhance mental health and educational outcomes for the children they serve should do all they can to **improve the stability of foster placements** (Pecora et al., 2005). To do this they should consider the following:

- Give caregivers full information. Foster parents' role as emotional stabilizers is critical; their influence upon the child is far reaching (Friedman, 2003). Complete information will help them advocate for the child and provide support.
- Build a crisis support plan that really works. Ask caregivers questions such as "What would you need if the child had a terrible day and nothing you could do would make him calm down? What would you need to feel safe?" (Pitonyak, 2002).
- Increase availability of respite services to give foster parents a break; provide timely crisis intervention services to prevent disruption (Pecora et al., 2005).

Training

- Provide specialized training to therapists who work with children and youth to enable them to properly assess and treat PTSD, depression, and other disorders (Pecora et al., 2005).
- Provide education and training for frontline staff and supervisors on trauma assessment, evidence-based trauma treatment, and the importance of traumatic reminders.
- Provide training and regular meetings to foster parents and other caregivers of children with PTSD; emphasize the child's ability to recover and heal (Pitonyak, 2002).

Other Ideas

- Use a child trauma profile instrument in the assessment and interview process so workers have a complete understanding of the child's trauma history.
- Given the higher rate of unmet mental health needs among children of color—African American and Hispanic children are least likely to receive services, and they need to display more pathology to be referred for mental health services (BPNP, 2003)—agencies should make a special effort to integrate culturally responsive mental health services with foster care programs (Pecora et al., 2005).

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