

Module 4: Trauma and the Child



Table of Contents

Unit 4.1: Trauma and its impact on the Child

What is Trauma?

Types of Childhood Trauma

What is Child Traumatic Stress (CTS)?

Child Development Stages Matrix

Impact of Trauma on the Child's Brain

The Impact of Trauma on Very Young Children

Compact Trauma and How it Impacts Children

Impact of Traumatic Stress on Visible Behavior

Trauma-Related Behavior in Children of Various Ages

Adverse Childhood Experiences (ACE) Study

Long Term Impact of Trauma

Culture and Trauma

Historical Trauma

Unit 4.2: Approaching Children and Families in a Trauma-Informed Manner

Henry's Story

Worksheet: Rewriting Henry's Experience with Us

Using a Trauma-Informed Approach in Child Welfare Practice

My Rules of Thumb – How I will behave in a Trauma-Informed Manner

Parents Must Truly Address the Roots of Their Trauma

How People Exposed to Trauma React to Authority

Unit 4.3: Referring and Advocating for the Child and Family in a Trauma-Informed Manner

Screening, Assessments and Evaluation

Other Referrals and Advocacy

Pharmacology and the Child or Adult

What Medication Does NOT Help

Evidence-Based Trauma-Informed Treatment Practices

Ways to Better Ensure a Trauma-Informed Approach When Culture and Historical Trauma are Considerations

Cultural Scenarios

Cultural Scenarios Worksheet

Unit 4.1: Trauma and its Impact on the Child

What is Trauma?

- Definition of Trauma: Trauma is an emotional response to an event. The emotional response is intense, distressing and/or painful, and can overwhelm your ability to cope. There can be direct involvement in the event or indirect through witnessing the event.
- Trauma also results from the persistent absence of responsive care during infancy and early brain development. The child experiences a lack of protection from his or her parent/caregiver and, as a result, can be severely traumatized.
- The stress that is caused by the trauma is called traumatic stress.
- The National Child Traumatic Stress Network has identified 13 types of trauma:
 - Community violence
 - Early childhood trauma
 - Domestic violence
 - Medical trauma
 - Natural disasters
 - Physical abuse
 - Neglect
 - Refugee and war zone trauma
 - School violence
 - Sexual abuse
 - Terrorism
 - Traumatic grief
 - Complex trauma
- The seven types of trauma that you will typically see in your work as a child welfare professional include:
 - Early childhood trauma
 - Domestic violence
 - Physical abuse
 - Neglect
 - Sexual abuse
 - Traumatic grief
 - Complex trauma or toxic stress

Types of Childhood Trauma

- **Early childhood trauma:** Generally refers to the traumatic experiences that occur to children aged 0-6. These traumas can be the result of intentional violence, such as child physical or sexual abuse and/or domestic violence, the persistent absence of responsive care or as the result of a natural disaster, accidents, or war.
- **Domestic violence** (intimate partner violence, domestic abuse, or battering): Actual or threatened physical or sexual violence, or emotional abuse between adults in an intimate relationship.
 - Three to 10 million children are exposed to domestic violence in the United States every year – most are under the age of eight.
- **Physical abuse:** Causing or attempting to cause physical pain or injury. It can result from punching, beating, kicking, burning or harming a child in other ways.
- **Child sexual abuse:** Takes place between a child and an older person or alternatively between a child and another child/adolescent.
 - Bodily contact: Such as sexual kissing, touching, fondling of genitals, and intercourse.
 - No bodily contact: Genital exposure ('flashing'), verbal pressure for sex, and sexual exploitation for purposes of prostitution or pornography.
- **Child neglect:**
 - When a parent or caregiver does not give a child the care he or she needs according to his/her age, even though that adult can afford to give that care or is offered help to give that care.
 - When a parent/caregiver is not providing a child with medical or mental health treatment or not giving prescribed medicines the child needs.
 - Neglect also includes exposing a child to dangerous environments or having poor supervision for a child (such as putting the child in the care of someone incapable of caring for children).
- **Child traumatic grief:** When someone important to the child dies - suddenly and unexpectedly, or even anticipated. The distinguishing feature of child traumatic grief is that the trauma symptoms interfere with the child's ability to go through the typical process of bereavement.
 - The child experiences a combination of trauma and grief symptoms so severe that any thoughts or reminders, even happy ones, about the person who died can lead to frightening thoughts, images, and/or memories of how the person died.
- **Complex trauma:** A child's exposure to multiple or prolonged traumatic events and the impact of this exposure on their development.
 - Involves simultaneous or sequential occurrences of child maltreatment - including psychological maltreatment, neglect, physical and sexual abuse, and domestic violence - that is chronic, begins in early childhood, and occurs within the primary caregiving system.
 - Often sets off a chain of events leading to subsequent or repeated trauma exposure in adolescence and adulthood.

What is Child Traumatic Stress (CTS)

- Child Traumatic Stress (CTS): A psychological reaction that some children have to a traumatic experience.
- These reactions can linger and affect their daily lives long after the traumatic event has ended.
- Untreated, CTS can interfere with a child's healthy development and lead to long-term difficulties with school, relationships, jobs and the ability to participate fully in a healthy life.
- Psychological trauma in childhood can be just as damaging as trauma that has caused physical injuries.
- Three levels of CTS:
 - Acute traumatic stress refers to exposure to a single event, such as a car accident.
 - Chronic traumatic stress refers to repeated events, such as physical or sexual abuse or exposure to ongoing domestic violence.
 - Complex traumatic stress refers to exposure to chronic, multiple types of trauma.

Child Development Stages Matrix

	Physical	Socio-Emotional	Cognitive	Indicators or Developmental Concern	Positive Parenting Characteristics
0-3 Months	<ul style="list-style-type: none"> ✓ Rapid height & weight gain ✓ Reflexes: sucking, grasping ✓ Lifts head ✓ Responds to sounds by blinking, startling, crying ✓ Shows growing ability to follow objects and to focus 	<ul style="list-style-type: none"> ✓ Concerned with satisfaction of needs ✓ Smiles in response to caregiver's voice ✓ Prefers primary caregiver to stranger 	<ul style="list-style-type: none"> ✓ From birth, infant begins to "learn" with eyes, ears, hands, etc. ✓ Vocalizes sounds (coos) ✓ Smiles when faces evoke memories of pleasure 	<ul style="list-style-type: none"> • Sucks poorly and feeds slowly • Doesn't follow objects with eyes • Doesn't respond to loud sounds • Doesn't grasp and hold objects • Doesn't smile at the sound of the primary caregiver's voice 	<ul style="list-style-type: none"> ✓ Makes eye contact with infant ✓ Interact with infant by talking, smiling, singing, etc. ✓ Gently rocks/bounces infant ✓ Picks infant up when distressed ✓ Allows for self-soothing (infant sucks fingers/pacifier, etc.)
3-6 Months	<ul style="list-style-type: none"> ✓ Rolls over ✓ Holds head up when held in sitting position ✓ Lifts knees, makes crawling motions ✓ Reaches for objects 	<ul style="list-style-type: none"> ✓ Smiles and laughs socially ✓ Responds to tickling ✓ Begins to distinguish own image in mirror from others' images 	<ul style="list-style-type: none"> ✓ Has recognition memory for people, places, and objects ✓ Uses both hands to grasp objects ✓ Exhibits visual interests ✓ Joins with caregiver in paying attention to labeling objects and events (4-6 months) 	<ul style="list-style-type: none"> • Doesn't hold head up • Doesn't coo, make sounds, or smile • Doesn't respond to sounds or turn head to locate sounds • Doesn't roll over in either direction • Not gaining weight 	<ul style="list-style-type: none"> ✓ Helps infant "practice" sitting ✓ Encourages floor time on a blanket for rolling and reaching ✓ Responds to fears, cries by holding, talking, and reassuring ✓ Talks and plays with infant
6-12 Months	<ul style="list-style-type: none"> ✓ Sits alone ✓ Feeds self finger foods; holds own bottle (6-9 months) ✓ Crawls, pulls up, and walks with support (9-12 months) ✓ Baby teeth begin to emerge 	<ul style="list-style-type: none"> ✓ Indicates preference for primary caregivers ✓ May cry when strangers approach (stranger anxiety) ✓ Shows signs of separation anxiety ✓ Repeats performances for attention (9-12 months) ✓ Drops objects on purpose for others to pick up (10-12 months) 	<ul style="list-style-type: none"> ✓ Finds objects hidden repeatedly in one place, but not when moved ✓ Plays peek-a-boo ✓ Has recall memory for people, places, and objects (9-12 months) ✓ Imitates speech sounds ✓ Says da-da and ma-ma and knows who these people are (10-12 months) ✓ Uses preverbal gestures to communicate (by 12 months) 	<ul style="list-style-type: none"> • Doesn't smile or demonstrate joy • Unable to sit without support • Does not follow objects with both eyes • Does not actively reach for objects • Doesn't look or react to familiar caregivers • Does not babble • Shows no interest in playing peek-a-boo (by 8 months) 	<ul style="list-style-type: none"> ✓ Discipline consists of redirecting to different activity. Sharp discipline, scolding, and verbal persuasion are not helpful ✓ Holds and cuddles baby ✓ Reads to baby ✓ Names objects when baby points to something ✓ Maintains consistent bed time routine of cuddling, rocking, and soothing

12-18 Months	<ul style="list-style-type: none"> ✓ Walks alone ✓ Manipulates small objects with improved coordination ✓ Drinks from a cup with a lid and uses a spoon ✓ Builds tower of 2 blocks ✓ Removes hat, socks, and shoes 	<ul style="list-style-type: none"> ✓ Extends attachment for primary caregivers to the world; seems in love with the world and wants to explore everything ✓ Recognizes image of self in mirrors ✓ Solitary or parallel play ✓ Fears heights, separation, strangers, and surprises 	<ul style="list-style-type: none"> ✓ Begins to show intentional behavior, initiates actions (drops, throws, shakes, bangs) ✓ Is curious about everything around him or her ✓ Sorts toys and other objects into groups ✓ Understands object permanence – realizes objects exist when out of sight and will look for them ✓ Says first words (mama, dada, doggie, bye-bye) 	<ul style="list-style-type: none"> • Doesn't respond to name • Unable to finger feed • Not gaining weight • Flat affect (no smiling) • Not interested in play such as peek-a-boo • Not taking steps • Cannot hold spoon • Doesn't look at pictures in book 	<ul style="list-style-type: none"> ✓ Encourages exploration ✓ Applauds child's efforts ✓ Interprets new/unfamiliar situations ✓ Talks to child in simple clear language about things going on in the environment
18-24 Months	<ul style="list-style-type: none"> ✓ Runs and walks up steps ✓ Can help get undressed ✓ Drinks from a cup ✓ Eats with a spoon ✓ Scribbles spontaneously ✓ Loves to practice new skills ✓ Makes tower of 4 blocks 	<ul style="list-style-type: none"> ✓ Likes to hand things to others as play ✓ May have temper tantrums ✓ Shows affection to familiar people ✓ Plays simple pretend, such as feeding a doll ✓ Explores alone but with caregiver close by 	<ul style="list-style-type: none"> ✓ Begins to make two-word combinations that mean something ✓ Imitates words readily and understands a lot more that he or she can say ✓ Shows memory improvements, understand cause and effect; experiments to see what will happen ✓ Begins to sort shapes and colors 	<ul style="list-style-type: none"> • Cannot walk • Does not speak at least 6 words • Does not imitate actions or words • Cannot push a wheeled toy • Does not follow simple instructions • Doesn't notice or mind when a caregiver leaves or returns 	<ul style="list-style-type: none"> ✓ Provides opportunities to choose ✓ Sets appropriate limits ✓ Assists child in coping with range of emotions ✓ Support new friendships and experiences ✓ Responds to wanted behaviors more than disciplining unwanted behaviors

2-3 Years	<ul style="list-style-type: none"> ✓ Has developed sufficient muscle control for toilet training ✓ Is highly mobile – skills are refined ✓ Uses spoon to feed self ✓ Throws and kicks a ball ✓ Disassembles simple objects and puts them back together ✓ Has refined eye-hand coordination- can do simple puzzles, string beads, stack blocks 	<ul style="list-style-type: none"> ✓ Has great difficulty sharing ✓ Has strong urges and desires, but is developing ability to exert self-control ✓ Wants to please parents but sometimes has difficulty containing impulses ✓ Displays affection – especially for caregiver ✓ Initiates own play activity and occupies self ✓ Is able to communicate and converse ✓ Begins to show interest in peers 	<ul style="list-style-type: none"> ✓ Is capable of thinking before acting ✓ Explores language ability – becomes very verbal ✓ Enjoys talking to self and others ✓ Loves to pretend and to imitate people around him or her ✓ Enjoys creative activities – i.e., block play, art ✓ Thinks through and solves problems in head before acting (has moved beyond action-bound stage) 	<ul style="list-style-type: none"> • Cannot run, jump, or hop • Cannot feed self with spoon • Does not speak in simple sentences that use normal word order • Does not enjoy make-believe games • Does not spontaneously show affection for familiar playmates • Does not express a wide range of emotions • Does not separate easily from primary caregiver • Does not object to major changes in routine 	<ul style="list-style-type: none"> ✓ Provides opportunities for child to make choices ✓ Encourages independence and provides guidance with self-care (dressing, hand washing, etc.) ✓ Sings, plays, and dances with child ✓ Counts objects and identifies colors with child ✓ Encourages creativity
3-4 Years	<ul style="list-style-type: none"> ✓ Continues to run, jump, throw, and catch with better coordination ✓ Walks up and down stairs, one foot on each step ✓ Rides tricycle ✓ Uses scissors ✓ Can button and lace ✓ Eats and dresses by self with supervision ✓ Uses toilet or potty chair; bladder and bowel control are usually established 	<ul style="list-style-type: none"> ✓ Emotional self-regulation improves ✓ Understands taking turns and sharing ✓ Self-conscious emotions become more common ✓ Forms first friendships ✓ Shows concerns for a crying friend ✓ May get upset with major changes in routine 	<ul style="list-style-type: none"> ✓ Asks “why” questions – believes there is a reason for everything and he or she wants to know it ✓ Engages actively in symbolic play – has strong fantasy life, loves to imitate and role-play ✓ Speech can be understood by others ✓ Should be able to say about 500 to 900 words ✓ Understands some number concepts ✓ Converses and reasons ✓ Is interested in letters ✓ Scribbles in a more controlled way – is able to draw circles, recognizable objects 	<ul style="list-style-type: none"> • Falls down a lot or has trouble with stairs • Drools or has very unclear speech • Doesn’t use sentences of more than three words • Can’t work simple toys (such as peg boards, simple puzzles, turning handle) • Doesn’t make eye contact • Doesn’t play pretend or make-believe • Doesn’t want to play with other children or with toys • Lashes out without any self-control when angry or upset 	<ul style="list-style-type: none"> ✓ Provides a sense of security by maintaining household routines and schedules ✓ Supports child’s need for gradual transitioning. <i>Example: Provides warning of changes so child has time to shift gears: "We're leaving in 10 minutes"</i> ✓ Points out colors and numbers in the course of everyday conversation ✓ Encourages independent activity to build self-reliance. ✓ Provides lots of sensory experiences for learning and developing coordination – sand, mud, finger paints, puzzles ✓ Reads and sings and talks to build vocabulary

4-6 Years	<ul style="list-style-type: none"> ✓ Has refined muscle development and is better coordinated, so that he or she can learn new skills ✓ Has improved finger dexterity – ties shoes; draws more complex picture; writes name ✓ Climbs, hops, skips, and likes to do stunts. Gross motor skills increase in speed and endurance 	<ul style="list-style-type: none"> ✓ Plays cooperatively with peers ✓ Enhanced capacity to share and take turns ✓ Recognizes ethnic and sexual identification ✓ Displays independence ✓ Protects self and stands up for rights ✓ Identifies with parents and likes to imitate them ✓ Often has “best friends” ✓ Likes to show adults what he or she can do ✓ Continually forming new images of self-based on how others view him or her 	<ul style="list-style-type: none"> ✓ Is developing longer attention span ✓ Understands cause and effect relationships ✓ Engages in more dramatic play and is closer to reality, pays attention to details ✓ Is developing increasingly more complex and versatile language skills ✓ Expresses ideas, asks questions, engages in discussions ✓ Speaks clearly ✓ Is able to draw representative pictures ✓ Knows and can name members of family and friends ✓ Increased understanding of time 	<ul style="list-style-type: none"> • Poor muscle tone, motor coordination • Poor pronunciation, incomplete sentences • Cognitive delays; inability to concentrate • Cannot play cooperatively; lack curiosity, absent imaginative and fantasy play • Social immaturity: unable to share or negotiate with peers; overly bossy, aggressive, competitive • Attachment problems: overly clingy, superficial attachments, show little distress or over-react when separated from caregiver • Excessively fearful, anxious, night terrors • Lack impulse control, little ability to delay gratification • Exaggerated response (tantrums, aggression) to even mild stressors • Enuresis, encopresis, self-stimulating behavior – rocking, head-banging 	<ul style="list-style-type: none"> ✓ Encourages exploration ✓ Applauds child’s efforts ✓ Interprets new/unfamiliar situations ✓ Reinforces good behavior and achievements ✓ Encourages child to express feelings and emotions ✓ Encourages physical activity with supervision ✓ Gives child chances to make choices ✓ Uses time-out for behavior that is not acceptable
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6-9 Years	<ul style="list-style-type: none"> ✓ Gradual replacement of primary teeth by permanent teeth throughout middle childhood ✓ Fine motor skills: writing becomes smaller and more legible; drawings become more organized and detailed and start to include some depth ✓ Gross motor skills: can dress and undress alone; Organized games with rough-and-tumble play become more common 	<ul style="list-style-type: none"> ✓ May have a special friend ✓ Likes action on television ✓ Enjoys books and stories ✓ May argue with other children but shows cooperation in play with a particular friend ✓ Self-concept includes identifying own personality traits and comparing self with others ✓ Becomes more responsible and independent ✓ Still obeys adults to avoid trouble ✓ Can adapt ideas about fairness to fit varied situations 	<ul style="list-style-type: none"> ✓ Thought becomes more logical, helping the child categorize objects and ideas ✓ Can focus on more than one characteristic of concrete objects ✓ Attention becomes more selective and adaptable ✓ Can use rehearsal and organization as memory strategies ✓ Emotional intelligence is developing: self-awareness and understanding of own feelings; empathy for the feelings of others; regulation of emotion; delaying gratification ✓ Vocabulary increases rapidly ✓ Makes the transition from "learning to read" to "reading to learn" ✓ Carries on long conversation 	<ul style="list-style-type: none"> • Low self-esteem • Acts sad and/or nervous much of the time • Aggressive much of the time (hits, fights, curses, breaks or throws objects) • Exhibits poor impulse control • Has difficulty concentrating or sitting still • Scapegoated/ ignored by other children • Poor grades • Doesn't respond to positive attention/praise • Seeks adult approval/attention excessively • Suspicious/mistrustful of adults; doesn't turn to adults for help/comfort • Little frustration tolerance; difficult to engage and keep interested in goal directed activity • Cannot adapt behavior to different social settings • Doesn't understand a person's identity remains the same regardless of outward changes (e.g., costume) • Can't understand concepts of space, time, and dimension • Can't differentiate real from pretend • Can't understand the difference between behavior and intent (breaking a lamp is equally bad regardless of whether on purpose or an accident) 	<ul style="list-style-type: none"> ✓ Shows affection for child; recognizes accomplishments ✓ Helps child develop a sense of responsibility – asks child to help with household tasks such as setting the table ✓ Talks with child about school, friends, and things to look forward to in the future ✓ Encourages child to think about consequences before acting ✓ Makes clear rules and sticks to them ✓ Engages in fun activities together ✓ Praises child for good behavior ✓ Supports child in taking on new challenges ✓ Gets involved in child's school
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9-11 Years	<ul style="list-style-type: none"> ✓ Girls' adolescent growth spurt begins ✓ Gross motor skills are better coordinated (running, jumping, throwing and catching, kicking, batting, and dribbling) ✓ Reaction time improves, which contributes to motor skill development ✓ Fine motor skills improve; depth cues evident in drawings through diagonal placement, overlapping objects, and converging lines 	<ul style="list-style-type: none"> ✓ Self-esteem rises ✓ Distinguishes between effort and luck as causes of successes and failures; can become critical of others quickly ✓ Has adaptive set of strategies for regulating emotion ✓ Peer groups emerge ✓ Friendships are based on the pleasure of sharing through activities or time spent together ✓ Sibling rivalry tends to increase 	<ul style="list-style-type: none"> ✓ Planning improves ✓ Can apply several memory strategies at once ✓ Long-term knowledge base grows in size and organization ✓ Improves in cognitive self-regulation (monitoring and directing progress toward a goal) ✓ Grasps double meanings of words as reflected in comprehension of metaphors and humor ✓ Improved understanding of complex grammatical constructions ✓ Conversational strategies become more refined 	<ul style="list-style-type: none"> • Low self-esteem • Acts sad and/or nervous much of the time • Aggressive much of the time (hits, fights, curses, breaks or throws objects) • Exhibits poor impulse control • Has difficulty concentrating or sitting still • Scapegoated/ ignored by other children • Poor grades • Doesn't respond to positive attention/praise • Seeks adult approval/attention excessively • Suspicious/mistrustful of adults; doesn't turn to adults for help/comfort • Little frustration tolerance; difficult to engage and keep interested in goal directed activity • Cannot adapt behavior to different social settings • Doesn't understand a person's identity remains the same regardless of outward changes (e.g., costume) • Can't understand concepts of space, time, and dimension • Can't differentiate real from pretend • Can't understand the difference between behavior and intent (breaking a lamp is equally bad regardless of whether on purpose or an accident) 	<ul style="list-style-type: none"> ✓ Helps child develop own sense of right and wrong. Talks with child about risky things, peer pressure, etc. ✓ Encourages child to respect other people ✓ Spends quality time listening to child and talking about accomplishments and possible challenges ✓ Talks with child about normal physical and emotional changes of puberty ✓ Is affectionate and honest with child.
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11-15 Years	<ul style="list-style-type: none"> ✓ Period of rapid skeletal and sexual maturation ✓ Preoccupation with body image ✓ Acne may appear ✓ Boys ahead of girls in endurance and muscular strength ✓ Rapid growth may mean large appetite but less energy ✓ There is a wide variation in beginning and completion of puberty (body hair, increased perspiration and oil production in hair and skin. Girls: breast and hip development, onset of menstruation. Boys: growth in testicles and penis, wet dreams, deepening of voice) ✓ Increased possibility of acting on sexual desires 	<ul style="list-style-type: none"> ✓ Critical of adults; annoyed by younger siblings; obnoxious to live with ✓ Wants unreasonable independence ✓ Dramatizes and exaggerates own positions; has many fears, worries, and tears ✓ Resists any show of affection ✓ Often moody; anger is common; resents being told what to do; rebels at routines ✓ Intense interest in teams and organized, competitive games; considers membership in clubs important; has whole gang of friends ✓ Girls show more interest in opposite sex than boys do ✓ Recognizes that differences exist between and within groups ✓ May experience prejudice, discrimination, or bias due to ethnicity or poverty 	<ul style="list-style-type: none"> ✓ Thrives on arguments and discussions; challenges adults ✓ Increasingly able to memorize, think logically; engage in introspection ✓ Can plan realistically for the future; may have interest in earning money ✓ Is critical of own artistic products ✓ Interested in world and community; may read a great deal ✓ Needs to feel important and believe in something ✓ Social cognition: <ul style="list-style-type: none"> ○ Belief in an imaginary audience, that others are as preoccupied with one as oneself is (e.g., "everyone is looking at me") ○ Personal fable – belief in personal uniqueness (e.g., "no one understands me") and belief that self is invulnerable ("I won't get hurt") ✓ Able to understand other points of view, but tends to be egocentric 	<ul style="list-style-type: none"> • By end of period, physically immature, small, not showing signs of puberty or secondary sex characteristics (wide range here; girls mature earlier) • Poor motor skills, coordination • Lack of peer group relationships and identification with peers • Can't think hypothetically; doesn't consider consequences of actions • Can't put him/herself in place of another; doesn't consider how behavior affects others • Difficulty problem solving; doesn't work through systematically and weigh solutions • Poor school performance • Doesn't reject or question parental standards and express self through clothes, hair, and other lifestyle choices • Poor self-esteem • Emotional and behavioral problems (anxiety, depression, withdrawal, aggression, lack of impulse control, anti-social behavior) • Withdrawal from friends and from activities once enjoyed • Changes in eating and sleeping habits • Abuse of alcohol or drugs 	<ul style="list-style-type: none"> ✓ Is tolerant, understanding, and supportive ✓ Accepts youth's feelings but tries to help youth evaluate more objectively ✓ Avoids being defensive; child is not challenging the adult's authority ✓ Sets limits, but gives opportunities for independence whenever possible ✓ Answers questions about bodily changes openly and honestly ✓ Encourages group activities and discourages solo dating ✓ Doesn't nag boys about food intake and seeming "laziness" ✓ Discusses ways to manage and handle stress ✓ Finds ways to spend time together ✓ Provides consistent, loving discipline with limits, restrictions, and rewards
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15-21 Years	<ul style="list-style-type: none"> ✓ By end of period, physically immature, small, not showing signs of puberty/secondary sex characteristics (wide range; girls mature earlier) ✓ Poor motor skills, coordination ✓ Lack of peer group rel. and identification with peers ✓ Can't think hypothetically; doesn't consider consequences of actions ✓ Can't put him/herself in place of another; doesn't consider how behavior affects others ✓ Difficulty problem solving; doesn't work through systematically and weigh solutions ✓ Poor school performance ✓ Doesn't reject or question parental standards and express self through clothes, hair, and other lifestyle choices ✓ Poor self-esteem ✓ Emotional and behavioral problems (anxiety, depression, withdrawal, aggression, lack of impulse control, anti-social behavior) ✓ Withdrawal from friends and from activities ONCE enjoyed ✓ Changes in eating Abuse of alcohol or drugs 	<ul style="list-style-type: none"> ✓ Relationships with parents range from friendly to hostile ✓ Usually has many friends and few confidants ✓ Worries about failure ✓ May appear moody, angry, lonely, impulsive, self-centered, confused, and stubborn ✓ Has conflicting feelings about dependence and independence ✓ Girls may form identity and prepare for adulthood through establishing relationships and emotional bonds ✓ Interest in forming romantic relationships part of separation task; implies separation from family ✓ Cultural differences may cause conflict 	<ul style="list-style-type: none"> ✓ May lack information or self-assurance about personal skills and abilities ✓ Continuing formal operational thought with abstract, idealistic, logical, hypothetical-deductive reasoning, complex problem solving, and critical thinking ✓ May enjoy debating and arguing ✓ Has a strong sense of awareness ✓ May be judgmental of adults or peers if they do not do what is "fair" ✓ Seriously concerned about the future ✓ Beginning to integrate knowledge leading to decisions about future 	<ul style="list-style-type: none"> • Physically immature, small, not showing signs of puberty or secondary sex characteristics • Unable to form or maintain satisfactory relationships with peers • Can't put him/herself in place of another; doesn't consider how behavior affects others • Poor self-esteem / guilt • Overcompensates for negative self-esteem by being narcissistic, unrealistically self-complimentary; grandiose expectations for self • Engages in self-defeating, testing, and aggressive, antisocial, or impulsive behavior • Lacks capacity to manage intense emotions; moods change frequently and inconsistently • Has emotional disturbances: depression, anxiety, post-traumatic stress disorder, attachment problems, conduct disorders 	<ul style="list-style-type: none"> ✓ Recognizes and compliments physical maturity ✓ Provides accurate information on consequences of sexual activity ✓ Tries not to pry; but is available to talk and listen ✓ Maintains positive relationship by being respectful and friendly ✓ Accepts feelings; doesn't overreact and avoids disapproval ✓ Recognizes and accepts current level of interest in opposite sex ✓ Encourages experiences with a variety of people (e.g., older, younger, different cultures) ✓ Encourages talking about and planning for future
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Adapted from One or More of the Following Sources

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Impact of Trauma on the Child's Brain

- Child brains exposed to chronic trauma and stress are wired differently.
- The brain's 'fight or flight' response is activated through increased production of the powerful hormone cortisol.
- Cortisol production can be protective in emergencies, but is toxic in situations of chronic stress. Cortisol can damage or kill neurons in critical regions of the brain. Unpredictable stressors create the most neurological damage.
- Children are more susceptible to post-traumatic stress, because in most situations, they are helpless and incapable of either 'fight or flight.'
- The untreated injuries sustained by trauma or neglect early in life lead to sustained damage reverberating in all ensuing developmental stages.
- During adolescence, the brain goes through another critical period of remodeling in the pre-frontal cortex, the highest functioning part of the brain - which is needed for good judgment, planning and other essential functions of adulthood. Trauma can impact brain development in adolescence and the neuronal connections are interrupted or not made.

The Impact of Trauma on Very Young Children

- Development is sequential - to fully mature, a child must successfully complete one developmental stage before they can enter and engage in the characteristics and skills of the next stage. Trauma due to maltreatment in infancy and early childhood can significantly and negatively impact a child.
- Maltreatment and related trauma make infants and toddlers more vulnerable to:
 - Developmental delays in any or all of the three domains (physical, cognitive, and social-emotional) as well as in language development
 - Failure to thrive; all aspects of development can regress
 - Feeding issues
 - Emotional
 - Regulation issues such as difficulty soothing
 - Limited or impaired social-emotional functioning
 - Aggression
 - Regression in language development and potty training

Complex Trauma and How It Impacts Children

Complex trauma exposure involves the simultaneous or sequential occurrence of child maltreatment - including psychological maltreatment, neglect, physical and sexual abuse, and domestic violence – that:

- Is chronic
- Begins in early childhood
- Occurs within the primary caregiving system.

This document outlines the various ways that children are impacted by trauma. These ways include:

- Attachment
- Biology
- Affect and emotional regulation
- Dissociation can occur in extreme cases
- Behavioral control
- Cognition issues
- Self-concept/Self-esteem issues

In each of these seven areas, you are provided a list of possible impacts on children.

Attachment

With complex trauma, the child has:

- Problems with boundaries.
- Uncertainty about the reliability & predictability of the world.
- Distrust and suspiciousness.
- Social isolation.
- Difficulty with perspective taking.
- Difficulty attuning to other people's emotional states and points of view.
- Difficulty enlisting other people as allies.

Biology

The child will present with:

- Sensorimotor developmental problems.
- Problems with coordination, balance, and body tone.
- Difficulties localizing skin contact.
- Increased medical problems.
- Hypersensitivity to physical contact.
- The feelings of actual physical conditions without a physical cause, i.e. stomach aches, headaches, etc.

Affect or Emotional Regulation

The child will:

- Be easily-aroused to high-intensity emotions.
- Have difficulty with emotional self-regulation.
- Have difficulty describing feelings and internal experience.
- Have chronic suicidal preoccupation.
- Demonstrate over-inhibition or excessive expression of anger.
- Experience chronic and pervasive depressed mood or sense of emptiness

- Have difficulty communicating wishes and desires.
- or deadness

Dissociation Can Occur in Extreme Cases

Chronic exposure to trauma causes a state of **hyperarousal** or **disassociation**.

- Hyperarousal is characterized by an elevated heart rate, slightly elevated body temperature and constant anxiety.
- Disassociation involves an internalized response in which the child shuts down, detaches, or “freezes” as a maladaptive way of managing overwhelming emotions and/or situations. The younger the child is, the more likely he/she will respond with disassociation.

Behavioral Control

Children can display:

- Poor regulation of impulses.
- Self-destructive behavior.
- Aggressive behavior.
- Sleep disturbances.
- Substance abuse
- Oppositional behavior.
- Eating disorders.
- Excessive compliance.
- Pathological self-soothing behaviors.
- Difficulty understanding and complying with rules and communication of traumatic past by reenactment in day-to-day behavior or play (sexual, aggressive, etc.).

Cognition Issues

Children may have difficulties in:

- Attention regulation and executive functioning.
- Focusing on and completing tasks.
- Demonstrating sustained curiosity.
- Language development.
- Learning
- Processing novel information.
- Impaired comprehension of complex visual-spatial patterns.
- Understanding their own contribution to what happens to them.
- Orientation in time and space.
- Acoustical and visual perceptions.
- Planning and anticipating.
- Possessing object constancy.

Self-Concept/Self-Esteem Issues

Children exposed to chronic trauma may also:

- Have issues related self-concept or self-esteem.
- Exhibit feelings of shame and guilt.
- Demonstrate a generalized sense of being ineffective in dealing with one's environment.
- Demonstrate disturbances of body image and shame and guilt.
- Possess a poor sense of separateness.
- Have a belief that one has been permanently damaged by the trauma.

The Impact of Traumatic Stress on Visible Behavior

- **Relationships:** Trauma-exposed children feel that the world is uncertain and unpredictable. Their relationships can be characterized by problems with boundaries, as well as distrust and suspicion. As a result, these children can become socially isolated and have difficulty relating to and empathizing with others.
- **Hypersensitivity:** Because children impacted by trauma may experience changes in brain chemistry and structure 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 knowing and describing their feelings. They can have difficulty appropriately communicating wishes and desires to others.
- **Dissociation:** As discussed earlier, trauma-exposed children may sometimes experience a feeling of detachment or depersonalization, as if they are 'observing' something happening to themselves that is unreal. They can also withdraw from the outside world or demonstrate an amnesia-like state.
- **Poor impulse control:** Traumatized children can demonstrate poor impulse control, self-destructive behavior, and aggression against others. Sleep disturbances and eating disorders can also manifest from child traumatic stress.
- **Cognitions:** Children exposed to trauma can have problems focusing on completing tasks in school, as well as difficulty planning and anticipating. They sometimes have difficulty understanding their own contribution to what happens to them. Some trauma-exposed children demonstrate learning difficulties and problems with language development.
- **Self-concept:** Trauma-affected children can experience a lack of continuous, predictable sense of self. They can suffer from disturbances of body image and low self-esteem.
- **Development:** Trauma can disrupt development processes and interfere with the mastery of age-appropriate tasks and skills.

Other trauma-based reactions could include:

- Aggressive or disruptive behavior
- Sleep disturbances
- Drug and alcohol use as a coping mechanism to deal with stress
- Self-harm, such as cutting
- Over- and underestimation of danger
- Increased risk of re-victimization.

Trauma-Related Behaviors in Children of Various Ages

Adapted from One or More of the Following Sources

Chadwick Trauma-Informed Systems Project. (2013). Guidelines for Applying a Trauma Lens to a Child Welfare Practice Model (1st ed.). San Diego, CA: Chadwick Center for Children and Families.

Reducing the Trauma of Investigation, Removal and Initial Out-of-Home Placement Project. (2008-2009). Trauma Informed Practice Strategies for Caseworkers. Portland State University, Center for Improvement of Child and Family Services.

Child Welfare Trauma Training Toolkit. (2013). The National Child Traumatic Stress Network.

In addition to what you have learned about the impact of trauma on the brain, this document provides a detailed listing and description of how you would expect the child at various ages to behave as the result of trauma. When you are trying to understand the child's behavior and how you might best respond to it in a trauma-informed manner, use this information as a basis for your decision-making.

Infants and Very Young Children

The child exposed to trauma in early childhood can have a difficult time coping with loss, although it may not be as easy to identify as in other age groups. Remember also that the young child's ability to manage his/her up emotions and to use his/her own and coping skills are not fully developed.

The young child's brain has the capacity remember traumatic events, even when he/she has not yet developed the ability to develop explicit memories. There is significant clinical evidence that a young child can retain physical body-based memories of the event which may become triggered (i.e., occur again and unexpectedly) by trauma reminders even when she he does not have conscious memories of what he/she has experience.

A young child may become more quickly **dis-regulated** when talking about the event. This means that he/she may talk about the event and then quickly shift activities (e.g., become more active, engage in nurturing play, become aggressive) when he/she becomes triggered.

Pre-School Children

Pre-natal cocaine exposure has also been found to be associated with difficulty in sustaining attention managing emotions in school-age children.

A preschool child often feels helpless and powerless and is unable to protect him/herself. A preschool child tends to be strongly affected by the reactions that his/her parents or caregivers have to a traumatic event. The more severely their parents or caregivers react to the event, the more likely the child is to show traumatic stress-related difficulties.

A preschool child with traumatic stress symptoms will tend to show regressive behaviors. He/she might revert to behaviors that had previously been outgrown, such as thumb-sucking. Similarly, a traumatized preschool child often becomes clingy and may be unwilling to separate from familiar adults including teachers. The child may also resist leaving places where he/she feels safe, such as home or classroom, or be afraid to go to places because the memory of a frightening experience is to be remembered.

Significant changes in eating and or sleeping habits are also common, and a young child who has experienced trauma may complain of physical aches and pains, such as stomachaches and headaches, they have no medical basis.

Additional behaviors traumatized preschool children may show include:

- Crying, whimpering, screaming
- Appearing to be frozen
- Moving aimlessly
- Trembling
- Speech difficulties
- Irritability
- Repetitive enactment/reenactment of trauma themes in play or other activities
- Fearful avoidance and phobic reactions
- Magical thinking related to trauma (such as ‘then when I jumped out the window and flew away’)

School-Aged Children

Elementary school-age child may exhibit regressive behaviors, such as asking adults to feed her or dress him. A school-age child may withdraw from his/her friends, show increased competition for attention, and refuse to go to school, or behave more aggressively. He/she may also be unable to concentrate and his/her school performance may decline.

Additional elementary school-aged child traumatic stress behaviors may exhibit include:

- Sadness and crying
- Poor concentration and other behaviors commonly seen in ADD or ADHD
- Irritability
- Fear of personal harm, or other anxieties and fears (such as fear of the dark)
- Nightmares and/or sleep disruption
- Bedwetting
- Eating difficulties

- Attention-seeking behaviors
- Trauma themes in play/art/conversation

Elementary school-each child may be preoccupied with details of the event and want to talk about continually, are made acted out in play. In addition, repetition of the event is one which might unconsciously attempt to come to terms with what he/she experienced.

Adolescents

A traumatized adolescent might show traumatic responses similar to those seen in adults, including flashbacks, nightmares, emotional numbing, avoidance of reminders of the trauma, depression, suicidal thoughts, and difficulties with relationships. You might observe any or all of the following behaviors in an adolescent:

- Report vague physical symptoms
- Seek attention from parents, caregivers and teachers
- Withdraw from others
- Experience difficulties
- Avoid school
- Show regressive behaviors, such as an inability to handle tasks and chores that he/she had formerly mastered.

Adolescent traumatic stress symptoms may include isolating him/herself, resisting authority, or becoming highly disruptive. His/her distress, coupled with age-appropriate feelings of immortality, may motivate him/her to experience high-risk behaviors such as substance abuse, promiscuous sexual behavior, or other act-risk behaviors such as driving at high speed to picking fights.

Adolescents face other challenges specific to their developmental stage.

An adolescent will tend to place more importance on groups, resist authority, and feel immune from physical danger. She or he may feel extremely guilty if he/her were not able to prevent injury to or loss of loved ones and fantasize about revenge against those he/he feels/knows cause the trauma.

You may expect reluctance on the part of the adolescent to discuss his/her feelings, or he/she might even deny any emotional reactions to the trauma, in part because he or she typically feels a very strong need to fit in with his/her peers.

Lastly, an adolescent with traumatic stress symptoms may begin to exhibit:

- Delinquent and/or self-destructive behaviors
- Changes in school performance
- Detachment and denial
- Shame about feeling afraid invulnerable

- Abrupt changes and/or abandonment of former friendships
- Pseudo -mature action such as getting pregnant, leaving school, getting married.

Key Points:

- According to the National Child Traumatic Stress Network, psychological safety is a sense of safety, or the ability to feel safe, within oneself and safe from external harm.

The Adverse Childhood Experiences (ACE) Study

About the Study: What Everyone Should Know!

Over 17,000 Kaiser Permanente members voluntarily participated in a study to find out about how stressful or traumatic experiences during childhood affect adult health. After all the identifying information about the patients was removed, the Centers for Disease Control and Prevention processed the information the patients provided in the questionnaires.

Here's What We Learned:

Many people experience harsh events in their childhood. 63% of the people who participated in the study had experienced at least one category of childhood trauma. Over 20% experienced 3 or more categories of trauma which we call [Adverse Childhood Experiences \(ACEs\)](#).

- 11% experienced emotional abuse.
- 28% experienced physical abuse.
- 21% experienced sexual abuse.
- 15% experienced emotional neglect.
- 10% experienced physical neglect.
- 13% witnesses their mothers being treated violently.
- 27% grew up with someone in the household using alcohol/or drugs.
- 19% grew up with a mentally-ill person in the household.
- 23% lost a parent due to separation or divorce.
- 5% grew up with a household member in jail or prison.

ACEs seem to account for one-half to two-thirds of the serious problems with drug use. They increase the likelihood that girls will have sex before reaching 15 years of age, and that boys or young men will be more likely to impregnate a teenage girl.

Adversity in childhood causes mental health disorders such as depression, hallucinations and post-traumatic stress disorders.

The more categories of trauma experienced in childhood, the greater the likelihood of experiencing:

- Alcoholism and alcohol abuse
- Chronic obstructive pulmonary disease (COPD)
- Depression

- Fetal death
- Poor health-related quality of life
- Illicit drug use
- Ischemic heart disease (IHD)
- Liver disease
- Risk for intimate partner violence
- Multiple sexual partners
- Sexually transmitted diseases (STDs)
- Smoking
- Obesity
- Suicide attempts
- Unintended pregnancies

If you experienced childhood trauma, you're not alone.

Talk with your family health practitioner about what happened to you when you were a child. Ask for help.

For more information about the ACR Study , email [carolredding @acestudy.org](mailto:carolredding@acestudy.org), visit www.acestudy.org, or the Centers for Disease Control and Prevention at <http://www.cdc.gov/NCCDPHP/ACE/>

Long Term Impacts of Trauma

The ACE study shows us that ‘adverse childhood experiences’ can exacerbate over time:

- In childhood, we see developmental delays;
- in adolescence we see higher rates of delinquency, mental health issues, sexual activity, drug and alcohol use and an increase in violence;
- in adulthood we see an increase in psychiatric problems, as well as drug and alcohol abuse and participation in criminal activities.

What these findings tell us is that there is a point where stress from trauma moves from tolerable to toxic.

- Toxic stress is stress that causes an excessive or prolonged stress response. In toxic stress situations, our ability to cope is depleted or in worst-case scenarios they are non-existent.
- Generational trauma or trans generational trauma is trauma that transferred from one generation to the next.
 - This pass-down of trauma can be either through duplicating the traumatic actions that occurred to the parent/caregiver such as physical abuse, or it can be passed down in terms of affect or coping mechanisms such as not being responsive and nurturing.

Culture and Trauma

- Culture influences how children might identify, interpret and respond to traumatic events.
- There are times when these rituals, roles or communication patterns are abusive and/or neglectful.
- However, this is the child's 'normal'. Their family is all they know. Children feel most attached and bonded to their families, even when their living circumstances are unsafe. Part of that attachment is related to the culture of the family and their community. Children do not have any other reference point.
- When we remove a child from their home, we run the risk of additional trauma to the child. It is essential as child welfare professionals to not underestimate the trauma experienced by the child due to this kind of disruption.

Historical Trauma

- Historical trauma: The cumulative exposure to traumatic events that not only affect the individual exposed, but continue to affect subsequent generations.
- Historical trauma can exacerbate the impact of present-day trauma for a family involved in the child welfare system, especially when system actions such as removal of children serve as triggers or unexpected reminders of the historical trauma for parents and family members.
- It is considered to be a psychological injury held personally and transmitted over generations.

Unit 4.2: Approaching Children and Families in a Trauma-Informed Manner

Henry's Story

My name is Henry, and I am five years old. All my life I have heard and seen Mommy and Daddy fighting. When they fight, I get really scared. It doesn't make sense – why are they fighting??? I love them, but I don't like it when they fight!

One night I woke up. Mommy was screaming, screaming, screaming in the kitchen! I got really afraid, because I thought maybe they were fighting about ME, because I got in trouble at school yesterday.

I snuck downstairs and peeked into the kitchen – my mommy was bleeding and laying on the kitchen floor. She wasn't moving!

Then all of a sudden, three big police officers crashed through the front door. They had guns in their hands, and I got scared more! I hid in the closet, but I heard a lot of yelling, and when I peeked out of the closet, I saw that one of the police officers was leading my Daddy out the front door in handcuffs. I started crying.

Then another police officer took me outside to the police car and began to drive away. I thought I was really in trouble. I started crying – I didn't know where my Mommy was and I didn't get to say goodbye to her. I was afraid - I did not know if she was okay. And I didn't know what was happening or where the police officer was taking me!

At the police station, a police officer gave me some juice and I laid down on the chairs and fell asleep. Next a lady came and picked me up and she took me to a different house. There was a man and a woman there that I did not know – they were *strangers*. But the lady seemed to know them. She left me with them, and then the man and woman changed my clothes and put me into a bed that wasn't mine. It was really big and didn't feel like my bed at all. I started crying, but I didn't cry loud because the man and woman might get mad at me. I went to sleep, but I was scared.

The next day, the woman took me to a new school for kindergarten. I had to wear some other boy's clothes, and they were kind of little for me. I didn't know anybody at the school and was scared. I didn't want to talk to anybody. At school I had a hard time paying attention to the teacher and obeying the rules. Sometimes I got in trouble for doing things I wasn't supposed to do and was afraid that my new teacher would become angry at me and yell just like my Daddy used to.

A few days later, a new lady came to the house and asked me a lot of questions. I asked about my Mommy and my Daddy. The lady told me about his parents and was told my Mommy was in the hospital and my Daddy was in jail.

I did not get to talk to my Mommy or Daddy for a long, long time. It made me angry and I was really confused. A lot of times I had a hard time sleeping, and sometimes I would have bad dreams and wet my bed. Then the man or woman would yell at me just like when my Daddy yelled at my Mommy. I was so scared when they yelled that I would hide under the table.

Pretty soon the new lady came back again and she took me to a new house. I didn't know if it was because I had done something bad. Now I wonder how many different houses I will have to go to and if I will ever get to see my Mommy and my Daddy again.

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Using a Trauma-Informed Approach in Child Welfare Practice

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Hotline

- Ask about any prior history of trauma when taking reports.
- Be alert for signs of traumatic stress in children and parents when taking reports (such as the reporter mentioning that the child or parent has nightmares, flashbacks, intrusive thoughts, heightened arousal, a state of being "on edge," avoidance of trauma reminders, emotional numbing).

Investigation

- As much as possible, slow down and plan out investigations to consider the impact on the child and family. Complete pre-commencement investigation activities and ensure that you take your "field kit" to the investigation (business card, *Your Rights and Responsibilities* brochure, referral information). Reduce the element of surprise, if possible.
- If responding with law enforcement, consider the possible impact of their uniforms and authority and how the child and parent might perceive their involvement.
- Separate the child from the chaos and the distress of arrest, interrogation, or resistance on the part of the parents.
- Adopt a calm, non-threatening approach and avoid sudden movements toward the child and loud noises that may trigger the child. Move slowly.
- Be prepared to give time and space to the child before, during, and at the close of the interview (allow time for emotional de-escalation at end).
- Minimize the number of interviews and number of interviewers through collaboration and precise documentation. Re-interview only if there are new issues to explore or if an additional interview is needed to provide a complete statement.
- Conduct interviews in locations that are child-friendly, private, and safe for the child.
- If interviewing child at school, offer a support person (such as teacher or school counselor) and ensure that interviews are conducted in a safe, private setting.
- Explain what is happening and who all of the people are (including the role of the social worker) in developmentally appropriate language.

- Reassure the child that he or she is not in trouble and did not do anything wrong. As appropriate, and with proper discretion, provide the child with information about the events that led to the removal in order to help the child correct distortions and reduce self-blame.
- Ask questions about traumatic events in a way to reduce risk of re-traumatization.
- Approach the parents as experts on their child.
- Talk to the parents in a calm manner and calm the parents to calm the child.
- Consider that the investigation may trigger the parents' own traumas.
- Educate the parents about typical behavior and reactions that a child may have in response to trauma.

Safety Planning

- Ensure safety plans incorporate both physical and psychological safety.
- Ensure family members, especially parents, understand the safety planning process and the purpose of safety plans. Ensure that parents are authentic partners in the development of their family's safety plan.
- Revisit safety plans at each contact to ensure that the child continues to be and to feel safe.
- Ensure safety plans take into account possible trauma triggers for the child and family members.

In-Home Family Support Services

- Provide parents and family members with information about trauma triggers, trauma reactions, and coping skills to help them manage child's trauma-related behaviors and emotions.
- Reframe child's behavior "problems" as possible trauma reactions when appropriate.
- Model and teach coping and stress management skills to parents and children.
- Educate parents about the importance of trauma-focused treatment for children (and/or for themselves) when current trauma reactions are present.
- Provide parents with information on obtaining trauma-informed services and provide support and advocacy as needed treatment.

Removal and Initial Placement

- Use genograms and eco-maps to place children with familiar adults.
- If the child has to wait while a placement is found, find a comfortable place for the child, away from calls for prospective placements to avoid the child from hearing possible rejections.
- If picking up the child from school, create a chance for the child (or friend or relative) to pick up items from home that may comfort the child.
- Place siblings together to minimize trauma.
- Allow siblings to room together to promote psychological safety.

- Provide the out-of-home caregiver at the time of placement with as much information as possible about the child in his/her family, including trauma history and related reactions and triggers. This results in building a bond of trust between the worker and the out-of-home caregiver and ensures that the out-of-home caregiver has information they need care for the child.
- Provide the child with information (including photos) about placement in advance and arrange pre-placement visit when possible. This helps restore a sense of predictability for children, which is important in the aftermath of trauma.
- Provide birthparents with information about the out-of-home caregiver at the time of placement to help allay parents' fears and develop a relationship between birthparents and resource families.
- Create an opportunity for the birth family and out-of-home caregiver to meet as soon as possible, to share information about the child and began to form partnership to enhance psychological safety and well-being of the child.
- Create an opportunity for the birth parents to talk with the child shortly after placement (within 24 hours) when appropriate.
- For a young child, ask the parents about feeding, schedules, and routines prior to, or at the time of the removal.
- Ask the parent and child about any medical conditions, allergies, or medications prior to, or at the time of the removal.
- Ask the child if he or she is hungry or thirsty and provide food or drink.
- When appropriate, allow the parent to assist in the removal process and say goodbye.
- Ask the parent or child to gather some familiar items from home before removing the child.
- Recognize that you may not have the power to alleviate the child's distress, but you can minimize the trauma.
- Be willing and able to tolerate and empathize with any signs of distress expressed by the child.
- Prepare for trauma-informed responses to typical child questions:
 - Why can't I stay with my parents?
 - When can I see my parents again?
 - How long will I be in foster care?
- Do not make promises you can't keep.
- Ask the child what he or she needs to feel safe.
- Take time to help the child transition into the new home. The child may have connected to you during the removal.

Transitions during Placement

- During transitions in out-of-home placement, do the following:
 - Create safety (physical and psychological) for the child.
 - Invite the expression of feelings.
 - Empower through predictability.

- Ensure relational continuity.
 - Facilitate contact between children and parents and siblings as soon as possible, unless contraindicated.
 - Work with resource parents to ease the transition for child.
 - Be prepared to stay for a while to help child adjust to placement.
 - Asked the child in the presence of the resource parent what will help him or her feel safe.
 - Ask about routines, especially for the rest of the evening in the next day, to provide predictability.
 - Ask about special rules the family has.
 - Address any questions child may have and optimize opportunities for child to be involved in making appropriate decisions and/or voicing his/her concerns and needs.
- Support the relationship between the birth and out-of-home caregiver through the time of placement to help children feel safe and supported.
- Nurture the child's strengths and interests by providing opportunities for sports and extracurricular activities.
- Attempt to keep the child in the same school.
- Help resource parents view children's behavior through a trauma lens.
- Help resource parents identify potential trauma triggers and assist them in reducing exposure to triggers when possible and managing child's reactions.
- When change of placement is necessary:
 - Prepare the child, caregivers, and parents in advance.
 - Help child and family plan special ways to commemorate their time together.
 - Encourage former resource parents to share information about the child with new resource parents.
 - Suggest a transitional object for the child to take to the new placement (such as photo child with former resource.)
 - Facilitate on-going contact with former resource parents when appropriate.
- In residential settings, identify environmental and situational trauma triggers for each child. Work with fellow staff to reduce exposure and work with child and treatment team to enhance coping strategies.

Family Time

- Facilitate family time with parents and siblings (if not placed together) within 72 hours of placement and frequently thereafter.
- Ensure that the person supervising visits fully understands safety concerns (physical and psychological safety) and that the child feels safe with the supervisor.
- Hold family time in a safe but natural setting.
- Prepare the child, birth family, and out-of-home caregiver for possible trauma triggers and reactions that may occur prior to, during, and after visits. Work on coping skills to help manage reactions.

- Utilize the family time visits as an opportunity for parents to practice trauma-informed parenting skills (such as setting appropriate limits and boundaries, managing the child's triggers and reactions, providing an emotional container for the child's overwhelming emotions, reinforcing safety messages).
- Ask the child how he or she feels about visitation and establish a word or sign to use if the child feels unsafe.
- Collaborate with therapists when considering changes to the visitation plan.

Participatory Case Planning

- Discuss perceived trauma-related needs and potential referrals with parents and the child and engage them in choosing appropriate services.
- Include specific behavioral goals for parents related to increasing physical and psychological safety and promoting resilience in the child.
- Include involvement of all appropriate caregivers in child's therapy in case plans.
- Utilize genograms and ecomaps with families to identify supports.

Referrals, Service Coordination, Ongoing Assessment

- Maintain frequent and purposeful contact with the child; be consistent and predictable.
- Ensure that the child has someone to talk to about the trauma and system interventions with whom he or she feels comfortable.
- For a child and parents with significant trauma histories and current trauma reactions, refer to trauma informed mental health provider.
- Make a list of providers in your area who have training and experience in treating trauma and who are trained in specific evidence-based treatment interventions.
- Provide treatment specialists with any known trauma history of the child and parents.
- Request that the treatment providers include current caregivers in treatment to educate them about the impact of trauma, trauma triggers, and reenactment behaviors.
- Request a trauma-informed mental health assessment, including using standardized trauma measures, as indicated through trauma screenings and other available sources of information.
- Ask mental health providers and agencies about their training and experience in treating children and families who have been impacted by trauma.
- Communicate with the school and other providers about the child's needs and appropriate strategies to promote trauma recovery.
- Organize regular case conference meetings with all providers working with the family (and ensure the family is also included wherever possible and appropriate) to develop a common trauma-informed language and framework for services.
- Use consistent trauma-informed language in expressing desired outcomes for the child and families as well as in discussing progress.

Permanency Planning

- Ensure that parents and caregivers are receiving appropriate services, including trauma-informed services as needed, to address barriers to permanency.
 - Refer parents to trauma therapy to address trauma issues that interfere with their protective capacity.
 - Refer parents and caregivers to trauma trainings and workshops to help them see their children's behaviors through trauma lens and learn trauma-informed parenting skills.
 - Educate parents and caregivers about secondary trauma and link them to support groups and treatment as needed.

Reunification

- Convene team staffings (including the child when age-appropriate) to establish expectations, address physical or psychological safety concerns, and plan for the transition.
- Create or amend safety plans with the family, including psychological safety (such as, what makes the child feel safe and unsafe, what can parents do to make the child feel safer).
- Help parents create a crisis plan including respite care.
- Schedule overnight or weekend visits prior to reunification to ease the transition for the child and family.
- Prepare parents for changes in behavior; educate parents about the impact of trauma on the child's behavior and functioning.
- Provide parents with child's schedule routine, including appointments, medications. Encourage parents to attend appointments, especially therapy appointments, with child prior to reunification.
- Keep the child in the same school when possible to minimize disruption and promote ongoing peer support. Help parents arrange transportation, if needed.
- Ensure the child and parents can continue therapy prior to and throughout the transition.
- Explore formal and natural supports for the child and family (such as parent partner, mentor, guardian ad litem, friends, faith community).
- Refer to wraparound services as needed.
- Facilitate the creation of a lifebook to help the child process trauma and substitute care experiences.
- Help the child maintain connection with the out-of-home caregiver.
- Actively facilitate and support connections between the birth and resource families prior to reunification to ease the transition for the child.

Adoption and Guardianship

- Use the National Center for Traumatic Stress Network's *Caring for Children Who Have Experienced Trauma* training curriculum or other specialized training focusing on trauma and loss for adoptive parents and guardians.

- Match the child to adoptive families or guardians based on their individual needs, including trauma-related needs.
- Ensure ongoing cultural connections for the child.
- Ensure that adoptive families and guardians have all the information about the child's trauma history and trauma reactions that they need in order to care for the child.
- Promote adoptive parent and guardian involvement in the child's therapy as well as conjoint or family therapy (when indicated) prior to adoption/guardianship.
- Prepare adoptive parents and guardians to support the child in talking about trauma and birth families.
- Help the child create lifebooks with photos to process experiences with birth family, trauma, foster care, and adoption/guardianship.
- Help the child process feelings about being adopted or entering into legal guardianship.
- Ensure that the child has a voice and choices in the adoption/guardianship process.
- Prepare the child for adoption/guardianship and allow transitioning at his or her own pace.
- Support ongoing contact with the birth family if in the best interest of the child.
- Educate adoptive families and guardians as to the importance of maintaining connections for the child.
- Support ongoing contacts with siblings, relatives, and kin connections (as defined by the child) whenever possible.
- Provide support for families in telling the child his or her adoption story.
- Help adoptive parents and guardians plan a special celebration for finalization of adoption/guardianship.
- Link families to resources and trauma-informed services.

Transitioning into Adulthood/Achieving Self-Sufficiency

- Conduct a thorough assessment of youth/young adult needs, including trauma-related needs, as they prepare to exit the system.
 - Engage youth in determining what services and supports are needed.
- Link transitioning youth to ongoing community support services:
 - Trauma treatment as needed.
 - Trauma-informed substance abuse treatment as needed.
 - Mentorship programs that focus on life skills, academic success, career success.
 - Programs that provide concrete services, such as housing and financial support.
- Ensure that youth/young adults have permanent connections to supportive adults.
- Help youth connect or re-connect with relatives, teachers, coaches, and other supportive adults.

My Rules of Thumb – How I will behave in a Trauma-Informed Manner

1.

2.

3.

4.

5.

6.

Parents Must Truly Address the Roots of Their Trauma

- For parents to be reunited with their children, they must be able to keep their child safe.
- For true change to occur in the conduct of the parent/ caregiver, they must address the root cause or causes of their diminished protective capacities.
- Even though you see them through a trauma-informed lens and appreciate what they have experienced, never forget the fact that they must change in significant ways in order for them to have the privilege of being reunified with their child.

How People Exposed to Trauma React to Authority

- Children and parent/caregivers who experienced traumatic stress as children likely had childhoods where the authority figures in their lives have not set the boundaries and expectations toward authority and/or rules that most of us find as acceptable.
- A child with a complex trauma history may be easily triggered or “set off” and is more likely to react very intensely. The child may struggle with self-regulation in knowing how to calm down and may lack impulse control or the ability to think through consequences before acting.
- A parent who was traumatized as a child but was never treated will tend to have the difficulty with authority figures.
- It is from their traumatic childhood experience that they have developed a working model of how relationships should look. Adults will carry forward the model of relationships they learned in childhood and seek to reenact them as parent/caregivers.

Unit 4.3: Referring and Advocating for the Child and Family in a Trauma-Informed Manner

Screening, Assessments and Evaluation

- While you will have no formal instrument to do so, with any child or parent/caregiver you meet, you must constantly be informally assessing, or screening, them for trauma.
- Using the information you have gotten from this module, your job is to keep your eyes and ears open to the possibility of traumatic experience.
- A formal trauma assessment identifies the child's and/or family's emotional and behavioral trauma. With the information acquired during this assessment, you are best able to advocate for the right and best treatment options during treatment planning.
- Trauma assessments also help determine if a child and or family member might benefit from a specific treatment approach. They must be completed by a mental health provider.
- A formal psychological evaluation differs from an assessment in that it is designed to answer a specific referral question such as to clarify a diagnosis. A psychological evaluation does not necessarily focus on specific reactions, and it is usually conducted by a court approved evaluator.

Other Referrals and Advocacy

Key ingredients to enable you to refer and advocate for the best and right trauma-informed services for the child and parent/caregiver:

- Be clear on their traumatic experiences and developmental stages.
- Collect sufficient information and conduct the analysis, critical thinking and decision-making to make the right referrals.

Pharmacology and the Child or Adult

- Child behavior often presents in very disruptive manners, with behaviors including things like extreme aggression, mood dysregulation, impulsivity, and emotion-altering behaviors. The same might be true for adults.
- The trauma MAY be driving this behavior, or it may be a true biochemical disorder.
- If the child or adult is unable to understand what is happening or what is being said to them because of the severity of their symptoms, often they must be medicated – sufficiently, and not over-medicated – before services can truly be effective.
- It is also very possible that the child or adult actually has one or more of these mental health issues, or it could be that they have both trauma and true mental health issues.
- They should not be on medication without concurrently being involved in evidence-based psychosocial therapeutic interventions that are designed for the types of challenges he or she faces.
- If the child does not receive the true therapeutic help he or she must have to be able to effectively heal from the trauma, then that child will grow up having to take medication perpetually in order to manage his or her symptoms.
- It will be important for you to monitor and advocate for the child's best interests during the time that they are on medication.
- It will be your responsibility to monitor the child's progress to effectively advocate for changes in therapeutic approach or medication if the child has responded to such an extent that they have healed from at least some of their traumatic experience.
- By behaving in a trauma-informed manner, including advocating for the best and right services for the child or adult, you can give them the best shot at moving past their traumatized history into a hopeful and bright future.

What Medication Does NOT Help

- Some mental health issues and resulting traumatic behaviors do not respond well to psychotropic medication.
- There are also trauma-related symptoms that are difficult to treat with medications. These include such behaviors as:
 - Overeating
 - Misinterpretation of other peoples' behavioral intentions
 - Thrill-seeking, risk taking behaviors such as substance abuse, sexual behavior and daring acts
- For these you will need to resort only to psychosocial interventions to help them recover.

Evidence-Based Trauma-Informed Treatment Practices

Practices	Description of Practices
<u>Alternatives for Families: A Cognitive-Behavioral Therapy (AF-CBT)</u>	<p>AF-CBT is an evidence-supported intervention that targets (1) diverse individual child and caregiver characteristics related to conflict and intimidation in the home, and (2) the family context in which aggression or abuse may occur.</p> <p>AF-CBT has been primarily used in outpatient and in-home settings; however, it can be delivered on an individual basis in alternative residential settings, especially if there is some ongoing contact between caregiver and child. AF-CBT is appropriate for use with physically coercive/abusive parents and their school-age children. Related methods are designed for use with physically abused children who present with externalizing behavior problems, notably aggressive behavior, coping skills/adjustment problems, poor social competence, internalizing symptoms, and developmental deficits in relationship skills. In addition, the approach includes methods to address parent-child conflicts.</p>
<u>Adapted Dialectical Behavior Therapy for Special Populations (DBT-SP)</u>	<p>This treatment addresses general symptoms of trauma rather than presenting a method of processing a specific trauma.</p> <p>Dialectical Behavior Therapy was popularized by Marsha Linehan, PhD (1993, Cognitive Behavioral Treatment of Borderline Personality Disorder, New York: Guilford Press). Linehan added “Mindfulness” to Cognitive Behavioral Therapy principles.</p>
<u>Assessment-Based Treatment for Traumatized Children: Trauma Assessment Pathway (TAP)</u>	<p>The TAP model utilizes clinical pathways and assessment-based treatment to help guide the decisions made throughout the course of treatment for any individual child. This allows for decisions regarding assessment and treatment interventions to be tailored to the individual needs of each child receiving services through this model. The first component of the model is conducting a thorough assessment. This process includes telephone screening, the clinical interview, observation, and completing standardized assessment measures. Through the assessment process, clinicians formulate a Unique Client Picture and gain a multidimensional understanding of the child that guides and informs their intervention decisions.</p>
<u>Attachment, Self-Regulation, and Competence (ARC): A Comprehensive Framework for Intervention with Complexly Traumatized Youth</u>	<p>ARC is a framework for intervention with youth and families who have experienced multiple and/or prolonged traumatic stress. ARC identifies three core domains that are frequently impacted among traumatized youth, and which are relevant to future resiliency. ARC provides a theoretical framework, core principles of intervention, and a guiding structure for providers working with these children and their caregivers, while recognizing that a one-size-model does not fit all. ARC is designed for youth from early childhood to adolescence and their caregivers or caregiving systems.</p> <p>The ARC approach is grounded in attachment theory and early childhood development, and addresses how a child’s entire system of care can become</p>

	<p>trauma-informed to better support trauma-focused therapy.</p> <p>The approach provides a framework for both trauma-informed and trauma specific therapeutic intervention.</p>
Child Adult Relationship Enhancement (CARE)	<p>CARE was adapted from Parent-Child Interaction Therapy (PCIT). PCIT is an intervention approach for children with behavioral problems aged 2-12 and their parents, caregivers, and/or teachers. It has been adapted for use with children and caregivers with histories of traumatic stress. PCIT sessions include live coaching of caretakers with their children in two major components:</p> <ul style="list-style-type: none"> • Relationship enhancement or Child-Directed Interaction (CDI) • Child behavior management or Parent-Directed Interaction (PDI) <p>PCIT has been shown to develop caretakers' competence in managing their child's problematic behavior, promote caretakers' reinforcement of child's positive behaviors, reduce conflict between caretakers and their child, and enhance positive interactions between the caretakers and their child.</p> <p>CARE utilizes the three P skills (Praise, Paraphrase and Point-out-Behavior) to connect with children and their caregivers. CARE provides a set of techniques for giving children and their caregivers effective positive commands, and the use selective ignoring techniques to redirect problematic behaviors. CARE also contains a trauma education component to contextualize the use of these skills with the kinds of behaviors and problems exhibited by many traumatized children and their caregivers.</p>
Child Development-Community Policing Program (CDCP)	<p>The CD-CP program brings police officers and mental health professionals together to provide each other with training, consultation, and support, and to provide direct interdisciplinary intervention to children who are victims, witnesses, or perpetrators of violent crime.</p> <p>The CD-CP program was developed by the Yale Child Study Center in New Haven, Connecticut, in 1992 to reduce the harm that chronic exposure to violence inflicts on children and families. The program provides a framework for a collaborative alliance among law enforcement, juvenile justice, domestic violence, medical and mental health professionals, and child welfare. CD-CP is a collaborative initiative between the National Center for Children Exposed to Violence at the Yale Child Study Center and the University of Connecticut's Department of Psychiatry that focuses on the development and study of assessment and treatment approaches for children exposed to violence.</p> <p>CD-CP has been replicated in many communities across the United States.</p>
Child-Parent Psychotherapy (CPP)	<p>CPP is a dyadic attachment-based treatment for young children exposed to interpersonal violence. This intervention is designed to allow parents and caregivers to develop secure relationships with their young children (up to age 5) and help form healthy attachments.</p>
Cognitive Behavioral Intervention for Trauma in Schools (CBITS)	<p>CBITS is designed for students in grades three through high school CBITS works on learning coping skills, decreasing symptoms of posttraumatic stress disorder, and improving relationships with others.</p>

<u>Combined Parent Child Cognitive-Behavioral Approach for Children and Families At-Risk for Child Physical Abuse</u>	CPC-CBT consists of 16 sessions that aim to empower parents to effectively parent their children in a non-coercive manner, improve parent-child relationships, assist children in healing from their abusive experiences, and enhance the safety of family members. This model helps to reduce the risk of the recurrence of child physical abuse in children and families at-risk for child physical abuse. The treatment consists of three components: (1) Parent Interventions, (2) Child Interventions, and (3) Parent-Child Interventions.
<u>Community Outreach Program – Esperanza (COPE)</u>	<p>The COPE program is a home- and school-based trauma-focused treatment. The emphasis is on case management to enable clinicians to offer evidence-based trauma treatments in community settings.</p> <p>The primary treatment modality is trauma-focused cognitive-behavioral therapy (TF-CBT) and culturally-modified trauma-focused treatment (CM-TFT). On an as needed basis, parents may be offered Parent-Child Interactive Therapy (PCIT) to help improve interactions with their children and to teach the discipline strategies of PCIT. Case management can include helping other family members access services to care for the child more effectively (e.g., helping a substance-abusing parent find treatment) or to address the family's basic needs (e.g., receiving clothing or food donations, applying for Medicaid or Crime Victims Compensation, or accessing legal assistance).</p>
<u>Culturally Modified Trauma-Focused Cognitive Behavioral Therapy (CMTF-CBT)</u>	CMTF-CBT is a components-based psychosocial treatment model that incorporates elements of cognitive-behavioral, attachment, humanistic, empowerment, and family therapy models.
<u>International Family Adult and Child Enhancement Services (IFACES)</u>	The IFACES program provides comprehensive community-based mental health services to refugee children, adolescents, and families. Outreach is seen as the cornerstone of the program and occurs throughout the treatment process. It includes identifying refugee children who can benefit from services, engaging them and their families in services, retaining them in services, and supporting them as necessary after the active treatment phase has ended. The program has evolved from decades of providing services to refugees at the agency, and is informed by experience providing resettlement, social, and mental health services to this population. The team approach and comprehensive services aspects of the model have been influenced by Assertive Community Treatment (ACT) and other community-based approaches used by agency programs that work with individuals who are homeless and have a serious mental illness. This approach emphasizes the importance of relationship between participants and service providers, a harm reduction philosophy, and a commitment to tailor services to clients' current needs.

Group Treatment for Children Affected by Domestic Violence	<p>This program utilizes trauma-focused intervention for complex trauma cases. It includes affect regulation and relaxation components of mindfulness, meditation, movement, art and music. This 44-week group program includes topic-driven modules—e.g., why am I here, my world, perceptions/awareness, environmental cues, thoughts/feelings/behaviors, communication, violence info, coping, anger management, blame/responsibility, feelings identification, loss/separation ambivalence. Children and parents attend parallel groups with similar content. Multi-group family sessions are held halfway through the program. Groups are open to accommodate families in need. Delivery of the entire intervention takes about one year.</p>
Honoring Children, Making Relatives	<p>“Honoring Children, Making Relatives” incorporates American Indian and Alaskan Native philosophies into the basic concepts of Parent-Child Interaction Therapy (PCIT), providing traditional aspects of parenting with American Indians and Alaskan Natives from their world view.</p> <p>PCIT was culturally adapted/translated to provide an effective treatment model for parents who have difficulty with appropriate parenting skills or for their children who have problematic behavior. Included in the curriculum are the issues of implementation and dissemination of evidence-based interventions in rural and/or isolated tribal communities with limited licensed professionals. Procedures are in place for assisting, measuring and monitoring the skills acquisition and treatment fidelity for rural/isolated or reservation based therapist-trainees. Online video consultation is used in the live remote, real-time coaching sessions to overcome the issue of distance and time constraints. This treatment is appropriate for children between the ages of 3 to 7 years of age.</p>
Honoring Children, Mending the Circle	<p>“Honoring Children, Mending the Circle” is the clinical application of the healing process in a traditional framework that supports the belief of American Indians and Native Alaskan culture of spiritual renewal leading to healing and recovery. This model combines trauma-sensitive interventions with elements of cognitive behavioral therapy into a treatment designed to address the unique needs of children with Post-Traumatic Stress Disorder (PTSD) and other problems related to traumatic life experiences. Training involves a four-day intensive session, follow-up weekly case consultation, web-based training and resources. It is appropriate for most types of trauma and for children up to the age of 18.</p>
Honoring Children, Respectful Ways	<p>"Honoring Children, Respectful Ways" is the cultural adaptation of Treatment for Children with Sexual Behavior Problems which can also be used as a prevention approach. It is the 6th in the 7 session series, Childhood Trauma Series in Indian Country. This therapy is appropriate for children between the ages of 3-12 years of age who have experienced traumas of sexual abuse, physical abuse, and violence in the family. Inappropriate sexual behaviors of American Indian and Alaska native children and youth can have wide ranging impact on not only the children but also can significantly affect the family, the extended family, and the community, and can result in serious negative social consequences. This webinar provides information about the intervention as well as the prevention aspects of this</p>

	approach.
<u>Integrative Treatment of Complex Trauma (ITCT-A)</u>	<p>ITCT-A is an evidence-based, multi-modal therapy that integrates treatment principles from the complex trauma literature, attachment theory, the self-trauma model, affect regulation skills development, and components of cognitive behavioral therapy. It involves structured protocols and interventions that are customized to the specific issues of each client, since complex posttraumatic outcomes are notable for their variability across different individuals and different environments.</p> <p>A key aspect of ITCT-A is its regular and continuous monitoring of treatment effects over time. This involves initial and periodic evaluation of the youth's symptomatology in a number of different areas, as well as assessment of his or her ongoing level of support systems and coping skills, family/caretaker relationships, attachment issues, and functional self-capacities. The client's social and physical environment is also monitored for evidence of increased stressors or potential danger from revictimization or broader community violence.</p> <p>Therapy may range from several months to a year or more, although most clients appear to require an average of approximately six to eight months of treatment.</p>
<u>Multimodality Trauma Treatment – Trauma-focused Coping (MMTT)</u>	<p>MMTT is a skills-oriented, cognitive behavioral treatment (CBT) approach for children exposed to single incident trauma and targets posttraumatic stress disorder (PTSD) and collateral symptoms of depression, anxiety, anger, and external locus of control. It was designed as a peer mediating group intervention in schools. It has been shown to be easily adaptable for use as group or individual treatment in clinic populations as well.</p>
<u>Parent-Child Interaction Therapy (PCIT)</u>	<p>PCIT is geared toward children exposed to substances prior to birth or to physical abuse. PCIT works with parents to learn skills for improving family relations.</p> <p>PCIT is an evidence-based treatment model with highly specified, step-by-step, live coached sessions with both the parent/caregiver and the child. Parents learn skills through PCIT didactic sessions. Using a transmitter and receiver system, the parent/caregiver is coached in specific skills as he or she interacts in specific play with the child. Generally, the therapist provides the coaching from behind a one-way mirror. The emphasis is on changing negative parent/caregiver child patterns.</p>

Real Life Heroes (RLH)	<p>RLH is based on cognitive behavioral therapy models for treating posttraumatic stress disorder (PTSD) in school-aged youth. Designed for use in child and family agencies, RLH can be used to treat attachment, loss, and trauma issues resulting from family violence, disasters, severe and chronic neglect, physical and sexual abuse, repeated traumas, and posttraumatic developmental disorder. RLH focuses on rebuilding attachments, building the skills and interpersonal resources needed to reintegrate painful memories, fostering healing, and restoring hope. These goals are accomplished using nonverbal creative arts, narrative interventions, and gradual exposure to help children process their traumatic memories and bolster their adaptive coping strategies.</p>
Safe Harbor Program	<p>Safe Harbor is a comprehensive program designed to help students, parents, and schools cope with the violence, victimization, and trauma that occurs in their communities. The program utilizes a "safe harbor" room in school as a low stigma, easy access entry point to attract distressed children/youth coping with violence. With a focus on leadership, empowerment, and developing social, emotional, and interpersonal skills, this program offers victim assistance, counseling, and concrete alternatives to violence at both the individual and school level.</p>
Safety, Mentoring, Advocacy, Recovery, and Treatment (SMART)	<p>The S.M.A.R.T. model is a structured, phase-based approach to treatment for sexually abused children who are exhibiting sexual behavior problems. The model has been successfully implemented with a primarily African American population since 1998. It incorporates already established practices proven to be effective in trauma treatment, such as CBT, as well as psychoeducation and skill building to directly address the behavioral and emotional concerns associated with the experience of child sexual abuse and the resultant victimizing behavior. The primary objectives of the model are: 1) to eliminate the sexual behavior problem; 2) to establish stability and a sense of safety in the lives of children; 3) to improve insight, judgment, and empathy; 4) to increase awareness of personal risk patterns and triggers; 5) to develop coping skills and strategies that improve emotional and behavioral regulation; 6) to provide parents with the skills to meet their children's physical/emotional needs; and 7) to increase children's connectedness to positive individuals and building internal goals that support future growth.</p>
Sanctuary Model	<p>The Sanctuary Model® represents a theory-based, trauma-informed, evidence-supported, whole culture approach that has a clear and structured methodology for creating or changing an organizational culture. The objective of such a change is to more effectively provide a cohesive context within which healing from psychological and social traumatic experience can be addressed.</p> <p>As an organizational culture intervention, it is designed to facilitate the development of structures, processes, and behaviors on the part of staff, clients and the community-as-a-whole that can counteract the biological, affective, cognitive, social, and existential wounds suffered by the victims of traumatic experience and extended exposure to adversity.</p> <p>The goal is to teach individuals and organizations the necessary skills for creating and sustaining nonviolent lives and nonviolent systems, and to keep believing in the unexplored possibilities of peace.</p>

Streetwork Project	<p>The Streetwork Program of New York City is based on a harm reduction philosophy that focuses on building trust and fostering self-esteem to empower youth to change their high-risk behaviors. This program provides counseling, stabilization, and case management and focuses on enhancing individuality to homeless, street-involved youth.</p> <p>Streetwork clients (children, teens and young adults up to age 24) are provided with the following free services: legal, medical and psychiatric services, individual and group counseling, case management, advocacy, help in obtaining identification, emergency and crisis housing, GED preparation and support, help in obtaining Medicaid and other benefits, hot meals, showers, clothing, wellness activities including acupuncture, yoga, nutritional counseling, HIV prevention counseling, parenting groups, drop-in groups and the opportunity to socialize in a safe, non-judgmental setting.</p>
Structured Psychotherapy for Adolescents Responding to Chronic Stress (SPARCS)	<p>SPARCS is a manually-guided and empirically-supported group treatment designed to improve the emotional, social, academic, and behavioral functioning of adolescents exposed to chronic interpersonal trauma (such as ongoing physical abuse) and/or separate types of trauma (e.g. community violence, sexual assault). The curriculum was designed to address the needs of adolescents who may still be living with ongoing stress and experiencing problems in several areas of functioning including difficulties with affect regulation and impulsivity, self-perception, relationships, somatization, dissociation, numbing and avoidance, and struggles with their own purpose and meaning in life as well as worldviews that make it difficult for them to see a future for themselves. The curriculum has been successfully implemented with at-risk youth in various service systems (e.g. schools, juvenile justice, child-welfare, residential) in over a dozen states.</p>
Trauma Affect Regulation: Guidelines for Education and Therapy for Adolescents and Pre-Adolescents (TARGET-A)	<p>TARGET is an educational and therapeutic approach for the prevention and treatment of complex Post-Traumatic Stress Disorder (PTSD). TARGET provides a practical skill-set that can be used by trauma survivors and family members to de-escalate and regulate extreme emotional states, to manage intrusive trauma memories in daily life, and to restore the capacity for information-processing and autobiographical memory. TARGET teaches a sequence of seven skills described as the FREEDOM steps.</p> <p>The focus in TARGET is on shifting the way a person processes information and emotions so that s/he is able to live life and make sense of memories they are experiencing.</p>
Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)	<p>TF-CBT is a combination of individual and joint therapy sessions for children and parents or caregivers that focuses on reducing emotional/behavioral issues resulting from childhood traumatic stress. TF-CBT is the most tested evidence-based treatment for traumatized youth. It is comprised of several treatment components, summarized by the acronym PRACTICE. These components are divided into 3 phases or modules: Coping Skills; Trauma Narrative and Processing and Treatment Consolidation and Closure.</p> <p>TF-CBT addresses the multiple domains of trauma impact including but not limited to Posttraumatic Stress Disorder, depression, anxiety, externalizing behavior problems, relationship and attachment problems, school problems and cognitive problems. TF-CBT includes skills for regulating affect, behavior, thoughts and relationships, trauma-processing, and enhancing safety, trust,</p>

	parenting skills and family communication.
Trauma Grief Component Therapy for Adolescents (TGCT-A)	<p>TGCT-A is a practice focused on adolescents to understand the effects of trauma on their behavior and strengthen self-regulation and coping skills. TGCT-A is a manualized treatment for trauma-exposed or traumatically bereaved older children and adolescents that may be implemented in school, community mental health, or other service settings.</p> <p>The program has been implemented with a wide range of trauma-exposed and traumatically bereaved older child and adolescent populations, in both the United States and international settings. These populations include youth impacted by community violence, traumatic bereavement, natural and man-made disasters, war/ethnic cleansing, domestic violence, witnessing interpersonal violence, medical trauma, serious accidents, physical assaults, gang violence, and terrorist events.</p>
Trauma Systems Therapy (TST)	<p>TST was inspired in part by Bronfenbrenner’s social-ecological model (Bronfenbrenner, 1979), which acknowledges the complexity of the social environment that surrounds an individual, and how disruptions in one area of the social ecology may create problems in another. Interventions in TST are designed to work in two dimensions: strategies that operate through and in the social environment to promote change, and strategies that enhance the individual’s capacity to self-regulate. The TST model involves choosing a series of interventions that correspond to the fit between the traumatized child’s own emotional regulation capacities and the ability of the child’s social environment and system-of-care to help him or her manage emotions or to protect him or her from threat.</p> <p>TST is not limited to one specific trauma type. Children who have participated in the program have experienced a wide range of traumas, such as domestic violence, physical abuse, sexual abuse, exposure to war, and medical trauma. Many of the children who have received TST experienced multiple traumas. In addition, TST specifically addresses social-environmental factors that compound the problems associated with trauma exposure, such as poverty or inappropriate school placements.</p>

Ways to Better Ensure a Trauma-Informed Approach When Culture and Historical Trauma are Considerations

Adapted from One or More of the Following Sources

Chadwick Trauma-Informed Systems Project. (2013). Guidelines for Applying a Trauma Lens to a Child Welfare Practice Model (1st ed.). San Diego, CA: Chadwick Center for Children and Families.

Reducing the Trauma of Investigation, Removal and Initial Out-of-Home Placement Project. (2008-2009). Trauma Informed Practice Strategies for Caseworkers. Portland State University, Center for Improvement of Child and Family Services.

Child Welfare Trauma Training Toolkit. (2013). The National Child Traumatic Stress Network.

Questions to Ask Myself: Assessing the Child and Family

1. What bias do I have towards this child or family? If I detect bias, is this due to the behavior I observe, or is there some other cultural or historical reason?
2. What are the cultural issues that I need to consider within this case in order to approach this child and family in a trauma-informed manner?
3. Does this child and/or family have a strong cultural identity? If this is a strength, how can it contribute to the resilience of the child, the family and the community?
4. How might this child's social and cultural realities influence his or her perception of risk, interpretation of experience, and definition of trauma?
5. Ask family members about traumas and losses they or their ancestors may have experienced their impact on the child and family today.
6. What traumatic events may have occurred in the family's country of origin before entering the immigration process in the US?
7. If this is a refugee family, what are their core stressors (things like traumatic stress, resettlement stress, acculturation stress, and isolation stress)?

8. Do culturally-based parenting and intergenerational differences in acculturation impact the family's functioning and behavior? If yes, explain how.
9. What might the protective factors be for this culture that will enable me to keep the family from needing out-of-home placement?

Questions to Ask Myself: Decisions You Must Make

1. How can I tailor-make services to meet the trauma-related needs of individuals in this situation?
2. Are the decisions I am making based in my bias towards this child and family or are they free from my personal biases?
3. When is necessary to arrange out of home care, am I working to locate kinship/foster/ adoptive family that embraces the child's cultural identity and has the knowledge, skills, and resources to help the child?
4. How is my own knowledge, experience, and cultural framing influencing your perceptions of the reported traumatic experiences, their impacts, and my choices of intervention strategies?

Questions to Ask Myself: Supportive Resources

1. Who are the cultural brokers, consultants, or liaisons who are members of the ethnic community for this child and family who could serve as a bridge between children and families, communities, and the agency?
2. Should I collaborate with members of the community to understand the needs at hand?
3. What resources does the family trust that I can use to supplement available services (such as bringing up priest or healer)?

4. If I need an interpreter, is the one I have qualified?
5. Have I allowed the family families to choose a face-to-face or telephone interpreter based on their preferences?
6. Have I made a special effort to integrate cultural practices and culturally responsive mental health services?
7. Have I ensured the referrals for therapy are made to therapists are culturally and linguistically responsive?

Cultural Scenarios

Joseph

Joseph is a 5-year-old American Indian boy. He is a registered member of his tribe through his father, who was murdered when Joseph was an infant. Joseph has lived with his mother, who has a drug and alcohol abuse problem, off and on his whole life. Recently, her boyfriend beat Joseph up because he was not listening to his mother. Joseph had a black eye and multiple contusions. Joseph's mother refused to believe her boyfriend had committed the assault and said she could not handle Joseph's behavior anymore.

Marcus

Marcus is a 10-year-old African-American male who lived with his grandmother until her sudden death last year. His mother died when he was one year old and his father is not listed on his birth certificate. He has no other known living relatives. When his grandmother died, Marcus came into custody. He was initially placed in a receiving center while a foster home was being identified. In his first 24 hours in the receiving center, Marcus was raped by a 15-year-old boy.

Mi Sun

Mi Sun is an 8-year-old Korean-American female who recently disclosed to her teacher that her father was sexually abusing her. The family emphatically denies the abuse, and Mi Sun was placed into foster care with a Caucasian family. Mi Sun's parents are very involved in a church community, who supports Mi Sun's father and is pressuring Mi Sun to rescind her abuse allegation.

Sylvia

Sylvia is a 14-year-old girl. Her family recently entered the country illegally from Mexico, fleeing from poverty and drug-related violence in their home town. Sylvia came into custody after her mother beat her for staying out all night, calling her a slut and telling her she will pay for her sins. Sylvia's father is still in Mexico serving a prison term. He was violent toward Sylvia's mother throughout Sylvia's childhood.

Charlie

Charlie is a 17-year-old Caucasian male. He recently ran away from home after his father beat him up when Charlie told his parents he was gay. He came to a drop-in center, stating that he had nowhere to go and has been living on the streets for the past several days.

Cultural Scenarios Worksheet

- [illegible]