Center for Advanced Studies in Child Welfare
School of Social Work
University of Minnesota

CW360°

a comprehensive look at a prevalent child welfare issue

Safety | Permanency | Well-Being

Trauma-Informed Child Welfare Practice
Winter 2013

From the Editors

We, at the Center for Advanced Studies in Child Welfare (CASCW), have had a very busy and exciting year in 2012 and are proud to present the first issue of CW360° for 2013! CW360°, typically released as an annual publication, was developed to provide communities, child welfare professionals, and other human service professionals with comprehensive information on the latest research, policies, and practices in a key area affecting child well-being today. We are once again fortunate to co-produce a special edition of CW360° with one of our partners at the University of Minnesota: Ambit Network.

As anyone working in the field of child welfare in the last few years can attest, there has been increased attention placed on the role of trauma in our work. In this issue, we shift our focus from the secondary trauma experienced by the child welfare workforce (the topic of our spring 2012 issue) to the examination of trauma-informed practice with children and families involved in the child welfare system. Recognizing an overwhelming body of research on the critical impact of trauma on almost every aspect of our lives, the field of child welfare is at the dawn of major shift in how it views its work. It is no longer a question of whether to incorporate trauma-informed organizational and practice strategies into child welfare practice, but how. As a leader in helping communities navigate research and practice in child trauma, Ambit Network has been an instrumental partner in bringing together the rich collection of practical knowledge and resources you will find throughout this issue.

As in previous editions, CW360° is divided into three sections: overview, practice, and perspectives. In the overview section, articles focus on key issues from research on complex trauma to the development of trauma-informed child welfare organizations. The practice section includes articles on evidence-based and promising practices that use a trauma-informed perspective for addressing the experiences of children and families in the child welfare systems. Finally, the perspectives section presents articles from a variety of child welfare stakeholders highlighting innovative examples of integrating a trauma-informed perspective into practice and policy and offering practical suggestions and strategies for system and practice improvements.

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This special issue of CW360°, focused on childhood traumatic stress, is a product of the long-standing partnership between Ambit Network and the Center for Advanced Studies in Child Welfare (CASCW). We are grateful to CASCW for this opportunity and we wish to express our deep appreciation to the many authors who contributed their expertise to this publication.

Ambit Network, a National Child Traumatic Stress Network (NCTSN) Community Treatment and Services Center funded through the Substance Abuse and Mental Health Services Administration (SAMHSA), is a university-community partnership committed to raising the standard of care and improving access to quality services for traumatized children, their families, and communities throughout Minnesota and eastern North Dakota.

Traumatic events can be devastating to children and families. Children and families can respond to traumatic events in a range of ways. Some children are resilient and have strong supports in their lives, which can mitigate the damage traumatic events often engender. Children and families in the child welfare system often experience trauma that is complex and ongoing and may lack the resources to resolve their traumatic experiences. It is our hope that this issue of CW360° will provide all of you who work alongside troubled children and families with a resource that guides you in your work as you recognize and understand the effects of traumatic stress.

Abigail Gewirtz, PhD, LP
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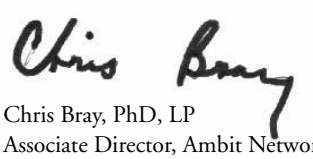

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Table of Contents

Overview

What is Traumatic Stress?, *Lucy Berliner, MSW* 4

The Impact of Trauma from Early Childhood through Adolescence: A Developmental Perspective, *Keri LM Pinna, PhD and Abigail Gewirtz, PhD, LP* 6

The Heart of the Matter: Complex Trauma in Child Welfare, *Joseph Spinazzola, Ph.D., Mandy Habib, Psy.D., Angel Knoverek, Ph.D., LCPC, Joshua Arvidson, MSS, LCSW, Jan Nisenbaum, MSW, Robert Wentworth, MSW, Hilary Hodgdon, Ph.D., Andrew Pond, LICSW, and Cassandra Kisiel, Ph.D.* 8

The Impact of Traumatic Stress on Parents Involved, in the Child Welfare System, *Erika Tullberg, MPH, MPA, Roni Avinadav, PhD, Claude M. Chemtob, PhD* 10

The Emergence of Trauma-Informed Child Welfare Systems, *Charles E. Wilson, MSSW* 12

By What Yardstick Should We Measure Success in Child Welfare Policy?, *Janice L. Cooper, PhD, MPA and Yumiko Aratani, PhD* 14

Integrating Safety, Permanency, and Well-Being for Children and Families in Child Welfare, *An excerpt from the 2012 year end message from Commissioner Bryan Samuels, Administration on Children, Youth and Families* 16

Practice

Operationalizing Trauma-Informed Child Welfare Practice using the Child Welfare Trauma Training Toolkit, *Alison Hendricks, LCSW* 18

Giving a Trauma Lens to Resource Parents, *Liz Sharda, LMSW* 19

Addressing Early Childhood Trauma in the Context of the Child Welfare System, *Betsy McAlister Groves, MSW, LICSW* 20

Trauma Screening within the Child Welfare System, *Lisa Conradi, PsyD and Cassandra Kisiel, PhD.* 21

Trauma-Focused Cognitive Behavioral Therapy (CBT) for Youth in Child Welfare, *Judith A. Cohen, MD and Anthony Mannarino, PhD* 22

Trauma-Informed PMTO: An Adaptation of the Oregon Model of Parent Management Training, *Laura A. Rains, MSW, LCSW, and Marion S. Forgatch, Ph.D.* 24

Cultural Adaptations of Trauma Treatments in Indian Country, *Wynette Whitegoat, AB, and Richard van den Pohl, PhD* 25

Homeless Youth Emerging from the Child Welfare System, *Arlene Schneir, MPH* 26

Trauma-Informed Care Using the 3-5-7 Model, *Darla L. Henry, PhD, MSW, and Amelia Franck Meyer, MS, MSW, APSW, LISW* 27

Perspectives

Repacking the Invisible Suitcase, *Chaney Stokes As told to Johanna Zabawa, Research Assistant* 28

A Birth Parent's Perspective: What Happened?, *Pamela Toohey* 29

Native Families Impacted by Historical Trauma and the Role of the Child Welfare Worker, *Marilyn J. Bruguier Zimmerman, MSW and Patrick Shannon, BSW* 30

Treating Child Traumatic Stress: Bearing Witness to Healing, *Sara Younge PsyD, LP* 31

Training New Child Welfare Workers, *Rebecca Wilcox, MSW, LGSW and Kristi Petersen, MSW.* 32

Lessons Learned from Implementing the Resource Parenting Curriculum with Foster and Adoptive Parents, *George S. Ake III, PhD* 33

Using a Trauma-Informed Lens To Create A Perspective Shift in Child Welfare Practice: One Organization's Journey, *Ann Leinfelder Grove, MSM* 34

Breaking Down Barriers Across Systems: Implementing a Trauma Perspective, *Beth Barto, LMHC* 36

References

Integrated Bibliography 38

Table of Contents

What is Traumatic Stress?

Lucy Berliner, MSW

What is a Trauma?

Traumas are events involving threat or danger. They do not have to be actually violent. The perception that something terrible could happen can make the event traumatic. Traumas may be directly experienced, witnessed or happen to a close loved one. They include child abuse, rape, violent crime, witnessing DV or community violence, serious accidents or natural disasters, and the violent or sudden death of a loved one. Not all bad experiences are traumas. Neglect, not being loved, foster care, parental incarceration and mental illness are adversities that can have negative effects.

The Prevalence of Traumatic Events

Exposure to trauma is very common. According to Finkelhor (Finkelhor et al, 2009) each year about 60 % of children experience at least one trauma. A subset, about 22%, has four or more different types of traumas. Traumas can range from the less serious, being hit by a sibling occasionally, to the extremely serious such as being raped or witnessing a parent murdered. Trauma exposure is almost universal among children in the child welfare system (CWS). For example, even though neglect comprises the majority of all CWS cases, many neglected children have witnessed DV or community violence.

What is Posttraumatic Stress (PTS) and How Does it Differ from Trauma?

Being exposed to a trauma is almost always upsetting. Trauma-specific reactions are called posttraumatic stress (PTS). PTS is unwanted and upsetting memories or dreams of the trauma and intense emotional and physical reactions when thinking about or being reminded of the traumas. Avoidance coping strategies decrease the negative emotional states when thinking about the traumas. PTS also includes heightened physical arousal responses such as jumpiness, irritability, difficulty concentrating, and trouble sleeping. Traumatic stress is a normal reaction to a very bad experience; most children exposed to traumas have at least some symptoms. PTS is not the only consequence of exposure to a trauma observed in children. Symptoms of general anxiety, depression, and behavioral disruption are also seen following traumas. Some children do not show distress following traumas, and for most the PTS will subside over time without treatment.

What is Post-Traumatic Stress Disorder (PTSD) and How Does it Differ from PTS?

A minority of children will experience persisting or worsening traumatic stress that becomes Post-Traumatic Stress Disorder. Occasionally, children develop PTSD after a period of appearing to be fine. To make the diagnosis, a qualified professional conducts a systematic assessment to find out if the symptoms required by the Diagnostic and Statistical Manual (DSM) are present. The diagnosis requires a certain number of symptoms of intrusive memories, avoidance or numbing reactions, and hyperarousal symptoms and that symptoms have persisted for at least a month and interfere with functioning. Just being exposed to a trauma or being upset about the trauma does not mean PTSD.

Finding out that a child has been exposed to trauma creates the opportunity for all involved in child serving settings to actively contribute to the child's recovery from the impact.

Predictors of PTSD in Children

Certain factors place children at greater risk for developing PTSD. The main predictors are more serious traumas, perception of life threat, prior traumas or psychiatric problems, and being female. A negative reaction from others also is associated with PTSD. Recent biological research demonstrates an association between child abuse and neglect, PTSD and altered brain structures and stress response systems. It is not clear whether these biological differences create increased susceptibility to PTSD or are the biological explanation of PTS (Neigh, Gillespie, & Nemeroff, 2009). Overall, research shows that the accumulated burden of multiple and different bad experiences (traumas and adversities) is more important than the specific type of trauma in predicting PTSD.

Immediate Responses to Trauma

We now have strategies to help children who have experienced trauma and have PTS. Psychological First Aid (PFA) (National Child Traumatic Stress Network, www.nctsn.org) is an approach for acute situations where the trauma has just occurred. It was originally designed for disasters, the psychological field response accompanying other rescue efforts. The main ingredients are focusing on here and now concerns, providing psychoeducational information and normalization, support, reinforcement of coping skills, and, when needed, facilitating access to ongoing services. With children, engaging caregivers is key. PFA usually involves one or two sessions. This type of approach can be used in emergency rooms, during child welfare investigations, in Child Advocacy Centers, and DV shelters. A

slightly more intensive approach is the Child and Family Traumatic Stress Intervention (Berkowitz, Stover, & Marans, 2011). This four session intervention is delivered within a month of the traumatic event and can significantly lower PTS and PTSD.

Screening for PTS and PTSD

Routine screening is the best way to identify children who have high levels of PTS or PTSD and would benefit by trauma-specific therapy. It is most important in child serving settings where children have high rates of exposure and are most likely to be significantly affected by their experiences, such as child welfare, mental health and juvenile justice. Experience shows that children are not distressed at being asked about traumas and are more likely to report when asked. There are checklists for screening for a trauma history (see the article by Conradi in this publication for more detailed information on screening). Screening is the first step to insure that children are assessed for mental health needs and to facilitate access to evidence-based therapy such as Trauma-Focused CBT (Cohen, Mannarin, & Deblinger, 2006). Professionals operating within the best practice multidisciplinary model or a Child Advocacy Center are well equipped to seamlessly facilitate access to trauma-specific assessment and therapy.

Providing Support

Simply asking about abuse and trauma is not sufficient since the children already know what they have experienced. The key is to learn about children's reactions and respond in a supportive way. Professionals and others such as foster parents can provide non-clinical interventions that are immediately helpful, such as normalizing PTS reactions, offering support and giving comfort. Even children who do not have significant PTS may have been affected by their experiences and appreciate acknowledgement that the trauma was bad, frightening or wrong. CPS investigators or forensic interviewers may be required to take care in the degree to which they validate children's reports of abuse, but they can still express appreciation and offer support.

PTS is a common reaction to exposure to trauma. Finding out that a child has been exposed to trauma creates the opportunity for all involved in child serving settings to actively contribute to the child's recovery from the impact. Simple steps such as acknowledgement, normalizing reactions, and providing support can reduce stress and potentially avert the development of longer-term consequences. It is also the platform for facilitating access to assessment and evidence-based trauma-specific treatment when necessary. The key to making a difference is not avoiding the trauma but rather communicating directly about the trauma and making sure there is access to needed care.

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The Impact of Trauma from Early Childhood through Adolescence: A Developmental Perspective

Keri LM Pinna, PhD and Abigail Gewirtz, PhD, LP

The impact of potentially traumatic experiences on a child's adjustment varies significantly depending on the developmental stage at which the child experiences trauma. This is true regardless of the nature of potentially traumatic event (i.e. whether it be abuse, neglect, exposure to violence, or some other traumatic event). Children's perceptions of threat during and following a potentially traumatic event (Kahana, Feeny, Youngstrom, & Drotar, 2006) and the nature of caregiver responses following the trauma (Scheeringa & Zeanah, 2001) are among the strongest predictors of children's adjustment following trauma. Children's perceptions of their experiences vary as a function of development as do the outcomes associated with caregiver responsiveness. Manners in which trauma-related symptoms manifest following a potentially traumatic experience also vary by developmental level. Thus, we explore developmental variations in children's perceptions of threat, outcomes associated with caregiver response to the child following trauma, and manifestations of trauma-related symptoms across developmental stages from infancy through adolescence.

Perceptions of Threat

Understanding how a potentially traumatized child experienced a traumatic event is the first step in determining how best to meet the child's needs in the immediate and longer-term aftermath. For an infant, facial expressions, tones of voice, sudden loud noises, and experience of caregiver responsivity to the infant's cues (e.g. crying) serve as the basis for interpreting safety versus danger (e.g. Moore, 2009). While an infant may not be capable of thinking "This is terrifying!," angry voices and facial expressions, and the sound of breaking glass in the next room are processed as threatening in the infant brain. Further, the absence of comfort in response to terrified cries leads an infant to learn that her caregivers cannot be trusted to provide comfort in times of need.

With each stage of development, perception builds on prior stages. For example, a **toddler** or **school aged child** also perceives facial expressions, tones of voice, sudden loud noises, and parental non-responsiveness to the need for comfort. As cognitive development becomes more advanced, the capacity for imagining the possibility of negative outcomes increases (Grist & Field, 2012). Thus, perception of threat begins to include what a child *imagines* could have happened if, for example, the police were not called when mommy and daddy were fighting near the kitchen knives. An **adolescent** is more likely to be able to gather and evaluate information about a potentially traumatic event to determine the actual threat involved but may also overestimate his/her sense of safety (Wickman, Greenberg, & Boren, 2010). The adolescent child of an abused mother may underestimate the risk involved in stepping in to protect his mother from her abusive partner. The adolescent's sense of invincibility may lead him to becoming the victim of the partner's abuse in the process, or even an unwitting perpetrator.

Caregiver Response & Attachment

When a child is traumatized in the presence of supportive caregivers, his responses may mimic those of the parent (van der Kolk, 2003). Children whose caregivers are unresponsive and/or inconsistent in their responses to the child's distress may develop insecure attachments and associated emotion regulation deficits. Disorganized attachment (one form of insecure attachment) develops when a parent responds to a child inconsistently, with frustration, violence, intrusiveness, or when a parent is severely neglectful. Children with disorganized attachment learn that they are unable to rely on their caregivers becoming either

Overview

extremely anxious and/or aggressive, or appearing paralyzed or frozen. Because their expressed emotions and behavioral attempts at gaining comfort from caregivers have been unsuccessful, they may have difficulty learning to trust their emotions or perceptions of danger. These attachment styles are developed early in life during **infancy** and the **pre-school years**.

The type of attachment relationship that is developed with a caregiver is believed to set the framework for the child's subsequent friendships during the pre-school and school aged years and for intimate relationships during adolescence (Furman, 2001). This likely contributes to the maltreated child's impairments in peer relationships and risk for aggressive behaviors (seen even more often following severe neglect than following physical abuse; Widom, 1989). Because social support is a strong buffer against future adversity, failure to develop healthy peer relationships contributes to an increased risk for poor adjustment following future adversity in children who have been traumatized in the absence of a supportive caregiver.

Similarly, failure to develop healthy romantic relationships also increases the risk for poor adjustment. Furthermore, violence within such relationships is a risk faced by many adolescents with histories of traumatic experiences. Attachment style has been shown to predict this risk differently for boys versus girls (Wekerle & Wolfe, 1998). Boys with a history of maltreatment who have developed avoidant and ambivalent attachment styles have been found to be at increased risk of perpetrating abuse within their romantic relationships while previously maltreated boys who developed anxious-ambivalent attachment styles were at risk of *being victimized* at the hands of their female partners. In adolescent girls, secure attachment despite a history of maltreatment was associated with *lower* likelihood of female-to-male perpetration. Avoidant attachment style has also been found to predict risk for violence within romantic relationships during adolescence regardless of gender (Weiss, MacMullin, Randall, & Werkle, 2001).

Developmental Variations in Trauma-related Symptoms

Traumatized youth often develop symptoms of anxiety, aggression, depression, and/or academic impairment. Temporary (and normative) unwanted and upsetting memories or dreams of the trauma, and intense emotional and physical reactions in response to reminders of the trauma appear to be nearly universal. Both these temporary/normative reactions and more severe, long-lasting, and debilitating symptoms present differently across different developmental stages.

Infants and Toddlers. Among infants who have been traumatized, sleep is often impaired and emotion regulation compromised (Perry, Pollard, Blakley, Baker, & Vigilante, 1995). Specifically, as secure attachment is disrupted or is never achieved, the infant does not benefit from caregiver attempts at soothing his/her distress, and the development of emotional self-regulation suffers. As infants grow into toddlers and become more mobile, they may become more reckless, accident prone, or inhibited (Lieberman & Knorr, 2007). These responses might also be understood as the hyperarousal, avoidance and emotional numbing symptoms that are associated with post-traumatic stress disorder (PTSD, a type of anxiety disorder). Hyperarousal may also present as increased anxiety, irritability, sleep disturbance, difficulties concentrating, and difficulties sitting still. These latter symptoms are sometimes misinterpreted as attention deficit-hyperactivity disorder (ADHD). Emotional numbing can manifest as withdrawal from play and peers. Toddlers and preschoolers often engage in symbolic play in which the trauma is re-enacted. This may reflect the behavioral manifestation of intrusive memories and the toddler/preschooler's effort at understanding the trauma. Children may also show regressive behaviors (e.g., a previously toilet trained child may begin wetting or soiling again).

School-aged Children. As children enter school, difficulties concentrating and sitting still (PTSD hyperarousal symptoms) may persist contributing to academic difficulties. As language becomes more sophisticated, symbolic play may decrease, and the child may become more able to use words to describe traumatic memories. However, the child may have difficulty understanding his/her emotional and behavioral responses to trauma-related cues. Traumatized children often more readily read social cues as threatening and aggress in response (Weinberg & Tronick, 1998). Classroom and playground altercations may be triggered by reminders of the traumatic event(s).

Adolescents. Problems sleeping are common across all developmental stages. However, given that moving towards independence is a crucial task for adolescents (and that hormonal and lifestyle changes are associated with different sleep patterns), caregivers may be unaware of the presence or extent of sleep problems. Post-pubertal adolescents are often physically similar to adults, but they do not yet possess the emotional maturity of adulthood. Thus, trauma-exposed adolescents are particularly at-risk for acting-out behaviors (e.g. truancy, risky sexual and drug use behaviors) that can be dangerous for themselves and others. Most adolescents in the juvenile justice system have been exposed to maltreatment and/or other traumatic events.

Increasing attention is being paid to 'crossover' youth, those involved in both the child welfare and juvenile justice systems. As many as two thirds of youth in the juvenile justice system have two or more disorders, including both externalizing (e.g. oppositional defiant disorder, drug & alcohol use disorders) and internalizing disorders (e.g. PTSD, depression; Ulzen & Hamilton, 1998). Such high rates of morbidity are believed to be the direct result of the traumatic experiences to which these youth have been exposed. Evidence for elevated rates of both trauma and trauma-related disorders in delinquent youth highlights the importance of maintaining awareness that trauma may manifest in acting out behaviors both in adolescents and at earlier developmental stages. Children's trauma-related symptoms, including both acting out and internalizing symptoms, are likely familiar to most experienced child welfare workers. Understanding these symptoms and how they vary across development can enhance trauma-informed care for vulnerable children.

Understanding how a potentially traumatized child experienced a traumatic event is the first step in determining how best to meet the child's needs in the immediate and longer-term aftermath.

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The Heart of the Matter: Complex Trauma in Child Welfare

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Complex trauma involves chronic or repeated, typically early-onset exposure to two or more of the following forms of trauma exposure: sexual, physical or emotional abuse, domestic violence, or neglect, as well as severe caregiver impairment and school/community violence (Kisiel et al., 2009). A national sample of over 2,200 children in child welfare found that over 70% met exposure criteria for complex trauma (Greeson et al, 2011). A substantial subset of children—typically those with the fewest social and economic resources, and those living amidst poverty, crime or cultural minority status (Cohen, 2007)—have experienced all of these forms of exposure.

Complex trauma impacts multiple core domains of functioning: children's physiology and brain development; their ability to identify, tolerate, control and appropriately express emotions, impulses and bodily sensations; to concentrate, learn and engage in goal-directed behavior; to form a positive and cohesive sense of self, meaningful values and hopeful future outlook; to cultivate secure and healthy attachment bonds, sustain intimate relationships, safely negotiate conflict and communicate their needs; and to interpret social cues accurately, set healthy personal boundaries and differentiate safe from threatening situations and interactions with peers and adults (Cook et al, 2005; Kisiel et al, 2009; Spinazzola et al, 2005). By the time they reach adolescence, many complexly traumatized youth are already caught in a vortex of intense somatic, behavioral and emotional dysregulation in which daily life is fraught with an ever-expanding host of traumatic reminders and subtle false alarms that activate extremes of hyper- and hypo-arousal. Like "live wires," complexly traumatized youth can become charged with heightened vigilance and physiological reactivity at levels that are emotionally overwhelming and debilitating to the immune system. Like "walking dead," they can retreat or slip into extended periods of severe withdrawal, emotional constriction, avoidance and numbing of consciousness induced via coping strategies that include dissociation, binge eating or substance dependence.

The legacy of unresolved complex trauma is staggering, and has been causally linked with increasingly dire outcomes across the lifespan that collectively place an enormous economic burden on society, conservatively estimated at over $200,000 per impacted child and over 100 billion per year (Fang et al, 2012). Long-term outcomes include scholastic failure, dropout and unemployment; early pregnancy, sexually transmitted disease, rape and domestic violence; chronic mental and physical illness, health risk behaviors, disability and premature mortality (Edwards et al, 2004; Felitti et al, 1998, Ford et al, 2010).

The legacy of unresolved complex trauma is staggering, and has been causally linked with increasingly dire outcomes across the lifespan that collectively place an enormous economic burden on society, conservatively estimated at over $200,000 per impacted child and over 100 billion per year

Psychological maltreatment: The sleeping giant of complex trauma

Psychological maltreatment has been recognized by the American Pediatric Association as the most prevalent form of child maltreatment and thus far the most overlooked despite substantial evidence of its deleterious impact at levels comparable to more readily recognizable forms of maltreatment such as physical and sexual abuse (Hibbard et al, 2012). Psychological maltreatment is comprised of various overt and subtle forms of chronic emotional abuse and neglect, including prolonged verbal abuse, terrorizing, shunning, and social isolation. A recent study on a large sample of over 5,000 children and adolescents from the Core Dataset of the NCTSN revealed psychological maltreatment to have equal or significantly greater association than physical or sexual maltreatment to 27 out of 30 frequency and severity symptom, diagnostic and risk indicators assessed (Spinazzola et al, 2011). Psychologically maltreated youth were the most likely to exhibit significant internalizing, attachment and substance abuse problems and the most likely to develop anxiety and depressive disorders. Also notable was that exposure to psychological maltreatment resulted in equal levels of PTSD symptom severity compared to physical or sexual abuse. The child welfare system can serve as a critical gatekeeper of suspected and reported psychological maltreatment in children and families with its power and authority to open the door to thorough investigation of its presence and impact in reported youth.

The term **complex trauma** was introduced by a special taskforce of the National Child Traumatic Stress Network (NCTSN) to help multidisciplinary service providers better understand and respond to the multifaceted relationship between children's exposure to multiple traumatic events and the wide-ranging, long-term impact of this exposure (Complex Trauma Taskforce, Cook et al, 2003, 2005, 2007). The complex trauma construct differs in important ways from other conceptual frameworks of child maltreatment. Whereas "polyvictimization" addresses the circumstances of children's exposure to multiple, often inter-related traumatic forms of trauma (Finkelhor et al., 2007, 2009), complex trauma speaks to the cascading interplay between trauma exposure, impact and (mal)adaptation. Moreover, unlike "Complex Posttraumatic Stress Disorder," introduced in an attempt to characterize a broader and more pronounced symptom-set exhibited in a subset of traumatized adults (Herman, 1992), the complex trauma construct was formulated in realization that the PTSD diagnosis neither typically nor sufficiently captures the cardinal features of disturbance observed in youth exposed to prolonged and severe maltreatment, violence, and neglect (Ackerman et al., 1998; Spinazzola et al., 2005).

What lies beneath: The need for comprehensive assessment

Children impacted by complex trauma are not only at high risk for revictimization but are more vulnerable than other youth to exposure to other forms of acute, non-interpersonal trauma. For example, chronically neglected children are at significantly increased risk of exposure to accidents and burns in the home. The aberrant socialization that frequently accompanies familial incest or emotional abuse can increase children's susceptibility to school bullying and lead to juvenile delinquency, substance abuse and high-risk sexual behaviors. In turn, chronic physical abuse often underlies and fuels conduct problems and social aggression. Comprehensive evaluation that includes a thorough caregiving and trauma history and integrates developmental, psychiatric, behavioral, scholastic and interpersonal strengths and difficulties is essential. The child welfare system can play a pivotal role not only through early screening and assessment, triage, and trauma-informed referral but in working with providers to connect all the dots. "Unpacking" these exposure, risk and protective trajectories for youth in the child welfare system is the critical first step toward rerouting pathways to healthy outcomes, fostering resilience, and disrupting intergenerational cycles of complex trauma (Layne et al, 2008).

Placement instability: The sine qua non of complex trauma?

Children in child welfare with complex trauma have been found to have significantly higher rates of placement disruption (Kisiel et al., 2009). A child's risk for poor outcomes can increase exponentially in child welfare as a result of cycles of impaired caregiving followed by periods of separation from primary caregivers, potential incidents of placement instability, revictimization in the new home, failed reunification attempts, or ultimate loss of primary caregivers. For children whose sense of self, intimate attachments, material possessions, access to friends and siblings—in effect, their entire world—hangs in the balance of the success or failure of these placements, each juncture can be experienced as another complex trauma exposure irrespective of the efforts and intentions of child welfare personnel and foster, kinship, or biological parents. The child welfare system can play a pivotal role in mitigating this risk by: a) recognizing the critical importance of placement stability in altering risk trajectories for complexly traumatized children, b) prioritizing careful deliberation around the timing and nature of placement decisions, c) establishing structures

to support emotional regulation of children facing unavoidable placement transitions, and d) delineating proactive strategies to prevent or rapidly respond to child decompensation associated with abrupt placement disruption.

Helping the most vulnerable: Complex trauma and residential care

Placement in a residential treatment facility can be a common outcome for those children most severely and chronically impacted by complex trauma. In turn, complex trauma is heavily over-represented in youth in residential care. Analysis of the NCTSN Core Dataset revealed that when compared with traumatized youth receiving outpatient or community-based services, those receiving residential services had the highest rates of trauma exposure and associated impairment (Briggs et al, 2012). While the majority of outpatient youth no longer exhibited symptoms by the end of treatment, a substantial percentage of complexly traumatized youth in residential care continued to manifest impairment indicating the need for more extensive services. The highly structured, predictable and consistent environment and caregiving offered within trauma-informed residential settings may provide these children with a sufficient sense of safety and emotional containment to begin to shift from a survival-based preoccupation with threat detection and avoidance to a more present and future-oriented focus on skill acquisition and identity development. A residential placement can afford child service providers a unique window of opportunity to guide complexly traumatized children in the development of internal capacities for self-control and affect management, in the rehearsal of effective problem-solving and communication skills, and in the delineation of interpersonal boundaries and cultivation of safe and healthy relationships. The child welfare system can provide leadership on initiatives that ensure maximal treatment gains for complexly traumatized children by making purposeful, collaborative, treatment-goal driven decisions about the timing, duration and type of residential placements to which complexly traumatized children are assigned, extended, transitioned and discharged.

Complex trauma requires complex solutions

Traditional treatment of PTSD in children has focused on processing and resolving vivid and painful memories, beliefs, and emotions associated with one or more specific traumatic experiences. Intervention models designed to treat complex trauma of necessity attend to the broader array of deficits and domains of maladaptive functioning. Of the over two dozen evidence-based and empirically supported interventions created or advanced by members of the NCTSN over the past decade (NCTSN, 2012), several have been specifically developed to treat complex trauma by addressing six core components identified in complex trauma intervention: safety; self-regulation; attachment; identity development; trauma experience integration; and strength-based cultivation of self-worth, positive affect, personal competencies and mastery experiences (Cook et al, 2005). Treatment models are predicated upon a shared recognition that training is insufficient to achieve successful intervention with complexly traumatized children; responsible treatment of complex trauma entails ongoing training, supervision, fidelity assessment and careful adaptation responsive to unique cultural, setting and developmental needs of

Continued on page 37

The Impact of Traumatic Stress on Parents Involved in the Child Welfare System

Erika Tullberg, MPH, MPA, Roni Avinadav, PhD, Claude M. Chemtob, PhD

Thomas is a new caseworker supervising a visit between his client, Denise, age 25, and her three children, Christopher, Jr., age 5, Tanya, age 3, and Damon, age 2. This visit has already been rescheduled twice – it was supposed to happen after the agency's weekly domestic violence group, which Denise is mandated to attend as part of her service plan, but she keeps missing the meetings. Thomas wants to talk to Denise about how she needs to come to these groups if she wants her kids back, but he has seen her temper and doesn't want to do anything to make today's visit go badly so decides to let it go.

Damon has not said anything since arriving at the agency; he is still strapped into his stroller and since coming into the visitation room has been whining and reaching up to Denise, but she keeps telling him to "behave" while she tries to get his siblings to settle down. After a few minutes of running around Christopher trips on his shoelaces and starts bleeding from his head – Tanya shrieks when she sees the blood, and Denise yells at Christopher saying that he's ruined the visit and is always out of control, just like his father. Thomas goes to comfort Tanya, who has started to shake and cry uncontrollably, but Denise steps in front of him saying that she can handle her kids and that they don't need his help.

The child welfare system has become increasingly attuned both to the trauma that children and youth in the system have experienced and to the importance of addressing such trauma as part of ensuring their safety, permanence and well-being (Kisiel, Fehrenbach, Small, & Lyons, 2009). Research on the impact of trauma on foster care placement stability in the short term, and long-term health outcomes over the lifespan, has helped to spur increased training on trauma for staff, resource parents, and other system stakeholders and availability of evidence-based interventions for children and youth (Landsverk, Garland, Reutz, & Davis, 2011).

However, we know that for children in the child welfare system, the trauma they have experienced has often happened at home: abuse or neglect from a caretaker, exposure to domestic violence, or separation from a parent due to homelessness, incarceration or other family stressors. For parents who grew up under similar circumstances, or who have experienced traumatic events in adulthood, it may be difficult to provide their own children with support and structure if their own trauma remains unaddressed. Research has demonstrated, in fact, that a parent's trauma history may increase his or her children's risk of maltreatment (Banyard, Williams, & Siegel, 2003; Cohen, Hien, & Batchelder, 2008), and that the parent's trauma-related symptoms and ability to respond in a protective manner to his or her children is a predictor of a child developing trauma symptoms following exposure to a traumatic event (Chemtob, Nomura, & Abramovitz, 2008). If parents do not feel safe, they will be less able to keep their children safe.

Research has shown that parents with histories of trauma can be harder to engage in services and have difficulty trusting service providers (Kemp, Marcenko, Hoagwood, & Vesneski, 2009; Dawson & Berry, 2002). Despite this and the prevalence of trauma among parents in the child welfare system, our experience is that it is relatively uncommon for parents to receive trauma-specific screening, much less trauma-informed mental health services – and many child welfare staff are not trained to recognize trauma symptoms and how trauma can impact parenting and child safety. As a result, child welfare staff may be more likely to regard parents like Denise as non-compliant, disengaged, detached from their children, angry and defensive.

For parents who grew up under similar circumstances, or who have experienced traumatic events in adulthood, it may be difficult to provide their own children with support and structure if their own trauma remains unaddressed.

Anecdotal evidence and growing research suggests that trauma is very common among parents receiving child welfare services. In New York City, the ACS-NYU Children Trauma Institute's **Safe Mothers, Safe Children program** is addressing trauma experienced by mothers receiving child welfare preventive services. During project planning interviews conducted in 2008, East Harlem preventive service program directors reported concerns about trauma experienced by their clients, citing related problems with their ability to have patience with, empathy for, and express affection towards their children. During subsequent screenings with mothers receiving services from a subset of these agencies, 92 percent reported at least one prior traumatic experience with the average being 2.6 categories of traumatic events. Fifty-four percent of mothers met probable criteria for post-traumatic stress disorder, 62 percent met probable criteria for depression, and 49 percent met probable criteria for both PTSD and depression (Chemtob, Griffing, Tullberg, Roberts, & Ellis, 2011).

How else could Thomas understand Denise, the decisions she's making, and how she responds to her children? How can he use that knowledge to help her? With the benefit of a "trauma lens," the above scenario could be reframed as follows:

- **Ask questions.** Caseworkers are often worried that asking clients detailed questions about their past traumatic experiences may cause their clients to become anxious or distraught, but after being trained to conduct trauma screenings by Safe Mothers, Safe Children project clinicians, caseworkers said they learned helpful information while reporting low levels of distress for themselves and their clients (Chemtob, Griffing, Tullberg, Roberts, & Ellis, 2011). Asking may also

help ease the shame associated with clients' past experiences and result in their feeling more supported and less alone.

- **Anticipate trauma triggers.** The domestic violence between Denise and her children's father was likely a traumatic experience for both her and her children, and the fact that she is not attending domestic violence groups may be due to avoidance, a common trauma symptom. Denise may be more likely to attend visits with her children if they were scheduled at a different time than these groups. Likewise, if Thomas approached Denise's non-attendance with this understanding and empathy, helping to explore the impact of her past experiences on her current actions, rather than by using a punitive approach, he could be more successful in engaging her in services.
- **Understand the impact of trauma on parent-child relationships.** Trauma can cause parents to have a negative world view and, in particular, develop negative attributions regarding their children's behavior. Their child's actions, or even their appearance, may trigger them resulting in them reacting in an overly harsh or punitive way. Helping parents to understand that their reactions may be a result of their trauma, and are not the fault of their children, can help them respond more positively to their children.
- **Understand the impact of trauma on children's development and mental health.** Children who have also experienced trauma, such as exposure to domestic violence, may have their own trauma symptoms—such as Tanya's extreme reaction to her brother's fall and her mother's harsh response—which can in turn be triggering for the parent. Children's development can also be impacted by trauma, and concerns such as Damon's potential speech delay may not be recognized by the parent because he or she is overwhelmed and/or does not have information about expected child development. When working with a parent or family that has experienced trauma, child welfare staff should be attuned to how it may have impacted each of the children.
- **Recognize and manage trauma reactions.** Thomas's past experiences with Denise's anger and defensiveness have led him to avoid addressing an important part of Denise's service plan and Christopher, Tanya and Damon's safety. He may also be frustrated by what he perceives to be her lack of concern for her children and lack of urgency around her service plan goals. Using a "trauma lens" could help Thomas better understand Denise's behavior towards her children and how he (as a man and as a person in a position of authority) could be triggering for her, and provide strategies for working together with her rather than feeling like they are at cross-purposes. This could help Thomas depersonalize Denise's reactions towards him, regulate his own emotions, and feel less frustrated putting him in a better position to approach her openly and with compassion.

Trauma can impact parents in many ways including their ability to keep their children safe. As described above, using a "trauma lens" can help child welfare staff more effectively partner with families, working together to ensure both their physical and psychological safety.

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The Emergence of Trauma-Informed Child Welfare Systems

Charles E. Wilson, MSSW

Over the last 30 years, society's understanding of the effects of traumatic stress has increased significantly and more recently we have begun to recognize the interaction between traumatic stress and the service systems we put in place to support vulnerable populations. Nowhere is this connection between trauma and the system more striking than in the nation's child welfare systems. Almost all children served by the child welfare system report chronic and complex trauma histories, complicated by system-imposed stresses such as removal and multiple foster care placements. Children with such experiences often require support of a skillful and well trained mental health professional, but treatment alone is not enough. Over the last six years, it has become clear to many working in the National Child Traumatic Stress Network[1] (NCTSN) that meaningful treatment of children in the child welfare system must be matched with system supports. Essentially, the entire child welfare system needs to be transformed into a "trauma-informed system."

What is a trauma-informed system? The term first appeared in substance abuse literature to recognize that many seriously addicted individuals had experienced major traumas, and those traumatic events had shaped their lives in sometimes disastrous ways (see Conradi & Wilson, 2010 for a full review of this topic). By 2004, NCTSN was applying similar concepts to child trauma victims and that work led to a variety of products and services developed within the Network. One definition of a trauma-informed system has been advanced by the Chadwick Trauma-Informed Systems Project (CTISP), with support of a national advisory committee. CTISP defines a trauma-informed child welfare system as a system *"in which all parties involved recognize and respond to the varying impact of traumatic stress on children, caregivers and those who have contact with the system. Programs and organizations within the system infuse this knowledge, awareness and skills into their organizational cultures, policies, and practices. They act in collaboration, using the best available science, to facilitate and support resiliency and recovery"* (Chadwick Trauma-Informed Systems Project, 2011).

There are key phrases in this definition that are worth pointing out. First, the definition applies to the wider child welfare system not just the public child welfare agency. Second, the definition focuses not only on child trauma victims but also their caregivers and the workforce who seek to support them. All three of these groups are affected by traumatic events, including primary traumatic experiences that threaten their own or their loved one's lives or physical integrity as well as vicarious trauma from what they see, hear, and experience when working intimately with traumatized children. The definition stresses the "varying impact of trauma," indicating that each child and adult is unique and reacts to trauma in his or her own way. Some children and adults have great resilience and may not require clinical intervention while others exposed to similar levels of trauma are devastated and require skillful intervention. The definition emphasizes that it is not enough to be knowledgeable about trauma but also asserts that the system must act to make use of that knowledge by integrating it into everyday interactions with families and their organizational cultures.

The system should offer universal screening for traumatic history and traumatic stress responses, which will assist the workers in understanding the history of a child or family.

To undertake this effort, the child welfare system needs a framework, and the NCTSN offers one in its "Essential Elements of a trauma-informed child welfare system." The NCTSN Child Welfare Committee is currently in the process of refining the essential elements, first introduced in 2006. What emerges are the following seven essential elements (Child Welfare Committee, personal communication, March 7, 2012).

1. Maximize Physical and Psychological Safety for the Child and Family

While child welfare has always had a focus on physical safety, a trauma-informed system must go further and recognize that psychological safety is important to the child's long-term recovery and social and emotional well-being and has direct implications for physical safety and permanence. Psychological safety is a sense of safety or the ability to feel safe within one's self and safe from external harm and is critical for functioning as well as physical and emotional growth. A lack of psychological safety can impact children's interactions with all other individuals, including those trying to help them, and can lead to a variety of maladaptive strategies for coping with the anxiety associated with feeling unsafe. These "survival strategies" often include a range of symptoms and behaviors from substance abuse to self-mutilation. Children and/or adults may continue to feel psychologically unsafe long after the physical threat has been removed or they have been relocated to a physically safe environment, such as a relative or foster home.

Even after the child or adults gains some degree of security, people, places, and events may unexpectedly remind them of past traumas and draw their attention back to intense and disturbing memories overwhelming their ability to cope again. At times, a seemingly innocuous event or sensory stimuli such as smells, sights, sounds, touches, or objects may trigger subconscious reminders of the trauma that produce a strong physiological response wherein the biochemical systems of the body react as if the trauma were happening again. A trauma-informed child welfare system understands that these pressures may help to explain a child or parent's behavior and can use this knowledge to help them better manage triggers and to feel safe.

2. Identify Trauma-Related Needs of Children and Families

The child welfare workforce should be educated on trauma and how it affects an individual at any stage of development and intersects with his/her culture. The system should offer universal screening for traumatic history and traumatic stress responses, which will assist the workers in understanding the history of a child or family. The screening will help identify potential triggers and will create a guide

[1]Established by Congress in 2000, the National Child Traumatic Stress Network (NCTSN) is a unique collaboration of academic and community-based service centers whose mission is to raise the standard of care and increase access to services for traumatized children and their families across the United States.

for direct trauma-informed case planning. Those who screen positive for trauma should receive a thorough assessment by a trained mental health provider. This professional will identify the reactions of a child or parent and determine how their behaviors are connected to a traumatic experience. This assessment will guide subsequent intervention efforts.

3. Enhancing Child Well-Being and Resiliency

A child's recovery from trauma often requires the right evidence-based or evidence-informed mental health treatment delivered by a skilled therapist who helps the child reduce overwhelming emotion related to the trauma, cope with trauma triggers, and make new meaning of his/her trauma history.

But to truly address the child's trauma the child needs the support of caring adults in his or her life. Many trauma-exposed children have significant symptoms that interfere with their ability to master developmental tasks, build and maintain relationships with caregivers and peers, succeed in school, and lead a productive and fulfilling life. Case planning must focus on giving children the tools to manage the lingering effects of trauma exposure and to build their relational capacity so they can take advantage of opportunities as they grow and mature. By helping them develop these skills in a clinical setting and build supportive relationships, we enhance their natural resilience.

4. Enhancing Family Well-Being and Resiliency

Most birth families that interact with child welfare systems have also experienced trauma. Providing trauma-informed education and services to birth parents and resource parents enhances their protective capacities, thereby increasing the resiliency, safety, permanency, and well-being of the child.

5. Enhancing Family Well-Being and Resiliency of Those Working in the System

Working within the child welfare system can be a dangerous business, and the workforce may be confronted with threats or violence in their daily work. Adding to these stressors, many workers experience secondary traumatic stress reactions, which are physical and emotional stress responses to working with a highly traumatized population. When working with children who have experienced maltreatment, parents who have acted in abusive or neglectful ways, and systems that do not always meet the needs of families, feelings of helplessness, anger, and fear are common. A trauma-informed system must acknowledge the impact of primary and secondary trauma on the workforce and develop organizational strategies to enhance their resilience.

6. Partnering with Youth and Families

Youth and family members who have experienced traumatic events often feel like powerless "pawns" in the system, reinforcing feelings of powerlessness felt at the time of the trauma. Providing youth and families with choices and a voice in their care plays a pivotal role in helping them to reclaim the power that was taken away from them during the trauma and tap into their own resilience.

7. Partnering with System Agencies

No one agency can function alone, and in trauma-informed systems child welfare must reach out and coordinate with other systems so they too can view and work with the child and family through a trauma lens. This partnering includes:

- Teaming with law enforcement to minimize the number of front-end interviews children must experience
- Cross training with other primary partners to enhance their understanding of their roles in the intervention process, recognize how steps within their processes can exacerbate existing traumas, trigger traumatic reactions and develop processes to reduce the risk of duplicative interactions with the child, family, and collaterals.
- Working with mental health agencies to ensure therapists are trained in specialized trauma assessment and evidence-based trauma treatments
- Coordinating with schools, the courts, and attorneys.

Such coordination is necessary to prevent one part of the system undoing the good trauma- informed work of another part of the system.

In the end, a trauma-informed system produces far greater synergy as one element of the system supports the work of the others with all working to build on the natural resiliency of the child and family.

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By What Yardstick Should We Measure Success in Child Welfare Policy?

Janice L. Cooper, PhD, MPA and Yumiko Aratani, PhD

The last decade has seen a tremendous change and progress in child welfare. This is particularly true of child welfare policy. The focus on permanency, led to increases in the percentage of foster care children adopted from 17% to 21% between 2000 and 2010 (U.S. Department of Health and Human Services Administration for Children and Families, 2011). There was a 26% decrease in the child welfare rolls from 552,000 to 408,000 during the same period (U.S. Department of Health and Human Services Administration for Children and Families, 2011). The rates of children being victimized (a child with maltreatment disposition substantiated, indicated, or having alternative response by the child welfare agencies) have declined from 12.2 to 10 per 1000 (U.S. Department of Health and Human Services, 2002, 2012). Conditions of foster care also improved, such as reduced average lengths of stay from 32 months to 26 months, marginal increases in kinship care (from 24% to 25%) and in non-relative foster care (from 47% to 48%), and reductions in the use of group homes and/or institutions from 18% to 15% (U.S. Department of Health and Human Services Administration for Children and Families, 2011). During the same period, there were increases in child welfare funding such as the Child Abuse Prevention and Treatment Act, State grants, and adoption incentive payments (American Humane Association, 2012). Also significant was a narrowing in disparities marked by reductions in the proportion of African-American children in foster care from 39% to 29% (American Humane Association, 2012). On the other hand, the period also saw setbacks. More young children (ages 0-5), entered foster care, increasing from 29% to 36% (American Humane Association, 2012).

This article focuses on the impact of policy on the child welfare system (CWS) using another measure: the extent to which infusing a trauma-informed care framework has taken hold. While not every child in the CWS will experience trauma, previous research shows different estimates of the prevalence of post-traumatic stress disorder (PTSD) among children in the CWS, ranging from 19% to 55% (Annie Casey Foundation, 2011; Grasso, et al., 2009; Greeson, et al., 2011; Jackson, O'Brien, & Pecora, 2011; Kolko, et al., 2010). Nearly 12% of children in child welfare who remained at home also experienced PTSD (Kolko, et al., 2010). Risk factors for PTSD include multiple exposures to maltreatment. Over 70% of children in foster care had two or more trauma experiences (Greeson, et al., 2011). Children with multiple trauma exposures tend to experience other mental health problems including depression and externalizing conditions (Kolko, et al., 2010; Richardson, 2001). Trauma experiences have a long-term detrimental effect on health and mental health and susceptibility to re-traumatization(Dube, 2001; Felitti, et al., 1998; Widom, Czaja, & Dutton, 2008).

Trauma-informed care and a trauma-informed framework

Trauma-informed refers to the process of engagement with a parent, child or family characterized by intentional efforts to ensure that no action is taken that further causes harm. It creates an environment that enables the victimized child or person to feel safe and promotes the ability of the victim to cope and to increase resiliency. A trauma-informed framework refers to embedding up-to-date robust knowledge on trauma in policy and practice such as how to prevent trauma, address its consequences, and ensure the system does not contribute to re-traumatizing. Operationally, this would suggest policies such as funding and supporting effective systems for prevention and intervention, beginning with evidence-based (EB) and culturally-normed screening and assessment of trauma, ensuring the widespread adoption of EB treatment and engagement strategies, support for training within and across child-serving systems, and requiring accountability throughout systems.

The way forward

A 2007 National Center for Children in Poverty report presented the adverse impact of the child serving systems in America and their failure systematically to adopt a trauma-informed perspective in policy (Cooper, Masi, Dababnah, Aratani, & Knitzer, 2007). It addressed the need to include the use of EB screening and treatment for trauma and related mental health conditions in the child welfare system. It called for increased

We offer the following recommendations to support improved practice and better outcomes.

- Mandate EB trauma screening at all entry points into child welfare and at discharge
- Require that child and adolescent trauma histories are integral to their confidential records available at all entry points to the care delivery system and that individualized care planning address the child and family needs in a trauma-informed manner
- Ensure that trauma-informed care is integrated into the pre-service training and continuing education for all child welfare professionals and para-professionals
- Set up systems to better identify and match staff suitable for working in the CWS, reward and support them appropriately and recognize the need for the human resource development plan to be trauma-informed.
- Increase funding and tie it not only to reduction in child welfare rolls but improved outcomes such as child and family health and mental health.
- Develop guidelines for regulations and/or certification pertaining to trauma expertise.
- Fund initiatives that support staff who work with children and youth who experienced trauma and reduce secondary trauma associated with trauma-related work.
- Partner with tribal and other colleges that target specific populations to develop workforce capacity in evidence-based practices for both tribal and nontribal communities.

financing and funding flexibility to support screening and intervention. Since 2007, one significant policy change was the Patient Protection and Affordable Care Act (2010) with $1.5 billion in mandatory funding for the Maternal, Infant, and Early Childhood Home Visiting Program. It requires states to give priority to providing services to identified "high-risk" young children and families, such as those in child welfare (Cooper, Banghart, & Aratani, 2010). In addition, the 2011 reauthorization of Title IV-B requires state child welfare agencies to address trauma in their plans (Samuels, 2011). These developments notwithstanding, today child welfare systems at the local, state, tribal and federal level are not fully equipped to respond comprehensively to the mental health needs of children, especially those with trauma exposure. Beginning with planning, child welfare authorities are often unaware of the prevalence of trauma. One study showed the potential for underestimated rates of trauma due to incomplete assessment data when multiple data sources were not used (Grasso, et al., 2009). There is urgent need of EB trauma screening for all children entering the child welfare system. Having information on children's conditions and trauma histories, a care delivery system would need to have staff and caregivers with the knowledge to support and facilitate appropriate trauma-informed care.

Instead some child welfare systems continue to fund ineffective and harmful services such as residential facilities that use seclusion and restraints, or group homes

with poor outcomes (LeBel, Huckshorn, & Caldwell, 2010; McCrae, Lee, Barth, & Rauktis, 2010). Nearly one-third of foster care alumni reported being re-traumatized while in foster care (Jackson, et al., 2011). Further, high staff turnover, staff burnout, and vicarious trauma can impede efforts to infuse EB practices (Aarons, Fettes, Sommerfeld, & Palinkas, 2012). Thus, institutional factors such as organizational climate and culture and degree of worker engagement are predictive of access to needed services and positive outcomes (Glisson & Green, 2006, 2011).

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Integrating Safety, Permanency, and Well-Being for Children and Families in Child Welfare

An excerpt from the 2012 year end message from Commissioner Bryan Samuels, Administration on Children, Youth and Families

In fiscal year (FY) 2012, the Administration on Children, Youth and Families (ACYF) disbursed $46.6 million to States, Tribes, Territories, and local entities and granted title IV-E child welfare waivers to nine States with the goal of more fully integrating the three aims of child welfare in the U.S.: safety, permanency, and well-being. These projects have a specific focus on addressing trauma and improving the well-being of children, youth, and families. Across Federal agencies, preventing trauma and mitigating its impact on healthy development is a growing priority. In much of its work, ACYF has partnered with the Centers for Medicare and Medicaid Services (CMS) and the Substance Abuse and Mental Health Services Administration (SAMHSA) to align and strengthen efforts; CMS and SAMHSA are engaged in several of the projects listed here.

The focus on preventing and treating early exposure to trauma, including child maltreatment, is grounded firmly in emerging science about its devastating impact on lifelong well-being, as detailed in many of the articles in this publication.

As we learn more about how trauma affects children's well-being, researchers and practitioners are developing increasingly effective methods for mitigating its harm. There is a rapidly growing array of evidence-based and evidence-informed interventions that, when delivered with fidelity, can help restore developmentally appropriate functioning and improve outcomes for children and youth who have experienced maltreatment. ACYF's projects promoting well-being revolve around better identifying children and youth whose development has been disrupted by trauma, increasing access to effective interventions, and strengthening linkages between systems that serve vulnerable children and families.

Historically, Federal policies have impelled child welfare systems to focus disproportionately on ensuring safety and permanency for the children they serve, with less emphasis on the promotion well-being. However, as policies shift to more fully integrate safety, permanency, and well-being in child welfare, systems are increasingly reorganizing themselves to better serve children and families.

The April 2012 information memorandum, *Promoting Social and Emotional Well-Being for Children and Youth Receiving Child Welfare Services* (http://www.acf.hhs.gov/sites/default/files/cb/im1204.pdf) lays out essential elements of the approach, summarized here. Child welfare systems and their partners should use screening and assessment tools that are valid, reliable, and normed to the general population to identify the needs and strengths of children and families. They should ensure that appropriate evidence-based interventions are used to address problems, reduce risks, and build strengths. The use of ongoing progress monitoring indicates whether interventions are working and provides data that can be used to fine-tune the array of services available to the population.

For children who have experienced trauma, healing and recovery take place in safe, nurturing contexts. The image above shows how an approach that promotes well-being for children known to child welfare ensures that young people receive the relational and environmental support they need to heal and recover, as well as intensive intervention, when necessary. The foundation of the approach is a knowledgeable workforce, assuring the use of an effective, trauma-informed response that promotes well-being for children and families.

Alignment of ACYF Opportunities to Promote Social and Emotional Well-Being

New title IV-E child welfare waiver demonstrations and ACYF's FY 2012 discretionary grant programs were designed to (1) increase the capacity of the workforce to meet the needs of children and families; (2) support caregivers so they can provide children with environments and relationships that offer security and developmental support; (3) offer targeted supports that help children build coping skills and social skills; and (4) enhance access to screening, assessment, and effective intervention. A list of evidence-based and evidence-informed interventions delivered by ACYF grantees can be found in the full year end message from Commissioner Samuels at http://z.umn.edu/acyf. While the projects have differing areas of focus and varied methods, the goal of each is to facilitate healing and recovery and promote social and emotional well-being for children and families.

By aligning funding opportunities around this vision achieved through shared methods, ACYF is helping to build nationwide capacity to identify and address trauma. A growing network of systems and providers are delivering evidence-based interventions to children and their families. In many of the projects described below, child welfare systems are partnering with mental health, substance abuse treatment, Medicaid, and other systems to streamline services and increase their effectiveness. Wherever you are, the odds are good that ACYF is supporting cross-system, evidence-based and evidence-informed strategies for treating trauma near you.

Child Welfare Demonstration Projects

Nine States received waivers to conduct **Title IV-E Child Welfare Demonstration Projects** beginning in 2012. Through an agreement with ACYF, these States have been granted flexibility to use Federal funds to test innovative child welfare strategies. The projects aim to increase safety, permanency, and well-being for children and families involved with child welfare. Nearly all of the demonstration projects will be implementing approaches designed to address trauma and improve the social and emotional well-being of the young people receiving services. These comprehensive projects incorporate screening and assessment, expand the array of available evidence-based interventions, and greatly enhance the capacity of the workforce to meet the needs of the population.

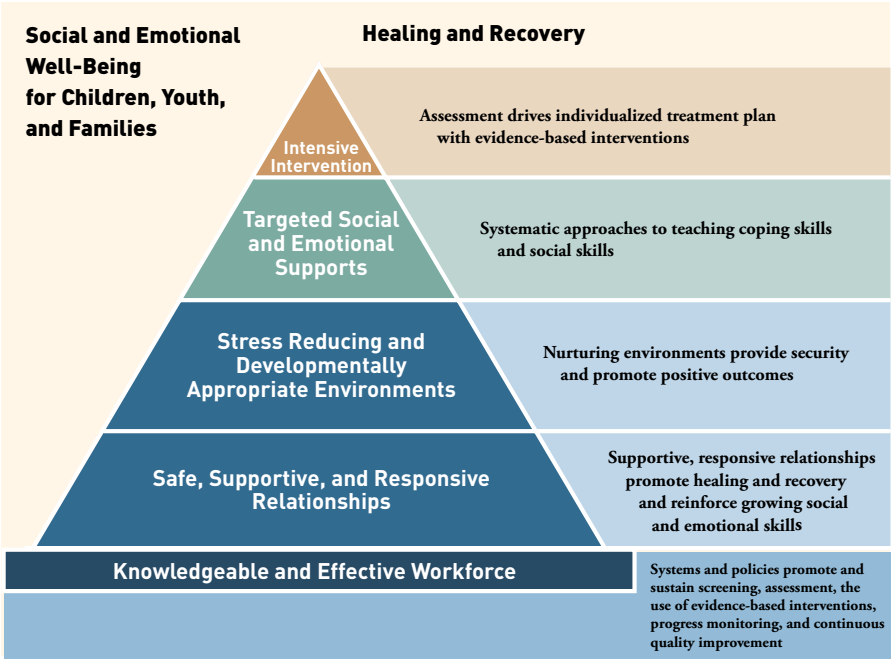
For example, Pennsylvania's demonstration project will test a new case practice model focused on family engagement, enhanced assessment, and the introduction or expansion of evidence-based programs. The project will target children 0-18 in or at risk of entering foster care with the goals of improving permanency, increasing positive well-being outcomes for children and families, and preventing maltreatment and re-entry of children into foster care. Pennsylvania's waiver team has already identified several standardized well-being, developmental and behavioral assessment tools for consideration, as well as potential evidence-based interventions. A robust evaluation will not only track changes in key child welfare outcomes for children and families participating in the demonstration but also assess the effectiveness of specific interventions with the population.

Discretionary Funding

Grantees in the Initiative to Improve Access to Needs-Drive, Evidence-Based/Evidence-Informed Mental and Behavioral Health Services in Child Welfare will focus explicitly on increasing screening and assessment and delivering evidence-based interventions. Using data from screening and assessment tools, each of the grantees will tailor their service array to better fit their population. While working to scale up evidence-based interventions, they will also identify and de-scale services that are not achieving the desired improvements in well-being for children and youth. One grantee, Western Michigan University and its partners, will use the Trauma Symptom Checklist to identify children with trauma-related needs. Using a Learning Collaborative model, the grantee will build the workforce's capacity to deliver evidence-based and evidence-informed trauma treatments, including Trauma-Focused Cognitive Behavioral Therapy (TF-CBT). Ongoing functional assessments will be used to track children's progress.

The **Family Connection Discretionary Grants Program** yielded three funding opportunities in FY 2012, each of which supports a distinct approach for ensuring that children have nurturing relationships in stable, developmentally appropriate environments. For instance, the **Combined Family-Finding/Family Group Decision-Making Programs** will use family-finding and/or family group decision-making methodologies to keep children safely with their parents, when possible, or locate kin caregivers. Because many families who come to the attention of child welfare systems have complex, multiple needs, **Comprehensive Residential Family Treatment Programs** will provide a range of services within a residential setting to strategically stabilize, preserve, and reunite families. The **Child Welfare/TANF Collaboration in Kinship Navigation Programs**, meanwhile, will specifically target kinship caregivers, providing supports and services that help them provide nurturing, stable environments for the children in their care.

Other discretionary grant programs target children and families facing particular risks. The **Regional Partnership Grants to Increase the Well-Being of, and to Improve the Permanency Outcomes for, Children Affected by Substance Abuse** will serve families with children who are in or at risk of entering foster care as a result of a parent's or caregiver's substance abuse. Grantees must strengthen existing collaborations across systems to deliver evidence-based and evidence-informed interventions to treat parental substance abuse and address the complex array of needs faced by these families. This includes building caregivers' parenting skills and responding to children's exposure to trauma. For example, Child and Family Tennessee aims to address the complex needs of its target population by collaborating with an array of partners to provide early intervention and family assessment, housing services, family-centered treatment and integrated healthcare services. Child and Family Tennessee will evaluate the effectiveness of the evidence-base and trauma informed approaches utilized, including the Matrix Model.



Adapted from the Technical Assistance Center on Social Emotional Intervention for Children and the Center on the Social and Emotional Foundations for Early Learning

Partnerships to Demonstrate the Effectiveness of Supportive Housing for Families in the Child Welfare System also target a specific at-risk population: children and families who come to the attention of the child welfare system due to severe housing and service needs. Grantees will provide community-linked services through the implementation of supportive housing services designed to respond to the complex needs of families with child protective services involvement in a multidisciplinary and ongoing way. These grants will demonstrate that strong collaborations between child welfare and housing authorities can make the delivery of services to high-need families more efficient and effective. For example, the San Francisco Human Services Agency's Rapid Support and Housing for Families Project will serve a minimum of 160 families who are homeless and at risk of foster care placement over the course of the five-year grant period. Elements of the project include identification, assessment, and rapid referral of families; use of multi-disciplinary teams to help families maintain housing and improve well-being; use of mobile housing vouchers; expanded trauma-informed services; and a focus on increasing family income through Supplemental Security Income advocacy and wage subsidies.

Looking Ahead

The projects funded by the ACYF in FY 2012 are ambitious. As they progress, they will contribute much to our understanding about how child welfare systems can meaningfully improve the well-being of the children, youth, and families they serve. Much of the work described here includes robust evaluation, both of individual grantees' work and across project sites. Findings and lessons learned will be disseminated widely and integrated throughout ACYF's ongoing activities. Around the country, we are collectively building a truly responsive system that facilitates the healing and recovery of our nation's most vulnerable children, proving that this urgent, important work, though complex, is possible.

This is an excerpt from the year end message from Commissioner Samuels, titled Integrating Safety, Permanency, and Well-Being for Children and Families in Child Welfare and available in full at http://z.umn.edu/acyf.

Operationalizing Trauma-Informed Child Welfare Practice using the Child Welfare Trauma Training Toolkit

Alison Hendricks, LCSW

The Child Welfare Trauma Training Toolkit (CWTTT) is a product of the National Child Traumatic Stress Network (NCTSN) in partnership with the Child and Family Policy Institute of California, the California Social Work Education Center, the California Institute for Mental Health, and the Chadwick Center of Rady Children's Hospital, San Diego.

The CWTTT was created in 2008 to educate child welfare professionals about the impact of traumatic events on children and to teach them how to intervene with children and families in a trauma-informed manner. The CWTTT is comprised of a Trainer's Guide, a Comprehensive Guide, and a slide kit with supplemental handouts to use in training.

The CWTTT includes case examples, interactive exercises, and practical tools to teach knowledge, skills, and values about working in the child welfare system with children who have experienced traumatic events. The training is organized into seven modules focusing on the nine Essential Elements of Trauma-Informed Child Welfare Practice and provides concrete examples of what child welfare workers can do to implement these elements in their daily practice (see Table 1).

The entire CWTTT can be downloaded from the NCTSN web-site: http://www.nctsnet.org/products/child-welfare-trauma-training-toolkit-2008. The CWTTT has been used to train thousands of child welfare professionals across the country. Several states, including Oklahoma and Texas, are using the CWTTT to train all child welfare workers and supervisors statewide. Although a formal evaluation of the CWTTT has not been conducted, general feedback from trainers and participants has been highly positive. The Chadwick Trauma-Informed Systems Project (CTISP, www.ctisp.org)

Continued on page 37

Table 1: Child Welfare Trauma Training Toolkit Modules

Module	Essential Element(s)	What a Child Welfare Worker Can Do
Module 1: Creating Trauma-Informed Child Welfare Practice: Introduction to the Essential Elements	Overview of all nine Essential Elements and what makes them essential	
Module 2: What is Child Traumatic Stress?		Recognize the signs and symptoms of child traumatic stress and how they vary in different age groups.
Module 3: The Impact of Trauma on Children's Behavior, Development, and Relationships	1: Maximize the Child's Sense of Safety 2: Assist Children in Reducing Overwhelming Emotion 3: Help Children Make New Meaning of their Trauma History and Current Exposure	While inquiring about emotionally painful and difficult experiences and symptoms, workers must ensure that children are provided a psychologically safe setting. Educate caregivers about the reasons for, and techniques to manage, children's emotional outbursts. Provide the child with appropriate information about events that led to child welfare involvement in order to help the child correct distortions and reduce self-blame.
Module 4: Assessment of a Child's Trauma Experiences	4: Address the Impact of Trauma and Subsequent Changes in the Child's Behavior, Development, and Relationships 5: Coordinate Services with Other Agencies 6: Utilize Comprehensive Assessment of the Child's Trauma Experience and Its Impact on the Child's Development and Behavior to Guide Service	Ask children and caregivers about potential trauma symptoms (e.g., nightmares, emotional outbursts) and make referrals to other professionals as needed. Organize quarterly meetings with other service providers to discuss common cases and develop a trauma-informed common language and shared framework regarding child traumatic stress. Gather a full picture of a child's experiences and trauma history.
Module 5: Providing Support to the Child, Family, and Caregivers	7: Support and Promote Positive and Stable Relationships in the Life of the Child 8: Provide Support and Guidance to the Child's Family and Caregivers	Pay attention to children's stress responses and seek to understand their trauma reminders to better inform decisions about placement, visitation, and permanency. Identify parents and caregivers who are struggling with their own traumatic experiences or secondary adversities and refer them to trauma-informed providers.
Module 6: Managing Professional and Personal Stress	9: Manage Professional and Personal Stress	Request and expect regular supervision and supportive consultation.
Module 7: Summary		

Giving a Trauma Lens to Resource Parents

Liz Sharda, LMSW

"Using a trauma lens has helped me to stop focusing on what is wrong with a kid and focus on what has happened to the child."—Pam, foster and adoptive parent

One of the surest ways to impact the life of a child who has experienced trauma is to inform and equip the adults around that child. For children involved in the child welfare system, this means reaching the adults providing care on a daily basis: foster parents, kinship care providers, and adoptive parents. Caring for Children Who Have Experienced Trauma: A Workshop for Resource Parents was developed for such a purpose.

In 2005, a group of professionals (clinicians, administrators, child welfare professionals, parents, and researchers) within the National Child Traumatic Stress Network (NCTSN) envisioned a resource that would fill a perceived gap in the child welfare system: training designed specifically for resource parents on the concept of trauma and its effect on children in care. This group collaborated with the Child Welfare League of America, the Children's Bureau, Casey Family Programs, and the National Association of Public Child Welfare Administrators, and received funding from SAMHSA to support the task of curriculum development. For nearly four years, the group labored over the curriculum and produced a draft for pilot testing in 2009. Final revisions followed the pilot testing, and in January 2010, Caring for Children Who Have Experienced Trauma was launched.

Caring for Children Who Have Experienced Trauma is composed of eight modules, each focusing on a particular aspect of child traumatic stress and its impact.

1. Introductions
2. Trauma 101
3. Understanding Trauma's Effects
4. Building a Safe Place
5. Dealing with Feelings and Behavior
6. Connections and Healing
7. Becoming an Advocate
8. Taking Care of Yourself

Each module is intended to be delivered in 1½ to 2 hour segments by a Master's level clinician or child welfare professional and a resource parent co-trainer. The curriculum has been delivered to resource parents in a variety of formats, including two full days, one full day and a series of evenings, and one evening per week for several weeks. The curriculum is designed to be flexible enough to meet the diverse needs of child welfare organizations.

Woven throughout the curriculum are activities and tools to encourage awareness as well as application of key concepts related to child traumatic stress. One such tool is called "The My Child Worksheet." Actually a series of worksheets, this tool asks each resource parent to select one child in his or her care during the first module. In the modules that follow, the parent applies the content of each module to that particular child. For example, in Module 2, "Trauma 101," the parent identifies the traumatic events in that child's life and the ages at which they occurred. While this may seem like a simple exercise, it is a powerful experience for foster parents to recognize and record all that the children in their care have endured. It builds a foundation of understanding revisited throughout the curriculum that a child who has experienced trauma is doing the best he or she knows how in light of his or her experiences. This simple exercise begins to change the question from "What's wrong with this child?" to "What happened to this child?"

Another valuable exercise, found in Module 3, "Understanding Trauma's Effects," is "The

Continued on page 38

Addressing Early Childhood Trauma in the Context of the Child Welfare System

Betsy McAlister Groves, MSW, LICSW

Three-year-old Kayla's mother was arrested at home by police for suspected drug possession and distribution. Kayla was with her mother at the time; her father's whereabouts were unknown. The police reported an unclean, chaotic household with scant food available, and they notified child protection services. The child was placed in a temporary foster home for 4 days and then moved to a kinship care placement.

The story of Kayla is all too common in the Child Protection System. Children 0-3 constitute 31.9% of all maltreatment victims reported to authorities and nearly 80% of all child fatalities age 0-4 (U.S. Department of Health and Human Services, 2011). These children are both the most vulnerable to abuse and neglect and the least able to communicate their experiences, fears and needs.

How does Kayla understand what happened? How might this event affect her behavior and her relationships with her mother and the adult caregivers she will now be living with? What supports do Kayla and the caregivers in her life need to manage the stress of these events? These questions are at the center of decision-making for all children in the child protection system. This article focuses on the unique needs of very young children.

Previously, it was thought that a young age somehow protected children from traumatic stress—they were too young to understand, and therefore, they could not be seriously affected. However, research has shown that babies and young children take in much more of their world than previously thought, and their brains are highly responsive to the caregiving environment. This knowledge of the sensitivity of very young children to their environment and the malleability of the developing brain in the newborn and early childhood developmental periods has increased the importance of understanding and responding to the impact of early childhood stressors.

At age three, Kayla lacks the cognitive abilities to understand what has happened. She cannot reliably anticipate danger or keep herself safe. Young children use their relationships with attachment figures to regulate their emotional responses in times of fear or stress, to help them cope with their negative feelings, and to help them learn adaptive ways to calm and regulate themselves (Lieberman, 2004). In Kayla's case, she has experienced the sudden, unanticipated loss of her mother. It is likely that the specifics of the arrest were highly stressful with screams, loud voices, perhaps a search of the house. Like all young children, she looks to her mother for comfort and cues as to how to react to this stress. In this case, her mother was not available. This disruption of the attachment relationship is at the core of risk for children. Kayla's sudden separation from her caregiver affects her expectations for protective caregivers and for a safe and predictable world (Groves, 2002).

Young children respond to trauma-related feelings of fear and vulnerability in a variety of ways. Often, the child is fearful and aggressive. They may be withdrawn, slow to warm up to others, and are anxious about their environments. Many have irregular sleeping and eating patterns. These behaviors may interfere with the child's adjustment to foster care and often are misunderstood by the adults who are providing care.

A trauma-informed child protection system is knowledgeable about the potential short- and long-term impacts of disruptions in attachment relationships on young children and encourages child protection workers to understand young children's behavior in the context of traumatic stress and disrupted attachment.

The child protection system will conduct an investigation and make recommendations to ensure Kayla's safety and well-being. However, in the initial period of crisis and highest stress for Kayla, the child protection worker's skills in making a trauma-sensitive intervention are essential. In Kayla's case, the child protection worker was able to talk with the mother after the arrest. She explained where Kayla was going; she obtained essential information about Kayla's health; she asked about Kayla's favorite toys and objects of comfort. She talked to Kayla in a soothing tone telling her in language that was appropriate for a 3-year-old about what was happening. She reassured Kayla that her mother would be okay. She gave the resource (foster) parent appropriate information so that she could understand Kayla's experiences. She maintained regular contact throughout the transition from the resource parent to the kinship care setting. By helping the caregivers understand the context of Kayla's experiences and behaviors, she helped them respond more sensitively to her stress and her needs for comfort.

A trauma-informed child protection system is knowledgeable about the potential short- and long-term impacts of disruptions in attachment relationships on young children and encourages child protection workers to understand young children's behavior in the context of traumatic stress and disrupted attachment. The workers are able to translate the meaning of this behavior to the adult caregivers in the child's life while also offering specific developmentally appropriate support and resources. The trauma-informed system understands that important relationships are key to a young child's feelings of safety; its efforts focus on supporting those relationships. These efforts are essential to the recovery and well-being of society's most vulnerable children.

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Trauma Screening within the Child Welfare System

Lisa Conradi, PsyD and Cassandra Kisiel, PhD

Children involved in the child welfare system (CWS) are particularly vulnerable to traumatic exposure and traumatic stress symptoms whether it is by virtue of the events that brought them into the system or through the process of removal from their caregivers. A national study of adult "foster care alumni" found higher rates of posttraumatic stress disorder (PTSD; 21%) compared with the general population (4.5%) (Pecora et al., 2006). If left untreated, the effects of child trauma can be far-reaching and pervasive.

Recently, the importance of screening for trauma among children in the child welfare system has received increased attention. In December 2011, the Child and Family Services Improvement and Innovation Act of 2011 PL 112-34 amended Title IV-B, in part, to require states to screen for "emotional trauma associated with a child's maltreatment and removal from the home." While specific guidelines are not yet established on how states will implement this mandate, it suggests that policy makers recognize screening for trauma as playing a critical role in assisting child welfare systems (CWS) towards meeting their goals of safety, permanency and well-being.

A trauma screening tool is designed to be universal, administered to every child within the CWS, and typically evaluates the presence of two critical elements: (1) exposure to potentially traumatic events/experiences and (2) endorsement of traumatic stress symptoms/reactions. Using a trauma screening tool is critical to understanding the unique experiences of children and their needs; however, there are a number of barriers that impede child welfare workers from conducting trauma screens on every child who comes into care. These barriers include lack of training on administration of screening, lack of time to administer screening tools, lack of training to effectively use the information gathered for case planning, and difficulty managing the effects of secondary/vicarious trauma that may emerge when asking a child about his/her traumatic experiences.

While there are barriers to administering universal trauma screening tools, there are a number of benefits. CW workers may already be asking about the child's traumatic exposure and symptoms although they may not explicitly identify their questions as such. For instance, many practices within child welfare, including Structured Decision Making (Wiebush, Freitag, & Baird, 2001) and Signs of Safety (Turnell, 2011) include questions related to a child's trauma history, fears, and triggers. Therefore, integrating some questions about specific trauma experiences and symptoms can readily be woven into existing practices and tools. Further, caseworkers who have conducted trauma screenings can identify the types of events or situations that may potentially trigger symptoms for the child. This information can be conveyed to the foster parent along with psychoeducation and skill-building on managing difficult behaviors and trauma triggers, ultimately helping the foster parent manage difficult behaviors and minimize placement changes. Finally, a trauma screening plays a critical role in determining whether or not a child should be referred for general mental health treatment and/or trauma-focused treatment, if needed.

In December 2011, the Child and Family Services Improvement and Innovation Act of 2011 PL 112-34 amended Title IV-B, in part, to require states to screen for "emotional trauma associated with a child's maltreatment and removal from the home."

Before implementing any screening tool or process, it is useful to integrate some general recommendations into existing child welfare practice:

1. Broad training on child traumatic stress should be made available to the entire child welfare workforce. This includes training on different trauma types (e.g., sexual abuse, physical abuse, neglect, exposure to domestic violence) and various traumatic stress reactions that children may exhibit, including internalizing and externalizing problems. There are a number of resources that exist to assist child welfare systems in training on these topics, including the Child Welfare Trauma Referral Tool (Taylor, Steinberg & Wilson, 2006).
2. The child welfare system should foster relationships with its mental health partners and actively work with them to build their capacity to provide trauma-focused mental health treatment when appropriate. If a screening process determines that a child would benefit from a trauma-focused mental health assessment, it is critical to link him or her to a provider who is trained in providing such an assessment.

There are several existing trauma screening tools designed to help child welfare workers get a better sense of the child's trauma history, make sense of the child's behavior problems, and inform the case planning process. For a fuller review of some commonly used screening tools and methods of administration, refer to Conradi, Wherry and Kisiel (2011). Given the extraordinary number of children who enter the CWS with a history of trauma, it is critical to embed a process in which children are screened for trauma exposure and reactions, and then referred for trauma-focused assessment and treatment as needed.

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Trauma-Focused Cognitive Behavioral Therapy (CBT) for Youth in Child Welfare

Judith A. Cohen, MD and Anthony Mannarino, PhD

Children show the negative effects of trauma experiences in different ways. Let's take a look at a couple of case examples that illustrate this point. Six year old Maria was sexually abused by her mother's boyfriend while her mother, who was addicted to drugs, was unable to protect Maria. Mother was sometimes present when her boyfriend, Jack, abused Maria. Maria cries and clings to her foster mother when she sees a man who looks like Jack. (This is an example of responding to a trauma reminder—a person, place, situation, smell, feeling, or something else that reminds the child of the original trauma experience.) Maria also has nightmares and is afraid to go to sleep alone at night (when Jack often abused her). She will only sleep if she is allowed to sleep in her foster mother's bed.

When asked about the abuse, Maria says she doesn't want to talk about it because it's "too scary." Foster parents, teachers and mental health professionals readily connect Maria's problems with her previous sexual abuse.

Robert, 13 years old, also does not want to discuss his past, which includes a long history of physical and verbal abuse and neglect, witnessing domestic violence, and bullying at school. Unlike Maria, Robert denies having nightmares and being afraid and does not appear to the adults in his life to be negatively affected by his past trauma. He has been removed from four foster homes due to his angry, aggressive behavior and refusing to comply with rules. Typically Robert tells his caseworker that the foster parents "disrespect" him; the parents say that Robert is the one being disrespectful. In his current foster home, as Robert has become more defiant, his foster parents have become increasingly strict, and are now giving him commands in loud voices. His foster father has even physically restrained him to "teach him who's the boss.". Like Maria, Robert is experiencing trauma reminders (in his case, loud voices and physical punishment from parent figures) and trauma responses (problems regulating his feelings, thoughts and behaviors in response to trauma reminders), but the adults in his life do not understand this; they see him as a kid with bad behaviors who needs discipline.

Trauma-focused Cognitive Behavioral Therapy is the most tested EBT for traumatized youth.

Maria, Robert, and thousands of other youth in the child welfare system need effective treatment for their trauma problems. They currently have little chance of receiving such treatment because few therapists treating these youth learn evidence-based trauma-focused treatments (EBTs).

Figure 1: TF-CBT PRACTICE Components

PRAC: Coping Skills Phase	**P:** Psychoeducation **P:** Parenting Skills **R:** Relaxation Skills **A:** Affective Modulation Skills **C:** Cognitive Coping Skills
T: Trauma Narrative and Processing Phase	**T:** Trauma Narrative and Processing
ICE: Treatment Consolidation and Closure Phase	**I:** In vivo Mastery of Trauma Reminders **C:** Conjoint Youth-Caregiver Sessions **E:** Enhancing Safety

(TG: Traumatic Grief Components as needed)

Evidence-Based Trauma Treatments

Evidence-based trauma treatments (EBTs) are trauma treatments that have been tested in scientific studies. The most rigorous kind of study to test a treatment's effectiveness is a randomized controlled trial (RCT). In a RCT the treatment being tested (Treatment A) is compared to another treatment (Treatment B) to see which works best to help traumatized children recover. In RCT studies, children are randomly assigned ("randomized") to receive Treatment A or Treatment B. This is done to eliminate the possibility of bias. In RCT studies, both treatments are monitored (e.g., by listening to audiotaped treatment sessions or using a fidelity measure) to assure that children are receiving the assigned treatment. Children's outcomes are evaluated by people who do not know which treatment the children have received ("blinded" evaluators). This is an additional step to prevent bias in the outcome of the study.

In order to be considered an EBT, Treatment A must produce significantly better outcomes than Treatment B in at least one RCT study. For trauma-focused treatments, these outcomes may include Posttraumatic Stress Disorder (PTSD), externalizing or sexualized behavior problems, anxiety, depressive symptoms, shame, or the child's negative beliefs about himself. Other important outcomes may relate to the caregiver, such as change in positive parenting practices, caregiver support of the child, or resolving caregiver emotional distress. Outcomes specific to children in child welfare may include prevention of placement disruption or running away from the child's current placement.

Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)

Trauma-focused Cognitive Behavioral Therapy (TF-CBT, Cohen, Mannarino & Deblinger, 2006; www.musc.edu/tfcbt) is the most tested EBT for traumatized youth. TF-CBT is comprised of several treatment components, summarized by the acronym PRACTICE. These components are divided into three modules or phases as shown in Figure 1: Coping Skills,; Trauma Narrative and Processing, and Treatment Consolidation and Closure. Typically TF-CBT treatment is 12-16 sessions, but for very complex trauma, this treatment may be 25-30 sessions. TF-CBT has been used for many youth in child welfare and applications for these youth have

been described (Dorsey & Deblinger, in press).

During each subsequent TF-CBT component youth use coping skills to tolerate gradually increasing exposure to their trauma reminders, a process called "gradual exposure". Caregivers (e.g., biological or foster parents) participate in parallel parenting sessions throughout TF-CBT treatment. However, youth with frequent changes in placement, youth without caregiver contact, or youth who refuse to allow the caregiver to participate in treatment can also receive TF-CBT. For these youth, TF-CBT engages the youth in the youth-focused components of TF-CBT while simultaneously attempting to create a supportive network from other available adults (www.cdc.gov). If feasible, another supportive adult may eventually participate in the youth's TF-CBT treatment.

The early coping skills phase consists of building skills for the youth to use when confronted with trauma reminders and to use generally when experiencing regulation difficulties. These skills are also important for the caregiver. Psychoeducation helps the caregiver to view the youth's problems as being related to his past trauma experiences rather than simply as "bad" behavior. Parenting skills provide the caregiver with tools to more effectively respond to the youth's trauma-related regulation problems. For children like Maria, a step- by-step in vivo (in real life) plan will help her master her fear of sleeping in her own bed. Since this may take several weeks, the in vivo mastery will begin early in TF-CBT. For youth like Robert with serious behavioral problems, it may take 10-12 sessions to achieve reasonable stability and self-regulation (Cohen, Berliner & Mannarino, 2010; Cohen, Mannarino, Kliethermes & Murray, in press).

The next phase of TF-CBT is trauma narrative and processing. During this phase the youth develops and processes a detailed description of his trauma experiences. A youth who has lived through chronic, multiple traumas may create a narrative focusing on his trauma theme (Cohen, et al, 2012). Creating and processing the narrative typically takes about 1/3 of the TF-CBT treatment.

After the youth has created and come to a better understanding of these experiences during sessions with the therapist and the therapist has shared this narrative with the caregiver in individual sessions, the youth shares it with the caregiver in conjoint youth-caregiver sessions. With appropriate preparation these sessions are highly rewarding and validating sessions for youth and caregivers. Finally, re-establishing a sense of safety for youth in child welfare is critical. For many youth in child welfare this is the most critical component and TF-CBT may begin and end with establishing trust and safety.

TF-CBT Effectiveness for Youth in Child Welfare

A dozen RCT studies have shown the effectiveness of TF-CBT in improving multiple outcomes (e.g., PTSD, depression, anxiety, behavior problems, youth cognitions, parenting outcomes) after traumas commonly experienced by youth in child welfare (e.g., sexual abuse, domestic violence, multiple traumas).

Two studies specifically focused on youth in child welfare. The first study examined youth in care in Illinois, comparing TF-CBT to youth receiving Systems of Care treatment as usual (SOC). TF-CBT was significantly superior to SOC in improving PTSD symptoms, emotional and behavioral problems as measured by the Child and Adolescent Needs and Strengths (CANS) and in preventing placement disruption and running away from current placement (Weiner, Schneider & Lyons, 2009). The other examined the effectiveness of TF-CBT with or without an additional module for engaging foster parents. This study found that the engagement strategy significantly improved foster parents engagement in their youths' TF-CBT treatment but otherwise did not change youth outcomes, with both groups experiencing significant improvement after receiving TF-CBT (Dorsey, 2011).

For more information about TF-CBT, therapists can refer to the free TF-CBT training resources available at www.musc.edu/tfcbt, www.musc.edu/ctg and www.musc.edu/tfcbt-consult. Information about upcoming TF-CBT training is available at www.musc.edu/tfcbt under "Resources." The location of over 200 TF-CBT trained clinicians in Minnesota is available at www.ambitnetwork.org.

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

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

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

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

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

PMTO interventions decrease coercive parenting and increase positive parenting (i.e., skill encouragement, problem solving, limit setting, positive involvement, and monitoring). Improvements in parenting, in turn, buffer the effect of stressful contexts

on youngsters and promote healthy adjustment. More than four decades of careful research with PMTO programs have shown benefits for youngsters in terms of reduced internalizing and externalizing behavior, deviant peer association, delinquency, police arrests, and increased academic functioning and positive peer relationships (Forgatch and Patterson, 2010). Several large-scale PMTO implementations have been conducted nationally and internationally. Adapted versions of PMTO are being tested with diverse populations, including English and non-English speaking Latinos, military personnel returning from the wars in Afghanistan and Iraq, Somali and Pakistani families in Minnesota and in Norway, and families in Mexico City.

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

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

> Intervention research must become standard practice to better understand the role of parenting in children's post-trauma recovery and the relationship between trauma-informed parent training and child welfare.

Families in the CW system need evidence-based practices to ensure enduring positive outcomes. Intervention research must become standard practice to better understand the role of parenting in children's post-trauma recovery (Gewirtz, Forgatch, & Wieling, 2008) and the relationship between trauma-informed parent training and child welfare. The hardworking practitioners whose mission

Continued on page 38

Cultural Adaptations of Trauma Treatments in Indian Country

Wynette Whitegoat, AB, and Richard van den Pohl, PhD

The National Native Children's Trauma Center at the University of Montana is funded by SAMHSA as a Treatment and Service Adaptation Center within the National Child Traumatic Stress Network. Centers such as ours are charged with replicating evidence-based trauma treatments while adapting them to meet the needs of local communities. Our work has focused on providing cognitive behavioral treatments, primarily Cognitive Behavioral Intervention for Trauma in Schools, or CBITS (Jaycox, 2004), in American Indian reservation schools. We also have worked to create trauma-informed behavioral health, juvenile justice, and child welfare systems. Indian and non-Indian staff members' backgrounds include psychology, education, social work, counseling, early childhood, law enforcement, and the military.

Inclusion of traditional Native cultural activities in evidence based trauma treatments has produced strong appreciation for our work by some tribal partners. It also has produced great concerns from other tribal partners largely due to sacredness of cultural activities. The use of traditional healing within the Native communities we work with is seen to be the most reasonable option in regaining health and balance. Because culture plays a critical role in facilitating healing among Natives, it is seen as an essential need toward wellbeing. Although all tribes are different in culture and hold a variety of perspectives and philosophies, the majority do share similar beliefs on the importance of wellbeing. The psychological, social, physical, and spiritual dimensions are interconnected and should be treated as one (LaFromboise, Trimble, & Mohatt, 1990). Ceremonies and other traditional practices bring comfort, hope, and rebalance to these four dimensions found within individual clients and their community (McCabe, 2007). Not only does traditional healing provide options for restoration but also increases opportunities for cultural preservation, reinforcement of ethnic/tribal identity, and connection to culture and the community (Hartmann & Gone, 2012; McCabe, 2007; Ranford, 1998).

While adaptation of evidence-based treatments may seem incompatible with high fidelity replication, we have found that adaptations can enhance acceptability, sustainability and effectiveness of trauma treatments. Most tribal communities in the United States experience some distrust of outsiders (Yellow Horse Brave Heart, 2003), particularly child welfare workers. Whether a Tribe has experienced theft of deceased grandparents' remains or whether "research" has been conducted that perpetuated racial stereotypes, there are good reasons for tribal members to be skeptical of outside experts who offer simplistic solutions for complex problems (Gone & Alcantara, 2007). While not conducive to short-term change, we have developed three developmental approaches that seem to support long term relationships with Tribes and tribal members. First, we only work in communities where we have been invited. Second, we consider that all data resulting from tribal partnerships are the property of the Tribe; the Tribe may or may not give us permission to disseminate those data. Third, in addition to protecting individual identity, we do not disclose the identity of a Tribe unless the Tribe asks us to do so.

We also have found it valuable to engage local community members in participatory dialog regarding their perceptions of the value of treating childhood trauma, what the outcomes of successful trauma treatment should look like, and whether there already are traditional support strategies that could be blended with the evidence-based trauma treatment. While some local adaptations have been procedural (e.g., inviting students to draw a picture to supplement their oral trauma narrative), we also have invited local cultural experts to contribute traditional language and traditional healing strategies during group trauma treatment.

While adaptation of evidence-based treatments may seem incompatible with high fidelity replication, we have found that adaptations can enhance acceptability, sustainability and effectiveness of trauma treatments.

In some communities, our early efforts to include traditional Native language and culture stimulated apprehensions among our tribal partners. One set of concerns involved the proprietary nature of Native language and culture. Closely linked were perceptions that researchers might exploit or otherwise profit from information shared by healers and Elders, and because we do this work as part of our university employment, we cannot completely nullify this perception.

To date, no Tribe has refused our request to share results of trauma treatment. However,

the extent to which we discuss traditional language and culture follows one of three protocols. The protocol that is followed is determined by Tribal Council decision with recommendations from Elders. In the first case, traditional language and healing ceremonies are made available to children and youth who choose them, but whether and how that occurs is not disclosed in our dissemination. In the second case, we report that a community volunteer with expertise in language and culture participated in the trauma treatment program, but the intervention(s) he or she used are not recorded, named or described. In the third case, the traditional ceremony may be named and may be described. In every case, we inform the Tribal Council of our findings before disseminating elsewhere.

Child welfare (CW) workers may be perceived as "outsiders," for example, if they are employed by the Bureau of Indian Affairs, a federal agency. In recent years, BIA has employed Native workers who also are community members—a practice consistent with Indian self-determination. Alternatively, Tribes can provide their own child welfare services. Regardless of agency type, CW workers face enormous challenges in child protection as the families they serve frequently are both neighbors and relatives. The adoption of Differential Response (DR) services has dramatically shifted the CW worker role from investigation only to a more integrated approach of family support services coupled with ensuring child safety. Such

Continued on page 38

Homeless Youth Emerging from the Child Welfare System

Arlene Schneir, MPH

The Hollywood Homeless Youth Partnership (HHYP), a collaborative of eight homeless youth serving agencies in Hollywood, California, has been involved as a center with the National Child Traumatic Stress Network since 2005. As a result of our work with the NCTSN, we believe that trauma-informed practices and evidence-based trauma focused treatment approaches can be more effective in helping youth who have experienced trauma and abuse understand their experiences, develop new and healthier coping strategies, create and sustain positive attachments with caring adults, and healthy relationships with peers, and promote post-traumatic growth. Most importantly, we strongly believe that early and on-going trauma-focused intervention with these young people can help prevent them from transitioning from our child welfare system into youth homelessness.

Unaccompanied homeless youth are found in every urban center in the U.S. and in many smaller cities and rural communities. Nationally, former foster care children and youth are disproportionately represented in the homeless population (National Alliance to End Homelessness, 2006). In 2007 and 2008, the HHYP conducted a multi-method needs assessment with unaccompanied homeless youth ages 12 – 25 to better understand their needs and experiences. The resulting report, "No Way Home: Understanding the Needs and Experiences of Homeless Youth in Hollywood" (Rabinovitz, Desai, Schneir, & Clark, 2010), included rich information about the characteristics of homeless youth in this community that can be useful for child welfare systems and other public and private institutions that serve these young people.

Approximately half (48%) of the youth surveyed (n=389) reported previous or current involvement with the child protective services system (CPS); forty percent of youth reported having been removed from their homes by CPS. The mean age when youth reported having been removed by CPS was 9.3 years old. Almost all (95%) of the youth who had been removed from home had been placed in a group home at some time, and close to one-third of the youth reported they had been in 6 or more group homes. Clearly, our child welfare system has not been effective in finding these children and youth the safe and permanent housing they require for healthy development.

As part of our analysis, we compared the homeless youth in our survey who had been removed from home by CPS with those who had not and found that youth who had been removed from home by CPS had poorer outcomes than their peers. Not surprisingly, youth who had been removed from home were more likely to report all types of abuse and neglect. These youth also reported more episodes of homelessness (8.1 vs. 5.3); were more likely to be engaged in the street economy (panhandling, shoplifting, trading sex, selling drugs, and/or pimping) (47% vs. 36%); and were more likely to have spent at least one night on the street in a place not meant for human habitation within the last month (59% vs. 45%).

In regard to mental health issues, youth who had been removed from home by CPS reported more psychiatric hospitalization and were more likely to report being diagnosed with a conduct disorder, bipolar disorder, or schizophrenia. They were also more likely to report self-injurious behavior. In regard to educational issues, youth who had been removed from home by CPS were also more likely to have been diagnosed with learning problems and enrolled in special education.

Homeless youth who had been removed from home complained most about the multitude of placements and how that interfered with their ability to connect with peers and caring adults.

In individual interviews and focus groups, homeless youth who had been removed from home complained most about the multitude of placements and how that interfered with their ability to connect with peers and caring adults. Youth also reported they were often moved from one placement to another without any warning or explanation. In addition, youth had many complaints about the mental health services they received when they were involved in the child protective system. They felt they were over-diagnosed, labeled, and medicated. As a result, many of these youth were reluctant to access mental health services even after their involvement with CPS ended.

Over the past two decades, the federal government and many state child protection agencies have intensified their efforts to ensure that child welfare services result in positive outcomes for children and families. However, there is clearly still work to be done. Based on our work with youth experiencing homelessness, we are particularly interested in efforts to support permanency for children and youth in the foster care system. We applaud new initiatives that make this possible, particularly for gay, lesbian, bisexual, and gender non-conforming children and youth.

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Trauma-Informed Care Using the 3-5-7 Model

Darla L. Henry, PhD, MSW, and Amelia Franck Meyer, MS, MSW, APSW, LISW

Although there has been an increasing focus on "trauma-informed care" for children in out-of-home care, for many, it has not been clear exactly what "trauma-informed care" means on the practice level. For example, "What do I do differently in my day-to-day interactions with the youth?" "What do foster parents do differently in the home?" Until Anu Family Services (www.anufs.org) became aware of the 3-5-7 Model©, the answers to these questions about the practice-level changes needed to address trauma were not as clear. The 3-5-7 Model©, in which all treatment foster parents and social workers are trained at Anu, helped to concretize how to address trauma for youth in out of home care. The 3-5-7 Model© helped to give a new perspective to the work: trauma is the experiences that have happened to these youth, losses are what they experience as a result of these multiple and complex traumas, and grieving is what social workers and foster parents help them do to heal their losses and trauma. Using loss as a lens by which to view trauma helps social workers, therapists and foster parents to understand what needs to happen next.

The 3-5-7 Model© is a promising practice that supports the work of children, youth and families in grieving their losses and rebuilding their relationships. The 3-5-7 Model© is a strengths-based approach that empowers children and youth to engage in activities that encourage expressions of hurt related to losses and to give meaning to significant relationships towards developing permanent connections. It supports deeper therapeutic work around the traumas of abuse, abandonment and neglect experiences that is or may be provided by other clinical professionals. As individuals begin to reconcile their grief, they may more readily enter into deeper, intensive therapies, if needed.

> Using loss as a lens by which to view trauma helps social workers, therapists and foster parents to understand what needs to happen next.

The 3-5-7 Model© incorporates three tasks, five conceptual questions and seven interpersonal skill elements to support this work. The three (3) tasks, clarification, integration and actualization, guide the activities that support the work of grieving and relationship building. Losses will be clarified, relationships will be integrated, and permanent connections will be actualized.

Clarification means to identify and make sense out of the events of the one's life, to provide a factual base for understanding what is real and what is not real. **Integration** is the process by which one develops the ability to understand their connections and membership in numerous families. **Actualization** is the visualization of permanency, that is, the sense of feeling safe and of belonging, claiming an identity, and establishing a place within family or other permanent relationship. Actualization is well-being. It is the ability of the child or youth to begin to see a possible permanent future with a family, parent, or guardian as the tasks of clarification and integration are occurring and evolving.

The five (5) conceptual questions, who am I, what happened to me, where am I going, how will I get there, and when will I know I belong, support the work of the three tasks.

The seven (7) interpersonal abilities guide the efforts of professionals, counselors and families as they support the grief work. These abilities are: engagement and listening skills, recognizing the pain reflected in behaviors, affirming and responding to these behaviors from a grief perspective, remaining present to these expressions of grief, creating opportunities for the perception of safety within the helping relationship, and recognizing that grief work and relationship building can be done only by those who have experienced the loss.

The 3-5-7 Model© provides tools, based on theoretical foundations, to support the work of the child or youth. For example:

Start the activity with the child by explaining that you are going to play a special kind of basketball, which will help them discuss happy and sad feelings. When the child throws a ball through the hoop, they select a card from a "happy face" pile. When the child misses the hoop, they select a card from a "sad face" pile. They share their feelings, or not, at a pace that is safe and comfortable for them (The 3-5-7 Model© Workbook, p.16, 2012 Edition). This is a safe way for the child to identify and express feelings and typifies the task of clarification by supporting them in telling the story of events that have happened to them. Questions related to identity and grieving are captured in this work.

Through learning the techniques and theories of the 3-5-7 Model©, workers and families become knowledgeable and comfortable in exploring the hurts of those they parent and work with, learning patience to support the expressions of their pain. As a practice for relational work, the use of this model has shown that children and youth do their work in grieving losses and are able to move forward towards permanency in relationships where they feel safe and secure.

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Repacking the Invisible Suitcase

Chaney Stokes As told to Johanna Zabawa, Research Assistant

"I believe that every young person should have a voice and I am striving to be that person who gives them the strength they need to be empowered." –Chaney Stokes.

Chaney Stokes is currently the Assistant Program Coordinator for SAYSO (Strong Able Youth Speaking Out), a non-profit organization in North Carolina. Stokes has been involved with SAYSO since entering into foster care at age fifteen. Since her transition from foster care, Stokes has become a dedicated advocate for change within the foster care system as well as an ally and support to those children and youth who have been through foster care placements. Below, Stokes discusses the "Invisible Suitcase," a concept that describes the thoughts and beliefs children with a history of trauma may carry with them about themselves, their caregivers, and the world at large (NCTSN.org).

Tell us a little about yourself

My name is Chaney Stokes and I am currently the Assistant Program Coordinator for SAYSO. After entering into foster care, I spent the majority of my teenage years in and out of placement. Being in foster care was very difficult for me at first because I still had a lot of unanswered questions about my past. I could not understand why people were telling me "it's not your fault," but I had to be removed from my home, my family, and my friends.

Tell us a little about your work with resource parents in the foster care system.

Over the last several years, I have worked closely with resource parents through state and national collaboratives. I have also been involved in the Resource Parenting Curriculum training (developed by the Child Welfare Committee of NCTSN), where I am a Family-Partner co-trainer. My role as a co-trainer is to support the curriculum material using my personal life experiences. A Family Partner co-trainer adds an authentic dynamic to the curriculum.

You've mentioned the "invisible suitcase;" can you tell us more about that?

In the Resource Parenting Curriculum, there is a module which gives information about an "invisible suitcase." The "invisible suitcase" is explained as being something that a young person who has experienced trauma will carry with them. Many young people in foster care will carry physical suitcases with them as they move from one place to another. The "invisible" suitcase is different because you can't see it which makes it harder to identify.

How does the "invisible suitcase" affect children in foster placement?

Besides the fact that a young person in foster care has experienced trauma and may have been hurt by someone they love, they will also carry thoughts about themselves that may be negative. For most young people in foster care it is not their choice or their fault that they have to be removed from their home, family, and friends. With unanswered questions about his/her life, it becomes very easy to think negative thoughts about yourself.

The "invisible suitcase" is explained as being something that a young person who has experienced trauma will carry with them.

What are some of the most important things that caregivers should know about the "invisible suitcase"?

The best thing caregivers can know about the "invisible suitcase" is that it can be repacked with positive thoughts. When a young person enters into care, it is best to know that he/she may have thoughts about adults, themselves, and others that are probably negative. The best way to repack those thoughts is by saying and doing the opposite of what they already believe. If a young person feels that all adults lie, a caregiver can show that young person that not all adults lie by always telling that young person the truth.

What happens if the suitcase is never addressed?

If the "invisible suitcase" is never repacked, a young person can have a hard time coping, building new relationships, or even staying connected to past relationships. He or she can also go into adulthood with negative thoughts and possibly prevent successful achievement in their lives.

How did learning about and identifying the contents of your own "invisible suitcase" help you?

The "invisible suitcase" is something I know all too well. My "invisible suitcase" was filled with things like "No one cares about me", "It's my fault", "I'm not pretty", "All adults will do things for their own benefit", "I can't be loved", "I will never have a family." I wasn't sharing this information, so no one knew how I truly felt about myself. Eventually, several adults entered my life who took the effort to repack my "invisible suitcase." I was able to see that I am loved, that being in foster care was not my fault, and, despite not being connected to my biological family, that I am a part of many different families and they all love me as one of their own. Having a brand new "invisible suitcase" has helped me become the person I am today.

For more information on "The Invisible Suitcase" visit the National Child Traumatic Stress Network at www.NCTSN.org.

Chaney Stokes is Assistant Program Coordinator for SAYSO (Strong Able Youth Speaking Out), in North Carolina. She can be reached at chaneyporter85@yahoo.com.

A Birth Parent's Perspective: What Happened?

Pamela Toohey

As a Parent Partner, in San Diego, I provide peer-to-peer support to parents involved with the child welfare system and its community partners. I recently attended a Team Decision Making (TDM) meeting as support for Toni*, a 20 year old mom just released from jail with two children under the age of three. Child Welfare scheduled the TDM to find safe and suitable out-of-home care for Toni's children. Four days prior, their hotel room was raided by police. Toni and a 17-year old friend were prostituting from the hotel room with two minor children present. Also staying in the room was Toni's current male partner, the father of her seven month old daughter and a known drug dealer. Police found proof of prostitution along with drugs and paraphernalia. The adults were taken into custody and so were the children.

Present at the TDM, besides agency professionals, were ten family members including aunts, uncles, and grandparents. All of the family members claimed to be clean and/or sober ranging from six months to seventeen years. All but two of the family members had previous child welfare involvement, and most had criminal backgrounds as well. Now solid members of their community, their pasts may still prevent them being considered for placement of the children.

This family's story is just one of many that I have heard. The families might look different with different cultures and socio-economical backgrounds. Their present conditions may or may not include: substance abuse, domestic violence, mental health issues; neglect, endangerment, physical or sexual abuse of their children; and homelessness, but each and every adult I've worked with reported an average of 4-5 adverse childhood experiences such as neglect, physical or sexual abuse, incarcerated or substance/alcohol abusing parents (acestudy.org). Many claimed their parents survived adverse childhood experiences as well.

What if we asked the parents, those adults who proclaim parental love of their children in spite of the situation they find themselves in, "What happened in your life as a child?" What if instead of viewing the adults as addicts, criminals, co-dependents, mentally challenged, and bad parents, we looked at them as adult children who have survived adverse childhood experiences and viewed their co-occurring conditions and maladaptive behaviors as symptoms of having survived these experiences? What if we explored a new kind of genogram to determine how many family members and ancestors displayed or presented the same life conditions or situations as the parent? What would we find?

In 1997, I was arrested and taken into custody, and my three year old son was placed in foster care. I was charged with being under the influence of methamphetamine, intent to sell, and child neglect and endangerment. I had a long history of substance abuse, domestic violence, and criminal activity. My life was in utter chaos, and my son was there with me.

I, too, was raised in a chaotic, dysfunctional home. My father was an alcoholic, who served in the Army and spent most of his time away from home. He left my sister and me in the care of my mentally ill mother. Both sets of grandparents were alcoholics. I was molested as a child; so were both of my parents and both maternal and paternal grandmothers. My paternal grandmother, great-grandmother, and my maternal grandmother became involved in prostitution. So did I. My paternal grandparents, maternal grandparents and great-grandparents were all involved in some form of criminal activity. So was I. They all abused and neglected their children. So did I. When would it stop?

When I was arrested, there were professionals concerned about my son's physical safety and development. They ordered psychological testing for my son; no one asked about me. My son went to foster care and had physical, developmental and mental health assessments and therapy. I went through all of the court ordered services: substance abuse treatment, probation, parenting classes, and in-home support services. I changed my life. I regained custody of my son. Yet no one thought to ask how I was doing or if I needed any help.

What if instead of viewing the adults as addicts, criminals, co-dependents, mentally challenged, and bad parents, we looked at them as adult children who have survived adverse childhood experiences and viewed their co-occurring conditions and maladaptive behaviors as symptoms of having survived these experiences?

In 2000, I received the trauma-focused therapy and help that I needed and so did my son. I didn't know to ask for it, so I didn't go looking for it; it found me. My son was molested by a neighborhood youth who had been in our home many times. I didn't know the red flags or recognize the signs of possible danger because no one had intervened, assessed, or educated me on my own molestation. If I had, this could have been prevented.

I believe that adverse childhood experiences and the maladaptive behaviors we develop in order to survive are intergenerational. I have learned to take a risk, to reach out and help educate the family members I work with, to understand the effects of trauma. I ask, "What happened to you as a child?" I refer them to appropriate and immediate mental health and community services and offer my support for as long as it's needed.

It's your turn to ask—not "What's wrong with you?" but "What happened to you?"

*Name changed to protect privacy.

Pamela Toohey is the Founder/CEO of the Birth Parent Association. She can be reached at www.birthparentassocation.com.

Native Families Impacted by Historical Trauma and the Role of the Child Welfare Worker

Marilyn J. Bruguier Zimmerman, MSW and Patrick Shannon, BSW

Historical trauma is a theory first devised by Yellow Horse Brave Heart as "the cumulative emotional and psychological wounding over the lifespan and across generations" (2003). The wounds include the loss of ancestral homelands, religion, language and culture. Most devastating to tribes was the impact of federal assimilation policies that forcibly removed tens of thousands of children from their families to be warehoused in boarding schools. The boarding school experience produced generations of children stripped of their cultural and spiritual traditions. Not having these protective influences, many began to suffer from mental and substance abuse disorders, impacting their ability to provide their children with safe and nurturing homes. For these parents, this is the entry point into the child welfare system.

Child welfare in Indian Country is a complicated amalgam of service providers and systems. The child welfare (CW) worker must understand historical trauma as well as the unique laws and policies of tribal child welfare practice. In 1978 Congress passed the Indian Child Welfare Act (ICWA) to "protect the best interests of Indian children and to promote the stability and security of Indian tribes and families" (25 U.S.C. § 1902). Today, state CW workers are mandated to provide active efforts in service delivery to enrollable Native children. The child's tribe has the authority to presume legal jurisdiction and ensure every effort is made for kinship placement within the tribal community.

As a CW worker, I routinely engage in training and education about the ICWA. Unfortunately, there was a failure to connect the ICWA's purpose and the historical context. The severity of maltreatment and complexity of issues which impact parents is only increased by the fact that they are living in tribal communities that experience the consequences of generational and historical trauma.

When I began to understand the impact of history on my clients, I became more present with them, more inclined to be empathetic, and more understanding of the challenges to their well-being. The family histories typically include drug use or unaddressed mental health issues, but I began to look at the family in the context of their tribe. When my clients begin to understand themselves within the framework of their tribal histories, they are able to identify the strengths of their people and the strengths of their families and themselves.

In many of my cases involving Native children, I began not only to address the safety and permanency needs of the child, but also to include tribal culture as a fundamental need of well-being. My treatment plans began to include cultural activities like attending powwows, connecting them to a tribal elder, and finding the spiritual teachers in their communities who provide opportunities for the child and family to participate in their tribal ceremonies (e.g. smudging, naming ceremonies or sweats). For most of the children I've served, these rich, cultural experiences provide a reconnection with their identity, their family, and their tribe.

I began to consult with tribal cultural and spiritual leaders, who were able to provide me with insight into the tribally specific ways of healing. The consultations allowed me to develop treatment plans for the parents that included their tribal ceremonies and culture, and the spiritual leaders became referral providers for the parents. Reconnecting a parent to their culture as well as integrating culture into treatment has been more meaningful for the parent, and, as a result, the parent is more engaged.

Many family members serve in caregiver roles in the child's life. This makes it necessary to include the family members to better understanding of the child's history, environment, and resources. One case comes to mind. I removed a six year old Native boy from the family home when both parents were arrested. I was unable to find the next of kin, yet I didn't have to look long. Within that same week the child's extended family reached out. Through a family group conference, I was able to place the child in the care of his family because his relatives came together so that they each had a role in the care of the child, but none was overwhelmed with the responsibility. Not only did this return the child to his family, but it empowered the family to advocate for their young relatives throughout the remaining life of the case.

The CW worker must face many issues when working with tribal children and families experiencing historical trauma, but first we must appreciate and honor the resilience of Native families. It is imperative that CW workers address historical trauma in the family using child welfare best practice and incorporate tribal kinship and cultural ways to facilitate healing and lasting change resulting in the safety, permanency and well-being of Native children and their families.

The CW worker must face many issues when working with tribal children and families experiencing historical trauma, but first we must appreciate and honor the resilience of Native families.

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Treating Child Traumatic Stress: Bearing Witness to Healing

Sara Younge PsyD, LP

Providing evidenced-based practices, specifically Trauma-Focused Cognitive Behavioral Therapy (TF-CBT), to children with symptoms of traumatic stress has been a primary focus of my clinical work for the past five years. As all therapists who work with children know, treating children requires considerable collaboration with their many different systems. As such, one of the most important partnerships is that between the therapist or mental health system and the child welfare system.

TF-CBT views the caregiver as the primary agent of change. Part of what I enjoy about providing TF-CBT to children is that I get to witness significant improvement not only within the child but also within the context of the parent/child relationship. As a therapist specializing in working with children who have experienced trauma, people often ask me how I can do this work and stay healthy. The answer to the question is that I can do this work because I get to bear witness to the resilience of these children and their families. They heal. They get better. They return to the business of being kids rather than being overwhelmed or paralyzed by their experiences and symptoms.

In the same way that the caregiver/child relationship is central to healing, strong relationships between mental health providers and child welfare workers are essential to the treatment of child traumatic stress. In my experience, effective partnerships result in children being referred by child welfare workers for trauma-informed assessments consistently and quickly. Trauma-informed assessments provide important information to parents, resource (foster) parents, child welfare workers, as well as therapists about whether or not children are experiencing significant symptoms of traumatic stress and would benefit from an evidenced -based practice such as TF-CBT. Another benefit to working closely with the child welfare system is that, over time, information is shared that bolsters the child welfare worker's ability to consider their client's complex needs through a "trauma lens." Additionally, once treatment has begun, the child welfare system is a therapist's most effective and important connection to the parents and resource parents who are the primary caregivers for children with symptoms of traumatic stress.

A previous client of mine was placed out of the home after witnessing a horrifying incident involving the child's father. A child protection worker, who I had worked with previously, immediately referred the child for a trauma-informed assessment. After

the trauma assessment indicated significant symptoms of traumatic stress, the child was enrolled in TF-CBT. I met regularly with the child's foster parents to provide them information about trauma and the ways in which they could best support this child's healing. Likely in part due to the relationship I had with the child welfare worker, I was allowed to meet regularly with the child's father to include him in the treatment even though he did not have legal or physical custody. Throughout the course of treatment, the young child's symptoms decreased significantly in large part due to the child's father and foster parents being active participants in TF-CBT. Although this child did not return to live with the father, child welfare played an important role in healing by allowing the child's father to participate.

There are several ways that therapists can create working relationships within the child welfare system. One of the ways is to participate in child protection team meetings. Another place where therapists can offer support and collaboration around issues related to traumatic stress is to participate in family planning or placement meetings.

Child welfare workers sometimes ask me what they can do to best support the children and families they work with. Referring all children, even those under age five, who have experienced or been exposed to scary event(s) for a trauma -informed assessment by trained therapists is one of the most important things a child welfare worker can do. Additionally, there are excellent resources available to foster parents and child welfare workers that provide information and support related to child traumatic stress. Those resources described in this publication and can be found at: www.nctsn.org.

In the same way that the caregiver/child relationship is central to healing, strong relationships between mental health providers and child welfare workers are essential to the treatment of child traumatic stress.

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Training New Child Welfare Workers

Rebecca Wilcox, MSW, LGSW and Kristi Petersen, MSW

The Minnesota Child Welfare Training System is committed to providing quality, evidence-based, and relevant training to new and experienced child protection workers in Minnesota's 87 counties and 11 tribes. Part of our commitment includes ensuring that workers receive training and information on current best practices that enhance safety, permanency and well-being for children and families. In August 2011, we had the opportunity to join the Ambit Network, an NCTSN Category III Community and Treatment Services Center, in Oklahoma City for a two-day Trauma Training of Trainers (TOT). The TOT gave us a foundation for defining child traumatic stress and methods to help child protection workers identify trauma in children and families on their caseload. Further, the TOT provided practical strategies that workers could use to mitigate behaviors often associated with trauma in children.

Perhaps the most beneficial aspect of the TOT was identification and conceptualization of the Nine Essential Elements of Trauma-Informed Child Welfare Practice into our training for new child welfare workers. As trainers, we have taken these elements back to the classroom and presented them through lecture and activities to child protection workers. Workers define the importance of each element and, subsequently, identify ways to implement the essential elements in the field. For example, when workers articulate that it is important to assist children in reducing overwhelming emotion, they simultaneously engage in identifying potential strategies for children to ease emotional responses. Practice strategies for this essential element may include assuring that comfort items are present, remembering ways that the fear response presents itself and using appropriate de-escalation techniques, and naming feelings. This activity helps workers realize that they are already doing the work, and it allows opportunities for them to learn what others are doing around the state. After the training, trainers compile the notes and send them out to participants so they can retain the knowledge and refer back to it if they need additional ideas.

We incorporated the DVD "Healing Neen," which is the story of Tonier Cain, into Child Welfare Foundation Training (CWFT). Ms. Cain's story is referred to throughout all three modules of the training. Her trauma responses and subsequent journey of healing help us engage in critical conversations about parent responses to trauma and child welfare interactions. When parents appear to be resistant, workers can reframe resistance through a trauma lens and ask, "What happened to you?" This type of conversation can provide key insights into parent behaviors and open doors for possible solutions that increase child safety, permanency and well-being. CWFT trainers received a knowledge gift from a Leech Lake Band of Ojibwe child welfare worker when she taught us that "Neen" means "me" or "mine" in Ojibwe.

The TOT also brought home a greater appreciation of the need to address secondary traumatic stress (STS) for workers during training events. We dedicate time in each training to engage in critical conversations about the impact of the work and the trauma experiences of children and families on individual workers. We spend time identifying self-care techniques, and we incorporate self-care into each action plan to help workers take time to value themselves.

Knowledge of trauma is necessary for child welfare workers because research is continuously demonstrating that child maltreatment is an adverse experience for children, and we can help children and families overcome the potential harm through appropriate interventions. A trauma lens helps workers be compassionate when asking questions and seeking services. If we recognize that trauma occurred for not only the child but most likely for the alleged offender (the parent or caregiver), then we, as practitioners, can locate services that can provide new meanings and positive replacement experiences for the trauma.

The TOT materials have changed our approach to training by helping us incorporate understanding of trauma throughout the entire new worker training series. We challenge workers to ask questions around trauma and to seek out additional resources when necessary. We encourage workers to always view children and families through trauma-informed lenses. Trauma-informed practice is a continuous strengths-based framework that, when incorporated throughout the life of the case, can help children and families journey towards healing and increased competence.

The Trauma Training of Trainers gave us a foundation for defining child traumatic stress and methods to help child protection workers identify trauma in children and families on their caseload.

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Lessons Learned from Implementing the Resource Parenting Curriculum with Foster and Adoptive Parents

George S. Ake III, PhD

Recent studies show that as many as 702,000 youth in care were identified as maltreatment victims (USDHHS, 2009) and that for many children in care there is a reciprocal relationship found between behavior problems and placement changes (Aarons et al., 2010). These studies suggest a need for more effective interventions targeting children's behavior along with better training and support for resource parents (including foster, adoptive, therapeutic, and kinship) in order to manage children's emotional and behavioral problems and to increase placement stability.

The Child Welfare workgroup within The National Child Traumatic Stress Network (NCTSN; www.nctsn.org) developed and piloted a new tool to help address the need for training and support of resource parents. This tool is called Caring for Children Who Have Experienced Trauma: A Workshop for Resource Parents, also referred to as the Resource Parent Curriculum (RPC). RPC was developed to help resource parents who may be parenting children with complex trauma histories and equally complex behaviors and emotions.

At the Center for Child and Family Health (CCFH), we began facilitating RPC as part of our proposal to SAMHSA for our NCTSN Community Treatment Services Center grant. Our main goals in selecting RPC were to:

1. help resource parents understand how exposure to traumatic incidents as well as placement disruptions can impact children's emotions and behavior,
2. provide concrete strategies for parents to use with children in their home,
3. help parents try to depersonalize some of their child's reactions to trauma reminders, and
4. educate parents to advocate for their children needing trauma-focused treatments. Our staff facilitators were selected based on their extensive experience in training other professionals to implement evidence based treatments for child trauma victims and their families.

While we understood the value of RPC and believed that it was well designed, I am not certain that any of us really were prepared for the magnitude of positive changes that it would soon bring. Here are a few of the lessons we learned from resource parents, child welfare workers, and our training faculty.

Resource Parents

Overall, resource parents taught us that their involvement in RPC helped them understand how approaching problem behaviors with a trauma lens was more effective than their previous approaches. They commented that they wished they had participated in RPC earlier and that resource parents should be required to complete this training as part of their in-service requirements given the number of children in care with trauma histories and the perceived lack of information about how to address it. While parents came in with very different levels of information and understanding about their children's history, most of them left the group having a greater appreciation for how children's experiences could impact their current behavior. In addition, parents generally reported that participating in RPC helped to alleviate their feelings of isolation and frustration while helping to empower them to advocate for trauma-informed services for their family.

Parents reported seeing positive changes in their day-to-day approach to parenting and many attributed this change to adjustments they made to accommodate their children's trauma histories. For example, one couple withdrew their child from water sports due to their new understanding of trauma triggers and their child's history of having previous caregivers who used water as part of their abusive discipline. Another couple felt like they had failed as parents of an adopted adolescent prior to RPC, but felt "enlightened" and more hopeful at the end of the group because they understood how their child's complex trauma history might be connected to difficulties establishing relationships with others. They also reported that meeting other parents with similar situations was encouraging throughout the group and, hopefully, following the group.

Child Welfare Professionals

The North Carolina Division of Social Services (DSS) has been a tremendous partner in making RPC a possibility for resource parents as part of a larger effort to make NC's child welfare system more trauma-informed. Many of these groups were held in county DSS offices, and the workers who were present for the groups commented that RPC made a difference and that they benefitted from hearing how to talk with parents about trauma.

> Resource Parent Curriculum was developed to help resource parents who may be parenting children with complex trauma histories and equally complex behaviors and emotions.

Training Faculty

After implementing this curriculum once in an eight-week group format with a trauma-informed mental health clinician and a foster parent or foster care alumni co-facilitator, we all were positive that this was the best platform to serve resource parents. Each group we have done has been more successful than the last as we have incorporated quality improvement activities and built on lessons learned. Currently, CCFH has a full time RPC trainer and through various funding sources plans on having completed a total of 57 groups between 2011 and 2016.

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Using a Trauma-Informed Lens To Create A Perspective Shift in Child Welfare Practice: One Organization's Journey

Ann Leinfelder Grove, MSM

St. Aemilian-Lakeside (SAL) is a Milwaukee, Wisconsin based organization that has introduced trauma-informed care into child welfare practice with positive results. Over the past five years SAL has developed a model for trauma-informed philosophy and practice across its entire organization. Foster care, education, and mental health services are the core business lines that annually serve 3,000+ children, families, and adults throughout Southeastern Wisconsin. Since 2009 SAL has had the contract to provide ongoing case management and intensive in-home services for the Bureau of Milwaukee Child Welfare. This contract gave SAL the opportunity to infuse its emerging success with trauma-informed care into child welfare practice.

SAL's transformation to a trauma-informed perspective originated in 2007 with a goal to reduce the use of physical restraint and decrease critical incidents, but the vision quickly expanded to become an agency-wide paradigm shift that continues to evolve today. Via staff training, a focus on organizational culture and changes in treatment delivery momentum grew. A major milestone was that the agency's clinical staff completed certification in the use of the Neurosequential Model of Therapeutics, an assessment approach developed by Dr. Bruce Perry and the Child Trauma Academy.

SAL's journey was representative of the fact that while attention to the concepts of trauma-informed care has grown immensely in traditional "clinical" circles (outpatient therapy, residential care systems, etc.), it is still catching fire in core child welfare arena. SAL's initiative was developed and nurtured in our residential, treatment foster care and day treatment programs and was introduced within our child welfare subsidiary two years later. It was in that introduction, however, that the larger system of care (Child Protective Services staff working with foster parents, outpatient clinicians, etc.) truly began to transform and produce the kinds of outcomes that the initiative is capable of delivering. This article summarizes some key learning our agency has experienced in its infusion of trauma-informed care into core child welfare practice.

> Child welfare staff are encouraged to ask themselves for every child they encounter "Does trauma have a part in this child's presentation?" Starting with this question will likely help the entire team reach the right conclusions regarding needed interventions, which can provide relief to both the child and the entire team.

Key learning #1 reinforces a core systemic value that all parts of the system need to have a shared understanding for the entire system to function effectively. Systems of care that persist in the belief that the entire system can become trauma-informed without including a key component of that system run the risk of poor outcomes. Conversely, when all the key stakeholders in a child and family's life are trauma-informed, remarkable outcomes are possible. We have experienced numerous examples of our child welfare staff, foster parents, clinicians and other stakeholders being on the same page regarding trauma-informed practice, producing inspiring stories.

One example is Jenni's story. Jenni is a 16 year old girl served by SAL's child welfare program, whose life was turned around by the collaborative, trauma-informed efforts of her caregiver aunt and other family members, her child welfare case manager, and the therapist and staff at the residential facility where she was placed due to suicidal behaviors. The entire team understood the importance of the trauma-informed lens that asks "what has happened to you " rather than "what is wrong with you." and they worked together to acknowledge Jenni's significant trauma history of sexual abuse and to introduce interventions that helped guide her treatment, including sensory activities that helped her regulate her emotions and behavior. One year later, Jenni now lives with her aunt and reports that she is "just a normal teenager," quite a remarkable expression of healing.

Key Learning #2 centers on a recognition that effective practice involves a combination of trauma treatments by trained clinicians and the actions of trauma-informed caregivers (parents, foster parents, service providers etc,). Historically, outpatient therapists were viewed in the child welfare system as a key driver in the process. Things got off track when the outpatient therapist and broader team believed that the change process took place only in the weekly therapy session(s). Key neurobiological learnings regarding how the learning and change process happen suggest that the outpatient process as the locus of change is an incomplete model for many kids who have experienced significant trauma. A child with significant dysregulation issues generally won't learn how to regulate the stress response process through conceptual techniques taught in weekly session(s) but can

and will learn regulation in the daily process of care and coaching from their parents or foster parents. By accepting this wisdom, outpatient therapists can play a key role in teaching, supporting and nurturing the targeted process between children and their caregivers as a means of maximizing success. Much more powerful outcomes are achieved when the parent/foster parent—child daily life process becomes the locus of change.

Key learning #3 reflects an appreciation for the significant prevalence of childhood trauma and how that understanding is applied. The general conclusion from child welfare staff is that nearly all children in the child welfare system have at least been exposed to trauma, often resulting in other difficulties. The application of this concept is where child welfare systems can see significant gain. Understanding how adjustment to trauma impacts children's behaviors is often the best and, arguably, first path to explore. Child welfare staff are encouraged to ask themselves for every child they encounter "Does trauma have a part in this child's presentation?" Starting with this question will likely help the entire team reach the right conclusions regarding needed interventions, which can provide relief to both the child and the entire team.

Key learning #4 is arguably the most significant. It is the notion that all stakeholders providing care are constantly ensuring that they approach the work and clients they serve from a place of optimal health and well-being. This is especially significant in child welfare circles where the context of practice is extremely challenging. One only has to experience the process of taking a child away from a screaming parent or to support a child through a medical exam checking for abuse to have those experiences indelibly etched into memory. In light of these challenges, there are some resource friendly interventions that agencies can use to help (i.e. effective supervision, group or individual de-briefings, spontaneous team lunch events that encourage peer connections).

The need to better understand the impact of trauma on the children and families we serve is likely only going to increase over the coming years. While the scope and significance of the challenge can be daunting, there is always hope that well-informed and coordinated systems of care can rise to meet the challenge. We are trying to do just that at St. Aemilian-Lakeside (http://www.st-al.org/) in Milwaukee.

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Breaking Down Barriers Across Systems: Implementing a Trauma Perspective

Beth Barto, LMHC

Over the past decade, our understanding of trauma has evolved from a focus on adult post-traumatic stress disorder to an emerging understanding of child traumatic stress, complex trauma, and developmental trauma disorders. In the past, the focus was often on treating maladaptive behaviors rather than understanding their underlying causes. My experience in mental health, as a practitioner, supervisor and administrator in non-profit mental health agencies, has allowed me to interface with both the mental health provider and child welfare systems. I have witnessed the effects of trauma on children and the systems that strive to help them. There are times when these systems, although working toward the same goal, feel like adversaries rather than partners, casting blame and abdicating responsibility. Acknowledging that these systems exhibit symptoms much like that of a traumatized child is necessary to realize a true collaboration. This was the situation prior to a small step of change that happened in Massachusetts.

Massachusetts was one of the teams selected to participate in the National Child Traumatic Stress Network's (NCTSN) Breakthrough Series Collaboration (BSC), "Using Trauma-Informed Child Welfare Practice to Improve Foster Care Stability" in 2010. Our team included a senior Department of Children and Families (DCF) administrator, DCF area office manager and direct service provider, LUK Inc. (mental health agency) leadership and clinicians, a birth parent, youth, and foster parent, as well as a community system partner. We focused on knowledge building, trauma-informed assessment, and trauma-informed case work practice. The consumers on our team kept us honest by candidly rating how trauma-informed our system was at baseline and follow-up. This construct allowed us to identify needs and test solutions without the usual bureaucratic constraints; thus, we created a model that was flexible and functional.

The BSC team educated all child welfare staff on the effects of childhood trauma, followed by advanced trauma training for all managers and supervisors in one DCF area office. Child welfare developed capacity to provide trauma-informed curricula and, with the trauma administrator, provided this training for another area office. Simultaneously, resource parents were trained in an NCTSN trauma-informed resource parent curriculum. This included a panel discussion by the BSC team consumers on the importance of maintaining connections for children in placement. The concepts of this curriculum were integrated into the training for all new foster parents. A local pediatrician included a trauma screen into the medical report of children in placement with DCF. Placement reviews began, allowing DCF leadership, social workers, foster parents and biological parents to discuss the goals of reunification and the well-being of the child. The meetings provided a forum to discuss any questions the resource and biological families had related to the child's adjustment. Information on the child was shared by both caregivers to begin a co-parenting foundation with the hope of improved reunification plans.

For its part, the mental health system acknowledged the need to improve communication. Clinicians began sharing trauma assessments with consumers and child welfare workers. LUK's trauma center reported a decrease of externalizing and internalizing behaviors in children receiving evidence-based trauma treatment (Figure 1). One participant stated, "I have taken several kids to therapy and this is my first experience with the trauma model. I never want to go back to any other style with teens in care. Truly this approach is the best I have ever experienced. 'My child' has made strides that I don't think would have been possible with a traditional approach." The child in this case said, "I like therapy. It is interesting. I get to tell my story and really think about it. I get to think about what is my fault and what isn't. It's like a healthy place to escape. I get to see how I could handle certain situations differently…I like to tell my story because sometimes rumors were said about me and I want to tell my story to someone who might actually listen or care."

The main lesson learned was that by identifying successes and sharing strengths both systems could identify and disseminate existing trauma-informed practices. In so doing, we did not create more work, but rather we redirected efforts toward more effective practices.

The BSC team's enthusiasm compelled leadership in both child welfare and mental health to apply for federal funds to scale up trauma-informed practices in Massachusetts. The proposal was funded in September 2011 through the passion and hard work of the BSC team as well as the foundation for excellence in the treatment of childhood trauma provided by NCTSN sites in Massachusetts. The hope is that the partnership between mental health, child welfare and consumers will be replicated across the state thus improving well-being, permanency and feelings of safety for children interfacing with child welfare.

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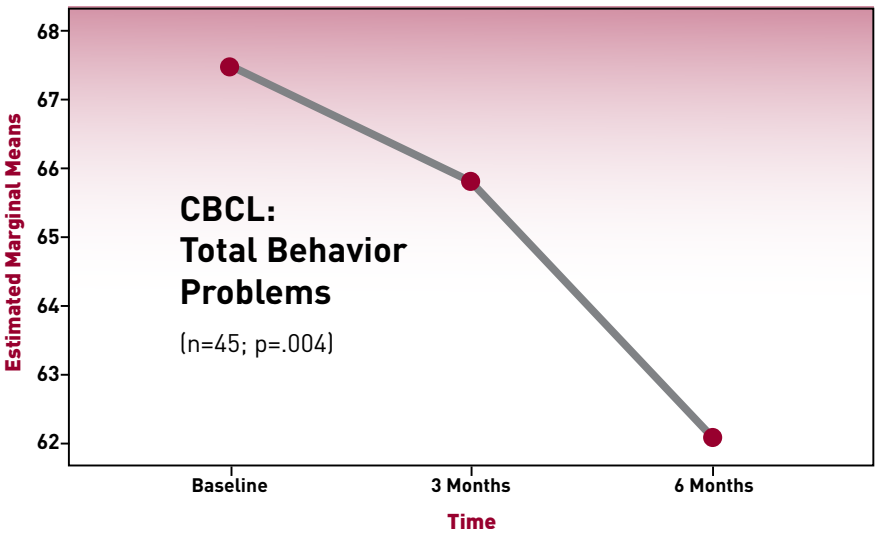
Figure 1



CMCTC data set 2010-2012

The Heart of the Matter: Complex Trauma in Child Welfare
Continued from page 9

those being served.

Two complex trauma intervention models bear special mention given their widespread dissemination with ethnoculturally diverse child welfare populations served in outpatient, residential, specialized foster care and scholastic settings. The Attachment, Self-Regulation and Competency (ARC) model provides a comprehensive, system-based approach to treating complexly traumatized children aged 3-21 (Blaustein and Kinniburgh, 2010; Kinniburgh et al., 2005). Particularly notable among published outcome evaluations on the ARC model is the finding that children involved in the Alaskan child welfare system who successfully completed ARC treatment exhibited placement stability rates over twice that of the state average only one year after starting treatment. Structured Psychotherapy for Adolescents Responding to Chronic Stress (SPARCS) is a well-supported, 16-session, manualized, group-based intervention for complex trauma that has been used extensively with high-risk youth populations (DeRosa and Pelcovitz, 2008). A project with youth served by the Illinois child welfare system found that adolescents in foster care who received SPARCS were half as likely to run away and one-fourth less likely to experience placement interruptions (e.g. arrests, hospitalizations) compared to a standard of care group (Mental Health Services & Policy Program, 2008).

The child welfare system can advance effective intervention for complexly traumatized children by facilitating appropriate referrals to empirically supported interventions designed to treat the whole child. This begins with education of child welfare personnel on the overarching treatment needs of complexly traumatized children and the specific evidence-based treatment models designed to target these clinical objectives and is followed by support of initiatives to establish and sustain local and regional service hubs trained to provide complex trauma treatment for child welfare-referred clients.

Conclusion

Consideration of childhood trauma from a complex trauma framework invites a subtle but pivotal paradigm shift: from the traditional premise that "traumatic stress" derives from exposure to one or more events that lead to specific manifestations of distress which in turn compromise certain aspects of a child's otherwise normative functioning, to the recognition that under certain circumstances the fundamental elements of a child's daily life can be characterized by violations so egregious or deficits so severe that these become primary determining factors shaping a child's foundational capacities and overall development. Cumulative exposure to trauma exponentially increases the likelihood of revictimization. In turn, maladaptive coping strategies developed in effort to survive experiences overwhelming to the child—including running away, self-harm, aggression or substance abuse—can evolve into direct or vicarious traumatic experiences in and of themselves for the child, their caregiving system, and secondary victims. These patterns of trauma exposure, coping deficits, illness, and retraumatization form the building blocks of intergenerational trauma. As prevention, detection and response to precisely these deleterious childhood adversities is, for better or worse, its unique purview, the child welfare system seeking to become truly trauma-informed cannot afford to overlook complex trauma. After all, it has always been the heart of the matter.

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Operationalizing Trauma-Informed Child Welfare Practice using the Child Welfare Trauma Training Toolkit
Continued from page 18

surveyed expert trainers on the CWTTT. The majority of trainers responded that all training modules were clear, easy to use, contained all relevant content for the child welfare workforce, and had the correct time allotment necessary to cover the material. Trainer feedback was both positive and constructive with recommendations for revision and improvement.

CTISP is leading a sub-committee of the NCTSN to revise the CWTTT incorporating feedback from trainers and other professionals in the field of child welfare. The revisions will incorporate recent research about trauma and its treatment as well as principles of adult learning and implementation science. These revisions include: streamlining and reorganizing the Essential Elements and structure of the CWTTT to facilitate training and integration; enhancing content related to topic areas including trauma among young children, the impact of trauma on brain development, trauma and culture, birth parent trauma, and secondary traumatic stress in the child welfare workforce; and providing guidance and support on training delivery and implementation. It is hoped that the revisions, which will be complete in the fall of 2012, will improve the quality of the CWTTT and its usefulness as a resource for educating child welfare professionals about trauma and for teaching them how to intervene to more effectively help children and families heal from traumatic experiences.

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Giving a Trauma Lens to Resource Parents
Continued from page 19

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

Caring for Children Who Have Experienced Trauma was designed to meet a need within the child welfare community for a trauma-informed, application-focused training for resource parents. It is not, however, designed to stand alone. This curriculum is one piece of a broader effort to build a more trauma-informed child welfare system. The NCTSN also has a curriculum designed for child welfare staff, the Child Welfare Trauma Training Toolkit (CWTTT), as well as a set of "Essential Elements of a Trauma-Informed Child Welfare System." When all parties within the child welfare system use the trauma lens, we will, together, be more effective in our efforts to promote safety, permanency, and well-being in the lives of children who have experienced trauma.

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

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Trauma-Informed PMTO: An Adaptation of the Oregon Model of Parent Management Training
Continued from page 24

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

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

– Father who completed parent group for reunification in Detroit

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Cultural Adaptations of Trauma Treatments in Indian Country
Continued from page 25

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

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

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Agency Discussion Guide

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

Between Supervisor/Workers

1. What are some practice implications for child welfare workers working with very young children who have experienced trauma? How might early exposure to trauma impact a child (and his/her family) throughout his/her development? How can workers prepare families for the re-emergence of trauma responses throughout the developmental lifespan? See Pinna & Gewirtz, and McAlister Groves.
2. How might trauma be experienced differently among children and families, based upon their diverse backgrounds (e.g. race, culture, socioeconomic status, education)? See Whitegoat & van den Pohl, and Zimmerman & Shannon.
3. The "Best Practices" section highlights some trauma-informed practice interventions. Which, if any, of these interventions seem applicable to our work? Do you think any should be implemented in our agency? What steps can you personally take?
4. Several of the articles in this issue focus on parents and their experience of trauma? How can we help parents and resource parents address their own trauma, as well as adopting a trauma-informed perspective in their parenting? See Tullberg, Sharda, Rains & Forgatch, Toohey, and Ake.

Between Manager/Supervisor

5. What does it mean to be a trauma-informed system or organization? What is agency already doing that is trauma-informed? What could we be doing that would move our agency closer to become trauma-informed in all aspects of our work? What resources would be needed to implement those changes? See Wilson, Leinfelder Grove, and Barto.
6. How can we make sure our workers are well-trained on trauma-informed practice strategies? See Wilson, Hendricks, and Wilcox & Petersen.
7. In thinking about the workers within your unit, as well as the agency as a whole, which interventions described in the "Best Practices" section seem to be interventions that could work here?

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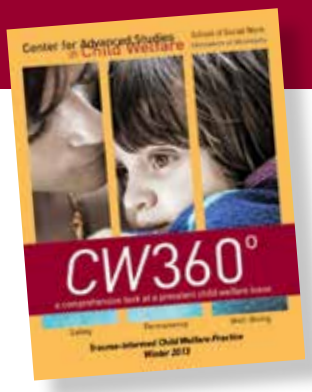

In This Issue of *CW*360°

- An overview of traumatic stress, including complex trauma, and its impact on systems, policies, and parents and children throughout the developmental cycle from early childhood to adolescence
- A discussion of the latest tools for trauma screening
- The importance of addressing early childhood trauma in the context of the child welfare system
- Specific trauma-informed intervention strategies that can be implemented by child welfare practitioners
- A discussion of cultural adaptations of trauma interventions
- The impact of trauma on homeless youth emerging from the child welfare system and specific strategies for use with this population
- Personal accounts of the impact of trauma on youth in foster care, birth parents and resource parents
- Using a trauma-informed lens to create a perspective shift in child welfare practice

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Feature Issue: Trauma-Informed Child Welfare Practice, Winter 2013

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