



# Child Welfare Trauma Training Toolkit

## Comprehensive Guide



2nd Edition

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### **From the National Child Traumatic Stress Network**

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

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# Child Welfare Trauma Training Toolkit: Comprehensive Guide—2nd Edition

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# What is Child Traumatic Stress?

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## Introduction

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

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

Children in the United States are exposed to a wide range of traumatic events, from natural disasters to motor vehicle accidents, dog bites, community violence, and physical and sexual abuse. Studies indicate that one in four children and adolescents experience at least one potentially traumatic event before the age of 16 (Costello et al., 2002). According to the National Survey of Adolescents (Kilpatrick et al., 2003):

- Four out of 10 adolescents have witnessed violence
- Seventeen percent have been physically assaulted
- Eight percent have experienced sexual assault

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

- The child's age and developmental stage
- The child's perception of the danger faced
- Whether the child was the victim or a witness
- The child's relationship to the victim or perpetrator
- The child's past experience with trauma

- The adversities the child faces in the aftermath of the trauma
- The presence/availability of adults who can offer help and protection

## Types of Traumatic Stress

### **Acute trauma**

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

- School shootings
- Gang-related incidents
- Terrorist attacks
- Natural disasters (e.g., wildfires, floods, hurricanes)
- Serious accidents
- Sudden or violent loss of a loved one
- Physical or sexual assault (e.g., being shot or raped)

Over the course of even a brief acute event, a child may go through a variety of complicated sensations, thoughts, feelings, and physical responses that rapidly shift as the child assesses and reassesses the danger faced and the prospects of safety. As the event unfolds, the child's pounding heart, out-of-control emotions, and other physical reactions are frightening in and of themselves and contribute to his or her sense of being overwhelmed.

### **Chronic trauma**

When a child has experienced multiple traumatic events, the term chronic trauma is used. Chronic trauma may refer to multiple and varied events—such as a child who is exposed to domestic violence, is involved in a serious car accident, and then becomes a victim of community violence—or longstanding trauma such as physical abuse or war. One prevalent form of chronic trauma is child neglect, defined as the failure to provide for a child's basic physical, medical, educational, and emotional needs. Neglect can have serious and lifelong consequences. Particularly for very young children who are completely dependent on caregivers for sustenance, experiencing neglect can feel acutely threatening. Neglect often occurs in the context of other maltreatment, such as periods of abandonment and abuse, and is frequently associated with other psychosocial stressors and forms of adversity such as extreme poverty and parental substance abuse.

The effects of chronic trauma are often cumulative, as each event serves to remind the child of prior trauma and reinforce its negative impact. A child exposed to a series of traumas may become more overwhelmed by each subsequent event and more convinced that the world is not a safe place. Over time, a child who has felt overwhelmed over and over again may become more sensitive and less able to tolerate ordinary everyday stress.

### **Complex trauma**

Complex trauma is a term used by some experts to describe both exposure to chronic trauma—usually caused by adults entrusted with the child’s care, such as parents or caregivers—and the immediate and long-term impact of such exposure on the child (Cook et al., 2005). Children who have experienced complex trauma have endured multiple interpersonal traumatic events (such as physical or sexual abuse, profound neglect, or community violence) from a very young age (typically younger than age 5).

When trauma is associated with the failure of those who should be protecting and nurturing a child, it has profound, multifaceted, and far-reaching effects on nearly every aspect of the child’s development and functioning. These children suffer impairment in many of the following areas:

- **Attachment.** Traumatized children feel that the world is uncertain and unpredictable. Their relationships can be characterized by problems with boundaries as well as distrust and suspiciousness. As a result, traumatized children can become socially isolated and have difficulty relating to and empathizing with others.
- **Biology.** Traumatized children demonstrate biologically based challenges, including problems with movement and sensation, hypersensitivity to physical contact, and insensitivity to pain. They can have problems with coordination, balance, and body tone, as well as unexplained physical symptoms and increased medical problems (e.g., asthma, skin problems, and autoimmune disorders).
- **Mood regulation.** Children exposed to trauma can have difficulty regulating their emotions as well as difficulty knowing and describing their feelings and internal states. They may struggle to communicate their wishes and desires to others.
- **Dissociation.** Some traumatized children experience a feeling of detachment or depersonalization, as if they are “observing” something happening to them that is unreal. They can also demonstrate amnesia-like states.
- **Behavioral control.** Traumatized children can demonstrate poor impulse control, self-destructive behavior, and aggression towards others. Sleep disturbances and eating disorders can also be manifestations of child traumatic stress.

- **Cognition.** Children exposed to trauma can have problems focusing on and completing tasks in school as well as difficulty planning for and anticipating future events. They sometimes have difficulty understanding their own contribution to what happens to them. Some traumatized children demonstrate learning difficulties and problems with language development.
- **Self-concept.** Traumatized children can experience a lack of a continuous, predictable sense of self. They can suffer from disturbances of body image, low self-esteem, shame, and guilt.

Children involved with the child welfare system are likely to have experienced both acute and chronic trauma, in environments characterized by adversity and deprivation, and often without the mitigating influence of consistent and supportive caregivers. It is important for child welfare workers to recognize the complexity of a child's lifetime trauma history and to not focus solely on the single event that might have precipitated a report. In general, children who have been exposed to repeated stressful events within an environment of abuse and neglect are more vulnerable to experiencing traumatic stress.

# The Incidence and Impact of Trauma on Children in the Child Welfare System

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## Prevalence of Traumatic Stress Among Children in the Child Welfare System

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

- Poverty
- Racism and other forms of discrimination
- Separations and frequent moves
- School problems
- Grief and loss
- Refugee or immigrant experiences

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

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

## The Impact of Traumatic Stress on Children's Sense of Safety, Permanency, and Well-Being

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

**Safety.** Traumatic stress can adversely impact the child's ability to protect himself or herself from abuse, or for the agency to do so, in numerous ways, including:

- The child's inability to regulate moods and behavior may overwhelm or anger caregivers to the point of increased risk of abuse or revictimization.
- The impact of trauma may impair a child's ability to describe the traumatic events in the detail needed by investigators.
- The child's lack of trust may lead to the child's providing investigators or the courts with incomplete or inaccurate information about abuse experienced or witnessed.
- Traumatic reactions may dull the child's emotions in ways that make some investigators skeptical of the veracity of the child's statements.
- The child's altered world view may lead to behaviors that are self-destructive or dangerous, including premature sexual activities.

**Permanency.** The child's reaction to traumatic stress can adversely impact the child's stability in placements, for example:

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

**Well-being.** Traumatic stress may have both short- and long-term consequences for the child's mental health, physical health, and life trajectory, including:

- The child's traumatic exposure may have produced cognitive effects or deficits that interfere with the child's ability to learn, progress in school, and succeed in the classroom and the community (and later in the workplace).
- The child's inability to regulate emotions may interfere with his or her ability to function in a family, a traditional classroom, and/or with peers in the community.
- The child's mistaken feelings of guilt and self-blame for the negative events in his or her life may lead to a sense of hopelessness that impairs his or her ability and motivation to succeed in social and educational settings.
- A child's traumatic experiences may alter his or her worldview so that the child now sees the world as untrustworthy and isolates himself or herself from family, peers, and social and emotional support.

### **Long-term Outcomes in Children Who Have Experienced Traumatic Stress**

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

- A national study of adult "foster care alumni" found higher rates of PTSD (21.5%) compared with the general population (4.5%). Interestingly, the foster care alumni group had higher rates of PTSD than American veterans of war (15% in Vietnam vets, 6% in Afghanistan vets, and 12% to 13% in Iraq vets). The foster care alumni group also had higher rates of major depressive episodes, social phobia, panic disorder, generalized anxiety, addiction, and bulimia (Pecora et al., 2003).
- By age 21, nearly 80% of abused children face at least one mental health challenge, including depression, suicide attempts, and eating disorders (Association of State and Territorial Health Officials, 2005).
- Adults who experienced multiple adverse childhood experiences, including child maltreatment, are more likely to develop health-risk behaviors such as alcoholism, drug abuse, depression, suicide attempts, smoking, physical inactivity, severe obesity, having more than 50 sexual partners, and contracting sexually transmitted

disease. The number of adverse childhood experiences showed a graded relationship to the presence of adult diseases including heart disease, cancer, chronic lung disease, skeletal fractures, and liver disease (Felitti et al., 1998).

### ***What can a child welfare worker do?***

- Recognize that exposure to trauma is the rule, not the exception, among children known to the child welfare system.
- Don't underestimate the impact of witnessing violence, including witnessing the abuse of a sibling or caregiver.
- Consider that many children bring a lifetime history of trauma, including acute and chronic situations, in addition to the event that precipitated the most recent report.
- Gather and document psychosocial information regarding all traumas in the child's life. This history has likely had an impact on the child's response to the current events and will be important information for any mental health professional to whom the child is referred for treatment.

## **The Impact of Traumatic Stress on Behavior**

Traumatized children encountered in the child welfare system exhibit a range of complex emotional and behavioral responses to the events they have experienced. When working with these children, it is important to be sensitive to the ways in which trauma history affects current behavior.

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

A trauma reminder is any person, place, situation, sensation, feeling, or thing that reminds a child of a traumatic event. When faced with these reminders, a child may reexperience the intense and disturbing feelings tied to the original trauma. These trauma reminders can

lead to behaviors that seem out of place in the current situation but were appropriate—and perhaps even helpful—at the time of the original traumatic event. For example:

- A seven-year-old boy whose father and brother fought physically in front of him becomes frantic and tries to separate classmates playfully wrestling on the schoolyard.
- A three-year-old girl who witnessed her father beating her mother clings to her resource mother and cries hysterically when her resource parents have a mild dispute in front of her.
- An eight-year-old boy whose father physically abused him is tapped on the shoulder by a boy behind him in line and responds by turning and raising his fists.
- A teenager who was sexually abused by her stepfather refuses to go to gym class after meeting the new coach, who wears the same cologne as her stepfather.

When faced with a trauma reminder, children with a history of trauma may feel frightened, angry, or shut down. Their hearts may pound or they may freeze in their tracks, just as one might do when confronting an immediate danger.

Sometimes children are aware of their reaction and its connection to the traumatic situation. But often they are unaware of the root cause of their own feelings and behaviors. They may also exhibit increased behavior problems as a way of coping with deficits in self-control. For instance, in the absence of more mature coping strategies, traumatized children and adolescents may use drugs and alcohol in order to avoid experiencing overwhelming emotions. Similarly, in the absence of knowledge of how to negotiate interpersonal relationships, sexually abused children may revert to sexual behaviors with others because that is the only way they have ever experienced any degree of acceptance or intimacy.

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

Neglect, in particular, has been associated with the following emotional and behavioral responses, notably (Hildyard & Wolfe 2002):

- Lack of self-worth and efficacy

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

Children who have been traumatized through maltreatment within their caregiving system can present a complicated array of behaviors. Some common responses reported by child welfare workers and foster parents include (Kerker & Dore, 2006):

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

All of these factors may endanger a placement when the acting out or detachment reaches a point where a foster parent or other caregiver feels he or she is not successfully parenting a very troubled child.

## **The Impact of Traumatic Stress on Brain Development**

To understand how trauma affects children, it is important to adopt a developmental perspective. When a child is exposed to trauma, a great amount of emotional and mental energy is expended to respond to, cope with, and come to terms with the event. This may reduce the child's capacity to explore the environment and master other age-appropriate developmental tasks. A child whose mind is occupied with intrusive images of traumatic events cannot learn, and so lags behind in school. A child who is trying to cope with frequent reactions to trauma reminders cannot devote his or her energies fully to forming relationships with peers. A child who is fearful of taking any risk cannot take on the challenges that would lead to growth. The longer traumatic stress goes untreated, the further children tend to stray from appropriate developmental pathways.

Recent research indicates that trauma early in life can have serious consequences for the normal development of children’s brains, brain chemistry, and nervous system. These changes can place them at risk for learning difficulties, drug abuse, teen pregnancy, risk-taking behavior, and psychiatric and health problems later in life.

In early childhood, trauma can be associated with reduced size of the cortex, the ability of brain hemispheres to connect (“cross-talk”), and the functioning of regions of the brain that govern emotions. These changes can affect IQ and the use of thinking to regulate emotions, and can lead to increased fearfulness and a reduced sense of safety and protection.

During school-age years, the brain develops more ability to manage fears, anxieties, and aggression, to sustain attention for learning, to allow for better impulse control, and to manage physical responses to danger that allow children to consider and take protective actions. Trauma that occurs during this period can undermine these developing capacities of the brain and result in major sleep disturbances, new troubles in learning, difficulties in controlling startle reactions, and behavior that alternates between being overly fearful and overly aggressive.

Throughout adolescence, the maturing brain permits improved consideration of the consequences of behavior, more realistic appraisals of danger and safety, enhanced ability to govern daily behavior to meet longer-term goals, and increased use of abstract thinking for academic learning and problem-solving. Trauma, by interfering in this stage of brain development, can result in reckless and risk-taking behavior, in “living for today and not tomorrow,” in underachievement and school failure, and in making bad choices. Because children and adolescents may experience traumatic stress across several developmental stages, they may have a combination of these behaviors.

The brain also controls stress hormones in the body, an important set of hormones that help us deal with danger. Traumatized children and adolescents show changes in the levels of these stress hormones like those found among combat veterans. A concern is that these changes may affect the way traumatized children and adolescents respond to future stress in their lives and may influence their long-term health (Pynoos et al., 1997).

## **Cultural Influences on Perceptions of and Responses to Traumatic Events**

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

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

Many children who enter the child welfare system are from cultural groups that experience prejudice, discrimination, negative stereotyping, poverty, and high rates of exposure to community violence. It is important to understand that such social and cultural realities can influence children’s risk for, and experience of, trauma. The responses and resilience of children, families, and their communities to child traumatic stress are also affected by their respective socioeconomic and cultural realities.

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

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

Also, it is important to understand that if a child enters the child welfare system and is a member of a cultural group that experiences prejudice, discrimination, or negative stereotypes, he or she needs a foster or adoptive family that understands the importance of embracing the child’s racial/cultural origins. Families with specialized knowledge, resources, skills, and capacities are needed to help children address the losses of racial, cultural, and family of origin identity, and to cope with social and familial acceptance of birth status and racial origin. Whenever possible, the child’s feelings and/or perceptions about living with a family of a different race or culture (either temporarily or permanently) should be considered along with the impact of those feelings on the understanding and experience of the traumatic event.

## Signs and Symptoms of Child Traumatic Stress by Developmental Stage

### ***Young children***

In response to trauma, young children may become passive, quiet, and easily alarmed. They can become more generally fearful, especially in regard to separations and new situations. In circumstances of abuse by a parent or caretaker, the young child may act confused as to where to find protection and what constitutes threat. A child may react to very general reminders, like the sounds of another child crying. The effects of fear can quickly get in the way of recent learning. For example, a child may start wetting the bed again or go back to baby talk following a traumatic event or traumatic reminder. The preschool child may have very strong startle reactions, night terrors, and aggressive outbursts.

### ***School-age children***

The responses of school-age children include their experiencing a wider range of unwanted and intrusive thoughts and images. School-age children think about frightening moments that occurred during their traumatic experiences. They also go over in their minds what could have stopped the event from happening and what could have made it turn out differently. They can have thoughts of revenge that they cannot resolve. School-age children respond to very concrete reminders (e.g., someone with the same hairstyle as an abuser, or the monkey bars on a playground where a child got shot), and are likely to develop intense, specific new fears that link back to the original danger. They can easily have “fears of recurrence” that result in their avoiding even enjoyable activities they would like to do. More than any other group, school-age children may shift between shy or withdrawn behavior and unusually aggressive behavior. Normal sleep patterns can be disturbed, and their lack of restful sleep can interfere with daytime concentration and attention.

### ***Adolescents***

Adolescents are particularly challenged by their traumatic stress reactions. They may interpret their reactions as childish or as signs of “going crazy,” being weak, or being different from everyone else. They may be embarrassed by bouts of fear and exaggerated physical responses. They may believe that they are unique in their pain and suffering, resulting in a sense of personal isolation. Adolescents are also very sensitive to the failure of family, school, or community to protect them or to carry out justice. After a traumatic event, they may turn even more to peers to evaluate risks and to support and protect them. Adolescent behavior in response to traumatic reminders can go to either of two extremes: reckless behavior that endangers themselves (such as self-cutting) and others, or extreme avoidant behavior that can derail their adolescent years. Adolescents may attempt to avoid overwhelming emotions and physical responses through the use of alcohol and drugs. Late-night studying, television watching, and partying can mask an underlying sleep disturbance.

## Implications for Child Welfare Practice

Child welfare system interventions intended to protect children have the potential to either exacerbate or decrease the impact of previous traumatic experiences. Traumatized children are extremely vulnerable to stress, and some lack the ability to cope with even minor everyday changes and stressors. In fact, many traumatized children have unexpected and exaggerated responses even when simply being told “no.” Yet children in the child welfare system must not only face everyday minor stressors but also endure a wide range of ongoing and frequently significant stressors, such as:

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

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

Developing trust with children through listening, frequent contacts, and honesty can mitigate previous traumatic stress for children. On the other hand, repeated interviewing of traumatized children, especially about experiences of sexual abuse, and unfulfilled professional promises are likely to increase traumatization (Henry, 1997). As the child goes through the child welfare system, the child welfare worker has a unique opportunity to help serve as a protective and stress-reducing buffer for the child.

Traumatized children may also have social resources and coping abilities that can help to reduce the negative impact of traumatic events. Such protective factors include:

- Caregiver and social support
- Community involvement
- Others’ belief in and validation of the child’s experience
- Positive attachments and connections to emotionally supportive adults
- Positive relationships with peers

- Cognitive and emotional self-regulatory abilities
- Positive beliefs about oneself
- Positive disposition or temperament
- Blaming external factors, instead of internal factors or oneself, for problems
- Special talents and creativity
- Spiritual/religious beliefs
- Intelligence

When dealing with children who have experienced trauma, the trauma-informed child welfare worker understands the impact of trauma on a child’s behavior, development, relationships, and survival strategies and can integrate that understanding into planning for the child and family. The trauma-informed child welfare worker also understands his or her role in responding to child traumatic stress.

#### ***What can a child welfare worker do?***

- Recognize the signs and symptoms of child traumatic stress, and how they vary in different age groups.
- Recognize that children’s “bad” behavior is sometimes an adaptation to trauma.
- Understand the impact of trauma on different developmental domains—for example, that trauma can influence how children think and can even increase physical health problems.
- Appreciate the impact of cultural issues on how trauma is experienced and on the child’s and family’s response.

# The Essential Elements of Trauma-Informed Child Welfare Practice

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## Introduction

Child welfare is charged with integrating multiple systems in the child's life in order to create consistency. The Essential Elements described here provide a framework for trauma-informed child welfare practices that address the needs of children who have been maltreated and traumatized. While certain Essential Elements may be addressed by professionals in other systems, such as mental health or schools, it is the child welfare worker who coordinates with other systems to ensure that these elements are present.

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

The Essential Elements are consistent with "best practice" in child welfare, and some mirror well-established child welfare priorities such as maximizing safety. The Essential Elements do not require more time from child welfare workers, but rather a redirection of their time. For each element, three types of potential strategies are identified:

- **Child Welfare Tools:** Tools and strategies available as part of standard child welfare practice
- **Resources and Supports:** Additional resources available through referral or consultation with others
- **Practical Assistance:** Intervention strategies that can be employed to provide immediate and practical support to children and families

### ***The Essential Elements of Trauma-Informed Child Welfare Practice***

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 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 experiences and their impact on the child's development and behavior to guide services.
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.
9. Manage professional and personal stress.



## ESSENTIAL ELEMENT 1

### Maximize the child's sense of safety.

#### ***Why it's essential***

Traumatic stress overwhelms a child's sense of safety and can lead to a variety of survival strategies for coping. After traumatic events are over, a child may continue to experience insecurity, both physically and emotionally. A sense of safety is critical for physical and emotional growth and functioning, appetite, digestion, and sleep. Both physical and psychological safety are important, at home and within service settings. If children or their caregivers are still living in an unsafe setting, this needs to be addressed immediately. Workers also need to provide a psychologically safe setting for children and families while inquiring about emotionally painful and difficult experiences and symptoms. Workers must explain clearly the limits of confidentiality and how certain information must be shared with other appropriate authorities.

#### ***What you can do***

##### **Child Welfare Tools**

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

##### **Resources and Supports**

- Refer child for pediatric assessment with primary health provider.
- Refer family for parenting skills training or family therapy.

##### **Practical Assistance**

- Provide support and comfort—an "island of safety"—for the child.
- Listen to the child's worries and reassure with realistic information.
- Reestablish the child's sense that adults will be protective.
- Give *repeated* concrete clarifications about how the child will be kept safe.

- Give *repeated* clarifications about the processes and systems that are in place for a child’s safety.
- Avoid exposing the child and family to inaccurate or potentially re-traumatizing information.
- Describe in advance to the child and caregivers how the child will interact with child placement and/or legal systems.
- Describe the child welfare worker’s role as a guide and a buffer for the child as he or she enters new situations.

## 2

### ESSENTIAL ELEMENT 2

#### Assist children in reducing overwhelming emotion.

#### ***Why it’s essential***

Trauma can result in such intense fear, anger, shame, and helplessness that the child feels overwhelmed by his or her emotions. This overwhelming emotion may delay the development of age-appropriate self-regulation. Emotions experienced prior to language development may be very real for the child but difficult to express or communicate verbally. Trauma may be “stored” in the body in the form of physical tension or health complaints.

#### ***What you can do***

##### **Child Welfare Tools**

- Continually monitor the child’s perception of risk.
- Share the child’s traumatic experiences and anticipated responses as appropriate with foster placement providers.
- Seek level of placement appropriate to child’s level of distress and risk.

##### **Resources and Supports**

- Refer to psychotherapy to help the child manage overwhelming emotions and build competencies and strengths.
- Refer child to appropriate skill-building groups (e.g., anger management, self-regulation) if available.
- Request medication assessment and/or psychiatric evaluation.
- Recommend parenting skills training to strengthen caregivers’ ability to handle children’s emotions.

### **Practical Assistance**

- Help the child identify and label his or her emotions.
- Let the child know that his or her emotions are normal and understandable.
- Help children avoid reminders that can result in overwhelming emotions. With older children, help them understand the links between trauma reminders and the overwhelming emotions they may experience.
- Provide basic information to children and caregivers on ways of coping with strong emotions, such as relaxation and physical exercise.
- Empower caregivers by supporting their capacity to calm and reassure children.

## **3**

### **ESSENTIAL ELEMENT 3**

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

#### ***Why it's essential***

Child trauma can result in serious misunderstandings about safety, personal responsibility, and self-concept. It can disorganize and distort the connections between thoughts, feelings, and behaviors, and can disrupt the encoding and processing of memory. Traumatic experiences may be difficult for children to communicate, thereby undermining their confidence and the social support they might receive from others. School-age and older children need to do more than just recall or repetitively replay trauma details; they need help developing a coherent understanding of their traumatic experience. The child needs to feel safe enough to face emotional experiences, begin to make sense out of what happened to him/her, and express this to others.

#### ***What you can do***

##### **Child Welfare Tools**

- Clarify with caregivers the child maltreatment issues that brought the child welfare and/or legal systems into their lives.
- Listen to and acknowledge the child's traumatic experience.
- Gather a good trauma history from the parents and the child.
- Support the child in the development of a Life Book (i.e., a book of stories and memories about the child's life).

## **Resources and Supports**

- Refer the child to trauma-specific mental health services.
- Recommend trauma-focused therapies for the child and family that are evidence-based.
- Require that mental health providers include current caregivers in treatment and educate them about the impact of trauma on child behaviors and behavior management.
- Consider therapy with a “trauma narrative” component for school-aged children and adolescents.
- Provide the therapist with a complete trauma history.

## **Practical Assistance**

- Actively listen to the child’s expression of his/her “story.”
- As appropriate, provide the child with information about events that led to child welfare involvement in order to help the child correct distortions and reduce self-blame.

# 4

## **ESSENTIAL ELEMENT 4**

### **Address the impact of trauma and subsequent changes in the child’s behavior, development, and relationships.**

#### ***Why it’s essential***

Traumatic events can affect many aspects of the child’s life beyond the initial trauma response and may create new or secondary problems. These effects may be adaptive in the short term but can, in the long term, become counterproductive and interfere with a child’s recovery. These effects can include difficulties in school and relationships, or health-related problems (e.g., weight gain) and substance abuse. Other consequences of trauma—or *secondary adversities*—can also include changes in the family system precipitated by a traumatic event. It may be important to address these issues along with, or before, trauma-focused treatment. Problems in these areas may be so extreme, pronounced, or troublesome that they mask other underlying traumatic stress symptoms.

#### ***What you can do***

#### **Child Welfare Tools**

- Provide leadership to the team of care providers working with the child and family to provide integrated, trauma-informed care.

- Help caregivers and other professionals involved with the child to understand the trauma issues that may be underlying more visible behavior problems.

### **Resources and Supports**

- Refer for more comprehensive assessment if needed.
- Consider intensive behavioral intervention such as Parent-Child Interaction Therapy (PCIT) or Child-Parent Psychotherapy (CPP).
- Partner with parents and caregivers to quickly address consequences of trauma/secondary adversities that may interfere with or undermine trauma recovery.
- Refer to health, mental health, and education providers to respond to the secondary effects of trauma.

### **Practical Assistance**

- Remind caregivers and other care providers that visible behavior problems can be a symptom of trauma rather than a sign of “bad” character. This does not relieve children from responsibility for their behavior but may support more constructive choices.
- Offer alternative coping strategies that are more adaptive.
- Encourage the child and family to work with other providers to address the secondary impact of trauma on behavior, development, and relationships.



## **ESSENTIAL ELEMENT 5** **Coordinate services with other agencies.**

### ***Why it's essential***

Traumatized children and their families are often involved with multiple service systems including law enforcement, child welfare, the courts, schools, primary care, and mental health. Service providers working with traumatized children should endeavor to develop common protocols and frameworks for documenting trauma history, exchanging information, coordinating assessments, and planning and delivering care. In contrast to a fragmented approach, cross-system coordination views the child as a whole person. When different systems have many different and potentially competing priorities, there is risk that children and their families will receive mixed or confusing messages—or simply fall through the cracks.

## ***What you can do***

### **Child Welfare Tools**

- Establish interagency coordination agreements.
- Establish and work with interagency, multidisciplinary teams.

### **Resources and Supports**

- Develop relationships with health and mental health providers and enlist them as trauma-informed team members in care plans for children and families.
- Communicate frequently with team members.

### **Practical Assistance**

- Develop a trauma-informed “common language” and shared framework regarding child traumatic stress.
- Promote continuity in helping relationships for the child and family.



## **ESSENTIAL ELEMENT 6**

**Utilize comprehensive assessment of the child’s trauma experiences and their impact on the child’s development and behavior to guide services.**

### ***Why it’s essential***

Millions of children experience some sort of trauma every year. Short-term effects might include behavioral difficulties or emotional and health problems. Long-term effects might include depression, anxiety disorders, PTSD, delinquency, substance abuse, and relationship problems. Trauma-specific standardized clinical measures identify the types and severity of symptoms the child is experiencing. A thorough assessment identifies potential risk behaviors (i.e., danger to self, danger to others) and aims to determine interventions that will ultimately reduce risk. Assessment also tells us why a child may be reacting in a particular way and the behavior’s connection to his/her experiences of trauma. Proper assessment provides a basis for the development of treatment goals with measurable objectives designed to reduce the negative effects of trauma.

## ***What you can do***

### **Child Welfare Tools**

- Be aware of the child’s full trauma history (e.g., child abuse, automobile accidents, exposure to family or community violence, painful medical procedures, or other types of traumatic experiences) and trauma reminders.

- Share important elements of the child’s trauma history and reminders with the child’s caregiver and therapist.
- Utilize other available resources to gain a full picture of a child’s experiences and trauma symptoms. If necessary, review the child’s records, conduct collateral interviews with other individuals in the child’s life, and, when appropriate, interview the child.
- Utilize tools such as the *Child Welfare Trauma Referral Tool* (Taylor, Steinberg & Wilson, 2006) to determine if the child needs a referral to trauma-specific mental health treatment.

### **Resources and Supports**

- Refer the child to a trauma-informed mental health provider who is knowledgeable about assessment instruments appropriate for assessing trauma (see last section, “Putting It Together: Working with Providers Who Deliver Trauma-Informed Care”).
- Interview therapists or agencies to determine which ones have the best preparation to deliver therapy to traumatized children.
- Request assessments regarding the child’s progress in therapy and trauma-related symptoms on a periodic basis, such as every three months.

### **Practical Assistance**

- Identify immediate needs and concerns.
- Gather enough additional information so that you can tailor and prioritize your interventions for specific individuals and their identified needs and concerns.
- Identify available social support within the community, including friends and family as well as community agencies with experience treating trauma.

# 7

## ESSENTIAL ELEMENT 7

### Support and promote positive and stable relationships in the life of the child.

#### ***Why it's essential***

Children form and maintain relationships to important figures in their lives through bonding and attachment. Being separated from an attachment figure, particularly under traumatic and uncertain circumstances, can be very stressful for a child. Within the child welfare system, the risk of separation from parents, siblings, and other important figures in a child's life is common (i.e., removal from home, multiple foster home placements, changes in school and/or community). Establishing permanency for children in the child welfare system is critical if children are to form and maintain positive attachments. Child welfare workers can play a huge role in encouraging and promoting the positive relationships in a child's life and minimizing the extent to which these relationships are disrupted by constant changes in placement. If a parent or caregiver is not available following a traumatic event, it is important for child welfare workers to understand that it may be necessary to engage other familiar and positive figures, such as teachers, neighbors, siblings, and/or relatives, to help provide comfort and consistency for the child. Depending on the age of a child, friends may also play an important role in supporting a child who has been exposed to trauma. Promoting these positive relationships is a child welfare best practice and is also critical to a child's sense of safety and well-being, particularly during a stressful time.

#### ***What you can do***

##### **Child Welfare Tools**

- If a child must be removed from the family either temporarily or permanently, try to place him or her with a family member or someone the child knows.
- In an effort to promote permanency, try to limit the number of placements a child must make (i.e., foster homes) as well as other changes (e.g., community, school).
- If removal is necessary, try to maintain existing positive relationships in the child's life (e.g., teachers, friends, siblings).
- Understand the child welfare worker's role as a potential attachment figure and if possible, try to minimize changes in caseworkers.

##### **Resources and Supports**

- Identify and promote positive adult relationships in the life of the child.
- Promote positive sibling relationships in the life of the child.

- Ensure consistent contact with supportive adults, especially when a parent or caregiver is not available.
- Encourage familiar and supportive adults to provide respite care for the child.
- Identify and encourage both new and existing positive friendships, especially for older children (e.g., childhood friends, mentors, a “Big Brother” or “Big Sister”).
- Encourage and support the child in his or her attempts to preserve memories of important relationships and connections (e.g., photos, Life Book, etc.).

### **Practical Assistance**

- Encourage contact with teachers, close friends, mental health professionals, and other supportive individuals in the child’s life.
- Include a child’s teacher, important family friend, religious/spiritual counselor, mental health counselor, etc., in discussions about what will be best for the child.
- Don’t make promises you can’t keep to the child (i.e., do not promise a child that he or she will be placed with a sibling or will be going back home when the situation is uncertain).
- Be careful when making statements of judgment, understanding that children may have mixed feelings and strong loyalties toward an offending parent or caregiver.
- Communicate with caregivers and other professionals about what to expect and what is “normal” for children who have gone through similar experiences.
- Help foster parents develop a trauma framework to better understand the child’s needs and reactions and to increase the likelihood of successful placement.
- Be aware of the child’s stress responses and seek to understand trauma reminders to better inform decisions about placement, visitation, and permanency.



## ESSENTIAL ELEMENT 8

### Provide support and guidance to the child's family and caregivers.

#### ***Why it's essential***

Children experience their world in the context of family relationships. Parents, kin, and other caregivers are the full-time and long-term supports for their children, and they will typically be involved in the child's life longer than will the child welfare or mental health professional. In many cases, the family system is experiencing traumatic stress along with the child. Promoting resilience and improving coping skills among family members helps them to deal with traumatic events and also prepares them for future challenges. Finally, family members are critical participants in service planning and delivery within systems of care.

Resource families have some of the most challenging and emotionally draining roles in the entire child welfare system. They must be prepared to welcome a new child into their home at any hour of the day or night, manage a wide array of emotions and behaviors, and cope with agency regulations, policies, and paperwork. They are also expected to provide mentoring support and aid to birth families while at the same time attaching to the children and youth in their care. They must prepare simultaneously for the child's reunification with his/her family or for the possibility of making a lifelong commitment to the child through adoption or legal custodianship.

Relatives caring for children and youth face many of the same challenges that other resource parents face and several that are unique. Unlike foster families who are not related to the young people they care for, relatives may not have been seeking this role at this time in their lives. However, they have stepped up to the challenge in order to be there in a time of need or crisis in their family. Thus, they are often dealing with their own conflicting emotions and experiences of trauma and crisis. Meeting the needs of the children they love, responding to the requirements of the agency and courts, and sorting out their own feelings about the children's parents and the situation that brought them to their home can be overwhelming at times.

#### ***What you can do***

##### **Child Welfare Tools**

- Address concrete needs in the family.
- Assess and integrate extended family, church, and community supports into a service plan for the family when appropriate.
- Utilize community-based family preservation services if available and appropriate.

- Help the family follow through in setting appointments and obtaining needed services, as appropriate.
- Provide the family with relevant information, in advance, about how the child will interact with the placement and legal systems.

### **Resources and Supports**

- Refer the family for mental health services, substance abuse treatment, and parenting skills training as needed.
- Make referrals sequentially so the family can access services as they are ready to receive them.

### **Practical Assistance**

- Empower families to set goals for themselves.
- Connect families to other families for mutual support.
- Help identify and build on existing supportive structures:
  - Give foster parents and caregivers information about a child's trauma history, enabling them to anticipate trauma reminders for the child and to advocate for appropriate services.
  - Increase the availability of respite services for foster and adoptive parents and provide timely intervention to prevent placement breakdown.
  - Provide training and regular support meetings to foster parents and other caregivers of traumatized children that emphasize the child's ability to recover and heal.
- Assist parents and caregivers who have secondary adversities and traumatic experiences of their own. Studies indicate that parents who cope well with adversities and their own reactions to trauma are better able to care for their children and can also assist with their children's coping strategies.
- Recognize the influence of a family's culture and incorporate culturally sensitive practices into the services offered to the family.



## **ESSENTIAL ELEMENT 9**

### **Manage professional and personal stress.**

#### ***Why it's essential***

Child welfare is a high-risk profession, and child welfare workers are confronted every day—both directly and indirectly—with danger and trauma. Threats may come in from violent or angry family members. On top of this, hearing about the victimization and abuse of children can be very disturbing for the empathetic child welfare worker and can result in feelings of helplessness, anger, and hopelessness. Those who are parents themselves or who have their own histories of childhood trauma might be at particular risk for the negative effects of secondary traumatic stress. Some professionals struggle with maintaining appropriate boundaries and with a sense of overwhelming personal responsibility. These challenges can be intensified in resource-strapped agencies where there is little professional or personal support available. It is critical to address professional or personal stress because, if left unaddressed, it can result in burnout and undermine work performance, to the detriment of the children and families served. Signs of burnout might include avoidance of certain clients, missed appointments, tardiness, and lack of motivation.

Awareness and a plan that provides positive coping strategies are critical to preventing the potential risk of secondary traumatic stress to staff and to program success.

Child welfare workers must have a thorough understanding of the impact of trauma on the child victims and families served. They also need to have an understanding of the impact this trauma may have on them. Staff can be stressed by hearing detailed reports of trauma from children on a daily basis and from having to deal with the powerful emotional responses and the impact of abuse and violence on children. Dealing with a community system with limited resources that is not always responsive to the needs of these children can also be stressful to staff. The trauma suffered by these children can result in serious and chronic emotional and behavioral problems. Feeling frustrated when trying to deal with a complicated, often insensitive, system and experiencing the sense of “helplessness” when trying to heal these children make staff vulnerable to developing their own emotional and physical problems (Perry, 2003).

There have been multiple terms used to designate exposure to the trauma experienced in one's role as a helper. Four terms are most common: countertransference, compassion fatigue, vicarious traumatization, and secondary traumatic stress. All of these terms describe the risk that exposure to trauma has for staff and the therapeutic process. Just as with the children themselves, staff members who work with victims are at risk of experiencing

alterations in their thinking about their world, in their feelings, in their relationships, and in their lives.

### ***What you can do***

#### **Child Welfare Tools**

- Work with teams within the child welfare agency and within the provider community.
- Request and expect regular supervision and supportive consultation.
- Utilize peer support.
- Provide regular safety training for all workers.
- Balance workers' caseloads so they are not dealing only with traumatized children and their families.
- Provide sufficient release time and safe physical space for workers.
- Provide training on secondary trauma for all staff.

#### **Resources and Supports**

- Seek continuing education on the effects of trauma on child welfare professionals.
- Utilize agency resources such as Employee Assistance Programs for intermittent support if needed.
- Cultivate a workplace culture that normalizes (and does not stigmatize) getting help for mental health difficulties.
- Consider therapy for unresolved trauma that the child welfare work may be activating.

#### **Practical Assistance**

- Set realistic goals and expectations.
- Practice stress management through meditation, prayer, conscious relaxation, deep breathing, and exercise.
- Develop a written plan focused on work-life balance.

## **Putting It Together: Working with Providers Who Deliver Trauma-Informed Care**

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While there is no one treatment intervention that is appropriate for all children who have experienced trauma, there is a set of evidence-supported interventions that are appropriate for many children and that share many common elements of “trauma-informed therapy.” Unfortunately, many therapists treating traumatized children lack the awareness and training necessary to deliver these research-proven interventions. When a choice exists, the child welfare worker would be well advised to select the therapist who is most familiar with the available evidence and has the best training to treat the child’s symptoms.

### **The Importance of Trauma Assessment**

Not all children who have experienced trauma need trauma-specific interventions. Some children have amazing natural resilience and are able to integrate the trauma experience with the help of their natural support systems such as parents, caregivers, teachers, and others. Unfortunately, many children in the child welfare system lack those natural helping systems and have often been exposed to multiple traumas resulting in very complex problems. Some may meet the clinical criteria for a diagnosis of PTSD. Many more will not reach the range and levels of symptoms required for a full PTSD diagnosis but will still have significant posttraumatic symptoms (e.g., intrusive thoughts about the event, hyperarousal to trauma reminders) that can have a dramatic adverse impact on their behavior, judgment, educational performance, and ability to connect with caregivers. For these reasons, the child welfare system needs resources in the community to conduct “trauma assessments” to help determine which interventions will prove most beneficial for specific children.

A trauma assessment typically involves a detailed social history. This includes a thorough trauma history that identifies all forms of traumatic events experienced directly or witnessed by the child. A full trauma history includes each child abuse incident, any automobile accidents, exposure to family or community violence, painful medical procedures, or other types of traumatic experiences. This history is supplemented with the use of trauma-specific standardized clinical measures to assist in identifying the types and severity of symptoms that the child is experiencing. Any therapist to whom the worker is contemplating making a referral for a trauma assessment should be familiar with some common measures used in assessing trauma symptoms, such as the University of California-Los Angeles PTSD Index for DSM-IV (Pynoos, et al., 1998) or the Trauma Symptom Checklist for Children (Briere, 1996).

## Identifying Trauma-informed Providers

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

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

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

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

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

*Providers should mention specific interventions by name, such as Trauma-Focused Cognitive Behavioral Therapy (TF-CBT), Child-Parent Psychotherapy (CPP), Cognitive-Behavioral Intervention for Treatment in Schools (CBITS), or Parent-Child Interaction Therapy (PCIT). A listing of evidence-based and promising intervention models for child trauma appears on the web site of the National Child Traumatic Stress Network, at [www.NCTSN.org](http://www.NCTSN.org). If providers cite treatment models with which you are unfamiliar, ask them for the research that supports their effectiveness.*

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

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

- **Building a strong therapeutic relationship.** Like most forms of therapy, trauma treatment requires the skillful development of a clinical relationship with the child and caregivers.

- ***Psycho-education about normal responses to trauma.*** Most trauma-informed therapy includes a component that helps the child and caregivers understand normal human reactions to trauma.
- ***Parent support, conjoint therapy, or parent training.*** Caregivers are typically powerful mediators of the child’s treatment and recovery. Involving the parent, resource parent, or other caregiver is a vital element of trauma treatment. Some trauma-informed interventions include a parenting component to give the parent greater mastery of child management skills.
- ***Emotional expression and regulation skills.*** Helping the child to identify and express powerful emotions related to the trauma and to regulate or control their emotions and behavior is an important element of trauma-informed therapy.
- ***Anxiety management and relaxation skills.*** To help with emotional regulation, it is typically necessary to teach the child (and sometimes the caregiver) practical skills and tools for gaining mastery of the overwhelming emotions often associated with trauma and its reminders.
- ***Cognitive processing or reframing.*** Many children form destructive misunderstandings in the aftermath of the trauma. They may assume a great deal of self-blame for the events or blame someone else for not protecting them even though doing so may have been beyond their capacity. They may associate unrelated events to the trauma and draw irrational causal relationships. Therapy often helps correct these misattributions.
- ***Construction of a coherent trauma narrative.*** Successful trauma treatment often includes building the child’s capacity to talk about what happened in ways that do not produce overwhelming emotions and that make sense of the experience. Many non-trauma-informed therapists are uncomfortable with this aspect of treatment, which sometimes involves gradual exposure to traumatic reminders while using newly acquired anxiety management skills.
- ***Strategies that allow exposure to traumatic memories and feelings in tolerable doses so that they can be mastered and integrated into the child’s experience.*** Treatment often encourages the gradual exposure to harmless trauma reminders in the child’s environment (e.g., basement, darkness, school) so the child learns to control emotional reactions to these reminders and to differentiate the new experiences from the old.

- ***Personal safety training and other empowerment activities.*** Trauma may leave children feeling vulnerable and at risk. Trauma treatment often includes strategies that build upon children's strengths. It teaches them strategies that give them a sense of control over events and risks.
- ***Resiliency and closure.*** The treatment often ends on a positive, empowering note, giving the child a sense of satisfaction and closure as well as increased competency and hope for the future.

## Conclusion

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A significant number of children in the child welfare system have been exposed to trauma. For child welfare workers, the ability to recognize and be sensitive to the effects of trauma on a child's behavior, development, and relationships is critical.

In this guide, we have furnished a general overview of child traumatic stress, outlined the Essential Elements of trauma-informed child welfare practice, and provided practical strategies that child welfare workers can use when they encounter children in the system who have experienced trauma.

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

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## Appendix A: Additional Reading and Resources

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## **Web Sites**

National Child Trauma Stress Network: [www.nctsn.org](http://www.nctsn.org)

California Evidence-Based Clearinghouse for Child Welfare: [www.cachildwelfareclearinghouse.org](http://www.cachildwelfareclearinghouse.org)

Child Trauma Academy: [www.childtrauma.org](http://www.childtrauma.org)

International Society for Traumatic Stress Studies: [www.istss.org](http://www.istss.org)

National Center for PTSD: <http://www.ncptsd.va.gov/ncmain/index.jsp>

Sidran Institute: Traumatic Stress Education & Advocacy: [www.sidran.org](http://www.sidran.org)

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