Common Core 3.0

Trauma-informed Practice

Trainee Guide

December 31, 2018

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Introduction to Common Core

California's Common Core Curricula for Child Welfare Workers is the result of the invaluable work and guidance of a great many people throughout the child welfare system in California and across the country. It would be impossible to list all of the individuals who contributed, but some groups of people will be acknowledged here.

The Content Development Oversight Group (CDOG) a subcommittee of the Statewide Training and Education Committee (STEC) provided overall guidance for the development of the curricula. Convened by the California Social Work Education Center (CalSWEC) and the California Department of Social Services (CDSS), CDOG membership includes representatives from the Regional Training Academies (RTAs), the University Consortium for Children and families in Los Angeles (UCCF), and Los Angeles County Department of Children and Family Services.

In addition to CDOG, a Common Core 3.0 subcommittee comprised of representatives from the RTAs, the Resource Center for Family Focused Practice, and counties provided oversight and approval for the curriculum development process.

Along the way, many other people provided their insight and hard work, attending pilots of the trainings, reviewing sections of curricula, or providing other assistance.

California's child welfare system greatly benefits from this collaborative endeavor, which helps our workforce meet the needs of the state's children and families.

In compliance with the Indian Child Welfare Act (1978) and the California Practice Model, social workers must identify American Indian/Alaska Native children in the system. For an overview of *Implementing the Indian Child Welfare Act* view: https://www.youtube.com/watch?v=BIQG65KFKGs

The curriculum is developed with public funds and is intended for public use. For information on use and citation of the curriculum, please refer to:
https://calswec.berkeley.edu/sites/default/files/citation_guideline_6-2018.pdf

FOR MORE INFORMATION on California's Core Curricula, as well as the latest version of this curriculum, please visit the California Social Work Education Center (CalSWEC) website: http://calswec.berkeley.edu

Curriculum Introduction

This curriculum is designed to provide an overview of trauma-informed practices in child welfare. Trainees will have an opportunity to learn more about the basic terms, definitions, and concepts related to trauma-informed practice. Children and adults who are impacted by trauma may have life-long consequences if there is not an appropriate intervention. Trainees will learn skills to identify and address trauma responses in the children, youth, and adults involved in the child welfare system. Additionally, trainees will be provided with resources and tools to help manage secondary traumatic stress and compassion fatigue, with a focus on self-care.

area for notes, if desired

Agenda

Welcome, Review of the Agenda and Learning Objectives	9:00 – 9:30 am
Trauma Basics	9:30 – 10:30 am
BREAK	10:30 – 10:45 am
Trauma Basics (cont'd)	10:45 – 12:00 pm
LUNCH	*12:00 – 1:00 PM*
Adverse Childhood Experiences	1:00 – 1:50 pm
Historical Trauma and Culture	1:50 – 2:20 pm
BREAK	*2:20 – 2:35 pm*
Child Welfare's Response to Trauma	2:35 – 2:50 pm
Self-Care	2:50 – 3:15 pm
Post-Test	3:15 – 3:45 pm
Wrap-up	3:45 – 4:00 pm

Learning Objectives

Knowledge

K1. The trainee will be able to describe the relationship between a person's culture, experiences of individual, familial and/or historic trauma, and his or her behaviors or responses.

K2. The trainee will be able to identify behaviors of children and parents in response to trauma or trauma triggers and ways to support positive adjustment.

K3. The trainee will be able to describe how child traumatic stress is exacerbated by ongoing stressors in a child's environment and within the child welfare system.

K4. The trainee will be able to identify three things social workers can do to mitigate the impact of and heal trauma for children and families.

K5. The trainee will be able to describe the effect of personal trauma history and secondary traumatic stress on social workers and their responses to families and children.

Skills

S1. Using a case example, the trainee will be able to recognize, identify, and assess symptoms of traumatic stress within a developmental and cultural context.

S2. Using a case example, the trainee will be able to demonstrate three things social workers can do to mitigate the impact of and heal trauma for children and families

Values

V1. The trainee will value referring children with a trauma history for a thorough trauma assessment and specific trauma-related mental health services.

V2. The trainee will value working to prevent or mitigate the impact of traumatic stress by using trauma-informed responses.

V3. The trainee will value the different roles for social workers and mental health providers in providing trauma-informed services.

Helping Traumatized Children: A Guide for Caregivers

By Dr. Bruce Perry

ChildTrauma academy

Helping Traumatized Children

A Brief Overview for Caregivers

Bruce D. Perry, M.D., Ph.D.

This booklet is one in a series developed by the ChildTrauma Academy to assist parents, caregivers, teachers and various professionals working with maltreated and traumatized children.

Introduction

Each year in the United States approximately five million children experience some form of traumatic event. More than two million of these are victims of physical or sexual abuse. Millions more are living in the terrorizing atmosphere of domestic violence. Natural disasters, car accidents, life-threatening medical conditions, painful procedures, or exposure to community violence – all can have traumatic impact on the child. By the time a child reaches the age of eighteen, the probability that any child will have been touched directly by interpersonal or community violence is approximately one in three. Traumatic experiences can have a devastating impact on the child, altering their physical, emotional, cognitive and social development. In turn, the impact on the child has profound implications for their family, community and, ultimately, us all.

Traumatic events in childhood increase risk for a host of social (e.g., teenage pregnancy, adolescent drug abuse, school failure, victimization, anti-social behavior), neuropsychiatric (e.g., post-traumatic stress disorder, dissociative disorders, conduct disorders) and physical health problems (e.g., heart disease, asthma). The deterioration of public education, urban violence and the alarming social disintegration seen in some of our communities can be linked to the escalating cycles of abuse and neglect of our children.

For most children, thankfully, a traumatic event is a new experience. And like all new experiences, the unknown will add to the confusing and frightening circumstances surrounding this overwhelming experience. The trauma may significantly challenge the child's sense of the world. A flood, tornado, car accident, shooting or abuse by a caregiver - all challenge the child's beliefs about the stability and safety of their world. Very young children may not understand what happened and will be confused or even frightened by the reactions of their siblings or caregivers.

The acute post-traumatic period is characterized by an attempt by the child to reorganize, reevaluate and restore their pre-traumatic world. Many of the emotional, behavioral and cognitive signs and symptoms of the acute post-traumatic period are due to these efforts. Unfortunately, children often do not have the same capacity to understanding or explaining most traumatic experiences. Young children may make many false assumptions about the event – "the tornado came because God was mad."

As with most situations, children seek answers and comfort from adults around them, yet we often feel helpless in this role. Indeed, most traumatic experiences challenge the most mature and experienced adult. While adults do not have all the answers, they can help children better understand the traumatic event and the ways we respond following trauma.

This booklet addresses some of the key issues related to the child's complex set of reactions that often follow traumatic events. While focused on caregivers, this information may be helpful to caseworkers, teachers, other family and other adults working and living with traumatized children.

This simple guide is intended to inform and provide general principles -- it is not intended to be comprehensive or to exclude other observations or approaches to helping traumatized children. The more we understand these children and the impact of traumatic experiences, the more compassionate and wise we can be as we try to help these children.

Frequently Asked Questions

1. **Should I talk about the traumatic event?**

Do not be afraid to talk about the traumatic event. Children do not benefit from 'not thinking about it' or 'putting it out of their minds.' If a child senses that her caregivers are upset about the event, she will not bring it up. In the long run, this only makes the child's recovery more difficult. A good rule of thumb is to let the child guide when you talk about it. If the child doesn't ask about or mention it, don't bring it up on your own, but when the child brings it up or seems to be thinking about it (see below), don't avoid discussion. Listen to the child, answer questions, and provide comfort and support. We often have no adequate explanations about senseless death or traumatic events. It is just fine to tell children that you do not know why something happened or that you get confused and upset by it, too. In the end, listening and comforting a child without avoiding or over-reacting will have long-lasting positive effects on the child's ability to cope with trauma.

2. **How should I talk about the event?**

Use age-appropriate language and explanations. The timing and language used are important. Immediately following the trauma, the child will not be very capable of processing complex or abstract information (see Table). As the child gets further away from the event, she will be able to focus longer, digest more and make more sense of what has happened. Sometimes young children act as if they have not 'heard' anything you have said. It takes many individual many moments of sad clarity or the reality of the trauma to actually sink in for young children. Between these moments of harsh reality, children use a variety of coping techniques – some of which can be confusing or upsetting for adults.

During this long process, the child continues to 're-experience' the traumatic event. In play, drawing and words, the child may repeat, re-enact and re-live some elements of the traumatic loss. Surviving adults will hear children ask the same questions again and again. They may be asked to describe 'what happened' again and again. The child may develop profound 'empathic' concerns for others experiencing trauma, including cartoon characters and

animals. "Is Mickey Mouse scared?" Or as they put their stuffed animals under the bed, they may explain "They have to go hide because the bad guy is coming with a gun." The child will experience and process the very same material differently at different times following the trauma. In the long run, the opportunity to process and re-process many times will facilitate healthy coping. This re-processing may take place throughout the development of a given child. Even years after the original trauma, a child may 'revisit' the loss and struggle to understand it from their current developmental perspective. An intensity of emotional feelings will often be seen on various anniversary dates following the trauma (e.g., one week, one month and one year). Children may develop unusual fears of specific days – "Bad things happen on Fridays."

One of the most important elements in this process is that children of different ages have different styles of adapting and different abilities to understand abstract concepts often associated with trauma such as death, hate or the randomness of a tornado's path or a drunk driver hitting their car.

3. **Should I talk to others about the traumatic event?**

Yes. Inform adults and children in the child's world what has happened. Let teachers, counselors, parents of the child's friends and, if appropriate, the child's peers know some of the pain that this child is living with. Sometimes this can allow the people in the child's life to give them the small amount of tolerance, understanding or nurturing that will smooth the way. People can often be intolerant or insensitive when dealing with the traumatized child "Isn't it about time they got over this?" When you see that this is occurring don't be shy about taking this person aside and educating them about the long-lasting effects of traumatic events and the long process of recovery.

4. **How long to these reactions last?**

An acute post-traumatic change in feeling, thinking and behaving is normal – persistence or extreme symptoms are not. Many clinicians working with traumatized have noted that the persistence of symptoms beyond three months is associated with increased risk for problems. If symptoms of re-experiencing, avoidance, fearfulness, sleep problems, nightmares, sadness or poor school or social functioning persist beyond three months, they need to be addressed. If they persist for six months or if the symptoms interfere with any aspect of

functioning, you should have the child see a professional. If the child is in therapy, communicate this with the therapist. Find out if school performance has been affected. Watch for changes in patterns of play and loss of interest in activities. Be observant. Be patient. Be tolerant. Be sympathetic. These children have been terrified and hurt.

In many cases, some form of post-traumatic symptom can last for many years. Indeed, more than thirty percent of children living through traumatic stress develop some form of post-traumatic stress disorder (PTSD) . This is a chronic disorder requiring the attention of mental health professionals.

5. Do children understand events accurately?

Young children often make false assumptions about the causes of major events. Unfortunately these assumptions may include some sense that they were at fault for the event -- including the death of a loved one. Adults often assume that causality is clear -- dying in a car accident, being shot in a drive-by shooting, dying in a fire. The child may very easily distort an event and make the wrong conclusions about causality. Mom died in the car accident because she was coming to get me at school. The other driver was mad at her. My brother is dead because he was helping me with my homework. The person that shot my brother was shooting at me and hit my brother because he was in my room. The tornado was God's way of punishing my family. In many of these distorted explanations, children assume some degree of responsibility for the traumatic event. This can lead to very destructive and inappropriate feelings of guilt.

Be clear. Explore the child's evolving sense of causality. Correct and clarify as you see false reasoning develop. Over time, the ability of the child to cope is related to the ability of the child to understand. While some elements of trauma seem beyond understanding, this can be explained to a child -- some things we don't know. Don't let the child develop a sense that there is a secret about the event -- this can be very destructive. Let the child know that adults can not and will not understand some things either.

6. Do all children have problems after traumatic events?

The majority of children experiencing trauma will have some change in their behavior and emotional functioning. In addition to the symptoms listed above,

these children will often be more irritable, tired and regressed. Fortunately, however, for the majority of these children these symptoms are short-lived. Some children may exhibit no easily observable changes in their thinking, feeling or behaving. In general, the more threatened a child felt, the closer they were to injury or death, the more the event disrupted or traumatized their family or community, the more likely there will be symptoms. In some cases, children's symptoms do not show up for many weeks or even months after the traumatic event, confusing many caregivers. Indeed, in these cases, caregivers or teachers may not even make a connection between the symptoms and the traumatic event.

How Can I Help?

1. **Don't be afraid to talk about the traumatic event.** Children do not benefit from 'not thinking about it' or 'putting it out of their minds'. If a child senses that his/her caretakers are upset about the event, they will not bring it up. In the long run, this only makes the child's recovery more difficult. Don't bring it up on your own, but when the child brings it up, don't avoid discussion, listen to the child, answer questions, and provide comfort and support. We often have no good verbal explanations, but listening and not avoiding or over-reacting to the subject and then comforting the child will have a critical and long-lasting positive effect.

2. **Provide a consistent, predictable pattern for the day.** Make sure the child has a structure to the day and knows the pattern. Try to have consistent times for meals, school, homework, quiet time, playtime, dinner and chores. When the day includes new or different activities, tell the child beforehand and explain why this day's pattern is different. Don't underestimate how important it is for children to know that their caretakers are 'in control.' It is frightening for traumatized children (who are sensitive to control) to sense that the people caring for them are, themselves, disorganized, confused and anxious. There is no expectation of perfection; caretakers themselves have often been affected by the trauma and may be overwhelmed, irritable or anxious. If you find yourself being this way, simply help the child understand why, and that these reactions are normal and will pass.

3. **Be nurturing, comforting and affectionate, but be sure that this is in an appropriate 'context.'** For children traumatized by physical or sexual abuse, intimacy is often associated with confusion, pain, fear and abandonment. Providing a hug, a kiss and other physical comfort to a young child can be very reassuring. A good working principle for this is to be physically affectionate when the child seeks it. When the child walks over and touches you, return in kind. The child will want to be held or rocked – feel free. On the other hand, try not to interrupt the child's play or other free activities by grabbing them and holding them. Further, be aware that many children from chronically distressed settings may have what we call attachment problems. They will have unusual and often inappropriate styles of interacting.

   Do not tell or command them to 'give me a kiss' or 'give me a hug.' Abused children often take commands very seriously. It reinforces a very malignant association linking intimacy/physical comfort with power (which is inherent in a caregiving adult's command to 'hug me').

4. **Discuss your expectations for behavior and your style of 'discipline' with the child.** Make sure that there are clear 'rules' and consequences for breaking the rules. Make sure that both you and the child understand beforehand the specific consequences for compliant and non-compliant behaviors. Be consistent when applying consequences. Use flexibility in

consequences to illustrate reason and understanding. Utilize positive reinforcement and rewards. Avoid physical discipline.

5. **Talk with the child.** Give them age appropriate information. The more the child knows about who, what, where, why and how the adult world works, the easier it is to 'make sense' of it. Unpredictability and the unknown are two things which will make a traumatized child more anxious, fearful, and therefore, more symptomatic. They may be more hyperactive, impulsive, anxious, and aggressive and have more sleep and mood problems. Without factual information, children (and adults) 'speculate' and fill in the empty spaces to make a complete story or explanation. In most cases, the child's fears and fantasies are much more frightening and disturbing than the truth. Tell the child the truth, even when it is emotionally difficult. If you don't know the answer yourself, tell the child. Honesty and openness will help the child develop trust.

6. **Watch closely for signs of re-enactment** (e.g., in play, drawing, behaviors), **avoidance** (e.g., being withdrawn, daydreaming, avoiding other children) **and physiological hyper-reactivity** (e.g., anxiety, sleep problems, behavioral impulsivity). All traumatized children exhibit some combination of these symptoms in the acute post-traumatic period. Many exhibit these symptoms for years after the traumatic event. When you see these symptoms, it is likely that the child has had some reminder of the event, either through thoughts or experiences. Try to comfort and be tolerant of the child's emotional and behavioral problems. These symptoms will wax and wane - sometimes for no apparent reason. The best thing you can do is to keep some record of the behaviors and emotions you observe (keep a diary) and try to observe patterns in the behavior.

7. **Protect the child.** Do not hesitate to cut short or stop activities that are upsetting or re-traumatizing for the child. If you observe increased symptoms in a child that occur in a certain situation or following exposure to certain movies, activities and so forth, avoid these activities. Try to restructure or limit activities that cause escalation of symptoms in the traumatized child.

8. **Give the child 'choices' and some sense of control.** When a child, particularly a traumatized child, feels that they do not have control of a situation, they will predictably get more symptomatic. If a child is given some choice or some element of control in an activity or in an interaction with an adult, they will feel safer, comfortable and will be able to feel, think and act in a more 'mature' fashion. When a child is having difficulty with compliance, frame the 'consequence' as a choice for them - "You have a choice- you can choose to do what I have asked or you can choose….." Again, this simple framing of the interaction with the child gives them some sense of control and can help defuse situations where the child feels out of control and therefore, anxious.

9. **If you have questions, ask for help.** These brief guidelines can only give you a broad framework for working with a traumatized child. Knowledge is power; the more informed you are, the more you understand the child, the better you can provide them with the support, nurturing and guidance they need. Take advantage of resources in your community. Each community has agencies, organizations and individuals coping with the same issues. They often have the support you may need to help you.

Special Considerations for Traumatized Infants

1. Can infants recall a traumatic experience later in life? The key word in this question is "recall." Unfortunately, for most, the concept of memory is limited to the storage and recall of cognitive, narrative memory. In this conceptualization, a preverbal infant would not be capable of "remembering" and "recalling" any event. Furthermore, we are all familiar with the developmental amnesia that occurs at approximately age three. In this normal developmental phase, there appears to be a reorganization of cognitive and memory functions such that narrative memory for events prior to age three or four are difficult to access later in life. These two points have led to the pervasive, inaccurate and destructive view that infants do not recall traumatic experience, including sexual abuse. Nothing could be further from the truth.

The human brain has multiple ways to "recall" experience. Indeed, the brain is designed to store and recall information of all sorts – motor, vestibular, emotional, social and cognitive. When you walk, play the piano, feel your heart race in an empty parking lot at night, feel calmed by the touch of a loved one or create a "first impression" after meeting someone for first time, you are using memory. All incoming sensory information creates neuronal patterns of activity that are compared against previously experienced and stored patterns. New patterns can create new memories. Yet the majority of these stored memory templates are based upon experiences that took place in early childhood – the time in life when these patterns of neuronal activity were first experienced and stored. And the majority of our 'memories' are non-cognitive and pre-verbal. It is the experiences of early childhood that create the foundational organization of neural systems that will be used for a lifetime.

This is why, contrary to popular perception, infants and young children are more vulnerable to traumatic stress – including sexual abuse. If the original experiences of the infant with primary caregiving adults involve fear, unpredictability, pain and abnormal genital sensations, neural organization in many key areas will be altered. For example, abnormal associations may be created between genital touch and fear, thereby laying the foundation for future problems in psychosexual development. Depending upon the specific nature of the abuse, the duration, the frequency and the time during development, a host of problems can result. In many ways, the long-term adverse effects of sexual abuse in infancy are the result of memories – physiological state memories, motor-vestibular memories and emotional memories, which in later years can be triggered by a host of cues that are pervasive. Incestuous abuse in infancy is most destructive in this regard. It will result in the association of fear, pain and unpredictability into the very core of future human functioning – the primary relational templates. If these original 'templates' for all future relationships are corrupted by sexual exploitation and abuse, the child will have a lifetime of difficulties with intimacy, trust, touch and bonding – indeed the core elements of healthy development and functioning throughout the lifecycle will be altered.

Furthermore, if the child is maltreated or abused during early childhood, they may not have any cognitive "memory" and be completely unaware that the source of their fears, difficulties with intimacy and relationships has its roots in this betrayal in infancy. This can lead to problems with self-esteem and, will make any therapeutic efforts more difficult.

2. Can trauma during infancy arrest cognitive, emotional or behavioral development? The abuse of an infant is often accompanied by extreme disruptions of normal caregiving behaviors and by extreme and prolonged stress responses. Altered caregiving and a prolonged stress response will alter the development of the infant. The major mediators of emotional, cognitive and social environment and, therefore, learning during infancy are the primary caregivers. Development in all domains can be disrupted if these primary relationships are compromised. As mentioned above, it is almost inevitable that emotional, behavioral and cognitive development will be arrested by early traumatic experience.

3. Are there physiological changes in the brain resulting from a traumatic event? As mentioned above, the brain is designed to change in response to experience. Indeed, all experience changes the brain. With traumatic experiences, the changes are in those parts of the brain involved in the stress and fear responses. Many studies with adults and, now with children, have demonstrated a host of neurophysiological changes that are related to traumatic stress. While many more well-controlled studies are needed, it is likely that certain brainstem catecholamine systems (e.g., locus coeruleus noradrengergic), limbic areas (e.g., amygdala), neuroendocrine (e.g., hypothalamic-pituitary-adrenal axis) and cortical systems involved in regulating stress and arousal may all be altered in traumatized children.

4. Do infants display problems similar to older children who are traumatized or abused? The long-term problems that result from maltreatment will vary as a function of several keys factors: what is the nature of the abuse, the duration, frequency, intensity, time during development and the presence of attenuating factors such as other caring, attentive caregivers in the child's life. In general, however, with all traumatic experiences, the earlier in life, the less "specific" and more pervasive the resulting problems appear to be. For example, when traumatized as an adult, there is a specific increase in sympathetic nervous system reactivity when exposed to cues associated with the traumatic event. With young children, following traumatic stress, there appears to be a generalized increase in autonomic nervous system reactivity in addition to the cue-specific reactivity. Due to the sequential and functionally interdependent nature of development, traumatic disruption of the organization and functioning of neural system can result in a cascade of related disrupted

development and dysfunction. Examples of this include the motor and language delays in traumatized children under age six. The "causes" of these delays are likely due to the primary, trauma-induced alterations in other domains (e.g., the stress response systems, thereby influencing physiological reactivity, hypervigilance, concentration), which, in turn, impair the young child's willingness to explore, capacity to process new information and ability to focus long enough on new information to learn.

Key Points: Helping Traumatized Infants

• Anything that can decrease the intensity and duration of the acute fear response (alarm or dissociative) will decrease the probability of that the infant or young child will have long term emotional, behavioral, social or cognitive problems. The longer an infant stays in a fear state, the more likely it will be that she will have problems.

• In general, structure, predictability and nurturing are key elements to a successful early intervention with a traumatized infant.

• The primary source of these key elements is the primary caregiver. Therefore, it is critical to help the caregivers understand as much about post-traumatic responses as possible. Further it is crucial to be sensitive to the needs of the caregiver.

• If the primary caregivers are impacted by the same trauma, it is imperative that they get treatment that compliments the work with the child. Indeed, the best intervention for infants and young children is treating the primary caregiving adults. As they become less anxious, fearful and impaired, the more available they are to the infant and toddler.

• Early assessment and intervention can be prophylactic -- helping prevent a prolonged acute neurophysiologic, neuroendocrine and neuropsychological trauma response. If an infant or young child has been in a traumatic event, or if the primary caregiver of young children has been traumatized, early aggressive intervention can be crucial.

• Contrary to popular belief, even infants and very young children experiencing traumatic events can be affected. Indeed, there is increasing evidence to suggest that the younger a child, the more pervasive are the post-traumatic problems. These are a few simple points to keep in mind. The infant's world is defined by his or her caregivers. If the caregivers are pre-occupied, depressed, anxious, exhausted or absent due to post-traumatic symptoms, this will adversely impact the infant and toddler.

About the drawings:

The Weeping Sun: from a drawing by a 12 yo Kosovar girl living in an Albanian refugee camp following displacement in 1999.*
The Firing Squad: from a drawing by an 11 yo Kosovar boy after witnessing the murders of members of his village in 1999.*
Mother and Child: from a drawing of the experiences of a 10 yo Kosovar boy.*

* Drawings from the collection of Dr. Shoaib (A trainee at the ChildTrauma program in 1998) obtained during clinical work at Kosovar refugee camps in Albania in 1999.

The Traumatized Child and Threat

Adaptive	REST	VIGILANCE	FREEZE	FLIGHT	FIGHT
Hyperarousal	REST	VIGILANCE	RESISTANCE	DEFIANCE	AGGRESSION
Dissociative	REST	AVOIDANCE	COMPLIANCE	DISSOCIATION	FAINTING
Regulating	**NEOCORTEX**	**CORTEX**	**LIMBIC**	**MIDBRAIN**	**BRAINSTEM**
Cognition	ABSTRACT	CONCRETE	EMOTIONAL	REACTIVE	REFLEXIVE
AROUSAL	**CALM**	**ALERT**	**ALARM**	**FEAR**	**TERROR**

When we are under threat, our minds and bodies will respond in an adaptive fashion, making changes in our state of arousal (mental state), our style of thinking (cognition) and in our body's physiology (e.g., increase heart rate, muscle tone, rate of respiration). To understand how we respond to threat it is important to appreciate that as we move along the arousal continuum - from calm to arousal to alarm, fear and terror - different areas of our brain control and orchestrate our mental and physical functioning. The more threatened we become, the more 'primitive' (or regressed) our style of thinking and behaving becomes. When a traumatized child is in a state of alarm (because they are thinking about the trauma, for example) they will be less capable of

concentrating, they will be more anxious and they will pay more attention to 'non-verbal' cues such as tone of voice, body posture and facial expressions. This has important implications for understanding the way the child is processing, learning and reacting in a given situation.

The key to understanding traumatized children is to remember that they will often, at baseline, be in a state of low-level fear -- responding by using either a hyperarousal or a dissociative adaptation -- and that their emotional, behavioral and cognitive functioning will reflect this (often regressed) state. The key points outlined in this booklet help a caregiver provide the structure, predictability and sense of safety that can help keep traumatized children from staying in a state of fear too long. And help them understand how the behaviors of the child can regress (move to the right on the Arousal Continuum).

Glossary

Trauma: A psychologically distressing event that is outside the range of usual human experience, often involving a sense of intense fear, terror and helplessness.

Post-traumatic Stress Disorder (PTSD): A neuropsychiatric disorder that may develop following a traumatic event that includes changes in emotional, behavioral and physiological functioning.

These resources will be periodically updated and posted in a special section of the ChildTrauma Academy web site www.ChildTrauma.org. Visit this site for updates and for other resource materials about traumatic events and children.

About the Author

Dr. Perry is the Senior Fellow of The ChildTrauma Academy, a not-for-profit organization based in Houston, TX (www.ChildTrauma.org), and adjunct Professor in the Department of Psychiatry and Behavioral Sciences at the Feinberg School of Medicine at Northwestern University in Chicago. He serves as the inaugural Senior Fellow of the Berry Street Childhood Institute, an Australian based center of excellence focusing on the translation of theory into practice to improve the lives of children.

Dr. Perry is the author, with Maia Szalavitz, of The Boy Who Was Raised As A Dog, a bestselling book based on his work with maltreated children and Born For Love: Why Empathy is Essential and Endangered. His most recent multimedia books, BRIEF: Reflections on Childhood, Trauma, and Society and RESILIENT: Six Core Strenths for Healthy Development were released in 2013. Over the last thirty years, Dr. Perry has been an active teacher, clinician and researcher in children's mental health and the neurosciences holding a variety of academic positions.

Dr. Perry has conducted both basic neuroscience and clinical research. His experience as a clinician and a researcher with traumatized children has led many community and governmental agencies to consult Dr. Perry following high-profile incidents involving traumatized children such as the Branch Davidian siege in Waco, the Oklahoma City bombing, the Columbine school shootings, the September 11th terrorist attacks, Katrina hurricane, the FLDS polygamist sect and most recently, the earthquake in Haiti, the tsunami in Tohoku Japan, and the recent Sandy Hook Elementary school shootings.

Dr. Perry is the author of over 500 journal articles, book chapters and scientific proceedings and is the recipient of numerous professional awards and honors. He has presented about child maltreatment, children's mental health, neurodevelopment and youth violence in a variety of venues including policy-making bodies such as the White House Summit on Violence, the California Assembly and U.S. House Committee on Education. Dr. Perry has been featured in a wide range of media including National Public Radio, The Today Show, Good Morning America, Nightline, CNN, MSNBC, NBC, ABC and CBS News and the Oprah Winfrey Show.

About The ChildTrauma Academy

The ChildTrauma Academy (CTA) is a not-for-profit organization based in Houston, Texas working to improve the lives of high-risk children through direct service, research and education. A major activity of the CTA is to translate emerging findings about the human brain and child development into practical implications for the ways we nurture, protect, enrich, educate and heal children. The "translational neuroscience" work of the CTA has resulted in a range of innovative programs in therapeutic, child protection and educational systems.

The mission of the ChildTrauma Academy is to help improve the lives of traumatized and maltreated children — by improving the systems that educate, nurture, protect and enrich these children. We focus our efforts on education, service delivery, program consultation, research and innovations in clinical assessment/treatment.

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YouTube Channel:
The ChildTrauma Academy

ReMoved: Discussion Questions

ReMoved: Discussion Questions

What strikes you about this video?

How did the abuse history of this child impact her later behavior / interactions with others?

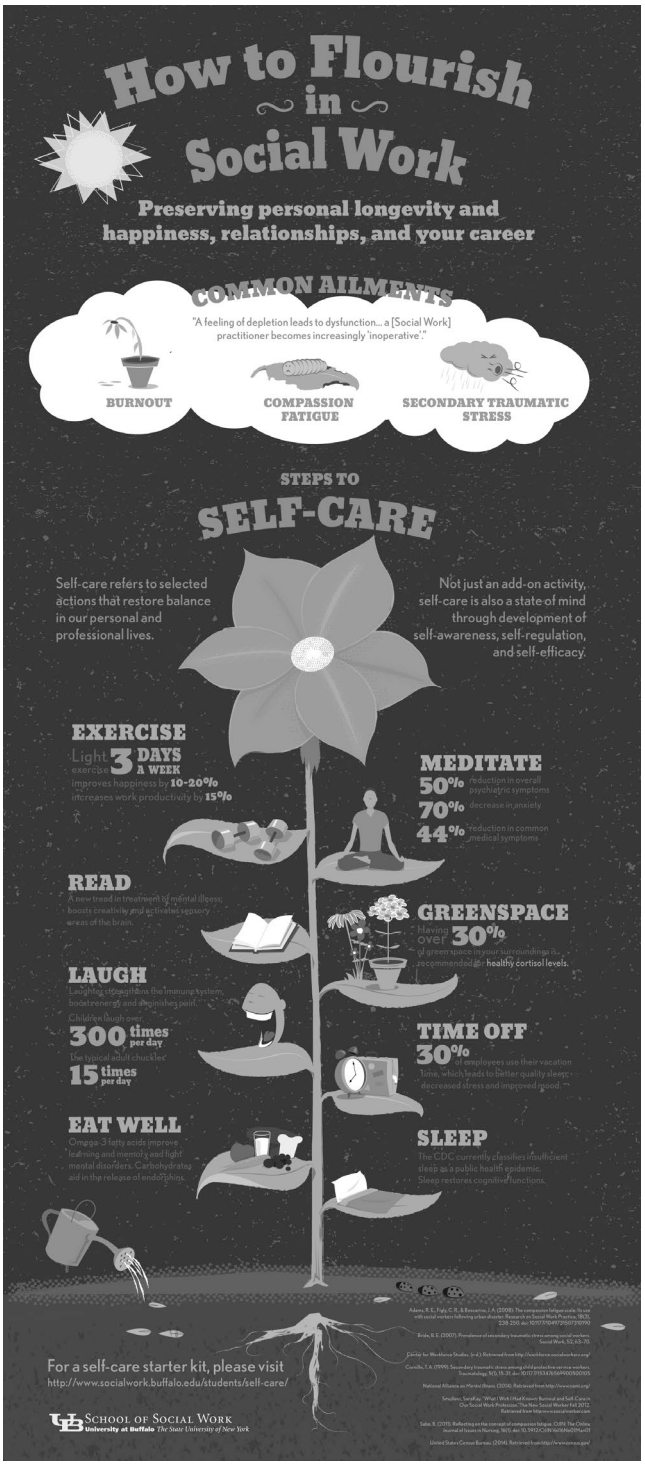
What triggers fight / flight / freeze responses for this child?

How did the adults who were trying to help, *unknowingly mimic* the behaviors of adults who had been hurtful in her life?

What could they have done to be "deliberately different"?

What actions by adults were healing for this child?

How to Flourish in Social Work



Research Brief

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Child TRENDS

ADVERSE CHILDHOOD EXPERIENCES:

NATIONAL AND STATE-LEVEL PREVALENCE

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OVERVIEW

Adverse childhood experiences (ACEs) are potentially traumatic events that can have negative, lasting effects on health and well-being.[1] These experiences range from physical, emotional, or sexual abuse to parental divorce or the incarceration of a parent or guardian. A growing body of research has sought to quantify the prevalence of adverse childhood experiences and illuminate their connection with negative behavioral and health outcomes, such as obesity, alcoholism, and depression, later in life. However, prior research has not reported on the prevalence of ACEs among children in a nationally representative, non-clinical sample.[2] In this brief, we describe the prevalence of one or more ACEs among children ages birth through 17, as reported by their parents, using nationally representative data from the 2011/12 National Survey of Children's Health (NSCH). We estimate the prevalence of eight specific ACEs for the U.S., contrasting the prevalence of specific ACEs among the states and between children of different age groups.

KEY FINDINGS

- Economic hardship is the most common adverse childhood experience (ACE) reported nationally and in almost all states, followed by divorce or separation of a parent or guardian. Only in Iowa, Michigan, and Vermont is divorce or separation more common than economic hardship; in the District of Columbia, having been the victim of or witness to violence has the second-highest prevalence, after economic hardship.
- The prevalence of ACEs increases with a child's age (parents were asked whether their child had "ever" had the experience), except for economic hardship, reported about equally for children of all ages, reflecting high levels of poverty among young families.
- Abuse of alcohol or drugs, exposure to neighborhood violence, and the occurrence of mental illness are among the most commonly-reported adverse childhood experiences in every state.
- Just under half (46 percent) of children in the U.S. have experienced at least one ACE. In 16 states, a slight majority of children have experienced at least one ACE. In Connecticut, Maryland, and New Jersey, 60 percent or more of children have never experienced an ACE.
- States vary in the pattern of specific ACEs. Connecticut and New Jersey have some of the lowest prevalence rates nationally for all ACEs, while Oklahoma has consistently high prevalence.

MEASUREMENT OF ADVERSE CHILDHOOD EXPERIENCES

We measured the prevalence of eight adverse childhood experiences (ACEs), consisting of whether the child ever:

1. Lived with a parent or guardian who got divorced or separated;
2. Lived with a parent or guardian who died;
3. Lived with a parent or guardian who served time in jail or prison;
4. Lived with anyone who was mentally ill or suicidal, or severely depressed for more than a couple of weeks;
5. Lived with anyone who had a problem with alcohol or drugs;
6. Witnessed a parent, guardian, or other adult in the household behaving violently toward another (e.g., slapping, hitting, kicking, punching, or beating each other up);
7. Was ever the victim of violence or witnessed any violence in his or her neighborhood; and
8. Experienced economic hardship "somewhat often" or "very often" (i.e., the family found it hard to cover costs of food and housing).

State-Level Variation in the Prevalence of Adverse Childhood Experiences

Research has found that the highest levels of risk for negative outcomes are associated with having experienced multiple adverse childhood experiences (ACEs).[3,4] Table 1 shows the number of ACEs parents reported for their child, by state. Nationally, a slight majority of children have not experienced any ACEs, but in 16 states more than half of children have experienced at least one ACE. In Montana and Oklahoma, 17 percent of children have experienced three or more ACEs. Some studies suggest that the experience of four or more ACES is a threshold above which there is a particularly higher risk of negative physical and mental health outcomes.[5,6] Prevalence at this threshold is lowest in New Jersey and New York, at around three percent, and highest in Oklahoma, Montana, and West Virginia, at 10 to 12 percent (data not shown in Table).

Table 1. Among Children Aged Birth to 17, Percentage Reported to Have Had Zero, One or Two, or Three or More Adverse Childhood Experiences (ACEs), Nationally, and by State

State	Number Of Adverse Childhood Experiences		
	0	1 OR 2	3+
United States	54	35	11
Alaska	51	35	14
Alabama	48	40	12
Arkansas	45	41	14
Arizona	44	40	15
California	57	33	9
Colorado	57	33	10
Connecticut	61	32	7
District of Columbia	51	37	11
Delaware	52	35	13
Florida	49	42	9
Georgia	53	38	9
Hawaii	56	35	9
Iowa	55	33	12
Idaho	50	35	15
Illinois	59	32	9
Indiana	49	36	15
Kansas	54	34	12
Kentucky	46	37	16
Louisiana	50	38	12
Massachusetts	58	33	9
Maryland	61	31	8
Maine	48	37	15
Michigan	51	35	14
Minnesota	56	34	10
Missouri	52	35	12
Mississippi	46	39	15
Montana	48	35	17
North Carolina	52	36	12
North Dakota	58	32	10
Nebraska	56	32	11
New Hampshire	55	33	12
New Jersey	61	32	7
New Mexico	47	39	14
Nevada	47	40	13

Table 1. Among Children Aged Birth to 17, Percentage Reported to Have Had Zero, One or Two, or Three or More Adverse Childhood Experiences (ACEs), Nationally, and by State

State	NUMBER OF ADVERSE CHILDHOOD EXPERIENCES		
	0	1 OR 2	3+
New York	58	34	8
Ohio	50	36	14
Oklahoma	45	38	17
Oregon	50	35	15
Pennsylvania	54	34	12
Rhode Island	53	37	11
South Carolina	49	39	12
South Dakota	58	30	11
Tennessee	48	38	13
Texas	54	36	10
Utah	59	31	9
Virginia	58	34	8
Vermont	50	38	11
Washington	53	36	11
Wisconsin	54	35	11
West Virginia	48	36	16
Wyoming	52	34	15

Economic Hardship is the Most Common Adverse Childhood Experience

By far, the most common ACEs in all 50 states are economic hardship, and parental divorce or separation (Table 2). Nationally, just over one in four children ages birth through 17 has experienced economic hardship somewhat or very often. Only in Iowa, Michigan, and Vermont is divorce more prevalent than economic hardship (in Wyoming and Oklahoma they are equally prevalent). In most states (45), living with a parent who has an alcohol- or drug-use problem is the third-most-prevalent ACE (national prevalence is about one in ten children). Death of a parent is experienced by three percent of children nationally and is relatively rare in all states: only in the District of Columbia and Mississippi is prevalence greater than five percent (seven and six percent, respectively).

Table 2. Four Most Common Adverse Childhood Experiences (and percentage prevalence) Among Children Ages Birth through 17, Nationally, and by State

State	Highest	2nd	3rd	4th
United States	Economic Hardship (26)	Divorce (20)	Alcohol (11)	Violence (9) Mental Illness (9)
Alaska	Economic Hardship (25)	Divorce (24)	Alcohol (15)	Mental Illness (11)
Alabama	Economic Hardship (29)	Divorce (23)	Alcohol (11)	Mental Illness (10)
Arkansas	Economic Hardship (33)	Divorce (26)	Alcohol (13)	Mental Illness (11)
Arizona	Economic Hardship (34)	Divorce (24)	Alcohol (16)	Violence (11)
California	Economic Hardship (22)	Divorce (17)	Alcohol (11)	Violence (8)
Colorado	Economic Hardship (23)	Divorce (21)	Alcohol (10)	Mental Illness (9)
Connecticut	Economic Hardship (22)	Divorce (16)	Alcohol (8)	Mental Illness (8)
District of Columbia	Economic Hardship (24)	Violence (17)	Divorce (15)	Incarceration (8)
Delaware	Economic Hardship (25)	Divorce (21)	Violence (12)	Alcohol (7)
Florida	Economic Hardship (30)	Divorce (20)	Alcohol (9)	Incarceration (8)
Georgia	Economic Hardship (26)	Divorce (19)	Violence (8) Alcohol (8) Incarceration (8)	Domestic Violence (7)
Hawaii	Economic Hardship (21)	Divorce (17)	Violence (11) Alcohol (11)	Domestic Violence (8)
Iowa	Divorce (22)	Economic Hardship (22)	Alcohol (13) Mental Illness (13)	Domestic Violence (8)
Idaho	Economic Hardship (27)	Divorce (25)	Alcohol (14)	Mental Illness (13)
Illinois	Economic Hardship (23)	Divorce (16)	Alcohol (9)	Violence (8)
Indiana	Economic Hardship (28)	Divorce (24)	Alcohol (13)	Incarceration (11) Mental Illness (11)
Kansas	Economic Hardship (28)	Divorce (22)	Mental Illness (10) Alcohol (10)	Violence (8)
Kentucky	Economic Hardship (30)	Divorce (29)	Alcohol (14)	Incarceration (13)
Louisiana	Economic Hardship (27)	Divorce (23)	Mental Illness (10) Alcohol (10) Violence (10)	Incarceration (8)
Massachusetts	Economic Hardship (22)	Divorce (19)	Alcohol (11)	Mental Illness (9)
Maryland	Economic Hardship (20)	Divorce (17)	Alcohol (8) Violence (8)	Mental Illness (7)
Maine	Economic Hardship (29)	Divorce (27)	Alcohol (14)	Mental Illness (13)
Michigan	Divorce (26)	Economic Hardship (25)	Alcohol (13)	Mental Illness (11)
Minnesota	Economic Hardship (22)	Divorce (20)	Alcohol (13)	Mental Illness (9)

Table 2. Four Most Common Adverse Childhood Experiences (and percentage prevalence) among Children ages Birth through 17, Nationally, and by State

State	Highest	2nd	3rd	4th
Missouri	Economic Hardship (28)	Divorce (23)	Alcohol (11) Mental Illness (11)	Violence (8)
Mississippi	Economic Hardship (32)	Divorce (22)	Alcohol (13)	Violence (12)
Montana	Economic Hardship (28)	Divorce (26)	Alcohol (19)	Mental Illness (14)
North Carolina	Economic Hardship (27)	Divorce (21)	Mental Illness (10) Violence (10) Alcohol (10)	Domestic Violence (9)
North Dakota	Economic Hardship (22)	Divorce (20)	Alcohol (13)	Mental Illness (10)
Nebraska	Economic Hardship (22)	Divorce (21)	Alcohol (12)	Incarceration (9)
New Hampshire	Economic Hardship (23)	Divorce (22)	Alcohol (12)	Mental Illness (11)
New Jersey	Economic Hardship (22)	Divorce (15)	Alcohol (9)	Mental Illness (6)
New Mexico	Economic Hardship (28)	Divorce (25)	Alcohol (17)	Violence (12)
Nevada	Economic Hardship (30)	Divorce (23)	Alcohol (13)	Mental Illness (10)
New York	Economic Hardship (22)	Divorce (15)	Violence (10)	Domestic Violence (7)
Ohio	Economic Hardship (27)	Divorce (23)	Violence (13)	Alcohol (12)
Oklahoma	Economic Hardship (30) Divorce (30)	Alcohol (17)	Violence (13)	Mental Illness (12)
Oregon	Economic Hardship (29)	Divorce (23)	Alcohol (17)	Mental Illness (14)
Pennsylvania	Economic Hardship (25)	Divorce (19)	Alcohol (10) Mental Illness (10) Violence (10)	Domestic Violence (8)
Rhode Island	Economic Hardship (29)	Divorce (19)	Alcohol (12)	Mental Illness (11)
South Carolina	Economic Hardship (27)	Divorce (23)	Alcohol (11)	Mental Illness (10)
South Dakota	Economic Hardship (21)	Divorce (19)	Alcohol (12)	Incarceration (8)
Tennessee	Economic Hardship (31)	Divorce (25)	Alcohol (12)	Mental Illness (11)
Texas	Economic Hardship (29)	Divorce (20)	Alcohol (10)	Mental Illness (8)
Utah	Economic Hardship (24)	Divorce (17)	Mental Illness (10) Alcohol (10)	Domestic Violence (7)
Virginia	Economic Hardship (21)	Divorce (18)	Alcohol (8) Mental Illness (8)	Violence (7)
Vermont	Divorce (26)	Economic Hardship (25)	Alcohol (15)	Mental Illness (11)
Washington	Economic Hardship (25)	Divorce (21)	Alcohol (12) Mental Illness (12)	Violence (9)
Wisconsin	Economic Hardship (25)	Divorce (20)	Alcohol (10) Mental Illness (10)	Violence (8)
West Virginia	Economic Hardship (29)	Divorce (28)	Alcohol (14)	Mental Illness (12)
Wyoming	Economic Hardship (25) Divorce (25)	Alcohol (13) Mental Illness (13)	Violence (10)	Incarceration (9)

The Prevalence of Specific Adverse Childhood Experiences Varies by Age (Except for Economic Hardship)

The prevalence of most ACEs naturally increases by age, since parents were asked whether their child had "ever" had the experience. As Table 3 shows, older children are more likely than younger children to have ever experienced each of the adverse childhood experiences, except for economic hardship, which is reported for 25 to 26 percent of children regardless of age. This reflects the high rates of poverty experienced by families with young children.

Divorce is the second-most-common ACE experienced by children in each age group. About equal numbers of children ages birth to five have lived with someone who has an alcohol or drug problem, or have lived with someone with mental illness. Living with someone with an alcohol or drug-use problem is reported among 12 percent of 6- to 11-year-olds and 15 percent of 12- to 17-year-olds. One in seven 12- to 17-year-olds (14 percent) was the victim of, or witness to, neighborhood violence.

State-level rates for specific ACEs vary greatly for a given age group. For example, in the District of Columbia, 32 percent of 12- to 17-year-olds have experienced violence, compared with 14 percent nationally and 10 percent in Connecticut. In Mississippi, 15 percent of 12- to 17-year-olds, and nine percent of children under five, have witnessed domestic violence in their home, compared with national rates of ten and four percent, respectively.

Table 3. Prevalence of Specific Reported Adverse Childhood Experiences (ACEs), Total, and by Age

ACE	National Prevalence (Percentage)	Range of State-Level Prevalence (Lowest - Highest Percentage)
Somewhat or very often hard to get by on income		
All children	26	20 (MD) - 34 (AZ)
0 to 5	25	17 (ND) - 34 (AZ)
6 to 11	26	18 (HI) - 34 (NJ)
12 to 17	26	17 (VT) - 38 (AZ)
Lived with parent/guardian who separated/divorced		
All children	20	15 (DC) - 30 (OK)
0 to 5	10	6 (NY) - 18 (KY)
6 to 11	22	14 (CT) - 35 (OK)
12 to 17	28	21 (NJ) - 39 (OK)
Lived with someone with alcohol or drug problems		
All children	11	6 (NY) - 19 (MT)
0 to 5	6	1 (DC) - 14 (MT)
6 to 11	12	6 (NY) - 20 (NM)
12 to 17	15	10 (VA) - 26 (AZ)

Table 3. Prevalence of Specific Reported Adverse Childhood Experiences (ACEs), Total, and by Age		
ACE	**National Prevalence (Percentage)**	**Range of State-Level Prevalence (Lowest - Highest Percentage)**
Lived with someone who was mentally ill		
All children	9	5 (CA) - 14 (MT)
0 to 5	6	2 (ND) - 10 (MI)
6 to 11	8	4 (CA) - 17 (MT)
12 to 17	12	7 (VA) - 19 (ME)
Victim or witness to violence in neighborhood		
All children	9	5 (NY) - 17 (DC)
0 to 5	3	1 (IL) - 6 (OH)
6 to 11	8	4 (NJ) - 19 (DC)
12 to 17	14	10 (CT) - 32 (DC)
Witness to domestic violence		
All children	7	5 (NJ) - 11 (OK)
0 to 5	4	2 (CO) - 9 (MS)
6 to 11	8	4 (NJ) - 13 (OK)
12 to 17	10	6 (CT) - 15 (MS)
Lived with parent/guardian who served time in jail		
All children	7	3 (NJ) - 13 (KY)
0 to 5	5	1 (HI) - 12 (KY)
6 to 11	8	2 (NY) - 16 (NM)
12 to 17	8	4 (NY) - 15 (KY)
Lived with parent/guardian who died		
All children	3	2 (CT) - 7 (DC)
0 to 5	1	0 (KS) - 4 (DC)
6 to 11	3	1 (MN) - 8 (MS)
12 to 17	5	1 (CT) - 12 (DC)

States in the Lowest and Highest Quartiles for Each Adverse Childhood Experience

Identifying which states fall into the highest and lowest quartiles of the distribution of prevalence rates provides another perspective on state-level variation. Although, as Table 3 shows, the states with the highest and lowest prevalence vary by ACE and by age group, some states stand out as having consistently high or low prevalence.

Two states–Connecticut and New Jersey–have rates in the lowest quartile for all eight ACEs, whereas Oklahoma has rates in the highest quartile for all ACEs (see Table 4). Other states have consistently high or low prevalence, relatively speaking, across most, but not all, ACEs. For example, Virginia is in the lowest quartile for all ACEs, except for the death of a parent, for which prevalence falls around the national average. Michigan is among the states with the highest prevalence for three ACES: ever lived with someone with mental illness, ever had a parent in jail, and ever lived with a parent who divorced or separated. However, Michigan is also among the states with the lowest prevalence of having witnessed domestic violence, and around the national average for all other ACEs. Policymakers may benefit from taking a closer look at the prevalence of specific adverse experiences among the children in their own state.

Table 4. States in the Lowest and Highest Quartiles for Prevalence of Reported Adverse Childhood Experience, and State Percentage Prevalence

	Economic hardship		Divorce/ Separation		Alcohol/ Drug		Mental illness		Violence		Incarceration		Death		Domestic violence	
Lowest Quartile	MD	20	DC	15	NY	6	CA	5	NJ	5	NJ	3	CT	1	NJ	5
	HI	21	NY	15	DC	7	FL	6	CT	6	NY	4	UT	2	CT	5
	VA	21	NJ	15	VA	8	GA	6	UT	6	CT	5	ME	2	VT	6
	SD	21	CT	16	GA	8	NJ	6	VA	7	RI	5	MN	2	MA	6
	MA	22	IL	16	CT	8	NY	7	NE	7	CO	5	WA	2	VA	6
	MN	22	CA	17	MD	8	IL	7	NH	7	MA	5	ND	2	IL	6
	ND	22	MD	17	IL	9	MD	7	TX	7	UT	5	NE	2	CO	6
	IA	22	HI	17	NJ	9	HI	7	ND	7	MN	5	IA	2	MD	6
	NY	22	UT	17	FL	9	DC	8	IA	7	HI	5	SD	2	RI	7
	NJ	22	VA	18	NC	10	SD	8	WI	8	NH	5	NV	2	UT	7
	CT	22	RI	19	TX	10	VA	8	FL	8	CA	5	CA	2	CA	7
	NE	22	PA	19	CO	10	CT	8	CA	8	VA	6	NJ	2	TN	7
Highest Quartile	RI	29	WY	25	IN	13	KY	11	NY	10	AR	9	NC	4	IN	8
	WV	29	NM	25	WV	14	NH	11	AK	11	WV	9	OH	4	OH	8
	TX	29	TN	25	ID	14	MI	11	IN	11	NE	9	KY	4	NC	9
	ME	29	ID	25	ME	14	WA	12	HI	11	WY	9	IN	4	AK	9
	KY	30	AR	26	KY	14	OK	12	AZ	11	AK	10	SC	4	AR	9
	NV	30	MI	26	VT	15	WV	12	WV	11	TN	10	LA	4	AZ	9
	OK	30	MT	26	AK	15	IA	13	DE	12	NM	10	NM	4	NM	9
	FL	30	VT	26	AZ	15	WY	13	MS	12	MI	10	GA	5	WV	9
	TN	31	ME	27	NM	17	ME	13	NM	12	OH	10	OK	5	KY	10
	MS	32	WV	28	OR	17	ID	13	OH	13	OK	10	AL	5	MT	10
	AR	33	KY	29	OK	17	OR	14	OK	13	IN	11	MS	6	MS	11
	AZ	34	OK	30	MT	18	MT	14	DC	17	KY	13	DC	7	OK	11

Research Brief

Adverse Childhood Experiences:
NATIONAL AND STATE-LEVEL PREVALENCE

Potentially traumatic experiences are common among U.S. children, with more than one in four having been exposed to economic hardship, even in the first five years of life. One in five has experienced parental divorce or separation, and one in ten has lived in a household where an adult has an alcohol or drug problem. More troubling still, more than one in ten children nationally—and, in a few states, about one in six—has experienced three or more adverse experiences. These findings have important implications for children's health and well-being, including the need for increased attention to the early detection and treatment of children affected by trauma, as well as to the conditions in families and communities that contribute to adverse development.

About the Data Used in this Brief

The National Survey of Children's Health (NSCH) was conducted in 2003, 2007 and 2011/12 in all 50 states and the District of Columbia by the National Center for Health Statistics, with funding from the Maternal and Child Health Bureau, U.S. Department of Health and Human Services. Telephone numbers from a random sampling process are used to contact households, and one child in each household with children is randomly selected to be the focus of the study. An adult in the household knowledgeable about the child answered questions about the child and themselves. The survey is representative of children under 18 years old nationwide and also within each state. A total of 95,677 interviews were completed in 2011/12.

The prevalence of ACEs described in this brief are derived from the following questions asked of parents:

- Did [SAMPLE CHILD] ever live with a parent or guardian who got divorced or separated after [SAMPLE CHILD] was born? (Yes/No)
- Did [SAMPLE CHILD] ever live with a parent or guardian who died? (Yes/No)
- Did [SAMPLE CHILD] ever live with a parent or guardian who served time in jail or prison after [SAMPLE CHILD] was born? (Yes/No)
- Did [SAMPLE CHILD] ever see or hear any parents, guardians, or any other adults in [his/her] home slap, hit, kick, punch, or beat each other up? (Yes/No)
- Was [SAMPLE CHILD] ever the victim of violence or witnessed any violence in [his/her] neighborhood? (Yes/No)
- Did [SAMPLE CHILD] ever live with anyone who was mentally ill or suicidal, or severely depressed for more than a couple of weeks? (Yes/No)
- Did [SAMPLE CHILD] ever live with anyone who had a problem with alcohol or drugs? (Yes/No)
- Since [SAMPLE CHILD] was born, how often has it been very hard to get by on your family's income, for example, it was hard to cover the basics like food or housing? (1: Very Often, 2: Somewhat Often, 3: Not Very Often, 4: Never)

Cases were not included in the analysis if any of the questions were not answered. 1.2% of the sample answered none of the questions, while an additional 3% answered less than all of them.

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Birth Parents with Trauma Histories and the Child Welfare System: A Guide for Child Welfare Staff

Birth Parents with Trauma Histories and the Child Welfare System

A Guide for Child Welfare Staff

KAREN'S STORY

Karen has two children, Jonathan, age 3 and Crystal, age 6. Karen was reported to child welfare authorities by Crystal's teacher, who was concerned about Crystal's excessive absences from school. The investigation revealed that Karen's boyfriend physically abused her and her children, and evidence emerged that she had physically abused them as well. There were several attempts to engage her in services, but because of her lack of follow-through and the ongoing safety concerns, her children were removed from her home and have been in foster care for six months.

Linda, Karen's caseworker, has referred Karen to parenting classes, domestic violence services, and for a mental health evaluation. Karen has not followed through on the referrals, is often not home when Linda has a scheduled visit, and when the foster parent last brought the children for visitation, Karen was alternately angry and defensive towards Linda and the foster parent and disengaged from her children. Linda is concerned because of the amount of time Crystal and Jonathan have been in foster care. A decision will be made shortly about their permanency plan, and Linda believes that she hasn't been able to engage Karen in either addressing her family's issues or identifying her strengths, much less come up with a plan that builds on them. Linda's supervisor asked Karen why she has made no progress and noted that the last visit between Karen and her children got "out of control," but did not offer any concrete suggestions to Linda as to how she could have handled it differently. When Linda tries to talk with Karen about the urgency of the situation, Karen minimizes her concerns and appears increasingly angry towards Linda and the system.

Just as many children in the child welfare system have experienced different kinds of trauma[1], many birth parents involved with child welfare services have their own histories of childhood and/or adult trauma. Untreated traumatic stress has serious consequences for children, adults, and families. Traumatic events in childhood and adolescence can continue to impact adult life, affecting an adult's ability to regulate emotions, maintain physical and mental health, engage in relationships, parent effectively, and maintain family stability. Parents' past or present experiences of trauma can affect their ability to keep their children safe, to work effectively with child welfare staff, and to respond to the requirements of the child welfare system. Providing trauma-informed services can help child welfare

[1] *In this fact sheet, trauma refers to events outside the typical range of human experience—that is, events involving actual or threatened risk to the life or physical integrity of individuals or someone close to them.*

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workers and parents meet the child welfare system's goals of safety, permanency, and well-being of children and families.

How Can Trauma Affect Parents?

A history of traumatic experiences may:

- Compromise parents' ability to make appropriate judgments about their own and their child's safety and to appraise danger; in some cases, parents may be overprotective and, in others, they may not recognize situations that could be dangerous for the child.
- Make it challenging for parents to form and **maintain** secure and trusting **relationships**, leading to:
  - Disruptions in relationships with infants, children, and adolescents, and/or negative feelings about parenting; parents may personalize their children's negative behavior, resulting in ineffective or inappropriate discipline.
  - Challenges in relationships with caseworkers, foster parents, and service providers and difficulties supporting their child's therapy.
- Impair parents' capacity to regulate their emotions.
- Lead to poor self-esteem and the development of **maladaptive coping strategies**, such as substance abuse or abusive intimate relationships that parents maintain because of a real or perceived lack of alternatives.
- Result in **trauma reminders**—or "triggers"—when parents have extreme reactions to situations that seem benign to others. These responses are especially common when parents feel they have no control over the situation, such as facing the demands of the child welfare system. Moreover, a child's behaviors or trauma reactions may remind parents of their own past trauma experiences or feelings of helplessness, sometimes triggering impulsive or aggressive behaviors toward the child. Parents also may seem **disengaged or numb** (in efforts to avoid trauma reminders), making engaging with parents and addressing the family's underlying issues difficult for caseworkers and other service providers.
- Impair a parent's **decision-making ability**, making future planning more challenging.
- Make the parent more **vulnerable to other life stressors**, including poverty, lack of education, and lack of social support that can worsen trauma reactions.

Although parents may experience the child welfare system as re-traumatizing because it removes their power and control over their children, there is potential for it to support their trauma recovery and strengthen their resilience. Caseworkers, as representatives of the child welfare system, can themselves serve as triggers to parents with trauma histories or can, through careful use of non-threatening voice and demeanor, be bridges to hope and healing. Viewing birth parents through a "trauma lens" helps child welfare staff—and parents themselves—see how their traumatic experiences have influenced their perceptions, feelings, and behaviors.[2]

How can caseworkers use a trauma-informed approach when working with birth parents?[3]

Caseworkers cannot reverse the traumatic experiences of parents, but they can:

[2] *Although the focus of this fact sheet is birth parents, we acknowledge that other adults—including non-parent partners, grandparents, and step-parents—may also have histories of traumatic experiences and could benefit from trauma-informed child welfare practice as well.*

[3] *For information about trauma-informed child welfare practice go to www.NCTSN.org/products/child-welfare-trauma-training-toolkit-2008.*

- **Understand that parents' anger, fear, or avoidance may be a reaction to their own past traumatic experiences, not to the caseworker him/herself.**
- **Assess** a parent's history to understand how past traumatic experiences may inform current functioning and parenting.
- **Remember that traumatized parents are not "bad"** and that approaching them in a punitive way, blaming them, or judging them likely will worsen the situation rather than motivate a parent.
- Build on parents' desires to be effective in keeping their children safe and reducing their children's challenging behaviors.
- Help parents **understand the impact of past trauma on current functioning and parenting**, while still holding them accountable for the abuse and/or neglect that led to involvement in the system. For many parents, understanding that there is a connection between their past experiences and their present reactions and behavior can empower and motivate them.
- Pay attention to ways trauma can play out during case conferences, home visits, visits to children in foster care, court hearings, and so forth. **Help parents anticipate their possible reactions** and develop different ways to respond to stressors and trauma triggers
- Refer parents to trauma-informed services whenever possible. Parents will be more likely to attend services that address their needs. Generic interventions that do not take into account parents' underlying trauma issues—such as parenting classes, anger management classes, counseling, or substance abuse groups—may not be effective.
- Become knowledgeable about evidence-supported trauma interventions to include in service planning. Linkages with programs that deliver trauma-informed services can support caseworkers in developing a plan that meets their clients' needs.[4]
- Advocate for the development and use of trauma-informed services in the community.

How can child welfare professionals protect themselves from secondary traumatic stress?

When child welfare staff work with traumatized families and directly see or hear of traumatic events, they can experience extreme distress and sometimes secondary or vicarious traumatic stress.[5] Supervisors, caseworkers, and administrators can—and should—find ways to take care of themselves and their staff and to address their own trauma reactions. Simply taking a walk at lunch or recognizing when they are getting overwhelmed or frustrated can make a difference.

Staff supervision can also be used to process the experience of working with traumatized clients.

This fact sheet is one in a series of factsheets discussing parent trauma in the child welfare system. To view others, go to http://www.nctsnet.org/resources/topics/child-welfare-system

[4] *For information on adult trauma treatments and interventions, go to: National Center for PTSD at http://www.ptsd.va.gov; Sidran Institute at http://www.sidran.org; California Evidence-based Clearinghouse for Child Welfare at http://www.cebc4cw.org; and the National Registry of Evidence-based Programs and Practices at http://www.nrepp.samhsa.gov. For help locating local adult trauma services,contact area rape crisis centers, domestic violence shelters, or Red Cross chapters.*

[5] *Secondary or vicarious traumatic stress (also called compassion fatigue) describes trauma reactions in helping professionals following extensive exposure to clients' retelling of their trauma experiences, for more information on self-care, go to: http://www.nctsnet.org/nctsn_assets/pdfs/CWT3_SHO_STS.pdf*

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.

Scenario: Birth Parents with Trauma History

Carol is a parent with whom you are working. Visits with her 2-year-old daughter, Angelique, are scheduled to take place at the child welfare agency office on Tuesdays and Thursdays for one hour. For the last four visits, Carol has either no-showed or has tested positive for methamphetamine prior to the visitation time. Carol hasn't seen Angelique in more than two weeks. You are meeting with Carol to talk about the visitation plan and try to collaborate about what can be put in place to make the visits a good experience for her and her daughter. In the past, when you have met with Carol, she has often gotten upset and raised her voice with you. She has stated on several occasions that the caregiver hates her and that the system is rigged to keep her kid away from her.

Module 1, Activity 1C; Module 7, Activity 7A

The Essential Elements of Trauma-Informed Child Welfare Practice

1. Maximize the child's sense of safety.

Why it's essential

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 living in an unsafe setting, this needs to be addressed immediately. Workers 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.

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.

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 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.

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.

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.

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 input for the development of treatment goals with measurable objectives designed to reduce the negative effects of trauma.

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 well-respected child welfare best practice and is also critical to a child's sense of safety and well-being, particularly during a stressful time.

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 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.

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 empathic 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 the child. 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. 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.

area for notes, if desired

Compassion Fatigue Self-Test: An Assessment

COMPASSION FATIGUE SELF-TEST: AN ASSESSMENT

Answer the questions below to the best of your knowledge. There is no right or wrong answer.

Assign one of these numbers to each one of the questions below:

Responses: 1 = Very True 2 = Somewhat True 3 = Rarely True

You will find summation directions at the end of the test.

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1. ____ When people get upset, I try to smooth things out.
2. ____ I am able to listen to other's problems without trying to "fix" them and/or take away their pain.
3. ____ My self-worth is determined by how others perceive me.
4. ____ When I am exposed to conflict, I feel it is my fault.
5. ____ I feel guilty when others are disappointed by my actions.
6. ____ When I make a mistake, I tend to be extremely critical of myself. I have difficulty forgiving myself.
7. ____ I usually know how I want other people to treat me.
8. ____ I tell people how I prefer to be treated.
9. ____ My achievements define my self-worth.
10. ____ I feel anxious in most situations involving confrontation.
11. ____ In relationships, it is easier for me to "give" than to "receive".
12. ____ I can be so focused on someone I am helping that I lose sight of my own perceptions, interests and desires.
13. ____ It is hard for me to express sadness.
14. ____ To make mistakes means that I am weak.
15. ____ It is best to not "rock the boat" or "make waves."

16. ☐ It is important to put people at ease.

17. ☐ It is best not to need others.

18. ☐ If I cannot solve a problem, I feel like a failure.

19. ☐ I often feel "used up" at the end of the day.

20. ☐ I take work home frequently.

21. ☐ I can ask for help but only if the situation is serious.

22. ☐ I am willing to sacrifice my needs in order to please others.

23. ☐ When faced with uncertainty, I feel that things will get totally out of control.

24. ☐ I am uncomfortable when others do not see me as being strong and self-sufficient.

25. ☐ In intimate relationships, I am drawn to people who are needy or need me.

26. ☐ I have difficulty expressing my differing opinion in the face of an opposing viewpoint.

27. ☐ When I say "no," I feel guilty.

28. ☐ When others distance from me, I feel anxious.

29. ☐ When listening to someone's problems, I am more aware of their feelings than I am of my own feelings.

30. ☐ I find it difficult to stand up for myself and express my feelings when someone treats me in an insensitive manner.

31. ☐ I feel anxious when I am not busy.

32. ☐ I believe that expressing resentments is wrong.

33. ☐ I am more comfortable giving than receiving.

34. ☐ I become anxious when I think I've disappointed someone.

35. ☐ Work dominates much of my life.

36. ☐ I seem to be working harder and accomplishing less.

37. ☐ I feel most worthwhile and alive in crisis situations.

38. ☐ I have difficulty saying "no" and setting limits.

39. ☐ My interests and values reflect what others expect of me rather than my own interests and values.

40. ☐ People rely on me for support.

It is important for you to periodically review your self-care, along with your needs and action plans to meet those needs. If you find that you responded with a 1 (Very True) to more than 15 of these items, it's definitely time to take a close and careful look at self-care issues.

area for notes, if desired

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