Trauma 101 Supplemental Handouts

Separated by Type of Audience

FRANKLIN COUNTY CARES

#STRENGTHENINGONETOSTRENGTHENALL

An interagency initiative that supports trauma-informed services and community education. We believe that trauma-informed care will help build stronger families and stronger communities.

WHAT IS TRAUMA?[1]

Any event that you witness or experience, that threatens your life or someone close to you, whether real or perceived.

Traumatic events could include witnessing or experiencing:

—Abuse —Abandonment —Neglect —Violent Crime
—Death or loss of a loved one —Life-Threatening Illness
—Automobile Accidents —Bullying —Community Violence
—Natural Disasters —Acts or Threats of Terrorism

NEGATIVE EFFECTS OF TRAUMA?[1, 2]

-Difficulty forming healthy, stable relationships

-Increased participation in risky behaviors

- Smoking
- Substance Use
- Poor Eating & Exercise Habits
- Promiscuity

-Problems with authority figures (i.e. police officers, teachers, bosses, etc.)

-Problems thinking clearly, planning ahead, and with memory

-Trouble focusing and problem solving

-Increased chance of chronic illness such as heart disease and cancer, and early death.

-Negative impact on the economy with costs totaling over $100 billion per year.

WHAT WE'RE DOING

Providing **FREE** training to community members and organizations:

- businesses
- childcare providers,
- medical professionals
- educators
- religious organizations

REFERRAL for children, families, and individuals to trauma-informed care services in Franklin County

WHAT YOU CAN DO

Schedule a **FREE** training for your organization.

Contact Emily Thoenen @ (314) 808-3997 to schedule a training to meet your organization's needs today!

FOLLOW US

Facebook: Franklin County Cares

Instagram: franklincountycares

Twitter: FCMO_Cares

EMAIL US

franklincountycareinfo@gmail.com

CONTACT

Lutheran Family and Children's Services
15 S Oak St.
Union, MO
(314) 808-3997

ACE Survey

Resilience Survey

1. National Child Traumatic Stress Network
2. Substance Abuse and Mental Health Services Administration

The Franklin County Community Resource Board (FCCRB) is dedicated to creating a System of Care for the Children and Families of Franklin County, Missouri. For the FLARES project, we decided to put our powers together with Franklin County agencies to help the whole family learn how to recover from trauma.

Franklin County Children and Families Community Resource Board

Franklin County Community Resource Board

501 West End Avenue,
Union, MO 63084

(636) 234-7133

www.franklincountykids.org

FLARES

Families Learning About Recovery Strategies

Flares
Families Learning About Recovery Strategies

Caregivers and their children working to together to overcome trauma.

Franklin County Community Resource Board

What is FLARES?

The aim of the FLARES project is to better serve families who are impacted by the experience of trauma thru working with the entire family. Our hope is that trauma therapy will be **even more** effective if we first help caregivers work through their own trauma so they can better support their child. Each FLARES family will have an adult and a child therapist working with them.

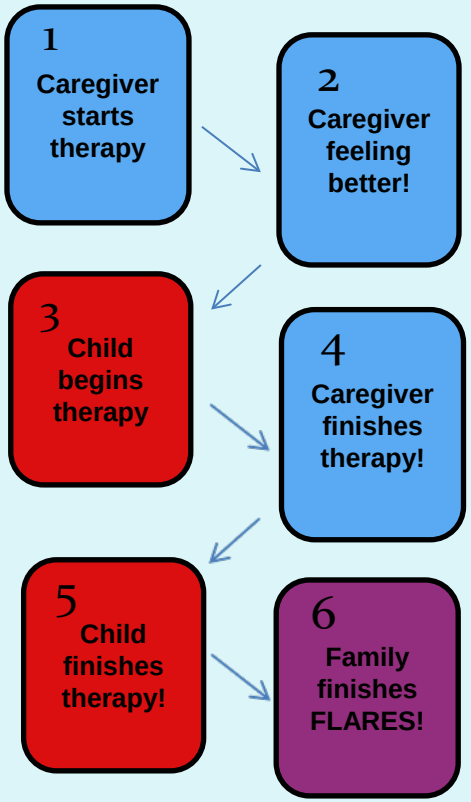
The FLARES Model:

Caregivers in the FLARES project will receive Cognitive Processing Therapy (CPT), an evidence-based therapy that is effective in reducing symptoms of trauma. Children in FLARES will receive Trauma-Focused Cognitive Behavioral Therapy (TF-CBT), which has also shown to help children overcome the impact of trauma. Caregivers first learn how to cope with their own distress related to trauma and how to best support their child's recovery. FLARES families will receive coordinated trauma-focused treatment that will work to help families heal.

Is FLARES right for us?

The FLARES program is for caregivers and children who have ***both*** experienced trauma and are ***both*** struggling to overcome its impact.

The FLARES Path:



Personal Support for You!

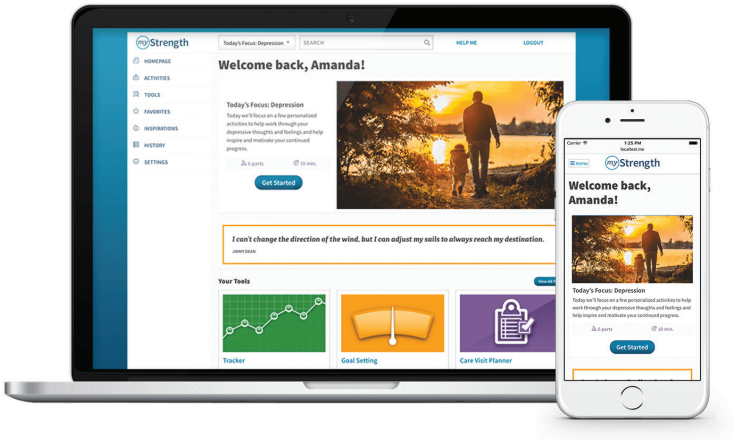
Behavioral Health Response introduces **myStrength**

We all have our struggles.

Finding support to focus on your emotional health is important.

Now you can use web and mobile tools to help you get better and stay mentally strong.

myStrength is safe and secure—just for you. It offers personalized resources to improve your mood. Learning to use myStrength's resources can help you overcome the challenges you face.



myStrength's proven tools can help strengthen your mind, body and spirit.

What myStrength users are saying

It's nice to have self-guided help that is so accessible.

myStrength gives back some of the 'light' I had lost.

myStrength gives me hope and inspiration for my recovery.

SIGN UP TODAY

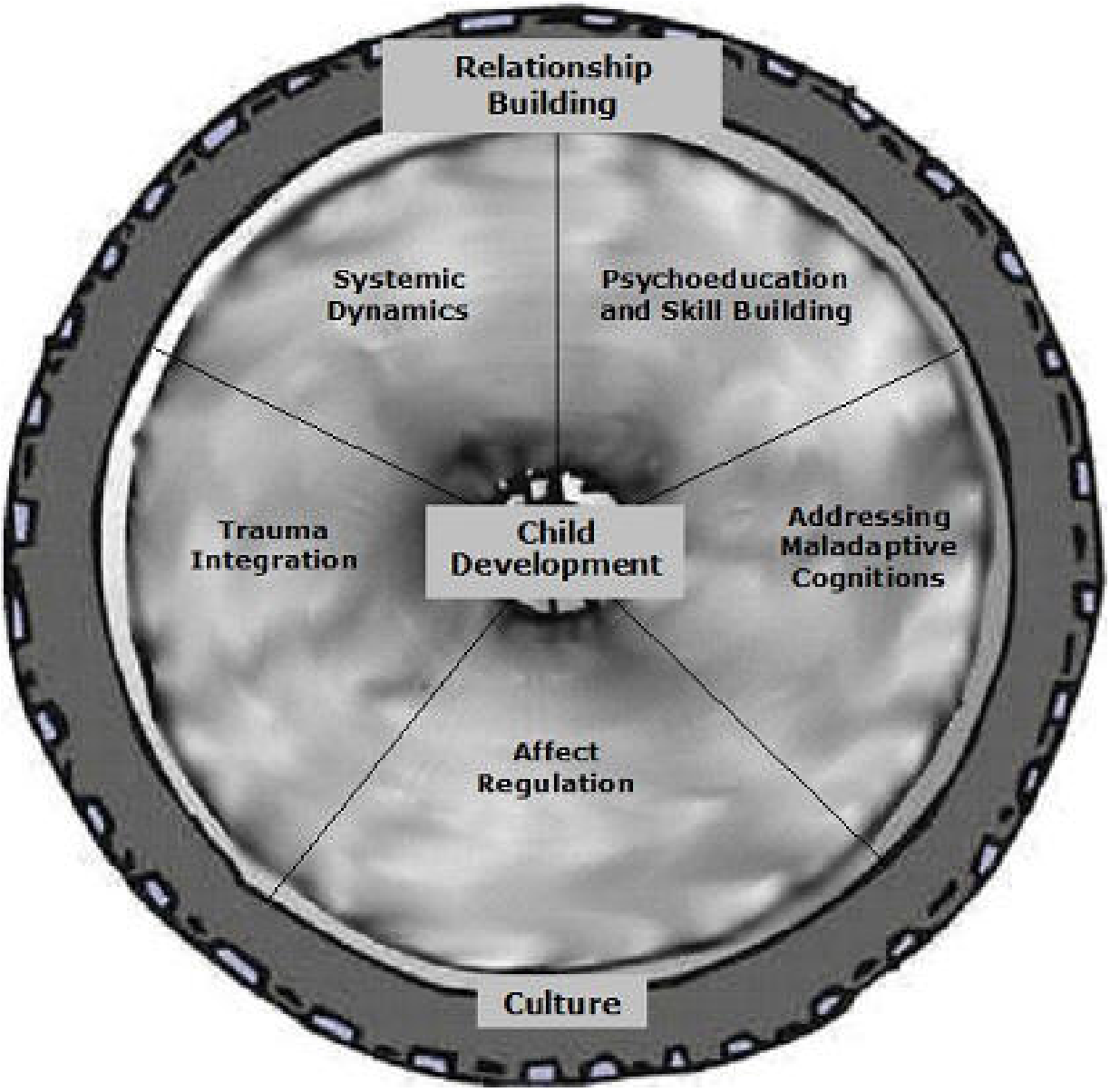
1. Go to www.mystrength.com
2. Click Sign Up
3. Enter the Access Code: **BHRCommunity**

BHR Behavioral Health Response

myStrength

FPF-SAC2-BHR-1216

TRAUMA WHEEL



What is Traumatic Stress?

Many children experience traumatic events. Some of these experiences happen once in child's lifetime, whereas others are re-occurring. A significant number of children have experienced multiple traumatic events.

The National Child Abuse and Neglect Data Systems (NCANDS) glossary in Child Maltreatment 2006 (http://www.acf.hhs.gov/programs/cb/pubs/cm06/index.htm) provides the backbone to the following categories of traumatic stress provided by the National Child Traumatic Stress Network (Core Clinical Characteristics form dated 9/2007):

Sexual Maltreatment/Abuse

Note: Sexual maltreatment/abuse refers to acts by an adult or older youth who is playing a caretaker role for the youth (e.g., parent, parent-substitute, babysitter, adult relative, teacher, etc.). Sexual contact/exposure by others (i.e., non-caretakers) should be classified as 'sexual assault/rape.'

- Actual or attempted sexual contact (e.g., fondling; genital contact; penetration, etc.) and/or exposure to age-in-appropriate sexual material or environments (e.g., print, internet or broadcast pornography; witnessing of adult sexual activity) by an adult to a minor child.
- Sexual exploitation of a minor child by an adult for the sexual gratification or financial benefit of the perpetrator (e.g., prostitution; pornography; orchestration of sexual contact between two or more minor children).
- Unwanted or coercive sexual contact or exposure between two or more minor children.

Sexual Assault/Rape

Note: Sexual assault/rape should include contact/exposure by perpetrators who are NOT in a caretaking role with the youth (sexual misconduct by caregivers should be recorded as 'sexual maltreatment/abuse.')

- Actual or attempted sexual contact (e.g., fondling; genital contact; penetration, etc.) and/or exposure to age-inappropriate sexual material or environments (e.g., print, internet or broadcast pornography; witnessing of adult sexual activity) by an adult to a minor child.
- Sexual exploitation of a minor child by an adult for the sexual gratification or financial benefit of the perpetrator (e.g., prostitution; pornography; orchestration of sexual contact between two or more minor children).
- Unwanted or coercive sexual contact or exposure between two or more minors.

Physical Abuse/Maltreatment

Note: Physical abuse/maltreatment refers to acts by an adult or older youth who is playing a caretaker role for the youth (e.g., parent, parent-substitute, babysitter, adult relative, teacher, etc.). Physical pain and/or injury by others (i.e., non-caretakers) should be classified as 'physical assault.'

- Actual or attempted infliction of physical pain (e.g., stabbings; bruising; burns; suffocation.) by an adult, another child, or group of children to a minor child with or without use of an object or weapon and including use of severe corporeal punishment.
- Does not include rough and tumble play or developmentally normative fighting between siblings or peers of similar age and physical capacity (e.g., assault of a physically disabled child by a non-disabled same-aged peer would be included in this category of trauma exposure).

Physical Assault

Note: Physical assault should include infliction of physical pain/bodily injury by perpetrators who are not in a caretaking role with the youth (such actions by caregivers should be recorded as 'physical maltreatment/abuse').

- Actual or attempted infliction of physical pain (e.g., stabbings; bruising; burns; suffocation.) by an adult, another child, or group of children to a minor child with or without use of an object or weapon and including use of severe corporeal punishment.
- Does not include rough and tumble play or developmentally normative fighting between siblings or peers of similar age and physical capacity (e.g., assault of a physically disabled child by a non-disabled same-aged peer would be included in this category of trauma exposure).

Emotional Abuse / Psychological Maltreatment

- Acts of commission against a minor child, other than physical or sexual abuse, that caused or could have caused conduct, cognitive, affective, or other mental disturbance. These acts include:
  - Verbal abuse (e.g., insults; debasement; threats of violence).
  - Emotional abuse (e.g., bullying; terrorizing; coercive control).
  - Excessive demands on a child's performance (e.g., scholastic; athletic; musical; pageantry) that may lead to negative self-image and disturbed behavior.
- Acts of omission against a minor child that caused or could have caused conduct, cognitive, affective or other mental disturbance. These include:
  - Emotional neglect (e.g., shunning; withdrawal of love).
  - Intentional social deprivation (e.g., isolation; enforced separation from a parent, caregiver, or other close family member).

Neglect

- Failure by the child victim's caretaker(s) to provide needed, age-appropriate care although financially able to do so, or offered financial or other means to do so. Includes:
  - Physical neglect (e.g., deprivation of food, clothing, shelter).
  - Medical neglect (e.g., failure to provide child victim with access to needed medical or mental health treatments and services; failure to consistently disperse or administer prescribed medications or treatments (e.g., insulin shots)).
  - Educational neglect (e.g., withholding child victim from school; failure to attend to special educational needs; truancy).

Domestic Violence

- Exposure to emotional abuse, actual/attempted physical or sexual assault, or aggressive control perpetrated between a parent/caretaker and another adult in the child victim's home environment.
- Exposure to any of the above acts of perpetrated by an adolescent against one or more adults (e.g., parents, grandparent) in the child victim's home environment.

War / Terrorism / Political Violence Inside the U.S.

- Exposure to acts of war/terrorism/political violence on U.S. soil (including Puerto Rico). Historical examples include attacks of 9-11, Oklahoma bombing, and anthrax deaths.
- Includes actions of individuals acting in isolation, e.g. sniper attacks, school shootings if they are considered to be political in nature.

War / Terrorism / Political Violence Outside the U.S.

- Exposure to acts of war/terrorism/political violence, including living in a region affected by bombing, shooting, or looting other than in the U.S.
- Accidents that are a result of terrorist activity (e.g., bridge collapsing due to intentional damage, hostages who are injured during captivity) outside the U.S.

Illness/Medical

- Having a physical illness or experiencing medical procedures that are extremely painful and/or life-threatening.
- The event of being told that one has a serious illness.
- Examples of illnesses include cancer or AIDS. Examples of medical procedures include changing burn dressings or undergoing chemotherapy.
- Does NOT include medical injuries that would otherwise be classified under Injury/accident (e.g., a child who is burned in a fire would be designated as experiencing an accident/injury trauma; however, if they then had to undergo repeated, painful dressing changes they would also qualify for illness/medical trauma).

Injury/Accident

- Injury or accident such as car accident, house fire, serious playground injury, or accidental fall down stairs.
- Does NOT include injury or accident caused at the hands of another person who is intending harm of any type (e.g. a child who falls down the stairs after a parent pushes him would be classified under physical maltreatment/assault, even if the parent didn't intend for the push to lead to the fall).
- Key concept here is "Unintentional."

Natural Disaster

- Major accident or disaster that is an unintentional result of manmade or natural event, e.g. tornado, nuclear reactor explosion.
- Does NOT include disasters that are intentionally caused (e.g., Oklahoma City Bombing, bridge collapsing due to intentional damage), which would be classified as acts of terrorism/political violence.

Kidnapping

- Unlawful seizure or detention against the child's will.
- May include kidnapping by non-custodial parent as well as by stranger.

Traumatic Loss or Bereavement

- Death of a parent, primary caretaker or sibling.
- Abrupt, unexpected, accidental, or premature death or homicide of a close friend, family member, or other close relative.
- Abrupt, unexplained and/or indefinite separation from a parent, primary caretaker, or sibling, due to circumstances beyond the child victim's control (e.g., contentious divorce; parental incarceration; parental hospitalization; foster care placement).

Forced Displacement

- Forced relocation to a new home due to political reasons. Generally includes political asylees or immigrants fleeing political persecution. Refugees or political asylees who were forced to move and were exposed to war may be classified here and also under war/terrorism/political violence outside U.S.
- Does NOT include immigrants who move voluntarily (e.g., moving due to poverty of home country), or families who are evicted.
- Does NOT include homelessness.
- The key concept here is "Political."

Impaired Caregiver

- Functional impairment in at least one of child's primary caregivers that results in deficient performance of the caretaking role (i.e., inability to meet the child's needs).
- Impairment means that caregiver(s) were neither able to provide children with adequate nurturance, guidance, and support nor attend to their basic developmental needs due to their own mental illness, substance abuse, criminal activity, or chronic overexposure to severe life stressors (e.g., extreme poverty, community violence).
- Impairment may be due to various causes (e.g., medical illness, mental illness, substance use/abuse, exposure to severance life stressors (e.g., extreme poverty, community violence))
- If impairment results in additional trauma (e.g., neglect, emotional abuse/psychological maltreatment), BOTH 'impaired caregiver' and the more specific type of trauma should be reported.

Extreme Personal/Interpersonal Violence (not reported elsewhere)

- Includes extreme violence by or between individuals that has not been reported elsewhere (hence, if the child witnessed domestic violence, this should be recorded as "domestic violence" and NOT repeated here).
- Intended to include exposure to homicide, suicide and other similar extreme events.

Community Violence (not reported elsewhere)

- This category is intended to capture episodic or pervasive violence in the youth's community that have not been captured in other categories.
- Include extreme violence in the community (i.e., neighborhood violence)
- Exposure to gang-related violence should be recorded here (though specific incidents of gang-related violence (e.g., homicide, assaults) should also be recorded under those more specific headings.

School Violence

- This category is intended to capture violence that occurs in the school setting and that has not been reported in other categories.
- It includes, but is not limited to: school shootings, bullying, interpersonal violence among classmates, and classmate suicide.

Coping with Trauma Reminders

What are trauma reminders?

Many children in the child welfare system have been through multiple traumatic events, often at the hands of those they trusted to take care of them. When faced with people, situations, places, or things that remind them of these events, children may re-experience 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 older 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, crying hysterically when her resource parents have a mild dispute in front of her.
- A nine-year-old girl who was repeatedly abused in the basement of a family friend's house refuses to enter the resource family's basement playroom.
- A toddler who saw her cousin lying in a pool of blood after a drive-by shooting has a tantrum after a bottle of catsup spills on the kitchen floor.
- A teenager who was abused by her stepfather refuses to go to gym class after meeting the new gym teacher who wears the same aftershave as her stepfather.
- A twelve-year-old boy who'd been molested by a man in a Santa Claus suit runs screaming out of a YMCA Christmas party.

What happens when a child responds to a trauma reminder?

When faced with a trauma reminder, children may feel frightened, jumpy, 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. Or they may experience physical symptoms such as nausea or dizziness. They may feel inexplicably guilty or ashamed or experience a sense of dissociation, as if they are in a dream or outside their own bodies.

Children's reactions may vary somewhat by age. Preschool children may:

- Feel vulnerable and helpless
- React very literally and dramatically (e.g., flinching, crying, trying to hide) to concrete reminders such as a raised hand or a facial expression
- Exhibit sudden strong emotional outbursts or tantrums
- Have little memory of the traumatic events that they can put into words
- Act out the traumatic events in play

School-aged children may:

- Exhibit physical symptoms, such as stomachaches or headaches
- Vacillate between being withdrawn and quiet or aggressive and noisy

Teenagers may:

- Respond recklessly, taking more risks or abusing substances
- Limit themselves or withdraw from activities to avoid reminders
- Fear that their strong reactions mean they are "going crazy"
- Feel stigmatized by having gone through traumatic events and may not feel that they can talk about them

Sometimes children are aware of their reaction and its connection to the original event. More often, however, they are unaware of the root cause of their feelings and may even feel frightened by the intensity of their reaction.

How can I help?

Children who have experienced trauma may face so many trauma reminders in the course of an ordinary day that the whole world seems dangerous, and no adult seems deserving of trust. Child welfare workers are in a unique position to help these children recognize safety and begin to trust adults who do indeed deserve their trust.

It's very difficult for children in the midst of a reaction to a trauma reminder to calm themselves, especially if they do not understand why they are experiencing such intense feelings. Despite reassurance, these children may be convinced that danger is imminent or that the "bad thing" is about to happen again. It is therefore critical to create as safe an environment as possible. Children who have experienced trauma need repeated reassurances of their safety. When a child is experiencing a trauma reminder, it is important to state very clearly and specifically the reasons why the child is now safe. Each time a child copes with a trauma reminder and learns once more that he/she is finally safe, the world becomes a little less dangerous, and other people a little more reliable.

Tips for Helping Children Identify and Cope With Trauma Reminders

- **Learn as many specifics as you can of what the child experienced** so that you can identify when the child is reacting to a reminder. Look for patterns (time of day, month, season, activity, location, sounds, sights, smells) that will help you understand when the child is reacting. Help the child to recognize these trauma reminders. Sometimes just realizing where a feeling came from can help to minimize its intensity.

- **Do not force the child into situations that seem to cause unbearable distress.** Allow the child to avoid the most intense reminders, at least initially, until he or she feels safe and trusts you.
- When the child is reacting to a reminder, **help him or her to discriminate between past experiences and the present one**. Calmly point out all the ways in which the current situation is different from the past. Part of the way children learn to overcome their powerful responses is by distinguishing between the past and the present. They learn, on both an emotional (feeling) and cognitive (thinking and understanding) level, that the new experience is different from the old one.
- **Provide tools to manage emotional and physical reactions.** Deep breathing, meditation, or other techniques may help a child to manage emotional and physical reactions to reminders. If you are unfamiliar with such techniques, ask a counselor to help.
- **Recognize the seriousness of what the child went through, and empathize with his or her feelings.** Don't be surprised or impatient if the child continues to react to reminders weeks, months, or even years after the events. Help the child to recognize that reactions to trauma reminders are normal and not a sign of being out of control, crazy, or weak. Shame about reactions can make the experience worse.
- **Anticipate that anniversaries of events, holidays, and birthdays may serve as reminders.**
- **With the child, identify ways that you can best reassure and comfort during a trauma reminder.** These might be a look of support, a reassurance of safety, words of comfort, a physical gesture, or help in distinguishing between the present and the past.
- **Seek professional help if the child's distress is extreme,** or if avoidance of trauma reminders is seriously limiting your child's life or movement forward.
- **Be self-aware.** A child's reaction to a trauma reminder may serve to remind you of something bad that happened in your own past. Work to separate your own reactions from those of the child.

For more information on the impact of trauma on children,
visit the National Child Traumatic Stress Network (NCTSN) at www.NCTSN.org.

Child Welfare Trauma Referral Tool (CWT)

(Nicole Taylor, Charles Wilson, & Alan Steinberg, 2006)

This measure is designed to help child welfare workers make more trauma-informed decisions about the need for referral to trauma-specific and general mental health services. It is to be completed by the child welfare worker through record review and key informants (i.e., natural parent, foster parent, child therapist, school-aged children or adolescents if appropriate, and other significant individuals in the child's life).

Section A allows the child welfare worker to document history of exposure to a variety of types of trauma and indicate the age range over which the child experienced each trauma. Section B allows the child welfare worker to document the severity of the child's traumatic stress reactions. Section C allows the child welfare worker to document attachment problems. Section D allows the child welfare worker to document behaviors requiring immediate stabilization. Section E allows the child welfare worker to document the severity of the child's other reactions/behaviors/functioning. Section F provides strategies for making recommendations to general or trauma-specific mental health services by linking the child's experiences to their reactions.

To obtain permission to use the Child Welfare Trauma Referral Tool, please contact Lisa Conradi, at lconradi@rchsd.org or 858-576-1700, ext. 6008.

Form Completed by (Name/Title/ID Code): _____ Date: _____

Child's Name: _____ Age: _____ Number of Months in Current Placement: _____

Reason for Current Evaluation (check all that apply):

☐ Baseline Assessment: New client ☐ New Trauma Reported ☐ Problematic Reactions/Behaviors Reported

☐ Change in Placement (Specify): _____ ☐ Other (Specify): _____

A. Behaviors Requiring Immediate Stabilization *(Refer to Flow Chart for Specific Referrals for each type of problem)*

	Yes	No	Suspected	How to Recognize Problem Behaviors: (Check Yes if child presents with any of the descriptors listed below)
Suicidal Ideation	☐	☐	☐	Thinking about, considering, or planning for suicide.
Active Substance Abuse	☐	☐	☐	An unhealthy pattern of substance (alcohol or drug) use that results in significant problems in one of the following ways: (1) An inability to adequately take care of your responsibilities or fill your role at work, school, or home; (2) The frequent use of substances in situations where it might be dangerous to do so (for example, driving while under the influence); (3) Repeated legal problems due to substance use (for example, public intoxication or disorderly conduct); and (4) The continued use of substances even though the substance use is causing considerable problems in your life.
Eating Disorder	☐	☐	☐	Any of several psychological disorders (as anorexia nervosa or bulimia) characterized by serious disturbances of eating behavior.
Serious Sleep Disorder	☐	☐	☐	Disturbance in the patient's amount of sleep, quality or timing of sleep, or in behaviors or physiological conditions associated with sleep.

B. Current Reactions/Behaviors/Functioning

	Does this interfere with child's daily functioning at home, school or in the community?			How to Recognize Problem Behaviors: (Check Yes if child presents with any of the descriptors listed below)
	Yes	No	Suspected	
Affect Dysregulation	☐	☐	☐	Children with affect dysregulation may have difficulty expressing specific feelings, whether positive or negative, and may have trouble fully engaging in activities. They may have problems modulating or expressing emotions, experience intense fear or helplessness, or have difficulties regulating sleep/wake cycle.
Anxiety	☐	☐	☐	Anxious children often appear tense or uptight. Worries may interfere with activities and they may seek reassurance from others or be clingy. These children may be quiet, compliant and eager to please, so they may be overlooked. They may report phobias, panic symptoms, and report physical complaints, startle easily, or have repetitive unwanted thoughts or actions.
Attachment Difficulties	☐	☐	☐	This category refers to a child's difficulty forming or maintaining relationships with significant parental or caregiver figures. It relates to the child's sense of security and trust in interacting with others. Often children with attachment difficulties interact with new acquaintances in unusual ways. They may bond too quickly (e.g., hugging strangers and climbing on their laps), or fail to engage in appropriate ways (e.g., avoid eye contact and fail to engage in appropriate conversations/interactions).
Attention/ Concentration	☐	☐	☐	Children with problems with attention, concentration and task completion often have difficulty completing schoolwork or may have difficulty forming strong peer relationships.
Conduct Problems	☐	☐	☐	Defined by a variety of different conduct problems. Child may be physically or verbally aggressive to other people or animals. Children with conduct problems may destroy property, steal, break the law, or start fires. They may run away from home or act in a sexually promiscuous or aggressive fashion.
Depression	☐	☐	☐	Depressed children may appear tearful/sad, show decreased interest in previous activities, have difficulty concentrating, or display irritability, They may present with depressed mood, social withdrawal, sleep disturbances, weight/eating disturbances, loss of motivation, verbal aggression, sullenness, grouchiness, hopelessness, or negativity. They may have frequent complaints of physical problems.

	Does this interfere with child's daily functioning at home, school or in the community?			How to Recognize Problem Behaviors: (Check Yes if child presents with any of the descriptors listed below)
	Yes	No	Suspected	
Dissociation	☐	☐	☐	Children experiencing dissociation may daydream frequently. They may seem to be spacing out and be emotionally detached or numb. They are often forgetful and sometimes they experience rapid changes in personality often associated with traumatic experiences.
Impulsivity	☐	☐	☐	Acting or speaking without first thinking of the consequences.
Oppositional Behaviors	☐	☐	☐	Defined by negativistic, hostile and defiant behaviors. Child may lose temper frequently, argue with adults, and refuse to comply with adult rules. Child may deliberately annoy people and blame others for mistakes or misbehaviors.
Regression	☐	☐	☐	Child ceases using previously adaptive behaviors. Child may begin wetting or soiling themselves after they had been potty trained, and may begin using baby talk or refusing to sleep alone when these skills were previously mastered.
Somatization	☐	☐	☐	Somatization is characterized by recurrent physical complaints without apparent physical cause. Children may report stomachaches or headaches, or on the more serious end of the spectrum, they may report blindness, pseudoseizures, or paralysis.
Suicidal Behavior	☐	☐	☐	Includes both superficial and more serious actions with potentially life-threatening consequences. Examples include overdosing, deliberately crashing a car, or slashing wrists.
Self-Harm	☐	☐	☐	When someone deliberately harms him or herself. Includes cutting behaviors, punching oneself, pulling out hair or eyelashes, picking skin causing sores, burning, inhaling or overdosing on medications.

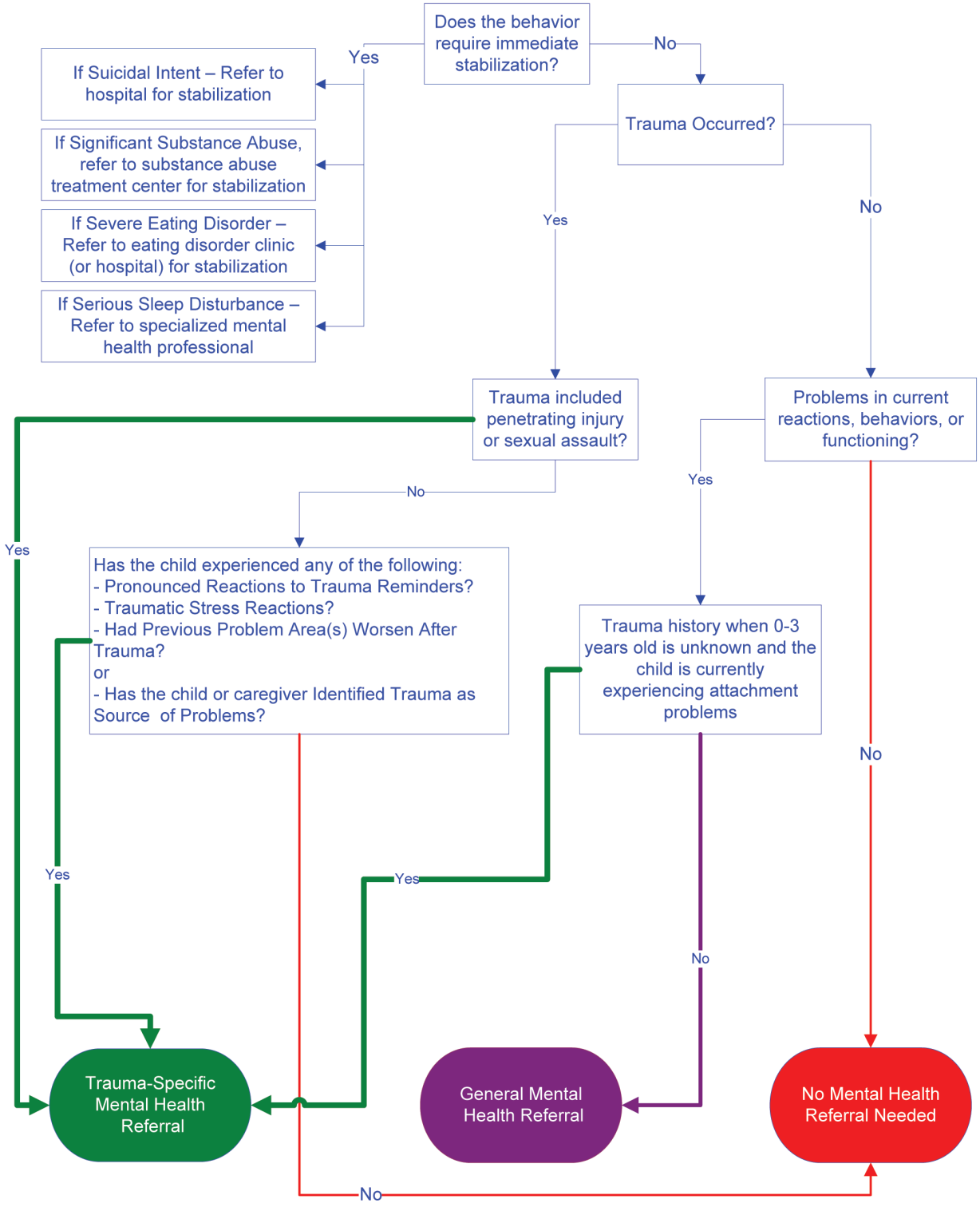
C. Trauma/Loss Exposure History

Trauma Type (Definitions attached)				Age(s) Experienced (Check each box as appropriate—example: sexual abuse from ages 6–9 would check 6, 7, 8, and 9)																			
	Yes	No	Suspected	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20
Community Violence Exposure	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Domestic Violence Exposure	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Emotional Abuse	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Extreme Personal/Interpersonal Violence Exposure	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Forced Displacement	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Natural or Manmade Disasters	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Neglect	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Physical Abuse or Assault	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
School Violence Exposure	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Serious Accident/Illness/Medical Procedure	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Sexual Abuse or Assault/Rape	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Systems-Induced Trauma	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Traumatic Grief/Separation (does not include placement in foster care)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
War/Terrorism/Political Violence	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

D. Current Traumatic Stress Reactions

	Yes	No	Suspected	Definition (Check Yes if child presents with any of the descriptors listed below)
Re-experiencing	☐	☐	☐	These symptoms consist of difficulties with intrusive memories or reminders of traumatic events, including nightmares, flashbacks, intense reliving of the events, and repetitive play with themes of specific traumatic experiences. Also included is pronounced reactivity to trauma or loss reminders. These symptoms are part of the DSM-IV criteria for PTSD.
Avoidance	☐	☐	☐	These symptoms include efforts to avoid stimuli associated with traumatic experiences. The child may avoid certain places or people, or avoid discussing the specifics of the trauma. These symptoms are part of the DSM-IV criteria for PTSD.
Numbing	☐	☐	☐	These symptoms include numbing responses that are part of the DSM-IV criteria for PTSD. These responses were not present before the trauma. Numbing symptoms include feelings of detachment or estrangement from others, restricted range of emotion (e.g., unable to have loving feelings), feeling out of sync with others, or having a sense of a foreshortened future.
Arousal	☐	☐	☐	These symptoms consist of difficulties with hypervigilance (an exaggerated awareness of potential dangers), difficulty concentrating, exaggerated startle reactions, difficulties falling or staying asleep, and irritability or outbursts of anger. Children with these symptoms often seem distractible, impulsive and inattentive, leading to a common misdiagnosis of ADHD.

Child Welfare Trauma Referral Tool: Referral Flowchart—Linking Experiences to Reactions



Referral Guidelines

In scoring the Child Welfare Trauma Referral Tool, the following guidelines are recommended (as outlined in the referral flowchart):

Trauma-Specific Mental Health Referral:

- The child has a trauma exposure history with a penetrating injury or sexual assault.
- The child exhibits traumatic stress reactions, regardless of the child's trauma history.
- The child had a trauma history before the age of three or the caregiver is unaware of the child's history before the age of three, and the child is experiencing attachment difficulties.
- The child has a history of trauma and this history is linked to current reactions/behaviors/functioning problems.

General Mental Health Referral:

- If the child exhibits current reactions/behaviors/functioning problems (other than traumatic stress reactions) in the absence of a trauma history.
- If the child exhibits behavior problems and these are not linked to the traumatic experiences.

Specific Mental Health Referral:

- Hospital: If the child presents with suicidal intent, a referral to the hospital for stabilization is recommended. The child should be re-assessed once they are stabilized.
- Substance-Abuse Program: If the child presents with a significant substance abuse problem, a referral to a substance-abuse specific program is recommended. The child should be re-assessed once substance-abuse problem is stabilized.
- Eating Disorder Program: If the child presents with a significant eating disorder, a referral to an eating disorder program for stabilization is recommended. The child should be re-assessed once they are stabilized.

No Mental Health Referral:

- If the child has a trauma exposure history but there are no traumatic stress reactions and the child is functioning well.

Definitions of Different Trauma/Loss Exposure History Categories

- **COMMUNITY VIOLENCE EXPOSURE** – Extreme violence in the community (i.e., neighborhood and gang violence).
- **DOMESTIC VIOLENCE EXPOSURE** – Exposure to emotional abuse, actual/attempted physical or sexual assault, or aggressive control perpetrated between a parent/caretaker and another adult in the child victim's home environment.
- **EMOTIONAL ABUSE** – Acts of commission against a minor child, including: Verbal abuse (e.g., insults; debasement; threats of violence), emotional abuse (e.g., bullying; terrorizing; coercive control), excessive demands on a child's performance (e.g., scholastic; athletic; musical; pageantry) that may lead to negative self-image and disturbed behavior.
- **EXTREME PERSONAL/INTERPERSONAL VIOLENCE** – Includes extreme violence by or between individuals that has not been reported elsewhere, including exposure to homicide, suicide and other similar extreme events.
- **FORCED DISPLACEMENT** – Forced relocation to a new home due to political reasons.
- **NATURAL/MANMADE DISASTERS** – Major accident or disaster that is an unintentional result of a manmade or natural event.
- **NEGLECT** – Failure by the child victim's caretaker(s) to provide needed, age-appropriate care although financially able to do so, or offered financial or other means to do so. Includes: Physical neglect (e.g., deprivation of food, clothing, shelter), Medical neglect (e.g., failure to provide child victim with access to needed medical or mental health treatments and services; failure to consistently disperse or administer prescribed medications or treatments (e.g., insulin shots), and Educational neglect (e.g., withholding child victim from school; failure to attend to special educational needs; truancy).
- **PHYSICAL ABUSE OR ASSAULT** – Actual or attempted infliction of physical pain (e.g., stabbings; bruising; burns; suffocation) by an adult, another child, or group of children to a minor child including use of severe corporal punishment.
- **SCHOOL VIOLENCE EXPOSURE** – Violence that occurs in a school setting (i.e., school shootings, bullying, classmate suicide).
- **SERIOUS ACCIDENT/ILLNESS/MEDICAL PROCEDURE** – UNINTENTIONAL injury or accident such as car accident, house fire, or accidental fall down stairs. Having a physical illness or experiencing medical procedures that are painful and/or life threatening.

- **SEXUAL ABUSE OR ASSAULT/RAPE** – Actual or attempted sexual contact (e.g., fondling; genital contact; penetration, etc.) and/or exposure to age-inappropriate sexual material or environments by an adult to a minor child.
- **SYSTEMS-INDUCTED TRAUMA** – Traumatic removal from the home, traumatic foster placement, sibling separation, or multiple placements in a short amount of time.
- **TRAUMATIC GRIEF/SEPARATION** – Includes: Death of a parent, primary caretaker or sibling; Abrupt, unexpected, accidental or premature death or homicide of a close friend, family member, or other close relative; Abrupt, unexplained and/or indefinite separation from a parent, primary caretaker, or sibling due to circumstances beyond the child victim's control.
- **WAR/TERRORISM/POLITICAL VIOLENCE** – Exposure to acts of war/terrorism/political violence. Includes incidents both within the U.S. (i.e., Oklahoma bombing, 9-11) and outside of the U.S. (i.e., bombing, shooting, or accidents that are a result of terrorist activity).

Questions to Ask Mental Health Providers

1. Does the individual/agency that provides therapy conduct a comprehensive trauma assessment?
   - What specific standardized measures are given?
   - What did your assessment show?
   - What were some of the major strengths and/or areas of concern?
2. Is the clinician/agency familiar with evidenced-based treatment models?
3. Have clinicians had specific training in an evidenced-based model (when, where, by whom, how much)?
4. Does the individual/agency provide ongoing clinical supervision and consultation to its staff, including how model fidelity is monitored?
5. Which approach(es) does the clinician/agency use with children and families?
6. How are parent support, conjoint therapy, parent training, and/or psychoeducation offered?
7. Which techniques are used for assisting with the following:
   - Building a strong therapeutic relationship
   - Affect expression and regulation skills
   - Anxiety management
   - Relaxation skills
   - Cognitive processing/reframing
   - Construction of a coherent trauma narrative
   - 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
   - Personal safety/empowerment activities
   - Resiliency and closure
8. How are cultural competency and special needs issues addressed?
9. Is the clinician or agency willing to participate in the multidisciplinary team (MDT) meetings and in the court process, as appropriate?

Empirically Supported Treatments and Promising Practices

The approaches listed in the Supplemental Handouts section are interventions being implemented by centers within the National Child Traumatic Stress Network. Please note that these interventions do not represent all relevant practices available for treating child traumatic stress. You can obtain additional information, and the efficacy ratings of these treatments, by visiting:

- The National Child Traumatic Stress Network Empirically Supported Treatments and Promising Practices webpage at ***http://www.nctsnet.org/nccts/nav.do?pid=ctr_top_trmnt_prom***
- The California Evidence-Based Clearinghouse for Child Welfare at ***http://www.cachildwelfareclearinghouse.org***.

List of practices:

- Alternatives for Families: A Cognitive-Behavioral Therapy
- Adapted Dialectical Behavior Therapy for Special Populations (DBT-SP)
- Assessment-Based Treatment for Traumatized Children: Trauma Assessment Pathway (TAP)
- Attachment, Self-Regulation, and Competence (ARC): A Comprehensive Framework for Intervention with Complexly Traumatized Youth
- Child Adult Relationship Enhancement (CARE)
- Child Development-Community Policing Program (CDCP)
- Child-Parent Psychotherapy (CPP)
- Cognitive Behavioral Intervention for Trauma in Schools (CBITS)
- Combined Parent Child Cognitive-Behavioral Approach for Children and Families At-Risk for Child Physical Abuse
- Community Outreach Program – Esperanza (COPE)
- Culturally Modified Trauma-Focused Cognitive Behavioral Therapy (CM TF-CBT)
- International Family Adult and Child Enhancement Services (IFACES)
- Group Treatment for Children Affected by Domestic Violence
- Honoring Children, Making Relatives
- Honoring Children, Mending the Circle
- Honoring Children, Respectful Ways
- Integrative Treatment of Complex Trauma (ITCT)
- Multimodality Trauma Treatment – Trauma-focused Coping (MMTT)
- Parent-Child Interaction Therapy (PCIT)
- Real Life Heroes

- Safe Harbor Program
- Safety, Mentoring, Advocacy, Recovery, and Treatment (SMART)
- Sanctuary Model
- Streetwork Project
- Structured Psychotherapy for Adolescents Responding to Chronic Stress (SPARCS)
- Trauma Affect Regulation: Guidelines for Education and Therapy for Adolescents and Pre-Adolescents (TARGET-A)
- Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)
- Trauma-Focused Cognitive Behavioral Therapy for Childhood Traumatic Grief (TF-CBT-CTG)
- Trauma Grief Component Therapy for Adolescents (TGCT-A)
- Trauma Systems Therapy (TST)

NCTSN The National Child Traumatic Stress Network

Birth Parents with Trauma Histories and the Child Welfare System

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

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.

This project was funded by the Substance Abuse and Mental Health Services Administration (SAMHSA), US Department of Health and Human Services (HHS).

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 behav¬iors 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.

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.

The Invisible Suitcase: **Behavioral Challenges of Traumatized Children**

The Invisible Suitcase

Children who enter the foster care system typically arrive with at least a few personal belongings: clothes, toys, pictures, etc. But many also arrive with another piece of baggage, one that they are not even aware they have: an "invisible suitcase" filled with the beliefs they have about themselves, the people who care for them, and the world in general.

For children who have experienced trauma—particularly the abuse and neglect that leads to foster care—**the invisible suitcase is often filled with overwhelming negative beliefs and expectations.** Beliefs not only about themselves . . .

- I am worthless.
- I am always in danger of being hurt or overwhelmed.
- I am powerless.

But also about you as a caregiver . . .

- You are unresponsive.
- You are unreliable.
- You are, or will be, threatening, dangerous, rejecting.

You didn't create the invisible suitcase, and the beliefs inside aren't personally about you. But understanding its contents is critical to your helping your child to overcome the effects of trauma and establish healthy relationships.

The Invisible Suitcase and Behavior

The negative beliefs and expectations that fill the invisible suitcase permeate every aspect of a child's life. Children who have been through trauma take their invisible suitcases with them to school, into the community, everywhere they go. They have learned through painful experience that it is not safe to trust or believe in others, and that it is best not to give relationships a chance.

As a result, children who have experienced trauma often exhibit extremely challenging behaviors and reactions that can be overwhelming for resource parents. These problems may include aggression, outbursts of anger, trouble sleeping, and difficulty concentrating. Very often, the behavior problems that are the most difficult to handle—those that may even threaten the child's placement in your home—come from the invisible suitcase and its impact on relationships. One way of understanding why this happens is the concept of reenactment.

Reenactment is the habit of recreating old relationships with new people. Reenactments are behaviors that evoke in caregivers some of the same reactions that traumatized children experienced with other

adults, and so lead to familiar—albeit negative—interactions. Just as traumatized children's sense of themselves and others is often negative and hopeless, their reenactment behaviors can cause the new adults in their lives to feel negative and hopeless about the child.

Why Do Children Reenact?

Children who engage in reenactments are not consciously choosing to repeat painful or negative relationships. The behavior patterns children exhibit during reenactments have become ingrained over time because they:

- Are familiar and helped the child survive in other relationships
- "Prove" the negative beliefs in the invisible suitcase, by provoking the same reactions the child experienced in the past. **(A predictable world, even if negative, may feel safer than an unpredictable one.)**
- Help the child vent frustration, anger, and anxiety
- Give the child a sense of mastery over the old traumas

Many of the behaviors that are most challenging for resource parents are strategies that in the past may have helped the child survive in the presence of abusive or neglectful caregivers. Unfortunately, these once-useful strategies can undermine the development of healthy relationships with new people and only reinforce the negative messages contained in the invisible suitcase.

What Resource Parents Can Do

Remember the suitcase

Keep in mind that the children placed in your home are likely to re-use the strategies they learned in situations of abuse and neglect. Because of their negative beliefs, children with an invisible suitcase have learned to elicit adult involvement through acting out and problem behavior. These behaviors may evoke intense emotions in you, and you may feel pushed in ways you never expected. Some common reactions in resource parents include:

- Urges to reject the child
- Abusive impulses towards the child
- Emotional withdrawal and depression
- Feelings of incompetence/helplessness
- Feeling like a bad parent

This can lead to a vicious cycle in which the child requires more and more of your attention and involvement, but the relationship is increasingly strained by the frustration and anger both you and the child now feel. If left unchecked, this cycle can lead to still more negative interactions, damaged relationships, and confirmation of all the child's negative beliefs about him–/herself and others. In some cases, placements are ended. And the suitcase just gets heavier.

Provide disconfirming experiences

Preventing the vicious cycle of negative interactions requires patience and self-awareness. Most of all, it requires a concerted effort to respond to the child in ways that challenge the invisible suitcase and provide the child with new, positive messages. Messages that tell the child:

- You are worthwhile and wanted.
- You are safe.
- You are capable.

And messages that say you, as a caregiver:

- Are available and won't reject him/her.
- Are responsive and won't abuse him/her.
- Will protect him/her from danger.
- Will listen and understand him/her.

For more on helping foster children who have been through trauma, see:

Delaney, R. (1998). *Fostering changes: Treating attachment-disordered foster children (*2nd ed.). Oklahoma City, OK: Wood 'N' Barnes Publishing.

Kagan, R. (2004). *Rebuilding attachments with traumatized children.* New York: The Haworth Press, Inc.

This does not mean giving children a free pass on their negative behaviors. As a parent, you must still hold children accountable, give consequences, and set expectations. But with the invisible suitcase in mind, you balance correction with praise, and deliver consequences without the negative emotions that may be triggered by the child's reenactments.

- Praise even the simplest positive or neutral behaviors. Provide at least 6 instances of warm, sincere praise for each instance of correction.
- Stay calm and dispassionate when correcting the child. Use as few words as possible and use a soft, matter-of-fact tone of voice.
- Be aware of your own emotional response to the child's behavior. If you cannot respond in a calm, unemotional fashion, step away until you can.
- Don't be afraid to repeat corrections (and praise) as needed. Learning new strategies and beliefs takes time.

Establish a dialogue

The strategies that maltreated children develop to get their needs met may be brilliant and creative, but too often are personally costly. They need to learn that there is a better way. Children need to learn that they can talk about the underlying feelings and beliefs contained in their invisible suitcase. They need to understand that you as the caregiver can tolerate these expressions without the common reactions they have come to expect from adults: rejection, abuse, abandonment. Help children learn words to describe their emotions and feelings and encourage them to express those feelings. When the contents of the invisible suitcase have been unpacked and examined, reenactments and negative cycles are less likely to occur.

The Suitcase and You: Tips for Avoiding Compassion Fatigue

Caring for traumatized children and adolescents can take quite a toll on resource parents. Remember that paying attention to your own feelings and needs is just as important as attending to the needs of your child. Without proper self-care, you can become physically, mentally, and emotionally worn out—as if you are carrying the child's traumas all on your own shoulders. Some people call this "compassion fatigue." When this happens, you may experience:

- Increased irritability or impatience with the child
- Denial of the impact traumatic events have had on the child
- Feelings of numbness or detachment
- Intense feelings and intrusive thoughts about the child's past traumas that don't lessen over time
- Dreams about the child's traumas
- The desire to get away from the child or get the child out of your home

If you experience any of these signs for more than two to three weeks, seek counseling with a professional who is knowledgeable about trauma. To avoid compassion fatigue, take the following preemptive steps.

- **Beware of isolation.** Successful resource parents know that they cannot go it alone when caring for children with trauma. Work in a team, talk to other foster parents and therapists, and ask for support.
- **Accept your reactions.** All too often, resource parents judge themselves as weak or incompetent for having strong reactions to a child's trauma. These feelings are not a sign of weakness or incompetence; rather, they can be the cost of caring.
- **Work on understanding and processing your own traumas.** Adults with a history of unresolved traumatic experiences are more at risk for compassion fatigue. Seek help to make sure your own traumatic history and reactions to trauma reminders don't get in the way of your being an effective parent.
- **Keep your perspective.** Remember, you are not *just* a resource parent. Make time to interact with children and adolescents who have not been maltreated, to socialize with adult friends, and to find joy in every day. Be sure to laugh often.

Adapted from "The Invisible Suitcase" by Jennifer Wilgocki, MS, LCSW and Jim Van Den Brandt, LCSW, ACSW.

For more information on the impact of trauma on children,
visit the National Child Traumatic Stress Network (NCTSN) at www.NCTSN.org.

Work/Life Balance Plan

DAILY Activities You Do for Yourself	**WEEKLY** Activities You Do for Yourself	**MONTHLY** Activities You Do for Yourself	**SPECIAL OCCASION** Activities You Do for Yourself (Sad or Happy)

1. What prevents you from doing these activities?

2. What can you do to include more of these activities in your life?

Self-Care Inventory

Rate the following areas in frequency:

5 = Frequently
4 = Occasionally
3 = Rarely
2 = Never
1 = It never occurred to me

Physical Self-Care	
	Eat regularly (e.g. breakfast, lunch and dinner)
	Eat healthy
	Exercise consistently
	Get regular medical care for prevention
	Get medical care when necessary
	Take time off when sick
	Dance, swim, walk, run, play sports, sing or do some other physical activity that is enjoyable to self
	Take time to be sexual
	Get enough sleep
	Take vacations
	Wear clothes you like
	Take day trips or mini-vacations
	Make time away from telephones
	Other _____

Psychological Self-Care	
	Make time for self-reflection
	Engage in personal psychotherapy
	Write in a journal
	Read literature that is unrelated to work
	Do something in which you are not an expert or in charge
	Cope with stress in personal and/or work life

	Notice inner experience (e.g., listen to and recognize thoughts, judgments, beliefs, attitudes and feelings)
	Provide others with different aspects of self (e.g., communicate needs and wants)
	Try new things
	Practice receiving from others
	Improve ability to say “no” to extra responsibilities
	Other _____

Emotional Self-Care	
	Allow for quality time with others whose company you enjoy
	Maintain contact with valued others
	Give self affirmations and praise
	Love self
	Reread favorite book or review favorite movies
	Identify and engage in comforting activities, objects, people, relationships and places
	Allow for feeling expression (laugh, cry, etc…)
	Other _____

Spiritual Self-Care	
	Allow time for reflection
	Spend time with nature
	Participate in a spiritual community
	Open to inspiration
	Cherish own optimism and hope
	Be aware of nonmaterial aspects of life
	Cultivate ability to identify what is meaningful and its place in personal life
	Meditate/pray
	Contribute to causes in which you believe
	Read inspirational literature (lectures, music etc…)

Workplace or Professional Self-Care	
	Allow for breaks during the workday
	Engage with co-workers
	Provide self quiet time/space to complete tasks
	Participate in projects or tasks that are exciting and rewarding
	Set limits/boundaries with clients and colleagues
	Balance workload/cases
	Arrange work space for comfort
	Maintain regular supervision or consultation
	Negotiate needs (benefits, bonuses, raise, etc…)
	Participate in peer support group
	Other _____

* Review assigned numbers. Appreciate areas of strengths while making positive changes in areas with significantly low scores to improve balance in life.

Adapted by Mental Health Services for Homeless Persons, Inc. (MHS), Cleveland, OH. Used with permission. Original source: Unknown.

Secondary Traumatic Stress

Christine B. Siegfried, MSSW
National Center for Child Traumatic Stress, UCLA

Researchers have identified some special issues of concern to professionals, such as child welfare workers, who work directly with traumatized children and families. Sometimes the vivid recounting of trauma by a trauma survivor causes trauma reactions in the helping person. The professional is, in essence, exposed indirectly to trauma through hearing about the firsthand trauma experiences of others. This is referred to as secondary traumatic stress (STS) which is sometimes also called "compassion fatigue," or "vicarious trauma," or "indirect trauma."

STS can be thought of as a form of occupational stress. It can be a cumulative response to working with many trauma survivors over an extended period of time, or it may result from reactions to a particular client's traumatic experience.

Common sources of secondary trauma in social services include:

1. Facing the death of a child or adult family member on the worker's caseload
2. Investigating a vicious abuse/neglect report
3. Frequent/chronic exposure to emotional and detailed accounts by children of traumatic events
4. Photographic images of horrific injuries or scenes of a recent serious injury or death
5. Continuing work with families in which serious maltreatment, domestic violence, or sexual abuse is occurring
6. Helping support grieving family members following a child abuse death, including siblings of a deceased child.

In addition to the secondary traumatic stress that may arise from helping children, many child welfare workers are exposed to traumatic or life threatening events of their own. These events may arise while removing a child from his or her home when emotional intensity is great. Child welfare professionals sometimes confront intense verbal or physical assault by clients or community members (Friedman, 2002). They are sometimes exposed to violent family members, car accidents, and neighborhood violence. Occasionally child protective workers are stabbed or shot. Like other people, most child welfare workers will have short-lived reactions to these threats. With support from their colleagues and families, most workers will recover without formal assistance.

STS may be exacerbated by feelings of professional isolation, frequent contact with traumatized people and visits to trauma environments or locations, such as accident sites. It may be aggravated by the severity of the traumatic material to which the helper is exposed, such as direct contact with victims, or exposure to graphic accounts, stories, photos, and things associated with extremely stressful events. Some researchers believe that dealing with the pain of children is especially provocative for people and makes them more vulnerable to secondary traumatic stress than working with adult trauma survivors (Figley, 1995).

Only a small percentage of individuals will develop STS. However, traumatic events can bring about various posttraumatic reactions in some child welfare workers.

What Are Signs of STS?

Symptoms of secondary traumatic stress can include some of the same symptoms experienced by the direct victims of trauma—including increased fatigue or illness, social withdrawal, reduced productivity, feelings of hopelessness, despair, nightmares, feelings of re-experiencing of the event, having unwanted thoughts or images of traumatic events, anxiety, excess vigilance, avoidance of people or activities, or persistent anger and sadness (ISTSS, 2005).

The effects of secondary traumatic stress may also include changes in how the individual experiences him or herself and others, such as changes in feelings of safety, increased cynicism, and disconnection from coworkers and/or loved ones. Exposure to terrible knowledge about inhumane treatment of children often forces staff to re-examine their assumptions about religion, God, families and life itself (Friedman, 2002). In the workplace, STS has been associated with higher rates of physical illness, great absenteeism, higher turnover, lower morale, and lower productivity.

People may also experience difficulties in their personal or professional relationships, in managing boundaries, and in dealing with their emotions. They may have difficulties sleeping, overeat, or use too much alcohol, have anxiety for their own children and irritability toward their colleagues and family.

STS is different from burnout, although STS and burnout have some risk factors in common—high caseload demands, a personal history of trauma, limited access to supervision, lack of a supportive work environment, and/or a supportive social network. Burnout is often due to long-term involvement in a nonsupportive work environment, large caseloads, and onerous paperwork. With burnout, increased workload and institutional stress are the precipitating factors, rather than exposure to clients' trauma.

Trauma 101 Educator/ ChildCare Handouts

FRANKLIN COUNTY CARES

#STRENGTHENINGONETOSTRENGTHENALL

An interagency initiative that supports trauma-informed services and community education. We believe that trauma-informed care will help build stronger families and stronger communities.

WHAT IS TRAUMA?[1]

Any event that you witness or experience, that threatens your life or someone close to you, whether real or perceived.

Traumatic events could include witnessing or experiencing:

—Abuse —Abandonment —Neglect —Violent Crime
—Death or loss of a loved one —Life-Threatening Illness
—Automobile Accidents —Bullying —Community Violence
—Natural Disasters —Acts or Threats of Terrorism

EFFECTS ON KIDS AND FAMILIES[1]

Increased intergenerational trauma

Unstable relationships between:

- Intimate adults
- Parent-child
- Siblings

Depletion of financial resources

Inability to carry out family and social responsibilities

EFFECTS ON CHILDCARE & AFTER SCHOOL PROGRAMS[1,2]

- Social, emotional, or cognitive delays

-Misdiagnoses in children with trauma histories including:

- ADHD
- Oppositional defiant disorder
- Conduct disorder
- Bipolar disorder
- Reactive attachment disorder

1. National Child Traumatic Stress Network
2. Substance Abuse and Mental Health Services Administration

WHAT WE'RE DOING

Providing **FREE** training to community members and organizations:

- businesses
- childcare providers,
- medical professionals
- educators
- religious organizations

REFERRAL for children, families, and individuals to trauma-informed care services in Franklin County

WHAT YOU CAN DO

Attend one of our **FREE** Trauma 101 Trainings at Lutheran Family and Children's Services in Union, MO;

- March 22nd 6pm-9pm
- March 23rd 12pm-3pm
- March 29th 12pm-3pm
- March 29th 6pm-9pm

Schedule a **FREE** training for your organization.

Contact Emily Thoenen @ (314) 808-3997 to RSVP for a scheduled training or to schedule your own.

Attend the **Franklin County Spring Institute** featuring keynote speaker ***Heather Forbes,*** author of *Beyond Consequences, Logic and Control*

- April 6th 8am-5pm

Register @ franklincountykids.org

NCTSN The National Child Traumatic Stress Network

Child Trauma Toolkit for Educators

This project was funded by the Substance Abuse and Mental Health Services Administration (SAMHSA), US Department of Health and Human Services (HHS). The views, policies, and opinions expressed are those of the authors and do not necessarily reflect those of SAMHSA or HHS.

NCTSN The National Child Traumatic Stress Network

Child Trauma Toolkit for Educators

October 2008

This project was funded by the Substance Abuse and Mental Health Services Administration (SAMHSA), US Department of Health and Human Services (HHS). The views, policies, and opinions expressed are those of the authors and do not necessarily reflect those of SAMHSA or HHS.

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.

Suggested Citation:
National Child Traumatic Stress Network Schools Committee. (October 2008). Child Trauma Toolkit for Educators. Los Angeles, CA & Durham, NC: National Center for Child Traumatic Stress.

NCTSN The National Child Traumatic Stress Network

Table of Contents

Information for Educators

Information for Parents and Caregivers

TRAUMA FACTS for Educators

FACT: One out of every 4 children attending school has been exposed to a traumatic event that can affect learning and/or behavior.

FACT: Trauma can impact school performance.

- Lower GPA
- Higher rate of school absences
- Increased drop-out
- More suspensions and expulsions
- Decreased reading ability

FACT: Trauma can impair learning.

Single exposure to traumatic events may cause jumpiness, intrusive thoughts, interrupted sleep and nightmares, anger and moodiness, and/or social withdrawal—any of which can interfere with concentration and memory.

Chronic exposure to traumatic events, especially during a child's early years, can:

- Adversely affect attention, memory, and cognition
- Reduce a child's ability to focus, organize, and process information
- Interfere with effective problem solving and/or planning
- Result in overwhelming feelings of frustration and anxiety

FACT: Traumatized children may experience physical and emotional distress.

- Physical symptoms like headaches and stomachaches
- Poor control of emotions
- Inconsistent academic performance
- Unpredictable and/or impulsive behavior
- Over or under-reacting to bells, physical contact, doors slamming, sirens, lighting, sudden movements
- Intense reactions to reminders of their traumatic event:
    - Thinking others are violating their personal space, i.e., "What are you looking at?"
    - Blowing up when being corrected or told what to do by an authority figure
    - Fighting when criticized or teased by others
    - Resisting transition and/or change

FACT: You can help a child who has been traumatized.

- Follow your school's reporting procedures if you suspect abuse
- Work with the child's caregiver(s) to share and address school problems
- Refer to community resources when a child shows signs of being unable to cope with traumatic stress
- Share Trauma Facts for Educators with other teachers and school personnel

This project was funded by the Substance Abuse and Mental Health Services Administration (SAMHSA), US Department of Health and Human Services (HHS). The views, policies, and opinions expressed are those of the authors and do not necessarily reflect those of SAMHSA or HHS.

What can be done at school to help a traumatized child?

- Maintain usual routines. A return to "normalcy" will communicate the message that the child is safe and life will go on.
- Give children choices. Often traumatic events involve loss of control and/or chaos, so you can help children feel safe by providing them with some choices or control when appropriate.
- Increase the level of support and encouragement given to the traumatized child. Designate an adult who can provide additional support if needed.
- Set clear, firm limits for inappropriate behavior and develop logical—rather than punitive—consequences.
- Recognize that behavioral problems may be transient and related to trauma. Remember that even the most disruptive behaviors can be driven by trauma-related anxiety.
- Provide a safe place for the child to talk about what happened. Set aside a designated time and place for sharing to help the child know it is okay to talk about what happened.
- Give simple and realistic answers to the child's questions about traumatic events. Clarify distortions and misconceptions. If it isn't an appropriate time, be sure to give the child a time and place to talk and ask questions.
- Be sensitive to the cues in the environment that may cause a reaction in the traumatized child. For example, victims of natural storm-related disasters might react very badly to threatening weather or storm warnings. Children may increase problem behaviors near an anniversary of a traumatic event.
- Anticipate difficult times and provide additional support. Many kinds of situations may be reminders. If you are able to identify reminders, you can help by preparing the child for the situation. For instance, for the child who doesn't like being alone, provide a partner to accompany him or her to the restroom.
- Warn children if you will be doing something out of the ordinary, such as turning off the lights or making a sudden loud noise.
- Be aware of other children's reactions to the traumatized child and to the information they share. Protect the traumatized child from peers' curiosity and protect classmates from the details of a child's trauma.
- Understand that children cope by re-enacting trauma through play or through their interactions with others. Resist their efforts to draw you into a negative repetition of the trauma. For instance, some children will provoke teachers in order to replay abusive situations at home.
- Although not all children have religious beliefs, be attentive if the child experiences severe feelings of anger, guilt, shame, or punishment attributed to a higher power. Do not engage in theological discussion. Rather, refer the child to appropriate support.

- While a traumatized child might not meet eligibility criteria for special education, consider making accommodations and modifications to academic work for a short time, even including these in a 504 plan. You might:
  - Shorten assignments
  - Allow additional time to complete assignments
  - Give permission to leave class to go to a designated adult (such as a counselor or school nurse) if feelings become overwhelming
  - Provide additional support for organizing and remembering assignments

When should a referral be made for additional help for a traumatized child?

When reactions are severe (such as intense hopelessness or fear) or go on for a long time (more than one month) and interfere with a child's functioning, give referrals for additional help. As severity can be difficult to determine—with some children becoming avoidant or appearing to be fine (e.g., a child who performs well academically no matter what)—don't feel you have to be certain before making a referral. Let a mental health professional evaluate the likelihood that the child could benefit from some type of intervention.

When to seek self care?

Seek support and consultation routinely for yourself in order to prevent "compassion fatigue," also referred to as "secondary traumatic stress." Be aware that you can develop compassion fatigue from exposure to trauma through the children with whom you work.

This project was funded by the Substance Abuse and Mental Health Services Administration (SAMHSA), US Department of Health and Human Services (HHS). The views, policies, and opinions expressed are those of the authors and do not necessarily reflect those of SAMHSA or HHS.

There are children in your preschool who have experienced trauma.

Consider Ricky. Ricky, a three-year-old boy, cries inconsolably when his mother drops him off at school in the morning. His teachers thought his crying would stop when he became more comfortable in the classroom; however, he continues to cry every day and does not interact with his teachers or play with his peers. Ricky also has a speech delay and gets very upset when the other students are loud or when his daily routine is interrupted. One day the teacher asked Ricky to talk about his drawing, and he said, "Daddy hurt mommy." Ricky's mother was later observed to have a black eye and bruises that were consistent with assault.

Another example is Alexa. Alexa, a four-year-old girl, has been kicked out of two other preschools and is about to be expelled from her current school. She curses at teachers, hits, kicks, and scratches other students, and bangs her head on the table when she is frustrated. Alexa's behaviors are most difficult when transitioning from one activity to another. When the teacher meets with Alexa's father, the father reports that Alexa's mother uses drugs, that Alexa has seen her mother arrested by the police, and that Alexa's mother often does not come home at night.

What do these children have in common? They have both been exposed to trauma, defined as *an experience that threatens life or may cause physical injury and is so powerful and dangerous that it overwhelms the preschool child's capacity to regulate emotions.* Generally, traumatic events evoke feelings of extreme fear and helplessness. Reactions to traumatic events are determined by the subjective experience of the child, which could be impacted by developmental and cultural factors. What is extremely traumatic for one child may be less so for another.

Some traumatic experiences occur once in a lifetime, others are ongoing. Many children have experienced multiple traumas, and for too many children, trauma is a chronic part of their lives. (For examples, see sidebar, at right.)

Some children show signs of stress in the first few weeks after a trauma, but return to their usual state of physical and emotional health. Even children who do not exhibit serious symptoms may experience some degree of emotional distress, which may continue or even deepen over a long period of time. Children who have experienced traumatic events may experience problems that impair their day-to-day functioning.

Children who have experienced traumatic events may have behavioral problems, or their suffering may not be apparent at all.

It is important to be aware of both the children who act out and the quiet children who don't appear to have behavioral problems. These children often "fly beneath the radar" and do not get help. In any situation where there is a possibility of abuse, as in the cases above, you may be legally required to report the information to social services or law enforcement.

Be alert to the possibility of misdiagnosis due to the many presentations of trauma-related anxiety. For instance, many behaviors seen in children who have experienced trauma are nearly identical to those of children with developmental delays, ADHD and other mental health conditions. Without recognition of the possibility that a child is experiencing childhood traumatic stress, adults may develop a treatment plan that does not fully address the specific needs of that child with regard to trauma.

Situations that can be traumatic:

- Physical or sexual abuse
- Abandonment
- Neglect
- The death or loss of a loved one
- Life-threatening illness in a caregiver
- Witnessing domestic violence
- Automobile accidents or other serious accidents
- Bullying
- Life-threatening health situations and/or painful medical procedures
- Witnessing or experiencing community violence (e.g., shootings, stabbings, robbery, or fighting at home, in the neighborhood, or at school)
- Witnessing police activity or having a close relative incarcerated
- Life-threatening natural disasters
- Acts or threats of terrorism (viewed in person or on television)
- Living in chronically chaotic environments in which housing and financial resources are not consistently available

What you might observe in Preschool children:

Remember, young children do not always have the words to tell you what has happened to them or how they feel. Behavior is a better gauge and sudden changes in behavior can be a sign of trauma exposure.

- Separation anxiety or clinginess towards teachers or primary caregivers
- Regression in previously mastered stages of development (e.g., baby talk or bedwetting/toileting accidents)
- Lack of developmental progress (e.g., not progressing at same level as peers)
- Re-creating the traumatic event (e.g., repeatedly talking about, "playing" out, or drawing the event)
- Difficulty at naptime or bedtime (e.g., avoiding sleep, waking up, or nightmares)
- Increased somatic complaints (e.g., headaches, stomachaches, overreacting to minor bumps and bruises)
- Changes in behavior (e.g., appetite, unexplained absences, angry outbursts, decreased attention, withdrawal)
- Over- or under-reacting to physical contact, bright lighting, sudden movements, or loud sounds (e.g., bells, slamming doors, or sirens)
- Increased distress (unusually whiny, irritable, moody)
- Anxiety, fear, and worry about safety of self and others
- Worry about recurrence of the traumatic event
- New fears (e.g., fear of the dark, animals, or monsters)
- Statements and questions about death and dying

Some children, if given support, will recover within a few weeks or months from the fear and anxiety caused by a traumatic experience. However, some children will need more help over a longer period of time in order to heal and may need continuing support from family, teachers, or mental health professionals. Anniversaries of the events or media reports may act as reminders to the child, causing a recurrence of symptoms, feelings, and behaviors.

Mental health counseling that has been demonstrated to be effective in helping children deal with traumatic stress reactions typically includes the following elements:

- Helping children and caregivers reestablish a safe environment and a sense of safety
- Helping parents and children return to normal routines
- An opportunity to talk about and make sense of the traumatic experience in a safe, accepting environment
- Explaining the trauma and answering questions in an honest but simple and age-appropriate manner
- Teaching techniques for dealing with overwhelming emotional reactions
- Helping the child verbalize feelings rather than engage in inappropriate behavior
- Involving primary caregivers in the healing process
- Connecting caregivers to resources to address their needs–young children's level of distress often mirrors their caregiver's level of distress

This project was funded by the Substance Abuse and Mental Health Services Administration (SAMHSA), US Department of Health and Human Services (HHS). The views, policies, and opinions expressed are those of the authors and do not necessarily reflect those of SAMHSA or HHS.

There are students in your school who have experienced trauma.

Consider Amy. Her teacher brought the third grader, who had been a model student, to the school nurse, complaining that she was not paying attention or completing her work. Quiet and withdrawn in the nurse's office, Amy eventually said, "May I tell you something?" She then proceeded to talk about seeing her cat hit and killed by a car. She was both sad and frightened, couldn't make sense out of what had happened, and was having nightmares.

Another example is John. He is constantly in trouble at school, and appears to have significant problems grasping fourth grade material. His mother describes the violence that is pervasive in both their home and neighborhood. She reports that John has witnessed his father repeatedly beating her, and has been a victim himself of his father's rages. During first grade he was placed in foster care. John has also seen gun violence in his neighborhood.

What do these two very different individuals have in common? They have both been exposed to trauma, *defined as an experience that threatens life or physical integrity and that overwhelms an individual's capacity to cope.* Generally, traumatic events evoke feelings of extreme fear and helplessness. Reactions to traumatic events are determined by the subjective experience of the child, which could be impacted by developmental and cultural factors. What is extremely traumatic for one student may be less so for another.

Students who have experienced traumatic events may have behavioral or academic problems, or their suffering may not be apparent at all.

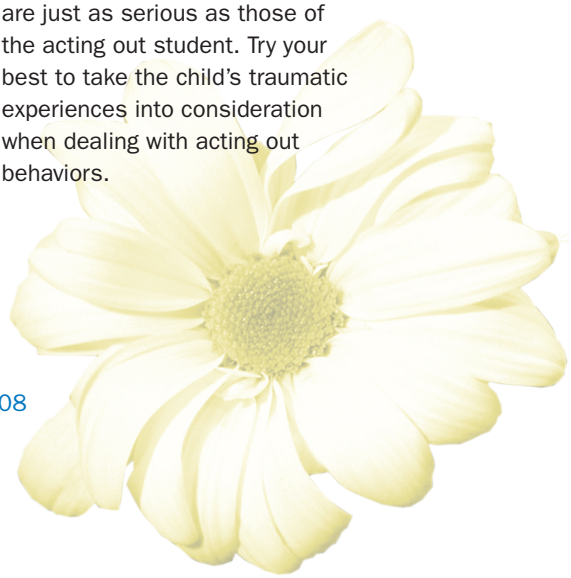
Some students show signs of stress in the first few weeks after a trauma, but return to their usual state of physical and emotional health. **Even a child who does not exhibit serious symptoms may experience some degree of emotional distress, and for some children this distress may continue or even deepen over a long period of time.**

Some traumatic experiences occur once in a lifetime, others are ongoing. Many children have experienced multiple traumas, and for too many children trauma is a chronic part of their lives. Students who have experienced traumatic events may experience problems that impair their day-to-day functioning.

Situations that can be traumatic:

- Physical or sexual abuse
- Abandonment, betrayal of trust (such as abuse by a caregiver), or neglect
- The death or loss of a loved one
- Life-threatening illness in a caregiver
- Witnessing domestic violence
- Automobile accidents or other serious accidents
- Bullying
- Life-threatening health situations and/or painful medical procedures
- Witnessing or experiencing community violence (e.g., drive by shooting, fight at school, robbery)
- Witnessing police activity or having a close relative incarcerated
- Life-threatening natural disasters
- Acts or threats of terrorism

Be alert to the behavior of the students who have experienced one or more of these events. **Be aware of both the children who act out AND the quiet children who don't appear to have behavioral problems.** These students often "fly beneath the radar" and do not get help. They may have symptoms of avoidance and depression that are just as serious as those of the acting out student. Try your best to take the child's traumatic experiences into consideration when dealing with acting out behaviors.



What you might observe in Elementary School students:

- Anxiety, fear, and worry about safety of self and others (more clingy with teacher or parent)
- Worry about recurrence of violence
- Increased distress (unusually whiny, irritable, moody)
- Changes in behavior:
  - Increase in activity level
  - Decreased attention and/or concentration
  - Withdrawal from others or activities
  - Angry outbursts and/or aggression
  - Absenteeism
- Distrust of others, affecting how children interact with both adults and peers
- A change in ability to interpret and respond appropriately to social cues
- Increased somatic complaints (e.g., headaches, stomachaches, overreaction to minor bumps and bruises)
- Changes in school performance
- Recreating the event (e.g., repeatedly talking about, "playing" out, or drawing the event)
- Over- or under-reacting to bells, physical contact, doors slamming, sirens, lighting, sudden movements
- Statements and questions about death and dying
- Difficulty with authority, redirection, or criticism
- Re-experiencing the trauma (e.g., nightmares or disturbing memories during the day)
- Hyperarousal (e.g., sleep disturbance, tendency to be easily startled)
- Avoidance behaviors (e.g., resisting going to places that remind them of the event)
- Emotional numbing (e.g., seeming to have no feeling about the event)

Some children, if given support, will recover within a few weeks or months from the fear and anxiety caused by a traumatic experience. However, some children need more help over a longer period of time in order to heal, and may need continuing support from family, teachers, or mental health professionals. Anniversaries of the event or media reports may act as reminders to the child, causing a recurrence of symptoms, feelings, and behaviors.

Mental health counseling that has been demonstrated to be effective in helping children deal with traumatic stress reactions typically includes the following elements:

- Education about the impact of trauma
- Helping children and caregivers re-establish a sense of safety
- Techniques for dealing with overwhelming emotional reactions
- An opportunity to talk about and make sense of the traumatic experience in a safe, accepting environment
- Involvement, when possible, of primary caregivers in the healing process

This project was funded by the Substance Abuse and Mental Health Services Administration (SAMHSA), US Department of Health and Human Services (HHS). The views, policies, and opinions expressed are those of the authors and do not necessarily reflect those of SAMHSA or HHS.

There are students in your school who have experienced trauma.

Consider Joy. Her teacher brought the sixth grader to the school nurse because she was complaining of a stomachache. The teacher was concerned about Joy's complaint and explained to the nurse that, while Joy had always been an enthusiastic and hardworking student, recently she had not been paying attention or completing her work. In the nurse's office, Joy was quiet and withdrawn, but eventually admitted that she had witnessed a girl being beaten by another student the previous day. She was sad, frightened, and afraid for her safety.

Another example is Trent. He is constantly getting into fights at school and appears to have significant problems understanding and completing his work. Trent was removed from his home in third grade and placed with his paternal grandmother. When contacted by the teacher about his problems in school, his grandmother explains that prior to coming to live with her, Trent lived in a community ridden with gang violence. His father was part of a gang and Trent used to see gun battles among gang members in his neighborhood. The grandmother also admits that Trent's father was very aggressive and may have physically abused Trent when he was younger.

What do these two very different individuals have in common? They have both been exposed to trauma, defined as *an experience that threatens life or physical integrity and that overwhelms an individual's capacity to cope.* Generally, traumatic events evoke feelings of extreme fear and helplessness. Reactions to traumatic events are determined by the subjective experience of the child, which could be impacted by developmental and cultural factors. What is extremely traumatic for one student may be less so for another.

Some students show signs of stress in the first few weeks after a trauma, but return to their usual state of physical and emotional health. Even a child who does not exhibit serious symptoms may experience some degree of emotional distress, and for some children this distress may continue or even deepen over a long period of time.

Some traumatic experiences occur once in a lifetime, others are ongoing. Many children have experienced multiple traumas, and for too many children trauma is a chronic part of their lives. Students who have experienced traumatic events may experience problems that impair their day-to-day functioning.

Students who have experienced traumatic events may have behavioral or academic problems or their suffering may not be apparent at all.

Situations that can be traumatic:

- Physical or sexual abuse
- Abandonment, betrayal of trust (such as abuse by a caregiver), or neglect
- The death or loss of a loved one
- Life-threatening illness in a caregiver
- Witnessing domestic violence
- Automobile accidents or other serious accidents
- Bullying
- Life-threatening health situations and/or painful medical procedures
- Witnessing or experiencing community violence (e.g., drive-by shooting, fight at school, robbery)
- Witnessing police activity or having a close relative incarcerated
- Life-threatening natural disasters
- Acts or threats of terrorism

Be alert to the behavior of students who have experienced one or more of these events. **Be aware of both the children who act out AND the quiet children who don't appear to have behavioral problems. These students often "fly beneath the radar" and do not get help.** They may have symptoms of avoidance and depression that are just as serious as those of the acting out student. Try your best to take the child's traumatic experiences into consideration when dealing with acting out behaviors.

What you might observe in Middle School students:

- Anxiety, fear, and worry about safety of self and others
- Worry about recurrence or consequences of violence
- Changes in behavior:
  - Decreased attention and/or concentration
  - Increase in activity level
  - Change in academic performance
  - Irritability with friends, teachers, events
  - Angry outbursts and/or aggression
  - Withdrawal from others or activities
  - Absenteeism
- Increased somatic complaints (e.g., headaches, stomachaches, chest pains)
- Discomfort with feelings (such as troubling thoughts of revenge)
- Repeated discussion of event and focus on specific details of what happened
- Over- or under-reacting to bells, physical contact, doors slamming, sirens, lighting, sudden movements
- Re-experiencing the trauma (e.g., nightmares or disturbing memories during the day)
- Hyperarousal (e.g., sleep disturbance, tendency to be easily startled)
- Avoidance behaviors (e.g., resisting going to places that remind them of the event)
- Emotional numbing (e.g., seeming to have no feeling about the event)

Some children, if given support, will recover within a few weeks or months from the fear and anxiety caused by a traumatic experience. However, some children need more help over a longer period of time in order to heal, and may need continuing support from family, teachers, or mental health professionals. Anniversaries of the event or media reports may act as reminders to the child, causing a recurrence of symptoms, feelings, and behaviors.

Mental health counseling that has been demonstrated to be effective in helping children deal with traumatic stress reactions typically includes the following elements:

- Education about the impact of trauma
- Helping children and caregivers re-establish a sense of safety
- Techniques for dealing with overwhelming emotional reactions
- An opportunity to talk about and make sense of the traumatic experience in a safe, accepting environment
- Involvement, when possible, of primary caregivers in the healing process

This project was funded by the Substance Abuse and Mental Health Services Administration (SAMHSA), US Department of Health and Human Services (HHS). The views, policies, and opinions expressed are those of the authors and do not necessarily reflect those of SAMHSA or HHS.

There are students in your school who have experienced trauma.

Consider Nicole. Her teacher noticed that the tenth grader, who had previously been a very outgoing and popular student, suddenly appeared quiet, withdrawn, and "spaced out" during class. When the teacher approached her after class, Nicole reluctantly admitted that she had been forced to have sex on a date the previous week. She was very embarrassed about the experience and had not told anyone because she felt guilty and was afraid of what would happen.

Another example is Daniel. Daniel has become increasingly aggressive and confrontational in school. He talks throughout classtime and has difficulty staying "on task." When approached by the teacher, his mother describes the constant neighborhood violence that Daniel is exposed to. He has witnessed a gun battle among gang members in the neighborhood and his mother suspects that he is in a gang. She is worried that he may be using drugs and alcohol. The mother also admits that during fifth grade, Daniel was placed in foster care due to physical abuse by his father and constant domestic violence in the home.

What do these two very different individuals have in common? They have both been exposed to trauma, defined as *an experience that threatens life or physical integrity and that overwhelms an individual's capacity to cope.* Generally traumatic events evoke feelings of extreme fear and helplessness. Reactions to traumatic events are determined by the subjective experience of the adolescent, which could be impacted by developmental and cultural factors. What is extremely traumatic for one student may be less so for another.

Some students show signs of stress in the first few weeks after a trauma, but return to their usual state of physical and emotional health. Even an adolescent who does not exhibit serious symptoms may experience some degree of emotional distress, and for some adolescents this distress may continue or even deepen over a long period of time. Some traumatic experiences occur once in a lifetime, others are ongoing. Many adolescents have experienced multiple traumas, and for too many adolescents trauma is a chronic part of their lives. Students who have experienced traumatic events may experience problems that impair their day-to-day functioning.

Be alert to the behavior of students who have experienced one of these events. **Be aware of both the adolescents who act out AND the quiet adolescents who don't appear to have behavioral problems.** These students often "fly beneath the radar" and do not get help. They may have symptoms of avoidance and depression that are just as serious as those of the acting out student. Try your best to take the adolescent's traumatic experiences into consideration when dealing with acting out behaviors.

Situations that can be traumatic:

- Physical or sexual abuse
- Abandonment, betrayal of trust (such as abuse by a caregiver), or neglect
- The death or loss of a loved one
- Life-threatening illness in a caregiver
- Witnessing domestic violence
- Automobile accidents or other serious accidents
- Bullying
- Life-threatening health situations and/or painful medical procedures
- Witnessing or experiencing community violence (e.g., drive-by shooting, fight at school, robbery)
- Witnessing police activity or having a close relative incarcerated
- Life-threatening natural disasters
- Acts or threats of terrorism

What you might observe in High School students:

Students who have experienced traumatic events may have behavioral or academic problems, or their suffering may not be apparent at all.

- Anxiety, fear, and worry about safety of self and others
- Worry about recurrence or consequences of violence
- Changes in behavior:
  - Withdrawal from others or activities
  - Irritability with friends, teachers, events
  - Angry outbursts and/or aggression
  - Change in academic performance
  - Decreased attention and/or concentration
  - Increase in activity level
  - Absenteeism
  - Increase in impulsivity, risk-taking behavior
- Discomfort with feelings (such as troubling thoughts of revenge)
- Increased risk for substance abuse
- Discussion of events and reviewing of details
- Negative impact on issues of trust and perceptions of others
- Over- or under-reacting to bells, physical contact, doors slamming, sirens, lighting, sudden movements
- Repetitive thoughts and comments about death or dying (including suicidal thoughts, writing, art, or notebook covers about violent or morbid topics, internet searches)
- Heightened difficulty with authority, redirection, or criticism
- Re-experiencing the trauma (e.g., nightmares or disturbing memories during the day)
- Hyperarousal (e.g., sleep disturbance, tendency to be easily startled)
- Avoidance behaviors (e.g., resisting going to places that remind them of the event)
- Emotional numbing (e.g., seeming to have no feeling about the event)

Some adolescents, if given support, will recover within a few weeks or months from the fear and anxiety caused by a traumatic experience. However, some adolescents need more help over a longer period of time in order to heal and may need continuing support from family, teachers, or mental health professionals. Anniversaries of the event or media reports may act as reminders to the adolescent, causing a recurrence of symptoms, feelings, and behaviors.

Mental health counseling that has been demonstrated to be effective in helping adolescents deal with traumatic stress reactions typically includes the following elements:

- Education about the impact of trauma
- Helping adolescents and caregivers re-establish a sense of safety
- Techniques for dealing with overwhelming emotional reactions
- An opportunity to talk about and make sense of the traumatic experience in a safe, accepting environment
- Involvement, when possible, of primary caregivers in the healing process

This project was funded by the Substance Abuse and Mental Health Services Administration (SAMHSA), US Department of Health and Human Services (HHS). The views, policies, and opinions expressed are those of the authors and do not necessarily reflect those of SAMHSA or HHS.

Brief Information on Childhood Traumatic Grief FOR SCHOOL PERSONNEL

This information sheet summarizes material found in the "In-Depth General Information Guide to Childhood Traumatic Grief" and "In-Depth Information on Childhood Traumatic Grief for School Personnel," available at www.NCTSN.org.

Childhood traumatic grief is a condition that some children develop after the death of a close friend or family member. Children who develop childhood traumatic grief reactions experience the cause of that death as horrifying or terrifying, whether the death was unexpected or due to natural causes. Even if the manner of death is not objectively sudden, shocking, or frightening to others, children who perceive the death this way may develop childhood traumatic grief.

For some children and adolescents, responses to traumatic events can have a profound effect on the way they see themselves and their world. They may experience important and long-lasting changes in their ability to trust others, their sense of personal safety, their effectiveness in navigating life challenges, and their belief that there is justice or fairness in life.

It's important to keep in mind that many children who encounter a shocking or horrific death of another person will recover naturally and not develop ongoing difficulties, while other children may experience such difficulties. Every child is different in his or her reactions to a traumatic loss.

Identifying Traumatic Grief in Students

Children at different developmental levels may react differently to a loved one's traumatic death. But there are some common signs and symptoms of traumatic grief that children might show at school. Teachers may observe the following in the student:

- Being overly preoccupied with how the loved one died
- Reliving or re-enacting the traumatic death through play, activities, and/or artwork
- Showing signs of emotional and/or behavioral distress when reminded of the loss
- Attempting to avoid physical reminders of the traumatic death, such as activities, places, or people related to the death
- Withdrawing from important aspects of their environment
- Showing signs of emotional constriction or "numbing"
- Being excessively jumpy or being easily startled
- Showing signs of a lack of purpose and meaning to one's life

How School Personnel Can Help a Student with Traumatic Grief

Inform others and coordinate services
Inform school administration and school counselors/psychologists about your concerns regarding the student. Your school district or state may have specific policies or laws about dealing with emotional issues with children. If you feel a student could benefit from the help of a mental health professional, work within your school's guidelines and with your administration to suggest a referral.

Answer a child's questions
Let the child know that you are available to talk about the death if he or she wants to. When talking to these children, accept their feelings (even anger), listen carefully, and remind them that it is normal to experience emotional and behavioral difficulties following the death of a loved one. Do not force a child to talk about the death if he or she doesn't want to. This may be more harmful than helpful for the child.

Create a supportive school environment
Maintain normal school routines as much as possible. A child with traumatic grief can feel that life is chaotic and out of his or her control. It's beneficial for the child to have a predictable class schedule and format. The child may also need extra reassurance and explanation if there is a change. Staff should look for opportunities to help classmates who are struggling with how best to help and understand a student with traumatic grief.

Raise the awareness of school staff and personnel
Teachers and school staff may misinterpret changes in children's behaviors and school performance when they are experiencing childhood traumatic grief. Although it is always a priority to protect and respect a child's privacy, whenever possible it may be helpful to work with school staff who have contact with the child to make sure they know that the child has suffered a loss and may be experiencing difficulties or changes in school performance as a result. In this way, the school staff can work together to ensure that children get the support and understanding they need.

Modify teaching strategies
Balance normal school expectations with flexibility. You might avoid or postpone large tests or projects that require extensive energy and concentration for a while following the death. Be sensitive when the student is experiencing difficult times—for example, on the anniversary of a death—so that you can be supportive and perhaps rearrange or modify class assignments or work. Use teaching strategies that promote concentration, retention, and recall and that increase a sense of predictability, control, and performance.

Support families
Build a relationship of trust with the student's family. On a personal level, be reliable, friendly, consistently caring, and predictable in your actions. Keep your word, and never betray the family's trust. It can be helpful for the school or district to designate a liaison who can coordinate the relationship among teachers, the principal, the guidance counselor, other appropriate school personnel, the family, and the child.

Make referrals
Consider referral to a mental health professional. Traumatic grief can be very difficult to resolve, and professional help is often needed. If possible, the student and him or her family should be referred to a professional who has considerable experience in working with children and adolescents and with the issues of grief and trauma.

For more information

Additional information about childhood traumatic grief and where to turn for help is available from the National Child Traumatic Stress Network at (310) 235-2633 and (919) 682-1552 or at www.NCTSN.org.

This project was funded by the Substance Abuse and Mental Health Services Administration (SAMHSA), US Department of Health and Human Services (HHS). The views, policies, and opinions expressed are those of the authors and do not necessarily reflect those of SAMHSA or HHS.

SELF CARE for Educators

"There is a cost to caring." *- Charles Figley*

Trauma takes a toll on children, families, schools, and communities. Trauma can also take a toll on school professionals. **Any educator who works directly with traumatized children and adolescents is vulnerable to the effects of trauma**—referred to as ***compassion fatigue*** or ***secondary traumatic stress***—being physically, mentally, or emotionally worn out, or feeling overwhelmed by students' traumas. The best way to deal with compassion fatigue is early recognition.

TIPS FOR EDUCATORS:

1. Be aware of the signs. Educators with compassion fatigue may exhibit some of the following signs:

- Increased irritability or impatience with students
- Difficulty planning classroom activities and lessons
- Decreased concentration
- Denying that traumatic events impact students or feeling numb or detached
- Intense feelings and intrusive thoughts, that don't lessen over time, about a student's trauma
- Dreams about students' traumas

2. Don't go it alone. Anyone who knows about stories of trauma needs to guard against isolation. While respecting the confidentiality of your students, get support by working in teams, talking to others in your school, and asking for support from administrators or colleagues.

3. Recognize compassion fatigue as an occupational hazard. When an educator approaches students with an open heart and a listening ear, *compassion fatigue* can develop. All too often educators judge themselves as weak or incompetent for having strong reactions to a student's trauma. Compassion fatigue is not a sign of weakness or incompetence; rather, it is the cost of caring.

4. Seek help with your own traumas. Any adult helping children with trauma, who also has his or her own unresolved traumatic experiences, is more at risk for compassion fatigue.

5. If you see signs in yourself, talk to a professional. If you are experiencing signs of compassion fatigue for more than two to three weeks, seek counseling with a professional who is knowledgeable about trauma.

6. Attend to self care. Guard against your work becoming the only activity that defines who you are. Keep perspective by spending time with children and adolescents who are not experiencing traumatic stress. Take care of yourself by eating well and exercising, engaging in fun activities, taking a break during the workday, finding time to self-reflect, allowing yourself to cry, and finding things to laugh about.

Resource: Figley, C.R. (1995). *Compassion fatigue: Coping with secondary traumatic stress disorder in those who treat the traumatized.* New York: Brunner/Mazel, Inc.

This project was funded by the Substance Abuse and Mental Health Services Administration (SAMHSA), US Department of Health and Human Services (HHS). The views, policies, and opinions expressed are those of the authors and do not necessarily reflect those of SAMHSA or HHS.

What is Child Traumatic Stress?

Child traumatic stress is when children and adolescents are exposed to traumatic events or traumatic situations, and when this exposure overwhelms their ability to cope.

When children have been exposed to situations where they feared for their lives, believed they could have been injured, witnessed violence, or tragically lost a loved one, they may show signs of traumatic stress. The impact on any given child depends partly on the objective danger, partly on his or her subjective reaction to the events, and partly on his or her age and developmental level.

If your child is experiencing traumatic stress you might notice the following signs:

- Difficulty sleeping and nightmares
- Refusing to go to school
- Lack of appetite
- Bed-wetting or other regression in behavior
- Interference with developmental milestones
- Anger
- Getting into fights at school or fighting more with siblings
- Difficulty paying attention to teachers at school and to parents at home
- Avoidance of scary situations
- Withdrawal from friends or activities
- Nervousness or jumpiness
- Intrusive memories of what happened
- Play that includes recreating the event

What is the best way to treat child traumatic stress?

There are effective ways to treat child traumatic stress.

Many treatments include cognitive behavioral principles:

- Education about the impact of trauma
- Helping children and their parents establish or re-establish a sense of safety
- Techniques for dealing with overwhelming emotional reactions
- An opportunity to talk about the traumatic experience in a safe, accepting environment
- Involvement, when possible, of primary caregivers in the healing process

For more information see the NCTSN website: www.nctsn.org.

What can I do for my child at home?

Parents never want their child to go through trauma or suffer its after effects.
Having someone you can talk to about your own feelings will help you to better help your child.

Follow these steps to help your child at home:

1. Learn about the common reactions that children have to traumatic events.
2. Consult a qualified mental health professional if your child's distress continues for several weeks. Ask your child's school for an appropriate referral.
3. Assure your child of his or her safety at home and at school. Talk with him or her about what you've done to make him or her safe at home and what the school is doing to keep students safe.
4. Reassure your child that he or she is not responsible. Children may blame themselves for events, even those completely out of their control.
5. Allow your child to express his or her fears and fantasies verbally or through play. That is a normal part of the recovery process.
6. Maintain regular home and school routines to support the process of recovery, but make sure your child continues going to school and stays in school.
7. Be patient. **There is no correct timetable for healing. Some children will recover quickly. Other children recover more slowly.** Try not to push him or her to "just get over it," and let him or her know that he or she should not feel guilty or bad about any of his or her feelings.

How can I make sure my child receives help at school?

If your child is staying home from school, depressed, angry, acting out in class, having difficulty concentrating, not completing homework, or failing tests, there are several ways to get help at school. Talk with your child's school counselor, social worker, or psychologist. Usually, these professionals understand child traumatic stress and should be able to assist you to obtain help.

Ask at school about services through Federal legislation including:

1. Special Education—the Individuals with Disabilities Education Act (IDEA) which, in some schools, includes trauma services; and
2. Section 504—which protects people from discrimination based on disabilities and may include provisions for services that will help your child in the classroom.

Check with your school's psychologist, school counselor, principal, or special education director for information about whether your child might be eligible for help with trauma under IDEA.

The good news is that there are services that can help your child get better. Knowing who to ask and where to look is the first step.

This project was funded by the Substance Abuse and Mental Health Services Administration (SAMHSA), US Department of Health and Human Services (HHS). The views, policies, and opinions expressed are those of the authors and do not necessarily reflect those of SAMHSA or HHS.

What Is Childhood Traumatic Grief?

This brief information guide to Childhood Traumatic Grief summarizes some of the material from the "In-Depth General Information Guide to Childhood Traumatic Grief," which can be found at www.NCTSN.org.

- Childhood traumatic grief is a condition that some children develop after the death of a close friend or family member.
- Children with childhood traumatic grief experience the cause of that death as horrifying or terrifying, whether the death was sudden and unexpected or due to natural causes.
- The distinguishing feature of childhood traumatic grief is that trauma symptoms interfere with the child's ability to work through the typical bereavement process.
- In this condition, even happy thoughts and memories of the deceased person remind children of the traumatic way in which they perceive the death of the person close to them.
- The child may have intrusive memories about the death that are shown by nightmares, feeling guilty, self-blame, or thoughts about the horrible way the person died.
- These children may show signs of avoidance and numbing such as withdrawal, acting as if they are not upset, and avoiding reminders of the person, the way the person died, or the event that led to the death.
- They may show physical or emotional symptoms of increased arousal such as irritability, anger, trouble sleeping, decreased concentration, drop in grades, stomachaches, headaches, increased vigilance, and fears about safety for themselves or others.
- These symptoms may be more or less common at different developmental stages.
- Left unresolved, this condition could lead to more serious difficulties over time.
- Not all children who lose a loved one in traumatic circumstances develop childhood traumatic grief; many experience normal grief reactions.

What Is Normal Grief?

In both normal childhood grief (also called uncomplicated bereavement) and childhood traumatic grief, children typically feel very sad and may have sleep problems, loss of appetite, and decreased interest in family and friends.

In both normal and traumatic grief, they may develop temporary physical complaints or they may regress, returning to behaviors they had previously outgrown, like bed-wetting, thumb-sucking, or clinging to parents.

Both groups of children may be irritable or withdrawn, have trouble concentrating, and be preoccupied with death.

Children experiencing normal grief reactions engage in activities that help them adapt to life.

Through the normal grief process children are typically able to:

- Accept the reality and permanence of the death
- Experience and cope with painful reactions to the death, such as sadness, anger, resentment, confusion, and guilt
- Adjust to changes in their lives and identities that result from the death

- Develop new relationships or deepen existing relationships to help them cope with the difficulties and loneliness that may have resulted from the death
- Invest in new relationships and life-affirming activities as a means of moving forward without the person being physically present
- Maintain a continuing, appropriate attachment to the person who died through such activities as reminiscing, remembering, and memorializing
- Make meaning of the death, a process that can include coming to an understanding of why the person died
- Continue through the normal developmental stages of childhood and adolescence

What Additional Challenges Increase the Risk of Childhood Traumatic Grief? (Secondary Adversities)

Some evidence suggests that bereaved children who experience additional challenges related to the death—called secondary adversities—or who are already facing difficult life circumstances, are at risk for experiencing traumatic grief. For example, a child who must move after the death of a father must contend with both the absence of a parent and disruption of a social network. A child who witnessed the murder of her mother may face an array of severe additional adversities, such as participation in legal proceedings and facing intrusive questions from peers. Children whose lives are already very complicated and filled with challenges and adversities may be particularly susceptible to developing traumatic grief reactions.

What to Do for Childhood Traumatic Grief

Children with childhood traumatic grief often try to avoid talking about the deceased person or their feelings about the death, but talking about it may be important for resolving trauma symptoms that are interfering with the child's ability to grieve. If symptoms similar to those listed on this sheet persist, professional help may be needed. The professional should have experience in working with children and adolescents and specifically with issues of grief and trauma. Treatment itself should address both the trauma of the death and grief symptoms. Effective treatments are available, and children can return to their normal functioning. If you do not know where to turn, talking to your child's pediatrician or a mental health professional may be an important first step. They should be able to provide you with a referral to a mental health professional who specializes in working with children and adolescents experiencing traumatic grief reactions. Additional information is available from the National Child Traumatic Stress Network at (310) 235-2633 and (919) 682-1552 or www.NCTSN.org.

This project was funded by the Substance Abuse and Mental Health Services Administration (SAMHSA), US Department of Health and Human Services (HHS). The views, policies, and opinions expressed are those of the authors and do not necessarily reflect those of SAMHSA or HHS.

Fidget Tools for Children

Visit the Franklin County Community Resource Board Pinterest page with more ideas:

https://www.pinterest.com/FCCRB_PuttingKidsFirst/fun-with-a-purpose/

← Weighted lap pad

http://lemonlimeadventures.com/simple-calming-weighted-lap-pad-cant-sit-

Weighted blanket →

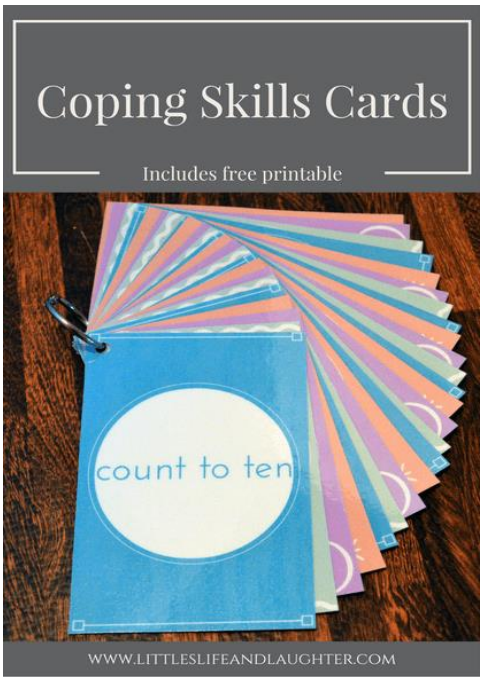
https://diyprojects.com/weighted-blankets-diy/

Scented Sensory Rainstick

https://childhood101.com/scented-rainstick-sensory-bottle/?utm_medium=social&utm_source=pinterest&utm_campaign=tailwind_tribes&utm_content=tribes

Key Ring with Beads

https://www.pinterest.com/pin/99008891791747356/



Coping Skills Cards

https://www.littleslifeandlaughter.com/coping-skills-cards/#more-240

Desk Fidget Tool

http://www.theottoolbox.com/2016/09/desk-fidget-tool-for-school.html

Trauma 101 Medical Handouts

FRANKLIN COUNTY CARES

#STRENGTHENINGONETOSTRENGTHENALL

An interagency initiative that supports trauma-informed services and community education. We believe that trauma-informed care will help build stronger families and stronger communities.

WHAT IS TRAUMA?[1]

Any event that you witness or experience, that threatens your life or someone close to you, whether real or perceived.

Traumatic events could include witnessing or experiencing:

—Abuse —Abandonment —Neglect —Violent Crime
—Death or loss of a loved one —Life-Threatening Illness
—Automobile Accidents —Bullying —Community Violence
—Natural Disasters —Acts or Threats of Terrorism

EFFECTS ON KIDS AND FAMILIES[1]

-Increased intergenerational trauma

Unstable relationships between:

- Intimate adults
- Parent-child
- Siblings

-Depletion of financial resources

-Inability to carry out family and social responsibilities

EFFECTS ON MEDICAL OUTCOMES[1,2,3]

-Increased prevalence of self-harm and self-destructive behaviors

-Increased

- Substance Abuse
- Migraine Diagnosis
- Heart Disease
- Diabetes

-Adverse Brain Development leading problems in attachment, attention and other behavioral problems

WHAT WE'RE DOING

Providing **FREE** training to community members and organizations:

- businesses
- childcare providers,
- medical professionals
- educators
- religious organizations

REFERRAL for children, families, and individuals to trauma-informed care services in Franklin County

WHAT YOU CAN DO

Attend one of our **FREE** Trauma 101 Trainings at Lutheran Family and Children's Services in Union, MO;

- March 22nd 6pm-9pm
- March 23rd 12pm-3pm
- March 29th 12pm-3pm
- March 29th 6pm-9pm

Schedule a **FREE** training for your organization.

Contact Emily Thoenen @ (314) 808-3997 to RSVP for a scheduled training or to schedule your own.

Attend the **Franklin County Spring Institute** featuring keynote speaker ***Heather Forbes***, author of *Beyond Consequences, Logic and Control*

- April 6th 8am-5pm

Register @ franklincountykids.org

FOLLOW US

Facebook: Franklin County Cares

Instagram: franklincountycares

Twitter: FCMO_Cares

Contact

Lutheran Family and Children's Services
15 S Oak St.
Union, MO
(314) 808-3997

1. National Child Traumatic Stress Network
2. American Academy of Neurology Annual Meeting 2016
3. Substance Abuse and Mental Health Services Administration

Long Term Physical Health Consequences of Adverse Childhood Experiences

Shannon M. Monnat, PhD and Raeven Faye Chandler

Shortened version of original article. For full article:

Long Term Physical Health Consequences of Adverse Childhood Experiences.html[6/15/2018 11:57:59 AM]

Abstract

This study examined associations between adverse childhood family experiences and adult physical health using data from 52,250 US adults aged 18–64 from the 2009–2012 Behavioral Risk Factor Surveillance System (BRFSS). We found that experiencing childhood physical, verbal, or sexual abuse, witnessing parental domestic violence, experiencing parental divorce, and living with someone who was depressed, abused drugs or alcohol, or who had been incarcerated were associated with one or more of the following health outcomes: self-rated health, functional limitations, diabetes, and heart attack. Adult socioeconomic status and poor mental health and health behaviors significantly mediated several of these associations. The results of this study highlight the importance of family-based adverse childhood experiences on adult health outcomes and suggest that adult SES and stress-related coping behaviors may be crucial links between trauma in the childhood home and adult health outcomes.

INTRODUCTION

A substantial literature addresses the associations between childhood household dysfunction and physical and mental well-being in adulthood. For a systematic review of this literature, see Norman et al. 2012. Children who are exposed to emotional, physical, or sexual abuse and other adverse conditions are at greater risk of several negative health outcomes in adulthood, including poor self-rated health, chronic diseases, functional limitations, premature mortality, and poor mental health (Amato 1991; Bauldry et al. 2012; Bonomi et al. 2008; Felitti et al. 1998; Kelly-Irving et al. 2013; Stack 1990). Given that early-life adversities lay a critical foundation for long-term health trajectories, the social and economic consequences of adverse childhood experiences (ACEs) are potentially far-reaching. ACEs can result in significant economic costs in the form of lost employment productivity and tax revenue and increased safety net and health care spending (Tang et al. 2006; Zielinksi 2009). ACEs are also associated with reduced adaptability and increased social isolation (Elliott et al. 2005), reduced self-esteem (Oates 1984), and increased rates of dissociation and anger hostility (Teicher et al. 2006). Yet we still know little about the complex pathways between ACEs and poor adult health outcomes, and how these pathways may vary across different adverse conditions and health outcomes.

The family is one of the most important contexts for human development. If the origins of adult disease and health disparities emerge in the childhood family environment (Shonkoff et al. 2009), then ameliorating these problems for children should help to protect their health over the life course. Accordingly, the objectives of the present study are to 1) examine whether there are significant associations between nine specific ACEs (physical abuse; sexual abuse; verbal abuse; witnessing parental domestic violence; experiencing parental divorce; living with anyone who was depressed, mentally ill, or suicidal; living with anyone who was a problem drinker or alcoholic; living with anyone who abused drugs; or living with anyone who was incarcerated, and four specific adult health outcomes (self-rated health, the presence of functional limitations, diabetes, and experiencing a heart attack; 2) determine whether adult socioeconomic status (SES) and/or poor mental health and stress-related coping behaviors serve as potential pathways linking ACEs with adult health; and 3) determine whether these mechanisms linking adversities during childhood to adult health vary for different adversities and different health outcomes.

BACKGROUND

Understanding the Link between Adverse Childhood Experiences and Adult Health

Insofar as ACEs contribute to the development of risk factors for poor health, then exposure to them should be recognized as a social determinant of health (Greenfield 2010). Previous research has found that childhood physical, verbal, and sexual abuse, witnessing parental domestic violence, parental divorce during childhood, and living with anyone who was depressed, abused substances, or was imprisoned are associated with increased odds of poor self-rated health and experiencing several chronic diseases and disorders in adulthood (Felitti et al. 1998; Irving and Ferraro 2006; Roettger and Boardman 2012; Schafer and Ferraro 2012; Springer et al. 2007; Springer 2009). While important, these studies have either examined one adverse experience at a time or summed them to create a cumulative ACE index, limiting our ability to understand which particular experiences are associated with each health outcome.

Although some researchers have argued that early risk factors have the potential to have enduring effects on individual life trajectories (Dannefer 2003; Ferraro and Kelley-Moore 2003), there may also be countervailing mechanisms to reduce the effects of early disadvantage on health (Ferraro and Kelley-Moore 2003). Identifying and targeting the potential links between ACEs and adult health may help to reduce one potential cause of health disparities throughout the life course.

Mechanisms Linking Adverse Childhood Experiences to Poor Health in Adulthood

The life course perspective is the dominant theoretical framework for understanding how conditions in childhood affect individuals throughout their lives. From this perspective, disadvantage is transmitted from parents to children through multiple pathways, and these early experiences can affect adult health through cumulative social and economic damage over time (Elder 1998; Hayward and Gorman 2004) and through the "biological embedding of adversities during sensitive developmental periods" (Shonhoff et al. 2009, 2252). Childhood is a particularly salient stage of development, and thus, adverse events during childhood have the potential to influence developmental pathways and shape the character and content of later life (Bauldry et al. 2012; Macmillan 2001). ACEs in the family environment may shape exposure to direct and indirect health risks, including disruption of neuroendocrine and immune functioning due to chronic arousal of the body's physiologic response to stress (Shonkoff et al. 2009); depression, PTSD, negative health attitudes and beliefs (Kendall-Tackett 2002); and economic tenuousness, stressful home environments, and poor health behavior choices in adulthood (Repetti et al. 2002), consequently leading to health disparities over the life course.

There are also sociological pathways related to decision-making and the accumulation of human capital that may explain the relationship between ACEs and poor adult health (Caspi 1987; Clausen 1991; Elder 1994; Macmillan 2001). The present research uses a large, diverse sample of US adults to examine two specific pathways that may link nine different ACEs and three specific adult health outcomes. Specifically, ACEs may be associated with negative health outcomes in adulthood through adult SES and/or stress and coping strategies that involve unhealthy lifestyle behaviors. Although these proposed pathways are not exhaustive of all potential mechanisms, they provide two useful starting points for understanding the links between ACEs and adult health.

Socioeconomic Status

We know a great deal about how childhood SES impacts adult health. Children who grow up in low SES households have worse self-rated health, higher chronic disease and mortality rates, and more functional limitations in adulthood compared to those who grew up in higher SES households (Bauldry et al. 2012; Hayward and Gorman 2004). In addition, Laaksonen et al. (2005) found that adult SES is associated with health independently of childhood economic difficulties. Few empirical studies, however, examine adult SES as a potential pathway linking ACEs to adult health, and those that do tend to focus on one type of adverse experience (usually physical or sexual abuse). There is some theoretical and empirical support for the idea that ACEs may be associated with adult SES, *net of the effects* of childhood SES. Children who grow up in unhealthy, unstable, or dangerous environments may be at greater risk of what Merton (1938) referred to as ritualism and retreatism. Retreatism involves rejecting goals and societal norms, and ritualism involves conforming to social norms related to legitimate means of attaining goals but lowering expectations, aspirations, and ambitions toward achieving those goals. Expanding on Merton, Agnew (1999) suggests that exposure to negative stimuli, like physical abuse or witnessing parental violence in the home, increases the likelihood of rejection of

conventional goals. Both ritualism and retreatism are associated with reduced effort to achieve success, resulting in lower educational attainment, lower likelihood of employment, and less income (Covey et al. 2013).

There is empirical evidence of negative educational and socioeconomic consequences of abuse in childhood. Abused children have been found to have lower IQ scores (Sadeh et al 1994), worse school achievement (Eckenrode et al. 1993), diminished educational aspirations and effort (Macmillan 2000), and lower educational attainment (Widom 1989). These educational deficits are then likely to result in worse employment prospects, lower income, and less human capital in adulthood
(Macmillan 2000). Childhood exposure to abuse has been found to be associated with dissociation, limbic irritability, depression, and anger-hostility (Teicher et al. 2006), all of which may make it more difficult to attain higher education and maintain employment. Exposure to abuse or adult depression or substance abuse in the home, for example, may produce negative models for interpersonal communication, which could then be incorporated as a behavioral response in adult settings, such as college and the workplace. In addition, these negative behavioral models may translate into criminal justice involvement, such as arrest and conviction
(Baglivio et al. 2014; Hagan and McCarthy 1997; Widom 1989), which can diminish future educational and employment prospects.

Research demonstrates that children who grow up in unhealthy, unsafe, or unstable environments are more likely to be economically disadvantaged as adults, *despite parental SES*. In a prospective cohort study using court-substantiated cases of childhood physical and sexual abuse, Currie and Widom (2010) found that adults with documented histories of childhood abuse and/or neglect had lower levels of education, employment, and earnings and fewer assets as adults compared with matched control children. Using longitudinal data and controlling for parental family structure and childhood SES, Covey et al. (2013) found significant associations between childhood physical abuse and witnessing adult domestic violence and adult income and net worth. Together, these economic disadvantages that are more prevalent among adults with ACEs may equate to worse health outcomes.

Adult SES is an established fundamental cause of health disparities because SES embodies a diverse collection of resources, such as money, knowledge, prestige, power, and important social connections that protect health (Adler et al. 1994; Link and Phelan 1995). SES differences exist for premature mortality (Idler and Benyamini 1997) and for almost every known disease and condition,

including self-rated health (Laaksonen et al. 2005; Lantz et al. 2005), chronic conditions (House 1990) and disability (Hemingway et al. 1997; Lantz et al. 2005). Adults with higher SES should have greater access to financial resources, knowledge, and social networks that can protect against negative health conditions that may be linked to their adverse childhood experiences.

Unhealthy Lifestyle Behaviors

Previous research suggests that survivors of ACEs experience greater perceived stress as adults compared with adults who did not experience adverse events as a child (Briere and Elliott 2003; Hyman et al. 2007). As a result, these individuals may have developed adaptive coping strategies that are harmful to their health. Adults with ACEs may attempt to manage psychological problems, like stress, through avoidance-focused coping mechanisms that may be adaptive means of coping with trauma but may be detrimental to health in the long term. Coping strategies like smoking, alcohol consumption, over-eating, and engaging in risky behaviors can temporarily alleviate distress, shame, and helplessness (Briere 2002) but can lead to health problems over time. Meanwhile, healthier coping mechanisms, like exercise, may be underutilized as adaptive strategies to deal with the childhood trauma.

A number of unhealthy lifestyle choices have been linked to growing up in adverse household conditions. Researchers have found higher rates of adult smoking, drug abuse, physical inactivity, poor diet, alcoholism, and risky sexual behaviors among individuals who experienced childhood maltreatment or household dysfunction (Dube et al. 2003; Felitti et al. 1998; Ford et al. 2011; Kendall-Tackett et al. 2000). Ultimately, individuals' self-regulatory processes may be important intervening variables through which ACEs contribute to poor adult health.

The Present Study

This study advances the literature on the relationship between ACEs and adult health in several ways. First, while previous studies have been restricted to specific US states or community-based samples, we use a large sample of adults who provided retrospective information about their childhood experiences and current health status. Second, previous research on ACEs and adult health has often failed to control for health care access, risking potential confounding of physical health factors with access to care. By controlling for health insurance status we reduce this risk. Third, previous research has tended to examine one ACE at a time or created a cumulative index of experiences,thereby reducing our ability to be able to identify the unique association of

each ACE with adult health, net of controls for other ACEs. Our research examines all of these associations while simultaneously controlling for each of the other ACEs in order to isolate the relationship of each ACE with adult health without risking the confounding that may occur when only examining one adverse condition at a time. Fourth, we use four distinct measures of health to explore whether ACEs differentially predict different adult health outcomes. Finally, we test two plausible pathways that may link ACEs to health, including adult SES, which is often neglected in studies examining relationships between ACEs and adult health despite it being an established fundamental cause of health disparities (Link and Phelan 1995).

Discussion

We used data from the four years in which the *adverse childhood experiences* module was available (2009–2012) in the Behavioral Risk Factor Surveillance System (BRFSS) to examine associations between adverse experiences during childhood and adult physical health and to explore plausible explanations for how these experiences may be connected to poor adult physical health. The results of this study highlight the importance of family-based ACEs on adult health outcomes and suggest that adult SES and stress-related coping behaviors are crucial links between trauma in the childhood home and adult health.

This research advances the literatures on ACEs and life course determinants of health in a number of important ways. First, findings indicate that, net of controls for concomitant ACEs and demographic characteristics of respondents, there are several important associations between adverse conditions in childhood and all four indicators of adult health. While previous research has examined relationships between adult health and one particular adverse experience at a time or combined ACEs into a single summed construct, by integrating all nine adverse experiences into the same analyses, we were able to reduce the risk of confounding that occurs when excluding potentially concomitant experiences while at the same time maintaining the ability to delineate the unique health outcomes associated with each type of adverse experience. This is important because we found that the associations between ACEs and adult health were not universal; some ACEs were associated with certain health outcomes but not others. For example, experiencing childhood physical abuse was significantly and substantively associated with all four health outcomes while verbal abuse was associated only with self-rated health and functional limitations and witnessing parental domestic violence was associated only with odds of a diabetes diagnosis. Combining the ACEs into a cumulative scale would mask these variations.

~~Second, our results largely suppo~~rt the hypothesis that adult SES helps to explain the relationship between ACEs and physical health outcomes. This is important considering that a large proportion of previous research on the relationship between ACEs and adult health downplays or completely ignores the role of adult SES. Formal statistical mediation analyses revealed that SES, particularly household income and educational attainment, significantly mediate associations between all four health outcomes and most of the ACEs. Children who grow up in unsafe and unhealthy environments may be at greater risk of rejecting social norms related to socioeconomic success or of having lowered expectations or ambitions for SES attainment (Agnew 1999; Covey et al. 2013; Merton 1938). Given the well-established role of SES as a social determinant of health (Link and Phelan 1995) adult economic disadvantage stemming from adverse conditions during childhood may then result in worse health outcomes in adulthood. A limitation to this study is that we were unable to control for childhood SES, which has been found in previous research to be associated both with adult SES and adult health (Hayward and Gorman 2004; Montez and Hayward 2014), leading to potential confounding in our results. Therefore, although the association between childhood adversity and adult health does appear to be at least partially explained by adult SES, this association is not independent of childhood SES. However, given recent findings that children who experienced abuse or neglect had lower SES in adulthood regardless of parental SES during childhood (Covey et al. 2013; Currie and Widom 2010), we are confident that our results would be robust to controls for childhood SES if they were available. Interestingly, despite the importance of health insurance in enabling access to health care resources and our finding that individuals who had no ACEs were more likely to have health insurance than those who had at least one ACE, we found that health insurance did not serve as a mediator between any of the ACEs and any health outcomes. Future research should more fully examine the role of insurance coverage in minimizing the impacts of trauma and stress on health throughout the life course. Rather than trying to reduce disease burden with health care system treatment, more effective strategies may include the promotion of positive coping behaviors and strategies to improve mental health.

Indeed, we found that poor mental health and poor stress-related coping behaviors, such as smoking, obesity, and lack of exercise were more prevalent among adults who experienced ACEs, and these behaviors and conditions helped to attenuate relationships between ACEs and

adult health. Poor mental health was particularly important in explaining associations between ACEs and the health outcomes. For example, the remaining associations between functional limitations and physical abuse, verbal abuse, living with someone who was depressed, and living with someone who abused alcohol were explained with the introduction of poor mental health. These findings support the vast literature suggesting that individuals who experienced adverse childhood conditions often develop adaptive coping strategies to deal with symptoms of depression and stress that are harmful to their health (Briere 2002; Dube et al. 2003; Felitti et al. 1998; Ford et al. 2011; Kendall-Tackett et al. 2000).

The results of this study also support and extend previous research suggesting that psychological maltreatment may be just as or more detrimental to health than physical abuse (Irving and Ferraro 2006; Teicher et al 2006). Even after all controls, childhood verbal abuse remained a robust and

enduring predictor of self-rated health and functional limitations, while physical abuse only remained associated with odds of having a heart attack, and sexual abuse only remained associated with odds of having a functional limitation. It is interesting that the enduring relationships between verbal abuse and adult health existed for the two items that were self-rated by respondents rather than the disease diagnoses items. Childhood verbal abuse may have a more enduring effect on individuals' *perceptions* of their own health. Future research should explore the mechanisms that link childhood verbal abuse to adult perceptions of health in an effort to propose interventions to reduce the lifelong burden of childhood verbal abuse.

Parental divorce also remained significantly and positively associated with odds of having a heart attack, net of all controls.. Previous research suggests that parental divorce can be stressful to children's developmental processes (Amato 2010). The disadvantaged circumstances that often occur for families before, during, and after divorce may influence risk of cardiovascular problems later in life in ways that we were unable to capture with the existing health behavior variables in the BRFSS. For example, the BRFSS item about exercise asks only whether the respondent engaged in any form of exercise, with no indication of frequency, amount, or energy expenditure, and the weight status variable uses the controversial proxy of body mass index which may not accurately capture obesity and obesogenic outcomes like heart disease and heart attack. Our measure of divorce is also unable to capture the overall family structure of respondents when they were children, including whether children were exposed to multiple divorces or other family transitions or whether the divorce improved or worsened living conditions for the child.

Although not the primary purpose of this study, we did find that certain SES and health history and behavior variables were more important for explaining some adult health outcomes than others. For instance, weight status was a particularly important predictor of diabetes; poor mental health and being unable to work were most strongly associated with having a functional limitation; exercise was a strong predictor of self-rated health, and weight status and smoking were strongly associated with heart attack. There were also some interesting findings related to SES. While individuals with household incomes of less than $75,000 had worse self-rated health and higher odds of diabetes than those with incomes of $75,000 or more, only the lowest income individuals (those with poverty incomes of $25,000 or less) had increased odds of a heart attack, and those with less than a high school diploma had over twice the odds of a heart attack than those with a college degree, suggesting that being in a precarious socioeconomic position puts one at particular risk of cardiovascular troubles. Unfortunately, we are unable to control for important indicators like fat and sugar consumption, energy expenditure, and cortisol levels that may explain this elevated risk of heart attack among socioeconomically disadvantaged individuals. Explanations of these phenomena are beyond the scope of this paper, but researchers should continue to examine the existence and strength of associations between various adult health outcomes and indicators of SES and health behaviors and not simply assume that those relationships are universal across all health outcomes.

A number of limitations should be considered when interpreting the results of this research. First, this study cannot account for childhood health and other conditions, which may confound the findings. It is possible that having a child with health problems may lead to marital problems and parental frustration that may increase the risk for physical and verbal abuse, parental depression, substance abuse, and divorce. Second, the effects of ACEs on adult health are likely conditioned by the age at which the child experienced the adversity (Elder 1994; Macmillan 2001) as well as the duration and severity of the adversity. Due to the retrospective nature of these data, we were unable to assess variation in timing, duration, and severity of ACEs. Instances of abuse that occurred many decades in the past may alter respondents' interpretation of events, and this in turn may bias our results. This is particularly important for verbal abuse since it is a far more ambiguous construct than the other ACEs, and it may be that those who are in poor health, and are therefore more pessimistic about their futures, retroactively interpret occasions of disagreement or discipline as more abusive than people who are in good health. It may also be that adults who interpret their current and retrospective life conditions in more negative terms are more likely to report both childhood verbal abuse and poor health.

Third, there are many different ways to measure health, and even though we have examined three distinct measures, a comprehensive health measure may more accurately represent an individual's health (Richardson and Zumbo 2000; Wolinsky and Zusman 1980). Similarly, the functional limitation dependent variable is measured with a binary 'yes/no' response in the BRFSS. A scale or index of functional limitations would allow for a more nuanced examination of the relationship between ACEs and functional limitations. Fourth, data limitations may lead to omitted variable bias, in this case related to the omission of other childhood adversities like household poverty, poor nutrition, residential instability, and dangerous neighborhood conditions.

Finally, due to the voluntary uptake of the ACE module in the BRFSS, this sample is not nationally representative. The states that included this module had lower percentages of Hispanics on average than the US as a whole. Given that Hispanics in our sample were more likely than whites to have reported ACEs, worse self-rated health, and higher chronic disease prevalence, the most likely consequence of the under-representation of Hispanics in our sample is that our results underestimate the prevalence of ACEs in the US.

Childhood is a period in the life course that has major implications for future educational, labor market, and health outcomes (Macmillan 2001; McLeod and Kaiser 2004). To the extent that ACEs are associated with poor health outcomes in adulthood, they should be considered life course social determinants of health and an issue deserving of public health attention. Given that ACEs may subject children to disadvantaged socioeconomic and health life-course trajectories, early interventions with unstable or abusive parents may be one of several strategies to prevent future SES disparities *and* health disparities. Interventions targeting the early childhood origins of adult health disparities may be more effective than attempting to modify health behaviors or improve health care access in adulthood (Shonkoff et al. 2009). Finally, while child protective service agencies and doctors have historically been more concerned about the impact and prevention of physical and sexual abuse (Manning and Cheers 1995), the results of this study suggest that screening for verbal abuse should also be a priority.

Acknowledgments

The authors would like to acknowledge support from the Population Research Institute at Penn State which receives core funding from the National Institute of Child Health and Human Development (Grant R24-HD041025). We would also like to thank Editors Betty Dobratz and Lisa Waldner, anonymous TSQ reviewers, and attendees at the 2014 Annual Meeting of the Population Association of America session on “Life Course Perspectives on Family and Health” for their helpful comments that have strengthened this article.

Contributor Information

Shannon M. Monnat, Assistant Professor of Rural Sociology, Demography and Sociology, Research Associate, Population Research Institute, The Pennsylvania State University.

Raeven Faye Chandler, PhD Student in Rural Sociology and Demography, The Pennsylvania State University .

References available at:

Long Term Physical Health Consequences of Adverse Childhood Experiences.html

How Childhood Trauma Could Be Mistaken for ADHD

Some experts say the normal effects of severe adversity may be misdiagnosed as ADHD.

REBECCA RUIZ

Jul 7, 2014


SHUTTERSTOCK

Dr. Nicole Brown's quest to understand her misbehaving pediatric patients began with a hunch.

Brown was completing her residency at Johns Hopkins Hospital in Baltimore, when she realized that many of her low-income patients had been diagnosed with attention deficit/hyperactivity disorder (ADHD).

These children lived in households and neighborhoods where violence and relentless stress prevailed. Their parents found them hard to manage and teachers described them as disruptive or inattentive. Brown knew these behaviors as classic symptoms of ADHD, a brain disorder characterized by impulsivity, hyperactivity, and an inability to focus.

When Brown looked closely, though, she saw something else: trauma. Hyper-vigilance and dissociation, for example, could be mistaken for inattention. Impulsivity might be brought on by a stress response in overdrive.

"Despite our best efforts in referring them to behavioral therapy and starting them on stimulants, it was hard to get the symptoms under control," she said of treating her patients according to guidelines for ADHD. "I began hypothesizing that perhaps a lot of what we were seeing was more externalizing behavior as a result of family dysfunction or other traumatic experience."

Considered a heritable brain disorder, one in nine U.S. children—or 6.4 million youth—currently have a diagnosis of ADHD. In recent years, parents and experts have questioned whether the growing prevalence of ADHD has to do with hasty medical evaluations, a flood of advertising for ADHD drugs, and increased

pressure on teachers to cultivate high-performing students. Now Brown and other researchers are drawing attention to a compelling possibility: Inattentive, hyperactive, and impulsive behavior may in fact mirror the effects of adversity, and many pediatricians, psychiatrists, and psychologists don't know how—or don't have the time—to tell the difference.

Though ADHD has been aggressively studied, few researchers have explored the overlap between its symptoms and the effects of chronic stress or experiencing trauma like maltreatment, abuse and violence. To test her hypothesis beyond Baltimore, Brown analyzed the results of a national survey about the health and well-being of more than 65,000 children.

Brown's findings, which she presented in May at an annual meeting of the Pediatric Academic Societies, revealed that children diagnosed with ADHD also experienced markedly higher levels of poverty, divorce, violence, and family substance abuse. Those who endured four or more adverse childhood events were three times more likely to use ADHD medication.

Interpreting these results is tricky. All of the children may have been correctly diagnosed with ADHD, though that is unlikely. Some researchers argue that the difficulty of parenting a child with behavioral issues might lead to economic hardship, divorce, and even physical abuse. This is particularly true for parents who themselves have ADHD, similar impulsive behavior or their own history of childhood maltreatment. There is also no convincing evidence that trauma or chronic stress lead to the development of ADHD.

For Brown, who is now a pediatrician at Montefiore Medical Center in the Bronx, the data are cautionary. It's not evident how trauma influences ADHD diagnosis and management, but it's clear that some misbehaving children might be experiencing harm that no stimulant can fix. These children may also legitimately have ADHD, but unless prior or ongoing emotional damage is treated, it may be difficult to see dramatic improvement in the child's behavior.

"We need to think more carefully about screening for trauma and designing a more trauma-informed treatment plan," Brown says.

Dr. Kate Szymanski came to the same conclusion a few years ago. An associate professor at Adelphi University's Derner Institute and an expert in trauma, Szymanski analyzed data from a children's psychiatric hospital in New York. A majority of the 63 patients in her sample had been physically abused and lived in foster homes. On average, they reported three traumas in their short lives. Yet, only eight percent of the children had received a diagnosis of post-traumatic stress disorder while a third had ADHD.

“I was struck by the confusion or over-eagerness–or both–to take one diagnosis over another,” Szymanski says. “To get a picture of trauma from a child is much harder than looking at behavior like impulsivity, hyperactivity. And if they cluster in a certain way, then it’s easy to go to a conclusion that it’s ADHD.”

A previous edition of the Diagnostic and Statistical Manual of Mental Disorders urged clinicians to distinguish between ADHD symptoms and difficulty with goal-directed behavior in children from “inadequate, disorganized or chaotic environments,” but that caveat does not appear in the latest version. Unearthing details about a child’s home life can also be challenging, Szymanski says.

A child may withhold abuse or neglect to protect his family or, having normalized that experience, never mention it all. Clinicians may also underestimate the prevalence of adversity. The Adverse Childhood Experiences Study, a years-long survey of more than 17,000 adults, found that two-thirds of participants reported at least one of 10 types of abuse, neglect, or household dysfunction. Twelve percent reported four or more. That list isn’t exhaustive, either. The study didn’t include homelessness and foster care placement, for example, and the DSM doesn’t easily classify those events as “traumatic."

It’s not clear how many children are misdiagnosed with ADHD annually, but a study published in 2010 estimated the number could be nearly 1 million. That research compared the diagnosis rate amongst 12,000 of the youngest and oldest children in a kindergarten sample and found that the less mature students were 60 percent more likely to receive an ADHD diagnosis.

Though ADHD is thought to be a genetic condition, or perhaps associated with lead or prenatal alcohol and cigarette exposure, there is no brain scan or DNA test that can give a definitive diagnosis. Instead, clinicians are supposed to follow exhaustive guidelines set forth by professional organizations, using personal and reported observations of a child’s behavior to make a diagnosis. Yet, under financial pressure to keep appointments brief and billable, pediatricians and therapists aren’t always thorough.

“In our 15-minute visits—maybe 30 minutes at the most—we don’t really have the time to go deeper,” Brown says. If she suspects ADHD or a psychological condition, Brown will refer her patient to a mental health professional for a comprehensive evaluation. “You may have had this social history that you took in the beginning, but unless the parent opens up and shares more about what’s going on in the home, we often don’t have the opportunity or think to connect the two.”

Caelan Kuban, a psychologist and director of the Michigan-based National Institute for Trauma and Loss in Children, knows the perils of this gap well. Four

years ago she began offering a course designed to teach educators, social service workers and other professionals how to distinguish the signs of trauma from those of ADHD.

“It’s very overwhelming, very frustrating,” she says. “When I train, the first thing I tell people is you may walk away being more confused than you are right now.”

In the daylong seminar, Kuban describes how traumatized children often find it difficult to control their behavior and rapidly shift from one mood to the next. They might drift into a dissociative state while reliving a horrifying memory or lose focus while anticipating the next violation of their safety. To a well-meaning teacher or clinician, this distracted and sometimes disruptive behavior can look a lot like ADHD.

Kuban urges students in her course to abandon the persona of the “all-knowing clinician” and instead adopt the perspective of the “really curious practitioner.”

Rather than ask what is wrong with a child, Kuban suggests inquiring about what happened in his or her life, probing for life-altering events.

Jean West, a social worker employed by the school district in Joseph, Missouri, took Kuban’s course a few years ago. She noticed that pregnant teen mothers and homeless students participating in district programs were frequently diagnosed with ADHD. This isn’t entirely unexpected: Studies have shown that ADHD can be more prevalent among low-income youth, and that children and adolescents with the disorder are more prone to high-risk behavior. Yet, West felt the students’ experiences might also explain conduct easily mistaken for ADHD.

Kuban’s course convinced West to first consider the role of trauma in a student’s life. “What has been the impact? What kind of family and societal support have they had?” West asks. “If we can work on that level and truly know their story, there’s so much power in that.”

As a school official, West sometimes refers troubled students to a pediatrician or psychiatrist for diagnosis, and meets with parents to describe how and why adversity might shape their child’s behavior. In her private practice, West regularly assesses patients for post-traumatic stress disorder instead of, or in addition to, ADHD.

Though stimulant medications help ADHD patients by increasing levels of neurotransmitters in the brain associated with pleasure, movement, and attention, some clinicians worry about how they affect a child with PTSD, or a similar anxiety disorder, who already feels hyper-vigilant or agitated. The available behavioral therapies for ADHD focus on time management and

organizational skills, and aren't designed to treat emotional and psychological turmoil.

Instead, West teaches a traumatized child how to cope with and defuse fear and anxiety. She also recommends training and therapy for parents who may be contributing to or compounding their child's unhealthy behavior. Such programs can help parents reduce their use of harsh or abusive discipline while improving trust and communication, and have been shown to decrease disruptive child behavior.

Szymanski uses a similar approach with patients and their parents. "I think any traumatized child needs individual therapy but also family therapy," she says. "Trauma is a family experience; it never occurs in a vacuum."

Yet finding a provider who is familiar with such therapy can be difficult for pediatricians and psychiatrists, Szymanski says. Though some hospitals have centers for childhood trauma, there isn't a well-defined referral network. Even then, insurance companies, including the federal Medicaid program, may not always pay for the group sessions commonly used in parent training programs.

Faced with such complicated choices, Szymanski says it's no surprise when clinicians overlook the role of trauma in a child's behavior and focus on ADHD instead.

While there are few recommendations now for clinicians, that will likely change in the coming years. The American Academy of Pediatrics is currently developing new guidance on ADHD that will include a section on assessing trauma in patients, though it won't be completed until 2016.

Dr. Heather Forkey, a pediatrician at University of Massachusetts Memorial Medical Center, who specializes in treating foster children, is assisting the AAP. Her goal is to remind doctors that inattentive and hyperactive behavior can be traced back to any number of conditions—just like chest pains don't have the same origin in every patient. Ideally, the AAP will offer pediatricians recommendations for screening tools that efficiently gauge adversity in a child's life. That practice, she says, should come before any diagnosis of ADHD.

When speaking to traumatized children inappropriately diagnosed with ADHD, she offers them a reassuring explanation of their behavior. The body's stress system, she says, developed long ago in response to life-or-death threats like a predatory tiger. The part of the brain that controls impulses, for example, shuts off so that survival instincts can prevail.

“What does that look like when you put that kid in a classroom?” Forkey asks. “When people don’t understand there’s been a tiger in your life, it looks a lot like ADHD to them.”

This story was produced for ACEs Too High

Rebecca Ruiz is a reporter based in Oakland. She has written for *NBC News*, *Forbes*, and *The American Prospect*.
Twitter

Trauma 101 Business/ Commerce Related Handouts

FRANKLIN COUNTY CARES

#STRENGTHENINGONETOSTRENGTHENALL

An interagency initiative that supports trauma-informed services and community education. We believe that trauma-informed care will help build stronger families and stronger communities.

WHAT IS TRAUMA?[1]

Any event that you witness or experience, that threatens your life or someone close to you, whether real or perceived.

Traumatic events could include witnessing or experiencing:

—Abuse —Abandonment —Neglect —Violent Crime
—Death or loss of a loved one —Life-Threatening Illness
—Automobile Accidents —Bullying —Community Violence
—Natural Disasters —Acts or Threats of Terrorism

EFFECTS ON KIDS AND FAMILIES[1]

-Increased intergenerational trauma

Unstable relationships between:

- Intimate adults
- Parent-child
- Siblings

-Depletion of financial resources

-Inability to carry out family and social responsibilities

EFFECTS ON BUSINESSES[1,2,3]

-Approximately 1 million workers are absent each day due to psychological stress

-Chronic Stress causes health issues resulting higher absenteeism and presenteeism

-Physical illnesses account for less absences than stress, anxiety and depression in the workplace

1. National Child Traumatic Stress Network
2. Emergency Management, Public Health
3. Workplace Strategies for Mental Health

WHAT WE'RE DOING

Providing **FREE** training to community members and organizations:

- businesses
- childcare providers,
- medical professionals
- educators
- religious organizations

REFERRAL for children, families, and individuals to trauma-informed care services in Franklin County

WHAT YOU CAN DO

Attend one of our **FREE** Trauma 101 Trainings at Lutheran Family and Children's Services in Union, MO;

- March 22nd 6pm-9pm
- March 23rd 12pm-3pm
- March 29th 12pm-3pm
- March 29th 6pm-9pm

Schedule a **FREE** training for your organization.

Contact Emily Thoenen @ (314) 808-3997 to RSVP for a scheduled training or to schedule your own.

Attend the **Franklin County Spring Institute** featuring keynote speaker ***Heather Forbes***, author of *Beyond Consequences, Logic and Control*

- April 6th 8am-5pm

Register @ franklincountykids.org

FOLLOW US

Facebook: Franklin County Cares

Instagram: franklincountycares

Twitter: FCMO_Cares

Contact

Lutheran Family and Children's Services
15 S Oak St.
Union, MO
(314) 808-3997

A Trauma Informed Workforce:

An introduction to workforce wellness

Purpose. This document provides foundational information about workforce wellness. It is intended for those who are beginning to consider ways to address workforce wellness in their programs and organization by providing background and definitions.

Background. Working with survivors of trauma can be extremely rewarding, but can also be challenging. Without direct attention to the needs of care providers, providing services to trauma survivors can increase the risk for burnout, vicarious trauma, and secondary traumatic stress. External factors and stressors, as well as workers' personal trauma histories can add to the risk.

Whether or not someone has a history of trauma, bearing witness to human suffering and adversity can be deeply impactful. Reactivity related to unresolved trauma among workers and those they serve can make working conditions more difficult and can undermine health and safety. Providing effective and sensitive care to survivors (trauma-informed care), requires an emotionally healthy, competent, and well supported workforce.

Definitions. The terms burnout, secondary traumatic stress, vicarious trauma, and compassion stress or fatigue are often used interchangeably. There are, however, important distinctions to consider when developing resources. It is important when addressing workforce wellness that organizations identify what resources and strategies the organization will provide. Workforce wellness strategies need to not only address the importance of self-care but identify how the organization will work to reduce stress, address vicarious trauma, and support self-care activities. For example, for an employee who is experiencing secondary traumatic stress, the organization would make trauma specific services available (e.g. counseling, EMDR). In addition to providing access to services organizations will likely need to accommodate employees' schedules.

Burnout: The term "burnout" has been applied across helping professions and refers to the cumulative psychological strain of working with many different stressors. It often manifests as a gradual wearing down over time.

Vicarious Trauma: Vicarious traumatization is the cumulative effect of working with survivors of trauma and includes cognitive changes resulting from empathic engagement and a change to your worldview.

Secondary Traumatic Stress: The term "Secondary Traumatic Stress" is used to describe professional workers' subclinical or clinical signs and symptoms of PTSD that mirror those experienced by trauma clients, friends, or family members. While it is not recognized by current psychiatric standards as a clinical disorder, many clinicians note that those who witness traumatic stress in others may develop symptoms similar to or associated with PTSD.

Compassion Stress: Compassion stress characterizes the stress of helping or wanting to help a trauma survivor. Compassion stress is seen as a *natural outcome* of knowing about trauma experienced by a client, friend, or family member, rather than a pathological process.

Protective Factors. There are personal and organization strategies that mitigate the impact of working with survivors of trauma and adversity. Below are a few to consider:

- **Team spirit**. Feeling part of a team (per program, department, entire agency) and having social support on the job can buffer workplace stress.
- **Seeing change as a result of your work**. Having tangible evidence that their work is important and helpful.
- **Training.** Feeling competent to apply a trauma informed approach, as a result of effective training and education.
- **Supervision.** Receiving regular and predictable supervision as a way to prevent, monitor, and respond to stress.
- **Balanced caseload.** Having a diversified caseload based on the topics, intensity, length of service and balance between challenging and successful cases.
- **Stress Inoculation Training**. Practicing response to stressful situations in order to have the skills needed to regulate a stress response.

Ideas for Workforce Wellness

- Space for self care
- Staff shout outs or thank you cards
- Wellness plans
- Supervision
- Employee Assistance Programs (EAP)
- Workplace wellness rituals (Friday walks, Thursday lunches).

Risk Factors. The following factors are related to workforce stress and vicarious trauma.

- **Personal trauma history**. An employee's past history with adversity can mitigate or create challenges to doing this work. Employees who are aware of their history and have developed helpful coping skills are able to easily relate and support survivors.
- **Type of story.** The type of trauma stories an employee is hearing in their work can make a difference in the impact on the employee.
- **Length of employment.** Employees who are new in the field or new to hearing stories about trauma and adversity without warning or coping strategies are at greater risk for work related stress.
- **Always being empathetic**. Employees who feel like they have to always be empathetic or "always on" because at home they care for elders, children, or other family members or have more than one human service related job.
- **Isolation.** Isolation can be experienced because of the location of the worksite, because you are the only staff doing a particular job (e.g. only psychologist, peer support), or because you are not able to share details about your work with friends and family.

The content in this TIP has been adapted from the following sources:

1. Adams, R.E., Boscarino, J.A., Figley, C.R. (2006). Compassion fatique and psychological distress among social workers: A validation study. American Journal of Orthospsychiatry, 76(1).
2. Berzoff, J., & Kita, E. (2010). Compassion Fatigue and Countertransference: Two Different Concepts. *Clinical Social Work*, *38*.
3. Cunningham, M. (2003). Impact of trauma work on social work clinicians: Empirical findings. *Social Work*, 48(4).
4. Cunningham, M. (2004). Teaching social workers about trauma: Reducing the risks of vicarious traumatization in the classroom. *Journal of Social Education*, *40*(2).
5. Richardson, J.W. (2001). Guidebook on Vicarious Trauma: Recommended Solutions for Anti-Violence Workers. *National Clearinghouse on Family Violence*

Trauma Informed Oregon is funded through Oregon Health Authority, and is a partnership between Portland State University, Oregon Health Sciences University and Oregon Pediatric Society.

In writing these TIPs, Trauma Informed Oregon will strive for easy to read text, avoiding technical language and spelling out acronyms as needed. For TIPs that include information from other sources this may not always be possible.

Oregon Health Authority

Promoting Prevention oregon Committed to Wellness

Strategies for Encouraging Staff Wellness in Trauma-Informed Organizations

By Christopher Menschner and Alexandra Maul, Center for Health Care Strategies

IN BRIEF

Trauma, an event or set of circumstances that are perceived as potentially harmful, has long-lasting effects. Exposure to trauma, particularly in childhood, can notably increase the risk of serious physical and behavioral health problems throughout life—an idea that health care providers increasingly recognize. Health care providers can address patients' traumatic experiences and their associated health effects by implementing trauma-informed approaches to care. Securing time and resources for staff wellness is one essential element to trauma-informed care, because supporting staff well-being helps them provide high quality care. This brief outlines the impact of chronic work-related stress and provides examples of two organizations that prioritize staff wellness: Camden Coalition of Healthcare Providers and Stephen and Sandra Sheller 11th Street Family Health Services of Drexel University.

This brief is part of technical assistance series from *Advancing Trauma-Informed Care,* a national initiative supported by the Robert Wood Johnson Foundation and led by the Center for Health Care Strategies. The brief series focuses on practical strategies for fostering trauma-informed approaches to care.

Addressing patients' traumatic experiences is key to improving care for patients, particularly those who have complex medical, behavioral health, and social needs. Though many of the strategies necessary for implementing trauma-informed care relate directly to the patient experience, one key element pertains to how an organization cares for its staff. Specifically, when working with patients with high rates of exposure to traumatic events, staff need to take time for self-care, both for their own wellness and the provider organization's ability to provide high-quality care.

Impact on Individual Providers

Without safeguards in place to help clinicians and staff process their emotions, anyone working with patients who have experienced trauma may be subject to chronic emotional stress. This stress can then negatively affect their own physical and psychological health. In particular, when clinicians seek to create a compassionate, emotional connection with patients to achieve a deeper understanding of patients' experiences — an aspect of patient-centered health care known as **empathetic engagement**[1] — they are even more likely to experience forms of chronic emotional stress such as secondary traumatic stress, vicarious traumatization, and burnout:

- **Secondary traumatic stress**, also known as **compassion fatigue**, is emotional duress that can result from hearing about another person's firsthand traumatic experiences and may manifest as changes in memory, sense of safety and trust, and other symptoms often associated with post-traumatic stress disorder.[2]
- Over time, **secondary traumatic stress** can lead to vicarious traumatization, the cumulative effect on the clinician after consistent exposure to other people's traumatic experiences.[2]

- Often, these indirect exposures to trauma can contribute to **burnout**, a form of physical, mental, and emotional exhaustion caused by chronic work-related stress.[3] Burnout is possible in any career and is not necessarily related to hearing about or empathizing with patients' trauma, but clinicians and front-line staff working with trauma survivors are at increased risk.

Impact on Provider Organizations

Chronic emotional stress can also affect patients and provider organizations. Clinicians and other front-line staff experiencing any of these conditions may struggle to provide high-quality care to patients. Chronic emotional stress often leads to staff turnover, which can create a negative feedback loop that intensifies similar feelings in remaining employees. Recruiting and training new employees can significantly drive up operating costs, leaving fewer resources for mission-related activities such as patient care, staff training, and program development.

Preventing Problems by Encouraging Staff Wellness

Successfully preventing chronic emotional stress can help staff to function optimally, increase staff morale, and reduce expenses associated with staff turnover. Strategies to prevent secondary traumatic stress, vicarious traumatization, and burnout can be broadly categorized as follows:

- **General wellness**: Encouraging and incentivizing activities like yoga, meditation, and exercise;
- **Organizational**: Fostering a culture that allows clinicians to seek support; keeping caseloads manageable; and providing sufficient mental health benefits;
- **Education**: Providing targeted trainings that create awareness of chronic emotional stress and the importance of self-care; and
- **Supervision**: Facilitating staff wellness through management strategies such as reflective supervision, a practice in which a clinician and supervisor meet regularly to address feelings regarding patient interactions.

Overcoming Common Barriers to Support Staff Wellness Strategies

Securing Funding for Staff Wellness Strategies: Identifying funding to invest in staff wellness poses a significant challenge to resource-strapped organizations. The Camden Coalition of Healthcare Providers earmarks portions of grants and savings from its accountable care organization to implement strategies to support its staff.

Making Time for Self-Care: Health care organizations often struggle with employees feeling as though they do not have the time to participate in staff wellness activities that are offered or practice their own self-care routines. 11th Street Family Health Services encourages leadership and supervisors to help staff arrange time for participation, and sets an organizational cultural precedent to prioritize these activities.

In-the-Field Innovations

The Camden Coalition of Healthcare Providers (Camden Coalition) in Camden, New Jersey, and the Stephen and Sandra Sheller 11th Street Family Health Services of Drexel University in Philadelphia, Pennsylvania, are implementing innovative strategies to promote staff wellness and help prevent and reduce chronic emotional stress in their organizations.

Camden Coalition of Healthcare Providers

The Camden Coalition provides an extensive array of wellness benefits and services to its staff, including mental health benefits to encourage staff to participate in self-care practices and use mental health counseling services. The Camden Coalition contracts with a third-party company to provide up to $2,000 of mental health benefits per employee per year in addition to standard health insurance coverage. These benefits include coverage for the employee and family, including psychiatric evaluation and testing for full-time employees.

The Camden Coalition also supports a culture of wellness through its policies on clinician workload. To encourage work/life balance and avoid burnout from long hours, organizational policies: (1) encourage clinicians to leave their work-designated cell phones in the office overnight; and (2) ensure that care team staff see patients only during office hours within a 40-hour work week. Administrative staff enforce these policies by ensuring work phones are left charging overnight and blocking time on staff schedules to make up for any late hours or "overtime" that were deemed necessary the prior day. When clinicians work late, other staff members provide coverage so clinicians can take "flex time" to maintain a 40-hour work week.

Each morning, teams gather together to kick off the day with a morning "huddle" centered on a different theme — from line-dancing Mondays to "Feelings Fridays." These huddles give the staff a few minutes to call out a fellow colleague's good work, let loose with some physical movement, or troubleshoot a nagging issue. Additionally, weekly care planning meetings offer the opportunity to not only discuss patients' issues and develop care plans, but to come together as a team, lean on each other for support, and feel safe while mentally processing professional or personal issues. The Camden Coalition also employs a PhD-level psychologist to support staff in setting up professional boundaries to prioritize wellness and reduce burnout. The psychologist attends care meetings as needed and reinforces the message that providers cannot care for patients without first caring for themselves.

The Camden Coalition staff lets loose by line dancing during a morning huddle.

On an organizational level, The Camden Coalition offers opportunities for staff to spend time together outside of the office, including seasonal events, team retreats, and annual office-wide retreats, to strengthen relationships and foster team-building efforts. Office policies, such as generous paid time off packages, encourage staff to prioritize wellness. Additionally, meeting-free Fridays allow staff uninterrupted time to complete assignments and decompress from the week.

The Stephen and Sandra Sheller 11th Street Family Health Services of Drexel University

The Stephen and Sandra Sheller 11th Street Family Health Services of Drexel University (11th Street) prioritizes staff satisfaction and wellness by training all staff to adopt mindfulness practices. The organization strives to infuse mindfulness tools, resources, and frameworks throughout both its clinical and organizational culture and processes.

11th Street offers mind-body classes for staff, such as yoga, dance/movement therapy, and mindfulness-based stress reduction courses, as well as a staff loss group that comes together monthly to discuss feelings related to patients who have recently passed away. It has also changed its physical space to provide areas for staff to be alone or relax in small groups. Furthermore, it offers a fitness center on site that is open for both patients and staff to use, as well as a nutritional learning kitchen where 11th Street plans to offer healthy food items to staff and patients. 11th Street also created a staff satisfaction team as a way to reduce staff traumatization and prioritize burnout prevention. This group plans events focused on team-building and interaction, and encourages a culture of relationships and healing.

Mindfulness Practice in Health Care

Mindfulness is the practice of focusing our attention purposely on the present moment and accepting it without judging. Mindfulness training in health care helps clinicians pay attention to what is happening immediately in front of them, opening them to the information being presented in a given moment. This helps providers focus, feel less overburdened, experience greater empathy, develop a deeper connection with patients, and ultimately take more pride and satisfaction in their work.[4]

Advancing Trauma-Informed Care is a multi-site demonstration project to better understand how to implement trauma-informed approaches to health care delivery. Supported by the Robert Wood Johnson Foundation and led by the Center for Health Care Strategies, this national initiative is developing and enhancing trauma-informed approaches to care and sharing emerging best practices. For more information, visit **www.chcs.org**.

Endnotes

[1] K. W. Saakvitne and L. A. Pearlman. *Transforming the Pain: A Workbook on Vicarious Traumatization*. New York: Norton Professional Books, 1996.

[2] The National Child Traumatic Stress Network (2011). "Secondary Traumatic Stress: A Fact Sheet for Child-Serving Professionals." Available at: http://www.nctsn.org/resources/topics/secondary-traumatic-stress.

[3] Substance Abuse and Mental Health Services Administration (2014). "Chapter 2: Building a Trauma-Informed Workforce." *Trauma-Informed Care in Behavioral Health Services*. Available at: https://www.ncbi.nlm.nih.gov/books/NBK207194/.

[4] M. S. Krasner, R. M. Epstein, H. Beckman, et al. "Association of an Educational Program in Mindful Communication with Burnout, Empathy, and Attitude among Primary Care Physicians." *Journal of the American Medical Association,* 302 (12):1284-1293, 2009.

Trauma support may help low-income families earn more

By Mary Gillis

(Reuters Health) - A federal assistance program designed to move low-income families toward financial independence comes up short – but results might improve if families also receive support that helps them deal with traumatic experiences, a new study suggests.

The Temporary Assistance for Needy Families program (TANF), part of the Department of Health and Human Service's Office of Family Assistance, is intended to help poverty-stricken recipients gain employment skills, secure jobs and adequate income so they can slowly become self-sufficient. Past or current physical or emotional distress are also entry criteria.

But years of study have shown the TANF program falls short of helping people enter the workforce and stay there.

To explore potential improvements, researchers conducted a study in which 103 caregivers of small children were assigned to three separate groups.

As reported in the Journal of Child and Family Studies, all three groups received standard TANF programming, consisting of 20 hours per week of supervised job training and job search activities.

One group also received assistance in opening a credit union savings account where their savings were matched, plus 28 weeks of financial education about entrepreneurial activities, retirement and reducing debt.

Another group received those same extra resources but in addition was invited to participate in a 28-week self-empowerment group to help people deal with trauma.

Examples of "trauma" include a work-limiting health condition, exposure to violence and adversity in the home, and physical, emotional and sexual abuse. These problems are common among TANF participants, and most families in the program have at least one household member in prison, according to the researchers.

Fifteen months later, the group that received the trauma support had improved scores in self-efficacy, while the group that TANF-only group had a significant decline in self-efficacy scores.

Participants who received the extra financial counseling but not the self-empowerment program had no change in self-efficacy scores.

Depressive symptoms also improved for the group that received all of the interventions, but remained unchanged in the other two groups.

"This is important, as even minor declines in depressive symptoms signals reduction in stress and better employment outcomes," study coauthor Mariana Chilton, from the Dornsife School of Public Health at Drexel University in Philadelphia, told Reuters Health by email.

Ultimately, the TANF-only participants were the only group to experienced increased employment 12 months after the study started. According to Chilton, this is largely a consequence of the goal of the standard TANF program, which has a strong focus on helping recipients to secure employment as quickly as possible – but whether recipients will sustain such employment and secure financial independence, which is the ultimate goal, is unclear.

Economic hardship, however - defined as food, housing or energy insecurity - declined significantly only in the full-intervention group. This group experienced a significant increase in earnings by the end of the study, while hourly earnings in the control and partial intervention groups remained unchanged.

The problem with TANF, Chilton and coauthor Sandra Bloom say, is that it doesn't address past and current exposure to trauma as a barrier into the workforce.

"Trauma-informed program approaches consider, 'what has happened' to a person as opposed to 'what is wrong with them,' to better support people in their recovery," Bloom said in an email.

The programming, Chilton adds, avoids punishing people for coping behavior, de-escalates potential conflict and creates avenues for recovery from trauma in a more caring and informed way.

"If a person has unaddressed or unrecognized behavioral health issues, and doesn't get time to work on their own sense of well-being, to acknowledge their emotions and learn to manage them or develop a sense of their own goals - as opposed to goals of the employment and training program - they won't perform well on the job," she said.