The Impact of Abuse and Neglect on Development

Child Development for Judges

PARTICIPANT HANDOUTS

Presenters
Mellicent Blythe, LCSW
Laura Phipps, MSW

School of Social Work
University of North Carolina at Chapel Hill

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SCHOOL OF SOCIAL WORK

Trauma and Development

	Possible Trauma Reactions	How Caregivers Can Help
Early Childhood	• Generalized fears that may not be directly related to the traumatic event • Loss of previously gained developmental skills (such as speech and toileting) • Increased separation anxiety • Sleep disturbance, increased nightmares, or night terrors • Repetitive play including traumatic themes (may or may not be directly related to the trauma)	• Provide comfort, rest, and opportunities to play or draw • Help children verbalize their feelings • Ensure that children feel safe, be consistent with pick up from school, inform children of parents' whereabouts at all times • Tolerate regressive behaviors
School Age	• Increased concern over safety issues (themselves and others) • Repetitive retelling of traumatic events • Feeling overwhelmed by fear, guilt, or sadness • Sleep disturbance/nightmares • Difficulty concentrating or learning at school • Complaints of headaches, stomach aches, and other ailments with no obvious cause • Increased aggressive behavior	• Reassure children that everyone is safe • Provide opportunities for children to talk about their experiences and emotions • Acknowledge the normalcy of their feelings and correct distortions or inaccurate beliefs about the trauma • Collaborate with teachers to provide children a place to go when feeling overwhelmed or distracted
Adolescence	• Withdrawal from friends and/or family • Increased anger, rage, and fantasies about revenge • Self-injury • Changes in eating and sleep patterns • Increase in dangerous behavior or may become more accident-prone • Increased substance use	• Still need reassurance that everyone is safe • Explain how trauma can put strain on relationships and offer support when these challenges occur • Help adolescents understand how "acting out" behavior is a way of trying to express feelings about trauma • Encourage discussion about the traumatic event and related feelings • Discuss how feelings when unexpressed can lead to dangerous behavior and explore other options for coping with emotions • Normalize feelings

Adapted from: "Age-Related Reactions to a Traumatic Event" Handout from NCTSN.org. Retrieved from: http://nctsn.org/resources/audiences/parents-caregivers

Psychologically Safe Courtrooms

Excerpted from: Substance Abuse and Mental Health Services Administration, SAMHSA's National Center on Trauma-Informed Care and SAMHSA's National GAINS Center for Behavioral Health and Justice: Essential Components of Trauma-Informed Judicial Practice. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2013. http://bit.ly/1w0Lmev

COURTROOM COMMUNICATION

Judge's Comment	Perception of Trauma Survivor	Trauma-Informed Approach
"Your drug screen is dirty."	"I'm dirty. There is something wrong with me."	"Your drug screen shows the presence of drugs."
"Did you take your pills today?"	"I'm a failure. I'm a bad person. No one cares how the drugs make me feel."	"Are the medications your doctor prescribed working well for you?"
"You didn't follow the contract, you're going to jail. We're done with you. There is nothing more we can do."	"I'm hopeless. Why should I care how I behave in jail? They expect trouble anyway."	"Maybe what we've been doing isn't the best way for us to support you. I'm going to ask you not to give you on recovery. We're not going to give up on you."
"I'm sending you for a mental health evaluation."	"I must be crazy. There is something wrong with me that can't be fixed."	"I'd like to refer you to a doctor who can help us better understand how to support you."

COURTROOM ENVIRONMENT

Physical Environment	Reaction of Trauma Survivor	Trauma-Informed Approach
The judge sits behind a large, high desk (or "bench"), and participants sit at a table some distance from the bench.	Feeling separate; isolated; unworthy; afraid	In some treatment courts, the judge comes out from behind the bench and sits at a table in the front.
Participants are required to address the court from their place at the defendant's table.	Fear of authority; inability to communicate clearly, especially if an abuser is in the courtroom.	When practical, ask the participant to come close; speak to them beside or right in front of the bench.
Multiple signs instruct participants about what they are not allowed to do.	Feeling intimidated; lack of respect; untrustworthy; treated like a child.	Eliminate all but the most necessary of signs; word those that remain to indicate respect for everyone who reads them.
A court officer jingles handcuffs while standing behind a participant.	Anxiety; inability to pay attention to what the judge is saying; fear.	Eliminate this type of nonverbal intimidation, especially if you have no intention of remanding the individual. Tell court officers not to stand too close. Respect an individual's personal space.
A judge asks a participant to explain her behavior or the impact of abuse without acknowledging the impact of others in the courtroom.	Intimidation or fear of abusers who may be in the courtroom; reluctance to share information in front of family members or others who do not believe them.	Save questions about sensitive issues for when the courtroom is empty or allow the participant to approach the bench. If ongoing abuse or intimidation is suspected, engage

		those people in activities outside the courtroom while the participant shares her story.

COURTROOM PROCEDURES

Courtroom Experience	Reaction of Trauma Survivor	Trauma-Informed Approach
A court officer handcuffs a participant without warning to remand him or her to jail because they have not met the requirements of their agreement with the court.	Anxiety about being restrained; fear about what is going to happen.	Tell the court officer and individual you intend to remand them. Explain why. Explain what is going to happen and when. (The court officer will walk behind you; you will be handcuffed, etc.)
A judge remands one individual to jail but not another when they both have done the same things (e.g., had a positive drug screen) and they both are in the courtroom at the same time.	Concern about fairness; feeling that someone else is getting special treatment.	Explain why you are doing this. For example, "Both Sam and Meredith had positive drug screens. Sam is new to drug court and this is the first time he had a positive screen. We are going to try again to see if the approach we're using can be effective. Meredith has had multiple positive drug screens; I'm remanding her to jail because the approach we've been using here hasn't been effective in supporting her recovery. I wish I had a better choice, and I hope she won't give up on her recovery."
Individuals who are frightened and agitated are required to wait before appearing before the judge.	Increased agitations; anxiety; acting out.	Clearly provide scheduling information in the morning so participants know what will be expected of them and when. To the greatest extent possible, prioritize who appears before you and when; those who are especially anxious may have the most trouble waiting and may be most likely to act out.
A judge conducts a sidebar conversation with attorneys.	Suspicion; betrayal; shame; fear.	Tell the participant what is happening and why. For example, "We have to discuss some issues related to your case. We just need a minute to do it on the side."
A participant enters a plea that does not appear to be consistent with the evidence, his or her own description of the event, or his or her own interests.	Memory impairment; confusion about courtroom procedures; inability to process implications of the plea.	Adjourn to allow time for courtroom team to discuss whether and how to accept the plea.

Psychologically Safe Courtrooms: Quotations from Participants

Excerpted from: Substance Abuse and Mental Health Services Administration, SAMHSA's National Center on Trauma-Informed Care and SAMHSA's National GAINS Center for Behavioral Health and Justice: Essential Components of Trauma-Informed Judicial Practice. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2013. http://bit.ly/1w0Lmev

During every incarceration, every institutionalization, every court-ordered drug treatment program, it was always the same: I was always treated like a hopeless case. All people could see was the way I looked or the way I smelled. It wasn't until I finally entered a recovery-oriented, trauma-informed treatment program, where I felt safe and respected that I could begin to heal…Someone finally asked me, "What happened to you?" instead of "What's wrong with you?"

— *Tonier Cain, Team Leader, SAMHSA's National Center for Trauma-Informed Care*

Someone who's been beaten as a child expects that they're going to get beaten. I saw the provocation al the time, with young men in particular. They provide the court officers so at least they're controlling when it happens. —*Treatment Court Judge*

I was in the mental health system for 14 years before somebody thought to ask me if I'd been hit, kicked, punched, slapped, or knocked out. When they asked those kinds of questions, I said, "Oh, yearh, sure." But when they asked if I'd been abused, I said."No." It was just my life.

— *A Trauma Survivor*

I deal with sexually violent persons. These men have at least two convictions each for either adult violent rapes or child molestation. I don't have any problems with security. I don't have one person that has to come into court in shackles, not one, because I give them respect. I call them by their names. It starts there.

— *Criminal Court Judge*

So here I was, in front of this judge, asking for a restraining order against a family member who was laso going to show up in that courtroom, and I was actively hearing voices. I was having a very hard time expressing what I needed to say to the get the job done. The restraining order was against my grandfather, and the judge was an older man who looked like my grandfather. I couldn't speak. I had to try to articulate something that I was not even able to speak about very well in the first place. And I needed to do it quickly and succinctly.

What the judge did was pretty incredible. He asked me to come forward. It created a sense of privacy. I didn't have to shout across a really busy courtroom. He really helped me in that simple act of asking me to come closer. I was able to do what I needed to do, and he was able to hear what he needed to hear. I had been in the mental health system for 14 years, and this judge changed my life in that one simple act.

— *A Trauma Survivor*

NCTSN The National Child Traumatic Stress Network

NCJFCJ est. 1937 NATIONAL COUNCIL OF JUVENILE AND FAMILY COURT JUDGES WWW.NCJFCJ.ORG

Dear Judge:

We are pleased to share the NCTSN Bench Card for the Trauma Informed Judge—an official product of the National Child Traumatic Stress Network's Justice Consortium in cooperation with the National Council of Juvenile and Family Court Judges. Designed by judges, lawyers, and behavioral health professionals, this card will assist you in your work with youth who struggle with traumatic stress.

Many court-involved youth have been exposed to traumatic events. They present with problems that require professional assistance to modify their behavior and protect the community. Strong connections have been made between early exposure to trauma and "derailed" child development. Traumatic experiences change the brain in ways that cause youth to think, feel and behave differently.

Trauma impacts many important court decisions, among them:

- temporary placement or custody,
- detention or hospitalization,
- residential or community based treatment,
- treatment and referrals to health and behavioral health services,
- transfers to adult criminal court,
- termination of parental rights and adoption,
- restoration and treatment for child victims,
- visitation with maltreating adults or jail/prison visitation.

For many traumatized children, the judge serves as the crucial professional to direct them to proper treatment. The good news is that, when properly treated through trauma-informed, evidence-based treatment, children can recover.

As a judge, we know you must balance your responsibilities to protect the public and restore victims while also trying to change the destructive life course of a struggling child or an offending teen. Judges know that failure to make such changes can lead to youths who become adults involved in the justice system. Judges often see those adults raise new generations who also appear in court—the outcome of the uninterrupted, intergenerational transmission of traumatic stress.

Enclosed are two bench cards. The first offers a series of questions to help you, as a judge, gather information necessary to make good decisions for children at risk of traumatic stress disorders. The second is a sample addendum designed to be copied or scanned and attached to your orders for behavioral health assessments. It will help mental health professionals develop reports that are trauma informed, admissible into evidence, and informative to you.

We hope that you find the bench cards to be helpful in your work with youth. For additional information and other trauma resources for judges and attorneys, please see http://www.nctsn.org/resources/topics/juvenile-justice-system

Should you have questions regarding the information contained in the cards, please contact Dr. James Clark at clark2j9@UCMAIL.UC.EDU or the NCTSN at help@nctsn.org

Sincerely,
The NCTSN Justice Consortium

NCTSN The National Child Traumatic Stress Network

NCJFCJ NATIONAL COUNCIL OF JUVENILE AND FAMILY COURT JUDGES

NCTSN BENCH CARD

FOR THE TRAUMA-INFORMED JUDGE

Research has conclusively demonstrated that court-involved children and adolescents present with extremely high rates of traumatic stress caused by their adverse life experiences. In the court setting, we may perceive these youth as inherently disrespectful, defiant, or antisocial, when, in fact, their disruptive behavior may be better understood in the context of traumatic stress disorders. These two Bench Cards provide judges with useful questions and guidelines to help them make decisions based on the emerging scientific findings in the traumatic stress field. These cards are part of a larger packet of materials about child and adolescent trauma available and downloadable from the NCTSN Trauma-Informed Juvenile Justice System Resource Site* and are best used with reference to those materials.

1. **Asking trauma-informed questions can help judges identify children who need or could benefit from trauma-informed services from a mental health professional. A judge can begin by asking, "Have I considered whether or not trauma has played a role in the child's[1] behavior?" Use the questions listed below to assess whether trauma-informed services are warranted.**

   TRAUMA EXPOSURE: Has this child experienced a traumatic event? These are events that involve actual or threatened exposure of the child to death, severe injury, or sexual abuse, and may include domestic violence, community violence, assault, severe bullying or harassment, natural or man-made disasters, such as fires, floods, and explosions, severe accidents, serious or terminal illness, or sudden homelessness.

   MULTIPLE OR PROLONGED EXPOSURES: Has the child been exposed to traumatic events on more than one occasion or for a prolonged period? Repeated or prolonged exposure increases the likelihood that the child will be adversely affected.

   OUTCOMES OF PREVIOUS SANCTIONS OR INTERVENTIONS: Has a schedule of increasingly restrictive sanctions or higher levels of care proven ineffective in this case? Traumatized children may be operating in "survival mode," trying to cope by behaving in a defiant or superficially indifferent manner. As a result, they might respond poorly to traditional sanctions, treatments, and placements.

   CAREGIVERS' ROLES: How are the child's caregivers or other significant people helping this child feel safe or preventing (either intentionally or unintentionally) this child from feeling safe? Has the caregiver been a consistent presence in the child's life? Does the caregiver acknowledge and protect the child? Are caregivers themselves operating in survival mode due to their own history of exposure to trauma?

   SAFETY ISSUES FOR THE CHILD: Where, when and with whom does this child feel safest? Where, when and with whom does he or she feel unsafe and distrustful? Is the home chaotic or dangerous? Does a caregiver in the household have a restraining order against another person? Is school a safe or unsafe place? Is the child being bullied at school or does the child believe that he or she is being bullied?

   TRAUMA TRIGGERS IN CURRENT PLACEMENT: Is the child currently in a home, out-of-home placement, school, or institution where the child is being re-exposed to danger or being "triggered" by reminders of traumatic experiences?

   UNUSUAL COURTROOM BEHAVIORS: Is this child behaving in a highly anxious or hypervigilant manner that suggests an inability to effectively participate in court proceedings? (Such behaviors include inappropriate smiling or laughter, extreme passivity, quickness to anger, and non-responsiveness to simple questions.) Is there anything I, as a judge, can do to lower anxiety, increase trust, and enhance participation?

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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.

2. **It is crucial to have complete information from all the systems that are working with the child and family. Asking the questions referenced below can help develop a clearer picture of the child's trauma and assess needs for additional information.**

   COMPLETENESS OF DATA FOR DECISIONS: Has all the relevant information about this child's history been made available to the court, including child welfare and out-of-jurisdiction or out-of-state juvenile justice information?

   INTER-PROFESSIONAL COOPERATION: Who are the professionals who work with this child and family? Are they communicating with each other and working as a team?

   UNUSUAL BEHAVIORS IN THE COMMUNITY: Does this child's behavior make sense in light of currently available information about the child's life? Has the child exhibited extreme or paradoxical reactions to previous assistance or sanctions? Could those reactions be the result of trauma?

   DEVELOPMENT: Is this child experiencing or suffering from emotional or psychological delays? Does the child need to be assessed developmentally?

   PREVIOUS COURT CONTACTS: Has this child been the subject of other court proceedings? (Dependency/Neglect/Abuse; Divorce/Custody; Juvenile Court; Criminal; Other)

   OUT-OF-HOME PLACEMENT HISTORY: How many placements has this child experienced? Have previous placements been disrupted? Were the disruptions caused by reactions related to the child's trauma history? How did child welfare and other relevant professionals manage these disruptions?

   BEHAVIORAL HEALTH HISTORY: Has this child ever received trauma-informed, evidence-based evaluation and treatment? (Well-intentioned psychiatric, psychological, or substance abuse interventions are sometimes ineffective because they overlook the impact of traumatic stress on youth and families.)

3. **Am I sufficiently considering trauma as I decide where this child is going to live and with whom?**

   PLACEMENT OUTCOMES: How might the various placement options affect this child? Will they help the child feel safe and secure and to successfully recover from traumatic stress or loss?

   PLACEMENT RISKS: Is an out-of-home placement or detention truly necessary? Does the benefit outweigh the potential harm of exposing the child to peers who encourage aggression, substance use, and criminal behavior that may possibly lead to further trauma?

   PREVENTION: If placement, detention or hospitalization is required, what can be done to ensure that the child's traumatic stress responses will not be "triggered?" (For example, if placed in isolation or physical restraints, the child may be reminded of previous traumatic experiences.)

   DISCLOSURE: Are there reasons for not informing caregivers or staff at the proposed placement about the child's trauma history? (Will this enhance care or create stigma and re-victimization?)

   TRAUMA-INFORMED APPROACHES: How does the programming at the planned placement employ trauma-informed approaches to monitoring, rehabilitation and treatment? Are staff knowledgeable about recognizing and managing traumatic stress reactions? Are they trained to help children cope with their traumatic reactions?

   POSITIVE RELATIONSHIPS: How does the planned placement enable the child to maintain continuous relationships with supportive adults, siblings or peers?

4. **If you do not have enough information, it may be useful to have a trauma assessment done by a trauma-informed professional. Utilizing the NCTSN BENCH CARD FOR COURT-ORDERED TRAUMA-INFORMED MENTAL HEALTH EVALUATION OF CHILD, you can request information that will assist you in making trauma-informed decisions.**

[1] The use of "child" on this bench card refers to any youth who comes under jurisdiction of the juvenile court.
*http://learn.nctsn.org/course/view.php?id=74

NCTSN The National Child Traumatic Stress Network

NCJFCJ NATIONAL COUNCIL OF JUVENILE AND FAMILY COURT JUDGES

NCTSN BENCH CARD

FOR COURT-ORDERED TRAUMA-INFORMED MENTAL HEALTH EVALUATION OF CHILD: SAMPLE ADDENDUM

This Court has referred this child[1] for mental health assessment. Your report will assist the judge in making important decisions. Please be sure the Court is aware of your professional training and credentials. In addition to your standard psychosocial report, we are seeking trauma-specific information. Please include your opinion regarding the child's current level of danger and risk of harm. The Court is also interested in information about the child's history of prescribed psychiatric medications. We realize that you may be unable to address every issue raised below, but the domains listed below are provided as an evidence-based approach to trauma-informed assessment.

1. SCREENING AND ASSESSMENT OF THE CHILD AND CAREGIVERS

Please describe the interview approaches (structured as well as unstructured) used for the evaluation. Describe the evidence supporting the validity, reliability, and accuracy of these methods for children or adolescents. For screens or tests, please report their validity and reliability, and if they were designed for the population to which this child belongs. If feasible, please report standardized norms.

Discuss any other data that contributed to your picture of this child. Please describe how the perspectives of key adults have been obtained. Are the child's caregivers or other significant adults intentionally or unintentionally preventing this child from feeling safe, worthy of respect, and effective? Are caregivers capable of protecting and fostering the healthy development of the child? Are caregivers operating in "survival mode" (such as interacting with the child in a generally anxious, indifferent, hopeless, or angry way) due to their own history of exposure to trauma? What additional support/resources might help these adults help this child?

2. STRENGTHS, COPING APPROACHES, AND RESILIENCE FACTORS

Please discuss the child's existing strengths and coping approaches that can be reinforced to assist in the recovery or rehabilitation process. Strengths might include perseverance, patience, assertiveness, organization, creativity, and empathy, but coping might take distorted forms. Consider how the child's inherent strengths might have been converted into "survival strategies" that present as non-cooperative or even antisocial behaviors that have brought this child to the attention of the Court.

Please report perspectives voiced by the child, as well as by caregivers and other significant adults, that highlight areas of hope and recovery.

3. DIAGNOSIS (POST TRAUMATIC STRESS DISORDER [PTSD])

Acknowledging that child and adolescent presentations of PTSD symptoms will differ from adult presentations, please "rule-in" or "rule-out" specific DSM-V criteria for PTSD for adolescents and children older than six years, which include the following criteria:

- Exposure to actual or threatened death, serious injury, or sexual violence, either experienced directly, witnessed, or learning that the event occurred to a close family member or friend (Criteria A)
- Presence of intrusion symptoms such as intrusive memories, distressing dreams, flashbacks, physical reactions, trauma-specific re-enactment through play, psychological distress at exposure to cues (Criteria B)
- Avoidance of stimuli or reminders associated with the traumatic event, including avoidance of internal thoughts and feelings related to the event, as well as external activities, places, people, or situations that arouse recollections of the event (Criteria C)

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- Negative changes in cognition, mood, and expectations; diminished interest in, detachment, and estrangement from others; guilt and shame; socially withdrawn behavior; reduction in positive emotions (Criteria D)
- Alterations in arousal and reactivity, including irritable or aggressive behavior, angry outbursts, reckless or self-destructive behavior, hypervigilance, exaggerated startle response, concentration problems, and sleep disturbance (Criteria E)
- Exhibiting these disturbances in behavior, thoughts and mood for over a month (Criteria F)
- Significant distress or impairment in relationships with parents, siblings, peers, or other caregivers or with school behavior (Criteria G)
- The disturbed behavior and mood cannot be attributed to the effects of a medication, street drug, or other medical condition (Criteria H)

PTSD can also be present for children ages six and younger. Criteria include exposure; intrusive symptoms, including distressing memories or play re-enactment and physiological reactions to reminders; avoidance of people, conversations or situations; negative emotional states such as fear, sadness, or confusion, sometimes resulting in constriction of play; irritable behavior and hypervigilance; and impairment in relationships with parents, siblings, peers or other caregivers.

Even if an official DSM-V diagnosis of PTSD is not warranted, traumatic stress reactions can definitely or potentially contribute to the child's behavioral, emotional, interpersonal, or attitudinal problems. Traumatic stress reactions may contribute to problems with aggression, defiance, avoidance, impulsivity, rule-breaking, school failure or truancy, running away, substance abuse, and an inability to trust or maintain cooperative and respectful relationships with peers or adults.

4. TRAUMA-INFORMED SERVICES

Has this child ever received Trauma-Focused, Evidence-Based Treatment?*** Sometimes well-intentioned psychiatric, psychological, social work, or substance abuse evaluations and treatment are incomplete and of limited effectiveness because they do not systematically address the impact of children's traumatic stress reactions.

The Court is interested in potential sources of trauma-informed services in your area and your thoughts about the likelihood that the child can receive those services.

In the meantime, what can be done immediately for and with the family, school, and community to enhance safety, build on the child's strengths, and to provide support and guidance? How can this child best develop alternative coping skills that will help with emotional and behavioral self-regulation?

5. SUGGESTIONS FOR STRUCTURING PROBATION, COMMUNITY SUPERVISION AND/OR PLACEMENT OPTIONS.

Structured case plans for probation, community supervision, and/or placement should consider the ability of the setting and the people involved to assist the child in feeling safe, valued, and respected. This is especially important for traumatized children. Similarly, the plan for returning home, for continuing school and education, and for additional court or probationary monitoring should also clearly address each child's unique concerns about safety, personal effectiveness, self-worth, and respect. Please consider where, when, and with whom this child feels most safe, effective, valued and respected. Where, when, and with whom does the child feel unsafe, ineffective, or not respected? What out-of-home placements are available that can better provide for this child's health and safety, as well as for the community's safety? What placements might encourage success in school, relationships, and personal development?

[1] The use of "child" on this bench card refers to any youth who comes under jurisdiction of the juvenile court.

*** Trauma-Focused, Evidence-Based (TF-EB) Treatment is science-based, often requires training in a specific protocol with careful clinical supervision, and emphasizes the treatment relationship, personal/psychological safety, emotional and behavioral self-regulation, development of coping skills, specific treatment of child traumatic experiences, and development of self-enhancing/pro-social thinking, feeling, decision-making, and behaving. TF-EB treatments include: Trauma-Focused Cognitive Behavioral Therapy, Parent-Child Interaction Therapy, Trauma Affect Regulation: Guidelines for Education and Therapy, Child Parent Psychotherapy and more. See website: http://www.nctsn.org/resources/topics/treatments-that-work/promising-practices

Evidence-Based Treatment

1. Attachment-Related

The following child treatment interventions include a focus on attachment and are offered in North Carolina. Each has enough supporting evidence to have been rated by the California Evidence-Based Clearinghouse for Child Welfare (CEBC4CW, 2016). The CEBC4CW rates programs on a scale of 1-5 from most to least evidence of effectiveness. Programs may also be rated as "NR" when there is not enough research evidence available to make a determination. For more details on the programs, visit the individual websites or http://www.cebc4cw.org.

Well-Supported by Research Evidence (Rating of 1)

Nurse-Family Partnership (NFP). For children ages 0-5 and their caregivers. Provides home visits by registered nurses to first-time, low-income mothers, beginning during pregnancy and continuing through the child's second birthday. Available in many counties throughout NC. http://www.nursefamilypartnership.org/locations/North-Carolina

Parent-Child Interaction Therapy (PCIT). For children ages 2 1/2-7 1/2 and their caregivers. Provides behavioral intervention focused on decreasing the child's behavior problems (e.g., defiance, aggression), increasing the child's social skills and cooperation, and improving the parent-child attachment relationship. Clinicians being trained in NC through the PCIT of the Carolinas based at the Center for Child and Family Health. http://www.ccfhnc.org

Promising Research Evidence (Rating of 3)

Attachment and Biobehavioral Catch-up. For foster parents of children ages 0-5.

Provides home visits designed to enhance caregivers' ability to respond sensitively to children who have experienced early trauma or maltreatment. Clinicians being trained in NC through the Center for Child and Family Health. http://www.ccfhnc.org

Parents as Teachers. For parents of children ages 0-5. Provides early childhood parent education, family support, and school readiness through home visiting by trained parent educators. Available in many counties throughout NC. http://www.parentsasteachers.org/location

2. Trauma-Related

Evidence-based, trauma-informed treatments are becoming more widely available in NC. For more information visit the individual websites below or the following listings:

- California Evidence-Based Clearinghouse for Child Welfare http://www.cebc4cw.org.
- National Child Traumatic Stress Network http://www.nctsn.org

Well-Supported by Research Evidence (Rating of 1)

Trauma Focused Cognitive-Behavioral Therapy (TF-CBT). For children 3-18. For a list of clinicians in your county who are rostered in TF-CBT, visit the NC Child Treatment Program at https://ncchildtreatmentprogram.org

Eye Movement Desensitization and Reprocessing for Children and Adolescents (EMDR). For children ages 2-17. According to the EMDR website, certified clinicians are available across NC. http://www.emdr.com/find-a-clinician.html

Supported by Research Evidence (Rating of 2)

Child-Parent Psychotherapy (CPP). For children 0-5 and caregivers. For a list of clinicians in your county who are being rostered in CPP, visit the NC Child Treatment Program at https://ncchildtreatmentprogram.org

Rated a Promising Practice by National Child Traumatic Stress Network

Structured Psychotherapy for Adolescents Responding to Chronic Stress (SPARCS)

For youth 12-19**.** A cognitive-behavioral based group intervention for adolescents who have experienced chronic trauma and have trauma-related symptoms. For a list of clinicians in your county who are rostered in SPARCS, visit the NC Child Treatment Program at https://ncchildtreatmentprogram.org

3. Treatment and Training for Parents

Substance Abuse and Mental Health Services Administration's National Registry of Effective Programs and Practices (NREPP) http://www.nreppp.samhsa.gov/

Evidence-informed models that *integrate issues of trauma, mental health problems, and substance abuse* for more effective comprehensive treatment include:

- Seeking Safety
- The Trauma Recovery Empowerment Model (TREM)
- Trauma Affect Regulation: Guide for Education and Therapy (TARGET)

- Helping Women Recover/Beyond Trauma/Helping Men Recover

There are also a number of parent training programs that have been rated by the California Evidence-Based Clearinghouse for Child Welfare (CEBC4CW, 2016) and are available in North Carolina.

Well-Supported by Research Evidence (Rating of 1)

The Incredible Years. A series of three separate curricula for parents, teachers, and children, ICY is designed to promote emotional and social competence and to prevent, reduce, and treat behavior and emotional problems in young children. www.incredibleyears.com/

Supported by Research Evidence (Rating of 2)

SafeCare. For children 0-5. A home visiting program that teaches parents how to interact in a positive way with their children, respond appropriately to challenging child behaviors, recognize hazards in the home, and recognize and respond to symptoms of illness and injury. Certified sites in NC include Exchange Clubs in Durham and The Children's Center in Dobson. http://www.safecare.org

Triple P Parenting. For Children and caregivers 0-16. Provides multiple levels of interventions with resources and modules based on developmental level.www.triplep.net

Promising Research Evidence (Rating of 3)

1-2-3 Magic: Effective Discipline for Children 2-12. A group approach that focuses on controlling negative behavior, encouraging good behavior, and strengthening the child-parent relationship. "The program seeks to encourage gentle, but firm, discipline without arguing, yelling, or spanking" (CEBC4CW, 2016).

Nurturing Parenting Program for Parents and their School-age Children 5 to 12 Years. A group based , 15-session model with concurrent sessions for parents and children. Training materials can be purchased from developer.

http://nurturingparenting.com/ecommerce/category/1:3:2

Trauma-Focused Questions for Mental Health Providers

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

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

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

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

3. **How do you approach therapy with traumatized children and their families?**

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

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

   - **Building a strong therapeutic relationship**. Like most forms of therapy, trauma treatment requires the skillful development of a clinical relationship with the child and caregivers.
   - **Psycho-education about normal responses to trauma**. Most trauma-informed therapy includes a component that helps the child and caregivers understand normal human reactions to trauma.
   - **Parent support, conjoint therapy, or parent training**. Caregivers are typically powerful mediators of the child's treatment and recovery. Involving the parent, resource parent, or other caregiver is a vital element of trauma treatment. Some trauma-informed interventions include a parenting component to give the parent greater mastery of child management skills.
   - **Emotional expression and regulation skills**. Helping the child to identify and express powerful emotions related to the trauma and to regulate or control their emotions and behavior is an important element of trauma-informed therapy.
   - **Anxiety management and relaxation skills**. To help with emotional regulation, it is typically necessary to teach the child (and sometimes the caregiver) practical skills and tools for gaining mastery of the overwhelming emotions often associated with trauma and its reminders.
   - **Cognitive processing or reframing**. Many children form destructive

misunderstandings in the aftermath of the trauma. They may assume a great deal of self-blame for the events or blame someone else for not protecting them even though doing so may have been beyond their capacity. They may associate unrelated events to the trauma and draw irrational causal relationships. Therapy often helps correct these misattributions.

- **Construction of a coherent trauma narrative**. Successful trauma treatment often includes building the child's capacity to talk about what happened in ways that do not produce overwhelming emotions and that make sense of the experience. Many non-trauma-informed therapists are uncomfortable with this aspect of treatment, which sometimes involves gradual exposure to traumatic reminders while using newly acquired anxiety management skills.
- **Strategies that allow exposure to traumatic memories and feelings in tolerable doses so that they can be mastered and integrated into the child's experience**. Treatment often encourages the gradual exposure to harmless trauma reminders in the child's environment (e.g., basement, darkness, school) so the child learns to control emotional reactions to these reminders and to differentiate the new experiences from the old.
- **Personal safety training and other empowerment activities**. Trauma may leave children feeling vulnerable and at risk. Trauma treatment often includes strategies that build upon children's strengths. It teaches them strategies that give them a sense of control over events and risks.
- **Resiliency and closure**. The treatment often ends on a positive, empowering note, giving the child a sense of satisfaction and closure as well as increased competency and hope for the future.

Source: Potter and Sullivan, 2011; National Child Traumatic Stress Network, 2008

Adverse Childhood Experiences

HOUSEHOLD DYSFUNCTION

Mentally ill household member

1. Did you live with anyone who was depressed, mentally ill or suicidal? [Yes/No]

Substance abuse in household

2. Did you live with anyone who was a problem drinker or alcoholic? [Yes/No]
3. Did you live with anyone who used illegal street drugs or who abused prescription medications? [Yes/No]

Incarcerated household member

4. Did you live with anyone who served time or was sentenced to serve time in a prison, jail or other correctional facility? [Yes/No]

Parental separation/divorce

5. Were your parents separated or divorced? [Yes/No]

Violence between adults in household

6. How often did your parents or adults in your home ever slap, hit, kick, punch or beat each other up? [Never/Once/More than once]

CHILDHOOD ABUSE

Physical abuse

7. How often did a parent or adult in your home ever hit, beat, kick or physically hurt you in any way? Do not include spanking. [Never/Once/More than once]

Emotional abuse

8. How often did a parent or adult in your home ever swear at you, insult you or put you down? [Never/Once/More than once]

Sexual abuse

9. How often did anyone at least 5 years older than you or an adult touch you sexually? [Never/Once/More than once]
10. How often did anyone at least 5 years older than you or an adult, force you to have sex? [Never/Once/More than once]
11. How often did anyone at least 5 years older than you or an adult, try to make you touch them sexually? [Never/Once/More than once]

Source: Austin, A. E. & Herrick, H. W. (2014). *The effect of adverse childhood experiences on adult health: 2012 North Carolina behavioral risk factor surveillance system survey*. Raleigh, NC: NC Dept. of Health and Human Services, Division of Public Health. http://www.schs.state.nc.us/schs/pdf/SCHS_Study_167_FIN_20140505.pdf

NCTSN The National Child Traumatic Stress Network

Birth Parents with Trauma Histories and the Child Welfare System

A Guide for Judges and Attorneys

Judges and attorneys who work in the child welfare system are well aware that many of the children in the system have experienced trauma[1]; less well recognized is that the birth parents of these children often have their own histories of childhood and adult trauma. For example, research indicates that 30-60% of maltreated children have caretakers who have experienced domestic violence themselves.[2] Past or present experiences of trauma can affect a parent's confidence and ability to keep children safe, work effectively with child welfare staff, and respond to the requirements of the courts. Fortunately, trauma-informed services are increasingly available for both parents and children who need them. Trauma-informed services include mental health services offered by trained professionals that address specific reactions to traumatic events. By recognizing the potential impact of trauma on parenting, judges and attorneys can more easily connect parents with those services.

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What are signs that trauma may be present?

Posttraumatic reactions can result whenever children or adults are exposed to threatening events that overwhelm their ability to cope. Posttraumatic reactions may include the following:

- Avoidance (especially of things that remind the person of the traumatic event)
- Feeling emotionally numb or disengaged
- Hyperarousal or emotional or behavioral agitation
- Re-experiencing (e.g., nightmares, intrusive memories, responding to reminders)
- Feelings of powerlessness and helplessness
- Feelings of hyper-vigilance (e.g. watchfulness, alertness, edginess, sleeplessness)

[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. Traumatic experiences may include, for example: unexpected death of a loved one, abuse and neglect, serious accidents, experiencing or witnessing interpersonal violence, house fires, combat injuries, natural disasters, acts of terrorism, and community violence. Trauma treatment refers to the mental health services that address behavioral responses to trauma.*

[2] *Katz, L. F., Lederman, C. S., & Osofsky, J. D. (2011). Child-Centered Practices for the Courtroom & Community: A Guide to Working Effectively with Young Children & Their Families in the Child Welfare System, Brooks Publishing.*

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In the child welfare system, legal professionals may observe parents who exhibit these posttraumatic reactions in court or when interacting with their children or case managers. It is not uncommon for the court setting or legal process to trigger feelings of helplessness or loss of control in parents, which may be exacerbated by the parents' past trauma and its reminders. A referral to determine whether post-traumatic stress is present may be appropriate.

How Can Trauma Affect Parents?

Trauma does not affect every parent in the same way, and not all parents will develop posttraumatic reactions after a traumatic event. However, trauma can influence parenting in ways that initially may not be obvious. For example, trauma reminders and recurrent posttraumatic reactions may interfere with parents' abilities to:

- React to a child's behavior in a calm and thoughtful manner, rather than responding impulsively
- Make appropriate safety judgments, resulting either in overprotection or an inability to recognize dangerous situations
- Meet their children's emotional needs or support their children's counseling
- Form trusting relationships with their children and with court personnel and service providers
- Moderate or control their emotions
- Make decisions or plan for the future
- Manage other stresses, such as poverty, racism, substance abuse, and lack of social support

Can trauma also affect judges and attorneys who work in family court?

For judges and attorneys working with child welfare cases, secondary or vicarious traumatic stress (also called compassion fatigue) may be a professional risk.[3] This may occur following extensive exposure to the retelling of trauma experiences in court.[4] It is important to keep in mind that, while effective trauma treatments are now more available for parents and children, they also are available for professionals working on a daily basis with difficult cases involving traumatic events.[5]

How can attorneys and judges use a trauma-informed approach when working with birth parents?

Judges and attorneys can effectively advocate for the welfare of the child and family by identifying the service needs of parents suffering from the effects of trauma. It is important to: carefully observe parents' behavior, ask them what they want and need, listen closely to their responses, and ensure a sufficiently safe legal and emotional environment for them to disclose their own trauma history. Once the legal professional identifies the need for a trauma assessment and/or treatment, he or she should consider the following suggestions to effectively link the parent with appropriate services:

- Empower parents by asking what services they think might be helpful, recognizing that they may not know.

[3] *Osofsky, J. D., Putnam, F. W., & Lederman, C. S., "How to Maintain Emotional Health When Working with Trauma," Juvenile and Family Court Journal, 59, (4), Fall 2008.*

[4] *Focus groups conducted by NCTSN at national judges meetings in 2005 and 2007 indicated that judges can feel overwhelmed by the prevalence of trauma in the courtroom, the magnitude of the needs of the children and families, and the lack of resources.*

[5] *For a state-by-state listing of free or low cost counseling referrals for legal professionals, see the American Bar Association Legal Assistance Program directory at http://apps.americanbar.org/legalservices/colap/lapdirectory.html*

- Identify any mental health services, especially trauma-informed services, the parent has already received, and how the parent responded. If a parent already has a supportive relationship with a mental health provider experienced in addressing trauma, then attorneys and judges can encourage and support this ongoing relationship.
- Ensure that there has been a trauma-informed assessment of the parent and the parent's relationship with each child. Do not assume that a general mental health evaluation includes a trauma assessment or that a traditional parenting program will work with a parent who has experienced trauma. In fact, generic interventions—such as parenting classes, anger management classes, counseling, or substance abuse groups that do not take into account parents' underlying trauma issues—may not be effective. An appropriate trauma-informed assessment would include the following information:
    - The parent's past or current traumas that may impact his or her current functioning
    - The parent's strengths in coping and problem-solving, and social supports
    - Self-report measures and clinical interviews assessing the parent's mental health status;
    - Observations of parent-child interaction
    - The presence or absence of posttraumatic reactions
    - Recommendations for treatment and additional assessment for trauma and non-trauma related services
- Work with local professionals to create a list of evidence-based treatment practices available for parents in your community or region. When trauma-focused treatment services are scarce or non-existent, judges should convene a multidisciplinary team to enhance services or training of clinicians in the community. In rural communities where resources are especially scarce, legal professionals might consider regional approaches or distance learning.
- Familiarize the court with the process and scope of evidence-based trauma treatment for adults, including the range of treatments available.[6]
- Watch for the co-occurrence of posttraumatic stress disorder (PTSD) and substance abuse, which is especially common among women. Substance use may be viewed as "self medication" to cope with the overwhelming emotional pain of trauma; but research shows that posttraumatic symptoms can trigger substance use, which, in turn, can heighten trauma symptoms.[7] When developing a case plan for parents, assessing for both substance abuse and trauma can ensure that the two problems are treated in an integrated manner, rather than sequentially.
- Keep in mind that parents who are adolescents or new immigrants, or have experienced adversities including disability, poverty, or homelessness, may be at higher risk for experiencing trauma; they also may have more barriers in accessing resources.
- Let parents know that you understand the significance of their past trauma, 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 traumatic events that have happened to them and their present reactions and behavior can empower and motivate them to make positive changes.

[6] *For more information on adult trauma treatments and intervention, 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; National Registry of Evidence-based Programs and Practices at http://www.nrepp.samhsa.gov*

[7] *Najavitz, Lisa M., Seeking Safety: A Treatment Manual for PTSD and Substance Abuse, Guilford Press, 2002.*

- Remember that the court experience itself can be confusing, intimidating, disempowering, and, at times, re-traumatizing to parents. When reminders cause some parents to seem numb or disengaged, let them know that attorneys and judges are there to guide them and want to preserve, strengthen, and support them and their family.

- Build on parents' strengths and their desires to be effective.

By working together, judges, attorneys, case managers, and parents can give children in the child welfare system the care and support they need. This will be achieved more easily if parents' needs, including the need for trauma assessment and treatment, are also adequately identified. Legal professionals now have resources available to refer parents for treatment for their own history of abuse and trauma. With appropriate help, parents will feel more empowered and supported by the child welfare system and, in turn, will be more able to support their children.

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

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