Virginia C. Strand · Ginny Sprang *Editors*

Trauma Responsive Child Welfare Systems

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Virginia C. Strand
National Center for Social Work Trauma Education and Workforce Development
Fordham University Graduate School of Social Service
West Harrison, NY, USA

Ginny Sprang
Department of Psychiatry
Center on Trauma and Children
University of Kentucky College of Medicine
Lexington, KY, USA

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Foreword

Much has been done to raise awareness in the child welfare field about the role of trauma in thwarting successful development of children and adults. Child welfare agencies and their partners are aware of the effects of trauma and, in some cases, are far better at recognizing when it is disrupting child functioning than they once were. However, the work is far from complete.

Recognizing trauma's immense and far-reaching impact has been the first step. As the title of this volume suggests, our work in educating system partners about the role and impact of trauma has amplified the need for the same systems to be prepared *to respond* to trauma. Increased awareness may have reduced the misuse of interventions and medications targeting attention and behaviors rather than their underlying causes, but in many parts of the United States, child welfare systems lack coordinated plans to respond appropriately to problems that stem from trauma exposure. And, while the proliferation of evidence-based treatment approaches has helped to guide practitioners toward more appropriate trauma-sensitive interventions for individual children and their families, we are still without guidance for the workforce at large; we are without an overarching organizational approach that links trauma-informed work to the child welfare goals of safety, permanency, and well-being.

This volume examines the role of the child welfare system in acknowledging and responding to trauma from numerous perspectives. It explores how trauma awareness might be enhanced and used to guide work in child protection, preventive, substitute care, and permanency services and how assessment strategies, treatment approaches, and practices might be realigned to promote trauma-informed responses all along the continuum of care. Using the conceptual frame of stabilization, integration, and consolidation, the chapters that follow draw parallels between the clinical work of healing and the practice and policy work of delivering agency- and system-wide responses to a vulnerable population.

Applying this framework at the macro level has many advantages. It can:

- Prepare a workforce to address challenging behavioral and relational issues and assist substitute and biological parents in delivering similarly appropriate and effective responses

- Encourage healing and self-regulation in the workforce
- Promote empathy and connections between workers and the children and families they serve in order to facilitate permanencies
- Build and strengthen the foundation of a common language within and between child-serving systems
- Engage the communities surrounding child welfare agencies in being similarly informed, educated, and prepared to respond to trauma-related issues when they arise

By underscoring the role of agency culture and the effect of trauma on the workforce delivering child welfare services, this work extends and deepens the conversation about trauma in ways that can enhance the quality of services aimed at achieving safety, permanency, and well-being. Addressing both the client and staff sequelae of trauma in one volume, Strand and Sprang draw parallels that highlight common experience and define a framework for recovery *and* organizational health. It is a framework worthy of attention and testing.

Indeed, *Trauma Responsive Child Welfare Systems* provides essential guidance for agencies that seek to ameliorate the effects of trauma and promote healing. While efforts to build trauma-responsive systems may be nascent, there are examples of initiatives and jurisdictions that have leveraged federal support to blend and braid funding streams, develop a common language, and build coordinated strategic approaches to recognizing *and* responding to trauma across human service systems including mental health, early childhood, juvenile justice, and child welfare. The material presented here will be invaluable to these initiatives, as a resource that provides multiple perspectives, details successful implementations, and illustrates the potential for maximizing positive child welfare outcomes. We believe these collective efforts may ultimately reduce the need for child welfare system involvement and promote well-being for all children and families.

Chapin Hall at the University of Chicago

Bryan Samuels
Dana Weiner
Clare Anderson

Contents

Contributors

Mary C. Acri New York University, McSilver Institute for Poverty Policy and Research, Trumbull, CT, USA

George S. Ake III, PhD Department of Psychiatry and Behavioral Sciences, Duke University Medical Center, Durham, NC, USA

Center for Child and Family Health, Durham, NC, USA

Janine Beaudry University of Vermont, College of Education and Social Services, Child Welfare Training Partnership, Burlington, VT, USA

Amy Bielawski-Branch University of Vermont, College of Education and Social Services, Child Welfare Training Partnership, Burlington, VT, USA

Melissa Bowman Brooklyn, NY, USA

Adam D. Brown, PsyD New York University School of Medicine, New York, NY, USA

Lisa Conradi Chadwick Center for Children and Families, Rady Children's Hospital – San Diego, San Diego, CA, USA

Jessica Eslinger University of Kentucky Center on Trauma and Children, Lexington, KY, USA

Tracy Fehrenbach Northwestern University Feinberg School of Medicine, Chicago, IL, USA

Geetha Gopalan University of Maryland School of Social Work, University of Maryland School of Social Work, Baltimore, MD, USA

Susan Hansen New York University School of Medicine, New York, NY, USA

James Henry Children's Trauma Assessment Center, Western Michigan University, Kalamazoo, MI, USA

Jennifer Hossler Chadwick Center for Children and Families, Rady Children's Hospital – San Diego, San Diego, CA, USA

Vivian H. Jackson, PhD, LICSW Georgetown University, Mitchellville, MD, USA

Jennifer Jorgenson, LICSW University of Vermont, College of Education and Social Services, Child Welfare Training Partnership, Burlington, VT, USA

Cassandra Kisiel Northwestern University Feinberg School of Medicine, Chicago, IL, USA

Julie A. Larrieu, PhD Tulane University School of Medicine, New Orleans, LA, USA

Mary McKernan McKay Washington University, George Warren Brown School of Social Work, St. Louis, MO, USA

Brian C. Miller Intermountain Primary Children's Hospital, Salt Lake City, UT, USA

Amy Perricone Children's Trauma Assessment Center, Western Michigan University, Kalamazoo, MI, USA

Barbara Pierce, PhD, LCSW Indiana University School of Social Work, Indianapolis, IN, USA

Marciana Popescu Fordham University Graduate School of Social Service, West Harrison, NY, USA

Jill Richard University of Vermont, College of Education and Social Services, Child Welfare Training Partnership, Burlington, VT, USA

Glenn N. Saxe New York University School of Medicine, New York, NY, USA

Ginny Sprang, PhD Department of Psychiatry, Center on Trauma and Children, University of Kentucky College of Medicine, Lexington, KY, USA

Tricia Stephens City University of New York, Hunter College – Silberman School of Social Work, New York, NY, USA

Virginia C. Strand, DSW National Center for Social Work Trauma Education and Workforce Development, Fordham University Graduate School of Social Service, West Harrison, NY, USA

Jessica Strolin-Goltzman University of Vermont, College of Education and Social Services, Child Welfare Training Partnership, Burlington, VT, USA

Kelly M. Sullivan Department of Psychiatry and Behavioral Sciences, Duke University Medical Center, Durham, NC, USA

Center for Child and Family Health, Durham, NC, USA

Elizabeth A. Thompson, PhD Center for Child and Family Traumatic Stress at Kennedy Krieger Institute, Baltimore, MD, USA

Elizabeth Torgersen Northwestern University Feinberg School of Medicine, Chicago, IL, USA

Cambria Rose Walsh The Center for Child Welfare Trauma-Informed Policies, Programs, and Practices, Chadwick Center, Rady Children's Hospital San Diego, San Diego, CA, USA

Lindsey E.G. Weil Northwestern University Feinberg School of Medicine, Chicago, IL, USA

Adrienne Whitt-Woosley University of Kentucky Center on Trauma and Children, Lexington, KY, USA

Part I
Setting the Stage

Chapter 1
Introduction: Developing Trauma Sensitive Child Welfare Systems

Virginia C. Strand

Achieving trauma-informed child welfare systems and services is a major challenge facing child welfare at the beginning of the twenty-first century. Bryan Samuels, former Commission of Administration on Children, Youth and Families, states that "The research is clear that the experience of abuse or neglect leaves a particular traumatic fingerprint on the development of children that cannot be ignored if the child welfare system is to meaningfully improve the life trajectories of maltreated children, not merely keep them safe from harm" (Samuels, 2011).

Much has been studied, advocated, and written about the trauma history and needs of children coming into the child welfare system (Kisiel, Ferenbach, Small, & Lyons, 2009; Kolko et al., 2010; Greeson et al., 2011; McMillen et al., 2005). Harris, Lieberman, and Marans (2007) noted that most children with trauma histories in child serving systems like child welfare do not receive mental health treatment. There is a genuine concern among both practitioners and researchers about how to better serve traumatized children and families (Ai, Foster, Pecora, Delaney, & Rodriguez, 2013; Black-Pond & Henry, 2007; Hendricks, Conradi, & Wilson, 2011; Ko et al., 2008).

Recently, The Substance Abuse and Mental Health Services Administration (SAMHSA) (2014) identified six key principles to guide a trauma-informed approach: (1) safety; (2) trustworthiness and transparency; (3) peer support and mutual self-help; (4) collaboration and mutuality; (5) empowerment, voice, and choice; and (6) attention to cultural, historical, and gender issues. In addition, the National Child Traumatic Stress Network has created a policy statement for the development of trauma-informed child welfare systems as follows: "Increasing knowledge and building skills among caseworkers and other child welfare person-

V.C. Strand, DSW (✉)
National Center for Social Work Trauma Education and Workforce Development, Fordham University Graduate School of Social Service,
400 Westchester Ave. Room 131, West Harrison, NY 10604, USA
e-mail: strand@fordham.edu

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nel are critical to identifying and providing early intervention for children traumatized by maltreatment." (http://www.nctsn.org/sites/default/files/assets/pdfs/Service_Systems_Brief_v1_v1.pdf). These principles and policy statement do not, however, provide sufficient direction for child welfare agencies in regard to *how to* apply these.

Trauma theory offers a conceptual framework to guide a process for more effective infusion of knowledge about trauma, its impact, and empirically supported interventions in child welfare agency practice with children and families. This framework also provides a foundation for understanding the impact on staff working with traumatized children and families in child welfare. In this chapter, the literature on trauma, its impact, and the nature of effective trauma treatments is used to highlight the types of revisions needed in child protection, preventive, foster care, and adoption services.

The Relevance of Trauma Theory and Knowledge

The Impact of Trauma

Trauma is defined as an adverse life experiences that overwhelm an individual's capacity to cope and to adapt positively to whatever threat they face. "Traumatic events produce profound and lasting changes in physiological arousal, emotion, cognition, and memory. Moreover, traumatic events may sever these normally integrated functions from one another." (Herman, 1992) We now know that these experiences can cause debilitating behavioral and health difficulties in adulthood (Felitti et al., 1998) as well as adverse outcomes for older youth (McMillen et al., 2005) and adults emerging from the foster care system (Pecora, 2010). The complex impact of trauma on children and families is well articulated (Cook et al., 2005, Courtois, 2004). When children have been exposed to chronic and/or severe trauma, functioning is often compromised across a number of domains (Lieberman & Knorr, 2007).

Of primary concern is the effect on the development of secure attachment (Blaustein & Kinniburgh, 2010), but affective, cognitive, behavioral as well as somatic functioning is typically impacted along with the child's attachment (Cook et al., 2005; Lieberman & Knorr, 2007). The child's perception of self and others may become distorted and the world in general viewed as unsafe. As children and adolescents seek to cope with these adverse experiences and changed worldview, they may employ avoidance strategies, demonstrate hyperarousal to trauma reminders, and have difficulty modulating feelings or regulating behavior. Interpersonal relationships may be perceived as a source of danger, leading to isolation or hostile interactions with others (Cook et al., 2005; Lieberman & Knorr, 2007; Saxe et al., 2007).

A history of abuse and neglect brings children to the attention of the child welfare system. We now know that a majority of children and often their primary caretakers

(Chemtob, Grifing, Tullberg, Roberts, & Ellis, 2011) have experienced trauma. Kolko et al. (2010) found that while the prevalence of posttrauma stress symptoms was on average 12% in a national sample of children referred to child welfare, the rate was almost double for children entering care (19.2% for out of home and 10.7% for those maintained at home). Critical to the experience of trauma is the child's sense of betrayal when the abuse or maltreatment has occurred at the hands of a parent or caretaker. When an intervention placing children in out-of-home care in order to keep them safe inadvertently place the child at further risk for secondary adversities (Appleyard, Egeland, van Dulmen, & Sroufe, 2005) the social contract dictating that a child should have been safe in any substitute care arrangement provided by the state has been breached. Children are then often faced with many new challenges, losses, and stressors. The cumulative impact of these stressors, if unaddressed, often leads to additional emotional difficulties and behavioral disruptions. The challenge for child welfare is to offer children and their families trauma-sensitive services while preparing and sustaining staff impacted daily by direct and vicarious exposure to traumatic events.

The experience of overwhelming danger that occurs at the time of a traumatic event affects the body's neurobiology, which mobilizes to ward off danger, often through fright, flight, or fight responses (Perry, 2008; Saxe et al., 2007). With severe and persistent trauma, even when the child is safe and regulated, the body responds to associations – an event, person, smell, sound, or activity – with past dangers as if they are occurring in the present. For the child and those around him – parents, caregivers, teachers, and peers – these inadvertent, automatic responses to past events can appear unprovoked. It is these reactions to trauma triggers that caregivers and staff need to be attuned. According to the US Substance Abuse and Mental Health Services Administration (SAMHSA) "trauma informed organizations, programs, and services are based on an understanding of the vulnerabilities or triggers of trauma survivors that traditional service delivery approaches may exacerbate, so that these services and programs can be more supportive and avoid re-traumatization" (SAMHSA, 2010). The need to put into place trauma-informed services is foremost for child welfare agencies.

If emotional well-being is defined in regard to the internal life of the child, social well-being is focused on the external environment. A trauma-informed definition of social well-being for a child or adolescent rests on the establishment of a secure attachment with at least one primary caregiver. Social well-being is reflected in peer relationships, and there is evidence that children with at least one close friend and who can maintain friendships over time function better. Children who are supported in school achievement through the communication of positive expectations have been found to do better (Lipschitz-El, 2005). From a trauma perspective, children living in safe, protective, and nurturing families, where family values and socialization practices encourage a child's sense of efficacy, promote responsibility and facilitate support from extended family networks as well as the community at large, are more likely to flourish (Werner & Smith, 2001).

Successful Trauma Interventions

We know a great deal about what works effectively with traumatized children, adolescents, and adults that can be used to inform the development of a trauma-informed workforce. There are a number of evidence-based trauma treatments which have been found to be effective with maltreated and violence-exposed children. (Chaffin & Friedrich, 2004; Cohen, Mannarino, & Deblinger, 2006). While there is varying emphasis across empirically supported trauma treatments, common elements found in most include attention to safety, regulating emotions, achieving behavioral control, addressing cognitive distortions, building or sustaining attachment relationships, processing and integrating the traumatic experiences, and attending to posttrauma growth. Posttrauma growth can be understood as an increase in mastery, competency, and self-esteem (Blaustein & Kinniburgh, 2010; Saxe et al., 2007; Strand, Hansen & Courtney, 2013).

Phase-oriented trauma treatment is widely accepted as a defining characteristic of trauma-informed interventions (Brown, Scheflin, & Hammond, 1998, Courtois, 2004) and has been utilized as a framework in treatments for children in the child welfare system (Collins, Strieder, DePanfilis, Tabor, Clarkson, Linde, & Greenberg, 2011). The names given to phases of treatment may vary but the phase-oriented dynamic is present. Most interventions acknowledge either explicitly or implicitly a stage-oriented approach for effective intervention which includes:

1. Stabilization: the establishment of physical safety and emotional stabilization, characterized by an emphasis on the present; a focus on trauma-informed assessment and the development of adaptive coping strategies to better modulate affect dysregulation, stress responses, behavioral dysregulation, and cognitive distortions. The focus is on the here and now.
2. Integration: Processing traumatic memories and experience with the goal of reducing their impact on current functioning; characterized by a focus on acknowledging the reality of traumatic events, harmful relationships, and making meaning of past events. Implicit in the stage is the achievement of a secure attachment relationship. The focus is primarily on the past.
3. Consolidation: Return to a normal developmental trajectory, characterized by the consolidation of personal and interpersonal growth and mobilization of energy to focus on developmental tasks for the future. The focus is on the future.

Trauma-focused cognitive behavioral therapy (Cohen et al., 2006), is an example that aligns with this phase-oriented approach. It is a trauma intervention receiving the highest scientific rating on the California Evidence-Based Clearing House for Child Welfare, http://www.cebc4cw.org/search/results/?scientific_rating[]=1&q_search=Search&realm=scientific_rating) and is rated by SAMHSA National Registry of Evidence-based Programs and Practices as a program with effective outcomes (http://nrepp.samhsa.gov/AdvancedSearch.aspx).

TF-CBT is an example of an evidence-based trauma treatment which illustrates the phase-oriented nature of intervention. The TF-CBT treatment components that

fit into the "stabilization" phase are psychoeducation, parenting skills, relaxation, affect expression and modulation, and cognitive coping and processing. Their "integration" phase trauma processing component is defined as a "trauma narrative", followed by cognitive coping and processing II, in vivo mastery conjoint child–parent sessions components. Their "enhancing future safety" component can be thought of as a consolidation element.

The child welfare outcomes of safety, permanency, and well-being align with this conceptual framework for phase-oriented treatment. Safety is achieved through stabilization, permanency through integration and well-being through consolidation of the traumatic experiences. In terms of the impact of trauma on the child, integration of the trauma experience can only happen once the child is safe and stabilized. Attention to well-being, however, is an iterative process and can begin during the stabilization phase, as children are helped with stress reduction and emotional regulation. A complicating factor for child welfare is that both birth and foster parents (kinship and nonkinship) may have their own unresolved trauma experiences, as well as additional psychosocial problems and stressors (substance abuse, homelessness, serious mental illness) which they will need help addressing in order to provide a psychologically safe environment for the child. Without the integration of the traumatic experience, attempts at reunification may fail, or foster placement, even adoption, be disrupted. Permanency can be achieved through the integration of traumatic experiences, and the role of primary caregivers – birth parents, foster parents, or adoptive parents – is crucial in this process. Consolidation is the foundation for child well-being, as it positions the child and primary caregiver to continue the developmental trajectory with emotional energy freed to direct to on-going maturational tasks.

Resolution of the impact of exposure to trauma will help a child move toward emotional and social well-being. Emotional well-being, using a trauma lens, is defined as the successful integration of traumatic experiences, resulting in emotional and psychological energy being available for the child or adolescent to attend to the developmental tasks at hand, free form preoccupation with danger and safety. The diminishment of internal arousal to trauma reminders, coupled with mastery of coping strategies to deal with some unavoidable physiological and emotional arousal, positions the child or adolescent to bring appropriate affect, attention, and action to the educational, peer, and family challenges facing him or her. It is the attention to these coping strategies which begin in the stabilization phase. Additionally, critical to the sustainability of emotional well-being will be the development of a secure attachment, whether with a biological parent or other primary caregiver.

The next two chapters expand on this framework, first at it relates to the provision of agency services, and secondly, as it relates to workforce development. Chapter 4, with its emphasis on cultural competence, is included in the introduction due to its salience for both direct practice and organizational change. Chapter 4 discusses cultural responsiveness and reviews how historical trauma has shaped the experience of children, families and workers, and what this means for successful engagement and service delivery by child welfare agencies. Historical trauma has been defined as the "cumulative and collective emotional and psycholgocial injury over the life span and across generations, resulting from a cataclysmic hisotry of

genocide" (Struthers & Lowe, 2003, p258). Understanding historical trauma is important for understanding disproportionality and disparity in child welfare and is critical to successful engagement. Subsequent chapters flesh out developments in the creation of trauma-informed child welfare services (child protection, preventive, foster care, and adoption) and in attention to a trauma-informed agency culture.

Organization of the Book

In Part II, the two chapters in the first section deal with the role of child protective services in stabilization and safety. Chapter 5 focuses specifically on trauma-informed family engagement with resistant clients. It will expand on the notion of collaborative practice with parents and caregivers. There is evidence that lack of engagement skills is associated with lack of cultural sensitivity. Some (Dettlaff & Rycraft, 2010) have found that cultural bias in staff was a barrier to equitable provision of services. Dumbril (2006), in his study of parents' experience of CPS workers, found that those parents who experience workers using their power with them, rather than over them, were much more likely to work with CPS, as opposed to fighting or "playing" along. This chapter will identify specific engagement strategies and approaches for child protective services work.

Chapter 6 describes and discusses a specific evidence-informed trauma treatment, trauma system therapy (Saxe, Ellis, & Kaplow, 2009) and describe how it has been implemented in both state and large metropolitan child welfare agencies. With an emphasis on work in the social environment as well as with the individual child and family, the role for CPS is clearly articulated.

A second section in Part II focuses on permanency and the role of preventive services. As children and families move from the crisis of child protective services report to either preventive services, whose goal is to prevent placement, or to foster care, the immediate need for physical safety subsides. This is the time for intervention to ameliorate the impact of traumatic experiences that were identified in the CPS phase of intervention. The section starts in Chap. 7 with an examination of successful implementation of standardized assessment tools in many state-wide child welfare agencies, highlighting the facilitating factors as well as barriers to the implementation of comprehensive trauma assessments.

Chapter 8 continues the discussion of trauma-informed assessment, identifying ways in which the public agency can partner with community agencies for trauma assessments. Again, the goal is to fully assess the trauma impact and to plan for evidence-based trauma treatment where relevant.

Chapter 9 describes the successful implementation of an evidence-based trauma treatment, child–parent psychotherapy (Lieberman & Van Horn, 2009) in a state-funded preventive services program. Designed for children under six and their parents/primary caregivers, this implementation uses both a home- and office-based intervention. Successes, including the use of fidelity instruments with both clinicians and supervisors are discussed; on-going challenges are also identified.

The final three chapters in Part II focus on permanency and the role of foster care, as well as the need to work with preadoptive parents from a trauma perspective. As children move into foster care, there is an important opportunity for intervention to help resolve the impact of the trauma that brought the child(ren) into care, for both children and birth parents. Starting with an emphasis on the importance of establishing psychological safety as well as physical security in the foster home, Chap. 10 will focus on innovative methods that are available to help foster or resource parents become trauma-informed and better able to assist children in their care with emotional and behavioral regulation. Chapter 11, by contrast, will focus on the therapeutic work that can be undertaken with birth parents to assist them in resolving their own histories of trauma that often contribute to disruptions in parenting, and Chap. 12 focuses on a trauma-informed intervention model for supporting pre-adoptive parents.

In Part III, the focus shifts to creating trauma-informed agency culture. The first chapter in this part, Chap. 13, introduces commonly accepted principles for implementation of new practices. Steps associated with each stage are discussed, and examples of implementation are provided. The next three chapters outline a framework of macro strategies aimed at creating stabilization and safety in the organizational culture. Chapter 14 outlines a guiding framework for trauma-informed care in public child welfare, with a focus on organizational policies, practices, workforce development strategies, and evaluation methods that have been successfully used to create a trauma-responsive culture and promote the goals of safety, permanency, and well-being in an effective manner. Building upon this framework of care, Chaps. 15 and 16 will focus on specific tools that public child welfare personnel at all levels can use to assess and monitor progress toward the goal of creating a trauma-informed system of care and promoting and maintaining a secondary traumatic stress informed workplace. In addition to providing an evaluation strategy for child welfare personnel, these tools serve as a checklist of activities that can be used to design a trauma-informed organizational development plan.

Two chapters (17 and 18) focus on micro strategies for the development of safe and stable organizational culture. They include strategies for trauma-informed staff recruitment and selection, as well as a description of a widely disseminated caseworker training tool.

Successful and sustained implementation of the trauma-informed principles and strategies outlined in this text are only realized when this guiding framework is successfully integrated into the agency's workforce development and support practices. In fact, a healthy, committed child welfare worker is one that is capable of delivering trauma-informed care in a sustained way and who works in an environment that is physically and psychologically safe, empowering, trustworthy, and collaborative. In this section, physical safety and psychological security are presumed, and activities are focused on "healing", creating optimism and competency through the integration of current and past traumatizing work experiences.

Two approaches for achieving these goals of strengthening the workforce's attachment are highlighted. Chapter 19 discusses an innovative approach to trauma-informed supervision and support that provides child welfare workers with the

knowledge and skills to regulate and process responses to working with trauma exposed clients on an on-going basis without sacrificing engagement. Chapter 20 describes professional development approaches to equip the worker with the skills needed to navigate the delivery of trauma-informed services. Finally, Chap. 21 outlines the challenges ahead for national transition to trauma-informed agencies and services.

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Chapter 2
Applying Trauma Theory to Agency Practice

Virginia C. Strand

Trauma-informed practice is possible in child protective, preventive, foster care, and adoption services. Applying the phase-oriented approach identified with successful treatment of traumatized children and adults, the first emphasis in work with children coming to the attention of the child welfare system should be on stabilization. This fits well with the organizational emphasis on safety reflected in the mandate for child protective services. While safety may be the focus in this first phase, it does not mean ignoring permanency and especially well-being. Addressing the mental health needs of children as they enter the system is key, as Chap. 6 will elaborate.

Clearly, preservice training for all child welfare staff should include information about the impact of trauma on children, birth and foster parents as well as the impact of working with traumatized populations on child welfare workers. An excellent resource for staff training is the *child welfare trauma training toolkit* (National Child Traumatic Stress Network [NCTSN], 2013) described in some detail in Chap. 18.

Child-Protective Services

The concept of safety includes not only physical safety but also the child's sense of internal or psychological safety. Actions often need to be taken in the external environment with parents or other caregivers so the adults act in ways that help a child establish that sense, and this has implications for referral. Three concepts are used to differentiate strategies designed to stabilize children's external environment from

V.C. Strand, DSW (✉)
National Center for Social Work Trauma Education and Workforce Development, Fordham University Graduate School of Social Service, 400 Westchester Ave. Room 131, West Harrison, NY 10604, USA
e-mail: strand@fordham.edu

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those to stabilize a child's internal, emotional environment: safety actions, safety promoting interventions, and safety planning interventions (Strand, Hansen, & Courtney, 2013).

Safety actions in the external environment include those designed to assure physical safety and reduce concerns about immediate physical risk to the child. This may mean removal, or in extreme cases, arrest of a perpetrator. More commonly it requires referral of a nonoffending parent to a domestic violence shelter, advocacy services, or preventive services for support related to reduction of inadequate care.

Less well understood is the need for psychological safety, which is addressed through safety-promoting and safety-planning interventions. *Safety-promoting interventions* include strategies to achieve internal emotional, behavioral, or cognitive stability when a child is at risk of immediate harm or self-injurious behavior. These include actions to reduce dangerously escalating behavior on the part of a parent or child or to intervene with a parent to protect the child. Interventions are directed at helping the child and family achieve internal emotional security and behavioral stability.

Safety planning interventions can be used when the child is safe and there are no concerns about immediate physical risk. They focus on plans for achieving internal control, with an emphasis on activities that help maintain the child, caregiver, and family's physical and emotional safety. They include identification of triggers and predictable stressors that have led to crises in the past and strategies to prepare in advance to stay in control. They may also include education about paying attention to one's sense of danger, body ownership (for example, "good touch–bad touch" explanations), risks involved with keeping secrets, and identification of key people the child can go to with safety concerns and ways to ask for help when feeling unsafe, along with the identification of other high-risk situations for abuse.

Child protective services are best positioned to help with safety actions and often with safety planning; foster care workers and foster parents can assist with safety planning; both foster care and preventive workers are ideally situated to implement safety promoting strategies.

Engaging parents is often the key to successful intervention by child protective services. Because the overwhelming majority of indicated cases seen by child protective services are not referred to family court, the ability to engage parents in understanding and accepting the need for help increases the likelihood that they will follow through with referrals.

Evidence suggests that child protective workers could be more effective by using a partnering rather than an authoritative approach with families (Dumbril, 2006). Family engagement better positions child protective workers to provide psychoeducation about the impact of trauma on children. The fact that traumatic events often result in impulsive behaviors and emotional states that are to a large degree involuntary is an important message to communicate and, if understood, may make parents more willing to accept referrals. Using reflective listening, which can be taught in preservice training, demonstrating empathy, and being knowledgeable about trauma-specific resources are also key components for effective practice.

Preventive Services

The preventive services worker is typically involved with a family once the child has been determined to be physically safe. The risk of placement may still be present, and there are often ongoing concerns about the child becoming unsafe in the current living situation. Assessment of the impact of the trauma exposure becomes critical here and is the key for safety-promoting and safety-planning interventions targeting both parents and children. An important skill for preventive services workers to develop is the capacity to intervene with a child and family or a dyad, since efficiency often requires that the child is not seen alone.

The possibility of traumatic exposure in the history of the birth parent is important to explore, as the child is typically living with the birth parent while receiving preventive services. If the parents have a history of abuse and neglect themselves, this will increase the likelihood of their responding impulsively and at times inappropriately in the care of their children. As with the child who has experienced trauma, the adult, too, may be dealing with emotional and behavioral dysregulation that is affecting their parenting. It may be important to identify this as an issue for the parents and work to help them accept a referral to a trauma-specific service to augment the help from preventive services.

Intervention with a child or adolescent often requires attention to behavioral, emotional, cognitive, and physical dysregulation. If the preventive services worker has the appropriate training, he or she can help the child identify, regulate, and express feelings. Assistance with behavioral regulation often requires that children or adolescents be helped to identify trauma reminders in their environment that may trigger actions that get them into trouble with peers, parents, and teachers.

If the preventive services worker is not trained to undertake this work, a referral to a trauma-specific service may be needed. However, the preventive worker may still need to coordinate services so that the important people in the child's school and family network are involved. This may involve psychoeducation with school personnel about trauma and the potential of trauma triggers at school to interfere with attendance, learning, and appropriate behavior. Trauma work with the parent to support the child's growth is also important, whether it is carried out by the preventive worker or another provider. Placement can be improved by the extent to which the preventive services worker can undertake and reinforce safety promoting interventions with the child and family.

Another key component for parents whose children are at risk for placement is parent training. Preventive services workers need to be aware of the range of evidence-based parent training that is currently available. Evidence suggests that didactic parenting classes are only minimally effective, if at all, in changing parenting practice (Casanueva, Martin, Runyan, Barth, & Bradley, 2008). On the other hand, research has identified a range of parent education programs with promising outcomes in changing abusive and neglectful parenting. Four of these have consistently been demonstrated to be effective in a variety of studies: the Incredible Year (Webster-Stratton & Hammond, 1997), Multisystemic Therapy (Henggeler et al.,

2003), Parent Training (Forgatch & Martinez, 1999), and Parent-Child Interaction Training (Eyberg & Robinson, 1982). While not specifically trauma focused, they have demonstrated effectiveness with parents coming to the attention of the child welfare system (Barth, 2009).

Foster Care Services

As with the preventive services worker, the role of the foster care worker is to provide safety promoting and safety planning services but with the foster parents. An excellent resource for foster care workers is the workshop *Caring for Children Who Have Experienced Trauma* (National Child Traumatic Stress Network [NCTSN], 2010). Ideally, it should become part of the mandatory training for foster parents, but when that is not the case, the curriculum provides excellent content and language that the foster care worker can use in educating foster parents about the impact of trauma and working with them to identify strategies they can use in their home.

While from the system's point of view placing children in foster care removes them from a physically unsafe environment, the child may not experience it this way. Given the heightened concern with danger and safety experienced by traumatized children, there are specific steps that foster parents can take to familiarize children in their care with their new environment, which will help them feel secure. This includes making them familiar not only with the physical environment but also with the structure and rules of the family. Foster parents also need to be prepared for common disruptions in eating and sleeping. Not only do children have trouble falling asleep, but sleep may also be disturbed by nightmares or night terrors (it's important for foster parents to know the difference), and children may have trouble waking up in the morning.

In terms of safety promoting interventions, it is as important for foster parents as for children to be aware of and able to use basic coping techniques to decrease arousal and dysregulation. These include strategies to calm down—listening to music, deep breathing, taking a time out, playing sports, talking, writing, or doing art—whatever works for a particular child. Foster parents will have an easier time and there is less likelihood of disruption if they can help the child regulate emotions and behavior.

Trauma-specific services are often crucial to a child's recovery. A number of evidence-based trauma treatments have been found to be effective with children in foster care. Weiner, Schneider, and Lyons (2009) found that three such treatments—child–parent psychotherapy, trauma-focused cognitive–behavioral therapy, and structured psychotherapy for adolescents responding to chronic stress—were equally effective in reducing symptoms and improving functioning in children in foster care. These treatments were implemented with a racially diverse sample of youth and found to result in no differences in outcome when making culturally sensitive adaptations to the model. Between them, the three models are able to reach a

wide age range; they are designed, respectively, for children under five, school-age children and their families, and adolescents who may not have a primary caregiver actively involved in treatment.

Adoption Services

Services for adoption preparation as well as supportive services to families after adoption appear to be an important factor in maintaining permanency (Coakley & Berrick, 2008). Relatively little attention has been paid to making these services trauma informed. The risk of adoption disruption for children with a preadoptive history of child sexual abuse is high, due to a number of factors. These include the behavioral and emotional problems resulting from sexual abuse, the tendency to have had more moves in care, and the difficulty these children have in attaching to the adoptive mother (Nalavany, Ryan, Howard, & Smith, 2008). This underscores the need for trauma-informed preadoption services. Research supports the need for workers to have the time to complete child and family assessments (Coakley & Berrick, 2008). In addition, the assessment should be expanded to include readiness to adopt a traumatized child; whether it is a kinship or stranger adoption, prospective adoptive parents should be trained in parenting traumatized children and adolescents.

One of the keys to successful adoption or kinship guardianship for traumatized children and adolescents is to help the child successfully resolve the impact of trauma—specifically, to decrease emotional and behavioral dysregulation and strengthen cognitive coping, particularly in the areas of attention and concentration, two areas in which the child will need to function well in order to complete school. The availability of a permanent home implies the opportunity for the development of a positive, secure attachment figure. As part of the preparation for the move to permanent status, it is important that the preadoptive parents are familiar with the impact of trauma, have the necessary skills to reinforce coping behaviors, and have worked on the development of their relationship with the child as a safe, secure emotional base. These developments will reduce the possibility of permanency disruption.

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Chapter 3
Applying Trauma Theory to Organizational Culture

Virginia C. Strand

Introduction

A framework for thinking about how child welfare agencies could be reformed is proposed, suggesting that the phase-oriented sequencing of treatment components reflected in effective trauma treatments offer a framework to consider ways in which child welfare agencies can become less trauma reactive and more effective in service provision. As described earlier, scholars and practitioners have written widely about the impact of trauma and many empirically supported treatments have been developed. Likewise, an increasing knowledge base has been developed about the nature of child welfare practice, the need for workforce development, and the contribution of child welfare agency culture and climate to workforce stabilization and effective service delivery. Yet, few discussions integrating these two lines of inquiry can be found in the literature. This chapter will attempt to summarize existing support for the proposed framework and identify the research gaps.

Impact of Trauma on Staff

Knowledge about the impact of trauma on children can be used to understand the impact on child welfare agency culture where staff are consistently interfacing with clients whose history of abuse and neglect bring them to the attention of child welfare. The effect of working with traumatized children and adolescents, as well as family perpetrators who may also be trauma survivors, can negatively impact staff,

V.C. Strand, DSW (✉)
National Center for Social Work Trauma Education and Workforce Development, Fordham University Graduate School of Social Service, 400 Westchester Ave. Room 131, West Harrison, NY 10604, USA
e-mail: strand@fordham.edu

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sometimes in ways that they may not recognize (Pryce, Schackelford, & Pryce, 2007). This is referred to in the literature as vicarious trauma, secondary traumatic stress, or compassion fatigue.

Vicarious trauma is generally defined as a change in cognitive *schemas*—beliefs, assumptions, and expectations related to psychological needs—that organize the experience of self and the world (McCann & Pearlman, 1990). It is thought to result from hearing about (indirect exposure) traumatic events. Traumatic stress is often thought to result from exposure to actual traumatic events, as is the case for police and firefighters and child protective workers (Figley, 1995; Stamm, 1995). Both vicarious trauma and secondary traumatic stress can result in behavioral change in workers, specifically the emergence of symptoms similar to those seen in PTSD, which can include intrusive cognitions related to the client's traumatic disclosures, avoidant responses, physiological arousal, distressing emotions, and functional impairment (Bride, 2007). Compassion fatigue, arising from both direct and indirect exposure, is associated with sadness and depression, sleeplessness, and general anxiety (Cerney, 1995).

Conrad and Keller-Guenther (2006) found that over 50% of child protective workers in one state system reported a high risk of compassion fatigue, even though an equally high percent report high compassion satisfaction. Littlechild (2005) reports on research documenting that violence and threats of violence were widespread sources of stress for child welfare workers. Horwitz (2006) found a positive association between direct and indirect traumatic events experienced by workers and the presents of negative work place effects. Caringi (2007), in an exploration of individual or organizational factors that contribute to secondary traumatic stress, also found that two individual factors were relevant: the unintentional choice of child protective services work, i.e., staff "happened" into the job, and consequently, staff had no relevant education or training for social services work.

Behaviors reflective of secondary traumatic stress can include:

- Avoidance of work responsibility or specific tasks as a fundamental coping mechanism.
- Impulsive behaviors reflected in decisions-making that is not well thought out or modulated.
- Verbal aggression or verbal retaliation with co-workers and sometimes clients.
- Absence from work due to fatigue, somatic complaints.
- Preoccupation with psychological danger and physical safety in the work environment.
- Secondary adversities: Just as the cascade of changes produced by trauma and loss can tax the coping resources of the child, family, and broader community, the increased use of sick days, erratic behavior on the job, distractibility, and irritability can result in increased tension with a supervisor and/or co-workers.
- These adversities and life changes can be sources of distress in their own right and can create challenges to adjustment and recovery.
- The development of risk-avoidant supervisory and management approaches;