RESILIENCE

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FACILITATOR HANDOUTS

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About this Publication

This collection of Facilitator Handouts is provided to you through the Mid-Hudson Regional Youth Justice Team, made possible by the **NYS Division of Criminal Justice Services**. The **Mid-Hudson Regional Youth Justice Team (MHRYJT)** is comprised of juvenile justice stakeholders including representatives from local government agencies, service providers, the judiciary, community organizations and youth and families who have been justice involved. Teams all around NY were created to further implement New York State's strategic plan for juvenile justice. The **MHRYJT** meets on a quarterly basis to share best practices, identify areas for practice improvement and provide input to state policymakers. The seven counties in the **MHRYJT** are as follows: Dutchess, Orange, Putnam, Rockland, Sullivan, Ulster and Westchester. These handouts were compiled and organized by Andrew Bell, Ph.D.

All handouts posted to this guide are available at conversations. westerchesterlibraries.org under "Resilience." The online version includes a linked Table of Contentes

Core Handouts

	# Pages	General	Schools	Systems Change	Racism	Early Childhood	Child Welfare	Juvenile Justice	Mental Health	Vicarious Trauma	Wellness
1. ACES Questionnaire, Resilience Questionnaire	2	X	X	X	X	X	X	X	X	X	X
2. Understanding Adverse Childhood Experiences	2		X	X	X	X	X	X	X	X	X
3. The Three Pillars of Resilience	1	X	X	X	X	X	X	X	X	X	X
4. Some Take Home Messages About Trauma and Resilience	1	X	X	X	X	X	X	X	X	X	
5. A Call to Action: Healing Through Equity and Resilience	2	X	X	X	X	X	X	X	X	X	X

General

	# Pages	General	Schools	Systems Change	Racism	Early Childhood	Child Welfare	Juvenile Justice	Mental Health	Vicarious Trauma	Wellness
1. Shifting From Trauma Informed Care to Healing Centered Engagement	2	X		X	X			X			
2. Trauma Informed Care for Children Exposed to Violence: Tips for Agencies and Staff Working with Youth	3		X			X	X	X	X		
3. How a Caregiver's Trauma Can Impact a Child's Development	1	X				X	X		X		
4. The Developmental Relationships Framework	1	X	X						X		
5. Your Heart Can Sync With a Loved One's	2	X									X
6. We Need to Understand How to Provide Trauma-Informed Care	4	X	X			X	X	X			X
7. Parents who had severe trauma in childhood more likely to have kids with behavioral health problems	2			X			X	X	X		
8. How Trauma Lingers in the Body	1	X							X		

Relevance of Handout to Audience and Topics

Education

	# Pages	General	Schools	Systems Change	Racism	Early Childhood	Child Welfare	Juvenile Justice	Mental Health	Vicarious Trauma	Wellness
1. Seeing Children through a Polyvagal Lens	5		x			x	x	x	x		
2. California's first surgeon general: Screen every student for childhood trauma	4		x	x							
3. Measuring Your Family-School-Community Partnerships: A Tool For Schools	3		x	x							
4. Schools' Program Provides Mental Health Care	4		x	x							
5. Trauma-Sensitive School Checklist	2		x								

Systems Issues

	# Pages	General	Schools	Systems Change	Racism	Early Childhood	Child Welfare	Juvenile Justice	Mental Health	Vicarious Trauma	Wellness
1. Social Determinants of Health	1	x		x							
2. Examples of Trauma-Informed Objectives (Organizational Level) - ITTIC, 2019	3			x			x	x	x		
3. Pair of ACES Tree	2	x		x	x						
4. Telling Your Public Story: Self, Us, Now	5			x							

Racism

	# Pages	General	Schools	Systems Change	Racism	Early Childhood	Child Welfare	Juvenile Justice	Mental Health	Vicarious Trauma	Wellness
1. A Learning Continuum for Race-Focused Work	1	x			x						
2. White People Think Niceness is the Answer to Racial Inequity. It's Not.	4	x			x						

Relevance of Handout to Audience and Topics

Early Childhood

	# Pages	General	Schools	Systems Change	Racism	Early Childhood	Child Welfare	Juvenile Justice	Mental Health	Vicarious Trauma	Wellness
1. Five Steps for Brain Building: Serve and Return	2	x	x			x					
2. In Brief: The Science of Neglect	2	x				x	x		x		

Child Welfare

	# Pages	General	Schools	Systems Change	Racism	Early Childhood	Child Welfare	Juvenile Justice	Mental Health	Vicarious Trauma	Wellness
1. Trauma-Informed Care for Children Exposed to Violence: Tips for Parents and Other Caregivers	3	x					x	x			
2. Easing Foster Care Placement: A Practice Brief	5						x	x			
3. Building a Trauma-Informed Child Welfare System	3			x			x				

Juvenile Justice and Family Court

	# Pages	General	Schools	Systems Change	Racism	Early Childhood	Child Welfare	Juvenile Justice	Mental Health	Vicarious Trauma	Wellness
1. ACEs in the Criminal Justice System	2			x			x	x			
2. Helping Traumatized Children: Tips for Judges	3							x			
3. Birth Parents with Trauma Histories and the Child Welfare System: A Guide for Judges	4						x	x			
4. NCTSN Bench Card for the Trauma-Informed Judge	4							x			
5. What Is a 'Trauma-Informed' Juvenile Justice System? A TARGETed Approach	4						x	x			

Mental Health

#	Handout	# Pages	General	Schools	Systems Change	Racism	Early Childhood	Child Welfare	Juvenile Justice	Mental Health	Vicarious Trauma	Wellness
1.	A Recovery Bill of Rights for Trauma Survivors	2	x	x						x		x
2.	National Child Traumatic Stress Network Position Statement: Prerequisite Clinical Competencies for Implementing Effective, Trauma-informed Intervention	1								x		
3.	Putting the Pieces Together: Janina Fisher's perspective on the history of trauma treatment	5								x		

Vicarious Trauma

#	Handout	# Pages	General	Schools	Systems Change	Racism	Early Childhood	Child Welfare	Juvenile Justice	Mental Health	Vicarious Trauma	Wellness
1.	Fact Sheet: Vicarious Trauma	2									x	
2.	Guidelines for a Vicarious Trauma-Informed Organization: Supervision	2			x						x	

Wellness

#	Handout	# Pages	General	Schools	Systems Change	Racism	Early Childhood	Child Welfare	Juvenile Justice	Mental Health	Vicarious Trauma	Wellness
1.	Activating Your Vagus Nerve: Some Simple Ways to Shift into States of Safety, Connectedness and Self-Regulation	1	x								x	x
2.	8 Dimensions of Resilience and Wellness	1	x									x
3.	How Your Breath Affects Your Nervous System	4	x									x
4.	Darwin the Buddhist	2	x									x

Core Handouts

ACES Questionnaire:

Listed below are the questions in the **Adverse Childhood Events** survey. This is a version provided to adults. For each positive answer, record a point. The number of points is your score. _Please remember:_ ACE scores don't tally the positive experiences in early life that can help build resilience and protect a child from the effects of trauma. This is an additional piece of information that may inform your own exploration and lead you to talk to your health care providers and others about what is challenging to you now and what supports you may need.

Prior to your 18th birthday…

1. Did a parent or other adult in the household often or very often… Swear at you, insult you, put you down, or humiliate you? or Act in a way that made you afraid that you might be physically hurt?

2. Did a parent or other adult in the household often or very often… Push, grab, slap, or throw something at you? or Ever hit you so hard that you had marks or were injured?

3. Did an adult or person at least 5 years older than you ever… Touch or fondle you or have you touch their body in a sexual way? or Attempt or actually have oral, anal, or vaginal intercourse with you?

4. Did you often or very often feel that … No one in your family loved you or thought you were important or special? or Your family didn't look out for each other, feel close to each other, or support each other?

5. Did you often or very often feel that … You didn't have enough to eat, had to wear dirty clothes, and had no one to protect you? or Your parents were too drunk or high to take care of you or take you to the doctor if you needed it?

6. Were your parents ever separated or divorced?

7. Was your mother or stepmother…Often or very often pushed, grabbed, slapped, or had something thrown at her? or Sometimes, often, or very often kicked, bitten, hit with a fist, or hit with something hard? or Ever repeatedly hit over at least a few minutes or threatened with a gun or knife?

8. Did you live with anyone who was a problem drinker or alcoholic, or who used street drugs?

9. Was a household member depressed or mentally ill, or did a household member attempt suicide?

10. Did a household member go to prison?

What's the Score in the Room? In some screenings and discussion, we offer the opportunity for participants to share their ACES score anonymously by following these steps:

1. Go to www.menti.com
2. Enter Code that you see on the top of the screen.
3. Enter your score.
4. Click submit.

For more information on the topic of Resilience and the Adverse Childhood Events, go to conversations.westchesterlibraries.org

The Resiliency Quiz

Instructions: *The Resiliency Quiz consists of 6 categories. Review items under each category to indicate the presence of a protective factor. Simply check ✓ YES, SOMETIMES, or NO for each item.*

1. Caring and Support	YES	SOME-TIMES	NO
I have several people in my life who give me unconditional love, listen without passing judgment, and who I know are "there for me."			
I feel valued and cared for on the job, at school, or in other groups.			
I treat myself with kindness and compassion and take care to nurture myself (eat right, exercise, sleep enough).			
2. Optimism and Hope for the Future	**YES**	**SOME-TIMES**	**NO**
I have several people in my life who let me know they believe in my ability to succeed.			
I get the message from others at work that "I can succeed."			
I believe in myself most of the time and usually give myself positive messages about my ability to accomplish my goals, even when I encounter difficulties.			
3. Opportunities for Meaningful Participation	**YES**	**SOME-TIMES**	**NO**
My voice (opinion) and choice (what I want) is heard and valued in my close personal relationships.			
My opinions and ideas are listened to and respected at work.			
I volunteer to help others or a cause in my community, faith organization, or at work.			
4. Positive Bonds	**YES**	**SOME-TIMES**	**NO**
I am involved in one or more positive after-work hobbies or activities.			
I participate in one or more groups (such as a club, faith community, or sports team) outside of work.			
I feel "close to" most people that I work with.			
5. Clear and Consistent Boundaries	**YES**	**SOME-TIMES**	**NO**
Most of my relationships with family members have clear, healthy boundaries (which include mutual respect, personal autonomy, and each person in the relationship both giving and receiving).			
I experience clear, consistent expectations at work.			
I set and maintain healthy boundaries for myself by standing up for myself, not letting others take advantage of me, and saying "no" when I need to.			
6. Life Skills	**YES**	**SOME-TIMES**	**NO**
I have (and use) good listening, honest communication, and healthy conflict resolution skills.			
I have the training and skills I need to do my job well, or all the skills I need to do well at work.			
I know how to set a goal and take the steps to achieve it.			
Total number of YES responses →			

Research suggests that the greater the number of protective factors and strengths (internal and external resources) the more resilient you are. ♦ You can build your own resilience by increasing available protective factors. Pick one item that you scored "sometimes." What can you do to increase the availability of this protective factor?

The Three Pillars of Resilience

WELLNESS HAPPENS WHEN WE FEEL SAFE, CONNECTED AND REGULATED

ADVERSITY HAPPENS WHEN THOSE PILLARS ARE SHAKEN

TRAUMA HAPPENS WHEN WE DON'T HAVE THE INNER RESOURCES OR EXTERNAL SUPPORTS TO RESTORE THE PILLARS

Safety

Connectedness

Self-Regulation

Resilience HAPPENS WHEN WE FIND NEW WAYS TO SHIFT INTO FEELING SAFE, CONNECTED AND REGULATED.

Some Take-Home Messages about Trauma and Resilience

Andrew Bell, Ph.D.

1. Resilience is the capacity to shift into a state of safety, connectedness and self-regulation, by engaging both internal skills and external supports.

2. If we as helpers can remain safe, connected and regulated, even when someone else is not, they will experience and learn resilience.

3. All it takes is one connected adult to counteract trauma and build resilience.

4. ACES are not diagnostic of trauma. The potential traumatic effects of ACES are counteracted by a safe, connected, and regulating environment.

5. Stress becomes toxic when it is not acknowledged or responded to.

6. Adversity becomes traumatic when experiences can't be shared or talked about.

7. Our own self-care and support are critical to our effectiveness as helpers and caregivers.

8. When we no longer feel safe, connected or regulated, we begin shift into primitive survival states of fight/flight or freeze/shut down.

9. Trauma happens when we get triggered into these states and can't get out; when we don't have the internal skills or external supports to restore safety, connectedness and self-regulation.

10. People in these states are often mistaken as oppositional or difficult.

11. It is possible to have both trauma and resilience at the same time. Many highly accomplished people develop amazing strengths but also have significant vulnerabilities. Relationships, organizations, systems, and communities can also have both trauma and resilience.

12. Racial and social inequities create toxic conditions that undermine resilience at all levels. Addressing these inequities builds resilience at all levels.

13. Creating external conditions of resilience in our relationships, service systems and communities is critical to systems change.

14. Bottom-up, mind-body interventions are critical for helping individuals develop implicit skills of resilience. These complement top-down therapeutic approaches and are especially important for people who experience trauma.

15. Preventing ACES in children means addressing the effects of ACES among caregiving adults. Helping parents address the impact of trauma and ACES in their own lives prevents trauma and ACES in children.

A Call to Action: Healing through Equity & Resilience

Wendy Ellis
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Apr 25 · 3 min read

Watch Building Community Resilience's Newest Video: Healing Through Equity & Resilience

For nearly 250 years policies, programs and practices of public systems have driven vicious cycles of disparity, racial trauma and inequity that were perfectly designed for the outcomes they produce. Shining a light on structural racism embedded in public policy and practice provides an opportunity for healing dialogue and a call to action to build equitable and resilient communities for all of our children.

In order to build resilient communities we must confront the inequities that drive adverse childhood experience and adverse community environments — or the "Pair of ACEs". In short, a resilient community is an equitable community. To learn more about the "Pair of ACEs" go to go.gwu.edu/bcrpairofacestree

In the Building Community Resilience movement, we focus on the drivers of inequity in the systems that most influence a community's access to the resources and supports necessary for early child development and wellbeing. These include housing, public education and criminal justice — in short the systems that influence the spaces and communities where children live, play, grow and learn.

Resilience does not simply reflect individual durability but rather indicates how well a community provides equitable access to supports that buffer individuals in times of adversity and to resources that support wellbeing and help children and families thrive. For children, the most important buffer is the support of a stable adult. In the absence of equitable access to affordable housing, jobs that provide living wages, quality education and social mobility, many families struggle to provide a safe, nurturing and healing environment for children to bounce back, let alone rise out of generational cycles of economic and social poverty. The evidence shows that just like health disparities, resilience is relational, place-based and dependent upon the demographic makeup of residents, historical patterns of place-based and race-based discrimination, jurisdictional policy and investment priorities.

Nearly 40 percent of American children live in households with incomes less than 200 percent of the federal poverty level, or approximately $49,000 in annual income for a family of four. Nationally, 14 percent or roughly 10-million American children live in areas of highly concentrated poverty. For African-American and Hispanic children that figure rises to 32-percent and 23-percent respectively in urban areas. **Many of the nation's poor live in communities of**

concentrated poverty not by choice, but rather by design — the cumulative result of social and criminal polices enacted over the course of our nation's history. For example, in the early 20th century federal policy and lending practices in the real estate industry supported housing segregation — creating patterns of racial and economic segregation that persist today. These policies combined with inequitable practices across criminal justice (enforcement, incarceration and the inequitable application of prosecutorial discretion) and public education (funding and district boundaries that reinforce segregation by race and income) also help to explain the place-based and race-based differences in who is arrested, how long they are incarcerated and the odds that they will complete high school, attain higher education, and achieve economic mobility.

While communities of color were the singular focus of inequitable policies and practices — what once aimed to limit the few is now destroying the many. As witnessed by the ongoing opioid crisis that has decimated both rural and urban communities, discriminatory and inequitable access to supports and buffers are now shared by many Americans, regardless of race or geography. Estimates suggest that up to 25 percent of children in the nation's rural communities live in extreme poverty, driven by inadequate funding for local education systems and the lack of upward mobility The majority of American children living in poverty are white (4.2 million).

With a continuing decline in life expectancy for all Americans, it is time for a dialogue and action to address inequity that drives what ails us as a nation. If we ground our work in undoing the systems and policies that promote racial inequity and trauma, we will build a more equitable nation for us all. We offer this video to help you begin the healing conversation in your community. Watch and then join us in building a Resilient and Equitable Nation!

The Pair of ACEs

Adverse Childhood Experiences

Maternal Depression

Physical & Emotional Neglect

Emotional & Sexual Abuse

Divorce

Substance Abuse

Mental Illness

Incarceration

Domestic Violence

Homelessness

Adverse Community Environments

Poverty

Violence

Discrimination

Poor Housing Quality & Affordability

Community Disruption

Lack of Opportunity, Economic Mobility & Social Capital

Ellis, W., Dietz, W. (2017) A New Framework for Addressing Adverse Childhood and Community Experiences: The Building Community Resilience (BCR) Model. Academic Pediatrics. 17 (2017) pp. S86-S93. DOI information: 10.1016/j.acap.2016.12.011

Shifting From Trauma Informed Care to Healing Centered Engagement

By Sam Piha

Photo Credit: Medium.com

Shawn Ginwright is a university professor, author, activist, and youth program leader. He is also a leading voice in the expanded learning field, deepening our understanding of new concepts and frameworks by bringing in the importance of context, culture, and race.

Dr. Ginwright recently authored an article entitled *Shifting From Trauma Informed Care to Healing Centered Engagement*. Below we offer a few excerpts from his article and urge everyone to read it in its entirety.

"Practitioners and policy stakeholders have recognized the impact of trauma on learning, and healthy development. Trauma informed care broadly refers to a set of principles that guide and direct how we view the impact of severe harm on young people's mental, physical and emotional health. Trauma informed care encourages support and treatment to the whole person, rather than focus on only treating individual symptoms or specific behaviors.

While trauma informed care offers an important lens to support young people who have been harmed and emotionally injured, it also has its limitations. For me, I realized the term slipped into the murky water of deficit based, rather than asset driven strategies to support young people who have been harmed. Without careful consideration of the terms we use, we can create blind spots in our efforts to support young people."

He goes on to explain how current formulations of trauma informed care presumes that the trauma is an individual experience, rather than a collective one:

"To illustrate this point, researchers have shown that children in high violence neighborhoods all display behavioral and psychological elements of trauma…

Second, trauma informed care requires that we treat trauma in people but provides very little insight into how we might address the root causes of trauma in neighborhoods, families, and schools. If trauma is collectively experienced, this means that we also have to consider the environmental context that caused the harm in the first place. By only treating the individual we only address half of the equation leaving the toxic systems, policies and practices neatly intact.

Third, the term trauma informed care runs the risk of focusing on the treatment of pathology (trauma), rather than fostering the possibility (well-being). What is needed is an approach that allows practitioners to approach trauma with a fresh lens which promotes a holistic view of healing from traumatic experiences and environments. One approach is called healing centered, as opposed to trauma informed. A healing centered approach is holistic involving culture, spirituality, civic action and collective healing. A healing centered approach views trauma not simply as an individual isolated experience, but rather highlights the ways in which trauma and healing are experienced collectively."

Dr. Ginwright goes on to offer some thoughts on practice and policy: *"Shifting from trauma informed care or treatment to healing centered engagement requires youth development stakeholders to expand from a treatment based model which views trauma and harm as an isolated experience, to an engagement model which supports collective well-being. Here are a few notes to consider in building healing centered engagement.*

- ***Start by building empathy.***
Healing centered engagement begins by building empathy with young people who experience trauma... However, building empathy is critical to healing centered engagement. To create this empathy, I encourage adult staff to share their story first, and take an emotional risk by being more vulnerable, honest and open to young people.

Fostering empathy allows for young people to feel safe sharing their experiences and emotions. The process ultimately restores their sense of well-being because they have the power name and respond to their emotional states.

- ***Encourage young people to dream and imagine!***
An important ingredient in healing centered engagement is the ability to acknowledge the harm and injury, but not be defined by it. Perhaps one of the greatest tools available to us is the ability to see beyond the condition, event or situation that caused the trauma in the first place.

Research shows that the ability to dream and imagine is an important factor to foster hopefulness, and optimism both of which contributes to overall well-being. Daily survival and ongoing crisis management in young people's lives make it difficult to see beyond the present. The greatest casualty of trauma is not only depression and emotional scares, but also the loss of the ability to dream and imagine another way of living.

By creating activities and opportunities for young people to play, reimagine, design and envision their lives this process strengthens their future goal orientation. These are practices of possibility that encourage young people to envision what they want to become, and who they want to be.

- ***Build critical reflection and take loving action.***
Healing and well-being are fundamentally political not clinical. This means that we have to consider the ways in which the policies and practice and political decisions harm young people. Healing in this context also means that young people develop an analysis of these practices and policies that facilitated the trauma in the first place. Without an analysis of these issues, young people often internalize, and blame themselves for lack of confidence. Critical reflection provides a lens by which to filter, examine, and consider analytical and spiritual responses to trauma.

The other key component, is taking loving action, by collectively responding to political decisions and practices that can exacerbate trauma. By taking action, (e.g. school walkouts, organizing peace march, or promoting access to healthy foods) it builds a sense of power and control over their lives. Research has demonstrated that building this sense of power and control among traumatized groups is perhaps one of the most significant features in restoring holistic well-being."

General

Trauma Informed Care for Children Exposed to Violence

Tips for Agencies and Staff Working with Youth

What happens to youth who have been exposed to violence?

Exposure to violence at home, in the form of child abuse and neglect, or in the community, whether at school or in the neighborhood, can affect young people in profound ways. Youth who have been exposed to violence may drop out of school, run away or become homeless, become involved in the juvenile justice system (regardless of whether it is the reason they come before the courts), abuse drugs or alcohol, or end up with labels like "conduct disordered." A significant portion of these youth may also go on to act violently against intimate partners or family members.

Because exposure to violence is often a hidden problem, adults may deem these youth undeserving of sympathy and view them as willfully bad kids who resist efforts to help them.

Read the rest of this tip sheet to find out how youth workers can identify youth exposed to violence and give them the sympathetic care they need.

What are some warning signs?

Some young people react immediately when exposed to violence. For other youth, signs of the exposure appear months, even years later.

In addition, young people's reactions differ in severity and include a range of behaviors. What warning signs appear will depend on the frequency and intensity of the traumatic events.

Youth

Youth may have one or more of the following symptoms:

- Physical complaints, such as headaches and stomachaches
- Constant worry about danger or the safety of loved ones
- Signs of depression, such as withdrawing from others or no longer enjoying favorite activities
- Difficulty paying attention in class, concentrating on work, or learning new information
- Outbursts of anger directed toward others or themselves
- Refusal to follow rules
- Use of violence to get what they want
- Rebellion at home and at school
- Bullying or aggression toward others
- Risky behavior such as driving fast or jumping from high places
- Revenge-seeking
- Abrupt changes in friends or dating relationships
- Stereotypical beliefs about males as aggressors and females as victims

What can youth workers do?

People who work with youth, such as social workers, teachers, coaches, therapists, and shelter staff, can play a critical role in reducing the impact exposure to violence has on youth.

First, youth workers can recognize that a lifetime of exposure to violence may be pervasive in young people's lives. To aid that recognition, youth-serving organizations can inform staff about the incidence and prevalence of exposure in the community they serve.

Second, staff must understand how exposure to violence may be affecting each individual young person. By identifying and addressing young people's exposure to violence and victimization, youth-serving organizations can attempt to break the cycle of violence.

Here are some steps organizations and their staff can take to support young people who have been exposed to violence:

Establish protocols to screen for exposure to violence symptoms and mental health needs on an ongoing basis.

Routine screening for possible exposure to violence and its impact on youth is recommended at every phase of youths' involvement with an agency.

Refer youth for comprehensive mental health assessment.

The assessment should evaluate direct victimization or exposure of violence, especially family violence in the home. The assessment will help identify trauma and stressors that might be contributing to a young person's problems. It will also help the agency decide how to intervene. The assessment should result in a plan to provide the services and supports that are needed to help the young person heal.

Plan individualized interventions that take traumatic experiences into consideration.

Youth respond to violence in different ways, depending on their gender, age, and past experiences. Each treatment plan should be individualized, age-appropriate, and tailored to the young person's family history. At the same time, every treatment plan should help the youth (and caregivers) re-establish a normal routine, safety, and predictability.

When planning for services, it is important to remember that young people's families may have been exposed to violence, too, and may have their own reactions to trauma. When that's the case, agencies should offer specific plans and supports that help parents address their own needs so they can become a powerful anchor for the youth treatment.

The Evidence-Based Practices for Children Exposed to Violence: A Selection from Federal Databases[1] describes several interventions that have shown success in helping children who have been exposed to violence. The publication also describes common characteristics of effective treatments.

Avoid staff burnout.

Youth workers may also have been exposed to violence, whether on the job or in their personal lives. To be able to effectively respond to their client needs, they should develop their own plans for resolving personal issues and addressing job stress.

Help youth feel safe and in control.

Adolescents may feel embarrassed to talk to adults about what they are going through. Youth workers can help them feel comfortable using some of the following strategies:

- Don't force them to talk if they don't want to.
- Find out what is making them feel unsafe and help them make a safety plan.
- Give straightforward explanations for things that are worrying them.
- Don't downplay their feelings by saying things like "Don't worry" or "Everything will be all right."
- Don't make commitments that you cannot honor.
- Look at their options and suggest concrete steps they can take.
- Help them think of positive ways to keep busy, such as playing sports, going out with friends, or making art or music.

When to seek professional help

If an adolescent is doing any of the following, youth workers should take serious notice and link the young person specialized mental health interventions:

- Being involved in violent dating relationships, either as abuser or victim
- Drinking and using drugs
- Skipping school a lot or dropping out
- Thinking about wanting to die or committing suicide
- Breaking the law or destroying things

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[1] https://ojjdp.ojp.gov/sites/g/files/xyckuh176/files/programs/safestart/ImprovingOutcomesforChildrenExposedtoViolence.pdf

Mandated Reporting

Many children experiencing crises or violence are also at risk for child abuse and neglect. All States have child welfare systems that receive and respond to reports of child abuse and neglect, offer services to families, provide foster homes for children who must be removed from their parents' care, and work to find permanent placements for children who cannot safely return home.

Domestic violence does not equal child abuse and neglect, and therefore not all cases of domestic violence must be reported to child protective services. When responding to families affected by domestic violence, it is very important to consider simultaneously the safety of the child and the safety of the adult victim.

State by State information on reporting requirements can be found at http://www.childwelfare.gov/systemwide/laws_policies/state

For more information and resources, please contact the Safe Start Center, a National Resource Center for Children's Exposure to Violence:

http://www.safestartcenter.org
1-800-865-0965
info@safestartcenter.org

Additional Resources

Baker, L.L. and Jaffee, P.G. (2003). *Youth Exposed to Domestic Violence: A Handbook for the Juvenile Justice System to Enhance Assessment and Intervention Strategies for Youth from Violent Homes.* Ontario, Canada: Centre for Children & Families in the Justice System.

National Traumatic Stress Network (2008). *Treatment for Youth with Traumatic Stress and Substance Abuse Problems —Fact Sheet.* Washington, DC: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services. http://www.nctsnet.org/sites/default/files/assets/pdfs/satoolkit_4.pdf

Whitman, J. (2007). *Reaching and Serving Teen Victims: A Practical Handbook.* Washington, D.C.: National Center for Victims of Crime and the National Crime Prevention Council. http://www.ncpc.org/resources/files/pdf/violent-crime/teen%20victims.pdf

How a Caregiver's Trauma Can Impact a Child's Development

EARLY DEVELOPMENT

Caregiver With Traumatic Experience

Mother releases cortisol

Baby absorbs cortisol through placenta

Can impact baby's:
- HPA axis
- Central nervous system
- Limbic system
- Autonomic nervous system

Caregiver struggles to regulate

Attachment relationship between caregiver and child may be strained

Can impact child's:
- Development of a core sense of self
- Ability to integrate experiences
- Epigenetic expressions

ADULTHOOD

A Person Who Has Had a Caregiver With *Untreated* Trauma May:

- Be more prone to PTSD after trauma
- Struggle to repair after conflict
- Struggle with relationships

- Unintentionally bring out negative behaviors in others
- Be emotionally detached
- Be more prone to dissociate

BREAKING THE CYCLE OF TRAUMA

This can become a cycle, impacting future generations.
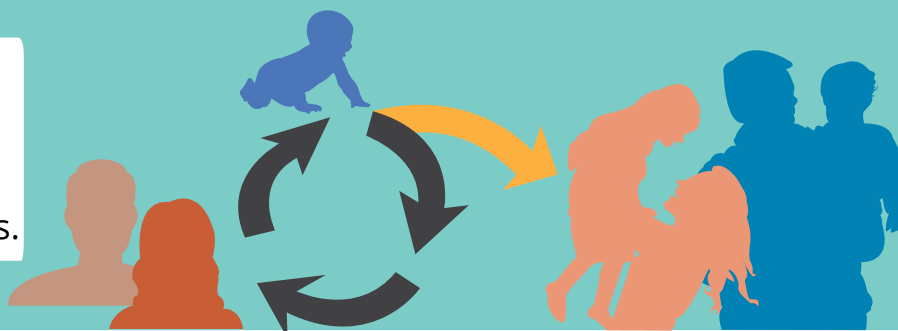
The good news is that healing trauma can break this loop. Seek help from a licensed health or mental health practitioner.

The Developmental Relationships Framework

Young people are more likely to grow up successfully when they experience developmental relationships with important people in their lives. Developmental relationships are close connections through which young people discover who they are, cultivate abilities to shape their own lives, and learn how to engage with and contribute to the world around them. Search Institute has identified five elements—expressed in 20 specific actions—that make relationships powerful in young people's lives.

Elements	Actions	Definitions
Express Care Show me that I matter to you.	• **Be dependable**............ • **Listen**.......................... • **Believe in me**............... • **Be warm**....................... • **Encourage**....................	Be someone I can trust. Really pay attention when we are together. Make me feel known and valued. Show you enjoy being with me. Praise me for my efforts and achievements.
Challenge Growth Push me to keep getting better.	• **Expect my best**............ • **Stretch**.......................... • **Hold me accountable**... • **Reflect on failures**........	Expect me to live up to my potential. Push me to go further. Insist I take responsibility for my actions. Help me learn from mistakes and setbacks.
Provide Support Help me complete tasks and achieve goals.	• **Navigate**....................... • **Empower**....................... • **Advocate**....................... • **Set boundaries**............	Guide me through hard situations and systems. Build my confidence to take charge of my life. Stand up for me when I need it. Put limits in place that keep me on track.
Share Power Treat me with respect and give me a say.	• **Respect me**.................. • **Include me**.................... • **Collaborate**.................. • **Let me lead**...................	Take me seriously and treat me fairly. Involve me in decisions that affect me. Work with me to solve problems and reach goals. Create opportunities for me to take action and lead.
Expand Possibilities Connect me with people and places that broaden my world.	• **Inspire**.......................... • **Broaden horizons**........ • **Connect**.......................	Inspire me to see possibilities for my future. Expose me to new ideas, experiences, and places. Introduce me to people who can help me grow.

NOTE: Relationships are, by definition, bidirectional, with each person giving and receiving. So each person in a strong relationship both engages in and experiences each of these actions. However, for the purpose of clarity, this framework is expressed from the perspective of one young person.

Your Heart Can Sync With a Loved One's:

Hearts harmonized when spectators watched friends or family fire walking.

By **Christine Dell'Amore**, National Geographic News

Watching a friend or relative in a stressful situation can loosely synchronize both of your heart rates, experiments at a fire walking ritual suggest.

In the experiment, when a spectator observed a relative or friend walk across hot coals, both the onlooker and performer's heart rates changed at the same time, though they didn't match each other beat for beat.

Past studies have observed that sports fans' hearts race when their teams score, but no one had yet delved into the physical effects on both spectators and participants, according to study co-author Ivana Konvalinka, a Ph.D. student at the Center of Functionally Integrative Neuroscience at Denmark's Aarhus University.

The finding suggests social bonds between people may manifest themselves even more powerfully than thought, Konvalinka noted.

The results show that "we can find markers of emotional connectedness in bodily measures as well —it's not just a cognitive effect," Konvalinka said.

Konvalinka suspects synchronization may occur between friends or relatives during other stressful or emotional events, such as weddings.

A Fire Walking First

For the experiment, Konvalinka and colleagues attended an annual fire walking ritual in the rural Spanish village of San Pedro Manrique (map).

The team put heart rate monitors on 12 fire walkers, 9 spectators who were relatives or friends of at least one fire walker, and 17 spectators with no connection to the fire walkers.

Advanced statistical analyses revealed that the heart rates of relatives and friends followed similar patterns as those of the performers. No such effect existed in onlookers who did not know the performers.

It's unknown how this mechanism actually occurs, noted Konvalinka, whose study appeared this week in the journal *Proceedings of the National Academy of Sciences*. For instance, part of the phenomenon may be because related people have similar heart rates. However, this is not enough to explain the entire effect, she said—for example, why similar effects were seen in friends.

Synced Heartbeats "New Avenue" for Bonding

The discovery that people's hearts can harmonize solely on visual or auditory information reinforces a law of nature, according to Michael Richardson, a psychologist at the University of Cincinnati in Ohio.

The natural law of coupled oscillators holds that when two or more rhythms meet, they will become coordinated—a phenomenon seen across the natural world, from fireflies matching their flashes to groups falling into step.

"We like to think, as we move through our world, we're this isolated being," Richardson said. This study, as well as a decade of laboratory work, has "demonstrated this is not the case."

Research has also shown this "social entrainment" helps keep our relationships healthy and may even reduce prejudice, he noted.

Ritual expert Richard Sosis added, "This study is opening up an entirely new avenue of research that will help us understand how people bond.

"Anthropologists have long appreciated that ritual binds people together, but it is unclear how this bonding is achieved," said Sosis, an anthropologist at the University of Connecticut.

"The primary assumption is that [group] activities such as communal dancing and singing and shared body movements would bind people together.

"But what they're finding is you don't need that."

We Need to Understand How to Provide Trauma-Informed Care

By **Beverly Tobiason** | July 18, 2016 <u>Youth Today</u>

The philosophy of trauma-informed care is becoming more and more embedded in the philosophies and practices of child-serving agencies.

When a child experiences a single traumatic event and is fortunate enough to be surrounded by supportive and nurturing adults, that trauma can generally be assessed and usually treated effectively with the help of parental support. When a traumatized child responds with internalized distress such as sadness, depression or anxiety, our systems appear to understand what that child needs to help in their healing and recovery.

However, when a child has experienced multiple and complex trauma, child-serving professionals, including those in behavioral health, child welfare, juvenile justice and educators, can struggle to see the connection between such histories and other common presentations.

It is not uncommon for children with histories of complex trauma to respond with externalizing behaviors and to be diagnosed with disruptive behavior disorders such as attention deficit hyperactivity disorder, oppositional defiant disorder or conduct disorder. Sometimes children also respond with agitated depression and anxiety. These are the children who may at times rage, fight, argue, refuse to comply, run away, lie and steal.

Why the disconnect between trauma experiences and disruptive behavior disorders? The Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-V) does not yet adequately capture the experiences of trauma in children. Instead, the available diagnoses capture only parts of a child's trauma experiences and presentation.

The problem that I see with this is that an individual diagnosis guides treatment intervention and interventions may or may not include the specific treatment of the trauma. When children are diagnosed with depression or anxiety, it is the

depression or anxiety that is targeted in the treatment, rather than the trauma, which is sometimes also the primary issue. When children are diagnosed with disruptive behavior disorders, targeted intervention tends to focus on these behaviors or the secondary symptoms of the trauma, rather than the trauma history itself.

When we think of trauma responses in the simplest form, we think of the "fight-flight-freeze" responses common in traumatized children. The "fight" response can present as verbal or physical aggression; the "flight" response can present as avoidance or refusal, and the "freeze" response can present as dissociation, daydreaming or numbing.

In turn, I see corresponding reactions from child-serving professionals who work with traumatized children. These are the children who can trigger countertransference reactions in the professionals meant to serve them.

The professionals can have a "fight" reaction, which can present as frustration, anger and punitive treatment recommendations; a "flight" response, which can present as child or case avoidance, feeling of hopelessness and referral elsewhere, or a "freeze" response, which can present as a feeling of helplessness or impotence in working with the child or not knowing what to do, so doing nothing.

I see these nontrauma-informed responses toward systems-involved children from both highly trained professionals and those with limited training in behavioral health, child welfare, juvenile justice, and education. Such triggers can elicit our own "fight-flight-freeze" responses to these children presenting with "fight-flight-freeze" reactions to ongoing trauma triggers.

When a trauma-informed approach is being fully used, the behaviors of these children should be seen as "normal" secondary reactions to the trauma they have and are still experiencing. An approach that is not fully trauma-informed will view these children's behaviors as volitional, purposeful, manipulative and in need of significant consequences.

That is not to say that children should not receive consequences for their behavior. However, such consequences should be focused on teaching

appropriate behavior rather than punishing the behavior, especially by escalated means when initial attempts are not successful.

Not uncommonly, staff serving a child agency are overwhelmed with the numbers of child with significantly complex needs, enormous corresponding paperwork requirements and strict deadlines. These working conditions can make otherwise caring, concerned and patient staff less so. Staff have varying degrees of education, experience and quality of ongoing training and supervision. Thus, it is not unusual when staff are triggered by children who challenge their authority or are not engaged.

Our responses of frustration, anger, avoidance and hopelessness only reinforce the same feelings in traumatized children. There is a saying in the school counseling field: "Those children needing the most love will ask for it in the most unloving ways."

It is easy to react in a trauma-informed manner when a child is responsive and appreciative of our efforts, and treats us with respect. It is harder to respond effectively when that child refuses to talk to us, comply with our requests, tells us off in colorful language or otherwise acts disrespectfully. But these are the children who need us the most.

Luckily, there is training and education available on the neurobiology of trauma. This is the important and emerging research that is connecting the effects of trauma to different domains of a child's functioning. The domains that can be affected include behavioral, cognitive, emotional and relational functioning.

Without understanding the common effects of trauma in a child's functioning, the obvious conclusion is that these children are behaving in volitional and manipulative means. If it is understood that these children have difficulty modulating their impulses and are responding in survival (fight-flight-freeze) mode, this allows for a more patient, respectful and positive intervention.

Understanding that these children's central nervous systems are activated and in need of calming allows us the patience to work with children in calm and respectful ways and reminds us that traumatized children do not "get it" the first, second or third time. Plus, traumatized children do not wake up one day to

Parents who had severe trauma, stresses in childhood more likely to have kids with behavioral health problems

July 9, 2018, University of California, Los Angeles

Credit: CC0 Public Domain

A new study finds that severe childhood trauma and stresses early in parents' lives are linked to higher rates of behavioral health problems in their own children.

The types of childhood hardships included divorce or separation of parents, death of or estrangement from a parent, emotional, physical or sexual abuse, witnessing violence in the home, exposure to substance abuse in the household or parental mental illness.

"Previous research has looked at childhood trauma as a risk factor for later physical and mental health problems in adulthood, but this is the first research to show that the long-term behavioral health harms of childhood adversity extend across generations from parent to child," said the study's lead author, Dr. Adam Schickedanz. He is a pediatrician and health services researcher and assistant professor in the department of pediatrics at the David Geffen School of Medicine at UCLA.

The study showed that the children of parents who themselves had four or more adverse childhood experiences were at double the risk of having attention deficit hyperactivity disorder and were four time more likely to have mental health problems.

A mother's childhood experiences had a stronger adverse effect on a child's behavioral health than the father's experiences, the study found.

Parents who lived through adverse childhood experiences were more likely to report higher levels of aggravation as parents and to experience mental health problems, the researchers found. However, these mental health and attitude factors only explained about a quarter of the association to their child's elevated behavioral health risks. The remainder of how the parent's adverse childhood experiences are transmitted to their child's behavior deserves further study.

The findings add to the evidence supporting standardized assessment of parents for adverse childhood experiences during their child's pediatric health visits.

"If we can identify these children who are at a higher risk, we can connect them to services that might reduce their risk or prevent behavioral health problems," Schickedanz said.

The researchers used information from a national survey containing information from four generations of American families, including information from parents about whether they were abused, neglected or exposed to other family stressors or maltreatment while growing up, and information on their children's behavior problems and medical diagnoses of attention deficit disorder.

With this data, they were able to find strong associations between the parents' adversity histories and their children's behavioral health problems, while controlling for factors such as family poverty and education level.

The next step for researchers is to look at how resilience factors, such as the support of mentors or teachers, could offset the harms of childhood traumas, Schickedanz said.

The study was published in the journal *Pediatrics*.

Education

In Consultation: Seeing Children through a Polyvagal Lens

As published in Psychotherapy Networker Magazine

Mona Delahooke, Ph.D. (/Speaker/Details/00735571?title=mona-delahooke-ph-d)

Q: I'm seeing a young child who misbehaves at school and isn't responding well to the reward system his teacher uses. Is there another approach I can recommend?

A: Offering external incentives like stickers, toys, or even social approval won't help many children change their behaviors because, contrary to popular beliefs, human behaviors aren't solely predicated on a drive to maximize gains and avoid losses. Rather, on a basic biological level, they reflect subconscious perceptions of safety and threat that are constantly in play through the actions of our autonomic nervous system (ANS).

With his Polyvagal Theory, neuroscientist Stephen Porges offers a road map for understanding the ANS based on the fact that humans come hardwired to avoid threat and seek physiological safety by connecting with others. From the moment we're born, our nervous systems are constantly searching for signs that it's safe to connect. When we can't connect to reduce our neuroception of threat, we experience stress responses, often in the form of behavioral challenges.

Unfortunately, many well-meaning educators are unaware of the powerful force that the ANS exerts on childhood behaviors, and so they continue to rely on the binary notion that children's behaviors are either compliant or noncompliant. This popular paradigm views all behaviors as incentivized and motivated, rather than instinctual and safety-seeking.

Beyond the Dots

When Colwyn êrst came to my oìce, he was êve years old and suéering from stomachaches that his pediatrician suspected stemmed from anxiety. A few months earlier, he'd started kindergarten. Though he'd been excited to attend "real" school like his two older sisters, he'd had a rough start. Accustomed to the more freewheeling environment of his preschool, he had difficulty adjusting to the demands of his new classroom, where he was expected to sit still and focus for long stretches. Instead, Colwyn would routinely get up to wander around the classroom, pulling out toys or otherwise disrupting the class.

His teacher, organized and energetic, immediately initiated a behavior-management approach using a system of green, yellow, and red dots that she affixed next to each child's name on a large board that hung on the classroom wall. Each week, the children who managed to accrue mostly green dots next to their name were rewarded with special prizes, such as frosted cupcakes with rainbow sprinkles or jars of colorful playdough she made from scratch in her kitchen.

Colwyn wanted the special prizes as much as his classmates did, but no matter how hard he tried, he regularly began the day with behavior that generated yellow dots. By the day's end, rather than work his way up to green ones, he'd displayed other disruptive behaviors, which earned him the dreaded red dots. Far from teaching or motivating him, the teacher's method caused Colwyn additional stress. Within weeks, he'd started crying and screaming before leaving the house in the morning, and eventually he refused to go to school at all.

Needless to say, Colwyn's teacher wasn't intentionally trying to cause him stress; she had the best intentions to motivate him toward good behavior. Various methods of rating and consequencing behaviors are standard fare in today's education system. But even though they're designed to act as visual reminders that incentivize children to develop selfcontrol and make good choices, I've found they often do the opposite for kids like Colwyn.

Why?

Many traditional approaches assume that all children's behaviors are deliberate, leading adults to react to problematic behaviors—whether in the form of language, physical actions, or emotional outbursts—by issuing consequences for this "choice" to misbehave. What we fail to recognize is that emotional and behavioral control is a developmental process, and many vulnerable children and teens require years to develop that ability. Contrary to current practices, the way to build it is by creating zones of relational safety around the child, not by offering rewards, consequences, and punishments.

Introducing a Reframe

Early on in my work with behaviorally challenged children, I often found that the techniques I was taught in graduate school were ineéective. To ênd out why, I went beyond the êeld of mental health to study brain development in young children. Then, inëuenced by the work of psychiatrist Stanley Greenspan and child psychologist Serena Wieder, who created DIR Floortime Model, I came to appreciate the importance of understanding that all behaviors have meaning. Rather than focusing on eliminating them, we need to understand the adaptive purposes they serve for each child. During this reeducation, Porges's Polyvagal Theory provided the neuroscientific rationale for embracing relational safety as central to human emotional regulation and behavioral control.

I began my work with Colwyn's teacher and parents by explaining the difference between bottom-up and top-down behaviors. Bottom-up behaviors are driven by an instinct for safety and survival. It's not until early toddlerhood that children even begin to develop top-down, deliberate control over their emotions and behaviors. Top-down control doesn't just happen at a certain age; it's a developmental process that's different for each child. Colwyn wasn't close to having control over his emotions and behaviors, and that's why the dot chart didn't work for him—no matter how much he wanted the teacher's cupcakes and homemade playdough.

It was my job to help the adults in Colwyn's life embrace a more developmental understanding of his social-emotional development and its impact on his lack of behavioral control. I explained that instead of seeing a little boy exhibiting "bad behaviors," I saw a child exhibiting "stress behaviors," adaptations of his ANS working valiantly to help him feel safe. Colwyn's disruptive behaviors were his body's way of managing his neuroception of threat and trying to feel safe. The sticker chart was ineffective because every time he got another red dot, his stress increased, causing the emotional outbursts. In other words, these were bottom-up behaviors, not the result of his poor choices.

While other kids in his class had more advanced self-regulation skills, Colwyn's neurobiological capacity for self-control wasn't there yet. Rather than punishments or rewards, he needed emotional support via cues of safety, communicated by caring adults. If his nervous system felt safe, his anxiety would decrease, and his external behaviors would reflect this emerging sense of inner calm.

I explained to his teacher that my evaluation of Colwyn revealed that he was particularly sensitive to adults' tone of voice and facial expressions. Most children, in fact, respond favorably to the cues of safety that adults project when they feel calm and in control. This led to a discussion about our "selves" as the most important tool in addressing children's behavior.

When an adult feels anxious or stressed, children pick up on it. To demonstrate, I showed her a video from a recent session, in which his mother and I were playing with Colwyn using a melodic voice and playful gestures, which helped him feel calm, and the teacher was surprised at how interactive and lighthearted he was. She'd never seen that side of him in the classroom. I let her in on a secret: playing with children, even if it's simply interacting in a playful way they enjoy, is a sure way to help them feel safe.

A New Approach

Once his teacher understood that Colwyn wasn't making poor choices but adapting to feeling physiologically overwhelmed in the classroom, we devised a new plan. Colwyn wasn't the only child whose developmental level made the color-coded chart an ineffective system, so she stopped using it. Instead, as soon as she noticed Colwyn start to bite at his fingers, anxiously scan the room, or rock in his chair—clear signs that he was moving out of a calm state and needed relational support—she'd cheerfully invite him to sit by her or bounce on an exercise ball his parents bought for the classroom. The teacher understood that what Colwyn really needed was a shift in how she interacted with him. And since she had a room full of other students to interact with as well, she requested a warm and engaging classroom aide who could provide the same cues of safety to each student in the classroom, so everyone benefited.

Over time, we transformed what had begun as a stressful kindergarten foray for Colwyn into a successful year. Without abdicating control, his teachers and parents shifted from managing his behaviors to truly understanding and working with them from a neurodevelopmental perspective. We can learn to appreciate that what some may see as "problematic" behaviors can actually teach us a lot about what children need from relationships and from the environment. When we shift our lens from viewing behaviors as either compliant or noncompliant to seeing them as adaptations, a whole new paradigm for supporting children's behavioral challenges opens up.

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Mona Delahooke, PhD, is the author of Beyond Behaviors: Using Brain Science and Compassion to Understand and Solve Children's Behavioral Challenges (https://www.pesi.com/store/detail/26266/beyond-behaviors)

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Get this NEW approach to solving behavioral challenges...

California's first surgeon general: Screen every student for childhood trauma

Dr. Nadine Burke Harris, founder and CEO of the Center for Youth Wellness, attends a briefing in Dirksen Building on "substance use and childhood trauma," on June 5, 2018.Tom Williams / AP

Oct. 11, 2019, 10:18 AM EDT / Updated Oct. 11, 2019, 10:22 AM EDT

By Patrice Gaines

Dr. Nadine Burke Harris has an ambitious dream: screen every student for childhood trauma before entering school.

"A school nurse would also get a note from a physician that says: 'Here is the care plan for this child's toxic stress. And this is how it shows up,'" said Burke Harris, who was appointed California's first surgeon general in January.

"It could be it shows up in tummy aches. Or it's impulse control and behavior, and we offer a care plan. Instead of reacting harshly and punitively, every educator is trained in recognizing these things. Instead of suspending and expelling or saying, 'What's wrong with you?' we say, 'What happened to you?'"

Burke Harris has dedicated her career to changing the way society responds to childhood trauma, which research has shown affects brain development and creates lifelong health problems.

"This involves public education, routine screening to enable early detection and early intervention, and cross-sector coordinated care," she said at a hearing on providing care in schools held by the House Committee on Education and Labor in September. "The opportunity ahead of us is about a true intersection of health care and education."

A study on youth trauma, known as Adverse Childhood Experiences, or ACES, was a landmark when it was published in 1998 by the Centers for Disease Control and Prevention and Kaiser Permanente. The study specified 10 categories of stressful or traumatic childhood events, including abuse, parental incarceration, and divorce or parental separation; its research showed that sustained stress caused biochemical changes in the brain and body and drastically increased the risk of developing mental illness and health problems.

Burke Harris first noticed this connection while treating children at a clinic in San Francisco.

"One thing that tipped me off was the number of kids being sent to me by schools -- principals, teachers and administrators -- with ADHD," she said, referring to attention deficit hyperactivity disorder). "What I found was that many of the kids were experiencing signs of adversity, and there seemed to be a strong association between adversity and the trauma they experienced and school functioning."

This finding spurred her to review the health records of over 700 of her patients. Her research team found that patients who had experienced severe trauma were 32 times more likely to be diagnosed with learning and behavioral problems than kids who had not.

Trauma in general leads to a surge in stress hormones. When this trauma goes unchecked and is sustained, it can disrupt a child's brain development, interfering with functions children depend on in school such as memory recall, focus and impulse control.

"When we talk about the effect of ACEs on learning, part of the impact is on the child's ability to sit still in class and ... be able to receive and process information," Burke Harris said.

She found that too often the children she saw at her clinic had been prescribed drugs that actually stimulated parts of the brain that did not need it -- and children did not improve as a result. If the children had been diagnosed with ACEs, Burke Harris said she believes treatment may have been as easy as teaching them how to calm themselves down.

She recalled seeing a boy, 14, who had recurrent abdominal pain. Instead of testing for ulcers, she tested for ACEs and found he scored six out of 10. His parents were going through a divorce and his father refused to see him. Burke Harris said the teen had a number of support systems in place, and she added another.

"I said, 'We are going to have you join a sports team,'" she said. "A month later his abdominal pain was gone and we didn't have to have expensive tests."

"When we are talking about addressing the root cause, science shows that safe, stable environments are healing for kids," said Burke Harris, who is also the author of "The Deepest Well: Healing the Long-Term Effects of Childhood Adversity."

"What research tells us is that sleep, exercise, nutrition, mindfulness and a nurturing environment can reduce stress hormones and enhance the ability of the brain to recover from stress," Burke Harris said. "As we're thinking about how to help students be successful, we must recognize that PE and team sports are part of a comprehensive response to address ACEs. What we put in our kids' lunches or provide in a school environment makes a difference in a child's ability to regulate stress response."

Toxic stress suffered by children because of ACEs can also result in health issues that cause absentism.

"The higher the ACEs score, the more likely a child is to miss a day in school," Burke Harris noted. "Asthma is the No 1 reason for chronic absenteeism, and kids with four or more ACEs experience a higher percentage of asthma."

In her congressional testimony, Burke Harris cited a pilot program in San Francisco in which students learn a form of deep meditation to reduce their stress.

"Not only did they see a reduction in school suspension rates and episodes of violence, but they also saw an increase in GPA and standardized tests," Burke Harris told NBCBLK.

As California's first surgeon general, Burke Harris sees herself as a leader in a national movement toward the creation of "trauma sensitive and trauma-informed" education programs that she hopes will lead to changes in school policies. She said she plans to travel the U.S. to call for a public initiative to address ACEs, which she refers to as "one of the most serious, expensive and widespread public health crises of our time."

"Ultimately, as a doctor I don't spend all day with a child," she said. "Part of treatment is recognizing that everyone in the educational environment has an opportunity to administer buffering care for kids. That's the power of a public initiative. Everyone from the superintendent to the teacher to the bus driver and the person cleaning recognizes and understands this information."

"When you have a whole community making real change," Burke Harris said, "you can have a big and lasting change."

This story appears as part of coverage for "NBC News Learn Presents: Education Now Detroit," a two-hour live community event supported by the Chan Zuckerberg Initiative. For more information, go to nbcnews.com/learndetroit.

Measuring Your Family-School-Community Partnerships
A Tool for Schools

Family-Community Partnership with the Schools

Parenting and Family Skills	Framework for Participation	Volunteering
Communicating		Decision Making
Learning at Home		Community Collaboration

Student-Centered Environment
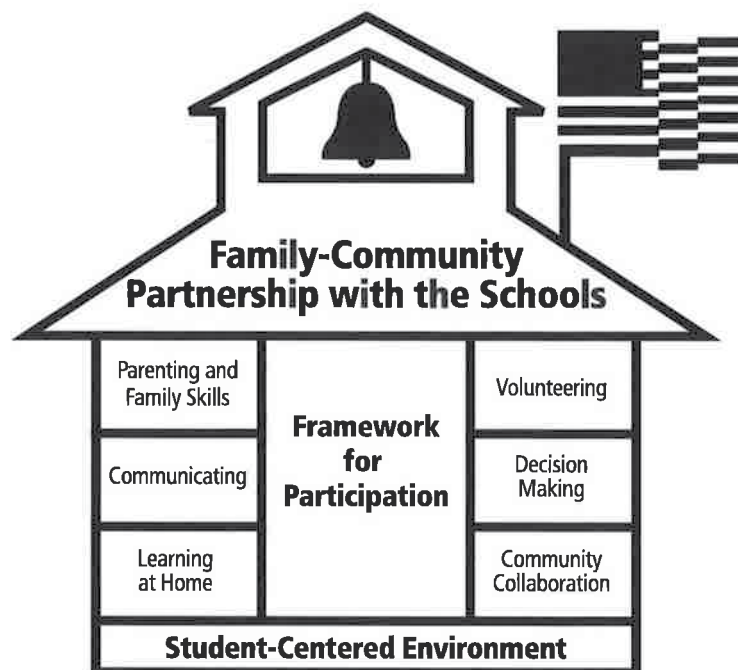
How does your school reach out to and involve families and the community in children's learning? This tool is based on the Six Types of Partnerships. It can help your school

- Assess the strength of the partnerships it conducts,
- Indicate the focus or direction of your partnerships, and
- Identify areas that can be changed.

   Your school may do all, some, or none of the activities or approaches listed. Not every activity is appropriate for every grade level. The items listed were selected because they show that schools in which they happen are meeting the challenge to involve families in many different ways. These activities can improve school climate, strengthen families, and increase student learning.

   Your school may also be conducting other activities. Be sure to add them under each type of involvement and include them in your school's assessment of its key partnership practices.

DIRECTIONS: Review the rating scale that follows. For each item, write the rating number that comes closest to describing your school. Practices that are strong and prominent will receive a score of 4. Practices rated 1, 2, or 3 are not yet part of the school's program or need improvement.

   After rating your school partnership practices, use the three Discussion Questions on the back page to assess the strengths, goals, and direction of your school partnerships for the next one to three years. Ask the members of your school Partnership Action Team or another parent-teacher decision-making group to participate in this process.

Rating Scale
1. **Never**. This strategy does not happen at our school.
2. **Rarely**. Happens in only one or two classrooms or classes. Receives isolated use or little time. Clearly not emphasized in the school's parent involvement plan.
3. **Sometimes**. Happens in some classes. Receives minimal or modest time or emphasis across grades. Included in, but not a notable part, of the school's parent involvement plan.
4. **Frequently**. Happens in most or all classes or grade levels. Receives substantial time and emphasis. An important part of the school's parent involvement plan.

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1. Parenting and Family Skills

Schools can help families build on their strengths and parenting skills. Schools can identify resources and support to help families nurture children. *Please rate using the scale on the right.*

Rating Scale

1. **Never**
2. **Rarely**
3. **Sometimes**
4. **Frequently**

Our School

___ Offers workshops and information for parents on child and adolescent development.

___ Reaches all families who want or need parenting information or assistance, not just the few who can attend meetings at school.

___ Makes sure that information for families is clear, usable, offered in a variety of ways and languages, and linked to children's learning.

___ Surveys families about the topics and issues they want information on.

___ Asks families about their children's strengths, goals, and learning styles.

___ Gives parents ideas and information on creating a "learning-friendly" environment at home.

___ Offers opportunities for parents to meet, network, and share parenting ideas.

Other Parenting and Family Skills efforts:

2. Communicating

Schools can plan and conduct workable methods of two-way communication—from school to home and from home to school. Communications, whether to groups or individual families, should focus on the child's learning. *Please rate using the above scale.*

Our School

___ Schedules parent-teacher-student conferences to monitor student progress at times convenient for parents.

___ Informs parents how and when they can reach teachers during and beyond the school day to talk about their child's learning.

___ Provides ways for parents to comment on school programs and activities, such as surveys, e-mail, comment forms, and others.

___ Develops ways to communicate with parents who do not speak or read English well, including providing translators and videotaped messages.

___ Provides parents with clear, regular information about children's progress, including information on testing, report cards, and the curriculum.

___ Convenes teachers and support staff to meet with and listen to parents of children with academic or behavior concerns.

___ Trains school staff on the value of and need for building effective ties with parents and the community.

___ Conducts these activities that research has shown improve children's learning:

    (a) Sponsors orientations for families new to the school

    (b) Produces a regular school or district newsletter

    (c) Sends home weekly folders of students' work

    (d) Staff makes home visits

___ Builds policies that encourage teachers to communicate frequently with parents about the curriculum, homework expectations, and how parents can help.

Other Communicating Activities

3. Learning at Home

Provide ways for families and school staff to, together, develop learning goals and continue children's learning at home and in the community to meet the goals. *Please rate using the above scale.*

Our School

___ Gives families information about how to keep track of, discuss, and support schoolwork at home.

___ Gives families information about skills required for their children in each subject.

___ Gives families information about how to help their children in areas that need improvement.

___ Helps families and students set academic goals and select courses and programs.

___ Makes families aware of the importance of reading daily to or with children.

___ Makes families aware of resources and programs in the community that promote learning.

Other Learning at Home Activities

4. Volunteering

Recruit and organize volunteer help from families and the community. *Please rate using the scale on the right.*

Our School

____ Offers flexible volunteer opportunities and schedules that allow all parents to participate.

____ Has a family center or other space where families and community members can volunteer, meet, and access resources that enhance their child's learning and development.

____ Schedules school events at different times of the day and evening so all parents can attend.

____ Surveys families annually to match parent interests, talents, and availability with school and classroom needs.

____ Provides childcare, transportation, translators, and food to eliminate barriers preventing some families from participating in school events.

____ Trains volunteers so their time is used effectively.

____ Recognizes volunteers for their time and effort.

____ Encourages families, students, and the community to be involved with the school in a variety of ways (tutoring, assisting with activities, giving talks, etc.)

Other Volunteering Activities

5. Decision making

Include parents in school decisions to develop leaders and represent all families in the school. *Please rate using the above scale.*

Our School

____ Has an active PTA, PTO, or other parent group.

____ Includes parent representatives on the school's advisory council, improvement team, site-based management team, or other committees.

____ Involves parents in organized, ongoing, and timely ways to plan, review, and improve school programs.

____ Involves parents in revising school and district curricula.

____ Has parent leaders who represent the ethnic and socioeconomic diversity of all students in the school.

____ Asks parents to help plan and develop out-of-school programs.

____ Includes students (with parents) in decision-making groups.

Other Decision-making Activities

6. Collaborating with the Community

Identify and connect community resources to strengthen families, school programs, and student learning. *Please rate using the above scale.*

Our School

____ Makes staff available to help families locate and use community resources.

____ Works with local businesses, parks, museums, libraries, and civic groups to enrich student and adult learning and skills.

____ Provides parents and students with a resource directory listing community services, programs, and agencies.

____ Makes the school building available for community use outside of regular school hours.

____ Offers after-school programs for students, supported by local businesses, agencies and volunteers.

____ Informs and involves community members in school building and district decision-making.

____ Tackles funding, staffing, and location issues that may arise so collaborative activities may occur.

Other Community Collaboration Activities

Schools' Program Provides Mental Health Care

Students from south side UCC schools get mental health help both at school and home.

By Analise Pruni, Milwaukee Neighborhood News Service - Jan 16th, 2019 01:53 pm

Children at Bruce Guadalupe Community School enjoy recess. Photo by Analise Pruni/NNS.

A new pilot program at Bruce Guadalupe Community School and Acosta Middle School is addressing children's mental health needs both at school and in the home.

Lutheran Social Services of Wisconsin and Upper Michigan (LSS) hired a therapist and a family coach in September to work with families of students who are receiving mental health services at the schools.

Bruce Guadalupe, 1028 S. 9th St., serves students in K4 through eighth grade while Acosta, 1038 S. 6th St., serves sixth- through eighth-grade students. Both charter schools are operated by United Community Center (UCC).

According to **Amanda Kryzkowski**, director of performance and quality improvement at LSS, children are referred to the program by the school counselor. The LSS therapist works with children during the school day, and the family coach makes weekly in-home visits. Fourteen children and their families are participating, and LSS hopes to expand that to 50 by the end of the school year.

For children who may be dealing with anxiety, depression, PTSD or other mental health problems, the therapist provides behavioral interventions for the classroom, and the family coach promotes parent skill development.

The purpose of integrating mental health services into students' home life is to reduce the need for foster care, lower truancy rates and school violence, and improve academic achievement, according to LSS.

LSS is using Bruce Guadalupe and Acosta as hubs to provide on-site therapy to children, according to **Héctor Colón**, president and CEO of LSS. "But then we want to wraparound to the parents; it might be mom, dad, grandmother… [a] cousin or friend that happens to be within that household."

LSS Family Coach Delia Corchado works with 14 children from two UCC schools and their families. Photo by Analise Pruni/NNS.

Delia Corchado, the family coach at LSS, said that most families want to receive services and support for themselves and their children. However, if they cannot afford basic needs such as food and transportation, it is more difficult to convince them to take advantage of the services.

"If they don't have food on the table then they don't have time for me," Corchado said.

She added that families have access to any services that they need, such as counseling, food pantries, clothing banks or help with transportation. These are all contributing factors to a child's overall mental health.

At the same time, "The backbone of successful treatment is relationship and connection," said Dr. **Steven Dykstra**, a clinical psychologist at the Milwaukee County Behavioral Health Division.

The pilot program originated from a discussion between Colón and UCC Executive Director Ricardo Díaz about the need for a more proactive mental health program at the schools. Colón recognized that because UCC has close connections to parents, it would make a perfect partner with LSS to broaden access to children's mental health services.

"Through our pilot with United Community Center, we hope to close the gap and give children the resources they need to grow into successful and thriving young adults by building healthy communities, beginning with a strong foundation of mental wellness," Colón said.

LSS hopes to receive state funding to institute five other school-centered pilot programs. It has established a committee consisting of state and county representatives, mental health

advocacy groups and community organizations to address local and state policy changes needed to sustain the programs.

"What we'd like to do is … achieve policy change for a more comprehensive model of school-based mental health," Colón said. That could include higher Medicaid reimbursements for clinical consultations and in-home family coaching.

According to Dr. **Judith McMullen**, a law professor at Marquette University who is on the LSS committee, by reaching beyond the boundaries of school walls, mental health professionals have a better chance of meeting children's needs. "Kids don't have issues in a vacuum. … Some issues stem from things going on at home."

As a member of the committee, McMullen is working to document the effectiveness of the LSS model. She said that part of the challenge is documenting what people believe anecdotally —that school-centered services are effective.

Pascual Rodriguez, principal of Bruce Guadalupe, said he is a firm believer in educating children physically, spiritually and emotionally. "I would consider my guidance counseling team the best in Milwaukee, but there are limitations on what we can and cannot offer some of these kids," he said. The LSS program helps fill that gap.

Dykstra added that with school-centered mental health programs, "We're not turning to schools and saying, 'do something about the mental health of children;' we're saying, 'let us work with you, let us partner with you, let us bring more resources to the school environment.'"

McMullen said that the Columbine shooting in 1999, in which 13 students were shot to death by two classmates, was a catalyst for viewing school as an appropriate place to address youth mental health. This shift in thinking has helped reduce stigma, she added.

According to Dykstra, famous athletes and celebrities who publicly discuss mental health also help lessen the stigma surrounding mental illness. Familiarizing children with these topics often, and from an early age, is beneficial.

"When they're 16-17 and they're facing depression or anxiety, the fact that this was destigmatized for them in childhood makes it easier for them to go [receive treatment] 10 or 20 years from now," Dykstra said.

This story was originally published by Milwaukee Neighborhood News Service, where you can find other stories reporting on eighteen city neighborhoods in Milwaukee.

Trauma-Sensitive School Checklist

Lesley University
Center for Special Education

Trauma and Learning Policy Initiative
of Massachusetts Advocates for Children
and the Legal Services Center of Harvard Law School

School _____   Date _____

Team Members (name and position)

_____

_____

_____

_____

_____

_____

This checklist is organized by five components involved in creating a trauma-sensitive school. Each component consists of several elements. Please assess your school on each element according to the following scale:

1 Element is **not at all** in place

2 Element is **partially** in place

3 Element is **mostly** in place

4 Element is **fully** in place

A trauma-sensitive school is a safe and respectful environment that enables students to build caring relationships with adults and peers, self-regulate their emotions and behaviors, and succeed academically, while supporting their physical health and well-being.

School-wide Policies and Practices

1	2	3	4	
☐	☐	☐	☐	• School contains predictable and safe environments (including classrooms, hallways, playgrounds, and school bus) that are attentive to transitions and sensory needs.
☐	☐	☐	☐	• Leadership (including principal and/or superintendent) develops and implements a trauma-sensitive action plan, identifies barriers to progress, and evaluates success.
☐	☐	☐	☐	• General and special educators consider the role that trauma may be playing in learning difficulties at school.
☐	☐	☐	☐	• Discipline policies balance accountability with an understanding of trauma.
☐	☐	☐	☐	• Support for staff is available on a regular basis, including supervision and/or consultation with a trauma expert, classroom observations, and opportunities for team work.
☐	☐	☐	☐	• Opportunities exist for confidential discussion about students.
☐	☐	☐	☐	• School participates in safety planning, including enforcement of court orders, transferring records safely, restricting access to student-record information, and sensitive handling of reports of suspected incidents of abuse or neglect.
☐	☐	☐	☐	• On-going professional development opportunities occur as determined by staff needs assessments.

Classroom Strategies and Techniques

1☐ 2☐ 3☐ 4☐   • Expectations are communicated in clear, concise, and positive ways, and goals for achievement of students affected by traumatic experiences are consistent with the rest of the class.

1☐ 2☐ 3☐ 4☐   • Students' strengths and interests are encouraged and incorporated.

1☐ 2☐ 3☐ 4☐   • Activities are structured in predictable and emotionally safe ways.

1☐ 2☐ 3☐ 4☐   • Opportunities exist for students to learn and practice regulation of emotions and modulation of behaviors.

1☐ 2☐ 3☐ 4☐   • Classrooms employ positive supports for behavior.

1☐ 2☐ 3☐ 4☐   • Information is presented and learning is assessed using multiple modes.

1☐ 2☐ 3☐ 4☐   • Opportunities exist for learning how to interact effectively with others.

1☐ 2☐ 3☐ 4☐   • Opportunities exist for learning how to plan and follow through on assignments.

Collaborations and Linkages with Mental Health

1☐ 2☐ 3☐ 4☐   • Policies describe how, when, and where to refer families for mental health supports; and staff actively facilitate and follow through in supporting families' access to trauma-competent mental health services.

1☐ 2☐ 3☐ 4☐   • Access exists to trauma-competent services for prevention, early intervention, treatment, and crisis intervention.

1☐ 2☐ 3☐ 4☐   • Protocols exist for helping students transition back to school from other placements.

1☐ 2☐ 3☐ 4☐   • Mental health services are linguistically appropriate and culturally competent.

1☐ 2☐ 3☐ 4☐   • Staff has regular opportunities for assistance from mental health providers in responding appropriately and confidentially to families.

Family Partnerships

1☐ 2☐ 3☐ 4☐   • Staff uses a repertoire of skills to actively engage and build positive relationships with families.

1☐ 2☐ 3☐ 4☐   • Strategies to involve parents are tailored to meet individual family needs, and include flexibility in selecting times and places for meetings, availability of interpreters, and translated materials.

1☐ 2☐ 3☐ 4☐   • All communications with and regarding families respect the bounds of confidentiality.

Community Linkages

1☐ 2☐ 3☐ 4☐   • School develops and maintains ongoing partnerships with state human service agencies and with community-based agencies to facilitate access to resources.

1☐ 2☐ 3☐ 4☐   • When possible, school and community agencies leverage funding to increase the array of supports available.

Systems Issues

SOCIAL DETERMINANTS OF HEALTH

SOCIAL, ECONOMIC & POLITICAL FACTORS

- Inequality
- Multiple Life Events
- Poverty
- Stigma
- Segregation
- Discrimination
- Communication
- Political Participation
- Social Cohesion
- Racism

LIVING & WORKING CONDITIONS

- Job Availability
- Wages & Benefits
- Violence & Crime
- Working Environment
- Air, Water & Soil Quality
- Disease Vectors
- Access To Food
- Housing

PUBLIC SERVICES & INFRASTRUCTURE

- Economic Development
- Transportation
- Health Care
- Community Center
- Education
- Parks

SOCIAL NETWORKS

- Relationships
- Family Dynamics
- Media
- Social Hierarchy
- Exclusion
- Stress

INDIVIDUAL BEHAVIORS

- Addiction
- Coping
- Diet
- Exercise
- Self Efficacy

INDIVIDUAL FACTORS

- Race, Age, Gender, Culture

"Factors that contribute to a person's current state of health.
These factors may be biological, socioeconomic, psychosocial, behavioral, or social in nature."

CCSI
Coordinated Care Services Inc.
Innovative Solutions in Human Service Delivery

Example Trauma-Informed Objectives (Organizational Level)

Leading and Communicating:

- Organization has a mission/vision statement that reflects a commitment to a trauma-informed approach
- Organization has a designated trauma-informed workgroup/committee that meets regularly to lead the trauma-informed change process
- Organization has completed a trauma-informed organizational assessment as a baseline evaluation to inform action steps
- Organization has a feedback system in place to engage all individuals in the trauma-informed change process (getting feedback to inform action steps)
- Organization's leaders/trauma-informed committee implement trauma-informed messaging strategies, to keep the conversation on-going in the day-to-day (e.g., newsletter, agenda item at meetings, bulletins, e-mail blasts, etc.)

Hiring and Orientation Practices:

- Organization has at least some trauma-informed interview questions with a focus on hiring employees who are knowledgeable about trauma and trauma-informed approaches
- Organization actively engages in promoting safety, trustworthiness, choice, collaboration and empowerment for new staff as they transition from new hire orientation into the workplace
  - Organization incorporates trauma-informed conversations into this process as well (e.g., point person from the Champion team meeting with them to discuss the initiative, what it looks like, etc.)

Training the Workforce:

- All staff in the organization receive "trauma 101" foundational education
- Organization offers on-going follow-up training and education on trauma and trauma-informed approaches to facilitate the on-going, digestive learning process (e.g., continuing education, use of 10-15 minutes of meetings, flash PD sessions, etc.)
- Organization has "mentors" that are able to informally provide education to colleagues and actively "model the model" of trauma-informed values and practices in all their interactions and conversations

Addressing the Impact of the Work:

- All staff receive training on secondary trauma, vicarious trauma, burnout and compassion fatigue

- Organization's leaders provide formal opportunities for check-in and debriefing, especially in the event that crises/incidences occur within the organization or in the community/world (e.g., loss of a client/staff member, news of community violence, etc.)
- Organization's leadership actively encourages and promotes wellness and self-care of staff (e.g., messaging, providing time/space for staff to be mindful, etc.)

Establishing a Safe Environment:

- Organization regularly conducts physical environment walk-throughs through a trauma-informed lens to identify opportunities to improve emotional/physical safety, be culturally responsive and accessible
- Organization ensures all signage/messaging in the building uses positive, welcoming language and states the desired or "prosocial" behavior rather what is not allowed
- Organization has a designated space for staff to practice self-care/be away from the work as needed during the day
- All staff engage in validating, respectful and transparent communication in all interactions
- Organization elicits feedback about the physical environment from clients, staff and community to inform changes

Screening for Trauma:

- Organization makes deliberate decision whether or not to screen/assess for trauma in clients—including where, when, what tool and by whom
- If decision made to screen, organization has a protocol for both positive and negative screens, including an updated list of referrals for trauma-specific treatment
- If decision is made to screen, those who are doing the screening are trained in how to provide the screen and have appropriate follow-up conversations

Treating Trauma:

- Organization has a system in place to refer clients who need trauma-specific treatment to affordable, evidence-based services (e.g., EMDR, CPT, TF-CBT, etc.)—internally or externally

Collaborating with Others:

- Organization has mapped out partners (including other agencies/programs, families/communities, clients) and identified opportunities to engage them in training/education and other parts of the trauma-informed initiative
- Organization has mechanisms in place to promote cross-sector training on trauma and trauma-informed approaches with partner agencies/programs

- Organization has methods of communication in place with other entities working with the same clients/families for making trauma-informed decisions (e.g., different staff within the organization, other providers, etc.)

Reviewing Policies and Procedures:

- Organization deliberately reviews its own written and informal policies/protocols for the potential for re-traumatization
- Organization deliberately reviews its own written and informal policies/protocols to ensure the values/principles of trauma-informed practice
- Organization deliberately reviews its own written policies/protocols to ensure they are written in positive language that depict the desired or "prosocial"/expected behavior
- Organization has a de-escalation policy to minimize the potential for re-traumatization
- Organization ensures client and staff rights, responsibilities and expectations are clear and easily accessible

Evaluating and Monitoring Progress:

- Organization has mechanisms in place for on-going assessment of a trauma-informed culture
- Organization incorporates trauma-informed values and practices in its quality improvement processes
- Organization ensures evaluation measures include the perspective of all stakeholders (clients, families/community, staff)
- Organization has mechanisms in place to share evaluation data in a transparent manner and regularly responds to feedback/evaluation

The Pair of ACEs
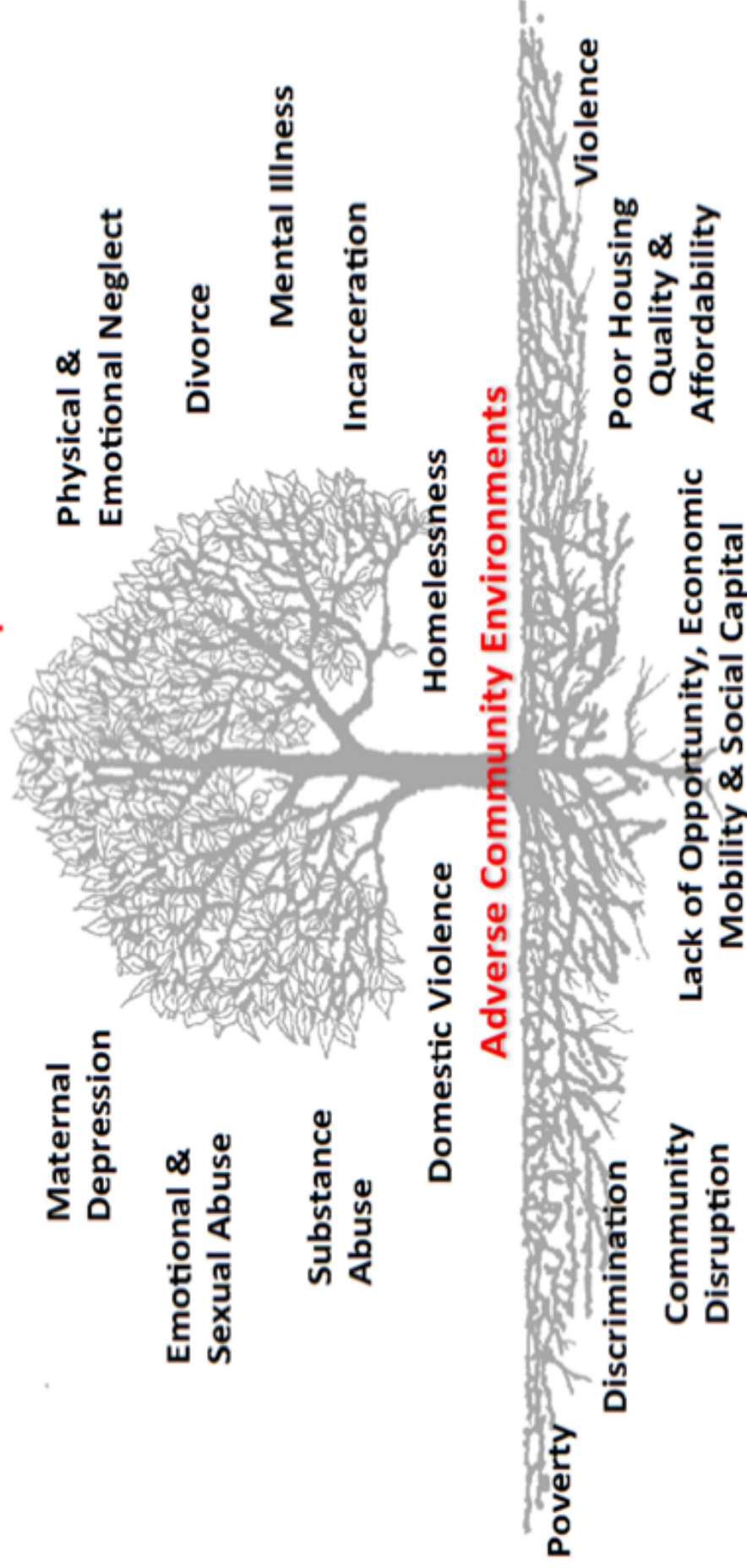
Adverse Childhood Experiences

Maternal Depression

Emotional & Sexual Abuse

Substance Abuse

Physical & Emotional Neglect

Divorce

Mental Illness

Incarceration

Domestic Violence

Homelessness

Adverse Community Environments

Poverty

Discrimination

Community Disruption

Lack of Opportunity, Economic Mobility & Social Capital

Poor Housing Quality & Affordability

Violence

WORKSHEET
TELLING YOUR PUBLIC STORY
Self, Us, Now
By Marshall Ganz

Stories not only teach us how to act – they inspire us *to* act. Stories communicate our values through the language of the heart, our emotions. And it is what we *feel* – our hopes, our cares, our obligations – not simply what we *know* that can inspire us with the courage to act.

A plot is structured with a beginning, movement toward a desired goal, an unexpected event, a crisis that engages our curiosity, choices made in response to the crisis, and an outcome. Our ability to empathetically identify with a protagonist allows us to enter into the story, feel what s/he feels, see things through his or her eyes. And the moral, revealed through the resolution, brings understanding. From stories we learn how to manage ourselves, how to face difficult choices, unfamiliar situations, and uncertain outcomes because each of us is the protagonist in our own life story, facing everyday challenges, authoring our own choices, and learning from the outcomes.

By telling our personal stories of challenges we have faced, choices we have made, and what we learned from the outcomes we can inspire others and share our own wisdom. Because stories allow us to express our values not as abstract principles, but as lived experience, they have the power to move others.

Stories are specific – they evoke a very particular time, place, setting, mood, color, sound, texture, taste. The more you can communicate this specificity, the more power your story will have to engage others. This may seem like a paradox, but like a poem or a painting or a piece of music, it is the specificity of the experience that can give us access to the universal sentiment or insight they contain.

You may think that your story doesn't matter, that people aren't interested, that you shouldn't be talking about yourself. But when you do public work, you have a responsibility to offer a public account of who you are, why you do what you do, and where you hope to lead. The thing about it is that if you don't author your public story, others will, and they may not tell it in the way that you like - as many recent examples show.

A good story public story is drawn from the series of choice points that have structured the "plot" of your life – the **challenges** you faced, **choices** you made, and **outcomes you experienced.**

Challenge: Why did you feel it was a challenge? What was so challenging about it? Why was it *your* challenge?

Choice: Why did you make the choice you did? Where did you get the courage – or not? Where did you get the hope – or not? How did it feel?

Outcome: How did the outcome feel? Why did it feel that way? What did it teach you? What do you want to teach us? How do you want us to feel?

The story you tell of why you sought to lead allows others insight into your values, why you have chosen to act on them in this way, what they can expect from you, and what they can learn from you.

A public story includes three elements:

- **A story of self**: why you were called to what you have been called to.

- **A story of us**: what your constituency, community, organization has been called to its shared purposes, goals, vision.

- **A story of now**: the challenge this community now faces, the choices it must make, and the hope to which "we" can aspire.

In this worksheet, we focus on the "story of self", but we also offer some suggestions on getting to a story of us and a story of now. Remember the art of story telling is in the telling, not in the writing. In other words, story telling is interactive, a form of social transaction, and can therefore only be learned by telling, and listening, and telling, and listening.

Story of Self

Take the time to reflect on your own public story by beginning with your story of self. Grab a notebook, a recorder, or a friend who will listen, and describe the milestones and experiences that have brought you to this moment. Go back as far as you can remember.

You might start with your parents. What made them the people they became? How did their choices influence your own? Do you remember certain "family stories", perhaps told so often you may have gotten tired of hearing them. Why did they tell these stories and not others? What was the moral of these stories? What did they teach? How did they make you feel?

In your own life, focus on challenges you had to face, the choices you made about how to deal with them, and the satisfactions – or frustrations - you experienced. What did you learn from the outcomes and how you feel about them today? What did they teach you about yourself, about your family, about your peers, about your community, about your nation, about the world around you, about people - about what really matters to you? What about these stories was so intriguing? Which elements offered real perspective into your own life?

If you're having trouble, here are some questions to get you started. These questions are NOT meant to be answered individually. They are intended to help to inspire you and get your memory gears rolling so that you can reflect on your public story and tell it with brevity and intentionality. Don't expect to include the answers to all these questions each time you tell your story. They are the building blocks of many potential stories, and the object right now is to lay them out in a row and see what inspires you.

What memories do you have as a child that link to the people, places, events that you value? What are your favorite memories?   What images, sounds or smells in particular come up for you when you recall these memories?

List every job or project that you have ever been involved with connected with these values, or not. Be expansive; include things like camping in the wild, serving in a youth group, going to a political rally, organizing a cultural club, experiencing a moment of transcendence. List classes you have taken, projects you have led, and work that you have done that connects with your values. Name the last five books or articles that you have read (by choice) or movies or plays that you have seen. What do you see as a connection or theme that you can see in all of the selections? What did you enjoy about these articles? What does your reading say about you?

Some of the moments you recall may be painful as well as hopeful. You may have felt excluded, put down or powerless, as well as courageous, recognized, and inspired. Be sure to attend to the moments of "challenge" as well as to the moments of "hope" – and to learn to be able to articulate these moments in ways that can enable others to understand who you are. It is the combination of "criticality" and "hopefulness" that creates the energy for change.

What was the last time you spent a day doing what you love doing? What in particular made you want to use that day in that way? What was memorable about the day? Is there a specific sight, sound or smell that you think of when you recall this day?

What factors were behind your decision to pursue a career in public work? Was there pressure to make different choices? How did you deal with conflicting influences?

Who in your life was the person who introduced you to your "calling" or who encouraged you to become active? Why do you think that they did this? What did your parents model? What was the role, if any, of a community of faith? Whom did you admire?

Whom do you credit the most with your involvement now in work for your cause? What about their involvement in your life made a difference? Why do you think it was important to them to do so?

Story of Us

We are all part of multiple "us's" – families, faiths, cultures, communities, organizations, and nations in which we participate with others. What community, organization, movement, culture, nation, or other constituency do you consider yourself to be part of, connected with? With whom do you share a common past? With whom do you share a common future? Do you participate in this community as a result of "fate", "choice" or both? How like or unlike the experience of others do you believe your own experience to be? One way we establish an "us" – a shared identity – is through telling of shared stories, stories through which we can articulate the values we share, as well as the particularities that make us an "us."

Your challenge will be to define an "us" upon whom you will call to join you in action motivated by shared values, values you bring alive through story telling. However you define the "us" whom you hope to move, it must consist of real people with whom you can communicate, move or not move, engage or not engage, get to act or not.

Here at Harvard there are many potential "us's" among your classmates, as there are in any community. They may come to think of themselves as an "us" based on enrolling in

this class, enrolling in the same year, enrolling in the same program, sharing similar aspirations, sharing similar backgrounds (work experience, religion, generation, ethnicity, culture, nationality, family status, etc.), sharing similar experiences coming to school here, sharing similar values commitments, similar career aspirations, etc. Your challenge will be to think through the "us" whom you hope to move to join you in acting together on behalf of a shared calling.

Some of the "us's" you could invite your classmates to join are larger "us's" in which you may already participate. You may be active in the environmental movement, for example, and may find others among your classmates who are as well. You may be active in a faith community, a human rights organization, a political campaign, a support organization, an immigrant association, a labor union, and alumni group, etc. Some "us's" have been around for literally thousands of years, such as the stories that define most faith traditions – some only for a few days. Most "us's" that have been around for a while have stories about how their founding, the challenges faced by the founders, how they overcame them, who joined with them, and what this teaches us about the values of the organization. They also usually have tales of critical crises that were faced, like the American Civil War, for example, about which Abraham Lincoln told such a powerful story in his Gettysburg Address and Second Inaugural Address.

So you may want to invite your classmates to join you in a larger "us" already working together or you may want to engage them in articulating a new "us" based on experiences that you are sharing now. In fact, you probably already have numerous stories of us that communicate what it means to be a "midcareer", for example, based on events that took place during the summer program. Remember, like all stories, a story of us is built from a challenge, the choice made in response to that challenge, and the moral taught by the outcome.

> How would you define the "us" whom you hope to call upon to join you in your public narrative? Please describe it in a single sentence if you can.

Story of Now

Now we know why you've been called to a particular mission, we know something of who it is you want to call upon to join you in that mission, so what action does that mission require of you right here, right now, in this place?

A 'story of now" is urgent, it requires dropping other things and paying attention, it is rooted in the values you celebrated in your story of self and us, and a contradiction to those values that requires action.

- Do you share the value that those who sacrifice for their country should be honored for doing so? Does the quality of care returning veterans receive meet this standard? If not, what are you going to do about it?
- Do you share the value that the current generation should pass on a livable world to the next generation? Do the measures being taken to deal with climate change meet this standard? If not, what are you going to do about it?
- Do you share the value that powerful institutions, especially those that benefit from public support, have moral responsibilities to the public in how they use their power? Which one's? How? What are you going to do about it?

- Do you share the value that all racial, religious, and cultural groups should be treated equally under the law? Can

Leaders who only describe problem, but fail to identify action those whom they bring together can take to address the problem, aren't very good leaders. A list of "100 things you can do to make the world better" is a "cop-out." If you are called to address a real challenge, a challenge so urgent have motivated us to face it as well, then you also have a responsibility to invite us to join you in action that has some chance of success. A 'story of now" is not simply a call to make a choice, to act – it is a call to "hopeful" action.

If you ask me to "change a light bulb" for example, to deal with climate change, do you really think it will happen? Especially if it's among 100 other things I might – or might not – do? But if you ask me to join you in persuading the Kennedy School to change all of its light bulbs by signing a student petition, joining you in a delegation to the dean, and, adding my name to a public list of KSG students who have committed to changing the light bulbs where they live, what do you think the odds are of success? An even if the possibility of success seems remote, why is credible action still required? Wouldn't forming a group committed to identifying action steps that can be taken by x date also be a form of action?

What urgent "challenge" might you call upon us to face?
What specific "action" might you call upon us to take?
Please respond with single sentences if you can.

LInking

In the end you will be asked to link your story of self, story of us, and story of now into a single public narrative. As you will see, however, this is an iterative – and non-linear – process. Each time you tell your story you will adapt it – to make yourself clearer, to adjust to a different audience, to locate yourself in a different context. As you develop a story of us, you may find you want to alter your story of self, especially as you begin to see the relationship between the two more clearly. Similarly, as you develop a story of now, you may find it affects what went before. And, as you go back to reconsider what went before, you may find it alters your story of now. You will not leave this class with a final "script" of your public narrative but, if we are successful, you will have learned a process by which you can generate that narrative over and over and over again when, where, and how you need to.

Racism

A LEARNING CONTINUUM FOR RACE-FOCUSED WORK
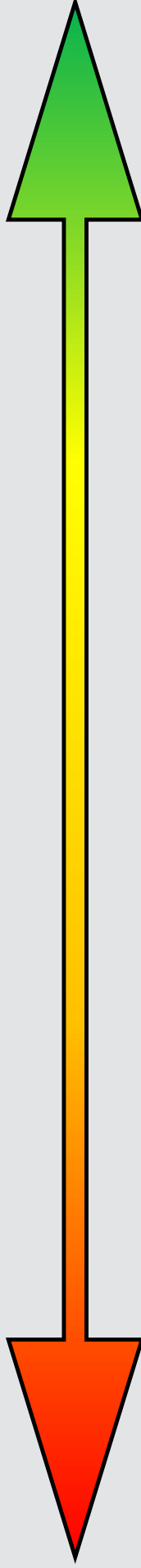
COLOR-BLIND

At this end of continuum is a "place" that is "color-blind," either by design or default.

That is, the organization tends to think that what's good for "everyone" will necessarily be good for people of color.

Thus, it does not lift up issues of equality, diversity, and inclusion in any regular or routine way.

Further, it may even take up the position that paying attention to racial/ethnic diversity or disparities diverts attention away from shared concerns.

(e.g. "All Lives Matter" notion when inserted into a "Black Lives Matter" conversation or when someone says "reverse racism")

DIVERSITY-ONLY

When organizations have decided, with deliberate emphasis, to focus on diversity (but, diversity-only), recognizing that it offers value to the workplace/space and the work/environment.

This "place" is not attuned to equity and may not even be active around issues of inclusion.

Organizations in this place may feel either (a) doing the work of creating diversity will allow other goals to fall in place, or (b) doing the work of diversity is itself labor-intensive, not really allowing space to work on issues of race.

(e.g. when people dismiss diversity as not being a "black and white" or race issue or when human resource policy says to recruit for diversity within staff, but do not create an environment to support that diverse staff)

RACE-TENTATIVE

Those organizations that find data showing racial disparities troubling, know something needs to be done, and yet are not sure how to act systemically on that concern.

They make take a step or two in the way of funding or outreach or hiring a person responsible for Diversity and Inclusion.

They may also recognize that their own staff and Board are not diverse but presume that slow turnover of staff and Board members dictates slow change.

(e.g. "We just don't know what to do, but we don't want to get it wrong.")

EQUITY-FOCUSED

The right end of the continuum is a racial equity approach, one which characterizes the most race-intentional organizations.

This "place" recognizes that virtually all programmatic and operational functions must be culturally competent, race-informed, and anti-oppressive in order to advance the overall organizational mission.

(e.g. elimination of disparities, closing the achievement gap, addressing health inequities, focus on issues of social justice, etc.)

White people assume niceness is the answer to racial inequality. It's not
Robin diAngelo

I am white. As an academic, consultant and writer on white racial identity and race relations, I speak daily with other white people about the meaning of race in our lives. These conversations are critical because, by virtually every measure, racial inequality persists, and institutions continue to be overwhelmingly controlled by white people. While most of us see ourselves as "not racist", we continue to reproduce racist outcomes and live segregated lives.

In the racial equity workshops I lead for American companies, I give participants one minute, uninterrupted, to answer the question: "How has your life been shaped by your race?" This is rarely a difficult question for people of color, but most white participants are unable to answer. I watch as they flail, some giving up altogether and waiting out the time, unable to sustain 60 seconds of this kind of reflection. This inability is not benign, and it certainly is not innocent. Suggesting that whiteness has no meaning creates an alienating - even hostile - climate for people of color working and living in predominantly white environments, and it does so in several ways.

If I cannot tell you what it means to be white, I cannot understand what it means not to be white. I will be unable to bear witness to, much less affirm, an alternate racial experience. I will lack the critical thinking and skills to navigate racial tensions in constructive ways. This creates a culture in which white people assume that niceness is the answer to racial inequality and people of color are required to maintain white comfort in order to survive.

An inability to grapple with racial dynamics with any nuance or complexity is ubiquitous in younger white people who have been raised according to an ideology of colorblindness. I have been working with large tech companies whose average employees are under 30 years old. White employees are typically dumbfounded when their colleagues of color testify powerfully in these sessions to the daily slights and indignities they endure and the isolation they feel in overwhelmingly white workplaces. This pain is especially acute for African Americans, who tend to be the least represented.

> **❝** How often will a white person accused of racism gather as evidence to the contrary friends and colleagues to testify to their niceness

While the thin veneer of a post-racial society that descended during the Obama years has been ripped away by our current political reality, most white people continue to conceptualize racism as isolated and individual acts of intentional meanness. This definition is convenient and comforting, in that it exempts so many white people from the system of white supremacy we live in and are shaped by. It is at the root of the most common kind of white defensiveness. If racists are intentionally and openly mean, then it follows that nice people cannot be racist. How often will a white person accused of racism gather as evidence to the contrary friends and colleagues to testify to their niceness; the charge cannot be true, the friend cannot be racist, because "he's a really nice guy" or "she volunteers on the board of a non-profit serving under-privileged youth". Not meaning to be racist also allows for absolution. If they didn't mean it, it cannot and should not count.

Thus, it becomes essential for white people to quickly and eagerly telegraph their niceness to people of color. Niceness in these instances is conveyed through tone of voice (light), eye contact accompanied by smiling and the conjuring of affinities (shared enjoyment of a music genre, compliments on hair or style, statements about having traveled to the country the "other" is perceived to have come from or knowing people from the other's community). Kindness is compassionate and often implicates actions to support or intervene. For example, I am having car trouble and you stop and see if you can help. I appear upset after a work meeting and you check in and listen with the intent of supporting me. Niceness, by contrast, is fleeting, hollow and performative.

In addition to niceness, proximity is seen as evidence of a lack of racism. Consider the claims many white people give to establish that they aren't racist: "I work in a diverse environment." "I know and/or love people of color." "I was in the Peace Corps." "I live

in a large urban city." These are significant because they reveal what we think it means to be racist. If I can tolerate (and especially if I enjoy and value) proximity, claims of proximity maintain, I must not be racist; a "real" racist cannot stand to be near people of color, let alone smile or otherwise convey friendliness.
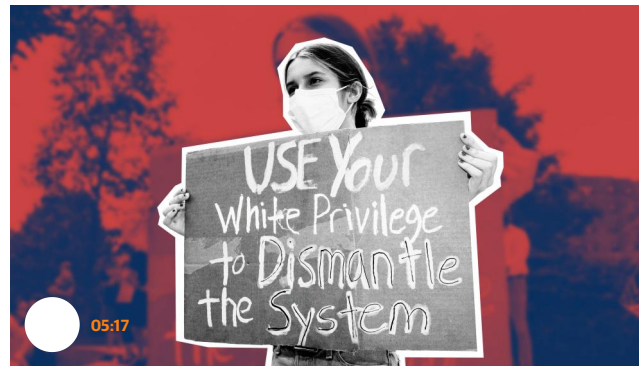
▲ How 'white fragility' reinforces racism – video explainer

In a 1986 article about black students and school success. Signithia Fordham and John

In a 1986 article about black students and school success, Signithia Fordham and John Ogbu describe a "fictive kinship" between African Americans, a kinship that is not consanguineal (by blood) or affinal but derived from the assumption of shared experience. The racial kinship white people attempt to draw from niceness might be seen as a false or fabricated affinity. Most white people live segregated lives and in fact have no lasting cross-racial relationships. We are in the position to choose segregation and often do. The claims of non-racism that we make are therefore based on the most superficial of shared experiences: passing people of color on the street of large cities and going to lunch on occasion with a co-worker.

Note that our cursory friendliness does not come without strings. Consider the case of a white California woman who called the police this past May when a group of black Airbnb guests did not return her smile. The expectation is that the "nod of approval", the white smile, will be reciprocated. This woman, like all the other white people who have called the police on people of color for non-existent offenses, vigorously denied she was racist. After all, she did smile and wave before reporting them.

I have heard many black Americans talk about the awkwardness of white people "over-smiling". The act is meant to convey acceptance and approval while maintaining moral integrity, but actually conveys white racial anxiety. Over-smiling allows us to mask an anti-blackness that is foundational to our very existence as white. A fleeting benevolence, of course, has no relation to how black people are actually undermined in white spaces. Black friends have often told me that they prefer open hostility to niceness. They understand open hostility and can protect themselves as needed. But

the deception of niceness adds a confusing layer that makes it difficult for people of color to decipher trustworthy allyship from disingenuous white liberalism. Gaslighting ensues.

The default of the current system is the reproduction of racial inequality. To continue reproducing racial inequality, the system only needs for white people to be really nice and carry on – to smile at people of color, to go to lunch with them on occasion. To be clear, being nice is generally a better policy than being mean. But niceness does not bring racism to the table and will not keep it on the table when so many of us who are white want it off. Niceness does not break with white solidarity and white silence. In fact, naming racism is often seen as *not* nice, triggering white fragility.

We can begin by acknowledging ourselves as racial beings with a particular and limited perspective on race. We can attempt to understand the racial realities of people of color through authentic interaction rather than through the media or through unequal relationships. We can insist that racism be discussed in our workplaces and a professed commitment to racial equity be demonstrated by actual outcomes. We can get involved in organizations working for racial justice. These efforts require that we continually challenge our own socialization and investments in racism and put what we profess to value into the actual practice of our lives. This takes courage, and niceness without strategic and intentional anti-racist action is not courageous.

Magazine Menu

RACISM IN MEDICINE

Through the Eyes of a Child

The barrage of strife, unrest, and outrage over the deaths of Black people in this country falls hard on the young

The Journey to Here

To Calm a Storm

Elizabeth Gehrman

Maybe it hasn't actually been the worst year ever, as internet memes are calling it, but for most of us, 2020 really has been "extra." Against the backdrop of a pandemic that has created economic havoc and kept people from loved ones and purpose-defining work, the country has endured its greatest social unrest in decades, largely driven by a relentless daily barrage of horrifying racial incidents delivered up close and in real time. And, in the ultimate betrayal, these incidents—from the killings of Black men at the hands of police to countless "Karen" encounters on public and private property—have often been encouraged by the very government meant to protect us.

If you, as an adult, have been feeling anxious and distressed, imagine what all this is doing to children.

"This year has been exceptionally challenging for Black youth," says James Huguley, interim director of the University of Pittsburgh's Center on Race and Social Problems. "Because of the racial disparities in our broken system, they're more likely to know someone affected by COVID-19. The social isolation makes everything worse, and most kids who receive mental health support get it at school, where most of them have not been since February. And at the same time all these racial atrocities in policing are happening."

Racial trauma operates on many levels, Huguley notes, from microaggressions to personal experiences with discrimination to longstanding, intentionally instituted structural disadvantages that over hundreds of years have led to ingrained economic hardship, housing insecurity, carceral system injustice, unsettling family dynamics, and other adverse consequences. "We do surveys with Black youth here in Pittsburgh, and kids ages 10 to 15 are reporting that people have been racist toward them," he says. "By tenth grade about fifty percent of them have encountered racial discrimination."

"The biology makes it clear: The body doesn't forget. Early experiences both positive and negative literally shape the architecture of the developing brain."

Black parents and educators point out that while white people are becoming more aware of discrimination, "where you stand depends on where you sit," according to Altha Stewart, past president of the American Psychiatric Association and a senior associate dean for community health engagement in the College of Medicine at the University of Tennessee Health Science Center. "If you sit in the midst of a storm of the kinds of events that don't usually make the news, that happen day in and day out in your community, it really is nothing new. The newness comes from the rapidity with which these images are coming at our kids."

And, Huguley points out, although children may not be experiencing firsthand the things they're seeing online or on television, "they're identifying with the person who is experiencing it, who looks like them, so the trauma is vicarious."

According to a 2018 paper in *Social Science & Medicine*, children are especially vulnerable to indirectly experienced racism because "children's lives are inevitably linked to the experiences of other individuals, and they are in critical phases of development." The researchers' review of the literature on vicarious racism and child health found thirty-eight statistically significant childhood outcomes—including "general illness," weight issues, depression, anxiety, socioemotional difficulties, delayed cognitive development, and externalized behavior problems —that can be associated with a child's indirect exposure to the prejudice and discrimination that friends, family, and strangers may experience and to experiences that "threaten a child's sense of the world as just, fair, and safe."

The effects of childhood trauma, whatever its cause, can be lifelong. A 2019 paper published in the U.S. Centers for Disease Control and Prevention's *Morbidity and Mortality Weekly Report* found that adverse childhood experiences, or ACEs, can "derail optimal health and development by altering gene expression, brain connectivity and function, immune system function, and organ function"; compromise "development of healthy coping strategies, which can affect health behaviors, physical and mental health, life opportunities, and premature death"; and have been linked with "increased risk for alcohol and substance use disorders, suicide, mental health conditions, heart disease, [and] other chronic illnesses," including stroke, asthma, lung disease, cancer, kidney disease, diabetes, and depression. Other studies have associated adverse childhood experiences with obesity, physical inactivity, and high-risk sex behaviors, and, the *MMWR* authors write, these experiences have "been linked to reduced educational attainment, employment, and income."

Bone deep

The roots of these effects can be seen far earlier than once thought possible. "We used to think that preschool kids experiencing a lot of adversity where they live or in their family didn't understand what was going on or were too young to remember," says Jack Shonkoff, an HMS professor of pediatrics at Boston Children's Hospital and director of Harvard's Center on the Developing Child, where he chairs the JPB Research Network on Toxic Stress, a research collaboration that is developing biological and behavioral measures of stress activation and resilience in children 4 months to 5 years old. These metrics include pro-inflammatory cytokine levels, epigenetic effects, cortisol levels over time, and measures of executive functioning skills and attention span.

"The general public belief is that early experiences don't have lasting impacts until kids get older," says Shonkoff, who is also the Julius B. Richmond FAMRI Professor of Child Health and Development at the Harvard T.H. Chan School of Public Health and Harvard Graduate School of Education and a research associate at Massachusetts General Hospital. "But now we know that even very young kids are affected. The biology makes it clear: The body doesn't forget. Early experiences both positive and negative literally shape the architecture of the developing brain and other biological systems from the beginning."

Alisha Moreland

Alisha Moreland, a member of the HMS faculty of psychiatry and director of trauma-informed treatment, consultation, and outreach at McLean Hospital's Center of Excellence in Depression and Anxiety Disorders, explains that the brain develops "from the bottom up and the inside out," with deep brain structures like the amygdala, hippocampus, and hypothalamus that play a role in

fear conditioning and the stress response; the brain stem and midbrain structures handling basic functions like regulating heart rate, breathing, sleeping, and eating; and the topmost parietal and frontal lobes managing sensation, perception, and executive function.

"Adolescents are impulsive and need external cues because their brains are still developing," she says. "Part of the work of becoming an adult is learning how to modulate the fear response and move toward safety. But when the sense of threat never goes away, and you're in a chronic state of seeking safety, that short circuits higher-order functions."

Moreland mentions the seminal ACEs study undertaken by the CDC and Kaiser Permanente and published in the *American Journal of Preventive Medicine* in 1998. For that study, researchers assessed responses from nearly ten thousand individuals who Moreland notes "were overwhelmingly white, middle class, insured, and educated." They found that more than one half of the respondents had had at least one adverse experience—a litany of harms that included psychological, physical, or sexual abuse, or living with a mentally ill or suicidal individual—that increased the risk for chronic health and behavioral problems. One quarter of the respondents had had two or more such experiences.

"That's significant because the cohort had so many protective factors," she says. "But even with working protective factors, individuals reported that something from their childhood had a significant impact."

Both Moreland and Shonkoff mention three kinds of stress children can experience. Positive stress, they explain—the body's response to normative experiences such as being made to share toys or going to day care for the first time—is healthy, teaching children coping mechanisms they can use throughout life. Tolerable stress is more serious, such as that following the death of a loved one, a natural disaster, or ongoing family discord. The most harmful level of stress, toxic stress, occurs when the stressor is severe and fairly continuous and there is no counterbalance, as experienced in some orphanages or other living situations marked by significant neglect or from the relentless additive effect of stressors such as deep poverty, systemic racism, and community violence. With toxic stress, Moreland points out that the need for safety—a basic need that forms the foundation of psychologist Abraham Maslow's hierarchy of needs pyramid—isn't fulfilled, making it more challenging for individuals to gain the sense of belonging, love, and self-esteem required to achieve the full potential and creativity at the pyramid's top. Shonkoff adds that the persistent wear-and-tear effects of toxic stress on multiple organ systems can lead to higher rates of chronic physical impairments across a lifespan.

Adverse childhood experiences can derail optimal health and development.
"Any environment that is devaluing or invalidating can contribute to stress," Moreland says. "And racism is one form of that." In children, toxic stress can look like clinginess, nervous habits, withdrawal, lack of focus, mood swings, reluctance to go to school, irritability, anger, acting out, and other troubling behaviors. "Black children and teens are more often misdiagnosed with disorders like ADHD because they are hypervigilant or aggressive," Stewart says. "This could be the result of racial trauma."

It also could be a perfect example of a vicious cycle created by bias in the labeling system. Oppositional defiant disorder is diagnosed more often in children of color, and at least one study found that among adolescents who become involved with the justice system, Black males are 40 percent more likely, and Black females 54 percent more likely, to be diagnosed with conduct disorder than white males and females, "even upon considerations of trauma, behavioral indicators, and criminal offending." And even though high school suspension rates have dropped in the past decade, a 2016 study by the federal government's Civil Rights Data Collection program found that Black students in high school are still twice as likely to be suspended as their white and Hispanic peers.

Clearly, something needs to change.

A guiding hand
The phrase "trauma-informed care" existed as far back as the mid-1980s, but the practice has come into widespread use only in the past decade. It's an ACEs-based care approach that assumes everyone has had some trauma in their lives, and it starts not by asking "What is wrong with this person?" but instead "What has happened to this person?" It informs all aspects of school and social service programs or medical practices beginning on the first day or in the waiting room by "creating a physically and emotionally safe environment, establishing trust and boundaries, supporting autonomy and choice, creating collaborative relationships and participation opportunities, and employing a perspective that focuses on strengths and empowerment to promote resilience," according to the Institute on Trauma and Trauma-Informed Care at the University at Buffalo Center for Social Research.

"Black children and teens are more often misdiagnosed with disorders like ADHD because they are hypervigilant or aggressive. This could be the result of racial trauma."
Trauma-informed care aims to help people get "through," not "over," hurtful events in their past, but some have suggested it doesn't go far enough for children and adults of color. Researchers from the National Crime Victims Research and Treatment Center at the Medical University of South Carolina, writing in the *Journal of Child and Adolescent Trauma* in 2020, suggested an update to the care protocol. The article, which proposes a culturally informed model for reducing the mental health effects of racism-related experiences, points out that "theoretical models of early childhood adversity have largely neglected the multifaceted influence of racism on mental health outcomes" and proposes extending the ACEs framework by making racism a distinct ACEs category.

"Gaining a more accurate and nuanced understanding of the prevalence, impact, and typologies of ACEs that disparately influence Black youth," the paper states, "can shed light on targetable areas of intervention at the individual (e.g., adaptive coping strategies), contextual (e.g., community initiatives), and institutional (e.g., equitable health care) levels that can disrupt the noxious and lasting effects of adversity."

Some schools and extracurricular programs have been leading this charge for decades. A scholar of the social foundations of education, Kristal Moore Clemons heads the Children's Defense Fund's Freedom Schools, a six-week summer literacy and cultural enrichment program that grew out of the Mississippi Freedom Summer Project of 1964 and, Clemons says, "empowers children to see beyond their current circumstances." It encourages children to read books that reflect the Black experience and starts each day with songs, cheers, chants, and stomps focused on the concept of harambee, which is Swahili for "let's pull together."

Inside, out
For clinical physicians, trauma-informed and culturally-informed ACEs care means conveying understanding and trust, being aware of structural identity-based issues, and collaborating with patients in the healing process. It also means being careful not to retraumatize patients by requiring them to tell their stories repeatedly, regarding them as a number, labeling them, or being punitive or oppressive in language or treatment approaches.

James Huguley

"Frankly, some of the most troubling disparities are in the health sciences," says Huguley. "On top of hundreds of years of medical exploitation, skewed research, gaps in infant mortality rates and maternal health, and clinical bias, there are countless sad stories about personal encounters in medical offices. Medicine really needs to look internally at this, because behind every hypertension statistic, there's a life."

Stewart agrees. "Anyone who is practicing today and not incorporating into their encounters with patients something that speaks to what's going on in their world that can contribute to their symptoms may not be taking into full account the extent of our oath to provide the best possible care to the people who come to us."

The first thing pediatricians and primary care providers must do is check their own biases and work to understand the origins of racial inequality, says Huguley. Mentoring students who are underrepresented in medicine also goes a long way toward increasing the pipeline of professionals all patients can relate to—and working to become part of the scaffolding of resilience for children can make a difference in individual lives.

"On top of hundreds of years of medical exploitation, skewed research, gaps in infant mortality rates and maternal health, and clinical bias, there are countless sad stories about personal encounters in medical offices. Medicine needs to look internally at this, because behind every hypertension statistic, there's a life."

We know we can keep tolerable stress from becoming toxic and behavior from going off the rails, Shonkoff notes, by providing protective adult relationships that make kids feel secure. "No child can survive significant adversity by pulling themselves up by the bootstraps," he says. "But whether it's a parent, a childcare or health care provider, a neighbor, or a teacher, just one person can confer the protective effect, bringing the stress system back to baseline by providing caring support."

Adults may be able to parse racial discrimination for both themselves and the children in their lives by finding and using daily techniques that aim to help navigate this world of traumas. One such technique, LET UP, was developed by Dana Elaine Crawford, a clinical psychologist practicing in New York City and now scholar-in-residence at Columbia University's Zuckerman Institute. It was first published in 2019 in the journal *Zero to Three*, a publication developed by the National Center for Clinical Infant Programs in collaboration with the American Academy of Pediatrics; the journal focuses on early brain and child development. The acronym, Crawford says, stands for "listen, empathize, tell your story, understand, psychoeducate."
The first three steps are designed to help the person who is being confronted by a racist statement or action to calm and center themselves and deflect deep harm by providing themselves with personal perspective.

Clinicians and nonminorities are the people for whom understanding is important, says Crawford. They must examine their role in the larger system of bias, prejudice, and racism and consider the experiences the person they're addressing has probably had. But the "psychoeducate" element of Crawford's method is for everyone and simply means talking to the perpetrator about what happened. Even younger children can benefit from such approaches, says Crawford, if they're presented in a developmentally appropriate way. "When I talk to kids about racism and bias," she says, "I tell them it's a type of bullying based on someone's skin color. 'People bully because they're scared or feel bad about themselves or because they're not sure they'll have enough of something so they want to keep it from you.' Once they get a little older you can start talking about structural racism."

In schools and neighborhoods, joining or creating anti-racist groups can not only help change subtle and overt bigotry but can also be empowering to those involved. "Parents should go to school board meetings, join parent-teacher associations, and talk to their children's teachers," says Clemons. "More than 90 percent of the parents we work with become interested in engaging in social action with the child, taking them to marches and so forth." Becoming an activist, in however small a way, Clemons adds, "will teach children a sense of community, encourage resilience, and show them how communicating can build better relationships."

Shonkoff says such interventions are helpful and that in the future, individualizing them will make them even more effective. "As with acute lymphoblastic leukemia in childhood," he says, "if conventional treatment isn't working, we don't just shrug and give up. We go to plan B. We start with what we know in general works, then focus on the fact that we'll see variability of response."

"Still," he says, "there is an even better way to solve the problem. In the same way that using a vaccine to prevent infection is better than trying to treat the illness, we really need to go upstream and address common sources of stress—poverty, racism, housing insecurity, and food insecurity—that pile up on families with young children."

Elizabeth Gehrman is a Boston-based writer.
Illustration: Traci Daberko. Images: Kelly Davidson (Moreland); Richard Kelly (Huguley)

Early Childhood

5 Steps for Brain-Building Serve and Return

from Filming Interactions to Nurture Development (FIND)

Child-adult relationships that are responsive and attentive—with lots of back and forth interactions—build a strong foundation in a child's brain for all future learning and development. This is called "serve and return," and it takes two to play! Follow these 5 steps to practice serve and return with your child.

Serve and return interactions make everyday moments fun and become second nature with practice.

By taking small moments during the day to do serve and return, you build up the foundation for children's lifelong learning, behavior, and health—and their skills for facing life's challenges.

For more on serve and return:
tinyurl.com/serve-return

Filming Interactions to Nurture Development (FIND) is a video coaching program that aims to strengthen positive interactions between caregivers and children. FIND was developed by Dr. Phil Fisher and colleagues in Eugene, Oregon.

For more about FIND:
tinyurl.com/find-program

1 Notice the serve and share the child's focus of attention.

Is the child looking or pointing at something? Making a sound or facial expression? Moving those little arms and legs? That's a serve. The key is to pay attention to what the child is focused on. You can't spend all your time doing this, so look for small opportunities throughout the day—like while you're getting them dressed or waiting in line at the store.

WHY? *By noticing serves, you'll learn a lot about children's abilities, interests, and needs. You'll encourage them to explore and you'll strengthen the bond between you.*

2 Return the serve by supporting and encouraging.

You can offer children comfort with a hug and gentle words, help them, play with them, or acknowledge them. You can make a sound or facial expression—like saying, "I see!" or smiling and nodding to let a child know you're noticing the same thing. Or you can pick up an object a child is pointing to and bring it closer.

WHY? *Supporting and encouraging rewards a child's interests and curiosity. Never getting a return can actually be stressful for a child. When you return a serve, children know that their thoughts and feelings are heard and understood.*

Center on the Developing Child 🛡 HARVARD UNIVERSITY

5 Steps for Brain-Building Serve and Return

Did you know that building a child's developing brain can be as simple as playing a game of peek-a-boo?

3 — Give it a name!

When you return a serve by naming what a child is seeing, doing, or feeling, you make important language connections in their brain, even before the child can talk or understand your words. You can name anything—a person, a thing, an action, a feeling, or a combination. If a child points to their feet, you can also point to them and say, "Yes, those are your feet!"

WHY? *When you name what children are focused on, you help them understand the world around them and know what to expect. Naming also gives children words to use and lets them know you care.*

4 — Take turns...and wait. Keep the interaction going back and forth.

Every time you return a serve, give the child a chance to respond. Taking turns can be quick (from the child to you and back again) or go on for many turns. Waiting is crucial. Children need time to form their responses, especially when they're learning so many things at once. Waiting helps keep the turns going.

WHY? *Taking turns helps children learn self-control and how to get along with others. By waiting, you give children time to develop their own ideas and build their confidence and independence. Waiting also helps you understand their needs.*

5 — Practice endings and beginnings.

Children signal when they're done or ready to move on to a new activity. They might let go of a toy, pick up a new one, or turn to look at something else. Or they may walk away, start to fuss, or say, "All done!" When you share a child's focus, you'll notice when they're ready to end the activity and begin something new.

WHY? *When you can find moments for children to take the lead, you support them in exploring their world— and make more serve and return interactions possible.*

Center on the Developing Child ★ HARVARD UNIVERSITY

A series of brief summaries of essential findings from recent scientific publications and presentations by the Center on the Developing Child at Harvard University.

Thriving communities depend on the successful development of the people who live in them, and building the foundations of successful development in childhood requires responsive relationships and supportive environments. Beginning shortly after birth, the typical "serve and return" interactions that occur between young children and the adults who care for them actually affect the formation of neural connections and the circuitry of the developing brain. Over the next few months, as babies reach out for greater engagement through cooing, crying, and facial expressions—and adults "return the serve" by responding with similar vocalizing and expressiveness—these reciprocal and dynamic exchanges literally shape the architecture of the developing brain. In contrast, if adult responses are unreliable, inappropriate, or simply absent, developing brain circuits can be disrupted, and subsequent learning, behavior, and health can be impaired.

1 **Because responsive relationships are both expected and essential, their absence is a serious threat to a child's development and well-being.** Sensing threat activates biological stress response systems, and excessive activation of those systems can have a toxic effect on developing brain circuitry. When the lack of responsiveness persists, the adverse effects of toxic stress can compound the lost opportunities for development associated with limited or ineffective interaction. This multifaceted impact of neglect on the developing brain underscores why it is so harmful in the earliest years of life and why effective early interventions are likely to pay significant dividends in better, long-term outcomes in educational achievement, lifelong health, and successful parenting of the next generation.

2 **Chronic neglect is associated with a wider range of damage than active abuse, but it receives less attention in policy and practice.** Science tells us that young children who experience significantly limited caregiver responsiveness may sustain a range of adverse physical and mental health consequences that actually produce more widespread developmental impairments than overt physical abuse. These can include cognitive delays, stunting of physical growth, impairments in executive function and self-regulation skills, and disruptions of the body's stress response.

Science Helps to Differentiate Four Types of Unresponsive Care

	OCCASIONAL INATTENTION	CHRONIC UNDER-STIMULATION	SEVERE NEGLECT IN A FAMILY CONTEXT	SEVERE NEGLECT IN AN INSTITUTIONAL SETTING
Features	Intermittent, diminished attention in an otherwise responsive environment	Ongoing, diminished level of child-focused responsiveness and developmental enrichment	Significant, ongoing absence of serve and return interaction, often associated with failure to provide for basic needs	"Warehouse-like" conditions with many children, few caregivers, and no individualized adult-child relationships that are reliably responsive
Effects	Can be growth-promoting under caring conditions	Often leads to developmental delays and may be caused by a variety of factors	Wide range of adverse impacts, from significant developmental impairments to immediate threat to health or survival	Basic survival needs may be met, but lack of individualized adult responsiveness can lead to severe impairments in cognitive, physical, and psychosocial development
Action	No intervention needed	Interventions that address the needs of caregivers combined with access to high-quality early care and education for children can be effective	Intervention to assure caregiver responsiveness and address the developmental needs of the child required as soon as possible	Intervention and removal to a stable, caring, and socially responsive environment required as soon as possible

With more than a half million documented cases in the U.S. in 2010 alone, neglect accounts for 78% of all child maltreatment cases nationwide, far more than physical abuse (17%), sexual abuse (9%), and psychological abuse (8%) *combined*. Despite these compelling findings, child neglect receives far less public attention than either physical abuse or sexual exploitation and a lower proportion of mental health services.

3 **Studies on children in a variety of settings show conclusively that severe deprivation or neglect:**

- **disrupts the ways in which children's brains develop and process information,** thereby increasing the risk for attentional, emotional, cognitive, and behavioral disorders.
- **alters the development of biological stress-response systems,** leading to greater risk for anxiety, depression, cardiovascular problems, and other chronic health impairments later in life.
- **is associated with significant risk for emotional and interpersonal difficulties,** including high levels of

negativity, poor impulse control, and personality disorders, as well as low levels of enthusiasm, confidence, and assertiveness.

- **is associated with significant risk for learning difficulties and poor school achievement,** including deficits in executive function and attention regulation, low IQ scores, poor reading skills, and low rates of high school graduation.

4 **The negative consequences of deprivation and neglect can be reversed or reduced through appropriate and timely interventions,** but merely removing a young child from an insufficiently responsive environment does not guarantee positive outcomes. Children who experience severe deprivation typically need therapeutic intervention and highly supportive care to mitigate the adverse effects and facilitate recovery.

For more information, see "The Science of Neglect: The Persistent Absence of Responsive Care Disrupts the Developing Brain" and the Working Paper series from the Center on the Developing Child at Harvard University. *www.developingchild.harvard.edu/resources/*

IMPLICATIONS FOR POLICY AND PROGRAMS

Science tells us that repeated and persistent periods of prolonged unresponsiveness from primary caregivers can produce toxic stress, which disrupts brain architecture and stress response systems that, in turn, can lead to long-term problems in learning, behavior, and both physical and mental health. These advances in science should inform a fundamental re-examination of our approaches to the identification, prevention, reduction, and mitigation of neglect and its consequences, particularly in the early years of life.

- **Address the distinctive needs of children who are experiencing significant neglect.** The immediate circumstances and long-term prospects of neglected children could be enhanced significantly by: (1) disseminating new scientific findings to child welfare professionals and focusing on the implications of this evidence for practice; (2) supporting collaboration between child development researchers and service providers to develop more effective prevention and intervention strategies; (3) coordinating across policy and service sectors to identify vulnerable children and families as early as possible; and (4) creating contexts for cooperation among policymakers, family court judges, and practitioners to improve access to non-stigmatizing, community-based services.

- **Invest in prevention programs that intervene as early as possible.** The earlier in life that neglected children receive appropriate intervention, the more likely they are to achieve long-term, positive outcomes and contribute productively to their communities. Key personnel in the primary health care, child welfare, mental health, and legal systems can work together to assure the earliest possible identification of families that require preventive assistance as well as children who need therapeutic intervention. Because child neglect often co-occurs with other family problems (particularly parental mental health disorders and addictions), specialized services that address a variety of medical, economic, and social needs in adults present important opportunities to identify and address neglectful circumstances for young children. Policies and programs that provide preventive interventions in high-risk situations before the onset of neglect present a particularly compelling goal.

Center on the Developing Child
HARVARD UNIVERSITY

www.developingchild.harvard.edu

Child Welfare

Trauma-Informed Care for Children Exposed to Violence
Tips for Parents and Other Caregivers

What happens when children are exposed to violence?

Children are very resilient—but they are not unbreakable. No matter what their age, children are deeply hurt when they are physically, sexually, or emotionally abused or when they see or hear violence in their homes and communities. When children see and hear too much that is frightening, their world feels unsafe and insecure.

Each child and situation is different, but exposure to violence can overwhelm children at any age and lead to problems in their daily lives. Some children may have an emotional or physical reaction. Others may find it harder to recover from a frightening experience. Exposure to violence—especially when it is ongoing and intense—can harm children's natural, healthy development unless they receive support to help them cope and heal.

What are some of the warning signs of exposure to violence?

Children's reactions to exposure to violence can be immediate or appear much later. Reactions differ in severity and cover a range of behaviors. People from different cultures may have their own ways of showing their reactions. How a child responds also varies according to age.

Young Children (5 and younger)

Young children's reactions are strongly influenced by caregivers' reactions. Children in this age range who are exposed to violence may:

- Be irritable or fussy or have difficulty calming down
- Become easily startled
- Resort to behaviors common to being younger (for example, thumb sucking, bed wetting, or fear of the dark)
- Have frequent tantrums
- Cling to caregivers
- Experience changes in level of activity
- Repeat events over and over in play or conversation

Elementary School-Age Children (6–12 years)

Elementary and middle school children exposed to violence may show problems at school and at home. They may:

- Have difficulty paying attention
- Become quiet, upset, and withdrawn
- Be tearful and sad and talk about scary feelings and ideas
- Fight with peers or adults
- Show changes in school performance
- Want to be left alone
- Eat more or less than usual
- Get into trouble at home or school

Teenagers (13–18 years)

Older children may exhibit the most behavioral changes as a result of exposure to violence. Depending on their circumstances, teenagers may:

- Talk about the event all the time or deny that it happened
- Refuse to follow rules or talk back with greater frequency
- Complain of being tired all the time
- Engage in risky behaviors
- Sleep more or less than usual
- Increase aggressive behaviors
- Want to be alone, not even wanting to spend time with friends
- Experience frequent nightmares
- Use drugs or alcohol, run away from home, or get into trouble with the law

What can you do?

The best way to help children is to make sure that they feel safe (for example, creating a predictable environment, encouraging them to express their feelings by listening and hearing their stories) and ensuring that they know that whatever happened was not their fault.

If your child's behavior worries you, share your concerns with a family member, friend, teacher, religious leader, or someone else you trust. Don't accept others' advice, such as "you worry too much" or "the child is too young to understand," that dismisses your concerns.

Other ways you can help children cope with the impact of exposure to violence include:

- Remaining calm and reinforcing a stable and safe environment
- Keeping a regular schedule or routine for meals, quiet time, playtime, and bedtime
- Helping children prepare for changes and new experiences
- Spending more time together as a family
- Being patient and letting children identify and express feelings
- Providing extra attention, comfort, and encouragement

With a younger child, it is helpful to provide comfort with frequent hugging and cuddling, following the child's lead (for example, wanting to be held, being clingy, or wanting to talk). You should also correct misinformation and answer questions without giving more information than what was asked for.

School-age children should be told that most people have many feelings when confronted with violence and it is normal to be upset, scared, angry, sad, or anxious. Children at this age need to have their questions answered, have the opportunity to correct their misconceptions, and talk about the experience as many times as needed.

Teenagers should not be forced to talk about the event, but they should have factual information if they request it and an opportunity to provide their perspective on the violent act. It helps for caregivers to be understanding of teenagers' moodiness, fears, and the need to be with peers.

How do you know if more help is needed?

Remember that when something frightening happens everyone has difficulty, including children. This is normal and may go away. But sometimes the impact stays with the child. If your child continues to experience problems after a few weeks or starts having more problems, you may want to talk to someone about how to help your child cope.

Do not ignore warning signs! It is natural to hope that your child's reactions will go away on their own if given enough time, but it is best to take positive action to help your child regain a feeling of safety and trust.

Mandated Reporting

Many children experiencing crises or violence are also at risk for child abuse and neglect. All States have child welfare systems that receive and respond to reports of child abuse and neglect, offer services to families, provide foster homes for children who must be removed from their parents' care, and work to find permanent placements for children who cannot safely return home.

Domestic violence does not equal child abuse and neglect, and therefore not all cases of domestic violence must be reported to child protective services. When responding to families affected by domestic violence, it is very important to consider simultaneously the safety of the child and the safety of the adult victim.

State by State information on reporting requirements can be found at http://www.childwelfare.gov/systemwide/laws_policies/state

For more information and resources, please contact the Safe Start Center, a National Resource Center for Children's Exposure to Violence:

http://www.safestartcenter.org
1-800-865-0965
info@safestartcenter.org

Additional Resources

Center for Mental Health Services. (2005). *Tips for Talking to Children and Youth After Traumatic Events: A Guide for Parents and Educators.* Rockville, MD: Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services. http://store.samhsa.gov/product/KEN01-0093R

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EASING FOSTER CARE PLACEMENT
A PRACTICE BRIEF

INTRODUCTION

While there is a significant amount of research regarding trauma experienced by children in foster care, less is known about the trauma of the actual transition and foster care placement process itself. Recent studies involving first-hand accounts from children indicate that the process of removal and initial placement can be profoundly frightening, disorienting, and frustrating for the child, and often exacerbate symptoms of hyperarousal, mistrust and disassociation that are connected with trauma and post-traumatic stress disorder (PTSD). The removal from parents and home has been shown to create "fears of being totally abandoned and an overwhelming feeling of helplessness [within the child], making it difficult for them to process any information given to them"[1]. Similarly, the ambiguity of the placement process can "[hinder] their ability to evaluate the potential of events to threaten their personal well-being, relationships, and matters of significance in their lives"[2].

Child welfare agencies around the country are placing increased emphasis on trauma-informed practices. For example, in 2008 the Center for Improvement of Child and Family Services at Portland State University embarked on a project to understand and address the role of trauma in investigation, removal and initial placement[3]; similarly themed workshops have been held for child welfare staff at Southwest Michigan Children's Trauma Assessment Center[4]. The Department of Children and Families in Florida is currently leading a statewide effort to incorporate trauma-informed care practices in both state and private agencies. Since 2008, Illinois has integrated an adaptation of Psychological First Aid into its emergency shelter system, which has resulted in reported improvements in staff's ability to address children's needs during their transition into foster care, and since 2010 the Chadwick Trauma-Informed Systems Project has been working with three laboratory sites around trauma-informed child welfare practice[5]. These are just a few examples of a growing body of work in this area.

Addressing trauma among children involved in the child welfare system has also been a focus of the National Child Traumatic Stress Network (NCTSN). In addition to the many NCTSN sites that are providing trauma-informed mental health services to child welfare clients, nine jurisdictions across the country are participating in a Network-sponsored Breakthrough Series Collaborative (BSC) focused on using trauma-informed child welfare practice to improve foster care placement stability. Through this BSC, child welfare providers, mental health agencies and other stakeholders are using trauma knowledge to develop ways to improve placement stability — examples include improving trauma assessment when children come into foster care, and increasing initial and ongoing communication between biological and foster parents.

These and similar efforts to ease children's transitions into foster care are preliminary but important steps towards creating a more trauma-informed child welfare system.

REMOVAL AND PLACEMENT PROCESS

In an ideal world, the removal of a child from an unsafe home is preceded by a thorough investigation by child protective services; cooperating with the biological parents around the plan for the removal, including identifying possible placement resources; and psychologically preparing the child for the event. However, this amount of preparation is often not possible; the abuse and neglect inherent in these cases can make planning difficult and at times necessitates an immediate removal, regardless of the time of day. The child is then faced with entering an uncertain, albeit temporary, limbo.

Many if not most child welfare systems have some sort of transitional setting where children have to wait hours or days before a foster family is found. These settings take a number of forms, including 24-hour emergency shelters, emergency foster care homes and receiving centers. Although the exact setting usually depends on the various needs of the communities it serves, all are designed to make the child's transition into foster care as smooth as possible. However, every system faces its own distinct challenges to providing care that is sensitive to the trauma the child has endured and that meets his or her safety, health, treatment and education needs.

In New York City, the Administration for Children's Services conducts family-team conferences before the removal of a child whenever possible; this conference is used to address the family's safety issues and, when possible, to come to a consensus about the plan going forward. If the decision is made for a child to come into foster care and a kinship resource or recruited foster family has not been identified in advance, or if the removal is made on an emergency basis, the child will come to the Children's Center, a 24-hour facility that provides short-term care for children who are awaiting foster care placement. Although the Children's Center is a full-service facility with on-site educational, medical and mental health services, the goal is for children to stay there for as short a time as possible.

WHAT WE'VE LEARNED IN NEW YORK CITY

The New York City Administration for Children's Services and the New York University Langone Medical Center have established the ACS-NYU Children's Trauma Institute (CTI), which seeks to use trauma- related knowledge to improve child welfare practice, and to help the child welfare system meet its goals on both the individual client and system levels. When the CTI received funding through the NCTSN, Children's Services asked it to determine what measures could be taken to reduce the trauma of children who have been removed from their parents and are waiting for foster care placement at the Children's Center.

For this project, CTI staff interviewed 31 youths between the ages of 12 and 17 on-site at the Children's Center. The interview surveyed the youths' experience at the Children's Center and with being placed in foster care. Topics included their experience with family court, questions they had about the foster care system and their attitudes and fears with regard to being placed in foster care in the future. They were also questioned about their feelings towards family relationships, connections with peers, and need for self-advocacy.

Of the 31 youths interviewed, 55 percent were female and 45 percent male. Fifty-two percent were African-American and 48 percent Latino/Latina. About half were at the Children's Center as a result of PINS (Persons in Need of Supervision) petitions, a third were new to foster care, and the remainder were either runaways or had been asked to leave their homes. The relatively high numbers of PINS and runaway youth are likely a result of our sample, which only included adolescents. We did not collect any identifying information in order to maintain the confidentiality of the interviewees.

Overall, the youths expressed positive attitudes towards the Children's Center, describing it as a safe place where their physical needs were met. They also regarded Children's Center staff as caring, supportive and honest – a quality that, as one interviewee said, is "good [for] kids with trust issues, like me." However, their answers regarding the process of being placed into foster care and their experiences in family court revealed confusion, frustration and a feeling of loss of empowerment. Interviewees said they felt "invisible" throughout the process, with many stating that they did not have the opportunity to speak on their behalf or ask questions about where they would be going.

Feelings of fear and confusion were especially prevalent in those youth who were new to the foster care system. A fundamental uncertainty about what foster care is caused a great deal of anxiety in these youth about what would happen to them. Common questions included: would they be separated from their siblings? Would they be placed in a group home? Would they have the opportunity to meet their foster parent before placement? Would a future foster parent "do what my mom did"?

When we relayed this information to Children's Center leadership, they confirmed that information is regularly conveyed to children throughout the removal and placement process, and that there are multiple opportunities for children to ask questions or get support. Based on our observations and the research in this area, we hypothesized that the trauma experienced by these youth made it difficult for them to process and retain the information that was relayed to them during the removal and placement processes.

To address the confusion and anxiety we repeatedly heard from youth, we conducted a brief therapeutic interview with a small number of youth that was designed to restore a sense of safety and mastery. Youth appeared to appreciate the individual attention provided by these interviews, which resulted in modest but positive changes on perceptions of safety, support and worries about the future.

RECOMMENDATIONS

There is broad agreement that there are things that child welfare systems can do to reduce the trauma experienced by children coming into foster care: providing early and consistent communication/ visitation between children and their parents, and between birth parents and foster parents; minimizing moves between transitional and foster care settings, and between different foster care placements; preparing the child for the removal as far in advance as possible; and placing siblings together and with family whenever possible. Based on our experience and what we have learned from colleagues in other jurisdictions, we have developed additional recommendations that we think will help ensure a successful and trauma-informed placement process:

Remember that children entering foster care are likely scared, confused and overwhelmed. The intense fear and helplessness children experience upon being taken from their parents — despite the neglect and/or harm they may have endured at their hands — can impact their ability to process new information. Often, they are unable to remember what is being told to them, and can subsequently develop distorted thoughts about the reasons for removal. It is crucial that caseworkers remember this, listen to and validate children's questions and feelings throughout the process, and help them understand that they are not to blame for their removal from home. Caseworkers and others who interact with the child should use simple language (avoiding acronyms) and give clear explanations. Other approaches, such as giving children age-appropriate written materials, or asking them to repeat back their understanding of what has been told to them, may help ensure that children understand and remember the information that is given to them.

Keep asking the child what he or she needs to feel comfortable. The psychological effort of coping with what is happening to them, coupled with distrust of their new caretakers, can cause children to stay silent. Asking them what they need to bring from home that gives them comfort, and again what they need to feel safe during different points in the placement process, can give a child a sense of control amidst the chaos and establish a level of trust with caseworkers and foster parents. In addition, assisting the child with expressing his or her fears and concerns to their foster parent through the initial adjustment period may ease their transition.

Prepare the foster parent. Any information you can provide the foster parent about the child, including the reason he or she is in foster care and the past traumas he or she has experienced, is helpful. The more foster parents know about kinds of behaviors to expect during the transition period (withdrawal, hostility, hoarding, limit-testing, etc.), the less likely they will be to personalize the child's reactions and the more likely the placement will be successful. Likewise, establishing a positive connection between the foster parent and birth parent can facilitate communication around the child's routines and needs, minimizing the child's fear and uncertainty and maintaining parents' focus on his or her well-being.

Keep calm. Children take psychological and emotional cues from their environment, so it is important that their fear and anxiety is not unnecessarily heightened. Although the event of removal can be highly charged emotionally, staff and others who come into contact with the child during the removal and placement process can help alleviate the tension being absorbed by the child. Having a calmer frame of mind will help the child "keep their wits about them" and greatly improve the experience and aftermath of the event. Talking about the child's anxieties, about his or her next steps, and helping him or her to anticipate ways to effectively deal with fears and concerns, can also be helpful.

Create continuity of care. The disruption of stability can have significant impact on a child's cognitive and emotional health. Instating a measure of constancy through follow-up visits to the foster home lessens the impact of this disruption and can help the child resume a semblance of normalcy throughout this turbulent time. Continuing communication with the child about his or her concerns and fears is key.

ACKNOWLEDGEMENTS

RECOMMENDED CITATION

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Building a Trauma-Informed Child Welfare System

How CONCEPT Transformed Child Welfare to Improve Support for Children and Families Exposed to Trauma

Beginning in 2011, Connecticut launched a seven-year effort to transform the child welfare system to be trauma-informed. The majority of children in the child welfare system have been exposed to trauma, including physical abuse, sexual abuse, and chronic neglect, however emerging best practices for children exposed to trauma had not yet been implemented in Connecticut or nationally. A federal grant provided an opportunity for Connecticut to apply the concept of a trauma-informed approach to the state's child welfare system. Today, Connecticut has made significant progress to ensure that children and families involved in the child welfare system are identified and have access to high-quality services. Connecticut is now one of the nation's leading examples of a trauma-informed child welfare system.

The costs of maltreatment and trauma to children, families, and society at large are profound:

- Each year in the United States, more than 6 million referrals are made to the child welfare system and more than 600,000 of these children are determined to be substantiated victims of abuse or neglect.

- Among children in the child welfare system, 85% have been exposed to at least one potentially traumatic event and most have experienced multiple forms of trauma.

- Children exposed to trauma experience significantly higher rates of chronic health and mental health problems, impaired academic performance, and involvement with juvenile justice and adult criminal justice systems.

- The costs to society of children maltreated in a single year are $124 billion in future health care and social service costs.

Trauma-Informed Care Leads to Cost Savings and Better Outcomes for Children

As policymakers and providers have gained a better understanding of the adverse effects of

trauma exposure and the benefits of treatment, there has been increasing support across child serving systems in Connecticut and nationally for early identification, intervention, and development of sustainable systems that incorporate a trauma-informed approach. The goal of a trauma-informed approach, also referred to as "trauma-informed care," is to enhance systems to better understand, identify, and serve children exposed to trauma through prevention, training, screening, policy development, and access to evidence-based interventions.

Connecticut's Approach to Addressing Trauma

The Connecticut Department of Children and Families (DCF) was one of the first child welfare agencies in the country to incorporate trauma-informed care as a core strategy. In 2007, CHDI and DCF co-hosted the Connecticut Trauma Summit and disseminated Trauma-Focused-Cognitive Behavioral Therapy to 16 community-based agencies. Shortly after, DCF successfully applied for federal funding to transform the child welfare system to be trauma-informed. In 2011, the federal government awarded DCF with a $3.2 million grant, which ended in 2018, to develop the Connecticut Collaborative on Effective Practices for Trauma (CONCEPT). Support for CONCEPT was provided by the Department of Health and Human Services, Administration for Children and Families, Children's Bureau, Grant #90CO1069. Partners included DCF, the Child Health and Development Institute (which served as the Coordinating Center), and The Consultation Center at Yale University (which served as the CONCEPT evaluator). The CONCEPT initiative has advanced four core components of a trauma-informed child welfare system:

1. **Workforce development:** More than 3,100 DCF staff members have received comprehensive training in childhood trauma using the National Child Traumatic Stress Network's (NCTSN) Child Welfare Trauma Training Toolkit. Training evaluations demonstrate significant improvements in DCF staff knowledge and practices

concerning trauma. The training has now become required training for all new hires.

2. **Trauma screening:** All children aged 3 and older who are placed into DCF care are now screened for trauma with the Child Trauma Screen (CTS). The CTS is an empirically supported 10-item screen that assesses trauma exposure and symptoms and can be administered by professionals in child welfare, juvenile justice, health, education, and behavioral health systems. More than 6,000 children, including 1,925 in child welfare, were screened through 2018 and referrals for specialty trauma-focused services are being made.

3. **Dissemination of evidence-based treatments:** CONCEPT has helped to support training of more than 30 agencies and more than 800 clinicians to offer Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) and the Child and Family Traumatic Stress Intervention (CFTSI). These models add to the availability of trauma-focused evidence-based treatments in the state including Modular Approach to Therapy for Children with Anxiety, Depression, Trauma, and Conduct Problems (MATCH-ADTC), Cognitive Behavioral Intervention for Trauma in Schools (CBITS), and Attachment, Regulation, and Competency (ARC). More than 13,000 children across Connecticut have received these treatments, including many involved in the child welfare system. Evaluation outcomes indicate significant reductions in symptoms of posttraumatic stress and depression.

4. **Trauma-informed policy:** The CONCEPT initiative has contributed to modifications of 37 DCF policies and practice guides to better address childhood trauma. For example, policies related to immigrant children, foster and adoptive services, and transgender youth and caregivers have been revised to ensure that DCF caseworkers consider children's exposure to trauma and how it may affect their current functioning.

Recommendations for Advancing a Trauma-Informed Child Welfare System

Through CONCEPT, Connecticut has improved outcomes for children exposed to trauma by leading enhancements in the areas of workforce development, screening, evidence-based treatments, and policy changes. Recommendations for furthering a trauma-informed approach in the child welfare system include:

- Expand collaboration between the child welfare, behavioral health, education, pediatrics, early care and eduation, juvenile justice, and other child-serving systems through cross-training and alignment of case plans, services, and data systems to move towards a statewide trauma-informed child health system. Existing statewide committees and workgroups focused on children's health and behavioral health could be used to advance these recommendations.

- Incorporate assessments of a trauma-informed approach, achievable goals, and action steps into strategic planning for DCF and other state agencies.

- Expand trauma screening to enhance early access to services for all children, including children involved with the child welfare system who are not placed out-of-home, as well as for children who are not involved in the child welfare system (e.g., schools and primary care settings).

- Advance policy and reimbursement strategies that support dissemination and sustainability of evidence-based treatments, including models specifically designed for children under age 6.

- Support research to better understand the effects of a trauma informed approach on child and family outcomes.

Connecticut's success in creating a trauma-informed child welfare system has spurred additional efforts across other child-serving systems including children's mental health, early care and education, home visiting, education, juvenile justice, and health care. Efforts to implement a trauma-informed approach, as well as share trauma-focused services across these systems, have benefited from DCF's leadership and the experiences and lessons learned through CONCEPT.

For more information, visit www.chdi.org, read CHDI's IMPACT: Advancing Trauma-Informed Systems for Children, download the CONCEPT infographic, or contact Jason Lang (jalang@uchc.edu, 860-679-1550). Visit CHDI's Evidence-Based Practice Directory to find sites offering some of the evidence-based practices available in Connecticut.

Juvenile Justice and Family Court

ACEs in the Criminal Justice System

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FOR MORE THAN 20 years I have served as a psychological expert witness in murder cases across the United States. Many of these have been "death penalty" cases, but increasingly they have been resentencing hearings for adults who were given automatic life without the possibility of parole sentences for murders committed when they were juveniles. These resentencing hearings resulted from the US Supreme Court's decisions in Miller v Alabama and Montgomery v Alabama that such sentences are unconstitutional and that this decision must be applied retroactively to the ≥2500 individuals that make up this class of inmates.

It should not come as a surprise that childhood adversity is common and prominent among individuals who kill people. Childhood adversity leads to trauma and toxic stress, and trauma and toxic stress lead to the kind of developmental damage that in turn can lead to violence (as one among many outcomes, or other outcomes such as substance abuse and mental health that could similarly have repercussions for incarceration either as juveniles or adults) in the United States. Over the past 20 years I have sat with more than 100 killers, many of them adolescents or young adults at the time they committed murder.[1] I ask questions. I listen to their stories. I read the records in the files that document their lives. And, I ask them the 10 adverse childhood experiences (ACEs) questions. Low scores are the exception; high scores are the rule.

I have come away from these experiences with the conviction that the best starting hypothesis in dealing with most killers is that they are "untreated traumatized children inhabiting and controlling the dangerous adolescents and adults that stand accused of murder." Approximately only 0.01% of Americans (1 in 1000) report an ACEs score of 8, 9, or 10.[2] The scores reported by the last 10 killers I interviewed had an average score of 8.

Acknowledging that the cases on which I am asked to consult might well not be a random sample, these cases do affirm that the accumulation of childhood adversity is linked to criminal violence. Thus, the entire criminal justice system should be built upon a "trauma-informed" approach to understanding and responding to violent behavior. How does this relate to the national agenda? What does it tell us about intervention policies and programs?

There are at least 3 ways in which recognizing the high prevalence of ACEs in the criminal justice system and the model underlying this approach suggests policy and practice recommendations for the criminal justice system. First, it grounds the discussions of "justice" in a developmental framework, and can move judicial consciousness to a more valid perspective on the concept of "choice." It is one thing to say a killer has made "bad choices" (which is the foundation for the entire criminal justice system). But do the 10 ACEs items really represent "bad choices" on the part of a child? Do children "choose" to accumulate the risk factors, trauma, and toxic stress assessed by the 10 ACEs questions—for example, to have separated or divorced parents, substance-abusing parents, suicidal parents, parents with mental health problems, or to be sexually or physically abused, to witness domestic violence or be emotionally neglected, or to have a parent or sibling go to prison? The answer is a resounding "no," and establishing this developmental context before any evaluation of individual culpability should be a requirement at every point in an individual's path through the criminal justice system.

Second, using the ACEs scores helps to ground the entire courtroom discussion in social reality, and dispel gratuitous comparisons or mythical understandings of what is needed in sentencing. All too often, a prosecutor will attempt to dismiss the relevance of a defendant's history of adversity and toxic stress with word to the effect of "lots of kids have bad childhoods; what's wrong with this guy?" But if "this guy" has an ACEs score of 8, 9, or 10 he did not just have a generically "bad childhood." He had a childhood worse than 999 of 1000 people in America! Indeed, it constitutes a compelling "mitigating factor" in a sentencing decision. In some states (eg, Florida) judicial training materials now include an emphasis on understanding the implications of emergent ACEs research for just this reason.

Third, focusing on the accumulation of childhood adversity grounds the criminal justice system in developmental psychology and public health. The fact that the ACEs score accounts for 65% of the variation in suicide attempts, 55% of the variation in substance abuse, 45% of the variation in depression, and 30% of the variation in violent behavior makes clear the developmental relevance of adversity and toxic stress.[3] More importantly, it dictates that the court should adopt a "trauma-informed" perspective in sentencing decisions.

Juveniles particularly must first be given access to trauma-informed therapeutic interventions before any long-term decisions concerning their fate are made.

Sentencing juvenile murderers to life without the possibility of parole is an affront to the state of the art in developmental science. The severity of a juvenile's crime does not correlate necessarily with their prognosis for rehabilitation and transformation in the years that follow adolescence. The immaturity of the adolescent brain and the malleability of adult brains alone is grounds for keeping the possibility of opening a door to release in the adulthood that follows after a murder is committed by a teenager.

The developmental pathways of many adults being resentenced under the Miller and Montgomery decisions by the US Supreme Court demonstrated the truth of this assertion. The terrible nature of the crimes these individuals committed as adolescents, in some cases decades ago, belied the fact that they could and in many cases did go on to become exemplary human beings. My preliminary hypothesis about these individuals is that access to therapeutic intervention and a subsequent spiritual transformation in the years after they were incarcerated led to their remarkable "recovery" as they matured. This hypothesis demands systematic research so that the policies and practices of the criminal justice system can be brought into line with the core principles of a "trauma-informed" response to the developmental effect of childhood accumulation of adversity, trauma, and toxic stress.

ACKNOWLEDGMENT

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Helping Traumatized Children: Tips for Judges

A majority of children involved in the juvenile justice system have a history of trauma.[1] Children and adolescents who come into the court system frequently have experienced not only chronic abuse and neglect, but also exposure to substance abuse, domestic violence, and community violence.[2]

The psychological, emotional, and behavioral consequences of these experiences can be profound, but may go unrecognized if judges and related personnel do not delve more deeply into the backgrounds of children and adolescents who come before the court.[2,3] By understanding the impact of trauma on children's development, beliefs, and behaviors, judges can become more effective in addressing the unique needs and challenges of traumatized children and adolescents involved in the juvenile and family court system.

Effects of Trauma on Children and Adolescents

Child abuse and neglect have been shown to adversely affect the growth of the brain, nervous, and endocrine systems and to impair many aspects of psychosocial development, including the acquisition of social skills, emotional regulation, and respect for societal institutions and mores.[4] Although a significant proportion of traumatized children seen in court meet the diagnostic criteria for posttraumatic stress disorder (PTSD),[5,6] many others suffer from traumatic stress responses that do not meet the clinical definition of PTSD. Traumatic stress may manifest differently in children of different ages. **Table 1** lists some of the most common traumatic stress reactions seen in children of various ages.

Table 1. Child Traumatic Stress Reactions (By Age Group)	
Age Group	**Common Traumatic Stress Reactions**
Young children (Birth–5 y)	▪ Withdrawal and passivity ▪ Exaggerated startle response ▪ Aggressive outbursts ▪ Sleep difficulties (including night terrors) ▪ Separation anxiety ▪ Fear of new situations ▪ Difficulty assessing threats and finding protection (especially in cases where a parent or caretaker was aggressor) ▪ Regression to previous behaviors (e.g., baby talk, bed-wetting, crying)
School-age children (6–12 y)	▪ Abrupt and unpredictable shifts between withdrawn and aggressive behaviors ▪ Social isolation and withdrawal (may be an attempt to avoid further trauma or reminders of past trauma) ▪ Sleep disturbances that interfere with daytime concentration and attention ▪ Preoccupation with the traumatic experience(s) ▪ Intense, specific fears related to the traumatic event(s)
Adolescents (13–18 y)	▪ Increased risk taking (substance abuse, truancy, risky sexual behaviors) ▪ Heightened sensitivity to perceived threats (may respond to seemingly neutral stimuli with aggression or hostility) ▪ Social isolation (belief that they are unique and alone in their pain) ▪ Withdrawal and emotional numbing ▪ Low self esteem (may manifest as a sense of helplessness or hopelessness)

Assessing the Effects of Trauma

Formal trauma assessment is critical to identifying children and adolescents in the courtroom who are suffering from traumatic stress.[2,3] Well-validated trauma screening tools include:

- UCLA PTSD Reaction Index[7]

- Trauma Symptom Checklist for Children (TSCC)[8]

- Trauma Symptom Checklist for Young Children (TSCYC)[9, 10]

- Child Sexual Behavior Inventory[11, 12]

Judges should use professionals experienced in administering and interpreting these assessments to make recommendations to the court.

In Stark County, the court now understands that when children have been affected by trauma, they are "stuck" in a hypervigilant response. Being constantly on alert to danger decreases the ability of a youth to study and learn. . . They lose their temper and fight with little or no provocation.

For years our court treated these cases as "bad behavior" and "lack of self control." It is only in the last several years that we, as a court, have educated ourselves about trauma. As a result, we now know that it is important to ask about trauma. Indeed, we often discover a history of trauma that has gone undetected, despite attempts to help the child through traditional counseling services.[3]

Judge Michael L. Howard & Robin R. Tener, PhD.

Choosing Appropriate Service Providers

When referring traumatized children and families for care, courts have the unique opportunity to choose practitioners or agencies that understand the impact of trauma on children and can provide evidence-based treatment appropriate to the child's needs.[2]

While treatment needs to be individualized depending on the nature of the trauma a child has experienced, clinicians should use treatments that have clinical research supporting their use. Evidence-based treatment practices are those that have been rigorously studied and found to be effective in treating child or adolescent trauma. Information on specific evidence-based treatments for child traumatic stress is available from:

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

- The National Child Traumatic Stress Network–
  Empirically Supported Treatments And Promising Practices
  (http://www.nctsnet.org/nccts/nav.do?pid=ctr_top_trmnt_prom)

- The National Crime Victims Research and Treatment Center–
  Child Physical and Sexual Abuse: Guidelines for Treatment
  (http://academicdepartments.musc.edu/ncvc/resources_prof/OVC_guidelines04-26-04.pdf)

Judges may want to develop a list of community providers who have training and experience in delivering evidence-based trauma practices. If the community lacks trained trauma professionals, creating an advisory group that can increase community awareness of evidence-based practices and necessary training requirements might be helpful. It is important to remember that trauma treatment may need to be combined with treatment for other conditions as well, such as substance abuse or learning disabilities. By becoming trauma-informed and encouraging the development and mobilization of trauma-focused interventions, judges can "make the difference between recovery and continued struggle"[3] for traumatized youth and their families.

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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.

> 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.

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)

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[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.*

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.

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[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.

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[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.

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?

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.**

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[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 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)

- 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?

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[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 (TI-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. TI-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

What Is a 'Trauma-Informed' Juvenile Justice System? A TARGETed Approach

By **Dr. Julian Ford** | June 20, 2016

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Adolescence is a time of great opportunity, but also turmoil. As many as two-thirds of all teens face the additional challenge of coping with traumatic events such as life-threatening accidents, injuries, illness, disaster, or violence or sexual or emotional abuse and exploitation. That figure rises to closer to 100 percent for those who live in families or communities in which violence, poverty, neglect, racism or discrimination based on gender, gender identity or disability are prevalent.

Not surprisingly, 90-plus percent of youths involved in juvenile justice have experienced at least one (and typically several) of these traumatic stressors, and as many as 25 to 33 percent of these youth (compared to 5 percent in community samples) have developed post-traumatic stress disorder (PTSD).

Youth in the juvenile justice system often have been exposed not only to multiple types of interpersonal victimization — polyvictimization — but also to other childhood adversities (such as separation from or impaired relationships with biological parents and family). In total, this more than doubles the number of traumatized youth in juvenile justice programs (i.e., 67 to 75 percent) who need effective services in order to recover from not only PTSD but also for a wide range of related emotional, developmental, academic and behavioral problems (such as substance use, attention deficit, oppositional-defiant, affective, anxiety, dissociative, sexual, sleep and eating disorders, suicidality self-harm and exploitation [e.g., sexual trafficking]).

For more information, visit the JJIE Resource Hub

These stark facts have led to a national (and international) call to action in the past decade for juvenile justice systems to become "trauma-informed." The 2012 report of the U.S. Attorney General's Task Force on Children Exposed to Violence identified nine practical steps based on the experience of experts in law enforcement, the judiciary, juvenile justice services, child protective services, racial and ethnic disparities, and traumatic stress. This was done under the leadership of Robert Listenbee, the administrator of the Office of Juvenile Justice and Delinquency Prevention:

1. Make trauma-informed screening, assessment and care the standard in juvenile justice services.

2. Abandon juvenile justice correctional practices that traumatize children and further reduce their opportunities to become productive members of society.

3. Provide juvenile justice services appropriate to children's ethnocultural background that are based on an assessment of each violence-exposed child's individual needs.

4. Provide care and services to address the special circumstances and needs of girls.

5. Provide care and services to address the special circumstances and needs of LGBTQ (lesbian/gay/bisexual/transsexual/questioning) youth.

6. Develop and implement policies in every school system across the country that aim to keep children in school rather than relying on policies that lead to suspension and expulsion and ultimately drive children into the juvenile justice system.

7. Guarantee that all violence-exposed children accused of a crime have legal representation.

8. Help, do not punish, child victims of sex trafficking.

9. Whenever possible, prosecute young offenders in the juvenile justice system instead of transferring their cases to adult courts.

The first recommendation speaks to the goal of not letting traumatized youth fall between cracks, instead identifying them and then providing them with services that actually help them to recover from chronic post-traumatic stress problems. Rather than treating traumatized youth as either irredeemably antisocial (and therefore warranting more restrictive sentences and confinement) or mentally deformed (and thus requiring psychiatric behavior management-oriented treatment), a less stigmatizing and potentially more effective approach is to provide evidence-based treatment or services designed to help them to overcome traumatic stress reactions.

That is the goal of TARGET (Trauma Affect Regulation: Guide for Education and Therapy), a multisession gender-specific ethnoculturally adapted intervention for traumatized youth (and adults) that can be done as a one-to-one, group, family or milieu therapy, and/or as a training on emotion regulation skills for juvenile justice staff to use on a 24-hour, seven-day-a-week basis in community or congregate justice programs.

TARGET begins with psychoeducation that explains PTSD as a survival adaptation by the brain's stress response system that makes sense but becomes a problem when the brain's amygdala (the "alarm") becomes stuck in survival mode and hijacks the hippocampus (the "memory filing center") and the prefrontal cortex ("thinking center") and body.

Overcoming traumatic stress reactions therefore means learning how to reset the brain's alarm so that it provides helpful alerts but isn't stuck in survival mode. TARGET then teaches a seven-

step sequence of emotion and behavioral self-regulation skills that accomplish the goal of resetting the alarm, summarized by an acronym, FREEDOM.

Two skills, Focusing and Recognizing triggers, enable the youth (or adult) to activate the brain's thinking and filing centers in order to think before reacting. The next four skills differentiate Emotions, Evaluative cognitions, Deliberate goals and Options for action, based on whether they are simply alarm messages or a team effort of the thinking, filing and alarm centers. A final skill, Making a contribution, helps youths (and adults) recognize that being able to handle stress reactions in a self-regulated manner makes them more effective in achieving their personal goals.

By providing practical knowledge that is interesting and useful for adolescents (and for adult staff, administrators, advocates and family members) TARGET provides a basis for truly collaborative and trauma-informed juvenile justice supervisory, rehabilitative and therapeutic services. With TARGET, everyone teams up to take on the challenge of thinking clearly and making choices that reflect their goals and values rather than impulsive or expedient reactions to stress.

This is a crucial paradigm shift that honors both youth's and adult/system's perspectives while calling upon all participants to take responsibility for mindfully handling stress reactions. In so doing, it enables the adults to demonstrate good faith by walking the walk (i.e., managing their own stress reactions just as they want the youths to manage theirs) without stigmatizing anyone (youth or adults) for having expectable (albeit not always adaptive) stress reactions.

TARGET is not a panacea, nor a replacement for other empirically supported approaches to traumatic stress treatment (and cognitive and behavioral rehabilitation) for traumatized youth in the juvenile justice system. It is an evidence-based clinical therapy and also a template for making traumatic stress understandable, transparent and manageable for youth and adults. As such it fosters communication and collaboration among law enforcement officers, program staff and administrators, treatment providers and the youth and family.

TARGET's goal is to enable youth and adults to recognize and responsibly handle stress reactions that may be due to trauma (for youths, and for adults who have trauma histories of their own) or to the expectable challenges of working in correctional/justice programs with youth who are dysregulated and in some cases capable of posing a threat to the adults' safety. This is the core goal of trauma-informed systems/services, to enable everyone — traumatized youth, their families, adults responsible for public safety and entire communities — to become safer and more effective.

The second recommendation speaks to the credo for all healing professions and services, "first do no harm." It, and the more specific recommendations that follow, are a call to stop or radically limit correctional practices that further traumatize youth, such as physical restraints, isolation and shackling.

Even when done in a manner that protects the youth's physical safety, these practices can activate post-traumatic survival fears and reactions that are psychologically harmful to the youth. They may also actually compromise the safety of law enforcement and juvenile program staff when the youth's survival reactions include fighting back against perceived victimizers. They also undermine the rehabilitative mission (pages 31-49) that has been at the core of Juvenile Courts since their origins more than a century ago.

However, balancing the goal of protecting youth and enhancing their productive participation in society with the other core juvenile justice goal of maintaining public safety and order is exceptionally difficult with youth who tend to be alienated, distrustful and prone to act either impulsively or strategically without due regard for the law and the values underlying the social contract (such as justice, fairness, respect for individual differences), as well as their own or others' safety.

Further complicating the picture, these youths often are reacting to current challenges based on alarm reactions and survival tactics learned from coping with traumatic violence or victimization in their own lives, and historically, as a result of their race, ethnicity, gender, gender identity, and problems with learning and discipline in school and family.

Therefore, it is essential that trauma-informed reforms go beyond simply acknowledging that many justice-involved youth have been traumatized, and provide practical skills that adults and youths together can use to prevent further traumatization of youths and of the adults who work with or supervise them, as is done by the TARGET program.

Within the National Child Traumatic Stress Network, I am privileged to direct the Center for Trauma Recovery and Juvenile Justice, which has partnered with several national organizations to champion the cause of trauma-informed reforms in juvenile justice. These organizations include the Center for Children's Law and Poverty, the Center for Juvenile Justice Reform, the Council of Juvenile Correctional Administrators, Equal Justice Initiative, Futures without Violence, the Juvenile Law Center, the National Center for Mental Health and Juvenile Justice, the National Center for Youth Law, the National Council of Juvenile and Family Court Judges, the National Juvenile Defender Center and the National Juvenile Justice Prosecution Center.

Our ongoing partnerships have resulted in several resources for those who seek to achieve trauma-informed juvenile justice systems, including the Essential Elements of a Trauma-Informed Juvenile Justice System, fact sheets on evidence-based practices and tools for identifying and treating traumatized youth, including girls and youth and families of ethnoracial minority backgrounds in the juvenile justice system, and webinars describing practical goals and guidelines.

Julian Ford is a clinical psychologist, professor of psychiatry and law at the University of Connecticut, director of the Center for Trauma Recovery and Juvenile Justice in the National

Child Traumatic Stress Network and co-founder and co-owner of Advanced Trauma Solutions, Inc., the sole licensed distributor of the TARGET intervention by the copyright holder, the University of Connecticut. He has been working for more than a decade with juvenile courts, diversion, probation, detention, and secure facilities to empower staff and administrators, and to assist youth and families with trauma-informed approaches to adjudication and services.

NCTSN The National Child Traumatic Stress Network

Published on *The National Child Traumatic Stress Network* (https://www.nctsn.org)

More than 80% of juvenile justice-involved youth report experiencing trauma, with many having experienced multiple, chronic, and pervasive interpersonal traumas. This exposure places them at risk for emotional, behavioral, developmental, and legal problems. Unresolved posttraumatic stress symptoms can lead to serious long-term consequences across the entire lifespan, such as problems with interpersonal relationships; cognitive functioning; and mental health disorders including PTSD, substance abuse, anxiety, disordered eating, depression, self-injury, and conduct problems—all of which can increase the likelihood of involvement in delinquency, crime, and the justice system. The prevalence and severity of traumatic stress reactions among juvenile justice-involved youth, caregivers, families, professionals, and providers, necessitates a system-wide response to prevent, identify, address, and minimize further traumatic stress.

The following represent the Essential Elements of a Trauma-Informed Juvenile Justice System:

Essential Elements of a Trauma-Informed Juvenile Justice System

1. Trauma-informed policies and procedures
2. Identification and screening of youth who have been traumatized
3. Clinical assessment and intervention for trauma-impaired youth
4. Trauma-informed programming and staff education
5. Prevention and management of secondary traumatic stress (STS)
6. Trauma-informed partnering with youth and families
7. Trauma-informed cross system collaboration
8. Trauma-informed approaches to address disparities and diversity

Printer-friendly version [1]

Source URL: https://www.nctsn.org/trauma-informed-care/trauma-informed-systems/justice/essential-elements

Links
[1] https://www.nctsn.org/print/871

Mental Health

A Recovery Bill of Rights for Trauma Survivors

By **Thomas V. Maguire, Ph.D.**

BY VIRTUE OF YOUR PERSONAL AUTHORITY YOU HAVE THE RIGHT TO...

Manage your life according to your own values and judgment.

Direct your recovery, answerable to no one for your goals or progress.

Gather information to make intelligent decisions about your recovery.

Seek help from many sources, unhindered by demands for exclusivity.

Decline help from anyone without having to justify the decision.

Believe in your ability to heal and seek allies who share your faith.

Trust allies in healing so far as one human can trust another.

Be afraid and avoid what frightens you.

Decide for yourself whether, when, and where to confront fear.

Learn by experimenting, that is, make mistakes.

TO GUARD YOUR PERSONAL BOUNDARIES YOU HAVE THE RIGHT TO...

Speak or remain silent, about any topic and at any time, as you wish.

Ask for help in healing, without having to accept help with everything.

Choose to accept or decline feedback, suggestions, or interpretations.

Be touched only with, and within the limits of, your consent.

Take action to stop a trespass that does not cease when challenged.

Challenge any crossing of your boundaries.
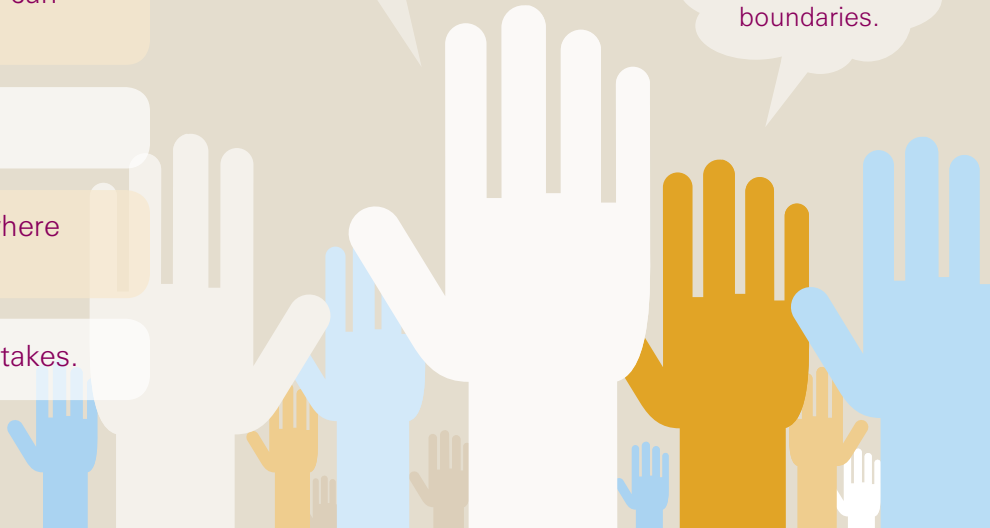
FOR THE INTEGRITY OF YOUR PERSONAL COMMUNICATION YOU HAVE THE RIGHT TO...

Ask for explanation of communications you do not understand.

Express a contrary view when you do understand and you disagree.

Acknowledge your feelings, without having to justify them.

Ask for changes when your needs are not being met.

Speak of your experience, without apology for your uncertainties.

Resolve doubt without deferring to the views or wishes of anyone.

FOR SAFETY IN YOUR PERSONAL DEPENDENCY IN THERAPY YOU HAVE THE RIGHT TO...

Hire a therapist or counselor as coach, not boss, of your recovery.

Receive expert and faithful assistance in healing from your therapist.

Know that your therapist will never have any other relationship with you— business, social, or sexual.

Be secure against any disclosure by your therapist, except with your consent or under court order.

Hold your therapist's undivided loyalty in relation to all abusers.

Obtain informative answers to questions about your condition, your therapist's qualifications, and any proposed treatment.

Have your safety given priority by your therapist, to the point of readiness to use all lawful means to neutralize an imminent threat to your life or that of someone else.

Receive a commitment from your therapist that is not conditional on your "good behavior" (habitual crime and endangerment excepted).

Make clear and reliable agreements about the times of sessions and of your therapist's availability.

Telephone your therapist between scheduled sessions, in urgent need, and receive a return call within a reasonable time.

Be taught skills that lessen the risk of re-traumatization:

- containment (boundaries for recovery work);
- control of attention and mental imagery;
- systematic relaxation.

Enjoy reasonable physical comfort during sessions.

NATIONAL COUNCIL
FOR COMMUNITY BEHAVIORAL HEALTHCARE

National Child Traumatic Stress Network Position Statement:
Prerequisite Clinical Competencies for Implementing Effective, Trauma-informed Intervention

The dissemination of standardized, effective, trauma-informed clinical interventions is a central means by which the NCTSN seeks to advance the standard of care for traumatized children and to increase the nation's capacity to meet the needs of these children. The safe and effective implementation of these interventions requires proficiency in several basic areas of clinical competency. This position statement contains the NCTSN consensus regarding the clinical competencies that must, at minimum, be present before a provider can be trained to effectively deliver an NCTSN-endorsed trauma-informed intervention.

Agencies seeking to implement these interventions should have processes in place to (1) ensure that certain clinical competencies are present before providers receive training in an NCTSN endorsed trauma-informed intervention, and (2) monitor the implementation of these competencies during the course of care.

The NCTSN regards the following as the foundation for competency in any clinical intervention disseminated through the NCTSN:

1. **Basic Assessment**: The clinician can efficiently and accurately gather the relevant clinical information to determine the appropriate problem(s) to be addressed in treatment and the various factors that may facilitate or impede a child's likelihood to benefit from treatment. This assessment includes identifying the ability of caregivers—and others in the child's environment—to support the child's specific needs.

2. **Risk Assessment**: The clinician can efficiently and accurately gather clinical information to determine (a) a child's likelihood to harm him or herself and/or others, (b) a child's likelihood to be harmed by others, and (c) the ability of caregivers—and others in the child's environment—to protect the child given his or her level of risk; the clinician has the knowledge and experience to use all this information to preserve safety.

3. **Case Conceptualization**: The clinician can integrate the assessment information to form an understanding of the child's key problems and strengths, including the developmental and sociocultural factors of race, ethnicity, culture, socioeconomic status, gender identity and expression, immigration status, and spirituality that may affect intervention.

4. **Treatment Planning**: The clinician can use the case conceptualization to determine treatment goals, selecting the most effective and feasible clinical approaches to address the child's identified clinical problems, including the referral to appropriate providers.

5. **Treatment Engagement**: The clinician can form a working alliance with the child and his or her family based on a treatment plan to address a set of problems that are meaningful to the child/family.

6. **Treatment Implementation**: The clinician can consistently deliver a course of treatment based on a defined treatment plan to meet the identified goals and objectives.

7. **Treatment Quality Monitoring**: The clinician can appraise progress and outcomes of treatment based on objective information and can adjust the treatment approach as needed to meet treatment goals.

Putting the Pieces Together: Janina Fisher's perspective on the history of trauma treatment

Janina Fisher, Ph.D. • 6/5/2015 •

*The following is an excerpt by **Janina Fisher, Ph.D.***

In 1989, trauma was still defined as "an event outside the range of normal human experience." As descendants of Freud, we believed that the therapist's role was to remain neutral and say as little as possible, often using the question, "How do you feel about that?"

By the early 1990s, however, *The Courage to Heal*, a self-help book by Ellen Bass and Laura Davis, introduced the main task of trauma work as retrieving the missing pieces of the abuse narrative and encouraging victims to confront their perpetrators with "their truth."

I was troubled by what the *The Courage to Heal* model required of my clients. At the hospital where I worked, we were seeing some dangerous effects of this approach. Many clients became overwhelmed by the flood of memories that came once Pandora's box was opened, and others began to doubt themselves when they couldn't access memories. Worse yet, family confrontations frequently ended in retraumatization for the victim. Rather than finding support, our clients often found themselves becoming family outcasts.

During this paradigm shift in the trauma-treatment world, Judith Herman, who'd published *Father-Daughter Incest* in 1980, was convinced that there was something deeply amiss and destabilizing about the confrontational tactics recommended by Bass and Davis. She believed that good trauma treatment required delaying the focus on traumatic memories until survivors felt safe in their daily lives and had sufficient affect regulation to tolerate the stress of remembering dark episodes in their histories.

Herman believed that therapists must become educators, providing information that made sense of the client's symptoms and helping them understand their intense reactions as survival adaptations to a dangerous and coercive childhood environment.

Just how revolutionary the idea of stabilization was in the early 1990s is illustrated by my meeting with a young client named Ariana. Despite a long history of childhood sexual abuse and many attempts to get help, she hadn't been able to tolerate therapy for more than a few months. "What told you in each of your experiences with therapy that it was time to leave?" I asked.

"Either the therapists wanted to make me cry-or they wanted to move in for the kill when they say, 'Next week, we can begin to address the trauma.'"

She's right, I thought. In those days, most trauma therapists would've wanted a client like Ariana to cry as evidence that she was "in touch" with her emotions.

It seemed to me, however, that stabilization gave clients their lives back, offered them a meaningful present as an alternative to reliving the past, and was invaluable in their learning to tolerate their often volatile emotions.

Busting the Monopoly of Talk Therapy
Neuroscience was brought into the field of trauma by psychiatrist **Bessel van der Kolk**. His curiosity and crusading spirit led him to explore trauma in ways that more cognitively focused researchers tended to ignore.

When I started working on van der Kolk's clinical team in 1996, he'd been arguing for years that traumatic memory included not just images and narratives, but also intrusive emotions, sensory phenomena, autonomic arousal, and physical actions and reactions. In 1994, when his paper *The Body Keeps the Score* was published in the American Journal of Psychiatry, the message that trauma often lives non-verbally in the body and brain was a source of tremendous discomfort in a field that didn't yet recognize body-based treatments as reputable. However, the advent of brain-scan technology allowed him to conduct the research needed to support his arguments. His findings laid the groundwork for an alliance between traumatologists and neurobiologists, one that challenged the reign of talk therapy.

In van der Kolk's 1994 study, 10 subjects volunteered to remember a traumatic event while undergoing a PET scan of their brain. As they began to recall these events, the cortical areas associated with narrative memory and verbal expression became inactive or inhibited, and instead there was increased activation of the right hemisphere amygdala, a tiny structure in the limbic system thought to be associated with storage of emotional memories without words. These volunteers had begun the scan with a memory they could put into words, but they quickly lost their ability to put language to their intense emotions, body sensations, and movements.

Retraumatization now made sense: if we purposefully or inadvertently trigger old traumatic responses, brain areas responsible for witnessing and verbalizing experience decrease activity or shut down, and the events are reexperienced in body sensations, impulses, images, and intense emotions without words.

This changes everything. Accustomed to using words as the primary treatment tool, talk therapists had to find other approaches, ones that weren't so dependent on language and narrative and could therefore address the brain and body shutdown demonstrated in van der Kolk's study.

Van der Kolk has been instrumental in bringing greater visibility and credibility to nontalk treatments. **EMDR**, in particular, expanded our notions of what constitutes effective psychotherapy in those early

years.
Developed and extensively researched by psychologist Francine Shapiro in the late 1980s, it uses bilateral stimulation to help clients process traumatic experiences. However, because of EMDR's unconventional, finger-waving method and a lack of support from other researchers at the time, it seemed more snake oil than legitimate therapy to many skeptics in the field.

But by the early 2000s, news of EMDR's success was commonly being noted in popular newspapers and magazines in print and online. EMDR spurred another revolution for therapists. It suddenly seemed like a logical next step to learn other approaches that involved something more than sitting in a chair, listening, and talking.

How Neuroscience Changed Psychotherapy
With the publication of works such as Allan Schore's *Affect Regulation and the Origin of the Self* in 1994, Joseph LeDoux's *The Emotional Brain* in 1996, and Daniel Siegel's **The Developing Mind** in 1999, the world of science began to inspire new growth in psychotherapy. Each argued that not just social-emotional development, but the slowly maturing brain and nervous system, could be dramatically and perhaps permanently affected by early attachment relationships, neglect, and trauma.

The case of Jessie illustrates my own education into how neuroscience came to guide more and more of my clinical work. Jessie's long history of suicide attempts, hospitalizations, and dramatic deteriorations in functioning challenged everything I thought I knew about treating trauma up to this point.
As I pieced together sessions of contradictory conversations, I realized that although she may not consistently have remembered being traumatized, her body and nervous system were constantly being activated by the simple challenge of maintaining a consistent sense of selfhood from day to day.

According to LeDoux, Jessie's amygdala-the part of the brain that scans for danger and initiates the stress-response system-had undoubtedly become irritable in the context of growing up with a frightening mother, a nonprotective father, and equally helpless siblings. Schore's work helped me think about Jessie's suicidality as a problem in affect regulation, rather than a wish to die. With a dysregulated nervous system and a coping toolbox limited by her childhood, her ability to soothe and regulate emotions was minimal. The affect associated with even acknowledging her traumatic experiences dysregulated her nervous system and set off false alarms in her amygdala, shutting down or hyperactivating autonomic arousal, and interfering with her ability to self-observe and think clearly.

My reading of Schore encouraged me to become more of a right-brain-to-right-brain interactive neurobiological regulator. Instead of using words, logic, or interpretation of the connections between emotions and triggers, I'd base my response on her response.

I concentrated on just two goals: not activating her amygdala in session and using my voice and body language to soothe and regulate her nervous system. That year, she made no suicide attempts and was more stable in sessions.

The Contribution of Somatic Psychotherapy
In 1999, van der Kolk's motto became "Go to the body!" Personally, I resisted undergoing any body-centered psychotherapy training.

In spite of myself, I signed up for Pat Ogden's training on sensorimotor psychotherapy after watching videotapes of her help clients resolve trauma. Slowly, I came to understand that a body-centered psychotherapy was less about touch and more about how to work effectively and sensitively with emotions and cognitive schemas.

This new understanding enhanced my work with Jessie. I chuckled when she said she had nothing to talk about, and I went on to ask her, "When you say, 'I have nothing to talk about' what happens inside? Do you feel more open or closed? Do you pull back a little? Shut down?"

"It's more like a wall all the way down my front," she said.

"And is it a familiar feeling?" I continued gently.

"Oh, yes! I get it with anyone who gets close to me. When I'm wishing to get to know them or wanting them to like me, it's not there. But when they get closer, when they want something from me, the wall goes up."

"How clever!" I said. "So your body created the wall to protect you from people who want things. That's brilliant! Let's just be curious about how it works, how your body knows when people want things." I noticed that as I reframed the wall as a helpful tool, she looked more relaxed-and eager to keep talking. She was no longer that person who had "nothing to talk about."

The Mindfulness Revolution
Mindfulness is inherently about relationships: how we relate to our bodies, beliefs, and emotions. In contrast, the hallmark of PTSD is being trapped in the past. While the neuroscientific world gave us the beginning of a science-based explanation for understanding PTSD, mindfulness offers a way for clients to change their relationship to the darkness of their pasts.

I now ask clients to avoid their usual habits of attachment or aversion and discover how to build new habits of nonjudgment, which, with sufficient repetition, evolve into increasing self-compassion, or at least neutrality. In this way, the mindfulness movement has been a practical extension of the neuroscience

revolution, which has shown us that mindful concentration activates the medial prefrontal cortex and decreases activity in the amygdala-which, in turn, eases regulation of the autonomic nervous system.

Helping clients heighten curiosity and interest while not automatically descending into shame and self-blame is a slower process than helping them tell a story, describe a problem, or even devise solutions.

Mindfulness has also introduced the psychotherapy community to the idea that, instead of looking to painful, dark emotional states, we can look to positive states of mind and body as the source and essence of healing.

As neuropsychologist and therapist **Rick Hanson** explains in his bestseller ***Hardwiring Happiness***, we need to be aware of "the negativity bias"-the human brain's tendency to attend preferentially to negative stimuli, scan for danger rather than pleasure, and encode negative experiences more rapidly and permanently than positive ones. Hanson warns that if we don't attend to and install positive experiences in psychotherapy, "the brain's net will automatically keep catching negative experiences."

In contrast with 25 years ago, the trauma treatment of today focuses survivors not primarily on pain, but on accessing new, more expansive feelings, the kinds of feelings they would have experienced if they'd never been traumatized. Listening to and witnessing the clients' experiences remains central to the treatment process, but we've learned to give weight to our clients' attachment experiences, to how their brains and nervous systems work, their ability to notice rather than judge, their appreciation of what it took of them to survive life's setbacks, and increasing their capacity for noticing what's happening in their bodies as the primary pathway for staying in tune with the present moment.

As I often say to my clients...

The goal of therapy is simply helping them reclaim their birthright, the basics to which all children are entitled: a sense of safety, welcome, and well-being.

This post is based on an article originally brought to life by our partner, **Psychotherapy Networker.**

To read the full article, "Putting the Pieces Together," written by **Janina Fisher, navigate below…**

https://www.psychotherapynetworker.org/magazine/recentissues/2014-mayjun/item/2486-putting-the-pieces-together/2486-putting-the-pieces-together

Vicarious Trauma

AMERICAN COUNSELING ASSOCIATION

Vicarious Trauma

The term vicarious trauma (Perlman & Saakvitne, 1995), sometimes also called compassion fatigue, is the latest term that describes the phenomenon generally associated with the "cost of caring" for others (Figley, 1982). Other terms used for compassion fatigue are:

- secondary traumatic stress (Stemm, 1995, 1997)
- secondary victimization (Figley, 1982)

It is believed that counselors working with trauma survivors experience vicarious trauma because of the work they do. Vicarious trauma is the emotional residue of exposure that counselors have from working with people as they are hearing their trauma stories and become witnesses to the pain, fear, and terror that trauma survivors have endured.

It is important not to confuse vicarious trauma with "burnout". Burnout is generally something that happens over time, and as it builds up a change, such as time off or a new and sometimes different job, can take care of burnout or improve it. Vicarious trauma, however, is a state of tension and preoccupation of the stories/trauma experiences described by clients. This tension and preoccupation might be experienced by counselors in several ways. They might:

- avoid talking or thinking about what the trauma effected client(s) have been talking about, almost being numb to it
- be in a persistent arousal state

Counselors should be aware of the signs and symptoms of vicarious trauma and the potential emotional effects of working with trauma survivors.

Signs and symptoms for counselors:

- having difficulty talking about their feelings
- free floating anger and/or irritation
- startle effect/being jumpy
- over-eating or under-eating
- difficulty falling asleep and/or staying asleep
- losing sleep over patients
- worried that they are not doing enough for their clients
- dreaming about their clients/their clients' trauma experiences

- diminished joy toward things they once enjoyed
- feeling trapped by their work as a counselor (crisis counselor)
- diminished feelings of satisfaction and personal accomplishment
- dealing with intrusive thoughts of clients with especially severe trauma histories
- feelings of hopelessness associated with their work/clients
- blaming others

Vicarious trauma can impact a counselor's professional performance and function, as well as result in errors in judgment and mistakes. Counselors may experience:

Behavior:

- frequent job changes
- tardiness
- free floating anger/irritability
- absenteeism
- irresponsibility
- overwork
- irritability
- exhaustion
- talking to oneself (a critical symptom)
- going out to avoid being alone
- dropping out of community affairs
- rejecting physical and emotional closeness

Interpersonal:

- staff conflict
- blaming others
- conflictual engagement
- poor relationships
- poor communication
- impatience
- avoidance of working with clients with trauma histories
- lack of collaboration
- withdrawal and isolation from colleagues
- change in relationship with colleagues
- difficulty having rewarding relationships

Personal values/beliefs:

- dissatisfaction
- negative perception
- loss of interest
- apathy
- blaming others
- lack of appreciation
- lack of interest and caring
- detachment
- hopelessness
- low self image
- worried about not doing enough
- questioning their frame of reference – identity, world view, and/or spirituality
- Disruption in self-capacity (ability to maintain positive sense of self, ability to modulate strong affect, and/or ability to maintain an inner sense of connection)
- Disruption in needs, beliefs and relationships (safety, trust, esteem, control, and intimacy)

Job performance:

- low motivation
- increased errors
- decreased quality
- avoidance of job responsibilities
- over-involved in details/perfectionism
- lack of flexibility

Vicarious trauma can also impact a counselor's personal life, such as relationships with family and friends, as well as the counselor's health, both emotional and physical.

Guidelines for a Vicarious Trauma-Informed Organization

Supervision

WHAT IS A VICARIOUS TRAUMA-INFORMED ORGANIZATION?

Vicarious trauma (VT), the exposure to the trauma experiences of others, is an occupational challenge for the fields of victim services, emergency medical services, fire services, law enforcement, and others. Working with victims of violence and trauma changes the worldview of responders and puts individuals and organizations at risk for a range of negative consequences (Bell, Kulkarni, and Dalton, 2003; McCann and Pearlman, 1990; Newell and MacNeil, 2010; Vicarious Trauma Institute, 2015; Pearlman and Saakvitne, 1995; Knight, 2013). A **vicarious trauma-informed organization** recognizes these challenges and proactively addresses the impact of vicarious trauma through policies, procedures, practices, and programs.

For more information on vicarious trauma and its effects, visit https://vtt.ovc.ojp.gov/.

(NOTE: Although these guidelines were created by a victim services organization, they contain insights and practices that first responder organizations can modify for their own use.)

Regardless of their role, all workers in a victim services organization are exposed to trauma and are at risk for the negative effects of VT. Supervision has been shown to be effective at decreasing the negative effects of exposure to the trauma experiences of others on staff and helping to mitigate turnover, burnout, and low morale. (Bell, Kulkarni, and Dalton, 2003; Middleton and Potter, 2015). In a vicarious trauma-informed organization, supervisors have the requisite knowledge and skills to help their staff and volunteers address VT.

Recommendations for Vicarious Trauma-Informed Supervision

Create a Safe Space for Addressing Vicarious Trauma

- Design a workplace that is safe, fosters collaboration, demonstrates respect for diversity, and acknowledges the importance of addressing VT on a regular basis.

- Affirm the importance of staff and volunteers and the work they do for the organization to advance its mission (Canfield, 2005).

- Provide regularly scheduled supervision that is evaluated by both the supervisor and the employee or volunteer.

- Acknowledge staff differences (e.g., in culture, race, identity, gender, survivor status, work experience) and discuss how they inform one's work and experience of VT.

- Openly discuss exposure to trauma and the resources available to help employees and volunteers address VT.

- Ensure that any discussion of the trauma history of a staff member or volunteer is solely to identify its potential impact on their work and their risk for vicarious traumatization.

Manage Workload and Expectations

- Monitor staff and volunteer workloads and jointly set realistic expectations for meeting clients' needs including, but not limited to, extra time for non-English speaking clients, time for writing notes, formal and informal meetings, stress-reducing and self-care activities, and time off (Schauben and Frazier, 1995).

- Attend to the "whole person," understanding the employee's client caseload, other life stressors, and symptoms of vicarious traumatization (Cerney, 1995; Trippany, Kress, and Wilcoxon, 2004).

- Offer staff and volunteers opportunities to have a wide range of cases and other work responsibilities (e.g., varied types of cases, policy advocacy, training, outreach).

- Offer opportunities for professional development through participation at conferences, trainings, and community meetings that also strengthen collaborations.

- Represent the organization on committees and task forces that address systemic issues.

- Discuss macro issues that impact both the supervisor and employee or volunteer (e.g., lack of critical resources for clients, lack of adequate staffing).

- Remind staff and volunteers of the important contributions they make for clients despite limited resources.

Identify and Address Warning Signs

- Be familiar with the warning signs of vicarious traumatization (Yassen, 1995) including, but not limited to—

  o disengagement from work, colleagues, and supervisor;

  o anger at clients;

  o changes in interpersonal relationships (e.g., less compassionate and patient, more irritable and negative);

  o incomplete or late paperwork; and

  o no recent time off or vacations.

- Discuss any warning signs you see with the employee or volunteer ("I have observed these things—have you?"), with a focus on introducing effective coping strategies.

Support Supervisors

- Recognize the organization's responsibility to its supervisors by addressing their needs as they manage the impact of VT on their staff and volunteers.

- Provide opportunities for supervisors to attend trainings about both supervision and strategies for addressing VT.

- Create forums for supervisors to use to debrief and discuss challenging issues with their staff and volunteers.

- Ensure that supervisors have varied workloads and supervise a reasonable number of staff and volunteers.

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For more information about vicarious trauma, visit https://vtt.ovc.ojp.gov/.

Wellness

Activating Your Vagus Nerve
Some Simple Ways to Shift into States of
Safety, Connectedness and Self-Regulation

Breathing

    Exhale slowly to calm down, create resistance with lips and tongue to enhance the effect
    Breathe in and out naturally and slowly to engage Heart Rate Variability (calm alertness)
    Imagine directing your breath to different parts of body as you breathe in and out
    Blow bubbles – practice slow exhalations to get them bigger

Posture and Gesture

    Wonder Woman Pose, Victory Pose, Welcoming Pose – counteracts helplessness, despair, shame
    Curl forward in chair when exhaling; expand and open up core when inhaling
    Gently bouncing on your toes or gently shaking in ways that feel good.
    Balancing exercises and activities involving fluid movement
    Dance (combines gesture, posture, gait, serve and return, co-regulation with others).

Somatic and Visceral Sensations

    Spinning, rocking, prayer wheel, rosary, fidget spinner, tapping
    Deep pressure and massage
    Hugging, holding hands
    Imagine you have roots anchoring your feet to the ground, strings holding your arms to the sky
    Body scan for tension, try tensing and relaxing different parts
    Try to detect your pulse in different parts of body
    Mindful eating – slow down and attend to the taste, smell, texture, and act of swallowing

Sound

    Humming and chanting – there's a direct nerve from larynx to the heart's pacemaker
    Positive self-talk (preferably out loud)
    Vary the cadence, tone, rate, pitch, volume, phrasing of your voice – note how it makes you feel
    Try speaking in long slow sentences with a pause at the end (sometimes used for stage fright)
    Listen to music, attend to different instruments, sound textures, harmonies, and rhythms
    Focus attention on distant sounds, then to sounds progressively closer, ending with those within
    Make music with others

Face and Head

    Practice softening your gaze when tense, allow your lips to part in a small smile
    Pay attention to your shoulders, jaw and facial muscles. Tensing sends signals of danger.
    Run an ice cube down your face, splash cold water, or chill briefly in a bowl of ice
    Widen your eye eyes slightly when listening – it helps you hear better, and reassures the speaker
    Move your eyes as if they were hands on the face of a clock, clockwise and counterclockwise

Co-Regulation and Play

    Toss a ball, do activities that involve serve-and-return, call-and response, variations on a theme.
    Play cooperative and friendly games that encourage expression and creativity
    Practice meaningful shared rituals, create your own rituals with others, celebrate events or transitions
    Engage in expressive arts like music, drumming, dance, drama, improvisation, poetry, murals
    Don't forget to laugh and find humor where you can.
    Share, be moved by, and create new stories with others.

**What do these "neural exercises" have in common?**

    They induce good stress and "tolerance" through controllable, predictable, and patterned activities
    They strengthen and extend the capacity to shift into states of safety, regulation, and connectedness

Resilience and Wellness

Wellness is being in good physical and mental health. Resilience is an outgrowth of wellness in your whole being.

Because mental health and physical health are linked, problems in one area can impact the other. At the same time, improving your physical health can also benefit your mental health, and vice versa. It is important to make healthy choices for both your physical and mental well-being. Wellness is not the absence of illness or stress; you can still strive for wellness even if you are experiencing these challenges in your life.

One way of thinking about wellness is as a whole composed of eight parts or dimensions.
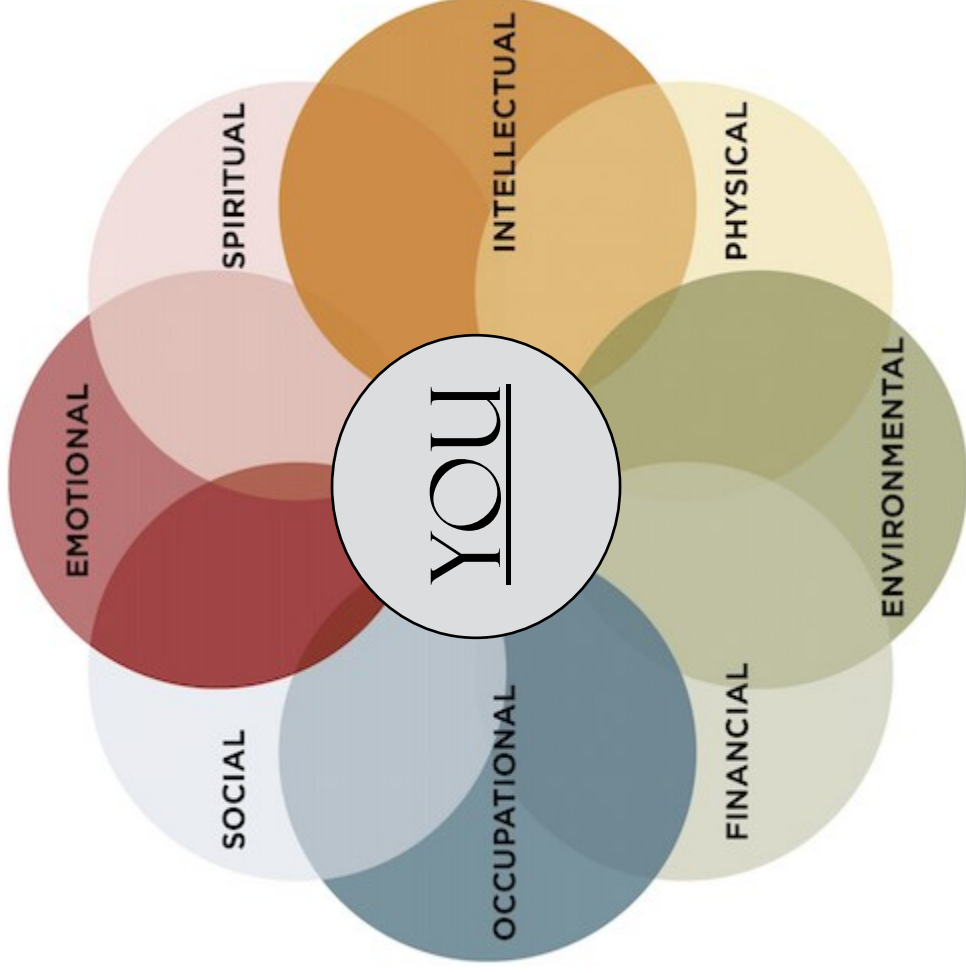
The eight dimensions of wellness are:

Emotional—Coping effectively with life and creating satisfying relationships

Environmental—Good health by placing yourself in pleasant, stimulating environments that support well-being.

Financial—Satisfaction with current and future financial situations.

**Intellectual**—Recognizing creative abilities and finding ways to expand knowledge and skills

Occupational—Enrichment and satisfaction from one's work

Physical—Recognizing the need for physical activity, healthy foods, and sleep

Social—Developing a sense of connection, belonging, and a well-developed support system

Spiritual—Expanding a sense of purpose and meaning in life

For more information on this topic go to https://www.samhsa.gov/wellness
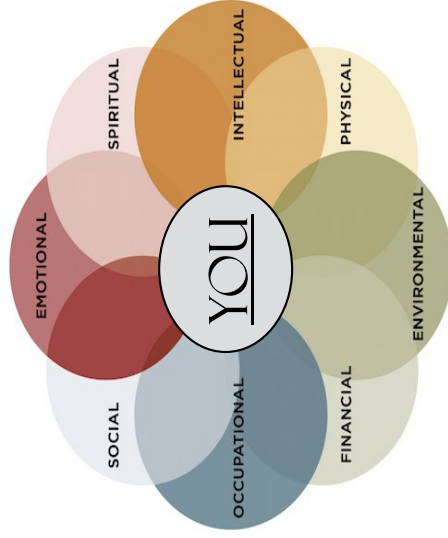
Actions for Resilience and Wellness

Learning about the Eight Dimensions of Wellness can help you choose how to make wellness a part of your everyday life. Wellness strategies are practical ways to start developing healthy habits that can have a positive impact on your physical and mental health.

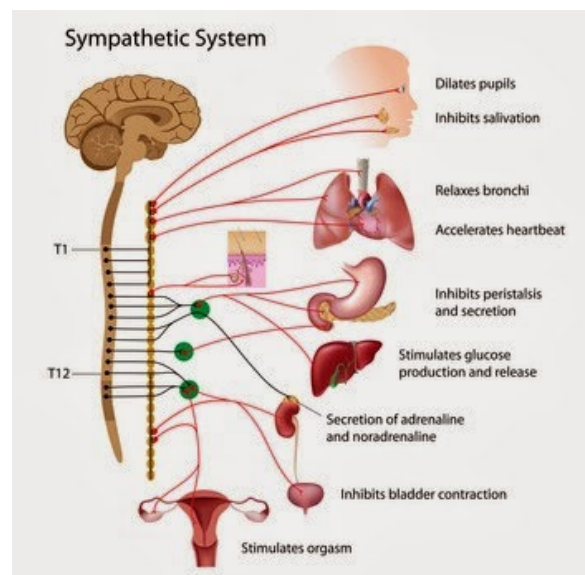| PHYSICAL	INTELLECTUAL	SPIRITUAL	EMOTIONAL
• Exercise • Eat well-balanced meals	• Stay curious & engaged in learning new things • Read for pleasure • Join a club that will build upon your interests	• Try to understand your beliefs & values • Spend time exploring your spiritual life	• Take a deep breath • Sit in the park • Play your favorite music • Take a nap • Hug someone • Smile
SOCIAL	**OCCUPATIONAL**	**FINANCIAL**	**ENVIRONMENTAL**
• Have a strong social network • Mentor or give guidance to someone else • Write a thank you letter to someone who helped you in the past	• Be mentally present when you are working • If you are able to, avoid working in toxic environments	• Plan for future financial health • Plan for large purchases • Look for sales/clip coupons	• De-clutter your room • Recycle • Volunteer to clean up the environment

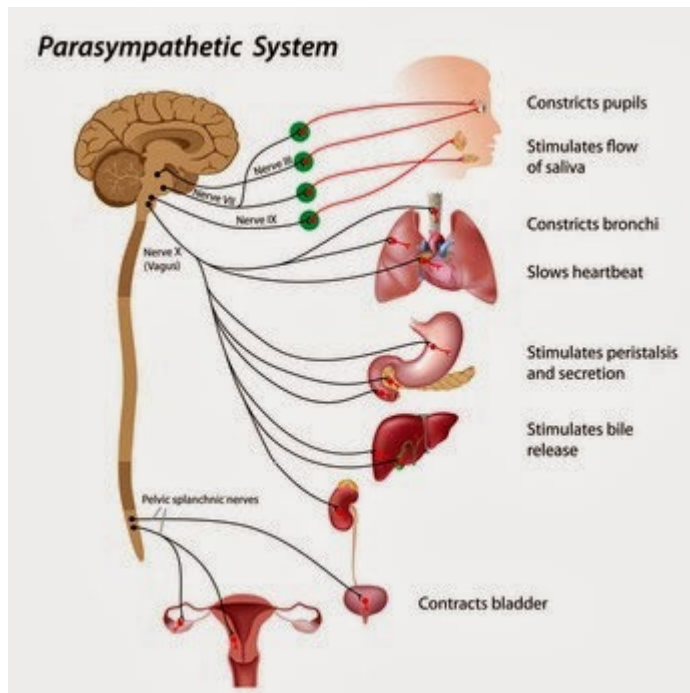# How Your Breath Affects Your Nervous System – Baxter Bell, MD

When I read the posts of my fellow Yoga for Healthy Aging bloggers, I often learn new perspectives that might differ from my own as well as new information that I was previously unaware of. Reading the posts also highlights occasions where I could have been clearer or given better information on a particular topic. As an example, I have written about breath techniques and their effect on the autonomic nervous system, as did Timothy in his awesome follow-up post on the buzzing bee breath, Bhramari Pranayama with Mudras. And we often mention that extending or lengthening the exhalation triggers the parasympathetic nervous system, the Rest and Digest part of our nervous system's balancing program. This made me realize that I could add a bit more detail to explain how that actually happens.

It turns out the Autonomic Nervous System (ANS) that connects brain to body is a two-way street. If I am anxious and nervous or stressed out by events in my life or simply the thoughts about those events, my brain, via the nerves of the ANS, will likely turn on the Sympathetic part of that system (the Fight or Flight response), which could result in faster heart and breathing rates, and increases in blood pressure, to mention just two of the most obvious physiological changes.

But the cool thing is that the lungs and heart can feed back to the brain and essentially convince the brain that things are calm and peaceful, even when there are still stressful circumstances. One neat way this happens involves the relationship of the heart and lungs and the nerves between them. In each round of breath, during your inhalation, your heart gets stimulated to beat a little faster. Then during the exhalation that follows, your heart gets told to slow down a tad. The overall effect is very little change in the heart rate from minute to minute. But when you make one part of the breath cycle, either the inhale or the exhale, longer than the other, and you do this for several minutes, the accumulated effect is that you will either slow the heart rate down or speed it up from where you started. When you make the inhales longer than the exhales, for example, by using a two-second inhale and a one-second exhale, and you keep this up for several minutes, the heart rate will go a bit faster. This will send a feedback message to the brain that things need to activate more in the brain and body for whatever work there is to be done, stimulating the Sympathetic portion of the ANS.

Parasympathetic System

Constricts pupils

Stimulates flow of saliva

Constricts bronchi

Slows heartbeat

Stimulates peristalsis and secretion

Stimulates bile release

Contracts bladder

Nerve VII

Nerve VIII

Nerve IX

Nerve X (Vagus)

Pelvic splanchnic nerves

With the very useful Bhramari breath Timothy expanded on Bhramari Breath with Mudras, we do the opposite. As we hum during the exhalation, the exhales get longer relative to the inhales, as when we do a 1:2 ratio breath practice without the humming. This new respiratory cycle begins to slow down the heart rate, sending a message to the brain that everything is more peaceful and calm than five minutes ago, allowing the brain to support this shift further by activating the Parasympathetic portion of the ANS (the Rest and Digest or Relaxation response) that goes back from brain to body.

Research has shown that the vagus nerve as well as certain chemical neurotransmitters account for these effects of breath patterns on heart rate and subsequently on shifting the balance between the Sympathetic and Parasympathetic parts of the ANS. Keep in mind that the ANS is trying to keep all background systems in balance and responding appropriately to ever-changing circumstances of our day.

I'm providing this information for those of you who want to go a bit deeper in your understanding of how breath patterns affect the nervous system balance and either excite the system or quiet it. Our conscious choice of breathing differently can shift us to a more desirable part of the ANS, either by stimulating the active Sympathetic branch or the quieting Parasympathetic branch. Most of us need more of the latter, but not always!

For a little more background on how the Respiratory system influences the Cardiac system, which in turn influences the Autonomic Nervous System, see The human respiratory gate as well as Effects of yoga on the autonomic nervous system, gamma-aminobutyric-acid, and allostasis in epilepsy, depression, and post-traumatic stress disorder.

Note: For more informative blogs from Baxter and the team visit "Yoga for Healthy Aging".

About Baxter Bell, MD: Baxter Bell, MD (ERYT 500) teaches, writes, and lectures internationally on the benefits of yoga as a powerful tool in addressing the underlying causes, not just the symptoms, of stress. A leading light in the movement to bring yoga into the mainstream medical world, Baxter has been actively deepening his understanding of yoga and relaxation since moving from his career as a busy family doctor to that of a yoga teacher and medical acupuncturist. He is deeply involved in the integration of therapeutic applications of yoga with Western medicine.

Director of Piedmont Yoga Studio's Deep Yoga Program, teaching the Experiential Anatomy, Yoga Technique, and Yoga Methodology portions of the training, Baxter as well teaches therapeutics at the Niroga Institute in Berkley and leads workshops on the subject globally. A true renaissance yoga teacher, Baxter has played the violin since age five, is a frequent contributor to Yoga Journal, and is a prolific and popular blogger on 'Yoga for Healthy Aging.'

LEARN MORE ABOUT BAXTER: www.baxterbellyoga & Baxter Bell Yoga on Facebook

Darwin the Buddhist? Empathy Writings Reveal Parallels

Christine Dell'Amore in Chicago

Charles Darwin probably didn't know it, but he held views on human empathy that mirror Buddhist beliefs, says a pioneer in decoding facial expressions.

Based on his interactions with foreign cultures, Darwin came to define empathy as a desire to end someone's suffering to assuage one's own discomfort.

Buddhist teachings also see empathy as a somewhat selfish motivation, but one that the Dalai Lama, the spiritual leader of Tibet, calls the "seed of compassion."

"It's an amazing coincidence that [Darwin's] views on compassion and morality are identical to the Tibetan Buddhist view," said Paul Ekman, a psychologist whose work decoding so-called micro-expressions is the basis for the new Fox television show *Lie to Me.*

Indeed, after reading Darwin's work on emotions, the Dalai Lama told Ekman he "would consider himself a Darwinian."

The parallel inspired Ekman to study the little-understood trait of compassion, which he discussed this weekend in Chicago at the annual meeting of the American Association for the Advancement of Science.

Though everyone is capable of compassion, Ekman said, some people seem to manifest it without effort.

(A related study revealed how bullies seem to experience pleasure when they see others suffer.)

Until psychologists figure out why the disparity exists, he said, "the survival of our planet" depends on cultivating compassion.

Universal Trait

Darwin became fascinated with the expression of emotions during his five-year voyage on the H.M.S. *Beagle* in the 1830s.

The British naturalist couldn't understand the words or gestures of the people he met, but he had no trouble interpreting their facial expressions.

In his lesser known 1872 book *The Expression of Emotions in Man and Animals,* Darwin proposed that empathy is a universal trait.

"He saw this book as an important contribution showing the commonality of all people," Ekman said. (Read more about Darwin's scientific legacy.)

It's also possible that Darwin encountered Buddhist teachings through letters from other scholars of the time, he added.

Over the past few years, Ekman examined Darwin's book along with Buddhist teachings and divided compassion into three types: simple, global, and heroic.

Simple compassion is the almost instinctual form that exists mostly between a mother and an infant.

Global compassion appears when people help distant strangers, such as the outpouring of international aid after the 2004 Indian Ocean tsunami.

And heroic compassion occurs when a person is motivated into epic acts of bravery, for instance, jumping into an icy pond to save someone else's life.

In a recent book co-authored with the Dalai Lama, Ekman suggests creating "compassion gyms" that could test a person's level of compassion and even offer exercises to prompt deeper caring for others.

The Dalai Lama, meanwhile, believes that just the sight of unbearable suffering is enough to inspire compassion.

Animal Emotions

Darwin also argued fervently in his 1872 book that animals and humans share the capacity for emotion, an idea that has been borne out by later research, Ekman noted.

(See photos showing how a dying elephant seems to elicit compassion from its herd.)

Many great ape studies, for example, show that the animals can place themselves into another's shoes, so to speak. This sensitivity comes from being self-aware, Barbara King, an anthropologist at the College of William and Mary in Virginia, told National Geographic News.

"We wouldn't be human in the ways we are human today if apes were not deeply emotional creatures and deeply social ones," King said. "We are … products of our past."