

TECHNICAL REPORT

Trauma-Informed Care: Strengths and Opportunities for Florida Child Welfare Professionals

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Stephanie C. Kennedy, MSW, Doctoral Candidate
Florida State University College of Social Work
296 Champions Way
Tallahassee, FL 32306
slc03k@my.fsu.edu
850.644.4751

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Executive Summary

Trauma-informed care represents a practice orientation or perspective, rather than a list of specific techniques or empirically supported interventions. In its simplest form, trauma-informed care is a way of thinking about and responding to clients' struggles – a lens through which many common behaviors and mental health symptoms encountered among children and youth in the child welfare system (e.g., externalizing or anti-social behaviors, and suicidality) can be better understood. However, the trauma-informed care perspective transcends the micro-level “in session” practice relationship and extends outward to encompass the entire service environment. Trauma-informed professionals advocate for institutional systems (e.g., the child welfare, behavioral health, or criminal justice systems) and agency policies to recognize and respond to trauma, and work towards reducing the potential for re-traumatization on all levels of client contact. In this report the key principles of trauma-informed practice are reviewed and application of the trauma-informed care perspective is applied to Florida's child welfare practice model. Three family-based trauma-informed interventions are discussed and two case applications are provided as examples. Online resources are provided in the resource section. The following five recommendations are suggested.

1. Deliver evidence-based and trauma-informed care training to all child welfare professionals and subcontracted service providers, including trauma screening and developmental assessment for all children, youth, and caregivers who make contact with the child welfare system (s. 409.986, Florida Statutes).
2. Provide child welfare professionals with pre- and in-service training and continuing education that emphasizes trauma-informed capacity-building and collaboration with children, youth, and their caregivers.
3. Integrate information and support on secondary trauma and self-care into child welfare professional pre- and in-service training, continuing education, and supervision.
4. Encourage the Agency for Health Care Administration to reimburse empirically supported treatment interventions like Trauma-focused Cognitive Behavioral Therapy, Child Parent Psychotherapy, and Parent Child Interaction Therapy with regard to treatment length and frequency.
5. Integrate resources from the National Child Traumatic Stress Network (NCTSN) Child Welfare Trauma Training Toolkit to ground evidence-based and trauma-informed trainings in research and promote standardization across the state.

Case Studies

Desmond

Desmond is a three year old boy with whom you have been working since he was 10-weeks old. His mother, Sienna, was just 19 when he was born and, having recently aged out of the foster care system herself, had little resources or support to help her care for a newborn. When you first met Desmond he was lethargic and underweight, was not meeting key developmental milestones, and had little interest in interacting with his mother and his physical environment. You connected Sienna with a variety of tangible resources including formula and diapers, WIC and Medicaid, and you also provided parent education and emotional support. In your assessment, you noted dramatic improvements over the following six months to both Desmond's physical condition as well as the mother-child relationship. However, Desmond's case was reopened last week after a physician at the local emergency department reported that while treating Desmond for a high fever, he observed old and new bruising patterns on the child's chest and stomach and scars on his legs and buttocks. The doctor noted that the child seemed very fearful of his mother's boyfriend, and began screaming, kicking, and biting his mother and members of the staff when the boyfriend entered the room.

Danny

Your new client, Danny, is a 16-year old girl with a long history of child welfare involvement. Reading her file, you note that she was removed from the care of her biological mother as a toddler due to severe neglect and physical abuse. She has two half-siblings who are also in care, and a handful of extended family members listed. Her mother recently completed a nine-year sentence in a state prison for the manufacture and distribution of a controlled substance. Danny was placed in several foster homes as a young child, but due to a variety of circumstances, was never adopted. From the ages of seven to ten, Danny was sexually abused by her foster father, who threatened to kill her if she told anyone about their "little secret." During this time, Danny's behavior became increasingly erratic and aggressive. She was expelled from her public school for fighting and moved into a therapeutic foster home by her caseworker after disclosing the abuse. However, within weeks of her new placement, Danny began hearing voices and attempted suicide. She was transferred to a behavioral health center for stabilization and after discharge, her caseworker placed her in a therapeutic group home for children with severe emotional disturbances. At 15 years old, Danny ran away from her group home and spent 10 months living in shelters and on the street before she was placed on probation for solicitation and possession of a controlled substance and sent to a group home for girls with a history of emotional disturbances and conduct disorder.

What is Known?

Children and youth who make contact with the child welfare system have been exposed to a variety of traumatic events including physical, sexual, and emotional abuse; physical and emotional neglect; peer bullying; witnessing maternal battering; witnessing community or neighborhood violence; and family instability (e.g., parent in prison, parent with serious substance abuse or mental health issues). Although experiences of child maltreatment are typically defined and measured as separate events (e.g., sexual abuse, neglect), there is mounting evidence to suggest that such experiences are not mutually exclusive – that is, experiencing one form of maltreatment increases the risk for experiencing other types of trauma and adverse experiences.^{1,2} Several cumulative victimization constructs (e.g., Poly-victimization, Adverse Childhood Experiences) measure traumatic exposure as having experienced four or more of six broad categories of trauma: sexual assault, child maltreatment, burglary/property victimization, physical assault, peer/sibling bullying, and witnessed indirect violence. Using these constructs, studies suggest that approximately 70% of children and youth nationally have experienced at least one category of trauma in the past year, with 12% reporting traumatic exposure consistent with cumulative victimization.³ However, for children and youth in the child welfare system, these figures rise dramatically. More than 90% of youth in the child welfare system report having experienced one category of trauma within the past year, with 54% indicating traumatic exposure consistent with cumulative victimization.⁴ That is, more than half of the children and youth in the child welfare system indicate having experienced four or more categories of trauma exposure within the previous 12 months. In this sense, children and youth in the child welfare system have life histories characterized by "unrelenting trauma,"⁵ or multiple, cumulative experiences of direct and witnessed interpersonal violence which begin within the family home – often perpetrated by a parent or caregiver – and continue out into the neighborhood and school environments, as well as within peer and intimate partner relationships.⁶ These unrelenting experiences of trauma shape both social and neurobiological brain development,⁷ and may serve to alienate children and youth from legitimate social institutions like family, school, and employment, thus increasing the likelihood of gang involvement, homelessness, and criminal behavior.⁸

Trauma-exposed children and youth are at higher risk for experiencing a constellation of difficulties across the life span, including externalizing or acting-out behavior problems, emotional and behavior regulation challenges, attachment disorders, and a range of mental health issues which both encompass and transcend our current understanding of posttraumatic stress reactions.^{9,10,11} These symptoms can include severe anxiety and symptoms of psychosis,^{12,13} major depression and suicide attempts,^{14,15} and drug and alcohol misuse problems.¹⁶ Further, as the behavioral and mental health consequences of trauma occur within the context of the family system, they negatively affect identity development, limit coping strategies, and contribute to parenting stress, all of which increases the risk for future maltreatment. As such, both trauma and trauma reactions can be better understood as cyclical and adaptive negative interactional patterns.¹⁷ That is, for many families in the child welfare system, force, hostility, and coercion are both the cause and the effect of the child's behavior challenges and mental health symptoms.

What is Trauma-informed Care and Why is it Important?

Trauma-informed care represents a practice orientation or perspective, rather than a list of specific techniques or empirically supported interventions. In its simplest form, trauma-informed care is a way of thinking about and responding to clients' struggles – a lens through which many common behaviors encountered among children and youth in the child welfare system (e.g., externalizing or anti-social behaviors, and suicidality) can be better understood.¹⁸ This practice orientation is sensitive to the long-lasting physical and mental health effects which occur in the wake of traumatic experiences, and helps clients make meaning out of their experiences. The trauma-informed care perspective allows child welfare professionals to adjust their direct practice to recognize, understand, and respond to the reality of unrelenting trauma in the lives of clients. In general, trauma-informed professionals emphasize physical, emotional, and psychological safety, and help clients regain control over problematic or troubling thoughts, feelings, and behaviors – all of which may have developed in an attempt to cope with their traumatic experiences of violence and uncertainty.

However, the trauma-informed care perspective transcends the micro-level “in session” practice relationship and extends outward to encompass the entire service environment. Trauma-informed professionals advocate for institutional systems (e.g., the child welfare, behavioral health, or criminal justice systems) and agency policies to recognize and respond to trauma, and work towards reducing the potential for re-traumatization on all levels of client contact. Further, just as child welfare professionals become sensitized to the long-ranging effects of trauma in their clients' lives, they recognize the potential for their own experiences of secondary (or vicarious) traumatization. Therefore, an institution or agency which provides trauma-informed care acknowledges the difficulties inherent to working with traumatized clients and provides guidance on self-care strategies to reduce secondary traumatization.¹

Although trauma-informed professionals pay special attention to traumatic experiences and their aftermath, this perspective emphasizes resilience and capability and maintains a strengths-based orientation. That is, trauma-informed care professionals do not focus specifically on deficits or equate experiences of trauma with lasting damage.¹⁹ Rather, the experience of trauma is used as a way to organize and explain the constellation of problems commonly expressed by children and families in the child welfare system and to help clients envision a new future for themselves moving forward. In the trauma-informed perspective, clients are viewed as inherently resilient and able to recover from traumatic events; alter established interactional behavior patterns; and succeed in creating a family system free from child maltreatment.

In many ways, it seems common sense to use trauma-informed care when working with children and families in Florida's child welfare system. The practice of many child welfare professionals may already incorporate some key elements of this perspective. However, fully implementing a trauma-informed care perspective requires professionals to take a step back and consider trauma as an organizing event, not just in the lives of the children, but as a long-standing pattern of experiences with a generational history. That is, parents with their own history of childhood abuse and neglect are more likely to struggle to bond appropriately with their children than parents with no history of abuse or neglect.²⁰ An impaired attachment in the first months and years of a child's life can have profound effects on the child's behavior and mental health. It can also impact how that child is disciplined, which may fuel the cyclical and adaptive negative interactional patterns described above. Further, parents who were abused or neglected as children may have their own insecure attachment issues and may hesitate to bond with their children due to a fear of rejection, abandonment, or failure.²¹ Many families, even those with severe multi-generational histories of abuse, are still in close contact with extended family members who provide childcare services or offer parenting advice.²² Therefore, a trauma-informed care perspective considers the family system in the broadest terms, identifies patterns of behavior congruent with traumatic exposure, and empowers individuals to make different choices in the future.

Guiding Principles of Trauma-informed Practice

Trauma-informed practice reflects the following six key principles.²³

1. **Safety** Ensuring physical and emotional safety.
2. **Trustworthiness and Transparency** Maximizing trustworthiness, making tasks clear, and maintaining appropriate boundaries.
3. **Peer Support** Increasing positive peer support.
4. **Collaboration and Mutuality** Maximizing collaboration and sharing of power with clients.
5. **Empowerment, Voice, and Choice** Prioritizing client empowerment and skill-building, hearing client desires and concerns, and prioritizing client choice.
6. **Cultural, Historical, and Gender Issues** Being sensitive to a variety of cultural, historical, and gender issues which affect service access, delivery, and client decision making.

These principles underscore how both interpersonal interactions and agency policies can exacerbate the struggles of traumatized children and families. At all levels of interaction, client safety, choice, and empowerment are prioritized, and authoritarian hierarchies between clients and child welfare professionals are traded for collaborative partnerships. Many traditional systems are

¹ See resources at the end of this report for more information on developing a trauma-informed agency, secondary trauma, and self-care.

characterized by a culture of shaming and blaming clients, misusing displays of power, creating authoritarian or punitive working relationships with clients, and envisioning future client failures. In contrast, trauma-informed systems:

- recognize that coercive interventions can be both traumatizing and re-traumatizing for clients;
- routinely assess for trauma and common traumatic stress-related mental health symptoms;
- solicit and value clients' opinions;
- include clients in treatment and case decision making processes;
- vision client success; and
- help clients make different choices moving forward.²⁴

Applying a Trauma-informed Care Framework to Florida's Child Welfare Practice Model

The trauma-informed care framework proposed here supports the goal of Florida's Child Welfare Practice Model: To achieve safety, permanency, child and family well-being through the use of a safety-focused, family-centered, and trauma-informed approach. Further, a trauma-informed care perspective supports Florida's compliance with the seven Child and Family Services Review (CFSR) standards set forth and monitored by the Children's Bureau, a division of the U.S. Department of Health and Human Services. These standards enable the Children's Bureau to ensure state conformity with federal child welfare requirements, to gauge the experiences of children, youth, and families receiving state child welfare services, and to assist states as they enhance their capacity to help families achieve positive outcomes.²⁵ CFSR standards are organized into the three domains of safety, permanency, and child and family well-being, and read as follows:

Safety

1. Children are, first and foremost, protected from abuse and neglect.
2. Children are safely maintained in their homes whenever possible and appropriate.

Permanency

3. Children have permanency and stability in their living arrangements.
4. The continuity of family relationships and connections is preserved for children.

Child and Family Well-Being

5. Families have enhanced capacity to provide for their children's needs.
6. Children receive appropriate services to meet their educational needs.
7. Children receive adequate services to meet their physical and mental health needs.

FLORIDA'S CHILD WELFARE PRACTICE MODEL

To achieve safety, permanency, child and family well-being through the use of a safety-focused, family-centered, and trauma-informed approach.

The state of Florida has undergone three rounds of CFSRs since 2001. In all three rounds, many strengths of the state's child welfare system were noted, although several challenges remain. Overall, the strengths of Florida's child welfare system include identifying the most vulnerable children, providing exhaustive in-home support and services prior to removing the child from the home, and honoring the ties of biological siblings, parents, and extended family members.²⁶ However, these strengths are hampered by high caseloads and professional turnover, which reduces the quality of professional visits and diminishes collaboration with clients and integration of client feedback. Further, a general lack of standardized assessment and evaluation is hypothesized to contribute to the issue of varying quality of services. And finally, the CFSR identifies a general lack of stability in foster care placements, which affects children's sense of security as well as their access to education, and physical and mental health care.^{27,28}

The key principles of trauma-informed care detailed above – safety; trustworthiness and transparency; peer support; collaboration and mutuality; empowerment; voice and choice; and cultural, historical, and gender issues – may help address the limitations of Florida's child welfare system identified in the most recent CFSR. Acknowledging the trauma experienced by the family unit and integrating both children and their families into assessment, goal setting, and treatment plans may improve overall treatment “buy in” – helping to engage and motivate parents to making positive changes to their parenting. Additionally, providing trauma-informed education to children, families, and foster parents may provide context to children's experiences and reactions, cultivating more productive strategies for managing trauma triggers, behavior issues, and mental health symptoms as they emerge. Ideally, increasing trauma-informed education and intervention will improve foster placement stability, as foster families will have a deeper understanding of the child's experiences, and have more skills to deploy when the child is triggered. Likewise, educating child welfare professionals about the reality of secondary trauma and how to access peer support and self-care may be key to managing burnout and reducing professional turnover. For illustration, a trauma-informed approach to direct child welfare practice; screening and assessment; looking beyond the nuclear family; and self-care are described below. (Adapted from the [Chadwick Center](#)).

PRINCIPLES OF TRAUMA-INFORMED CARE

- Safety
- Trustworthiness and transparency
- Peer support
- Collaboration and mutuality
- Empowerment
- Voice and choice
- Cultural, historical, and gender issues

Direct Practice

Every job function within the child welfare system (e.g., abuse hotline, intake, assessment, treatment, foster/adoptive placement, supervised visitation) employs a trauma-informed approach to decrease the impact of previous trauma and prevent future harm. Caseworkers establish a supportive, collaborative relationship with children and families to minimize inherent power imbalances. Child welfare professionals are respectful, empathetic, genuine, consistent, predictable, non-shaming, and non-blaming. Lines of questioning shift from “What’s wrong with you?” to “What has happened to you?” When working with families, professionals will also examine the parents’ trauma history and how these early traumatic experiences affect their ability to parent. The choices and preferences of all persons in the child’s life (including the child him/herself) are incorporated into the treatment plan. Consistent, supportive, and effective family involvement is promoted to increase safety, permanency, and well-being for all involved. Stable, positive relationships are fostered for children and their parents to improve their quality of life and increase access to support and resources.

Screening and Assessment

Trauma screenings are routinely conducted on all children and families at the earliest point of contact, regardless of the types of behavioral or mental health symptoms displayed. Screenings assess traumatic exposure and a range of traumatic stress symptoms using a standardized process and instrument. Screenings are repeated at regular intervals (e.g., every six months). Children with positive trauma screenings are referred to empirically supported, trauma-focused interventions which focus on altering the family system whenever feasible. The trauma histories of the child and parent(s) are recorded in case notes to improve continuity of care and allow for tailored service provision. The treatment plan contains short- and long-term goals related to trauma exposure and the current behavioral and mental health consequences of that exposure.

Looking Beyond the Nuclear Family

Other caregivers are incorporated into the treatment plan and provided education on the behavioral and mental health effects of trauma. Child care providers, school staff members, foster parents, and other important sources of support in the child’s life are identified and helped to reframe the child’s problematic behaviors as learned responses to managing trauma. Caregivers are guided to identify potential triggers of behavior problems, incorporate trauma-informed response techniques to deescalate the behavior as it occurs, avoid re-traumatization in their behavior management strategies, and to help the child practice new, healthier coping skills in the moment. When relevant, caregivers with their own histories of trauma exposure are guided to community resources to help them identify the role of trauma in their lives, especially as it relates to caretaking and experiences of secondary trauma.

Self-care

Child welfare professionals (e.g., judges, attorneys, Guardians ad Litem, foster parents, contracted providers, etc.) develop a self-care plan to recognize key areas of stress in their personal and work lives, identify basic self-preservation and burnout prevention strategies, and employ techniques to manage job-related stress. Professionals also guide parents and allied caregivers to these resources. Trauma-informed agencies provide workshops for all employees to manage stress, maintain a trauma-informed approach when working with all clients (especially challenging clients), improve morale in the work environment, foster supportive coworker relationships, and prevent secondary trauma. Supervision is provided using a trauma-informed approach, with supervisors helping professionals to identify strengths and areas for improvement, decrease stress and burnout, increase self-care, and reduce the incidence and negative effects of secondary traumatization.

Trauma-informed Interventions

There are a variety of empirically supported, trauma-informed interventions designed for use with children and families in crisis. The [California Evidence-Based Clearinghouse for Child Welfare](#) maintains a searchable national registry of evidence-based programs and practices, freely available to the public. Three empirically supported interventions which work with the whole family system (rather than children or youth in isolation) are reviewed below. Although these interventions represent a variety of theoretical orientations, including cognitive-behavioral, attachment, social learning, and family systems approaches, they are all congruent with a trauma-informed care service model. Professionals work with the family system to empower caregivers to recognize the effects of trauma and to develop positive parenting skills to manage their child’s behavior and mental health symptoms in the context of that trauma.

Trauma-Focused Cognitive Behavioral Therapy

[Trauma-Focused Cognitive Behavioral Therapy](#) (TF-CBT) is a psychosocial treatment model designed to treat posttraumatic stress and related emotional and behavioral problems in children and youth. This intervention was developed to specifically address trauma related to experiences of sexual abuse, although the model has been adapted for use with children who have endured those experiences directly and witnessed traumas typically reported by children and youth prior to foster care placement. At treatment onset, 90-minute sessions are split into two individual 45-minute sessions – one for the child and one for the caregiver. As treatment progresses, conjoint child-caregiver sessions are increasingly incorporated. The model applies a trauma-informed orientation to cognitive behavioral therapy techniques. The acronym PRACTICE reflects the components of the treatment model: Psychoeducation and parenting skills, Relaxation skills, Affect expression and regulation skills, Cognitive coping skills and processing, Trauma narrative, In vivo exposure (when needed), Conjoint child-caregiver sessions, and Enhancing safety and future development. Although TF-CBT is generally delivered over the course of 12-18 sessions, successful adaptations have incorporated a longer-term treatment process and group therapy formats.

Target population: Children and youth aged 3-18 and their caregivers.

Treatment length and frequency: 90-minute weekly sessions for 12-18 weeks (or longer) conducted in the home or agency.

Goals: To provide knowledge and skills related to processing trauma, managing distressing thoughts, feelings and behaviors, and enhancing safety, parenting skills, and family communication. TF-CBT directly addresses children's feelings of shame related to trauma, distorted beliefs about self and others, acting-out behavior problems, and management of common mental health symptoms. Caregivers are coached on inappropriate parenting practices and parental trauma-related emotional distress.

Professional training: A treatment manual and both web and face-to-face trainings are available. Please note, although all therapists, clinicians, and students are welcome for training, a Master's degree in a clinical field is required for certification in the model.

Child Parent Psychotherapy

Child Parent Psychotherapy (CPP) is a relational treatment model for trauma-exposed young children who are experiencing behavior, attachment, and/or mental health problems as a result. The primary goal of CPP is to strengthen the relationship between child and caregiver, ultimately increasing the child's perception of safety and caregiver attachment and decreasing behavior problems and mental health symptoms. The child and his/her primary caregiver are seen together and the dyad is the unit of treatment. CPP is grounded in attachment theory, although it integrates skills from a variety of developmental, social learning, psychodynamic, and cognitive-behavioral theories. In sessions, the patterned maladaptive representations that child and caregiver have of themselves and each other are challenged. Specific interactional behavior patterns which exacerbate the child's problematic behavior or mental health symptoms are identified and interrupted. Throughout the year-long intervention, the professional helps the child and caregiver to create a new, joint narrative of the traumatic event and to identify and problem-solve potential triggers.

Target population: Children from birth through age five and their caregivers.

Treatment length and frequency: 60-90 minute weekly sessions for 52 weeks.

Goals: To provide knowledge and skills related to trauma exposure, and the internalizing and externalizing behavioral problems and mental health symptoms which commonly follow for young children. Caregivers' negative attributions about the child are interrupted and maladaptive parenting strategies addressed. Trauma-focused alternative strategies are offered and, when relevant, caregiver mental health symptoms (including depression, anxiety, and posttraumatic stress) are addressed.

Professional training: A treatment manual and training are available. Training typically involves an initial three-day training session; two telephone case consultation calls per month for 18 months; and an additional two-day follow-up training session at six-month intervals. Tuition does not include costs for books or travel.

Parent Child Interaction Therapy

[Parent Child Interaction Therapy](#) (PCIT) is a relational parent-training intervention originally developed for use with young children (aged 2-7) with externalizing behavior problems. However, recently PCIT has been used with a variety of physically abusive or at-risk families in the child welfare system, and preliminary evidence suggests that PCIT is effective at reducing future abuse.^{29,30} PCIT is grounded in social learning and attachment theories and employs a family systems approach to change both child and caregiver behavior patterns. Treatment includes both the child and caregiver in sessions, using real-time coaching via a one-way mirror and a "bug in the ear" device to train the caregiver to positively engage their child in play and respond appropriately to their child's behavior. PCIT consists of two phases: 1) to enhance the child-caregiver relationship (described as Child-Directed Interaction or CDI), and 2) to improve child compliance (described as Parent-Directed Interaction or PDI). PRIDE skills – Praise, Reflection, Imitation, Description, and Enthusiasm – are enhanced, and appropriate discipline techniques are provided. A *hands-off* version of PCIT is commonly used when implementing the program with child welfare involved families. The hands-off model eliminates all physical holding and bottom-swats as a back-up to time-out, instead substituting a time-out room or some other non-physical second layer of discipline. Additionally, the hands-off model of PCIT works with children up to age 12, as the focus of change is the caregiver's behavior, rather than the child's behavior.³¹

Target population: Children and youth aged 2-12 and their caregivers.

Treatment length and frequency: 60-minute weekly sessions for 14-20 weeks.

Goals: To enhance the child-caregiver relationship, improve child compliance, and model positive parenting and non-physical discipline. Improving the child-caregiver relationship and interrupting negative or coercive interaction patterns between child and caregiver are hypothesized to reduce the child's behavioral and mental health issues.

Professional training: A treatment manual and both web and face-to-face training programs are available. The [web training](#) is a free 10-hour, 11-module course to provide fundamental information about providing PCIT. Although completion of the web course alone will not provide certification in the model, it provides familiarity with PCIT fundamentals and is a part of the certification process.

Case Application

The trauma-informed care framework emphasizes physical, psychological, and emotional safety for both clients and professionals, and has an explicit goal of client empowerment. The case applications below detail how a trauma-informed care perspective can be infused into child welfare practice in concert with empirically supported interventions. These interventions use a trauma-informed approach and work with the family system to acknowledge trauma, improve communication and positive interactions, and foster resilience among families with a history of child maltreatment. Even in communities where access to empirically supported interventions is limited, the case applications highlight the intersection between trauma-informed care and child welfare practice.

Desmond

When Desmond's file is referred to your caseload, you are struck by an overwhelming sense of sadness. Although you hadn't thought about Desmond in a few years, you had hoped that he and his mother Sienna were thriving together as a family. The case notes, however, indicate that they are both in danger. Before contacting Sienna, you take a moment at your desk to write down your greatest fears for Desmond and Sienna and also to envision a safe, happy future for them together. You pick up the phone, genuinely happy to hear Sienna's voice and schedule a home visit for the following day.

When you arrive at the home, you notice piles of garbage and scrap metal strewn across the porch and yard. Sienna opens the door and as she invites you inside, tears begin flowing down her cheeks. She bends over to pick up Desmond and you notice bruising on her neck and collarbones. Desmond clings to her and you can see fresh bruising on his arms. You sit together in the living room and you ask her how she has been and what has been going on in her life since the last time you saw her. Sienna forces a smile and tells you how great things have been and how lucky she is to have met her boyfriend Darryl. She describes him as a provider and a great father to Desmond. Desmond remains motionless in her lap. You tell her that you're worried about Desmond and you're worried about her, and that you're afraid they aren't safe. She tells you that the bruises were accidental, and then proceeds to describe a harrowing interaction between Desmond and Darryl involving a leather belt and toilet training. You repeat that you're worried about them both, and use the toilet training story to provide tangible evidence of your concern. You ask her if she's happy, and if this is the future she had visioned for herself when Desmond was a baby. Sienna begins to cry and says that coming from nothing, she has no right to dream better for herself. Darryl also controls her money and benefits, so she couldn't leave even if she wanted to. You reframe these sentiments, highlighting how far she has come and remarking on how strong a bond she and Desmond share. You remind her of her successes when you first met her and how strong she and Desmond are together. You ask her to describe what her ideal life would look and feel like – where she and Desmond might live, what activities they would do together. Sienna closes her eyes, still holding Desmond on her lap, and describes a light-filled kitchen overlooking green grass, walking Desmond to kindergarten, smiling as he runs ahead with his backpack bouncing on his shoulders before doubling back to her side. She tells you she wants Desmond to have a peaceful life, the kind of childhood that she never had. She wants to protect him in a way that she was never protected. She begins to cry as she opens her eyes and she asks you for help – help to get to that life.

Over the next few months, you work with Sienna to create a treatment plan that meets her goals as well as your agency objectives. She agrees to move with Desmond into a domestic violence shelter and to meet weekly with a counselor trained in Child Parent Psychotherapy. Together, Sienna and Desmond begin to retell their life story as one bursting with triumph and survival, rather than a hopeless tale of failure and pain. With the aid of the CPP therapist, both Sienna and Desmond identify their trauma triggers and make a plan for how to make different choices under stress in the future. Sienna notes that she makes impulsive decisions when she feels alone and abandoned. After connecting this behavior pattern to her own trauma history, she feels empowered to foster positive social relationships with women from the shelter program and from her church. For Desmond, Sienna notes that his acting-out behaviors are directly related to instability and a lack of routine. She also identifies how terrified he becomes when people yell, even if that yelling is not coming from a place of anger. You help Sienna communicate these triggers to the residents and staff at the shelter, and problem solve ways to deescalate when either Sienna or Desmond are triggered in the moment.

At six months, you reassess Sienna and Desmond and note a dramatic decrease in behavioral problems and mental health symptoms. Sienna is active in shelter programming and has started studying for the GED. She tells you that she wants to work with other women like her, who lose their way in relationships with men who treat them badly. Sienna has taken a part-time job at a local bakery, and walks Desmond to preschool every morning. She is on a waiting list for a supportive independent living program located just a few blocks away. At your last visit, Desmond gives you a handmade card with a red heart on the cover. Sienna had helped him write "Thank you, Love Desmond" on the inside. She hugs you, and thanks you for believing in her, and for helping her to dream bigger for herself than she ever thought possible.

Danny

You meet with Danny for the first time at her group home. The home has a distinctly institutional feel and serves approximately 30 youth with a history of behavior problems, conduct disorder, and criminal involvement. When you see Danny, she's sitting at a table in the kitchen with her head rested face down on her arms. You sit down at the table across from her, introduce yourself, and ask her how she's feeling. She lifts her head, shrugs, and tells you she feels like everything is painful and pointless. You empathize with her, noting how her placement in this group home is just one of many unsettling changes she's had to endure.

You tell her that your priority is getting her into a safe, stable permanent home. You ask her what those words mean to her, and where she would like to live. Danny suddenly gets very agitated and begs you not to send her to a family foster home. She says she'd rather go to prison than stay where she is forced to pretend to be a "normal" kid. You tell her that you will work with her to find the right fit, that you will not send her somewhere she doesn't want to go. You ask about her family, and whether she's had contact with her mother or other family members. She tells you that her mother has written a letter to her every month for as long as she can remember. Danny picks them up a few times a year when she visits her aunt Tara. She tells you that she wishes she could live with her aunt, but her aunt was rejected as a placement more than once by previous caseworkers. You ask her what it feels like when she reads the letters, and Danny says they make her sad. She tells you that her mother got sober in prison, and now spends a lot of time apologizing for how Danny was treated. Danny says her two sisters are now living with their father out of state, and her mother updates her on how they're doing. She tells you that sometimes the letters make her so sad, she just throws them away without even opening them.

You tell her that you've been in contact with the judge, Danny's mother, and her aunt Tara, and tell her that Tara has been approved by the judge for placement. Danny brightens visibly. She tells you that Tara had wanted to take her six years ago, but was unable to because she was only 21 and living in campus housing. Then, after things started to fall apart in the years that followed, the caseworker worried Tara was too inexperienced to manage Danny's emotional and behavioral challenges. You begin to craft a treatment plan with Danny, who becomes increasingly more excited as you identify short and long-term goals together. She is hesitant to return to her old school, as she feels like she's fallen too far behind, and you agree to look into alternative schools in the area. She also agrees to see a trauma-focused cognitive behavioral therapist in the community with her aunt, and although she doesn't want to talk to her mother right now, she agrees to revisit the issue in six months.

Over the next few days, you help Danny transition out of the group home and into her aunt's home. You work with them to craft house rules, establish a routine and problem-solve a variety of behavioral, social, emotional, and mental health issues which may crop up over the next few months. You provide education on how the issues that Danny has experienced can really be thought of as a reaction to trauma. You highlight her strengths and coping skills, and encourage her to think about herself as a resourceful and resilient young woman. Danny commits to telling Tara if she hears voices or begins to think about suicide. She commits to calling you if she starts thinking about running away.

You meet with Danny and Tara monthly over the next year and are proud of the strides they have made as a family. Danny is enrolled in an alternative high school program for girls and has connected with several teachers and students. Danny and Tara completed 18 sessions with the trauma-focused cognitive behavioral therapist and worked hard to create emotional connections and manage negative thoughts, feelings, and behaviors. Danny continues to see the counselor individually twice a month. At your six-month assessment, Danny decided she was ready to contact her mother, and the two have been talking on the telephone once or twice a month. Danny tells you that although she isn't ready for a closer relationship with her mother, she has let go of the fear, anger, and resentment she was harboring. She remarks that she was surprised to find that when she acknowledged what had happened to her as a girl and gave voice to her feelings, that the voices stopped and she no longer thought about suicide. She tells you that now she mostly thinks about school, and boys, and maybe even going to college.

Recommendations for Practice and Policy

Trauma-informed care represents a practice orientation, organizational structure, and treatment framework that involves understanding, recognizing, and responding to the effects of all types of trauma. This approach is based on open and honest communication between professionals and the children and families they serve. Therefore, although coercive action must occur in some cases to protect the safety of a child, these decisions should be discussed honestly with all clients, with special attention to including the child in the decision-making process. The professional, client, and agency should work together to help children and families recover from traumatic events, alter established negative behavior patterns, and succeed in creating a life free from child maltreatment. To achieve these goals, the following five recommendations are suggested:

1. Deliver evidence-based and trauma-informed care training to all child welfare professionals and subcontracted service providers, including trauma screening and developmental assessment for all children, youth, and caregivers who make contact with the child welfare system (s. 409.986, Florida Statutes).
2. Provide child welfare professionals with pre- and in-service training and continuing education that emphasizes trauma-informed capacity-building and collaboration with children, youth, and their caregivers.
3. Integrate information and support on secondary trauma and self-care into child welfare professional pre- and in-service training, continuing education, and supervision.
4. Encourage the Agency for Health Care Administration to reimburse empirically supported treatment interventions like Trauma-focused Cognitive Behavioral Therapy, Child Parent Psychotherapy, and Parent Child Interaction Therapy with regard to treatment length and frequency.
5. Integrate resources from the National Child Traumatic Stress Network (NCTSN) Child Welfare Trauma Training Toolkit to ground evidence-based and trauma-informed trainings in research and promote standardization across the state.

Summary

Trauma-informed care is a way of thinking about and responding to clients' struggles – a lens through which many common behaviors and mental health symptoms encountered among children and youth in the child welfare system can be approached. Although this perspective can work in concert with empirically supported interventions, the trauma-informed care perspective transcends the micro-level practice relationship to encompass the entire service environment. Trauma-informed professionals advocate for all aspects of the institutional systems clients engage to recognize and respond to trauma, and work towards reducing the potential for re-traumatization on all levels of client contact.

Resources

[Substance Abuse and Mental Health Services Administration \(SAMHSA\)](#)

- [National Center for Trauma-Informed Care and Alternatives to Seclusion and Restraint \(NCTIC\)](#)
- [Trauma-Informed Approach and Trauma-Specific Interventions](#)

[The Trauma-Informed Care Project](#)

[The California Evidence-Based Clearinghouse for Child Welfare](#)

- [Trauma Focused-Cognitive Behavioral Therapy \(TF-CBT\)](#)
- [Child Parent Psychotherapy \(CPP\)](#)
- [Parent Child Interaction Therapy \(PCIT\)](#)

[Chadwick Center for Children and Families](#)

Resources include:

- Adaptation Guidelines for Serving Latino Children and Families Affected by Trauma
- Assessment-Based Treatment: A Trauma Assessment Pathway Model
- Creating Trauma-Informed Child Welfare Systems: A Guide for Administrators
- Desk Guide on Trauma-Informed Mental Health for Child Welfare
- Desk Guide on Trauma-Informed Child Welfare for Child Mental Health Practitioners
- Guidelines for Applying a Trauma Lens to a Child Welfare Practice Model
- Trauma-Informed Child Welfare Practice Toolkit
- Trauma System Readiness Tool

[Secondary Trauma and Self-care for Child Welfare Professionals](#)

[Strategies for Developing a Trauma-Informed Agency](#)

Cumulative victimization resource portals with information, research findings, and community supports:

- [Poly-victimization](#)
- [Adverse Childhood Experiences](#)

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