NCTSN The National Child Traumatic Stress Network

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

Dear Judge:

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

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

Trauma impacts many important court decisions, among them:

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

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

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

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

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

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

Sincerely,
The NCTSN Justice Consortium

NCTSN The National Child Traumatic Stress Network

NCJFCJ NATIONAL COUNCIL OF JUVENILE AND FAMILY COURT JUDGES

NCTSN BENCH CARD

FOR THE TRAUMA-INFORMED JUDGE

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

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

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

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

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

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

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

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

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

CONTINUED ON BACK →

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

NCTSN The National Child Traumatic Stress Network

NCJFCJ NATIONAL COUNCIL OF JUVENILE AND FAMILY COURT JUDGES

NCTSN BENCH CARD

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

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

1. SCREENING AND ASSESSMENT OF THE CHILD AND CAREGIVERS

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

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

2. STRENGTHS, COPING APPROACHES, AND RESILIENCE FACTORS

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

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

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

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

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

CONTINUED ON BACK →

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

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

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

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

4. TRAUMA-INFORMED SERVICES

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

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

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

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

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

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

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

What you might observe in Preschool children:

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

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

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

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

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

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

What you might observe in Elementary School students:

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

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

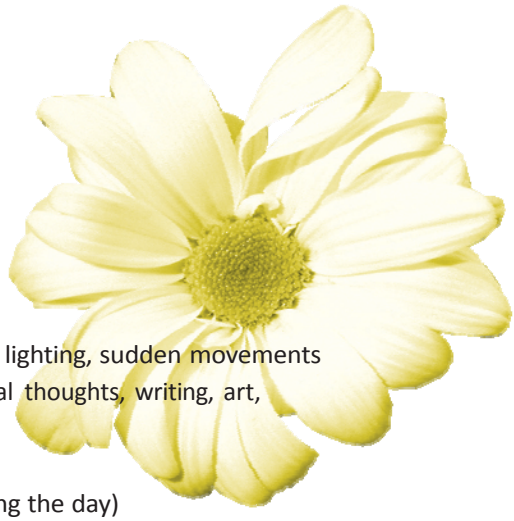
Mental health counseling that has been demonstrated to be effective in helping children deal with traumatic stress reactions typically includes the following elements:

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

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

What you might observe in High School students:

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



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

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

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

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

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

NCTSN The National Child Traumatic Stress Network

Birth Parents with Trauma Histories in the Child Welfare System

A Guide for Parents

You may be one of the many parents involved with the Child Welfare System who has experienced or witnessed dangerous, even life-threatening, events known as trauma. If so, this resource is for you. It includes facts about trauma that you may find helpful and one parent's story.

KAREN'S STORY

Karen feels completely overwhelmed. She has been trying so hard to hold everything together, but no matter how much effort she puts in, she can't seem to do anything right. She has been through a lot. She remembers watching her father beat up her mother and being put in foster care. She didn't think anything could be worse than her own childhood, but seeing her own kids go through the same stuff is worse. She never intended to end up like her mom—it just seemed to happen. Her kids' father died three years ago, and Karen wound up with a partner who hit her and them. She felt helpless, unable to protect her kids from him, but sometimes she got so upset that she would hurt them too. Six months ago, Protective Services put her kids in foster care, and now she feels even more helpless. Every time she sees Jonathan, age 3, and Crystal, age 6, they are crying and yelling, and she just can't get them to behave. Karen gets upset when they call their foster mom "Grandma." On top of it all, the caseworker Linda accuses her of not working hard enough to do the things she said she'd do. Sometimes the system makes her feel like that six-year-old foster child all over again — alone and powerless.

Although Karen wants her children back, she worries that everyone may be right: she is a bad mother. Maybe that's why her kids aren't happy to see her and why they seem to like the foster parents more. While she knows some things she could do to improve, she is too exhausted to make any changes. Her house is getting really messy, but with her kids and her boyfriend gone, it doesn't seem to matter anymore.

Karen has gone to therapy a few times, but she's never liked it. It's easier to just forget about things. Talking about them over and over only makes it harder to sleep at night. Also, she's afraid about what the therapist is saying about her to the caseworker. The couple of times she has made it to her kids' therapy appointments, she thought the therapist acted as if he knew Jonathan and Crystal better than she does. If her kids could just come home, she knows she could work everything out.

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

What is trauma?

A trauma is an intense event that threatens a person's life or safety in a way that is too much for the mind to handle and leaves the person powerless. Trauma can bring about physical reactions such as rapid heart rate, tense muscles, or shallow breathing. Common traumatic events could be going through or seeing:

- Family violence
- Sexual abuse
- Emotional abuse
- Violence in the community

For many parents, having a child removed from home and dealing with the child welfare system are traumatic events.

People who have experienced trauma might:

- Have nightmares, memories, or flashbacks that feel as if they're going through the traumatic event all over again
- Avoid things or people that remind them of the trauma
- Feel "on guard" or "jumpy," making it hard to sleep or concentrate

> Karen experienced trauma both as a child and as an adult. She saw and heard her father beating her mother. She was removed from her parents' home and put into foster care. As an adult, her partner hit her. Now, she tries not to talk about any of it, because thinking about the past makes it hard for her to sleep.

How can trauma affect you and your parenting?

A history of trauma may make it difficult for you to:

- Recognize what is safe and what is unsafe, and keep you and your children from harm
- Stay in control of your emotions, especially in stressful situations like interviews with Child Protective Services, court hearings, or visits with your children
- Deal with stress in healthy ways
- Trust other people

When parents have lived through trauma, they may also struggle with reminders of those events. Reminders can happen without warning: a sound, smell, or even a feeling makes survivors of trauma feel the experience all over again. Reactions to reminders may include:

- Physical feelings: rapid heartbeat, shallow breathing, or tense muscles
- Emotional over-reactions: anger, fear, irritability in situations or toward people— without even realizing it
- Avoiding: staying away from others or putting off daily tasks—in order to avoid more reminders
- Using alcohol or drugs to try to feel better

Trauma can affect your relationship with your child:

- Your children may not trust that you can keep them safe.
- You and your children may remind each other of the traumatic event just by being together, even if you weren't together when it happened.
- You and your children may expect "bad things" to happen again.
- You may not recognize when your children's behaviors are caused by reactions to trauma reminders and think they are misbehaving on purpose to make you mad.

Karen has trouble trusting Linda, her case worker. Linda says she's there to help, but Karen can remember plenty of people who said they'd "be there," but have ended up hurting her. Also, Linda keeps telling her to talk to the therapist about her past, but Karen would much rather avoid thinking about it.

What can you do?

If you are a parent who has had trauma, consider trying the following:

- Remember that your symptoms are normal reactions to traumatic events.
- Talk about your thoughts, feelings, and reactions with people you trust.
- Become aware of reminders of traumatic events.
- Learn healthy ways to feel safe and relaxed:
  - Practice slow breathing
  - Say positive things to yourself ("This is scary, but I'm safe now")
  - Listen to a relaxation CD or to music that calms you
  - Leave on a night light
- Find someone who has been in your shoes—who understands what it's like to be in the system and has come through it well. Your community may offer Peer Mentors or Parent Advocates for parents in the child welfare system.
- Be patient with yourself. Healing is a process that takes time.
- Be patient with your children; they may misbehave because of the trauma.
- Seek professional help. Therapy is a good way to start making sense of what happened, how it has affected you, and how you can heal.

How can therapy help?

A therapist who understands trauma will work with you to do the following:

- Feel safe
- Decide on goals for therapy
- Learn about trauma and its effects on thoughts, feelings, and actions
- Use healthy ways to relax and cope with stress
- Make sense of the past and find ways to build a more hopeful future

SIX MONTHS LATER...

What Karen has to say: I didn't realize that the trauma I went through as a child was still affecting me—making me feel helpless. Having my kids removed was the worst thing that ever happened. My life started to change when I began to believe that I could make things better for me and my kids. It's been a long time, but I have started to heal. My therapist helps me learn ways to manage my trauma symptoms, like taking slow breaths when I start to feel upset. My Parent Advocate helps me understand how my trauma reactions affect my parenting. Now, I take better care of myself AND my kids. We go to the local community center for classes and family activities, and I go to a Domestic Violence Support Group. My children are doing better too, although they still talk about bad times and have nightmares once in a while. Crystal was in trouble at school for being too active and not listening to directions, so now my kids come to therapy with me. I guess we'll go for as long as we need too. Life can be difficult at times — because I am a single mom — but it sure is better than before. I don't ever want to go back, and I know now that I don't have to.

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

Resources:

National Child Traumatic Stress Network: www.nctsn.org
National Center for PTSD: www.ptsd.va.gov
Parents Anonymous: www.parentsanonymous.org

Established by Congress in 2000, the National Child Traumatic Stress Network (NCTSN) is a unique collaboration of academic and community-based service centers whose mission is to raise the standard of care and increase access to services for traumatized children and their families across the United States. Combining knowledge of child development, expertise in the full range of child traumatic experiences, and attention to cultural perspectives, the NCTSN serves as a national resource for developing and disseminating evidence-based interventions, trauma-informed services, and public and professional education.