MODULE 2
What Is Child Traumatic Stress?

Training Time: 155 minutes (2 hours 35 minutes)

Key Learning Points

1. Child trauma comes in various forms, and many children entering the child welfare system have experienced many different types of trauma. These experiences range from abuse and neglect, to witnessing violence or the traumatic loss of a loved one, or to involvement in accidents or community violence that may be unrelated to the reason the child comes to the attention of the child welfare system.
2. Child traumatic stress should be understood utilizing a developmental and cultural framework. Trauma can derail attachment and development and requires different strategies and responses depending on the child's developmental stage.
3. Most children who come to the attention of the child welfare system have likely had multiple exposures to trauma.
4. Trauma can be cumulative, with multiple traumatic events building upon one another in a negative way. Sustained, chronic, or multiple exposures to trauma have an impact on children's development and on their ability to form attachments and relationships, to self-regulate, and to learn.
5. Without help and support, children often develop a variety of negative coping responses to traumatic stress. A child's response to traumatic stress may manifest across multiple domains of functioning and developmental processes, including emotional, behavioral, interpersonal, physiological, and cognitive functioning.
6. The realities of the child welfare system can and often do exacerbate a child's traumatic response by introducing even more stressors into the child's environment (including separation/loss of caregivers, foster placement stress, etc.). Fortunately, children often have a variety of coping responses, strengths, and protective factors that promote positive adjustment. Child welfare workers can identify these strengths and support their development and use.
7. Trauma can change children's worldviews, their sense of safety, and how they interpret the meaning of the behavior of others—including people who are trying to help them.

8. Children often have multidimensional trauma histories, and adults should not assume that they know what was most traumatic for the child. The event(s) that led to child welfare involvement may not be the child's most significant trauma experience.

ACTIVITY 2A
LECTURE, POWERPOINT SLIDES, AND AUDIO CLIP
What Is Child Traumatic Stress?

Activity Time: 25 minutes

Materials Needed

- *Comprehensive Guide,* pp. 5–9
- PowerPoint Slides 20–31
- Audio clip of Lisa 9-1-1 call (included on accompanying CD)
- Speakers (if using the LCD to project video and audio clip)

TRAINER TIP: Because of the volume of information in this module, it relies more heavily on content contained in the PowerPoint slides. Please review the slides and the *Comprehensive Guide* in detail prior to conducting a training. You may adapt the lecture/PowerPoint format to be more interactive with the group. For example, prior to presenting the material on types of trauma, you can ask the group for examples of common types of trauma experienced by children they may encounter in the child welfare system. You can then use the slides to add anything that was not covered in the participants' answers.

Trainer Activities

- Using lecture format, present the material in PowerPoint Slides 20–31. The content covered includes information on types of traumatic stress, prevalence of trauma in the United States, prevalence of trauma in child welfare populations, and other sources of ongoing stress.

- If available, you may want to substitute prevalence statistics for your state or county in this section (PowerPoint Slide 30).
- Play the audio clip of Lisa 9-1-1.

TRAINER TIP: This audio clip is an actual 9-1-1 call made to San Diego emergency services by a young girl who was witnessing a domestic violence incident between her parents. The audio clip is quite intense and may be difficult for some participants to listen to, especially those who have personally experienced or witnessed domestic violence. Before you play the recording, you should alert participants to this and tell them that they may step out of the room if they wish.

- After you play the recording, allow time for general reflections and responses. This is important due to the intensity of the material. The amount of time needed to discuss reactions to the clip may vary depending on the group. If participants need more time to process their reactions to the clip, feel free to cut out some of the following suggestions for debriefing on the clip.
- Next, ask the group to describe what they imagined was going on physically in the child's home. Then ask them what was going on internally with the child—in her brain, her body, and in her thoughts and fears. Be sure to encourage comments about Lisa's efforts to regulate her emotions and her changing emotions as the threat changed.
- Next, ask participants to describe how their own bodies and minds were reacting to this audio, which was recorded long ago and in which they were not threatened personally. Explain that while no one was actually seriously injured that night (confirmed by San Diego 9-1-1), the traumatic stress was quite obvious and real.
- Ask participants to brainstorm other types of events that might produce the same intense reactions. Look for answers such as: physical abuse/assault, sexual abuse, life-threatening violence in the house or community/school, auto accidents, natural disasters, etc.

IF PRESENTING THIS TRAINING IN TWO FULL DAYS,
TAKE A 15-MINUTE BREAK HERE.

ACTIVITY 2B
LECTURE
How Does Trauma Affect Children?

Activity Time: 30 minutes

Materials Needed

- *Comprehensive Guide,* pp. 5–8, 11–15
- PowerPoint Slides 32–44

Trainer Activities

- Using lecture format, present the material in PowerPoint Slides 32–33. This material covers information about the variability of children's responses to stressors and traumatic events and can be found in the *Comprehensive Guide,* pp. 5–6.
- Use the *Comprehensive Guide,* pp. 7–8 and pp. 11–12, and the bulleted points below to augment the information on PowerPoint Slides 34–37:

  Children with histories of complex trauma, including multiple or prolonged traumatic events, may demonstrate impairment in many of the following areas:

  - ***Attachment.*** Traumatized children feel that the world is uncertain and unpredictable. Their relationships can be characterized by problems with boundaries, as well as distrust and suspiciousness. As a result, traumatized children can become socially isolated and have difficulty relating to and empathizing with others.
  - ***Biology.*** Traumatized children demonstrate biologically based challenges, including problems with movement and sensation, hypersensitivity to physical contact, and insensitivity to pain. They can have problems with coordination, balance, and body tone, as well as unexplained physical symptoms and increased medical problems (e.g., asthma, skin problems, and autoimmune disorders).
  - ***Mood regulation.*** Children exposed to trauma can have difficulty regulating their emotions, as well as difficulty knowing and describing their feelings and internal states. They can have difficulty appropriately communicating wishes and desires to others.

- ***Dissociation.*** Some traumatized children sometimes experience a feeling of detachment or depersonalization, as if they are "observing" something happening to themselves that is unreal. They can also withdraw from the outside world or demonstrate amnesia-like states.
- ***Behavioral control.*** Traumatized children can demonstrate poor impulse control, self-destructive behavior, and aggression against others. Sleep disturbances and eating disorders can also be manifestations of child traumatic stress.
- ***Cognition.*** Children exposed to trauma can have problems focusing on and completing tasks in school, as well as difficulty planning and anticipating. They sometimes have difficulty understanding their own contribution to what happens to them. Some traumatized children demonstrate learning difficulties and problems with language development.
- ***Self-concept.*** Traumatized children can experience the lack of a continuous, predictable sense of self. They can suffer from disturbances of body image, low self-esteem, shame, and guilt.

■ Use the bulleted points below to augment the information on PowerPoint slides 38–39:

- Posttraumatic stress disorder (PTSD) is defined in the DSM-IV (APA, 2000) as:
  - The precipitating event(s) involve actual or threatened (perceived) death or serious injury, rape, or child sexual abuse, to self or others.
  - The event causes intense subjective responses, such as fear, helplessness or horror (in children, this may be expressed instead by disorganized or agitated behavior).
  - The event(s) can be acute (duration of symptoms less than three months), chronic (duration of symptoms is three months or more), or with delayed onset (onset of symptoms is six months or more after the event).

  Key symptoms in children:

  - *Persistent re-experiencing of the traumatic event:* intrusive, distressing recollections of the event; flashbacks (feeling as if the event were recurring while awake); nightmares (can involve the event or "monsters," or can be a frightening dream without recognizable content); exaggerated emotional and physical reactions to reminders of the event (e.g., a child who starts hitting the pizza delivery guy who reminds him of the suspect with the gun); trauma-specific re-enactment or repetitive play, in which themes or aspects of the trauma are expressed.

- *Avoidance:* of activities, places, thoughts, feelings, or conversation related to the trauma. A child may be unable to recall an important aspect of the trauma (e.g., children who, during forensic interviews, cannot recall details); may show markedly diminished interest or participation in significant activities; may avoid feelings or intentionally detach from others; may show a restricted range of affect and be unable to have loving feelings; or may have a sense of foreshortened future.
- *Increased arousal:* difficulty sleeping; irritability or outbursts of anger; difficulty concentrating; hypervigilance; exaggerated startle response.

- PowerPoint Slide 40 identifies other common diagnoses for children in the child welfare system: Reactive Attachment Disorder, Attention Deficit Hyperactivity Disorder, Oppositional Defiant Disorder, Bipolar Disorder and Conduct Disorder. Emphasize that these diagnoses generally do not capture the full extent of the developmental impact of trauma.
- PowerPoint Slides 41–44 focus on the effect of trauma on the brain. If you, as the trainer, need more information about this topic, please refer to the following resources:
  - Putnam, F. (2006) The impact of trauma on brain development. *Juvenile and Family Court Journal, 57*(1), 1–12.
  - DeBellis, M. D. (2005). The psychobiology of neglect. *Child Maltreatment, 10*(2), 150–172.
  - Perry, B. D., & Marcellus, J. E. (1997). The impact of abuse and neglect on the developing brain. [Electronic Version]. *Colleagues for Children, Missouri Chapter of the National Committee to Prevent Child Abuse, 7,* 1–4. Retrieved January 31, 2008, from http://www.childtrauma.org/ctamaterials/AbuseBrain.asp.

ACTIVITY 2C
LECTURE AND DISCUSSION
What Is the Influence of Culture?

Activity Time: 20 minutes

Materials Needed

- *Comprehensive Guide,* pp. 15–16
- PowerPoint Slides 45–51

Trainer Activities

- Using lecture format, present the material in PowerPoint Slides 45–49. These slides cover the mutual influences of culture and trauma.

TRAINER TIP: If you are less familiar with specific dynamics of sexual abuse, you may wish to read two of the citations in the bibliography in preparation for this activity: Roland Summit's landmark article, "The child sexual abuse accommodation syndrome" (see full citation on p. 107 of this *Training Guide*), and Chapter 6 in Lisa Aronson Fontes' *Child Abuse and Culture* (see p. 105 of this *Training Guide*). If you have access to the Fontes book, you may wish to mark examples of certain cases to supplement the case examples *(see below)* provided by participants.

- Use the bulleted points below to augment the information on PowerPoint Slide 49:
  - We are going to look at one type of child traumatic stress—sexual abuse—as an example of how culture might influence responses to trauma.
  - In her book, *Child Abuse and Culture,* Lisa Aronson Fontes notes that shame is a central notion in the experience of sexual abuse. She also notes that the degree of shame still experienced one year after a disclosure of sexual abuse correlated greatly with adjustment, and that it was even more important than the severity of the abuse in determining how children fared psychologically.

- Emphasize the importance of using community and family allies (e.g., priests, spiritual leaders) when possible, in order to make a child and/or family feel more comfortable.
- Fontes notes that shame as an aspect of sexual abuse is nearly universal, but the way that children experience it and the way it is handled by others (including and most especially, their family) varies within different cultures.
- Slide 49 notes the eight components of shame described by Fontes. Define each of these components of shame *(see below).* As time allows, ask participants to volunteer their own case examples to illustrate several of these components. Encourage participants to share examples of situations in which culture provided strength and contributed to a decrease in the experience of shame, AND situations in which a cultural frame may have increased a child's shame.

TRAINER TIP: You should listen carefully to the discussion to correct any stereotypes that emerge during this conversation. For example, this discussion tends to elicit case examples involving religion and religion's negative attribution of shame. Remind participants that these stories depict individual cases and the role of culture in them but that culture can increase children's experience of stress as well as contribute to strength and resilience. Also, remember to tie the discussion back to how culture specifically impacts trauma.

- ***Responsibility for the abuse.*** Sometimes, blame for the abuse may be inappropriately placed on actions of the child or non-offending parent, rather than on the offender, by the child, the family, and community members.
- ***Failure to protect.*** This generally refers to the actions of non-offending parents or other family/kin/community members, and can profoundly affect belief systems regarding the role of parents, gender roles, etc.
- ***Fate.*** Some cultures place a locus of control on the individual, or on forces beyond, which they use to explain how/why sexual abuse has occurred.
- ***Damaged goods.*** This is the sense of being soiled, dirty, bad, or unworthy as a result of the sexual abuse. This can be especially poignant for victims who complied with the abuser's demands, who experienced sexual arousal or orgasm during the sexual abuse, or who enjoyed the closeness and favored status that the relationship with the perpetrator offered.

- ***Virginity.*** Virginity is highly valued among numerous ethnic, religious, and regional groups. In many cultures, a girl who has engaged in any kind of sexual activity, even against her will, may be perceived as having lost her virginity and thereby be considered either unsuitable for marriage or of lesser value as a bride. Children who have promised "abstinence only" or taken "pledges of virginity" may feel that they have not lived up to their pledge.

- ***Predictions of a shameful future.*** Cultural and popular notions hold that girls who have experienced sexual abuse are likely to become promiscuous and that boys who are abused by men are likely to become homosexuals or offenders. Families may also severely punish the sexual play, masturbation, or reenactment behaviors that occur during or following victimization. Families with taboos about discussing any kind of sexual behavior may be particularly reluctant to discuss sexual abuse, contributing to a feeling that it is too shameful to discuss. Conversely, families comfortable with discussing sexual issues may create an environment where the child feels comfortable disclosing details and feelings about the abuse.

- ***Revictimization.*** In some cultures, if a girl is known to have been sexually abused or considered to have been "asking for it," she is considered "fair game" for additional victimization. Or families may be so fearful of revictimization that they overprotect or isolate their children. This can contribute to children feeling that they are being punished for their victimization or that it is their fault.

- ***Layers of shame.*** Members of certain cultures, minority groups in particular, can either feel proud and empowered because of their cultural identity, or ashamed for not conforming to a dominant "ideal."

- End the lecture and discussion with Slides 50–51, "What can a child welfare worker do?"

ACTIVITY 2D
LECTURE
What Is the Influence of Developmental Stage?

Activity Time: 25 minutes

Materials Needed

- *Comprehensive Guide,* p. 17
- PowerPoint Slides 52–59

Trainer Activities

- Using lecture format, present the material in PowerPoint Slides 52–59. These slides cover the mutual relationships between developmental stage and trauma.

TRAINER TIP: The sources for these slides are the *Comprehensive Guide* as well as the NCTSN fact sheets in Appendix C. You are encouraged to read these documents as part of your preparation for this section. Additional fact sheets related to trauma can be found on the NCTSN web site (www.nctsn.org). Several slides address the relationship between trauma and substance abuse in adolescence. These resources are designed to help workers prepare to look for possible substance abuse and other "behaviors in need of immediate stabilization" in the *Child Welfare Trauma Referral Tool,* introduced in Module 4.

- After presenting the PPT slides, acknowledge that working with adolescents can be difficult.
- Ask participants to raise case examples from their own practice that illustrate the challenges they have faced when working with adolescents involved in the child welfare system. Encourage participants to share strategies that can overcome some of these challenges.
- Allow ample time for comments and questions.

**IF PRESENTING THIS TRAINING IN TWO FULL DAYS,
TAKE A ONE-HOUR LUNCH BREAK HERE.**

ACTIVITY 2E
CASE VIGNETTE
Tommy

Activity Time: 45 minutes

Materials Needed

- Supplemental Handout: *Case Vignette—Tommy*
- Flip chart
- Markers

Trainer Activities

- Break participants into three small groups.
- Distribute *Case Vignette—Tommy.*
- Review the instructions on the case vignette. Participants will complete all three Sections listed under Case Exercise, before returning to the large group.
- With 10 minutes remaining, gather the large group together. Have each of the groups report on ONE of the questions (a–c) in Section 3 of the case vignette, Evaluation and Assessment. After each presentation, solicit additional ideas from the other two groups.

ACTIVITY 2F
LECTURE AND DISCUSSION
What Child Welfare Workers Can Do

Activity Time: 10 minutes

Materials Needed

- *Comprehensive Guide,* pp. 18–19
- PowerPoint Slides 60–62
- Flip chart
- Markers

Trainer Activities

- Ask participants: "What thoughts/feelings/concerns did the Tommy case bring up for you?" Answers to this question can help to provide you with a "pulse" on how participants are managing this emotionally-laden material, and help you to identify important points to discuss regarding what child welfare workers and systems can do to prevent further traumatization of children.
- Ask the group how the child welfare system may have contributed adversely to Tommy's trauma history. Lead the discussion to underline the traumatic impact of removal and placement, of losses of contact with family, siblings (through separate placements), pets, neighbors, etc. Also draw out discussion about the impact of multiple placements, changes in schools and therapists, and other transitions and losses common in the child welfare system.

TRAINER TIP: Child welfare workers may perceive other system entities (courts, foster parents, schools, therapists) as barriers to the Essential Elements. Discussion can quickly deteriorate into "blaming." It is critical that you appreciate the potential system barriers while simultaneously challenging worker participants to be aware of how they can shift their practice to be more trauma-informed. Otherwise, the discussion becomes a complaint forum rather than a vehicle for self-reflection and possible change. You should be sure to emphasize that when systems such as child welfare, the courts, and mental health are trauma-informed, care can be taken to prevent further traumatization to the child.

- Summarize the above discussions: Although we sometimes tend to dwell on the way the "system" adversely affects children, there are many things a child welfare worker can do proactively to minimize trauma and to assist in healing.
- Present the material in PowerPoint Slides 60–62. Ask participants to list ideas about actions that child welfare workers can take, utilizing material they heard during the morning in the *Lisa 9-1-1 audio clip* and the morning's discussion, and any additional ideas from their own work experience. List these ideas on the flip chart. Tell participants that the *Comprehensive Guide* lists additional ideas.

IF PRESENTING THIS TRAINING IN TWO FULL DAYS,
TAKE A 15-MINUTE BREAK HERE.