



**September 16,
2016**

**8:00 - 5:00 pm
Continental Breakfast,
Lunch and
Reception**

**LOCATION:
USF St. Petersburg
USC 200 6th Ave S.
St. Petersburg, 33701**



**Thank You
Sponsors!**

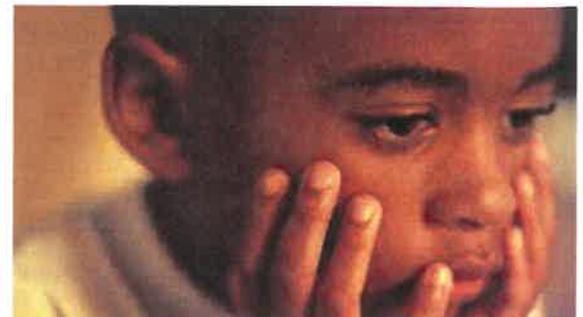
Adverse Childhood Experiences: Recognized and Addressed in Family Court

Participants:

USF St. Petersburg, Judges, General Magistrates, Child Support Hearing Officers, and Case Managers of the 6th Circuit Family Law Division; Family Law Attorneys; and the Mental Health & Medical Community



Training Content: Understand Trauma, Toxic Stress and ACEs and their effect on Children and Families. Develop a collaborative partnership with The Family Court, Family Attorneys, and Mental Health Community to Effectively address the trauma and toxic stress in high conflict Family Law cases



Adverse Childhood Experiences: Recognized and Addressed in Family Court



September 16, 2016

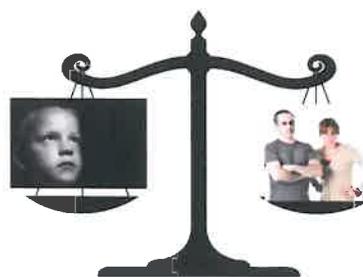
8:00 am - 5:00 pm

Conference Agenda

- 8:00 – 9:00 Registration – Continental Breakfast
- 9:00 – 9:10 Welcome- Judge Jack Helinger
- 9:10 – 9:45 Introduction to ACEs- Video presentation- Lela Bloodsworth, LMHC
- 9:45 – 10:00 ACE test (Personal & pending/closed case)
- 10:00 – 10:30 Introduction to the Effects of ACEs and Trauma throughout the Lifespan-
Lisa S. Negrini, LCSW USFSP Family Study Center
- 10:30 – 10:45 Break
- 10:45 – 12:00 ACE's in High Conflict Families and Family Court Processes- James P.
McHale Ph.D. and Lisa S. Negrini, LCSW
- 12:00 - 1:15 Luncheon Plenary- James P. McHale, Ph.D. USFSP Family Study Center-
Supporting Children through Trauma-Informed Coparenting Alliances
- 1:30 - 2:20 Small Group Discussion by Profession- (Break-outs)
1) Judges, 2) Attorneys, 3) Mental Health Community, 4) Politicians,
Parenting Coordinators, GAL's, General Magistrates, Court Admin.,
and Others.
- 2:20 - 2:30 Break
- 2:30 - 3:00 Table Discussions- (Back at your tables) Mixed Professions
- 3:00 - 4:00 Report out and Sharing- Conceptualizations of Future Efforts
- 4:00- 5:00 Networking Reception



HOW DOES THIS WORK FOR CHILDREN????



Adverse Childhood Experiences: Recognized and Addressed in Family Court

Instruction Sheet for Break-Outs:

Small Group Discussion by Profession- (Break-outs with Committee Members facilitating discussions)

The Group will be divided up into 4 groups by profession-

- 1) Judges
- 2) Attorneys
- 3) Mental Health
- 4) GAL's, General Magistrates, Court Admin, Case Workers, School Admin., Politicians, Other

Each group will meet to discuss the following questions:

- 1) What can your profession do to minimize the impact of ACEs for children in high conflict families?
- 2) What strategies can your profession implement to reduce the impact of trauma and/or heal the impact of trauma on children?
- 3) How can your profession work with other professions/stakeholders within the Family Law Division to minimize the negative effects of ACES on children?

Second Discussion Session- At original tables:

Table Discussions- Please return to your tables to have a discussion your table professionals

Each table will meet to discuss the following questions:

- 1) In what ways can Family Law division professionals work together to minimize the impact of ACEs on children? (to be documented for distribution)
- 2) How would we begin to implement those ways?
- 3) What are one or two priority actions that we can implement to begin to create change in the Family Law court system?

Whole room report out and share answering this question:

- 1) What is the most important action step that we can take to create a more trauma-informed, responsive Family Law Division to reduce the effect of ACEs on children?



Register Today!

Join Us!

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Continental Breakfast
8:00-9:00
Reception 4:00-5:00

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USC 200 6th Ave S.
St. Petersburg, 33701



**Sponsorships
Invited!**

(at the \$250 level)

Adverse Childhood Experiences: Recognized and Addressed in Family Court

Discussing and Considering...

- ◇ Trauma, Toxic Stress and Adverse Childhood Experiences (ACEs) during Family Court process
- ◇ How to Reduce the Negative Effects of Trauma and ACEs in High Conflict Families

Participants:

USF St. Petersburg, Judges, General Magistrates, Child Support Hearing Officers, and Case Managers of the 6th Circuit Family Law Division; Family Law Attorneys; Mental Health & Medical Community; (Psychologists, Parenting Coordinators, Physicians, Family and Child Counselors)
CLE, CEU's available (7 hours)
(mental health professionals, psychologists, attorneys, judges)



Training Content:

Understand Trauma, Toxic Stress and ACEs and their effect on Children and Families. Develop a collaborative partnership with The Family Court, Family Attorneys, and Mental Health Community to Effectively address the trauma and toxic stress in high conflict Family Law cases

Register today at: Click here or go to

https://secure.touchnet.com/C20235_ustores/web/product_detail.jsp?PRODUCTID=5718

Or contact Radhika Dang at rdang@mail.usf.edu

**Cost: \$50.00 includes breakfast,
lunch and reception and CLE/CEU's**



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17. Doreen & Philip A. McLeod, Esq.
18. Myrtle Avenue Pediatrics – Greg Savel, M.D.
19. Lynn Romano, M.A .
20. The Fleming Law Group
21. Clarie Law Offices, P.A.
22. Child Advocacy Foundation
23. McClanathan, Burg & Associates , LLC



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<http://www.usfsp.edu/wp-content/uploads/2012/01/CAMPUSMAP300.pdf>

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Finding Your ACE Score

While you were growing up, during your first 18 years of life:

1. Did a parent or other adult in the household **often or very often...**
Swear at you, insult you, put you down, or humiliate you?
or
Act in a way that made you afraid that you might be physically hurt?
Yes No If yes enter 1 _____
2. Did a parent or other adult in the household **often or very often...**
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or
Ever hit you so hard that you had marks or were injured?
Yes No If yes enter 1 _____
3. Did an adult or person at least 5 years older than you **ever...**
Touch or fondle you or have you touch their body in a sexual way?
or
Attempt or actually have oral, anal, or vaginal intercourse with you?
Yes No If yes enter 1 _____
4. Did you **often or very often** feel that ...
No one in your family loved you or thought you were important or special?
or
Your family didn't look out for each other, feel close to each other, or support each other?
Yes No If yes enter 1 _____
5. Did you **often or very often** feel that ...
You didn't have enough to eat, had to wear dirty clothes, and had no one to protect you?
or
Your parents were too drunk or high to take care of you or take you to the doctor if you needed it?
Yes No If yes enter 1 _____
6. Were your parents **ever** separated or divorced?
Yes No If yes enter 1 _____
7. Was your mother or stepmother:
Often or very often pushed, grabbed, slapped, or had something thrown at her?
or
Sometimes, often, or very often kicked, bitten, hit with a fist, or hit with something hard?
or
Ever repeatedly hit at least a few minutes or threatened with a gun or knife?
Yes No If yes enter 1 _____
8. Did you live with anyone who was a problem drinker or alcoholic or who used street drugs?
Yes No If yes enter 1 _____
9. Was a household member depressed or mentally ill, or did a household member attempt suicide?
Yes No If yes enter 1 _____
10. Did a household member go to prison?
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Now add up your "Yes" answers: _____ This is your ACE Score.

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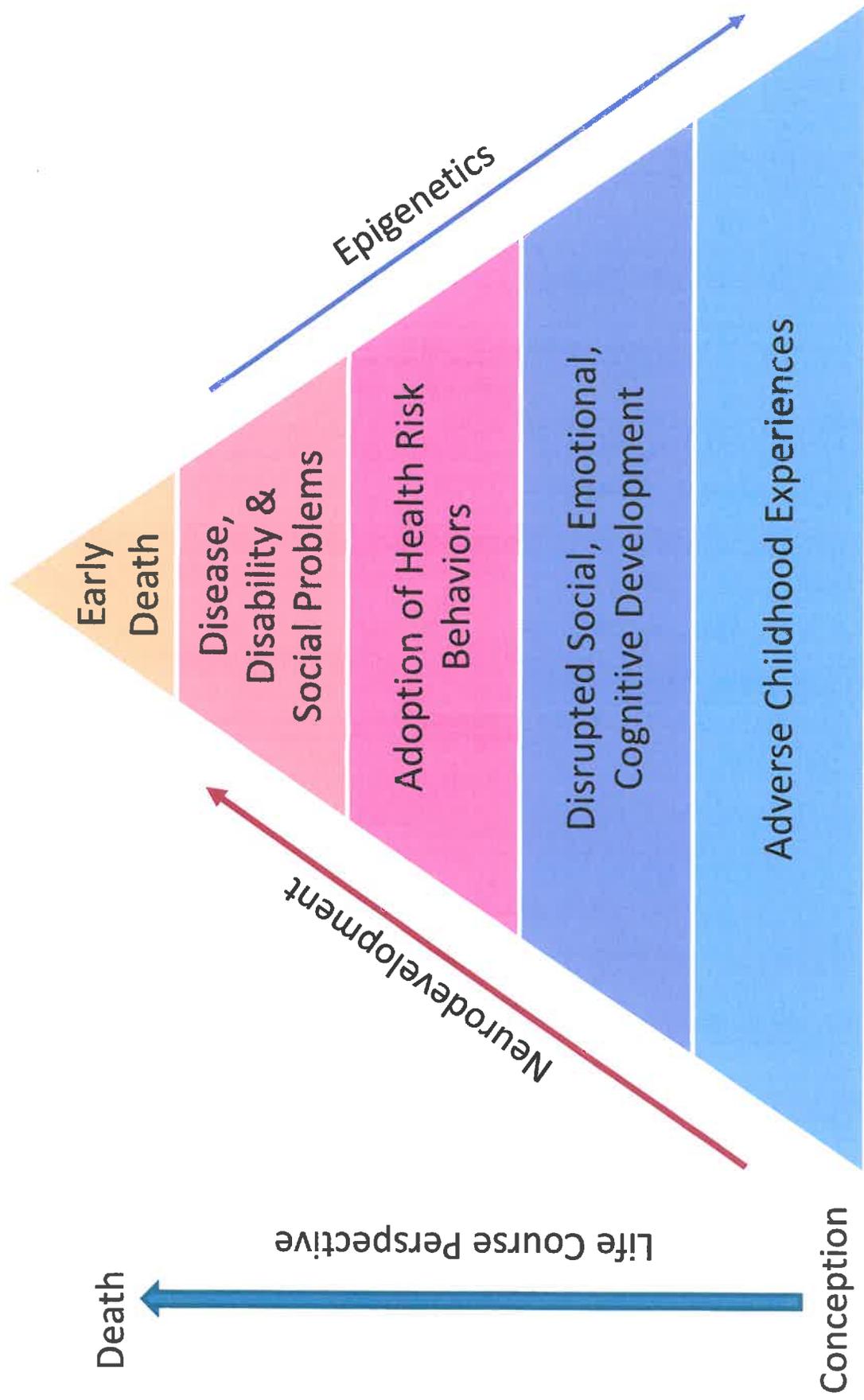
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Adverse Childhood Experience “The ACE Study”



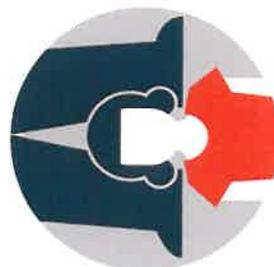
ABUSE



Physical



Emotional



Sexual

NEGLECT



Physical

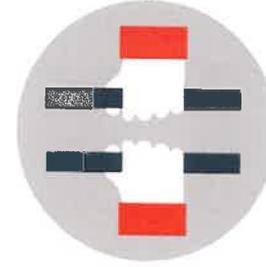


Emotional

HOUSEHOLD DYSFUNCTION



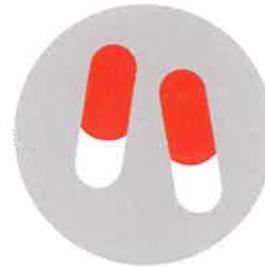
Mental Illness



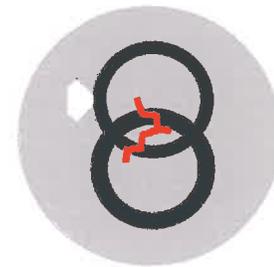
Incarcerated Relative



Mother treated violently



Substance Abuse



Divorce

Outcomes Attributable to ACEs

Risk

Smoking
Heavy drinking
Obesity
Risk of AIDS
Taking painkillers to get high
Obesity

Poor Mental Health

Frequent mental distress
Sleep disturbances
Nervousness
MH problem requiring medication
Emotional problems restrict activities
Serious & persistent mental illness

Health & Social Problems

Fair or poor health
Life dissatisfaction
Health-related limits to quality of life
Disability that impedes daily functioning
Don't complete secondary education
Unemployment
History of adult homelessness

Prevalent Disease

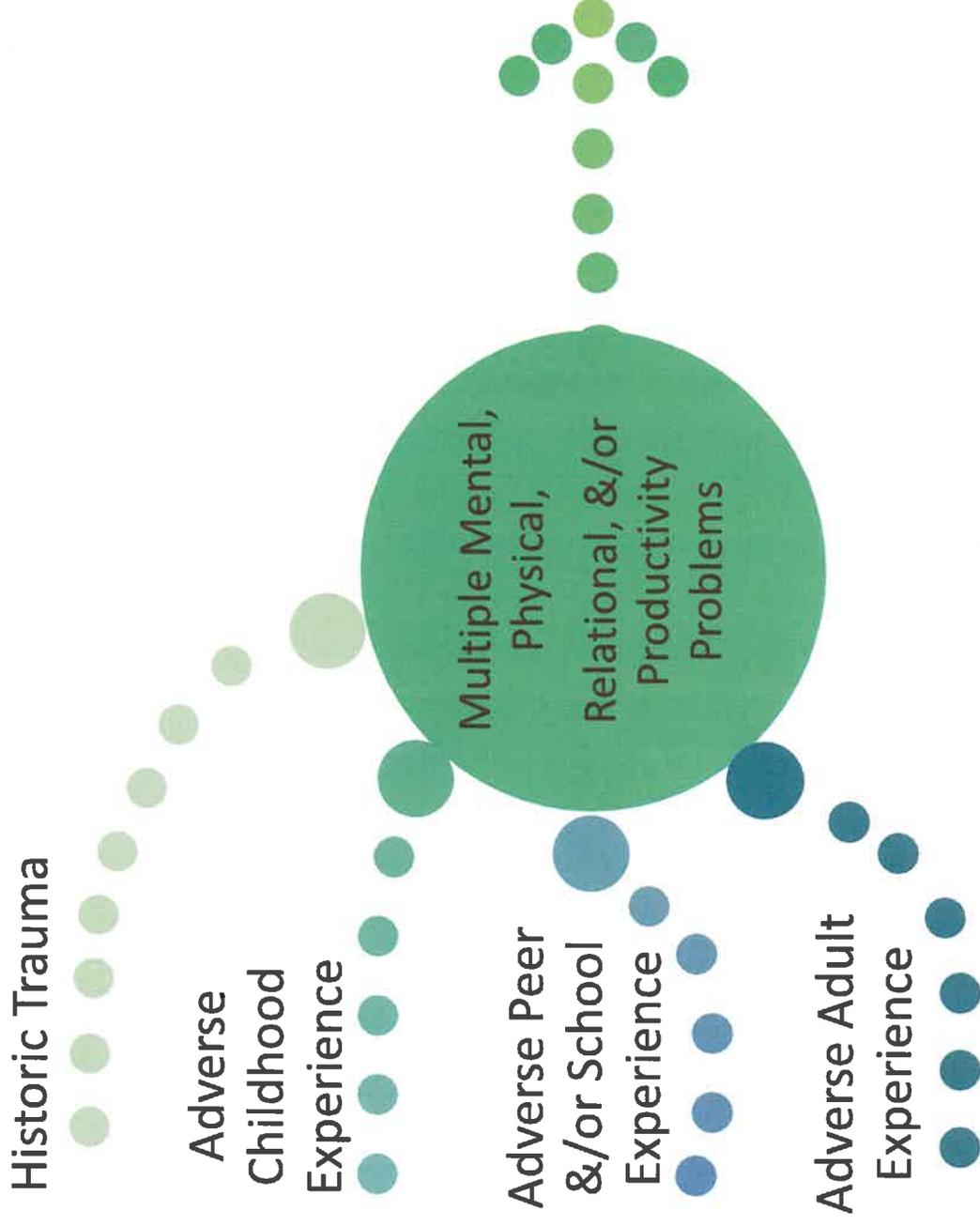
Cardiovascular
Cancer
Asthma
Diabetes
Auto immune
COPD
Ischemic heart disease
Liver disease

Intergenerational ACE Transmission

Mental Illness
Drugs or Alcohol Problem
Multiple divorces, separations
Victim of family violence
Adult incarceration

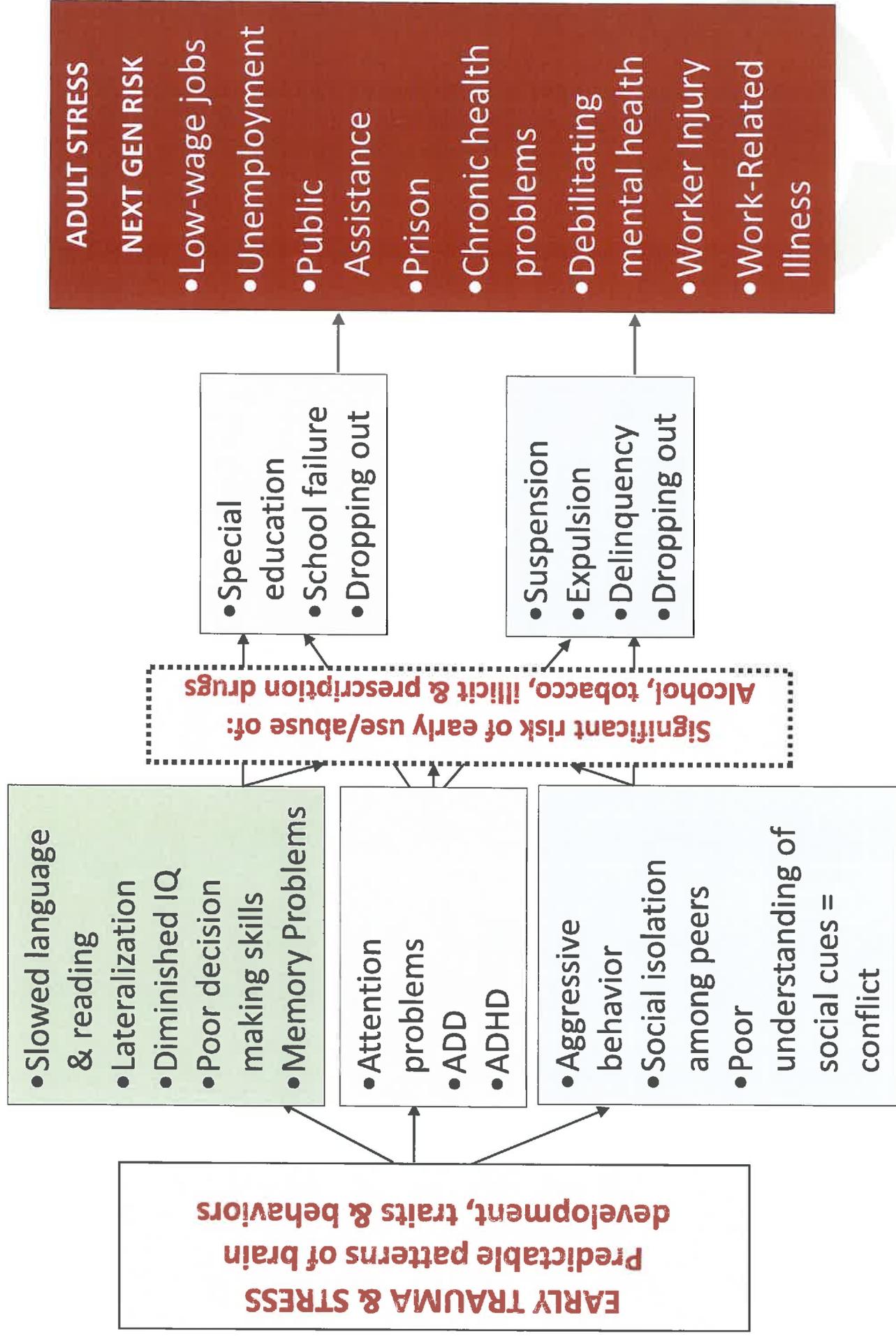


Cascade of Experience- Societal Response Matters

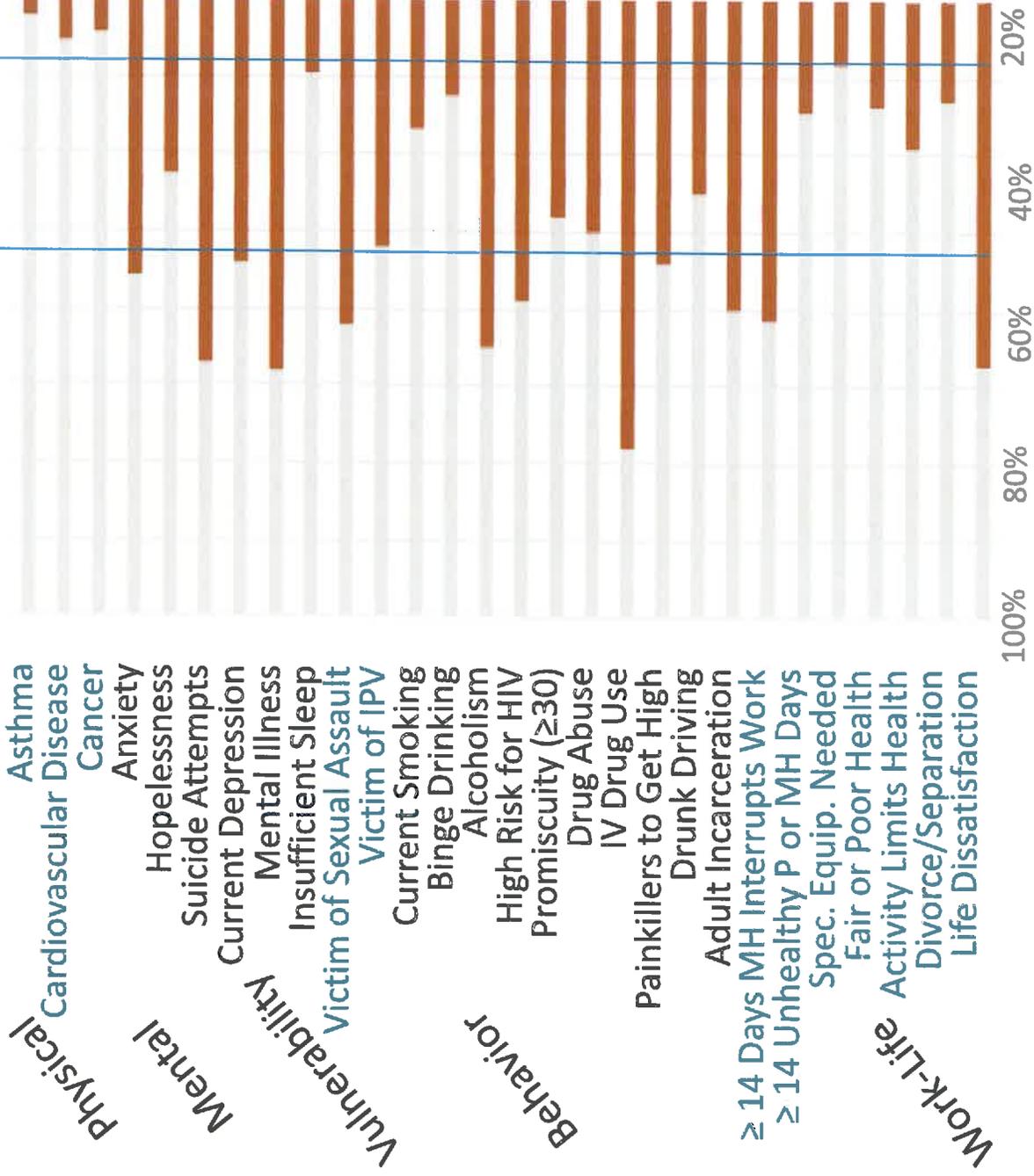


ACE
Transmission
Risk

The Fast Track to Poverty



The Magnitude of the Solution



Population Risk of Disease Attributable to ACEs.

ACE Prevention Reliably Predicts Concurrent Rate Reductions for All ACE-Attributable Problems



STRESS & EARLY BRAIN GROWTH

Understanding Adverse Childhood Experiences (ACEs)

What are ACEs?

ACEs are serious childhood traumas -- a list is shown below -- that result in toxic stress that can harm a child's brain. This toxic stress may prevent child from learning, from playing in a healthy way with other children, and can result in long-term health problems.

Adverse Childhood Experiences can include:

1. Emotional abuse
2. Physical abuse
3. Sexual abuse
4. Emotional neglect
5. Physical neglect
6. Mother treated violently
7. Household substance abuse
8. Household mental illness
9. Parental separation or divorce
10. Incarcerated household member
11. Bullying (by another child or adult)
12. Witnessing violence outside the home
13. Witness a brother or sister being abused
14. Racism, sexism, or any other form of discrimination
15. Being homeless
16. Natural disasters and war

Exposure to childhood ACEs can increase the risk of:

- Adolescent pregnancy
- Alcoholism and alcohol abuse
- Depression
- Illicit drug use
- Heart disease
- Liver disease
- Multiple sexual partners
- Intimate partner violence
- Sexually transmitted diseases (STDs)
- Smoking
- Suicide attempts
- Unintended pregnancies

How do ACEs affect health?

Through stress. Frequent or prolonged exposure to ACEs can create toxic stress which can damage the developing brain of a child and affect overall health.

Reduces the ability to respond, learn, or figure things out, which can result in problems in school.

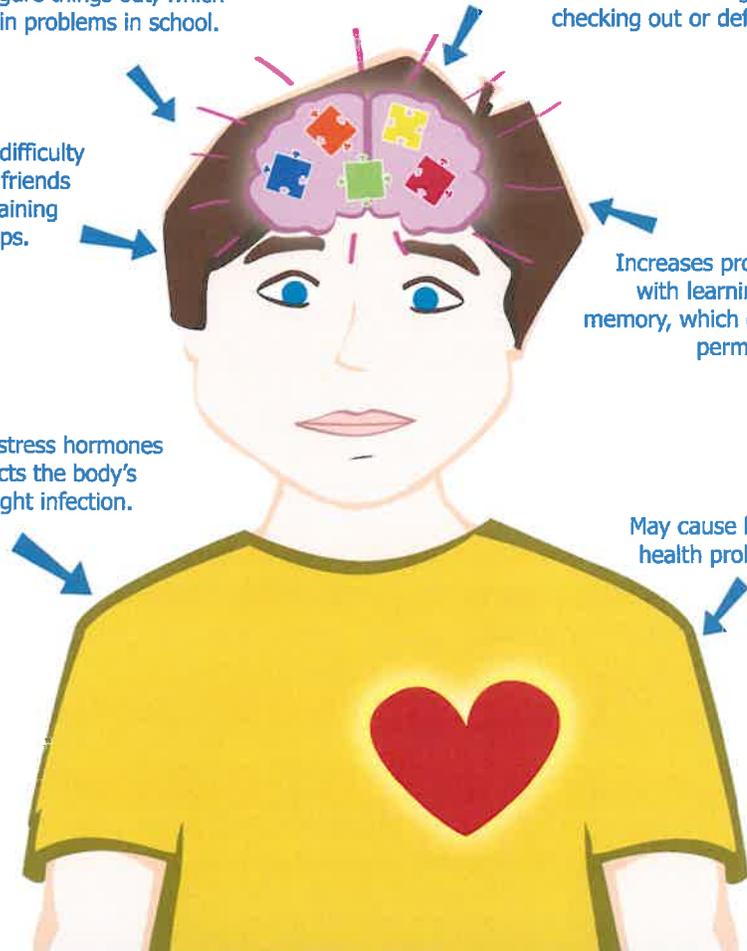
Lowers tolerance for stress, which can result in behaviors such as fighting, checking out or defiance.

Increases difficulty in making friends and maintaining relationships.

Increases problems with learning and memory, which can be permanent.

Increases stress hormones which affects the body's ability to fight infection.

May cause lasting health problems.



A Survival Mode Response to toxic stress increases a child's heart rate, blood pressure, breathing and muscle tension. Their thinking brain is knocked off-line. Self-protection is their priority. In other words:

"I can't hear you! I can't respond to you! I am just trying to be safe!"

The good news is resilience can bring back health and hope!

What is Resilience?

Resilience is the ability to return to being healthy and hopeful after bad things happen. Research shows that if parents provide a safe environment for their children and teach them how to be resilient, that helps reduce the effects of ACEs.

Resilience trumps ACEs!

Parents, teachers and caregivers can help children by:

- Gaining an understanding of ACEs
- Creating environments where children feel safe emotionally and physically
- Helping children identify feelings and manage emotions
- Creating a safe physical and emotional environment at home, in school, and in neighborhoods

What does resilience look like?

1. Having resilient parents

Parents who know how to solve problems, who have healthy relationships with other adults, and who build healthy relationships with their children.

2. Building attachment and nurturing relationships

Adults who listen and respond patiently to a child in a supportive way, and pay attention to a child's physical and emotional needs.

3. Building social connections

Having family, friends and/or neighbors who support, help and listen to children.

4. Meeting basic needs

Providing children with safe housing, nutritious food, appropriate clothing, and access to health care and good education.

5. Learning about parenting and how children grow

Understanding how parents can help their children grow in a healthy way, and what to expect from children as they grow.

6. Building social and emotional skills

Helping children interact in a healthy way with others, manage their emotions and communicate their feelings and needs.

Resources:

ACES 101

<http://acestoohigh.com/aces-101/>

Triple-P Parenting

www.triplep-parenting.net/global/en/home/

Resilience Trumps ACEs

www.resiliencetrumpsACEs.com

CDC-Kaiser Adverse Childhood Experiences Study

www.cdc.gov/violenceprevention/acesstudy/

Zero to Three Guides for Parents

www.zerotothree.org/about-us/areas-of-expertise/free-parent--brochures-and-guides/



Got Your ACE Score?

What's Your ACE Score? (and, at the end, What's Your Resilience Score?)

There are 10 types of childhood trauma measured in the ACE Study. Five are personal — physical abuse, verbal abuse, sexual abuse, physical neglect, and emotional neglect. Five are related to other family members: a parent who's an alcoholic, a mother who's a victim of domestic violence, a family member in jail, a family member diagnosed with a mental illness, and the disappearance of a parent through divorce, death or abandonment. Each type of trauma counts as one. So a person who's been physically abused, with one alcoholic parent, and a mother who was beaten up has an ACE score of three.

There are, of course, many other types of childhood trauma — watching a sibling being abused, losing a caregiver (grandmother, mother, grandfather, etc.), homelessness, surviving and recovering from a severe accident, witnessing a father being abused by a mother, witnessing a grandmother abusing a father, etc. The ACE Study included only those 10 childhood traumas because those were mentioned as most common by a group of about 300 Kaiser members; those traumas were also well studied individually in the research literature.

The most important thing to remember is that the ACE score is meant as a guideline: If you experienced other types of toxic stress over months or years, then those would likely increase your risk of health consequences.

Prior to your 18th birthday:

1. Did a parent or other adult in the household often or very often... Swear at you, insult you, put you down, or humiliate you? or Act in a way that made you afraid that you might be physically hurt?
No___If Yes, enter 1 __
2. Did a parent or other adult in the household often or very often... Push, grab, slap, or throw something at you? or Ever hit you so hard that you had marks or were injured?
No___If Yes, enter 1 __
3. Did an adult or person at least 5 years older than you ever... Touch or fondle you or have you touch their body in a sexual way? or Attempt or actually have oral, anal, or vaginal intercourse with you?
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6. Were your parents ever separated or divorced?
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No ___ If Yes, enter 1 ___

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

No ___ If Yes, enter 1 ___

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

No ___ If Yes, enter 1 ___

10. Did a household member go to prison?

No ___ If Yes, enter 1 ___

Now add up your "Yes" answers: _ This is your ACE Score

Now that you've got your ACE score, what does it mean?

First...a tiny bit of background to help you figure this out....(if you want the back story about the fascinating origins of the ACE Study, read [The Adverse Childhood Experiences Study — the largest, most important public health study you never heard of — began in an obesity clinic. \(https://acestoohigh.com/2012/10/03/the-adverse-childhood-experiences-study-the-largest-most-important-public-health-study-you-never-heard-of-began-in-an-obesity-clinic/\)](https://acestoohigh.com/2012/10/03/the-adverse-childhood-experiences-study-the-largest-most-important-public-health-study-you-never-heard-of-began-in-an-obesity-clinic/))

The CDC's Adverse Childhood Experiences Study (ACE Study (<http://www.cdc.gov/ace/index.htm>)) [uncovered \(http://www.cdc.gov/ace/findings.htm\)](http://www.cdc.gov/ace/findings.htm) a stunning link between childhood trauma and the chronic diseases people develop as adults, as well as social and emotional problems. This [includes \(http://www.newyorker.com/reporting/2011/03/21/110321fa](http://www.newyorker.com/reporting/2011/03/21/110321fa) fact tough) heart disease, lung cancer, diabetes and many autoimmune diseases, as well as depression, violence, being a victim of violence, and suicide.

The first research results [were published in 1998, followed by 57 other publications through 2011 \(https://acestoohigh.com/research/\)](https://acestoohigh.com/research/). They showed that:

- o childhood trauma was very common, even in employed white middle-class, college-educated people with great health insurance;
- o there was a direct link between childhood trauma and adult onset of chronic disease, as well as depression, suicide, being violent and a victim of violence;
- o more types of trauma increased the risk of health, social and emotional problems.
- o people usually experience more than one type of trauma – rarely is it only sex abuse or only verbal abuse.

A whopping two thirds of the 17,000 people in the ACE Study had an ACE score of at least one — 87 percent of those (http://www.acestudy.org/yahoo_site_admin/assets/docs/ARV1N1.127150541.pdf) had more than one. Eighteen states have done their own ACE surveys; their results are similar to the CDC's ACE Study.

Number of Adverse Childhood Experiences (ACE Score)	Women	Men	Total
0	34.5	38.0	36.1
1	24.5	27.9	26.0
2	15.5	16.4	15.9
3	10.3	8.6	9.5
4 or more	15.2	9.2	12.5

(<https://acestoohigh.files.wordpress.com/2011/11/acescores.png>)

The study's researchers came up with an ACE score to explain a person's risk for chronic disease. Think of it as a cholesterol score for childhood toxic stress. You get one point for each type of trauma. The higher your ACE score, the higher your risk of health and social problems. (Of course, other types of trauma exist that could contribute to an ACE score, so it is conceivable that people could have ACE scores higher than 10; however, the ACE Study measured only 10 types.)

As your ACE score increases, so does the risk of disease, social and emotional problems. With an ACE score of 4 or more, things start getting serious. The likelihood of chronic pulmonary lung disease increases (<https://acestoohigh.com/category/ace-study/>) 390 percent; hepatitis, 240 percent; depression 460 percent; suicide, 1,220 percent.

(By the way, lest you think that the ACE Study was yet another involving inner-city poor people of color, take note: The study's participants were 17,000 mostly white, middle and upper-middle class college-educated San Diegans with good jobs and great health care – they all belonged to the Kaiser Permanente health maintenance organization.)

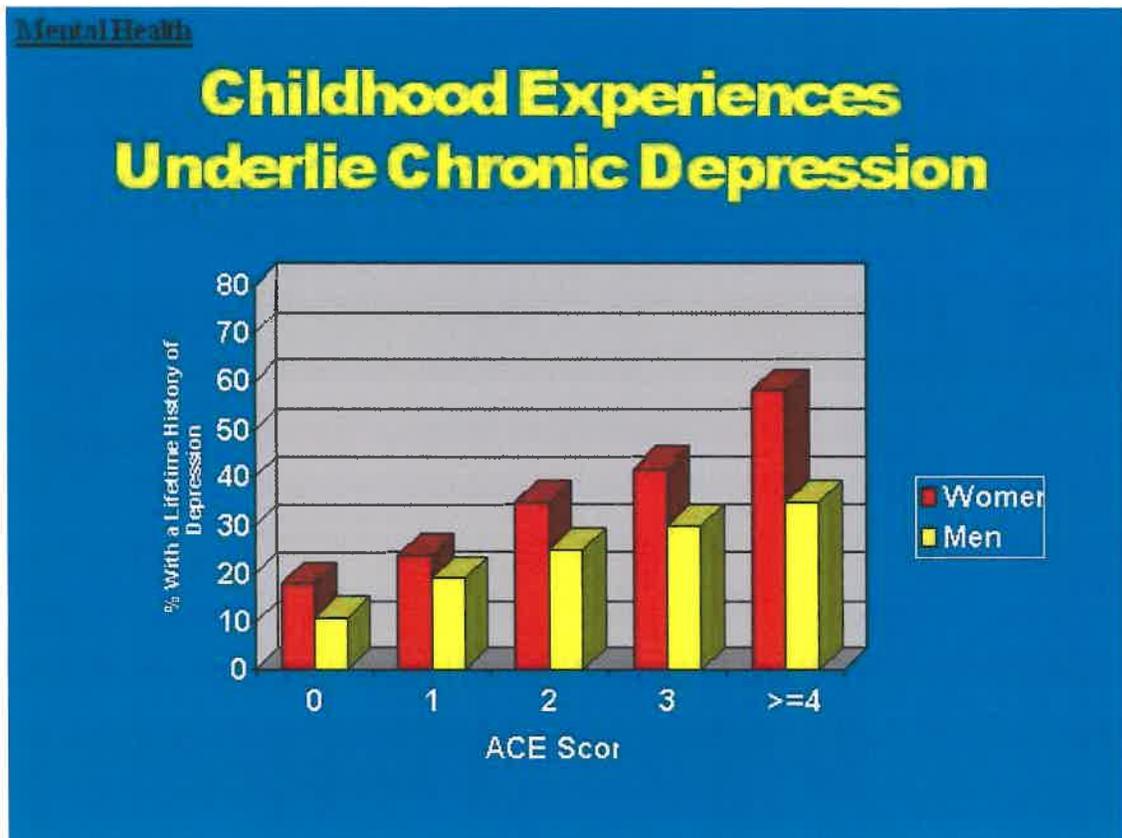
Adverse Childhood Experiences Are Common	
<u>Household dysfunction:</u>	
Substance abuse	27%
Parental sep/divorce	23%
Mental illness	17%
Battered mother	13%
Criminal behavior	6%
<u>Abuse:</u>	
Psychological	11%
Physical	28%
Sexual	21%
<u>Neglect:</u>	
Emotional	15%
Physical	10%

(<https://acestoohigh.files.wordpress.com/2011/11/aceslist1.jpg>)

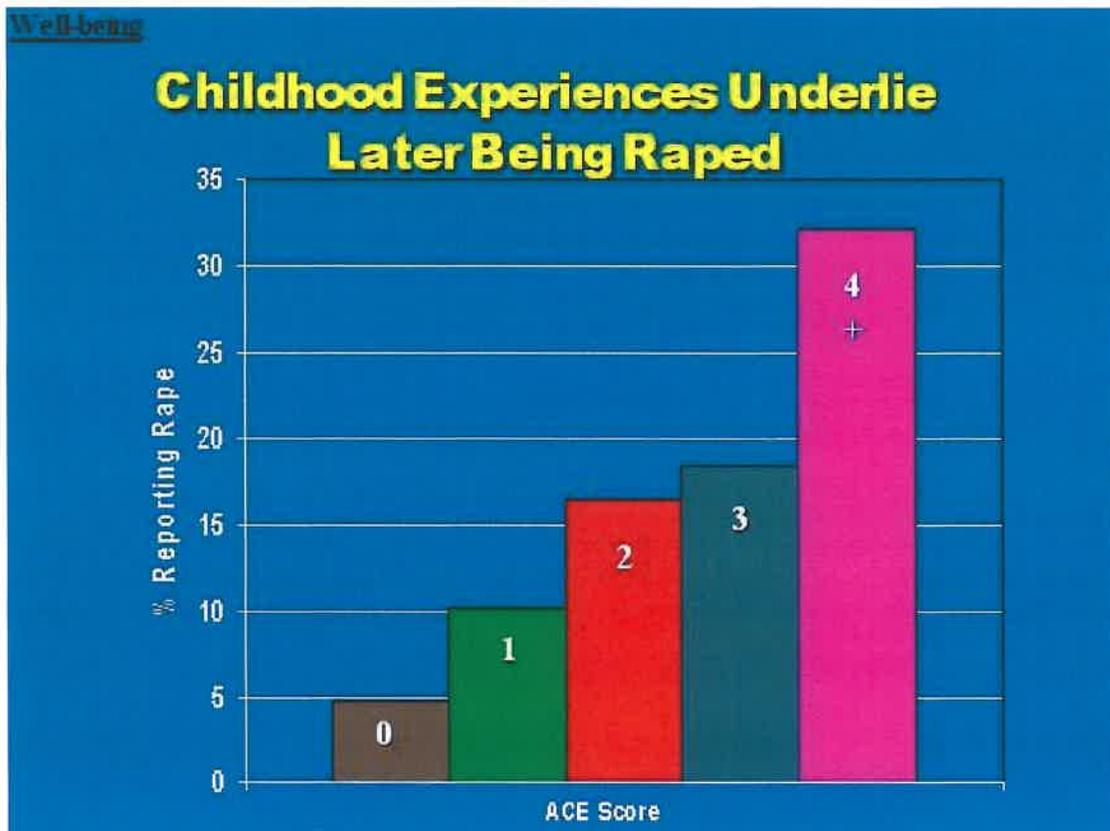
Here are some specific graphic examples of how increasing ACE scores increase the risk of some diseases, social and emotional problems. All of these graphs come from "The relationship of adverse childhood experiences to adult health, well being, social function and health care", a book chapter by Drs. Vincent Felitti and Robert Anda, co-founders of the ACE Study, in "The Hidden Epidemic: The Impact of Early Life Trauma on Health and Disease." (http://www.cambridge.org/gb/knowledge/isbn/item2709685/?site_locale=en_GB)



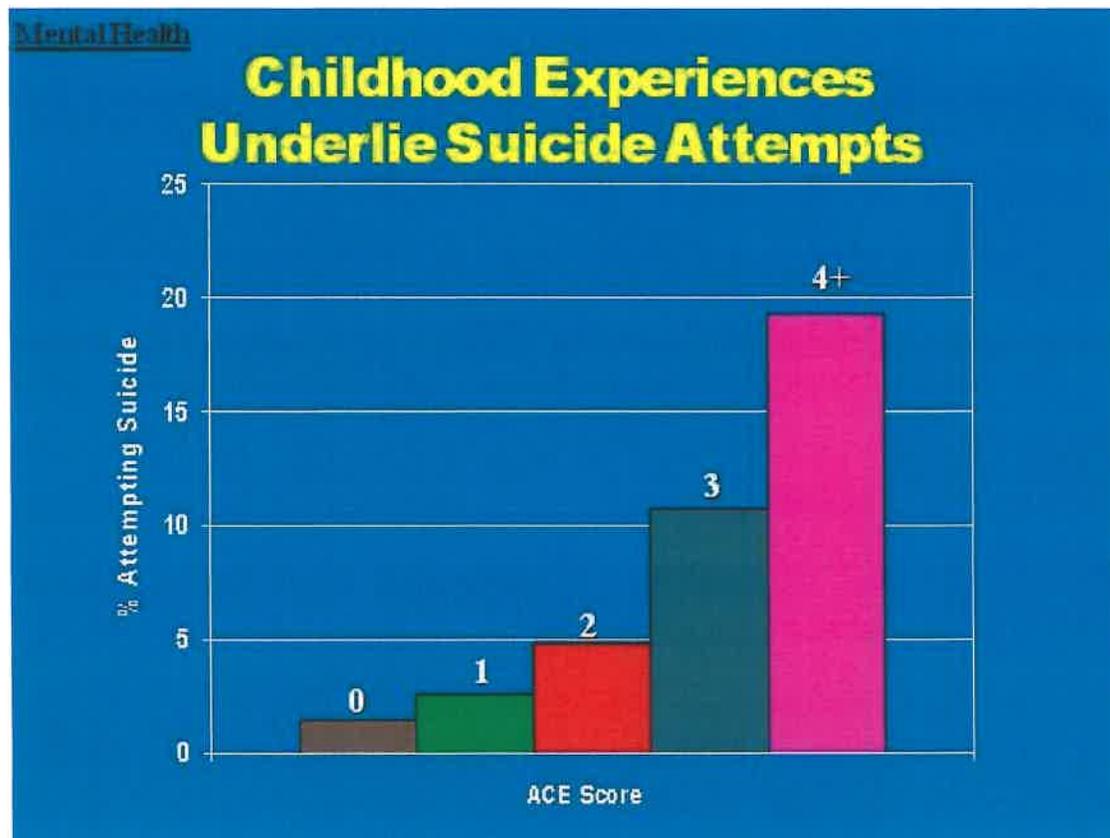
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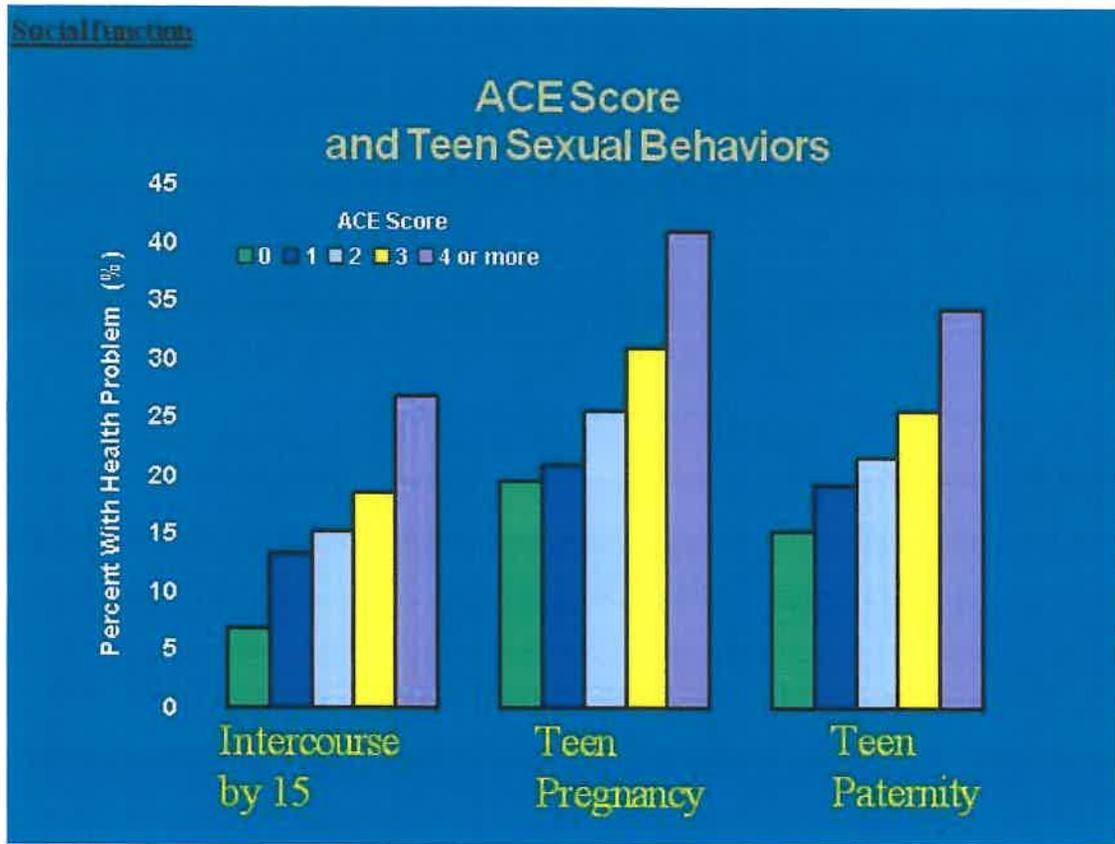
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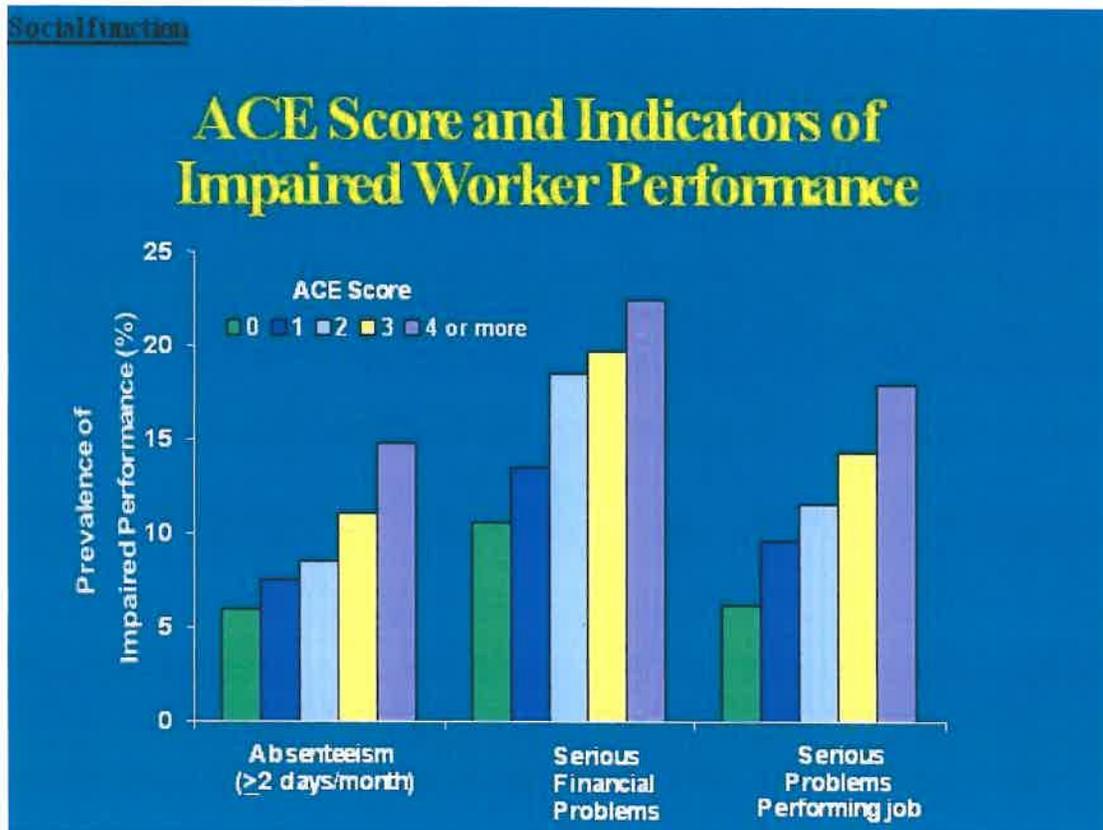
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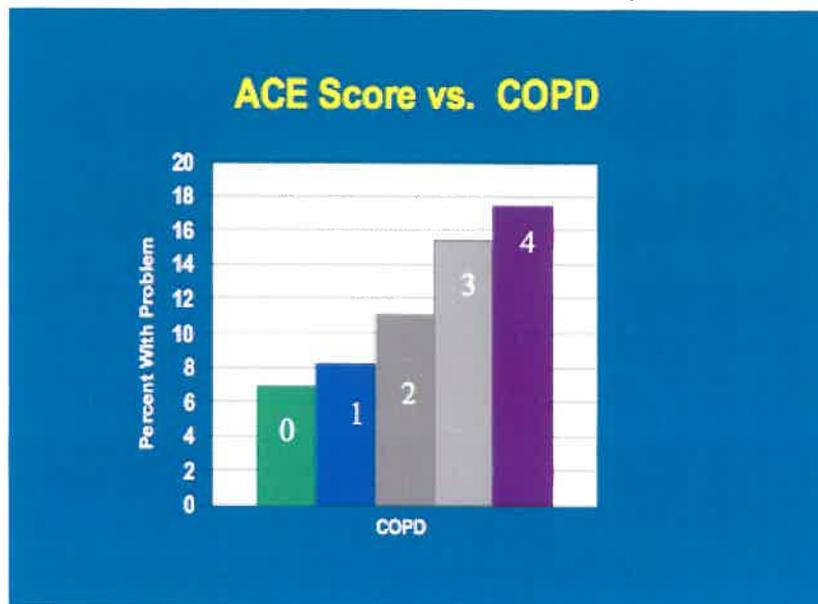
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(<https://acestoohigh.files.wordpress.com/2011/11/acescopd.png>)

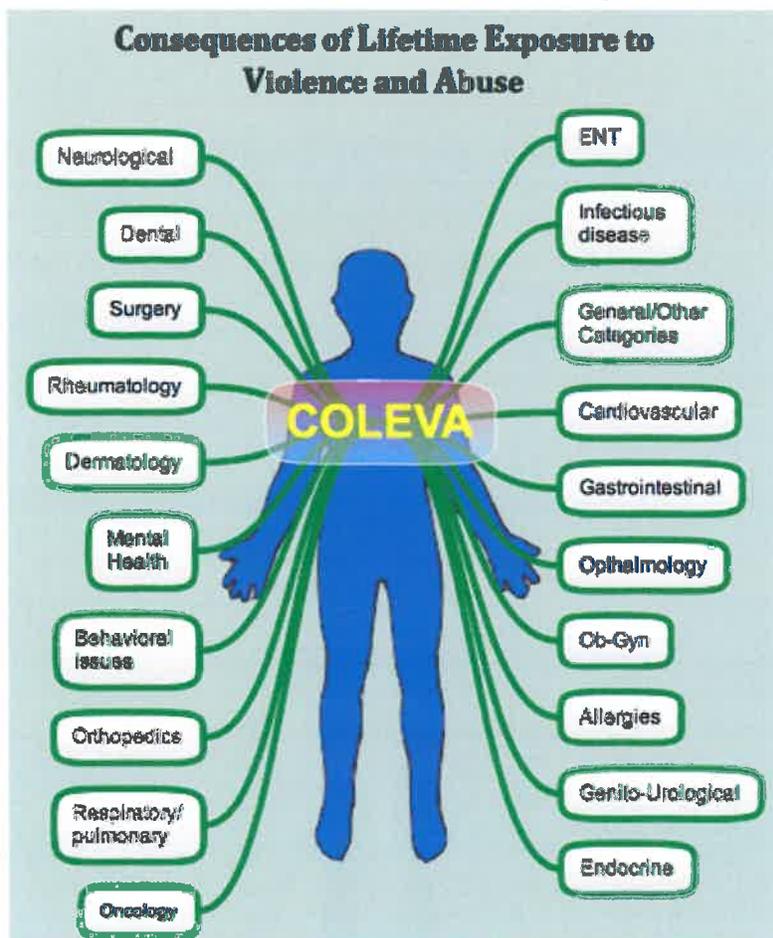
What causes this?

At the same time that the ACE Study was being done, parallel research on kids' brains found that toxic stress physically damages a child's developing brain. (<http://developingchild.harvard.edu/>) This was determined by a group of neuroscientists and pediatricians, including neuroscientist Martin Teicher (<http://www.mclean.harvard.edu/about/bios/detail.php?username=mteicher>) and pediatrician Jack Shonkoff (http://developingchild.harvard.edu/about/center_director_and_staff/#Shonkoff), both at Harvard University, neuroscientist Bruce McEwen (<http://www.rockefeller.edu/research/faculty/abstract.php?id=109>) at Rockefeller University, and pediatrician Bruce Perry at the Child Trauma Academy (<http://www.childtrauma.org/>).

When children are overloaded with stress hormones, they're in flight, fright or freeze mode. They can't learn in school. They often have difficulty trusting adults or developing healthy relationships with peers (i.e., they become loners). To relieve their anxiety, depression, guilt, shame, and/or inability to focus, they turn to easily available biochemical solutions — nicotine, alcohol, marijuana, methamphetamine — or activities in which they can escape their problems — high-risk sports, proliferation of sex partners, and work/over-achievement. (e.g. Nicotine reduces anger, increases focus and relieves depression. Alcohol relieves stress.)

Using drugs or overeating or engaging in risky behavior leads to consequences as a direct result of this behavior. For example, smoking can lead to COPD (chronic obstructive pulmonary disease) or lung cancer. Overeating can lead to obesity and diabetes. In addition, there is increasing research that shows that severe and chronic stress leads to bodily systems producing an inflammatory response that leads to disease.

For more information about that aspect, check out the interactive graphic COLEVA — Consequences of lifetime exposure to violence and abuse. (<http://www.coleva.net/COLEVA-Main-2-2-2011-v2.html>) Here's a screen-grab of the home page of that site to give you an idea of how extensive the research is.



<https://acestoohigh.files.wordpress.com/2011/11/coleva.png>

Fortunately, brains and lives are somewhat plastic. The appropriate integration of resilience factors born out of ACE concepts — such as asking for help, developing trusting relationships, forming a positive attitude, listening to feelings — can help people improve their lives.

For more information about the ACE Study, check out the [CDC's ACE Study site](http://www.cdc.gov/ace/index.htm)

(<http://www.cdc.gov/ace/index.htm>).

Here's a link to the [long questionnaire](http://www.cdc.gov/ace/questionnaires.htm) (200+ questions) (<http://www.cdc.gov/ace/questionnaires.htm>).

What's Your Resilience Score?

This questionnaire was developed by the early childhood service providers, pediatricians, psychologists, and health advocates of Southern Kennebec Healthy Start, Augusta, Maine, in 2006, and updated in February 2013. Two psychologists in the group, Mark Rains and Kate McClinn, came up with the 14 statements with editing suggestions by the other members of the group. The scoring system was modeled after the ACE Study questions. The content of the questions was based on a number of research studies from the literature over the past 40 years including that of Emmy Werner and others. Its purpose is limited to parenting education. It was not developed for research.

RESILIENCE Questionnaire

Please circle the most accurate answer under each statement:

1. I believe that my mother loved me when I was little.

Definitely true Probably true Not sure Probably Not True Definitely Not True

2. I believe that my father loved me when I was little.

Definitely true Probably true Not sure Probably Not True Definitely Not True

3. When I was little, other people helped my mother and father take care of me and they seemed to love me.

Definitely true Probably true Not sure Probably Not True Definitely Not True

4. I've heard that when I was an infant someone in my family enjoyed playing with me, and I enjoyed it, too.

Definitely true Probably true Not sure Probably Not True Definitely Not True

5. When I was a child, there were relatives in my family who made me feel better if I was sad or worried.

Definitely true Probably true Not sure Probably Not True Definitely Not True

6. When I was a child, neighbors or my friends' parents seemed to like me.

Definitely true Probably true Not sure Probably Not True Definitely Not True

7. When I was a child, teachers, coaches, youth leaders or ministers were there to help me.

Definitely true Probably true Not sure Probably Not True Definitely Not True

8. Someone in my family cared about how I was doing in school.

Definitely true Probably true Not sure Probably Not True Definitely Not True

9. My family, neighbors and friends talked often about making our lives better.

Definitely true Probably true Not sure Probably Not True Definitely Not True

10. We had rules in our house and were expected to keep them.

Definitely true Probably true Not sure Probably Not True Definitely Not True

11. When I felt really bad, I could almost always find someone I trusted to talk to.

Definitely true Probably true Not sure Probably Not True Definitely Not True

12. As a youth, people noticed that I was capable and could get things done.

Definitely true Probably true Not sure Probably Not True Definitely Not True

13. I was independent and a go-getter.

Definitely true Probably true Not sure Probably Not True Definitely Not True

14. I believed that life is what you make it.

Definitely true Probably true Not sure Probably Not True Definitely Not True

How many of these 14 protective factors did I have as a child and youth? (How many of the 14 were circled "Definitely True" or "Probably True"?) _____

Of these circled, how many are still true for me? _____

987 responses

H. DAVEN says:

August 18, 2016 at 4:55 pm

ACE score 7

Resilience score 12

College dropout but do have an AA. History of depression and substance abuse but not currently. Weight fluctuation throughout my twenties, right now on a downward trend. I'm about to turn 30. Just got married. Love my work but not where I work. Kinda loving life right now. Kids eventually... Past few years have actually been the best of my adult life. Through choices I made to be better.

LISA LUCAS-DEAN says:

August 18, 2016 at 9:18 am



Adverse Childhood Experiences and the Lifelong Consequences of Trauma

Many people can identify a person in their lives who struggles with a chronic illness like heart disease, diabetes, or hypertension. Most people also know someone who struggles with mental illness, substance abuse, or relationships in general. Traditionally, the health care system would point to high-risk behaviors such as poor diet, drug use, or a sedentary lifestyle as the primary causal factors. Questions for patients have focused on “What’s wrong with you?” rather than “What happened to you?” A 1998 study from the Centers for Disease Control and Prevention (CDC) and Kaiser Permanente is leading to a paradigm shift in the medical community’s approach to disease. This study of more than 17,000 middle-class Americans documented quite clearly that adverse childhood experiences (ACEs) can contribute significantly to negative adult physical and mental health outcomes and affect more than 60% of adults.^{1,2} This continues to be reaffirmed with more recent studies.



Adverse childhood experiences include

- Emotional abuse
- Physical abuse
- Sexual abuse
- Emotional neglect
- Physical neglect
- Mother treated violently
- Household substance abuse
- Household mental illness
- Parental separation or divorce
- Incarcerated household member

Along with the original 1998 ACE Study, there are known predictive factors that make sense to include in the list of adverse experiences. These can be single, acute events or sustained over time. Examples include death of a parent and the detrimental effect of community violence and poverty, among others.³ Adverse childhood experiences occur regularly with children aged 0 to 18 years across all races, economic classes, and geographic regions; however, there is a much higher prevalence of ACEs for those living in poverty.

While some stress in life is normal—and even necessary for development—the type of stress that results when a child experiences ACEs may become toxic when there is “strong, frequent, or prolonged activation of the body’s stress response systems **in the absence of the buffering protection of a supportive, adult relationship.**”^{4,5} The biological response to this toxic stress can be incredibly destructive and last a lifetime. Researchers have found many of the most common adult life-threatening health conditions, including obesity, heart disease, alcoholism, and drug use, are directly related to childhood adversity. A child who has experienced ACEs is more likely to have learning and behavioral issues and is at higher risk for early initiation of sexual activity and adolescent pregnancy. These effects can be magnified through generations if the traumatic experiences are not addressed. The financial cost to individuals and society is enormous.⁶

Never before in the history of medicine have we had better insight into the factors that determine the health of an individual from infancy to adulthood, which is part of the **life course perspective**—a way of looking at life not as disconnected stages but as integrated across time.

What happens in different stages of life is influenced by the events and experiences that precede it and can influence health over the life span. An expanding body of convergent knowledge generated from distinct disciplines (neuroscience, behavioral science, sociology, medicine) provides child health care professionals the opportunity to reevaluate what care is needed to maximize the effect on a child’s lifelong health. Importantly, an extensive body of research now exists demonstrating the effect of traumatic stress on brain development. Healthy brain development can be disrupted or impaired by prolonged, pathologic stress response with significant and lifelong implications for learning, behavior, health, and adult functioning.⁴

WHAT IS THE ROLE OF STRESS?



Stress in itself need not result in injury and is, by its nature, a subjective experience. Stress in a supportive environment may not be toxic. The perception of stress varies from child to child; serious threats may not disturb one child, while minor ones may be traumatic to another. This variability is multifactorial depending on a child’s previous trauma, social-emotional support, and genetic predisposition.

Just as the stress of ambulation helps promote bone and muscle growth, a child needs to experience some emotional stress to develop healthy coping mechanisms and problem-solving skills. Experts categorize stress as *positive*, helping to guide growth; *tolerable*, which, while not helpful, will cause no permanent damage; or *toxic*, which is sufficient to overcome the child’s undeveloped coping mechanisms and lead to long-term impairment and illness.⁵

Toxic stress response can occur when a child experiences strong, frequent, or prolonged adversity, such as physical or emotional abuse, chronic neglect, caregiver substance abuse or mental illness, exposure to violence, or the accumulated burdens of family economic hardship, in the absence of adequate adult support. This kind of prolonged activation of the stress response systems can disrupt the development of brain architecture and other organ systems and increase the risk of stress-related disease and cognitive impairment well into the adult years.

THE BIOLOGY OF TRAUMA ✂

The past few years have brought a dramatic improvement in our understanding of how a healthy brain develops and the effect, positive or negative, that a child's environment has on that process. Several systems—social/behavioral, neuroendocrine, and even genetic—are all influenced by early experiences and interact with each other as a child grows and develops. The ability of an individual to successfully overcome negative experiences from trauma depends on many factors related to the complex interaction between these systems. Several key observations have emerged from recent research.

- **The brain is not structurally complete at birth.**
 - Myelination, proliferation of synaptic connections, and development of glial and circulatory support systems all continue long after a child has entered the world. Nature gives children a chance to adapt to the specific needs presented by the environment into which they have been born.

Among other things, optimal development of the neuroendocrine system is dependent on adequate nutrition and absence of toxins like lead, mercury, alcohol, other drugs, and toxic stress.

- **Structural development is guided by environmental cues.**
 - An infant's brain adapts to what it sees, hears, and feels. Researchers have demonstrated critical periods for effective development of many brain systems.

Proper structural growth depends on a nurturing, loving, and stimulating environment, one that prepares the child for future circumstances.

- **Effective stimulation requires interaction with other people.**
 - Children can't be expected to provide their own high-quality stimulation. They learn from every person encountered—especially primary caregivers.

Other people must be present, attentive enough, and consistent or predictable enough to teach the lessons the developing brain needs. Stimulation from television, smartphones, or tablets does not replace interaction with people.

The National Child Traumatic Stress Network (NCTSN) definition of *traumatic stress* encompasses the physical and emotional responses of a child to events that threaten the life or physical integrity of the child or of someone critically important to the child (eg, parent, sibling). It is this out-of-control physiological arousal that is the hallmark of stress that becomes traumatic and can incite what is initially an adaptive response to the stressor that ultimately becomes maladaptive and destructive. While a single event like a natural disaster or an assault by a stranger may constitute toxic stress, the effects multiply when the trauma continues, whether by repetition of similar stresses (eg, an environment of domestic violence or parental drug abuse) or accumulation of disparate ones (eg, parental illness and a hurricane hits town). In other words, there is a dose-response relationship. The effect may be particularly severe when trauma involves the child's primary caregiving system. Termed *complex trauma* by the NCTSN, this reaction develops over time, as subsequent events reinforce the lessons learned previously.⁷

The effect of toxic stress resulting from trauma may not be immediately visible or appear as one would expect. In addition, some traumatic sources of toxic stress may not be readily apparent to the clinician. Psychological maltreatment can be traumatic and stressful.⁸ Neglect can also be traumatic. Neglect is almost always chronic, as basic needs such as food, shelter, or emotional security are continually not being met. Neglect is often seen in conjunction with abuse and may be exceptionally severe; 71% of child maltreatment fatalities are due to neglect exclusively or in combination with another maltreatment type.⁹

For most children who have experienced trauma and toxic stress, the experiences began at an early age. As a result, the events may be remote and documented history is often buried among old records or nonexistent. Prenatal exposures that influenced brain development may not be detectable in obstetric records. Pediatricians should understand that presentations of attention deficits, emotional dysregulation, and oppositional behaviors may have their roots in early abuse or neglect or other sources of toxic stress. Recognition of the power of early adversity to affect the child's perceptions of and responses to new stimuli may aid the pediatrician or other clinician in appropriately understanding the causes of a child's symptoms.

- **Gene expression determines neuroendocrine structure and is strongly influenced by experience.**

– Genetic research has identified a variety of alleles that appear to protect against, or predispose to, long-term sequelae of traumatic stress by varying the sensitivity of stress hormone receptors in the limbic system.^{10,11,12} An increasing body of evidence points to the ability of early life experience to trigger epigenetic modifications, effectively altering brain structure by changing gene transcription.^{13,14}

One way, then, that early adversity can affect long-term change is by altering the way an individual's genetic blueprint is read, thus influencing the stress response.

- **The body's systems are mutually interactive.**

– Social interactions (or the lack thereof) may affect neuroendocrine development, which can alter observed behaviors (Figure 1). Behavior, in turn, produces social feedback, which stimulates a neuroendocrine response (a physiological response) and, if severe, may cause modifications in brain structures (an anatomic response). Another word for this complex system of interactions is *learning*. When the body learns under conditions of extreme stress, epigenetic modifications in gene transcription can be produced and cause structural changes in the developing brain.^{12,15} This process can operate both ways. The epigenetic modifications to gene transcription ultimately determine the brain's structure, which governs behavior. The behavior can result in interactions that reinforce or reactivate the stress response, causing additional negative modifications to the brain architecture. This interactive cascade of responses among social/behavioral, neuroendocrine, and genetic/epigenetic systems has recently been dubbed the ecobiodevelopmental model.⁴

The more emotionally charged a learning situation is, the more likely it is to result in long-term modifications.

EFFECT OF TRAUMA ON PARENTING ABILITY



Adults who have experienced ACEs in their early years can exhibit reduced parenting capacity or maladaptive responses to their children. The physiological changes that have occurred to the adult's stress response system as a result of earlier trauma can result in diminished capacity to respond to additional stressors in a healthy way. Adverse childhood experiences increase the chance of social risk factors, mental health issues, substance abuse, intimate partner violence, and adult adoption of risky adult behaviors. All of these can affect parenting in a negative way and perpetuate a continuing exposure to ACEs across generations by transmission of epigenetic changes to the genome.

RESILIENCE AND OTHER REASONS FOR OPTIMISM



Adverse experiences and other trauma in childhood, however, do not dictate the future of the child. Children survive and even thrive despite the trauma in their lives. For these children, adverse experiences are counterbalanced with protective factors. Adverse events and protective factors experienced together have the potential to foster resilience. Our knowledge about what constitutes resilience in children is evolving, but we know that several factors are positively related to such protection, including cognitive capacity, healthy attachment relationships (especially with parents and caregivers), the motivation and ability to learn and engage with the environment, the ability to regulate emotions and behavior, and supportive environmental systems,

Figure 1.

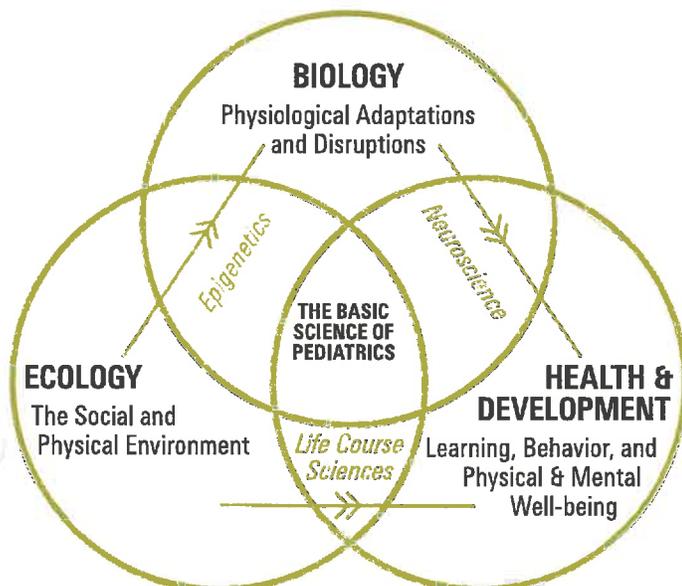


Figure 1. The basic science of pediatrics. An emerging, multidisciplinary science of development supports an ecobiodevelopmental framework for understanding the evolution of human health and disease across the life span. In recent decades, epidemiology, developmental psychology, and longitudinal studies of early childhood interventions have demonstrated significant associations between the ecology of childhood and a wide range of developmental outcomes and life course trajectories. Concurrently, advances in the biological sciences, particularly in developmental neuroscience and epigenetics, have made parallel progress in beginning to elucidate the biological mechanisms underlying these important associations. The convergence of these diverse disciplines defines a promising new basic science of pediatrics.

including education, cultural beliefs, and faith-based communities.¹⁶ The **protective factors framework** developed by Strengthening Families¹⁶ as well as the **Essentials for Childhood** program from the CDC¹⁷ provide more detail.

There are additional reasons for optimism. There now exist several evidence-based, effective clinical treatments to call on in intervening with children who have experienced trauma and adversity, including Trauma-Focused Cognitive-Behavioral Therapy¹⁸ and Parent-Child Interactive Therapy.¹⁹ Each of these programs includes attention to parenting ability and works on establishing behaviors that promote resilience in the child and parent. Proactive initiatives like home visitation programs for high-risk families, though not widely disseminated, have incredible promise for the prevention or mitigation of parent- and environment-mediated ACEs specifically because they are focused on critical periods in human development—prenatal through the first 2 to 3 years of life.²⁰

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Please see the AAP Web site for the online version of this document as well as additional information at www.aap.org/traumaguide

The recommendations in this toolkit do not indicate an exclusive course of treatment or serve as a standard of medical care. Variations, taking into account individual circumstances, may be appropriate.

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Trauma:

A Public Health Issue

Prevalence:

Trauma is common among adults and children in social service systems.

98%

of female offenders have experienced trauma, often interpersonal trauma and domestic violence



96%

of adolescent psychiatric inpatients have histories of exposure to trauma



93%

of homeless mothers have a lifetime history of interpersonal trauma



90%

of juvenile justice-involved youth have experienced trauma, often multiple traumas from an early age



75%

of adults in substance abuse treatment report histories of trauma



70%

of children in foster care have experienced multiple traumas



Goal:

Trauma-Informed Systems

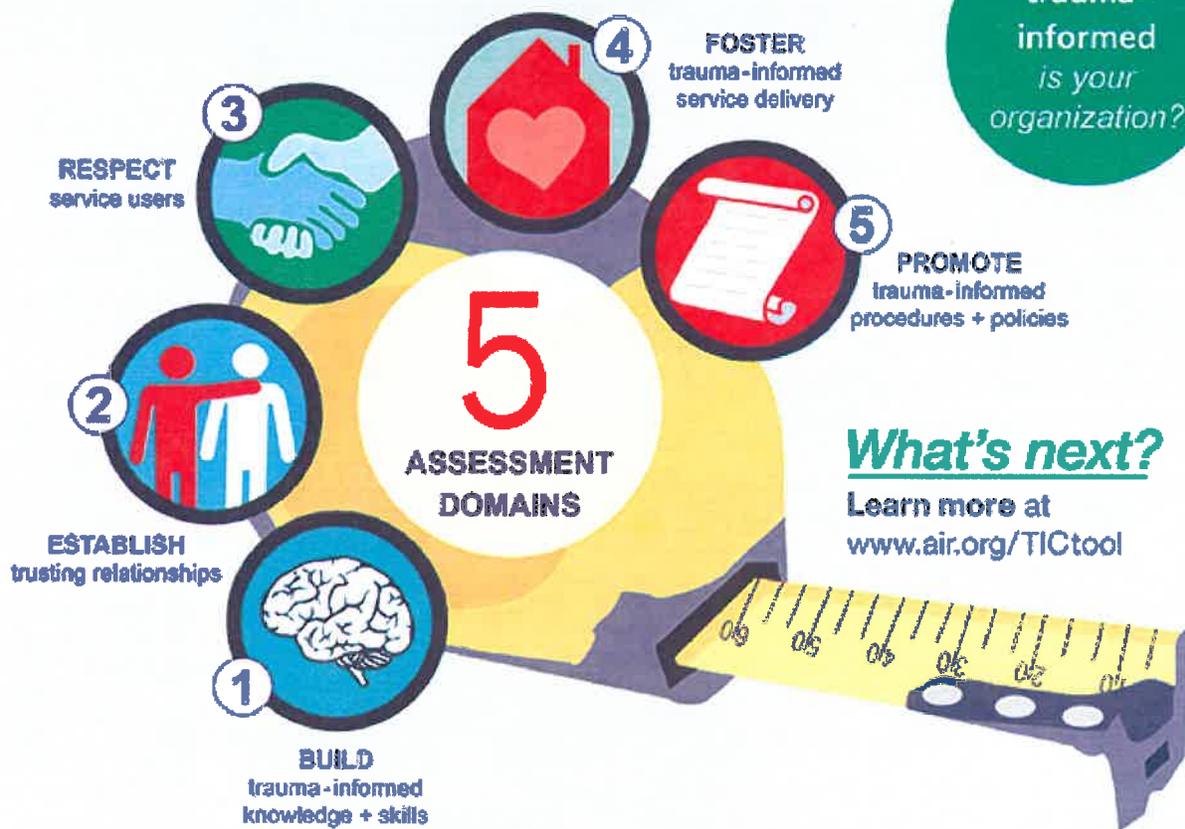
Systems that recognize the impact

Systems that recognize the impact of trauma and promote resilience and healing



A First Step: Agency-Wide Assessment

How trauma-informed is your organization?



What's next?

Learn more at www.air.org/TICtool

Sources: Green, Miranda, Daroowalla, & Siddique, 2005; Havens, Gudine, Diamond, Weis, & Cloitre, 2012; Hayes, Zonneville, & Bossuk, 2013; Abram, Teplin, Charles, Longworth, McClellan, & Dulcan, 2004; Dierkhising, Ko, Woods-Jaeger, Briggs, Lee, Pynoos, 2013; SAMHSA/CSAT, 2000; Greeson, Briggs, Kisiel, Layne, Ake, Ko... & Fairbank, 2011

American Institutes for Research | www.air.org

Related Work

Resources for Judges and Attorneys

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 clark219@UCMAIL.UC.EDU or the NCTSN at help@nctsn.org

Sincerely,
The NCTSN Justice Consortium

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’s¹ 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?

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- 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 BENCH CARD

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

This Court has referred this child¹ 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 →

- 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>

RED FLAGS OF TRAUMA/ACEs
in Children & Parents Reading Between the Lines

- **CIRCUMSTANCES OF CASE:** Domestic violence, physical punishment
- **LIVING CIRCUMSTANCE:** Hazardous conditions, no utilities, on the streets, in a shed, with friends or relative, in their car
- **STATUS:** Runaway, jail, prison, mental health or substance abuse facility
- **REPORTED HOTLINE HISTORY:** A parent's childhood or sibling's history, adopted? permanent guardianship/relative caregiver?, sibling's locations (jail, dead, mental health issues)
- **INDICATED & UNFOUNDED REPORTS:** Give them weight: unfounded doesn't = untrue
- **TYPES OF CHARGES AND FREQUENCY:** Multi batteries included on LEO or staff, sex offenses (a victim of child sex abuse?)
- **SCHOOL HISTORY:** Graduate from HS?, suspensions & expulsions
- **DOMESTIC VIOLENCE:** Victim or offender
- **MENTAL HEALTH HISTORY:** Age, multi diagnosis: ADHD, PTSD, bi-polar, anxiety, explosive disorder, hospitalizations
- **MULTI-SEXUAL PARTNERS:** Unknown fathers?, children who were product of rape?
- **TATOOS:** Branding by a trafficker?
- **PHYSICAL APPEARANCE AND EMOTION:** Aggressive, antsy, no eye contact, hunched, exhausted
- **PHYSICAL HEALTH:** Diabetes, heart disease, cancer, auto-immune diseases, sores
- **DRUGS:** Marijuana use despite substance abuse counseling
- **MEN WITH SIGNIFICANT ATTACHMENT TO DOG:** A recent study shows *male* victims of sex abuse cope through a relationship with their dog

Guiding Principles for Defining and Implementing a Model Family Court

Adopted by the Florida Supreme Court In re Report of the Family Court Steering Committee, 794 So. 2d 518, 522 (Fla. 2001)

Children should live in safe and permanent homes.

The needs and best interests of children should be the primary consideration of any family court. All persons, whether children or adults, should be treated with objectivity, sensitivity, dignity and respect.

Cases involving inter-related family law issues should be consolidated or coordinated to maximize use of court resources to avoid conflicting decisions and to minimize inconvenience to the families.

A key part of the family court process should be establishment of processes that attempts to address the family's interrelated legal and nonlegal problems to produce a result that improves the family's functioning. The process should empower families through skills development, assist them to resolve their own disputes, provide access to appropriate services, and offer a variety of dispute resolution forums where the family can resolve problems without additional emotional trauma.

Whenever possible, parties and their attorneys should be empowered to select processes for addressing issues in their cases that are compatible with the family's needs, financial circumstances, and legal requirements.

The court is responsible for managing its cases with due consideration of the needs of the family, the litigants, and the issues presented by the case.

There should be a means of differentiating among cases so that judicial resources are conserved and cases are diverted to non-judicial and quasi-judicial personnel for resolution, when appropriate and consistent with the ends of justice.

Trial courts must coordinate and maximize court resources and establish linkages with community resources.

The court's role in family restructuring is to identify services and craft solutions that are appropriate for long-term stability and that minimize the need for subsequent court action.

Court services should be available to litigants at a reasonable cost and accessible without economic discrimination.

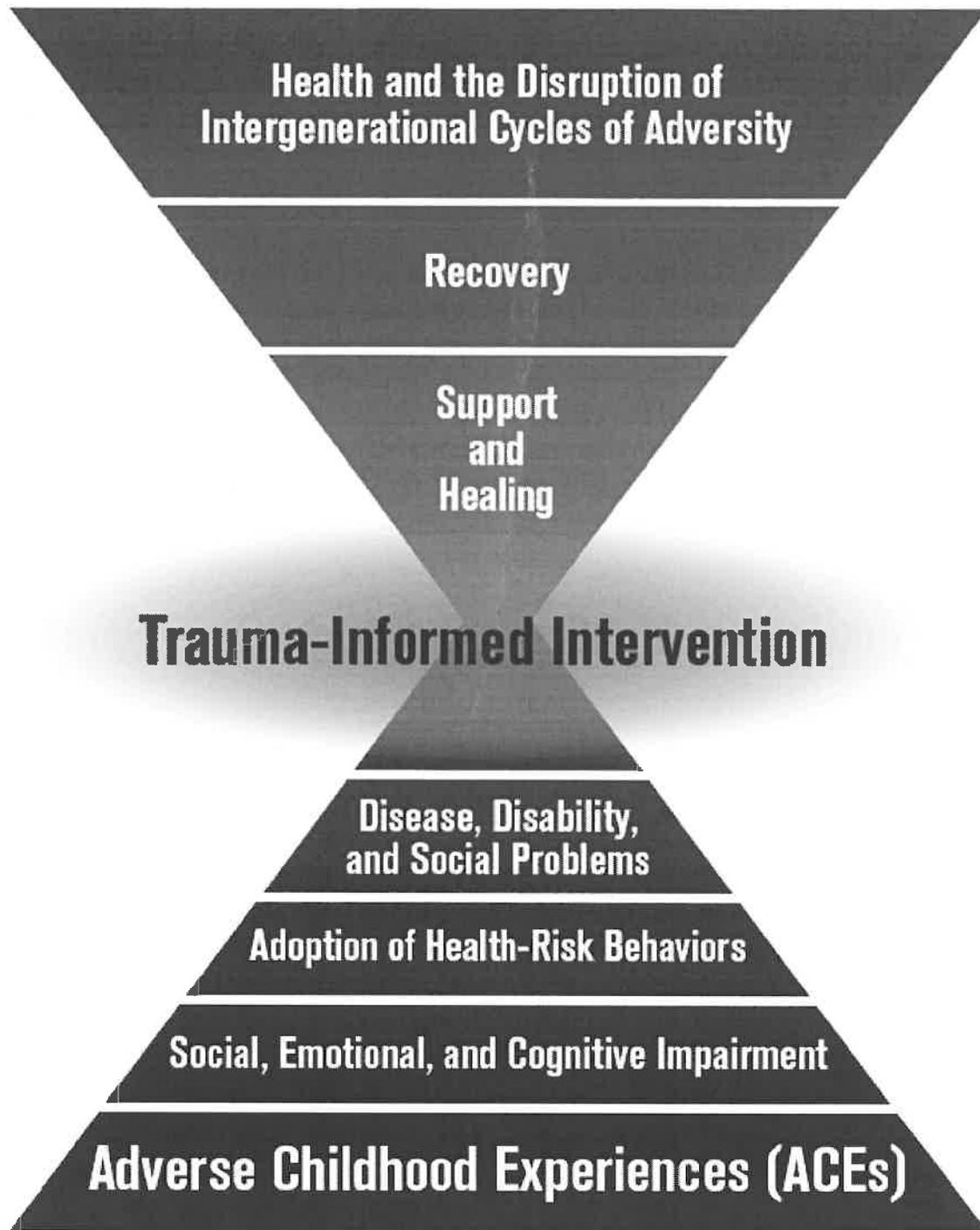
Courts should have well trained and highly motivated judicial and non-judicial personnel.

The Goal

The goal of a trauma-responsive, developmentally-informed court is to change the trajectory for children and families who have experienced trauma – "...improving the long-term health and well-being of children and families and disrupting intergenerational cycles of adversity."

(Shawn C. Marsh, Ph.D. and Carly B. Dierkhising, MA, Juvenile and Family Justice Today, Summer 2013)

CHANGING THE TRAJECTORY



[Continue to "Court Implications" >](#)

Court Implications

Recognizing that trauma, child development, and outcomes are inextricably linked, what does that mean from the bench? See below for ten practical tools.

Click [here](#) for the Florida state statutes, a judicial canon, Florida Supreme Court opinion, and federal regulations that authorize application of the ten tools below.

"I am astounded every day at how effective this trauma-informed approach is. I can assure you this creates a very different courtroom and courthouse atmosphere than I had 20 years ago. The satisfaction and transformations are tremendous." - *The Honorable Lynn Tepper, Sixth Judicial Circuit. Circuit judge since January 1989 and county judge 1985-1988.*

THE BIG 10

1. Understand trauma and child development.

Read the research, attend trainings, and talk with local trauma and child development experts.

The links below provide milestones, red flags, and common traumatic stress reactions.

Click [here](#) for birth to 5.

Click [here](#) for 6 to 12.

Click [here](#) for 13 to 18.

Click [here](#) for all ages (birth to 18).

The links below provide listings of related research.

[Center on the Developing Child, Harvard University](#)

[ACES Too High](#)

[Child Trauma Academy](#)

Click [here](#) for the September 2014 trauma edition of the American Bar Association's *Child Law Practice*.

Click [here](#) for a directory of Florida's Early Learning Coalitions. These coalitions can provide linkages to local child development experts.

Click [here](#) for web-based trainings at the Learning Center for Child and Adolescent Trauma, hosted by the National Child Traumatic Stress Network.

2. Presume trauma.

First and foremost, presume that every family in court has been impacted by trauma in some way. Consider that many parents have experienced numerous adverse childhood experiences, not just the children and youth in court. Similar to the universal precautions that emerged in response to HIV/AIDS whereby everyone was assumed to have the disease when blood exposure was a factor, a universal precautions approach to trauma assumes that people appearing in courts have experienced adversity in some manner.

(NCJFCJ, Juvenile and Family Justice Today, Summer 2013) It means having a secure, safe, and calm court environment – one that attempts to limit heightened agitation, arousal, and stress. Further, it means that all who appear before the court, and all who work in the courthouse, are treated with respect and dignity.

Click [here](#) for learning about "what hurts" and "what helps" related to judicial communication, courthouse environment, and self-awareness.

Click [here](#) for a quick refresher on trauma-informed communication.

3. Coordinate all cases involving one family.

There are many important reasons why a circuit should coordinate related family court cases. For families who have experienced multiple traumatic events and chronic stress, it is imperative to coordinate their cases. Specifically, for these families, their cases should be coordinated and heard by only one judge, using the one family/one judge model. Just as trauma from adverse childhood experiences most often occurs within intimate relationships, healing also happens within relationships. A family's trajectory can be significantly impacted through relationships. The one family/one judge model can lessen the time for the family and court partners to develop trust, and can lessen the amount of times the family may have to recite painful memories and events. It also lessens the likelihood of additional trauma caused by preventing conflicting orders and conflicting service interventions.

Click [here](#) for rules of procedure related to coordinating cases.

Click [here](#) for examples of circuit administrative orders related to coordinating cases.

4. Set an expectation for trauma and child development information.

Require child development and trauma information from attorneys, guardians ad litem, juvenile probation officers, child protective investigators, child welfare case managers, domestic violence advocates, parenting coordinators, and treatment providers who appear before the court.

Click [here](#) for information on what to expect.

The National Child Traumatic Stress Network has produced a trauma bench card for judges. The [card](#) offers a series of questions to help gather information necessary to make good decisions for children at risk of traumatic stress disorders. It also contains a sample addendum designed to be copied or scanned and attached to orders for behavioral health assessments.

5. Read the case file with a trauma lens.

When reviewing the file, circle developmental red flags and trauma events.

Click [here](#) for a listing of trauma types.

Click [here](#) for developmental red flags.

6. Order screening, assessment, and treatment.

When indicated, order screening for trauma exposure and related symptoms and require the use of evidence-based screening tools. Order an evidence-based and culturally appropriate assessment when the screening recommends it, and evidence-based treatment when the assessment shows the need.

Click [here](#) for additional information on screening, assessment, and treatment.

Click [here](#) for how to learn if therapists and service providers understand trauma.

7. Hold all accountable.

Hold the delinquent youth accountable for completing trauma treatment. Hold the child welfare investigator accountable for gathering information about the parents' and children's trauma histories. Hold the case managers accountable for seeking evidence-based, trauma-informed treatment for families. Hold the therapist accountable for using evidence-based treatment. Hold the divorcing couple accountable for respecting the trauma experienced by the children during transitions. Hold the batterer accountable for understanding the trauma experienced by children living in violent homes. Hold the bailiff accountable for maintaining an orderly courtroom and exhibiting calm behavior. Hold the attorneys accountable for considering the parents' schedules when setting the next court date.

What are they doing Down Under? Click [here](#) for a thoughtful view from the Australian Association for Infant Mental Health regarding the importance of considering early childhood development and trauma when developing parenting plans.

What are they doing closer to home? Click [here](#) for a guide, prepared by a subcommittee of the Family Law Advisory Group in the 8th circuit, for making parenting time decisions while considering child development.

Click [here](#) for the link to the Florida Supreme Court approved supervised/safety-focused parenting plan form. This parenting plan template provides guidance for establishing a plan to protect the children when families are experiencing domestic violence, substance abuse, or other traumas.

8. Be a convener.

Bring community partners together to address trauma and advocate for evidence-based treatment. Issues related to trauma are complex and require that representatives from multiple systems work together. Judges have influence and authority, and are able to call people together and facilitate collaboration.

Click [here](#) for tips for conveners.

9. Monitor the data.

Review and analyze data. Learn from the data. Adjust court practices based on your findings. Share promising practices with other judges.

Florida Dependency Court Information System (FDCIS)

FDCIS is for judges, magistrates, and court staff. FDCIS is a web-based case management system that provides the judiciary with resources to ensure timeliness of court events, with a goal of achieving positive outcomes for Florida's abused and neglected children. For judges, magistrates, court staff only: To request access to the Florida Dependency Court Information System or receive additional information, please contact: mailto:fdcis_support@flcourts.org

Department of Children and Families Performance Dashboard

Community-Based Care Agency Scorecards

Trend / Spinner Reports

Fostering Connections

Florida Delinquency Profile

Judicial Branch Statistics

10. Take care of yourself.

Learn about vicarious trauma, secondary trauma, compassion fatigue, and burnout. Know the warning signs, monitor yourself, and take inventory of the balance between work and personal life. Understand that it is normal to be affected by the type of work you do.

Click [here](#) for descriptions of vicarious trauma, secondary trauma, compassion fatigue, and burnout.

Click [here](#) for research on this subject.

Click [here](#) for early warning signs of judicial burnout.

Click [here](#) for signs and symptoms of compassion fatigue and vicarious trauma.

Click [here](#) for Florida judicial branch's employee assistance program.

Click [here](#) for self-care tips.

Click [here](#) for additional self-care resources.

[Continue to "Resources" >](#)

Communication, court environment, self-awareness: What hurts and what helps?

	What hurts?	What helps?
Communication	Interactions that are humiliating, harsh, impersonal, disrespectful, critical, demanding, and judgmental.	<p>SHOW RESPECT. Interactions that express respect, kindness, patience, reassurance, and acceptance.</p> <ul style="list-style-type: none"> • Instead of talking at the person by saying "Let me give you some advice," talk with the person by saying "What do you think?" or "What can we do to solve the problem?" • Use "please" and "thank you" frequently. • Use the name of the people before you, addressing them by their surnames preceded by "Mr." or "Ms." • Ask the person before you if he or she has any questions. • Use short encouraging statements such as: "Your commitment really shows;" "It's clear you are trying to change;" "Despite what happened in court last time, you have been able to..." • Provide praise that is concrete, specific and delivered with a neutral tone. "I heard that you earned a one month token in AA. I know you worked hard for that." "I read in the court report that you followed last month's visitation schedule without any problems. This will help your child." • Instead of "I'm sending you for a mental health evaluation," try "I'd like to refer you to a doctor who can help us better understand how to support you." • Instead of "You are going to a commitment program; we are done with you. There is nothing more we can do," try "Maybe what we've been doing isn't the best way for us to support you. I'm going to ask you not to give up on recovery. We're not going to give up on you."
	Distracted listening.	<p>LISTEN. Use active listening.</p> <ul style="list-style-type: none"> • Maintain eye contact. • Listen without judgment. • Examine your body language. Are you conveying attention? • Also, pay attention to the speaker's body language. This is a facet of true listening. • While listening, do not plan what you will say next. Think only about what the person is saying. • Provide regular feedback by reflecting and paraphrasing the content. For example, "I can see you are confused" or "Sounds like you are saying..." • Refrain from looking at the computer or reading the case file while the person is speaking.
	Thinking and/or asking "What's wrong with you?"	<p>UNDERSTAND. Think and ask "What has happened to you?"</p> <ul style="list-style-type: none"> • Recognize that some behaviors (hypervigilance, dissociation, avoidance) can be self-protective coping strategies; the trauma "symptoms" may be adaptations. • Instead of discussing sensitive issues related to trauma in open court ask the attorneys and parties to approach the bench and conduct a sidebar conversation. Or, if rule and statute permits, and the attorneys agree, clear the courtroom.
	Becoming aggressive and hostile when confronted with aggression and hostility.	<p>REMAIN CALM. Use a quiet tone of voice and a slow pace of speaking that encourages stability and physiological regulation.</p> <ul style="list-style-type: none"> • Recognize that the displayed anger could be increased activation of the arousal systems associated with survival, that the behavior could be self-protective, and that victims of trauma can often overexaggerate the "threat." This doesn't justify the behavior but it can provide insight; insight leads to compassion and problem-solving. • Gently name the person's behavior in a nonjudgmental way. For example, say "I can hear how upset you are." • Ask questions to clarify the issue. This shows a willingness to understand. However, avoid "why" questions and use "what" or "how." Use active listening as mentioned above. • If necessary, call a recess to allow the person an opportunity to self-regulate. • Do not threaten; inform of consequences.
	Allowing court processes to be unknown and unexpected.	<p>BE TRANSPARENT. Use clear, simple language to let people know what is happening and why.</p> <ul style="list-style-type: none"> • Explain the purpose of each hearing and who is in the courtroom. • Use non-technical language. • For example, instead of conducting sidebar conversations without explanation, tell the person that a sidebar conversation will occur and why - saying "We have to discuss some issues related to your case. We just need a minute to do it on the side."
Court Environ	Congested, noisy waiting areas.	<p>Reduce stress prior to the hearing by offering a calm and quiet space to wait.</p> <ul style="list-style-type: none"> • Advocate for a well-maintained and clean waiting area and facility. • Notice the lighting and temperature and make sure it is adequate and comfortable. • Ask for security staff to be present in the waiting areas.
	Congested, noisy courtrooms.	<p>Ensure that the overall noise level of the courtroom is kept to minimum, along with the level of movement and activity.</p> <ul style="list-style-type: none"> • Advocate for a well-maintained and clean courtroom. • Notice the lighting and temperature and make sure it is adequate and comfortable. • Keep the noise limit low enough so that the noise is not distracting and provides a calm environment.
	Confusing signage.	<p>Reduce anxiety prior to the hearing by offering clear directions to the courtroom and posting simple courthouse rules.</p> <ul style="list-style-type: none"> • Walk through the courthouse and notice if signage is clear. Are there courthouse maps that are easy to read? Are the courtrooms clearly labeled? Do you need signage in multiple languages? • Are simple rules about noise and courtroom decorum posted and easily understood?
	Not feeling safe and secure.	<p>Advocate for adequate courthouse security and ensure safety in your courtroom.</p> <ul style="list-style-type: none"> • Follow a security protocol to protect victims of domestic violence. • Review safety and security measures and audits with your trial court administrator. • Have routine conversations with your bailiff about safety expectations. Seek ideas and recommendations from your bailiff.
	Long periods of wait time before appearing before the judge.	<p>Institute time-specific docketing to reduce anxiety and agitation.</p>
	Vast physical distance between the judge and the parties.	<p>Consider conducting family court hearings at a table.</p>
	An elevated bench between the judge and the parties.	<p>Move from behind the bench and instead sit at the head of a table.</p>
	Intimidating behavior by the bailiffs.	<p>Eliminate forms of nonverbal intimidation (jingling handcuffs or keys).</p>
Recalling traumatic events, memories, and feelings in open court.	<p>Use caution when questioning about traumatic events. Consider having a trained mental health professional on-site to debrief with families and children after court.</p>	
Self-Awareness	Personal bias.	<p>Be vigilant in your awareness of your own personal biases as it can alter your perception of the impact of trauma.</p> <ul style="list-style-type: none"> • Take note of any "baggage" you hold from your own traumatic experiences or trauma events experienced by loved ones. • Identify your potential biases and how they might color your interpretations without your even being aware of it. • Understand and appreciate the culture, race, ethnicity, economic situation, religion, and place of residence of court-involved families. • Ask whether proposed case plans/probation sanctions/visitation orders are reasonably tailored to the specific needs of the child and family. Research has shown that many parents need practical help, but this kind of assistance is not always a priority. • Be open to and encourage appropriate connections to religious, community, and cultural institutions. • If you are working with a youth or adults whose sexual orientation differs from yours, get training to understand their needs and how the system might affect them.

Source material:

- Using Trauma-Informed Practices to Enhance Safety and Security in Women's Correctional Facilities, National Resource Center on Justice Involved Women, Alyssa Benedict
- Essential Components of Trauma-Informed Judicial Practice, Substance Abuse and Mental Health Services Administration
- Safeguards Against Bias, National Court Appointed Special Advocate Association
- Pasco County Circuit Court Trauma Audit, National Council of Juvenile and Family Court Judges

Communicating in a trauma-informed tone and manner: a quick refresher

“What has happened to you?”

“What do you think?”

“What can we do to solve the problem?”

“Please.”

“Thank you.”

“Your commitment really shows.”

“It’s clear you are trying to change.”

“Despite what happened in court last time, you have been able to...”

“I heard that you earned a one month token in AA. I know you worked hard for that.”

“I read in the court report that you followed last month’s visitation schedule without any problems. This will help your child.”

“I’d like to refer you to a doctor who can help us better understand how to support you.”

“Maybe what we’ve been doing isn’t the best way for us to support you. I’m going to ask you not to give up on recovery. We’re not going to give up on you.”

“I can see you are confused”

“I can hear you are frustrated.”

“Sounds like you are saying...”

“Sometimes bad things happen to children when they’re younger. Those are crimes. That shouldn’t have happened. It’s not your fault. There is nothing you could have done to stop it. You deserve to be happy. You can heal from bad things in the past. I can get you someone to talk to who could help. Do you think that might help?”

“Something bad happened. You’re okay now. There is hope for the future.”



Ask the Experts:

Top 10 Critical Issues in Child Development for Family and Juvenile Judges

Honorable Karen Adam

Honorable Ernestine Gray

Kirsten Lysne, PhD

Philip Stahl, PhD, ABPP

Family and juvenile court judges make important decisions in complex cases every day. These cases often involve substance abuse, mental health, family violence, and trauma. Before a judge can make an appropriate decision regarding custody, parenting time, reunification, child support, or relocation, she must also consider how the child will be impacted. Those decisions require knowledge of child development; most judges are not experts in the field nor have access to those with that expertise. Here are ten of the most important things every juvenile and family court judge needs to know to make informed and developmentally appropriate decisions in the best interests of children.

1. Child Development is Brain Development

Children develop in utero in predictable and organized ways, which it makes it possible to know, for example, at how many weeks into a pregnancy an ultrasound will allow us to determine whether the baby is a boy or a girl. In this same predictable way, development unfolds throughout childhood. Most of this development is based on the growth and maturation of the brain. As the child's brain develops, the child acquires new capacities in their thinking and navigation of their interpersonal world.

In family court, we understand that very young children are not mature enough to indicate their preferences about parenting plans. Often when it comes to school-aged children, however, parents argue that a child is "mature for their age" and should therefore have a role in decision-making. Children may be perceived as mature when they are intelligent or have particularly strong verbal skills. It is critical to remember, however, that despite intelligence, brain development takes the full span of childhood to evolve. No 9-year-old child can take the perspective of other family members nor consider the long term consequences of their actions in the way a 14-year-old child can, and neither can do so as well as a 17-year old child can.

2. Very Young Children have an Organized System for Using their Parents to Regulate Themselves, and We Must Protect this System.

Babies and toddlers cannot manage their bodies and emotions on their own; they require the responses of adults for every basic need. This includes the physical tasks of feeding and changing, but also the emotional and relational tasks of managing distress, soothing the body into sleep, and regulating the interplay of facial expressions and responses that become the foundations for emotional stability and interpersonal skills. The developmental task for infants and toddlers is to build a system of attachment to their primary caregivers that organizes how they will manage themselves by utilizing their interactions with each parent.

Divorce and separation can disrupt the systems that small children have built and are relying upon. This can be disorganizing for children and cause setback in their developmental progress. Our task as family court practitioners is to preserve the systems that small children have built. For children whose self-regulation system has developed in the context of shared care by both parents, a parenting plan should include frequent and abundant contact with both parents and prevent lengthy separations from either parent. For those children who have developed within a context of care by a single, primary parent, then the focus should be on minimizing lengthy separations from that caregiver. Once children are three or four years old, they can become less reliant on these internal co-regulation systems and more flexibly manage life in two homes.

3. The impact of exposure to violence and trauma is likely to be worse for infants than for older children.

Counterintuitive to most people's thinking, the baby in the crib may be more severely damaged than the 4-year-old, or 10-year-old, in the family. Yes, the older children hear and see what is going on, may be put into a protective role (e.g., calling the police, yelling at the abusive parent to stop, etc.) and may express fears, confusion, or sadness. And yes, the infant doesn't "know" what is going on and doesn't realize that violence or trauma is occurring. However, the infant's brain is affected significantly by all of the noise and negatively-charged emotions. The brain remembers what the brain experiences, and the impact on the developing brain is *huge*. Additionally, the older child can use words to help mediate the emotional response, whereas the infant cannot. When parents say that their infant wasn't harmed because the infant doesn't know what happened, judges can explain the opposite.

For a detailed and compelling explanation of these issues, watch the video, "First Impressions - Exposure to Violence and a Child's Developing Brain," available on www.youtube.com

4. Child development is always relevant in family law decisions and knowledge about child development can help judges better estimate a child's maturity level and the custodial wishes of the child.

Most state family law statutes do not specifically require consideration of child development factors in judicial decision-making concerning custody, relocation, parenting time, and child support. Instead, judges are directed to consider the best interest of the child, the child's needs, or the child's emotional and psychological wellbeing. It is hard to imagine how a judge can make decisions about best interest, needs, or wellbeing without knowing what is developmentally appropriate for the child. A parenting plan that would be perfect for a ten-year-old will likely be a disaster for a two-year-old, due to the developmental differences between the two children. Judges must recognize the importance of child development when crafting orders that can either enhance or hinder that development. By carefully reviewing statutory mandates for phrases such as best interests or wellbeing, a judge will find the authority to consider and apply child development principles in decisions about custody, parenting time, relocation, and child support.

In general, children are better served by having relationships with both parents, assuming both can support the child's health, safety and welfare. Recognizing that parents may have mastery of different parenting skills, all children need a predictable schedule that supports those relationships and takes into account their developmental and individual needs, and allows both parents to be involved in all important aspects of their lives. Children under age 3 may need more frequent transitions and shorter amounts of time with each parent, whereas children from 3-5 can begin to tolerate more time away from each parent. School-aged children can benefit even longer time away from each parent, while preserving those relationships in ways that utilize each parent's healthy parenting styles optimally. Finally, adolescents may want an increasing voice in those parenting plans.

A great resource is "Planning for Parenting Time: Arizona's Guide for Parents Living Apart" (2008).

5. The Rhythm of Parenting Time is as Important as the Quantity of Parenting Time

Often in family court, parents, attorneys and other adults focus on the quantity of parenting time allotted to each parent, when what matters most to a child, particularly a younger child, is the qualitative elements of the schedule, particularly the rhythm of transitions between their homes. A child's perception of a schedule that has 10 consecutive days with Parent A followed by 4 consecutive days with Parent B is vastly different from a schedule that has four 2-3 day spans with Parent A interrupted by 1-day contacts with Parent B, although each of these schedules include ten days with Parent A and four with Parent B. Adjustment of this rhythm is the simplest method of adapting the schedule to suit the developmental stage of a young child.

Younger children cannot carry within themselves their sense of comfort and relationship with others, so they need face-to-face contact with caregivers on a schedule that prevents lengthy separations. Older children and teens have developed this ability to carry the comfort of parental relationships within themselves and they are

developmentally able to use the technology of phones to supplement their sense of connection. Children of more mature ages need not transition between their homes as frequently because of this developmental advancement.

6. Parents with Certain Strengths and Capacities Can More Effectively Share Care

Jennifer McIntosh and her colleagues in Australia conducted several studies of parental overnights. Much of the discussion following the release of their findings in 2010 focused on the results indicating that multiple overnights with a non-primary parent are disruptive to the long-term development of very young children. Another substantial finding of these studies, which is often overlooked, is that particular capacities in parents allow them to more successfully share care in a manner that supports their children's development. Note that in this discussion, sharing care includes equally shared schedules (50/50) as well as unequal schedules that provide abundant care for both parents.

McIntosh and colleagues identified these capacities as forms of "equipment" that co-parents carry, and outlined them as follows.

Developmental Equipment includes the ability of parents to understand the child's developmental stage and to adapt their parenting plan to their child's capacities and stage. This factor trumps all others in predicting children's success in shared care.

Relationship Equipment includes positive relationships between each parent and the child as well as a cooperative and respectful relationship between the co-parents. It also includes having supportive, respectful relationships with both extended families. This factor is more predictive of children's outcomes than the number of overnights in each parent's care.

Socio-Economic Equipment includes living in geographic proximity to the child, and having adequate income and work flexibility to provide comfortable housing, and the ability to be present with the child.

Maintenance Equipment includes the ability of the parents to be flexible and responsive to the child's needs, and to have a business-like co-parenting relationship.

We, as professionals, are wise to urge parents to invest their time and energy in developing the equipment outlined above if they prefer to have abundantly shared parenting time.

Professor McIntosh, Professor Kline Pruett, and Dr. Kelly focusing on risk and protective factors that are critical for very young children, added more information on these issues in two articles on overnights with young children, published in *Family Court Review*, April 2014, suggesting how decision-makers can use these factors to ensure developmental and relationship success for young children.

7. Be mindful that children's statements may be influenced by both internal and external factors, and thus may not be reliable.

It's easy for judges to understand that parents may try to influence what their children say in family and juvenile court matters. What's more difficult to understand is the myriad of internal and external factors that may also contribute to children's suggestibility. Various external factors that increase the risk of suggestibility in children include, but aren't limited to:

- Question type – Open-ended questions are always preferable over forced choice, or yes/no, questions.
- Suggestive questions – Questions that imply a particular person caused them harm, such as, "When your daddy ...?"
- Source Monitoring – It's always important to ask children how they know something, i.e., did they see it or did someone tell them about it. Younger children are particularly susceptible to source monitoring problems.
- Repeated questions – Children respect adults and often think that if adults ask the same question several times, their previous answers are incorrect and they change their answer accordingly. Some interviewers then stop asking questions when they get the answer they want to hear, and that reinforces for the child that they got it right this time.

Various internal factors that increase the risk of suggestibility include, but aren't limited to:

- Age – Younger children are always more susceptible to being influenced by these external factors.
- Emotions – Children might be ashamed, anxious, angry, scared, sad, or have other emotions that influence the nature of what they say.
- Loyalty – Children are often influenced by loyalties that they feel toward one or both parents.
- Failure to understand – Adults often use language that children, especially children under 5 years old, don't understand and they answer questions incorrectly because of it. Use language that is appropriate to the age of the child.

8. In domestic violence or abuse cases, when appointing an expert to conduct an evaluation, provide therapy, or serve in some other capacity, be certain that your expert understands the unique and necessary considerations in those cases.

Many experts are knowledgeable and understand complexities associated with family and juvenile court matters. But not all experts are expert in the particular matter of *your* case. For example, if you are dealing with a family experiencing sexual abuse allegations, domestic violence allegations, or allegations of child alienation (or all 3), be certain that your expert has the appropriate knowledge and skills to use protocols

appropriate to the case.

For more information, see the recently completed AFCC Guidelines for Examining Intimate Partner Violence (2016) and the AFCC Model Standards of Practice for Child Custody Evaluation (2006).

9. What To Do When You're Not an Expert

Judges bring to the bench, and to their decisions, who they are and what they've experienced. Few judges are experts in neuroscience, child development, family systems, family violence, substance abuse, or behavioral health. The best judges learn as much as possible about those topics so that they can ask the questions that will lead to the evidence they need to make good decisions. It is the lucky judge who can rely on the testimony of a professional about a particular child and family. More often, judges learn from the parents, the child, or non-professional witnesses such as family members and friends. That is why it is critical that judges have a basic understanding of child development (and of the other topics noted above). If there is no expert available, the judge must advise the lawyers and/or litigants about what she will use to make her decision. If she has heard a speaker, read an article, or attended a training, and plans to rely on what she learned to make her decision, she should provide that same information to the lawyers and/or litigants so that they are able to respond.

10. Judges need to understand that trauma (e.g., from substance abuse, high-conflict divorce, neglect and abuse) can derail a child's development.

Trauma comes in many forms, and significantly increases the risk that a child's development will become derailed. Symptoms can take on many forms. Some are internalized symptoms, including, but not limited to failure to thrive, depression, fears, anxiety, lack of self-confidence, lack of initiative, lack of self-esteem, or academic difficulties. Others are externalizing, including, but not limited to bullying, temper outbursts, failure to respond to authority, or ADHD symptoms. These children often have somatic symptoms, as well, including but not limited to sleep problems, regressions in toileting, speech and language, facial tics, or simply holding the tension in their bodies.

With the limited time you have with the family, screening for these symptoms is important. Independent child lawyers and parents should be queried about any symptoms that the child is experiencing that are related to the experienced traumas so that remedies and interventions can be part of the overall court-ordered plans. Interventions can include, but aren't limited to: play therapy, yoga, group therapy, and perhaps medication. As described in #9, although judges aren't the experts and you may not have experts to help in a given case, your experience and training will help guide you in recognizing the symptoms, the traumas associated with those symptoms, and providing direction for appropriate interventions.

Compiled and organized by:

ENGAGING YOUNG CHILDREN (AGES 0-12 MO) IN THE COURTROOM

JUDICIAL BENCH CARD¹

Document court actions

Document in the court order:

- Whether the infant is present at the hearing.
- OR if not present, address the reasons why the infant is not in attendance.
 - Ask why the infant is not present and what efforts were made for the infant's attendance.
 - Explore and encourage resolution of transportation issues as a reason for nonattendance.
 - Depending on the situation, consider postponing the hearing until the infant can be present.
 - Request a current picture that will be introduced into the record.²

Observe the infant's behavior and appearance

- How does the child interact and respond to caregivers, parents, and guardians?
- Assess whether the child appears healthy and well kept.
- Does the child exhibit appropriate developmental milestones?³

Preparations for court attendance

- Ensure that your courtroom is child friendly.⁴
- Ensure all children are accompanied by a familiar caregiver.

Possible questions to ask the caregiver about the infant

- Is the infant forming healthy attachments?⁵ With whom?
- Is the infant meeting developmental milestones?⁶

AGE	MILESTONES*
2 months	Lifts head up 45 degrees Laughs Smiles spontaneously
4 months	Rolls over Follows to 180 degrees Turns to rattling sound
6 months	Sits with no support Turns to voice Feeds self
9 months	Pulls to stand Says "Dada" and "Mama," nonspecific Waves bye-bye
12 months	Stands alone Can say 1 word Imitates activities
18 months	Runs Can remove garment Can point to at least 1 body part

*50% to 90% of children can perform these milestones.

The Milestone Chart was adapted from Hagan JF, Shaw JS, Duncan PM, eds. 2008. *Bright Futures: Guidelines For Health Supervision of Infants, Children, and Adolescents*, Third Edition, Elk Grove Village, IL: American Academy of Pediatrics and Schor EL, ed. 2004. *Caring For Your School-Age Child*, New York: Bantam Books.

¹ This bench card was created to assist judges when a child is present in the courtroom. It does not include what information the judge should require from additional parties, such as a report from the child's therapist about the child's mental health status.

² The social worker or caregiver can provide the court with a picture.

³ Please refer to the Milestone Chart. For more information about child development, see Genie Miller Gillespie and Diane Boyd Rauber (eds.), *A Judge's Guide: Making Child-Centered Decisions In Custody Cases* (ABA Child Custody and Adoption Pro Bono Project and ABA Center on Children and the Law 2d ed, 2008).

⁴ It may be necessary to address issues related to the infant's safety at the courthouse and the appropriateness of courtroom waiting areas. Judges may find it beneficial to have age-appropriate toys and books available.

⁵ For more information about attachment, see JoAnne Solchany and Lisa Pilnik, *Healthy Attachment for Very Young Children in Foster Care*, Child Law Practice, Vol. 27, No. 6 (August 2008).

⁶ Please refer to the Milestone Chart.

Guiding Principles for Defining and Implementing a Model Family Court

Adopted by the Florida Supreme Court In re Report of the Family Court Steering Committee, 794 So. 2d 518, 522 (Fla. 2001)

Children should live in safe and permanent homes.

The needs and best interests of children should be the primary consideration of any family court. All persons, whether children or adults, should be treated with objectivity, sensitivity, dignity and respect.

Cases involving inter-related family law issues should be consolidated or coordinated to maximize use of court resources to avoid conflicting decisions and to minimize inconvenience to the families.

A key part of the family court process should be establishment of processes that attempts to address the family's interrelated legal and nonlegal problems to produce a result that improves the family's functioning. The process should empower families through skills development, assist them to resolve their own disputes, provide access to appropriate services, and offer a variety of dispute resolution forums where the family can resolve problems without additional emotional trauma.

Whenever possible, parties and their attorneys should be empowered to select processes for addressing issues in their cases that are compatible with the family's needs, financial circumstances, and legal requirements.

The court is responsible for managing its cases with due consideration of the needs of the family, the litigants, and the issues presented by the case.

There should be a means of differentiating among cases so that judicial resources are conserved and cases are diverted to non-judicial and quasi-judicial personnel for resolution, when appropriate and consistent with the ends of justice.

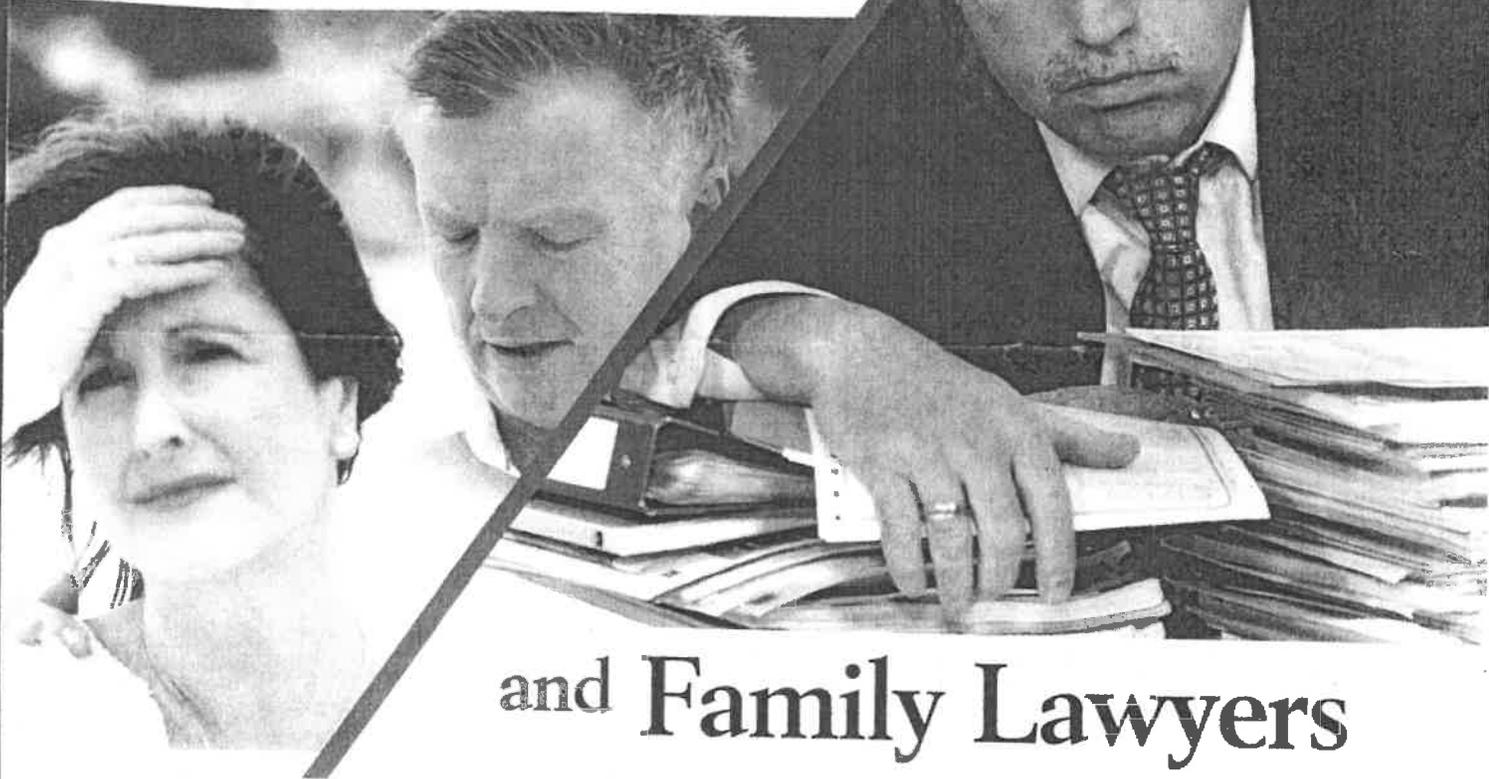
Trial courts must coordinate and maximize court resources and establish linkages with community resources.

The court's role in family restructuring is to identify services and craft solutions that are appropriate for long-term stability and that minimize the need for subsequent court action.

Court services should be available to litigants at a reasonable cost and accessible without economic discrimination.

Courts should have well trained and highly motivated judicial and non-judicial personnel.

Secondary Traumatic Stress



and Family Lawyers

Practicing family law is stressful, and we now have some validation that listening to our clients' traumatic stories can and does affect family lawyers.

By Cindi Barela Graham, Family Lawyer, and Dr. Lynn Jennings, Professional Counselor

Secondary Traumatic Stress (STS) is the indirect exposure to trauma through either a firsthand account or narrative of a traumatic event. For example, hearing a client recall, in vivid detail, the beatings by her husband which has left her face scarred and paralyzed can cause STS. Hearing that account coupled with seeing the physical evidence of the pictures of the client's face immediately after the beatings causes yet even further stress for the family lawyer. Hearing accounts related to children is even more traumatic.

STS is an occupational hazard to a

range of professionals including family lawyers, and there is a general consensus in the literature that it has negative associated effects. Some research argues that it is wrong or improper for a practitioner to have feelings of sympathy and sorrow for their clients' suffering with the caveat that practitioners need to understand their limitations in helping alleviate the pain suffered by their clients. However, compassion is also necessary for the establishment of the lawyer-client relationship, so it can be a fine line that needs to be recognized and adhered to.

How STS Affects Family Lawyers

Dr. Charles Figley (1995) distinguished STS from other types of stress as that resulting from a deep involvement with a primarily traumatized individual. STS effects or symptoms are cumulative and permanent. The more accounts a professional hears of the abuse or trauma, the more it begins to affect them. The effect can be presented as a lack of sleep, poor eating habits, hypervigilance, abuse of alcohol or drugs, relationship issues, and detachment issues.

Cont. on page 60

While boundaries are helpful for any professional to establish with their client, hearing about a traumatic event, coupled with the professional's desire to assist their client, still impacts and exposes the practitioner to the effects of STS.

Symptoms of STS

The initial indicators are changes in sleep and eating habits. As it progresses, sufferers may experience hypervigilance or a heightened sensitivity to interactions with others or things going on around them. People with STS often have a harder time winding down and have a decreased ability for separating their professional work from their personal lives. STS can lead to paranoia and feelings of helplessness. Disassociation, withdrawing from society, and isolation are often common; increased drug and/or alcohol use as a coping mechanism is common as well.

Becoming increasingly argumentative with family members or needing time alone after coming home from work or after a trial are potential symptoms of STS. That said, any time we deal with psychologically trying events, time alone to process what we have experienced does facilitate the compartmentalizing of work-related stress from our personal lives.

Minimizing the Effects of STS

Communication is key. Family members will likely notice the effects of STS in the lawyer before the lawyer notices them himself. Educating the family about STS can aid in minimizing the negative effects it causes.

By implementing daily self-care practices that allow them to process their feelings, family lawyers can minimize the negative effects of STS. Self-care practices include getting adequate sleep, exercising, healthy hobbies, eating a healthy diet, minimizing alcohol use, practicing healthy spiritual activities such as meditation or prayer, along with maintaining a

balanced lifestyle between work and home life.

Family Lawyers Can Help Each Other Deal with STS

Many family lawyers have said: "My friends are lawyers, but my best friends are family lawyers." Recognizing STS within themselves will help family lawyers recognize it in others. Collaboration and mentorship can be helpful, and discussing and debriefing with each other following particularly traumatizing events – such as a hotly-contested trial – can be very therapeutic for family lawyers. Having friends in related fields who are not lawyers can help to balance perspectives: for example, having good relationships with mental-health care professionals, accountants, or other experts you may use in the presentation of your case can help minimize the effects of STS as these professionals have insight to the cause of the stress. The different perspectives of these professionals can also help normalize the feelings caused by the trauma.

The Long-Term Effects of STS for Family Lawyers

STS is similar to Post-Traumatic Stress Disorder (PTSD). Normal PTSD symptoms, such as dissociative episodes (flashbacks, splitting of personalities), intrusive memories in dreams, abnormal eating and sleeping patterns, hypervigilance, and detachment can be indicators that STS is present.

STS becomes a part of a person's life to the degree that they ignore how this type of long-term stress impacts them. It can be nearly impossible to treat without medical and psychological intervention, along with a good diet, exercise, and good stress-management techniques. STS can have potentially fatal effects such as a heart attack, stroke, suicide, and even violence, as well as other stressor-related issues if not treated.

We know that practicing family law is stressful, and now we have some validation that listening to our clients' traumatic stories can and does affect

us. No matter how hard we try to stay neutral or try to maintain a professional view of our cases, we cannot help but be affected by stories of physical or emotional brutality.

To help us be better practitioners to our clients and better partners in our personal relationships, we need to recognize the effects STS can have on us. We all need to maintain a healthy balance between work and our social lives. STS reminds us that we need to take care of ourselves – both physically and mentally – so that we can be the best we can – both in and out of the courtroom. ■



Cindi Barela Graham is Board Certified in Family Law and has been named a Texas Super Lawyer every year since 2003. She currently serves as a director to the Texas Academy of Family Law Specialists and is on the Board of the Texas State Bar's Family Law Section.



Dr. Lynn Jennings has spoken throughout Texas and New Mexico on Secondary Traumatic Stress. She has been a counselor in private practice for thirteen years in Amarillo, Texas, and is adjunct professor at Texas Tech University, Eastern New Mexico University, and Prescott College.
www.jenningscounselingtx.com

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By Dr. Mel Borins
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www.familylawyer magazine.com/articles/mindfulness-based-stress-reduction

Family Law Forum Fall 2014

Adverse Childhood Experiences: Implications for Family Law Practice and the Family Court System

Jan Jeske and Ret. Judge Mary Louise Klas

“Everyone has the right to a future that is not dictated by the past.”¹

Introduction

The purpose of this article is to increase awareness within the family law community of the research study project on Adverse Childhood Experiences conducted by Kaiser Permanente and Centers for Disease Control and Prevention. The article will highlight Minnesota’s studies on Adverse Childhood Experiences [hereinafter ACEs], and ACEs impact on child and adult physical and mental health and social well-being. Our hope is to expand on this knowledge base in a forthcoming Spring 2015 article and to suggest trauma-informed measures which practitioners, judicial officers, court staff and other stakeholders can take to work more effectively with parties who suffer from the negative impact of ACEs.

Whenever a family interacts with the court system – whether family court, child protection, juvenile delinquency, domestic violence, or paternity court - the system should endeavor to mitigate the harm already done and do no further harm.² This is likely best accomplished by ensuring that every actor with whom the family comes in contact understands the effects of ACEs and takes responsibility for his/her part in mitigating the harms already done and preventing future harm.³ The system’s intervenors must assess the harm done and construct the future, as best they can, to do no more harm.⁴ This requires meaningful information on the past, present and future parenting behavior of those who have influenced and may, in the future, influence the child’s environment.⁵

A national task force found that 60% of American children can expect to have their lives touched by violence, crime, psychological abuse and trauma.⁶ Our present efforts to understand the longstanding effects of adverse childhood experiences may only be the tip of the iceberg. Trauma is a buzzword now in social services, public health, education, juvenile justice, mental health, pediatrics, criminal justice, medical research and even business. But not everything is trauma, and in most cases spanking and yelling, taking away the child’s cell phone or differing rules/expectations for children in separated or divorced parents’ homes is not trauma.⁷

Traumatic stress may interfere with a parent’s ability to interact with an attorney who represents him/her. Trauma affects what the client needs from an attorney, as well as how an attorney will interact with the client who has experienced ACEs. The client may be reluctant to reveal critical information that could be outcome determinative. Further, a history of traumatic stress may inhibit the client’s ability to form trusting relationships with others, such as their own children or court service workers. This inability could negatively impact case outcomes and may foster inappropriate judgments such as overprotective false allegations in custody and parenting time actions or underprotective care of the child(ren) involved which could lead to child in need of protection (CHIPS) proceedings.

What are ACEs?

“Adverse Childhood Experiences” are stressful or traumatic experiences, including abuse, neglect and a range of household dysfunctions.⁸ Adverse childhood experiences’ cumulative impact on adult health outcomes had not been previously detailed before an important study was undertaken in the mid-1990’s in the United States. This study examined the relationship of health risk behavior and disease in adulthood to the breadth of childhood exposure to ten (10) categories of trauma which encompassed emotional, physical, or sexual abuse, emotional and physical neglect, an incarcerated household member, parental separation and or divorce, domestic violence where mother or stepmother was treated violently and other household dysfunction which includes substance abuse or mental illness. Indeed, longitudinal research in a different study shows that children who are court-ordered into joint custody in highly conflicted families and in those where there has been domestic violence are negatively affected and are likely to be more emotionally disturbed as a consequence.⁹ Witnessing domestic violence affects children emotionally, behaviorally, academically and socially and domestic violence does not necessarily end with divorce.¹⁰

While the impact of adverse childhood experiences on adult health outcomes is a relatively new body of knowledge in Minnesota and other states, its recognition is growing throughout the country. Nationwide, by 2014, at least 21 states have adopted the Kaiser Permanente-CDC ACE study criteria and adapted this information for use in their individual statewide public health studies on ACEs,¹¹ and Minnesota is no exception.¹² “According to Dr. Robert Anda, one of the co-founders of the Kaiser Permanente/CDC’s ACE Study, 21 states have done or are completing their own ACE surveys.” Washington State was one of the early adopters in these efforts and a working group from Minnesota met with Washington stakeholders to learn from their work.¹³

Childhood exposures are defined by the categories listed earlier. The ACEs study used questions related to three categories of childhood abuse: psychological abuse (2 questions), physical abuse (2 questions) and contact sexual abuse (4 questions).¹⁴ There were also questions on four categories of exposure to household dysfunction during childhood: exposure to substance abuse (defined by 2 questions), mental illness (2 questions), violent treatment of mother or stepmother (4 questions) and criminal behavior (1 question). If a respondent answered yes to one or more questions within a category they were defined as exposed to that category of ACE.

What is the ACE Study?

The ACE Study is ongoing collaborative research between the Centers for Disease Control and Prevention in Atlanta, GA, and Kaiser Permanente in San Diego, CA. The Co-principal Investigators of the study are Robert F. Anda, MD, MS, with the CDC; and Vincent J. Felitti, MD, with Kaiser Permanente. Over 17,000 Kaiser patients participating in routine health screening volunteered to participate in the study. Data resulting from their participation continues to be analyzed; it reveals staggering proof of the health, social, and economic risks that

result from childhood trauma.¹⁵ Notably, the study participants are middle class, college educated and mostly white. As a rule, participants had jobs and access to good health care.

It is only recently that medical investigators in primary care settings have begun to examine associations between childhood abuse and adult health risk behaviors and disease.¹⁶ These associations are important because it is now clear that the leading causes of morbidity and mortality in this country are related to lifestyle factors that have been called “actual” causes of death.¹⁷ To the degree that abuse and other potentially damaging childhood experiences contribute to the development of these risk factors, adverse childhood exposures should be regarded as the basic causes of morbidity and mortality in adult life.¹⁸

The purpose of the ACE Study is to describe the long-term relationship between childhood experiences and important medical and public health problems by assessing retrospectively and prospectively the impact of childhood abuse and household dysfunction on the following outcomes in adults: disease risk factors and incidence, quality of life, health care utilization, and mortality.¹⁹

Why Should Practitioners and Family Court Professionals Care About ACEs?

There are currently more than 500 articles written on adverse childhood experiences (ACEs) study research findings which suggests the interest in and importance of this knowledge base including developments in epidemiology, neurobiology, and biomedical and epigenetic consequences of toxic stress. Professionals, organizations, agencies and communities are implementing best practices based on the ACEs research in family law, education, juvenile justice, criminal justice, public health, medicine, mental health, social services, and in municipalities and states. The authors hope is to publish a follow up article in spring 2015 with the goal of reporting on resources that incorporate ACEs research and to make recommendations on how to use these resources to implement trauma-informed best practices. This information may help family law practitioners, judicial officers, guardians *ad litem*, court staff and other stakeholders in the family court system to work more efficiently and increase the likelihood of better case outcomes.

A Duluth area attorney’s practice has been transformed by her understanding of the neurological ramifications of trauma that affect the thinking and brain function of her clients and their children. “Example: I had a mediation set for today on a post decree parenting time issue. I knew the woman had been a victim of domestic violence during the marriage but she never wanted to share much. Yesterday I texted her, reminding her of the date, etc. She responded saying she was so nervous about the whole thing. My normal response would have been to reassure her that things would be fine, that I would be there, etc, etc. Instead, I responded with one word: Why? I felt like I really needed to know why she was nervous. Her response spoke volumes about her past trauma. Simply asking “why?” transformed how the mediation went today, helped me understand her boundaries, what she was worried about, and so on. It also communicated to her that her fear was valid. This, of course, was something she never experienced in the marriage.”²⁰

The ACE Study became even more significant with the publication of parallel research that provided the link between why traumatic childhood experiences could have adverse health consequences throughout all of adulthood. The stress of severe, chronic childhood trauma such as being constantly belittled, berated, slapped or punched or watching father inflict physical violence on mother releases flight, fight or freeze hormones that physically damage a child's developing brain because they become toxic when they are turned on too long.²¹ This was the finding of neuroscientists and pediatricians at Harvard and the Child Trauma Academy. A San Francisco pediatrician found that for her patients who had four or more categories of adverse childhood experiences "their odds of having learning or behavior problems in school were 32 times as high as kids who had no adverse childhood experiences."²²

Family law attorneys may wonder how it benefits them to consider the negative effects of adverse childhood experiences on their clients and or on the client's family members. Clients may be more apt to exchange relevant information with an attorney who demonstrates an understanding of the trauma that ACEs may have caused to the client. The efficacy of an attorney-client relationship may depend on an implicit level of trust. Without such trust, the attorney may lack information that is essential to keeping such a case on track or to narrowing the critical issues.

Family law practitioners face fewer court resources; this makes it more important than ever that their clients who may be referred to court services are not distrustful of court staff because of adverse or traumatic childhood experiences. Such distrust may inhibit volunteering of information that could help to positively impact the client's procedural alternatives and case outcomes. A child's loss of time with a non-custodial parent and the divorce process are in themselves adverse childhood experiences.

Study Method

The Adverse Childhood Experiences study protocol was approved by the Institutional Review Boards of the Southern California Permanente Medical Group, the Emory University School of Medicine and the Office of Protection from Research Risks of the National Institutes of Health. Questions about health-related behaviors and problems were taken from health surveys directed by the Centers for Disease Control and Prevention. The ACE study is based at the Kaiser Permanente San Diego Health Appraisal Clinic with patients who had completed a standardized medical evaluation. Patients were mailed a questionnaire about adverse childhood experiences and 9,508 (70.5%) responded.

What is an ACE Score?

The ACE score attributes one point for each category of exposure to child abuse and/or neglect. Points are added up to arrive at a score of 0 to 10. The higher the score, the greater the exposure, and therefore the greater the risk of negative consequences to future health and well being.²³ What follows is the ACE score calculator that can be found on the Kaiser Permanente ACE Study website:

ACE Score Calculator

Finding Your ACE Score

While you were growing up, during your first 18 years of life:

1. Did a parent or other adult in the household **often or very often**...

Swear at you, insult you, put you down, or humiliate you?

or

Act in a way that made you afraid that you might be physically hurt?

Yes No If yes enter 1 _____

2. Did a parent or other adult in the household **often or very often**...

Push, grab, slap, or throw something at you?

or

Ever hit you so hard that you had marks or were injured?

Yes No If yes enter 1 _____

3. Did an adult or person at least 5 years older than you **ever**...

Touch or fondle you or have you touch their body in a sexual way?

or

Attempt or actually have oral, anal, or vaginal intercourse with you?

Yes No If yes enter 1 _____

4. Did you **often or very often** feel that ...

No one in your family loved you or thought you were important or special?

or

Your family didn't look out for each other, feel close to each other, or support each other?

Yes No If yes enter 1 _____

5. Did you **often or very often** feel that ...

You didn't have enough to eat, had to wear dirty clothes, and had no one to protect you?

or

Your parents were too drunk or high to take care of you or take you to the doctor if you needed it?

Yes No If yes enter 1 _____

6. Were your parents **ever** separated or divorced?

Yes No If yes enter 1 _____

7. Was your mother or stepmother:

Often or very often pushed, grabbed, slapped, or had something thrown at her?

or

Sometimes, often, or very often kicked, bitten, hit with a fist, or hit with something hard?

or

Ever repeatedly hit at least a few minutes or threatened with a gun or knife?

Yes No If yes enter 1 _____

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

Yes No If yes enter 1 _____

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

Yes No If yes enter 1 _____

10. Did a household member go to prison?

Yes No If yes enter 1 _____

Now add up your "Yes" answers: _____ This is your ACE SCORE

Results

The ACE Study

Persons who had experienced four or more categories of childhood exposure, compared to those who had experienced none, had a 4- to 12-fold increased health risk for alcoholism, drug abuse, depression, and suicide attempt; a 2- to 4-fold increase in smoking, poor self-rated health, > or = 50 sexual intercourse partners, and sexually transmitted disease; and a 1.4- to 1.6-fold increase in physical inactivity and severe obesity.

State ACE's Studies

In the CDC's Morbidity and Mortality Weekly Report (Dec. 17, 2010) an analysis of the ACE module implemented by 5 states in the Behavioral Risk Factor Surveillance System (BRFSS) stated that "ACEs have been linked to a range of adverse health outcomes in adulthood, including substance abuse, depression, cardiovascular disease, diabetes, cancer, and premature mortality."²⁴ The markedly lower prevalence for all the ACE categories among those aged ≥55 years were similar to findings from the Kaiser-CDC ACE study, which suggested that a higher number of ACEs were associated with premature mortality (up to 20 years of life lost).²⁵

The Minnesota ACE Study and Initiatives

The following are categories of changes, efforts or initiatives related to ACEs with a few specific examples from within the Minnesota Department of Human Services [hereinafter DHS] and other Minnesota State agencies:²⁶

Training

The Minnesota Department of Human Services and other state agencies and community organizations are providing training for members of the general public on ACEs, trauma, and their effects on brain development. As one example, programs for teen mothers may offer an incentive to attend by giving vouchers for a free car seat.

Trauma Informed Services and Policies

The Minnesota DHS Children's Mental Health Division (CMH) and Child Welfare in particular have been investing in efforts to ensure that service providers are trained to be trauma informed. This has various meanings. CMH has been training providers to implement evidence-based treatment programs to address trauma in children, such as Trauma-Focused Cognitive Behavioral Therapy. Child Welfare has implemented efforts to ensure that state policies are trauma informed including but not limited to the goal of fewer out-of-home-placements for children. Chemical Health Services for Women has been piloting a trauma-informed organizational assessment tool to evaluate the organization's policies and practices, in addition to evaluating their trauma-informed treatment modalities. The Minnesota Department of Public Health Safe Harbor No Wrong Door program model recognizes the need to ensure that juvenile victims of sexual exploitation receive effective victim-centered and trauma-informed services.²⁷

Tools

Certain tools are used to make service provisions more trauma informed. One example of such a tool is termed "Motivational Interviewing." This is a tool to help clients create their own

goals and make progress toward those goals. The Minnesota Family Investment Programs are training their employment counselors and workers in the Family Home Visiting programs (funded through Minnesota Department of Health) on the use of this tool. Evidence suggests that this technique may help with executive functioning, which can be compromised when a person's brain that has had a history of repeated toxic stress encounters a stressful situation.²⁸

New Initiatives/Programs/Services

DHS has recently submitted legislative proposals for several prevention and early intervention services to individuals and families with trauma, as has the Minnesota Department of Health [MDH]. The MDH is now in the process of hiring a mental health prevention coordinator. The Minnesota Department of Education has just opened a new office in response to the recently enacted Anti-Bullying legislation. The initiatives of these agencies are using an ACEs focused lens, although the programs are not necessarily a direct response to the ACEs study data.

Screening

Currently available information does not indicate that any agencies or organizations in Minnesota are using the ACE score calculator as a screening tool as a matter of policy including DHS, a statewide Association of Pediatrics or the MDH Health Homes program in which primary care providers, families and patients work in partnership to improve health outcomes and quality of life for individuals with chronic health conditions and disabilities.²⁹ However, there may be ongoing discussions about the use of ACEs scores. Minnesota offers developmental and mental health screening for all children enrolled in a Minnesota Health Care Program. The approved screening instruments include social and environmental questions but these screening tools may not reflect all of the generally used ACEs or trauma-informed questions. There is also a current effort to expand and/or require the utilization of maternal depression screening.³⁰

There is an ongoing major effort to require developmental screening for all children in child welfare programs and any other children at-risk for developmental and behavioral problems who are referred to the HelpMeGrow [HMG] program. The HMG system is a national effort that builds collaboration across sectors and assists states in identifying at-risk children, then helps families find existing community-based programs and services. HMG does not provide direct services, rather, it is a system for improving access to existing resources and services for children ages zero through age eight. Minnesota is now in the process of becoming a HelpMeGrow state with the goal of early detection and linkage to needed services for the best child health outcomes.

Data Collection

The 2013 Minnesota Student Survey (MSS) does not give an ACEs score for individual students, but raw data from the survey is accessible rather than data associated with any individual student. There are ongoing discussions about how to use the existing administrative data, including ACEs related data, to evaluate health care services quality.

Community Capacity

Building community capacity is a principal goal of the Minnesota Department of Health and it is related to the prevention and mitigation of the effects of ACEs. Increasing opportunities for individuals to develop leadership and related skill sets, is in and of itself a way to help people who have experienced ACEs to cope with trauma. An increased opportunity to engage in community and address relevant issues is another strategy.

ACEs provides a framework that is increasingly impacting Minnesota state agencies provision of services, policies and priorities. An author of the Minnesota ACEs study is now assisting with the implementation of new state child welfare reform initiatives which includes working with state district court judges involved in child welfare cases to develop trauma-informed practices and protocols. This work is being conducted through the Family Support and Placement Services Department of the Child Safety and Permanency Administration.³¹

Discussion of the Research

The 2013 Minnesota Student Survey (MSS) was administered in 84% of public schools that agreed to participate³² and revealed effects of adverse childhood experiences that are of profound concern. Across Minnesota, 66% of 5th graders, 71% of 8th graders, 69% of 9th graders and 62% of 11th graders participated. Thirty-five percent of students had one or more ACEs and 8.5% had three (3) or more ACEs. Of serious concern is that for students with four (4) or more ACEs, 29.5% reported binge drinking in the past 30 days, 41.9% had seriously considered suicide in the last year and 20.6% had attempted it, 27.1% have a physical disability or long term health problems such as cancer, epilepsy, diabetes, asthma or other, and 77.2% had experienced bullying in the past 30 days, while 55.8% had exhibited bullying in the past 30 days. A Hennepin County judge points to the Kaiser-CDC ACEs study correlation between adult behavior and childhood adversity, as it found that people with four or more ACEs are five times as likely to engage in sexual intercourse by age 15 and seven times more likely to perpetuate domestic violence than those with no ACEs.³³

In 2008, the CDC developed a set of ACE questions for states to use in the Behavioral Risk Factor Surveillance System (BRFSS), which is a survey used by individual states to determine the status of their residents' health based on behavioral risk factors.³⁴ Minnesota's 2011 BRFSS *results are consistent with the findings from the initial ACE study and other states' ACE studies*. ACEs are common in Minnesotans, they frequently occur together and over half of Minnesotans experiencing ACEs had more than two ACEs which have a strong and cumulative impact on the health and well being of adults. The most common ACEs reported by Minnesota adults that occurred in their childhood are physical abuse (16%), emotional abuse (28%), separation or divorce of a parent (21%), living with a problem drinker (24%), and mental illness in the household (17%).

Trauma Informed Care

Trauma informed care is grounded in a thorough understanding of the effects of trauma and violence on health and well-being and the prevalence of these effects.³⁵ It is also important to develop and sustain organizational supports to lessen the effects of traumatic stress (e.g.

secondary trauma, burnout, vicarious trauma) that naturally occur among providers of empathic care, which can include family law practitioners, other family law professionals and stakeholders.³⁶

Web Resources

Brain Rules by John J. Medina is an online multimedia project explaining how the brain works, including the effects of stress that damage virtually every kind of cognition and actually shrink the size of the brain. It includes a book, a feature-length documentary film, and a series of rules to follow to enhance the optimal functioning of the brain. Medina explains that the brain is not designed for long term stress that a person feels they have no control over. He posits that the emotional stability of the home is the single greatest predictor of a child's academic success.³⁷

John Gottman's laboratory studies on children found that marital discord can influence children indirectly by decreasing the effectiveness of the parents' monitoring, emotion coaching, and other parenting skills and can directly influence children by creating emotional distress in the children.³⁸ Ongoing research continues to examine how some children remain resilient in the circumstance of an emotionally unstable home. The use of "emotion coaching" is taught to improve the emotional communication between parents and children to positively influence the developmental trajectory of children who are exposed to marital conflict.

The Human Development Center (HDC) in Duluth, Minnesota, has trauma-informed therapists who work with parents and/or children who have experienced traumatic events. In October 2014, HDC offered trainings in evidence based Trauma Focused Cognitive Behavioral Therapy specifically focused on professional therapists and psychologists who work with children and adolescents. HDC also offers training in Trauma Focused Cognitive Behavioral Therapy to bachelor level practitioners who work with children and families.³⁹

Readers may track future ACEs publications or read abstracts by using the free National Library of Medicine web site, Pub Med, at <http://www.ncbi.nlm.nih.gov/entrez/query.fcgi> and entering *Anda* or *Felitti* under 'author name.'⁴⁰ Between the two ACE study co-principal investigators are already 141 published ACEs articles and numerous forthcoming articles. Using Google Scholar also works very well. Information of interest may be found at the web site www.ACEsTooHigh.com, and at the CDC web site: <http://www.cdc.gov/NCCDPHP/ACE/>. At the latter site, abstracts may be read by clicking on titles. Another site of interest is the ACEs Connection website: <http://www.acesconnection.com/> which posts articles on such topics as trauma in humans coming from our ancient "Reptilian Brain Freeze" reflex.⁴¹

Recommendations: How might knowledge of adverse childhood experiences (ACEs) inform family law practitioners, court officers and personnel in their work with parties?

The ACEs background information is basic. Our readers are experts in court interventions with families. We urgently request our readers to give us their best suggestions on how to use their understanding of ACEs in their work each day.

Examples:

- A client's trauma history may impact parenting style and what is needed from an attorney.
- It may take more time to prepare clients who have experienced ACEs for alternative dispute resolution.

Please send suggestions and comments to the co-authors listed below.

Provision of Resources

Traditional parenting approaches and parenting classes may not be effective to address the categories of trauma that we call adverse childhood experiences. There is a need to expand resources for Children's Therapeutic Services and Support (CTSS) programs, so that someone is in the home with the parent(s) and child(ren) doing hands on, real time parenting and skill building.⁴² The services and support also need to be culturally and age appropriate.

There are other current resources that are effective to develop parenting skills that may mitigate the effects of ACEs on the child(ren) involved in a family law matter. However, we need to develop further effective parenting skills resources. Often times family law professionals and stakeholders focus on the client or parties current issue(s) such as chemical dependency, mental illness or detrimental behaviors with their child(ren), and in that focus they may forget that the parent likely was a victim of trauma and carries that with them. Therefore, the parents historical trauma has to be dealt with along with the trauma of their child(ren) that is due to adverse childhood experiences. It can be easy to forget that the parent we are working with is parenting how they were parented. The challenge is to teach struggling parents a new path to healthier and more functional ways of being in the world for the benefit of their children without denigrating the parents of the dysfunctional parent who is involved in the family law system.

The State of Minnesota has seen growth in the number of trauma-informed therapists who work with parents that have been or need to be referred for this type of therapy. However, there is a need for more trauma informed therapists to meet the current demand. The question is, how can these therapists be identified and accessed by practitioners and the family court system? One resource is the Human Development Center (HDC) in Duluth⁴³ which provides trauma informed therapists and also gives referrals. Also, there are frequently questions posted on the MSBA family law list serve for referrals for particular types of therapists. Another resource is the University of Minnesota Ambit Network list of Trauma Focused-Cognitive Behavioral Therapy providers, which is one evidence based treatment for trauma available at the following website <http://www.cehd.umn.edu/fsos/projects/ambit/default.asp>

The family court system needs additional resources to "acknowledge the strengths of parent-child relationships" and yet fashion a non-destructive environment for the child(ren) in a situation where domestic violence has occurred. We need to train people differently, whether lawyers, judicial officers, court staff, *guardian ad litem*s, social workers, therapists, teachers, and other stakeholders to understand that parents do not intend to do a poor job of parenting. Most parents do the best with what they have and we know that children generally return to their parents, despite an abusive relationship. This points to the need for more whole family foster homes so that parents and children can live in a warm, supportive, educational environment.

If the goal of the family court system is to mitigate the harm resulting from ACEs and to do no harm, family law practitioners and family law decision-makers can make the best use of our current ACEs knowledge base by thinking before they speak to or judge clients and parties. Again, clients do the best they can with what they have. If our job is to help find a new and less destructive path for the family, then we need to start with an open mind and heart and help create the path for the client or parties.

In light of the paucity of family court resources, how can we gather reliable information on what ACEs have happened in a parent or child's life and what custodial arrangement will be best for the child? Many would say this is up to the guardian *ad litem*. But what if there isn't one? Then it is up to the attorneys to ask the right questions. Therefore, more training, more awareness, more forms, checklists, and books are needed. At the 2014 Family Law Institute the co-presenters of a breakout session on the staggering costs of childhood trauma and legal responses to improve outcomes expected to have about a dozen attendees in the room since the session was held in the afternoon of the last day. However, that fact that the room was full suggests how important/difficult/timely this issue is to the family law community. One of the presenters recently suggested the possibility of having a session just on how the system deals with physical abuse cases and to use Adrian Peterson as an example case as there is much that could be learned from that.

Conclusion

The Kaiser Permanente-CDC ACEs Study, the Minnesota ACEs Study and the Minnesota Student Survey which focuses on ACEs have had a dramatic impact on our recognition of the profound effects of trauma on lifelong physical and emotional health and social functioning. The data changes how we understand our fellow human beings. Family law professionals and system intervenors have a responsibility to incorporate this critically important ACEs knowledge in what we do. We challenge our readers to assume that responsibility.

Our hope is to follow up with a future article in the spring 2015 issue of this publication with effective, realistic recommendations that will increase the quality of relationship between families and family law professionals.

¹ A resource for service organizations and providers to deliver services that are trauma informed, *Trauma-informed: The Trauma Toolkit*, Clinic Community Health Centre (2nd ed. 2013) (last visited Sept. 28, 2014) http://trauma-informed.ca/wp-content/uploads/2013/10/Trauma-informed_Toolkit.pdf. (quoting Karen Saakvitne, SAAKVITNE, K. W. & PEARLMAN, L., TRANSFORMING THE PAIN: A WORKBOOK ON VICARIOUS TRAUMATIZATION. The Traumatic Institute/Center for Adult and Adolescent Psychotherapy. (New York: Norton.) (1996).

² Email response follow up to telephone interview with Mary Louise Klas, Ret. Judge, Minn. Second Jud. Dist. (Judge Klas served for fourteen years on the Ramsey County trial court bench and in retirement formed the Isaiah Project Domestic Violence Task Force) (Aug.3, 2014).

³ *Id.*

⁴ *Id.*

⁵ *Id.*

⁶ 2014 Minn. Fam. Law Inst. PowerPoint Presentation, Terri Port Wright & Saprina Matheny, *The Staggering Costs of Childhood Trauma: Legal Responses to Improve Outcomes* (Mar. 25, 2014) (citing U.S. Attorney General's National Task Force on Children Exposed to Violence 2012).

⁷ Port Wright, *supra* note 6.

⁸ Baum, Adolfson, & Maruska, *Adverse Childhood Experiences in Minnesota: the Research, the Data and the Minnesota Response, How Communities Can Reduce ACEs and Build Resilience*, Minnesota Department of Human Services + Minnesota Department of Health 2014 22 (last visited Sept. 7, 2014), http://www.macmh.org/wp-content/uploads/2014/05/41_Baum-+Adolfson+-Maruska_Adverse-Childhood-Experiences.pdf.

⁹ Ret. Judge Mary Louise Klas, *The Way We Were: A Retrospective of Family Law and the Issue of Domestic Violence*, 18 No. 3 FAM. L. F. 54, 56 (Summer 2010) (citing Johnston, M. Kline & J. Tschann (1989) 'Ongoing Postdivorce Conflict: Effects on Children of Joint Custody and Frequent Access.' *American J. of Orthopsychiatry* 59(4) 576-592).

¹⁰ Email from Rebekah Moses, Program Manager: Areas of specialty include: Legislative and Public Policy Organizing, Minn. Coalition for Battered Women, to the MCBW DV Laws Committee (Oct. 2, 2014).

¹¹ Jane Ellen Stevens, *The Growing Interest in ACEs and Trauma-informed Practices, ACEs Too High*, (June 21, 2013) (last visited Sept. 12, 2014), <http://acestoohigh.com/page/12>.

¹² Baum, *supra* note 8 at 39 (in the 2013 Minnesota Student Survey (MSS) some questions on adverse childhood experiences were new in 2013: other questions were reworded to better align with national ACEs surveys).

¹³ Telephone interview with Melanie Peterson-Hickey, Director, Center for Health Equity, Minnesota Department of Health (Jul. 16, 2014).

¹⁴ Vincent J. Felitti, Robert F. Anda, et al., *Relationship of Childhood Abuse and Household Dysfunction to Many of the Leading Causes of Death in Adults*, Intro., 14 Iss. 4 AM. J. PREV. MED., 245 § 1.5 (Defining Childhood Exposures) (May 1998).

¹⁵ The Centers for Disease Control and Prevention and Kaiser Permanente ACE Study, *Linking Childhood Trauma to Long-Term Health and Social Consequences*, 1 <http://acestudy.org/> (last visited Sept. 7, 2014).

¹⁶ Vincent J. Felitti, Robert F. Anda, et al., *Relationship of Childhood Abuse and Household Dysfunction to Many of the Leading Causes of Death in Adults*, Intro., 14 Iss. 4 AM. J. PREV. MED., 245 (May 1998) (citing F. Springs & W.N. Friedrich, Health Risk Behaviors and Medical Sequelae of Childhood Sexual Abuse, 67 MAYO CLIN. PROC. 527 (1992); D.A. Gould, N.G. Ward, et al., *Self-Reported Childhood Abuse in an Adult Population in a Primary Care Setting*, 3 ARCH. FAM. MED. 252-256 (1994)).

¹⁷ Felitti, *supra* note 16, at Intro.

¹⁸ Felitti, *supra* note 16, at Intro.

¹⁹ Felitti, *supra* note 16, at Intro.

²⁰ Email and telephone interviews with Terri Port Wright, Port Wright Law Office, Cloquet, Minn. (Ms. Port Wright trains legal professionals on using trauma informed best practices with clients and parties, at the 2014 Minn. Fam. Law Inst. and in other settings) (Sept. 19, 2014).

²¹ Reclaiming Futures, Communities Helping Teens Overcome Drugs, Alcohol & Crime, Jane Stevens, *Adverse Childhood Experiences Study – The Largest Public Health Study You Never Heard Of*, (parallel research findings that affirmed the significance of the result of the ACEs Study were determined by a group of neuroscientists and pediatricians, including neuroscientist Martin Teicher and pediatrician Jack Shonkoff, both at Harvard University, neuroscientist Bruce McEwen at Rockefeller University and pediatrician Bruce Perry at the Child Trauma Academy) (Oct. 16, 2012) (last visited Sept. 21, 2014) <http://reclaimingfutures.org/adverse-childhood-experiences-study>.

²² San Francisco pediatrician Nadine Burke Harris recently explained to host Ira Glass on the radio program, *This American Life*, if you're in a forest and see a bear, a very efficient fight or flight system instantly floods your body with adrenaline and cortisol and shuts off the thinking portion of your brain that would stop to consider other options.

Family Law Forum Spring 2015
Adverse Childhood Experiences: Implications and Recommendations for Family Law Practice and the Family Court System

Transforming Childhood Trauma and Toxic Stress into Hope and Potential

By: Jan Jeske and The Honorable Mary Louise Klas

Lifelong injuries persist like shrapnel pushing its way out years after the war is over.¹

Introduction

This article aims to increase awareness within the family law community of the landmark Kaiser Permanente and Centers for Disease Control and Prevention [hereinafter CDC] research study project on Adverse Childhood Experiences which was published in 1998. The study examines a range of early childhood traumatic stressors and their relationship to public health and social problems throughout the lifespan. We investigate the implications for legal setting intervention and recommend cost-effective, practical ways to implement this knowledge so as to prevent further trauma because of ACEs exposure and child maltreatment. Presently there is a nationwide explosion of interest in adversity in the form of acute trauma or environmental chronic, toxic stress and how that adversity affects a child's developing brain and why some exposed children prove resilient and others do not.² "Everyone has the right to a future that is not dictated by the past."³

This article will highlight the recommendations derived from family law professionals, insights from the Kaiser Permanente-CDC ACE study as well as studies in Minnesota and elsewhere on Adverse Childhood Experiences [hereinafter ACEs], and ACEs impact on child and adult physical and mental health and social well-being. We hope to expand on this knowledge base and to suggest to practitioners, judicial officers, court staff, GALs, custody evaluators and other family law stakeholders measures which will help these professionals to work more effectively with clients who suffer from the negative impact of ACEs.

States are forming collaborative partnerships, task forces and work groups to develop policies and practices which can mitigate conditions arising from toxic stressors and that increase the health and wellbeing of children and their families.⁴ The Kaiser Permanente-CDC ACEs study of over 17,000 American middle-class adults demonstrated that toxic stress and traumatic childhood experiences can lead to significant social, emotional and cognitive impairments, as well as chronic diseases and unhealthy behaviors across the lifespan.⁵ Integration into a family law setting of best practices evolving from ACEs research is on a continuum which requires us to continue to ask what we need to do about ACEs.

The ACE Study defines adverse childhood experiences as:

1. emotional, physical or contact sexual abuse;
2. emotional or physical neglect;
3. witnessing domestic violence of mother/stepmother;

4. growing up with alcohol or substance abuse;
5. mental illness of a household member;
6. loss of a parent because of separation or divorce;
7. an incarcerated family member; or
8. criminal behavior in the household

The ACEs study reveals that these experiences can lead to:

1. social, emotional and cognitive impairments;
2. increased risk of unhealthy behaviors;
3. violence, victimization or re-victimization;
4. disease, disability and premature mortality.⁶

An ACE score of six (6) or higher categories of exposure in childhood indicated that household dysfunction reduced life expectancy by an average of twenty (20) years.⁷

Breakthroughs in neurobiology demonstrate that ACEs disrupt neurodevelopment and can have lasting effects on the biologic pathways of brain structure and function. This leaves children who are exposed to ACEs vulnerable to poor health outcomes throughout their lives.⁸ Efforts are being made to develop an ACEs questionnaire that will better reflect the inner city, multicultural socio-economic determinants of health that may play a key role in racial and ethnic health disparities and their implications for interventions in pediatric settings⁹ Such determinants would logically carry over to the family law justice system. Children and youth who are involved in family law proceedings need interventions and structures that will help them make good choices and to move away from choices that increase the likelihood of suffering and poor social, economic and health outcomes.

Maslow's expanded hierarchy of needs includes basic safety needs such as security, order, stability and freedom from fear.¹⁰ With regard to learning, students need to feel physically and emotionally safe to progress and reach their full potential in the classroom.¹¹ Contemporary research has tested Maslow's theory by surveying 60,865 participants in 123 countries from 2005 to 2010.¹² The results of the study support the view that these universal human safety needs appear to exist regardless of cultural differences.¹³

Whenever a family interacts with the court system – whether family court, child protection, juvenile delinquency, domestic violence, or paternity court – the system should endeavor to mitigate the harm already done and do no further harm.¹⁴ This might best be accomplished by ensuring that every actor with whom the family comes in contact understands the effects of ACEs and performs his/her responsibilities in accord with the goal of mitigating and preventing harm.¹⁵ The system's intervenors must assess the harm done and construct the future, as best they can, to do no more harm.¹⁶ This requires meaningful information on the past, present and future parenting behavior of those who have influenced and may, in the future, influence the child's environment.¹⁷

A national task force found that 60% of American children can expect to have their lives touched by violence, crime, psychological abuse and trauma.¹⁸ Our present efforts to understand

the longstanding effects of adverse childhood experiences can only hope to reach the tip of the iceberg. Trauma is a buzzword now in *social services, public health, education, juvenile justice, mental health, pediatrics, criminal justice, medical research and even business*. But not everything is trauma. In most cases spanking and yelling, taking away the child's cell phone or differing rules/expectations for children in separated or divorced parents' homes is not trauma.¹⁹

Traumatic stress may interfere with a parent's ability to interact with an attorney who represents him/her. Trauma affects what the client needs from an attorney, as well as how an attorney will interact with the client who has experienced ACEs. The client may be reluctant to reveal critical information that could be outcome determinative. Further, a history of traumatic stress may inhibit the client's ability to form trusting relationships with others, such as their own children or court service workers. This inability could negatively impact case outcomes and may promote inappropriate judgments such as overprotective false allegations in custody and parenting time actions or underprotective care of the child(ren) involved which could lead to child in need of protection (CHIPS) proceedings.

Trauma Audits: Juvenile and Family Courts

The early adversity of child abuse and neglect can lead to high-risk health behaviors as a coping mechanism and thus early mortality.²⁰ The long term, costly consequences of ACEs emphasize the critical need for family and juvenile courts to identify traumatized individuals and undertake trauma-responsive prevention and intervention strategies to promote the health and well-being of children and families over the lifespan.²¹ Judges and trauma professionals are beginning to understand that trauma-informed means that environments, practices and policies must be designed to reduce the possibility of triggering stress reactions in those who have been trauma-exposed.²²

Tools have been developed to evaluate rural and urban court environments, practices, policies and court professionals' attitudes and behaviors through a trauma-responsive lens which incorporates the needs of both clients and court professionals.²³ It is important to note that child-friendly does not equal trauma-responsive.²⁴ Small changes, such as a designated court waiting room for children and victims, may reduce trauma triggers, promote engagement and support healing for traumatized parties and their children.

Researchers or consultants with expertise in trauma visit a court over a two or three day period to collect quantitative and qualitative data on the court environment and current practices. Trauma audits may include focus groups with court professionals, courtroom observation, court file review and surveys to identify challenges the court faces in becoming trauma-responsive.²⁵

Preliminary findings from seven trauma audits show that many courts do not have designated waiting rooms for victims and children, security is intermittent, knowledge and attitudes about trauma vary widely across court professionals, trauma screenings are inconsistent and many court professionals are unaware of available evidence-based practices, and more effort needs to be made during hearings to solicit the perspective of children and parents.²⁶

Trauma Informed Care²⁷

Trauma-informed care has become a direction underway in many professional settings. Medical models of trauma-informed care are based on the recognition that while not directly injured in an assault or an accident, first responders, observers and peers are often psychologically adversely affected by peripheral, marginal or anecdotal exposure. Often, the institutional response can only be reactive, such as bringing in counselors to a group, which occurred on 9/11 to address the anxiety and vulnerability of a city traumatized by an unthinkable act, or as the “new normal” response to a school shooting, the death of a student by suicide or accident, or staff terrorized by a co-worker “going postal” in the work place. Repeatedly, newscasters warn parents not to allow children to see the planes flying into the Twin Towers, images repeated even to this day. Such warnings occur almost weekly when the graphic scenes of a violent incident are broadcast.

The vicious 2010 attack upon a family lawyer in her office by an angry litigant gave rise to any number of security assessments in law offices, while family lawyers and their staff grappled with the reality that it could just as easily have been them. The same sense of vulnerability was experienced in judicial, legal and community settings following the 2003 shooting outside an area of housing court commonly called “harassment court” in Hennepin County or the 2011 shooting in the Grand Marais courthouse after a verdict.

When a patient was beaten to death by another patient in 2014 at St. Peter Regional Treatment Center, staff who worked to resuscitate the patient were not the only persons psychologically affected by the incident. Other patients and staff, both on the unit and throughout the hospital, who were not necessarily involved in any way or even present at the homicide, responded with stress symptomology arising from a reduced sense of safety and heightened sense of vulnerability. The ripple effect of numerous corridor and break discussions surrounding the event, and the many investigative interviews, served to re-traumatize and continue the psychological stressors. The “circle of observation” spread far beyond those immediately involved or present on the unit at the time as ripple effects not immediately discernible continued well past the immediacy of the event into the future lives of many individuals.

In the medical and social work fields, trauma-informed care tries to pre-empt a reactive response with the recognition that a serious illness, the death of a patient, an assault on a social worker, nurse, behavioral analyst or another patient can and does cause trauma not only to the people directly involved in the incident but with the trauma moving outward in ripples from observers to persons who hear about the incident or recount their hearsay versions of the event.

An ill or injured child creates traumatic stress reactions not only for family members but even in classroom or activity settings, where other children start to worry about their own safety or well-being, which forces their anxiety to be dealt with by parents, teachers and other involved adults. Becoming “trauma-informed” starts with the recognition that people experience different types and levels of trauma in their lives and one precipitating incident can cause different stress reactions across the board. This understanding becomes the starting point for treatment to enable a person to move forward or past the trauma by processing the experience in hopes of reducing the stress reactions by re-building a sense of safety, control and empowerment.

In high stress occupations, processing groups where problems or experiences are shared often evolve through work-required counseling, peer groups or informal gatherings at lunches and social settings. While such discussions can be mere ventilating or processing, the empathy of the audience with similar experiences or background can be key to moving through or past the trauma to start healing. In a school setting, the age and maturity levels of students make reporting of bullying, hazing or taunting sporadic at best. Bringing secrets of ongoing family abuse, alcoholism, or molestation into the open is even more difficult for children. There is also little recognition in the educational system of the long-term psychological detriment to learning as a result of such familial problems. Of even greater concern is the deterioration of functioning with too many children funneling into varying levels of depression, emotional malfunctioning, maladaptive behaviors or mental illness.

Underlying Values and Philosophy

- Clients should not feel afraid, isolated or trapped.
- A trauma-informed model must ground the provision of service.
- Services should be responsive to the needs of an individual client.
- Clients have the right to privacy and self-determination.
- In working with clients who have experienced ACEs, prevention of future trauma, rather than intervention, is critical.

Recommendations for working with clients

When a family law professional responds to a client in a manner that reassures safety, facilitates an open sharing of information, minimizes the chance of triggering a client who has experienced traumatic events and makes the client feel heard, the response is not therapy, it is an intelligent, cost-effective and practical, timesaving manner of legal service provision.

Methodology (working with family law clients)

Client Interview

- It is important to remember that a party may have had a trauma experience which is abnormal but the party's response to that experience is not abnormal.
- Become more trauma-informed, including knowing resources that provide evidence-based, trauma-focused treatment to bolster resiliency.
- It cannot be emphasized enough that a party who has experienced traumatic stressful events needs to feel that a family law professional is respectful of the party's boundaries and privacy.
- Instill hope that it will get better because even if a client is not depressed, the divorce client can lose hope.
- Keep repeating to the client that there is hope and it will get better.
- Try to instill a sense of safety and predictability in the world.

Attorney Knowledge

- Know that the initial personae demonstrated by a client who has experienced traumatic stress may change dramatically if a level of safety-producing trust can be established with the family law professional.
- Note that you will most likely need many encounters with a client who has experienced ACEs before the client fully discloses.

Interview Tips

- Seat the client with a view of the door, possibly with the door open just a little.
- A warm smile may relax the client somewhat.
- Face the client with shoulders squared.
- Share with the client that there is no judgment in the attorney notes that will be taken during the meeting.
- Tell the client what you are writing down about him/her and their case.
- Clarity, transparency and giving more information to a client may help to lessen the level of trauma in a client who has experienced ACEs.
- Try to slow the client down to encourage more cohesive narrative from the client.
- Use enough eye contact so that the client feels s/he is being listened to and yet does not feel intimidated by intense eye contact or staring. This is an important aspect of any client visit when the client has experienced traumatic stress.
- Use a softer tone of voice.
- Do not walk behind the client; this may arouse hypervigilance because of prior trauma.

Client Autonomy and Understanding

- Let the client lead and have a measure of control.
- Give the client a choice over the agenda of a call or meeting and choice over the order of the agenda.
- If a client seems concerned or fearful of service, court or visiting with an attorney or family law professional ask why the client is afraid.
- Ask clients “why...” and know that the tone of voice when asking the question is crucial to avoid sounding accusatory or putting the client on the defensive.
- Rephrase what the client has divulged to arrive at a shared narrative.
- When confirming whether a client understands information given, it can be helpful to ask “how do you understand that?”
- The goal is to ensure as much as possible that clients receive effective trauma-informed provision of legal services.
- Help families understand what may happen in the future as a result of exposure to high levels of traumatic stress due to ACEs.
- Be aware that many of the children involved in family law legal proceedings who have increased levels of traumatic stress because of ACEs have parents or caregivers who have been exposed to multiple categories of ACEs as well.

- Know how positive coping skills can help to mitigate the effects of ACEs on parties and children alike.

Sample Questions for Clients

The following questions and the answers may cue family law professionals about trauma and toxic stresses that can have an enormous impact on the child(ren)'s health and well being:

- What is different for your children since you separated/started the custody/parenting time/divorce process?
- What happens to your children when they misbehave?
- Does the child(ren) have bad dreams or nightmares? If so, related to what?
- Do you think your child(ren) feels safe at home?
- What concerns does your child(ren) express to you?
- What words or actions does your child(ren) speak or act out that show you they are under stress? Is this happening now?

Further Work/Outstanding Issues

- Develop and disseminate trauma-informed ACEs best practices for family law professionals so that they can identify and provide effective legal services to survivors of ACEs and their child(ren) by means of broad-based multidisciplinary workgroups.
- Expand ways to connect statewide institutions, organizations and trauma-informed stakeholders and individuals who are working to advance the ACEs knowledge base, emerging best practices and trauma-informed policies applicable to family law professionals and stakeholders.
- Develop a statewide model protocol for family justice system professionals on identifying and effectively working with clients who have experienced ACEs and mitigating the damage to the child(ren) involved in family court legal proceedings.
- Conduct statewide training for family justice system professionals on how to work more effectively with survivors of ACEs and methods to promote healing for clients and their child(ren) such as parenting plans and custody arrangements that minimize the trauma to children from changes in family structure.
- Formulate strategies to educate and mobilize family justice professionals and decision makers on ACEs trauma-informed research, practice and advocacy.
- Build support for state level policy change across a robust set of domains, including but not limited to domestic violence, law enforcement and family law practice.
- Establish a national ACEs center as a resource for states who are in the process of or interested in determining the nature and scope of ACEs as related to public policy changes to minimize toxic stress and trauma that family law clients and their child(ren) experience and have experienced.

Follow up questions for readers of the article:

- What barriers or issues have you encountered with serving the population of individuals who have experienced Adverse Childhood Experiences or traumatic stressful events?

- What have you seen or heard in the legal profession or community regarding ACEs and trauma-informed family law practice and judicial decision making?

Conclusion

Awareness can make the difference between good and poor physical and mental health and even be the difference between life and premature death.²⁸ This awareness can close the information gap and thereby positively impact the lives of current and future generations. Our efforts to educate family law professionals and policy makers on the detrimental effects of ACEs and corresponding remedies are based on the premise that children deserve lives free of unnecessary emotional pain and related health problems over their lifespan.

¹ MARLENE JEZIERSKI, BEYOND THE MIRROR: PEACEFUL HOMES: A BASIC HUMAN RIGHT Introduction (2008) (Anoka, MN, emergency nurse for decades who has taught about family violence).

² Pacific Standard Magazine, *What Does it Take for Traumatized Kids to Thrive?* (May/June 2013) (citing bestselling book *How Children Succeed* by Paul Tough which inspired columns in the NYT and discussions on national television and radio; citing Department of Education report, *Promoting Grit, Tenacity, and Perseverance* on specific non-cognitive skills which are being discussed by increasing numbers of researchers; citing Washington State brain scientist/molecular biologist John Medina, speaker and author of a best-selling book, *Brain Rules* whose research, among others, has galvanized the Washington Family Policy Council).

³ A resource for service organizations and providers to deliver services that are trauma informed, *Trauma-informed: The Trauma Toolkit*, Clinic Community Health Centre (2nd ed. 2013) (last visited Apr. 27, 2015) http://trauma-informed.ca/wp-content/uploads/2013/10/Trauma-informed_Toolkit.pdf. (quoting Karen Saakvitne, SAAKVITNE, K. W. & PEARLMAN, L., TRANSFORMING THE PAIN: A WORKBOOK ON VICARIOUS TRAUMATIZATION. The Traumatic Institute/Center for Adult and Adolescent Psychotherapy. (New York: Norton.) (1996).

⁴ Institute for Safe Families: Imagining a Better Future, Philadelphia ACE Task Force The Philadelphia ACE Project (Apr. 22, 2015), available at <http://www.instituteforsafefamilies.org/philadelphia-ace-task-force>.

⁵ *Id.*

⁶ *Id.*

⁷ HOW do ACES AFFECT OUR SOCIETY? People with six or more ACEs died nearly 20 years earlier on average than those without ACEs, (average age of death with 6 or more ACEs is age 60, compared with average age of death with no ACEs is age 80), available at http://www.ncdsv.org/images/CDC_ACES-Infographic_2013.pdf

⁸ Institute for Safe Families, *supra* at note 4.

⁹ Institute for Safe Families, *supra* at note 4

¹⁰ Huitt, W. Maslow's hierarchy of needs. *Educational Psychology Interactive*. Valdosta, GA: Valdosta State University (2007), available at <http://www.edpsycinteractive.org/topics/conation/maslow.html>.

¹¹ Simply Psychology (Apr. 23, 2015), available at <http://www.simplypsychology.org/maslow.html>

¹² *Id.*

¹³ *Id.*

¹⁴ Email response follow up to telephone interview with The Honorable Mary Louise Klas, Minn. Second Jud. Dist. (Judge Klas served for fourteen years on the Ramsey County trial court bench and in retirement formed the ISIAAH Domestic Violence Task Force) (Aug. 3, 2014).

¹⁵ *Id.*

¹⁶ *Id.*

¹⁷ *Id.*

¹⁸ 2014 Minn. Fam. Law Inst. PowerPoint Presentation, Terri Port Wright & Saprina Matheny, *The Staggering Costs of Childhood Trauma: Legal Responses to Improve Outcomes* (Mar. 25, 2014) (citing U.S. Attorney General's National Task Force on Children Exposed to Violence 2012).

¹⁹ Port Wright, *supra* at note 18 (the authors wish to acknowledge Cloquet, Minnesota, attorney Terri Port Wright for her pioneering work incorporating ACEs knowledge into family law practice, education of the bench and bar on ACE's relevance to the domestic violence and family law justice system, and her substantial contributions to this section and the article in general).



AIR's Framework for Building Trauma-Informed Organizations and Systems

AIR's **Framework for Building Trauma-Informed Organizations and Systems** offers a process and curriculum for adopting organizational trauma-informed care. Implementing a system-wide approach to addressing trauma requires a commitment to changing the practices, policies, and culture of an entire organization. AIR's framework reflects a decade of developing and implementing effective practices to support organizations serving vulnerable children, adults, and families to become trauma-informed.

Our Approach

AIR believes that building trauma-informed organizations is a long-term process that requires

- 1) Organizational commitment to changing culture and practice;
- 2) A framework for organization-wide implementation; and
- 3) Support for organizations throughout the change process.

AIR's framework offers a phased approach to adopting organizational trauma-informed care that is grounded in implementation science and systems theory and offers organizations a roadmap for change. AIR provides targeted training and technical assistance (TTA) to support systems change at each stage of implementation.

AIR's framework can be applied to organizations and systems of varied size, structure, and phase in the process of adopting trauma-informed care. AIR recognizes that the process of building trauma-informed organizations and systems includes unique components based on context. AIR's TTA curriculum is adaptable to particular systems and the populations they serve.

AIR's framework includes the following training and technical assistance activities across four phases:

PHASE 1: EXPLORATION

- Provide access to AIR's Trauma-Informed Organizational Capacity (TIC) Scale to measure current level of organizational trauma-informed care.*
- Provide introductory training on trauma, trauma-informed care, and the organizational change process for leadership and staff.
- Explore organizational needs and readiness for change.

PHASE 2: INSTALLATION

- Support organizations to establish the infrastructure for change, including a multidisciplinary work group and mechanisms for communicating, monitoring, and evaluating progress.
- Support organizations through an implementation planning and goal setting process using AIR's Trauma-Informed Care Curriculum, including an implementation-planning guide tailored by setting and population.

PHASE 3: INITIAL IMPLEMENTATION

- Provide customized training and coaching to support adoption of organizational trauma-informed care within and across core domains of AIR's Trauma-Informed Care Curriculum: 1) Build trauma-informed knowledge and skills; 2) Establish trusting relationships; 3) Respect service users; 4) Foster trauma-informed service delivery; and 5) Promote trauma-informed procedures and policies.
- Assist organizations in developing a plan for evaluating the process and impact of adopting organizational trauma-informed care.

PHASE 4: FULL ADOPTION AND SUSTAINABILITY

- Support organizations to fully embed and sustain practices.
- TTA may include: developing and supporting a training-of-trainers model for the organization; supporting policy-level change; evaluating outcomes related to adopting a trauma-informed approach; and offering strategies for bringing this approach to the broader system.

*Conducted with all organizations.

Expert Contact

For more information on AIR's Framework for Building Trauma-Informed Organizations and Systems or for training and technical assistance for your agency, please contact Kathleen Guarino at kguarino@air.org. Learn more about AIR's instrument to measure trauma-informed care at <http://www.air.org/resource/trauma-informed-organizational-capacity-scale>.

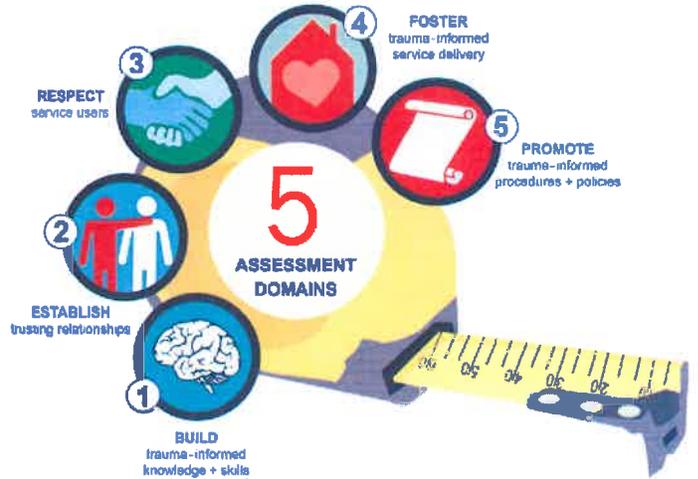


Trauma-Informed Organizational Capacity Scale (TIC Scale)

An Agency-Wide Assessment

What is the TIC Scale?

The Trauma-Informed Organizational Capacity Scale (TIC Scale)* is the first brief, psychometrically validated instrument to measure organizational trauma-informed care across health and human service settings. The TIC Scale includes 35 items across five domains: 1) Build trauma-informed knowledge and skills; 2) Establish trusting relationships; 3) Respect service users; 4) Foster trauma-informed service delivery; and 5) Promote trauma-informed procedures and policies. Items represent the strongest indicators of trauma-informed care based on a sample of 424 respondents representing 68 human service agencies including behavioral health, housing and homelessness, child welfare, domestic violence, and community health and hospitals. The TIC Scale provides scores for each domain and an overall score.



Why Use the TIC Scale?

Exposure to trauma is common among children, youth, and adults in health and human service settings. Service systems must be prepared to identify and address trauma that, if ignored, can impact quality of care, degree of trust in providers, service use, and ultimately, health outcomes. Organizational trauma-informed care is a system-wide approach to addressing trauma that ensures the entire service delivery system is grounded in an awareness and understanding of trauma and its impact and designed to foster healing and resilience for everyone in the system. All dimensions of an organization – mission, culture, and practice – are aligned to support wellbeing and success and lessen the detrimental effects of trauma on individuals, communities, and organizations.

The TIC Scale provides an unprecedented opportunity for health and human service organizations to measure the extent to which they provide trauma-informed care agency-wide at single point in time or repeatedly to assess for changes in level of trauma-informed care. The tool provides a common definition and measure of organizational trauma-informed care for a wide range of service systems.

How Do You Use the TIC Scale?

The TIC Scale is administered online and takes approximately 15 minutes to complete. The tool may be completed by all staff at all levels and across all programs or departments within an organization. To accurately assess an organization's degree of adoption, we encourage organizations to ensure that as many staff as possible completes the TIC Scale. Staff members are asked to rate the extent to which they agree that their organization incorporates each of the measure's 35 items.

Organizations can use the TIC Scale to:

- Determine their baseline for organization-wide trauma-informed care;
- Target strategic planning and professional development activities;
- Monitor change over time; and
- Assess whether improvements in organizational trauma-informed care influence success for service users.

The TIC Scale can be administered across health and human service agencies as a common measure of trauma-informed care. Individual organizational scores can be analyzed collectively to determine the extent to which a larger system is trauma-informed.

The American Institutes for Research (AIR) provides organizations and systems access to the instrument, a comprehensive analysis of results tailored to each organization or system, and consultation to review results and next steps. AIR believes that the TIC Scale represents one aspect of a larger change process. Our expert staff is available to support organizations in assessing and implementing organizational trauma-informed care. If you are interested in additional information about the TIC Scale and our training and technical assistance in this area please contact:

Kathleen Guarino at kguarino@air.org

Learn more about AIR's Framework for Building Trauma-Informed Organizations and Systems at <http://www.air.org/resource/framework-building-trauma-informed-organizations-and-systems>.

*AIR served as sole funder in the development of the Trauma-Informed Organizational Capacity Scale with the Center for Social Innovation and leveraged its prior work, served on the expert panel, provided methodological expertise, and acted in an advisory capacity. AIR shares distribution rights to the instrument with the Center for Social Innovation where the tool is also known by the name "TICOMETER".



Resources on the Impact of Trauma

Understanding Child Traumatic Stress



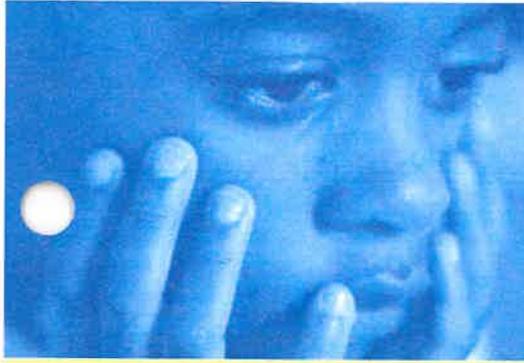
NCTSN

The National Child
Traumatic Stress Network



Understanding Child Traumatic Stress

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What Is Child Traumatic Stress?

When a child feels intensely threatened by an event he or she is involved in or witnesses, we call that event a trauma. Child traumatic stress (CTS) is a psychological reaction that some children have to a traumatic experience.

“Children who suffer from child traumatic stress have developed reactions to trauma that linger and affect their daily lives long after the traumatic event has ended.”

There are numerous kinds of traumas, such as:

- Automobile accidents
- Serious injuries
- Acts of violence
- Terrorism
- Physical or sexual abuse
- Medical procedures
- The unexpected death of a loved one
- Life-threatening natural disasters

Children who suffer from CTS have developed reactions to trauma that linger and affect their daily lives long after the traumatic event has ended. These children may experience:

- Intense and ongoing emotional upset
- Depression
- Anxiety
- Behavioral changes
- Difficulties at school
- Problems maintaining relationships
- Difficulty eating and sleeping
- Aches and pains
- Withdrawal
- Substance abuse, dangerous behaviors, or unhealthy sexual activity among older children

Not every child experiences CTS after a trauma. All children are different, and many children are able to adapt to and overcome difficult events and situations. But one out of every four children will experience a traumatic event before the age of sixteen, and some of these children will develop CTS.

If left untreated, CTS can interfere with a child's healthy development and lead to long-term difficulties with school, relationships, jobs, and the ability to participate fully in a healthy life. Fortunately, there are proven and effective treatments for CTS, and it's the mission of the National Child Traumatic Stress Network (NCTSN) to bring awareness of CTS and effective treatments to a wide audience.



How Danger Becomes Trauma

Before understanding what is meant by a traumatic experience or traumatic stress, we must first think about how we recognize and deal with danger. Our minds, our brains, and our bodies are set up to make sure we make danger a priority.

Things that are dangerous change over the course of childhood, adolescence, and adulthood.

- For very young children, swimming pools, electric outlets, poisons, and sharp objects are dangerous.
- For school-age children, walking to school, riding a bike in the street, or climbing to high places present new dangers.
- For adolescents, access to automobiles, guns, drugs, and increased independence, especially at night, are new dimensions to danger.

We live with dangers every day. They can become traumatic when they threaten serious injury or death or when they include physical or sexual violation. The witnessing of violence, serious injury, or grotesque death can be equally traumatic.

“We live with dangers every day. They can become traumatic when they threaten serious injury or death or when they include physical or sexual violation. The witnessing of violence, serious injury, or grotesque death can be equally traumatic.”

In traumatic situations, we experience an immediate threat to ourselves or to others, often followed by serious injury or harm. We feel terror, helplessness, or horror because of the extreme seriousness of what is happening and the failure of any way to protect against or reverse the harmful outcome. These powerful, distressing emotions go along with strong, even frightening physical reactions, such as rapid heartbeat,

trembling, stomach dropping, and a sense of being in a dream. When our reactions persist, they can become CTS or sometimes the more well-known posttraumatic stress syndrome (PTSD). CTS and PTSD share many features, but PTSD is a formal

psychiatric diagnosis that is made when specific criteria about the number, duration, and intensity of symptoms are met. CTS is not a formal diagnosis but describes a range of a child's or adolescent's distressing reactions to trauma.



Responding to Trauma After the Event

For reasons that are basic to survival, traumatic experiences, long after they are over, continue to take priority in the thoughts, emotions, and behavior of children, adolescents, and adults. Fears and other strong emotions, intense physical reactions, and the new way of looking at dangers in the world may recede into the background, but events and reminders may bring them to mind again.

have nightmares. We have strong physical and emotional reactions to stress reminders that are often part of our daily life. We may have a hard time distinguishing new, safer situations from the traumatic situation we already went through. We may overreact to other things that happen, as if the danger were about to happen again.

■ Third, our bodies may continue to stay "on alert." We may have trouble sleeping, become irritable or easily angered, startle or jump at noises more than before, have trouble concentrating or paying attention, and have recurring physical symptoms, like headaches or stomachaches.

“For reasons that are basic to survival, traumatic experiences, long after they are over, continue to take priority in the thoughts, emotions, and behavior of children, adolescents, and adults.”

There are three core groups of posttraumatic stress reactions.

■ First, there are the different ways these types of experiences stay on our minds. We continue to have upsetting images of what happened. We may keep having upsetting thoughts about our experience or the harm that resulted. We can also

■ Second, we may try our best to avoid any situation, person, or place that reminds us of what happened, fighting hard to keep the thoughts, feelings, and images from coming back. We may even "forget" some of the worst parts of the experience, while continuing to react to reminders of those moments.

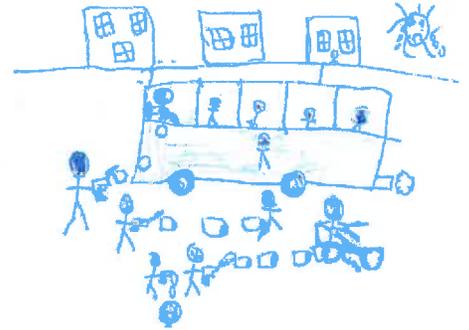


Child Development and Traumatic Stress



“More than twenty years of studies have confirmed that school-age children and adolescents can experience the full range of posttraumatic stress reactions that are seen in adults.”

Age, developmental maturity, and experience can influence the way we react to stress after the traumatic experience is over. More than twenty years of studies have confirmed that school-age children and adolescents can experience the full range of posttraumatic stress reactions that are seen in adults. We might wish to believe that children under five years of age are too young to know what was happening during a traumatic event and that whatever impression was left would be forgotten soon. However, recent studies show that traumatic experiences affect the brains, minds, and behavior of even very young children, causing similar reactions to those seen in older children and adults.





Traumatic Stress and Young Children

Think of what it is like for young children to be in traumatic situations.

- Young children can feel totally helpless and passive.
- Young children can cry for help or desperately wish for someone to intervene.
- Young children can feel deeply threatened by separation from parents or caretakers.
- Young children become particularly upset when they hear cries of distress from a parent or caretaker.

“It is extremely difficult for very young children to experience the failure of being protected by adults when something traumatic happens.”

Young children rely on a protective shield provided by adults and older siblings who can judge the seriousness of danger and ensure their safety and welfare.

- Young children often don't recognize a traumatic danger until it happens—for example, in a near drowning, an attack by a dog, or an accidental scalding.

- Young children can be the target of physical and sexual abuse by the very people they rely on for their protection and safety.
- Young children can witness violence within the family or be left helpless after a parent or caretaker is injured, as might occur in a serious automobile accident.

It is extremely difficult for very young children to experience the failure of being protected by adults when something traumatic happens.

- Young children may become passive and quiet, easily alarmed, and less secure about being provided with protection.
- Their minds may stay on a central action, like being hit or seeing someone fall to the floor.

- Young children may have simple thoughts about protection, for example, "Daddy hit mommy, mommy call police."
- Young children can become more generally fearful, especially in regard to separations and new situations.
- In circumstances of abuse by a parent or caretaker, the young child may act confused as to where to find protection and where there is threat.
- A child may respond to very general reminders of a trauma, like the color red or the sounds of another child crying.

The effects of fear can quickly get in the way of recent learning. For example, a child may start wetting the bed again or go back to baby-talk. Because a child's brain does not yet have the ability to quiet down fears, the preschool child may have very strong startle reactions, night terrors, and aggressive outbursts.



Traumatic Stress and School-age Children

School-age children start to face additional dangers, with more ability to judge the seriousness of a threat and to think about protective actions.

- School-age children usually do not see themselves as able to counter a serious danger directly, but they imagine actions they wish they could take, like those of their comic strip heroes.

- In traumatic situations when there is violence against family members, they can feel like failures for not having done something helpful.

- School-age children may also feel very ashamed or guilty.

They may be without their parents when something traumatic happens, either on their own or with friends at school or in the neighborhood. Sexual molestation occurs at the highest rate among this age group.

The reactions of school-age children after a trauma include a wide range of intrusive images and thoughts.

School-age children think about lots of frightening moments during their traumatic experiences. They also go over what could have stopped them from happening and what could have made them turn out differently.

“The reactions of school-age children after a trauma include a wide range of intrusive images and thoughts.”

School-age children respond to very concrete reminders about the trauma, such as:

- Someone with the same hairstyle as an abuser

- The monkey bars on a playground where a child got shot

- A feeling of being alone inside like they had when one parent attacked the other

They are likely to develop intense specific new fears that link back to the original danger. They can easily have fears of recurrence that result in their avoiding even enjoyable things they would like to do.

- More than any other group, school-age children may go back and forth between shy or withdrawn behavior and unusually aggressive behavior.

- School-age children can have thoughts of revenge that they cannot resolve.

- Normal sleep patterns can be easily disturbed. They can move around restlessly in their sleep, vocalize, and wake up tired.

- Their lack of restful sleep can interfere with their daytime concentration and attention.

- It can then be more difficult for them to study because they remain on alert for things happening around them.



“During traumatic situations, adolescents make decisions about whether and how to intervene, and about using violence to counter violence.”

Traumatic Stress and Adolescents

With the help of their friends, adolescents begin a shift toward more actively judging and addressing dangers on their own. This is a developing skill, and lots of things can go wrong along the way. With independence, adolescents can be in more situations that can turn from danger to trauma. They could:

- Be drivers or passengers in car accidents
- Be victims of rape, dating violence, and criminal assault
- Be present during school or community violence
- Experience the loss of friends under traumatic circumstances

During traumatic situations, adolescents make decisions about whether and how to intervene, and about using violence to counter violence.

They can feel guilty, sometimes thinking their actions made matters worse. Adolescents are learning to handle intense physical and emotional reactions in order to take action in the face of danger. They are also learning more about human motivation and intent and struggle over issues of irresponsibility, malevolence, and human accountability.

Adolescents are particularly challenged by reactions that persist after traumatic experiences.

- Adolescents can easily interpret many of these reactions as being regressive or childlike.
- Adolescents may interpret their reactions as signs of "going crazy," of being weak, or of being different from everyone else.
- Adolescents may be embarrassed by bouts of fear and exaggerated physiological responses.
- Adolescents may harbor the belief that they are unique in their pain and suffering.

These reactions may result in a sense of personal isolation. In their posttrauma thoughts, adolescents think about behavior and choices that go back to well before a traumatic situation. They are also very sensitive to the failure of family, school, or community to protect them or carry out justice. Afterward they may turn even more to peers to judge risks and to take protective action. They may be especially "grossed out" or fascinated by grotesque injury or death and remain very focused on their own scars that serve as daily trauma reminders.

While younger children may use play, adolescents may respond to their experience through dangerous reenactment behavior, that is, by reacting with too much "protective" aggression for a situation at hand. Their behavior in response to reminders can go to either of two extremes: reckless behavior that endangers themselves and others, or extreme avoidant behavior that can derail their adolescent years.

The avoidant life of an adolescent may go unnoticed.

- Adolescents try to get rid of post-trauma emotions and physical responses through the use of alcohol and drugs.
- Their sleep disturbance can remain hidden in late night studying, television watching, and partying.
- It is a dangerous mix when adolescent thoughts of revenge are added to their usual feelings of invulnerability.



Recovering from Traumatic Stress

How children or adolescents recover from trauma depends a lot on the different ways that their lives are changed by what happened.

Cognitive-behavioral therapies have been proven effective in helping children with CTS. These therapies generally include the following features:

“Foregoing help can have long-lasting consequences, and fortunately, entering treatment can have concrete beneficial results.”

There may be a dramatic change because of the loss of a family member or friend during the traumatic situation. Dealing with both posttraumatic and grief reactions can make recovery much more difficult. If a child you know has experienced any of the symptoms or signs of ongoing difficulties following a traumatic experience, it's important to seek help for them. Foregoing help can have long-lasting consequences, and fortunately, entering treatment can have concrete beneficial results.

- Teaching children stress management and relaxation skills
- Creating a coherent narrative or story of what happened
- Correcting untrue or distorted ideas about what happened and why
- Changing unhealthy and wrong views that have resulted from the trauma
- Involving parents in creating optimal recovery environments



The National Child Traumatic Stress Network

The National Child Traumatic Stress Network (NCTSN) is working to advance effective interventions and services to address the impact of traumatic stress. Our nation is in a position to take advantage of the full range of scientific knowledge, clinical wisdom, and service sector expertise to preserve and restore the future of traumatized children across the United States.

Comprising over 50 centers from across the United States, the NCTSN integrates the strengths of academic institutions that are dedicated to developing research-supported interventions and training people to deliver them, and community-based treatment and service centers that are highly experienced in providing care to children and families.

As an outgrowth of bipartisan federal legislation, the Donald J. Cohen National Child Traumatic Stress Initiative was funded in October 2001. Under the leadership of the U.S. Department of Health and Human Services, the Substance Abuse and Mental Health Services Administration (SAMHSA), and the Center for Mental Health Services (CMHS), this Initiative has represented a unique opportunity to contribute to our national agenda to transform our mental health systems of care.

The NCTSN has developed a comprehensive website that provides a range of resources for professionals and the public about child traumatic stress, including informational guides, statistics, breaking information in the field, and access to the latest research and resources. For more information about child traumatic stress and the NCTSN, visit www.NCTSN.org or e-mail the National Resource Center at Info@NCTSN.org.

National Center for Child Traumatic Stress—UCLA
11150 West Olympic Boulevard
Suite 650
Los Angeles, CA 90064
Phone: (310) 235-2633

National Center for Child Traumatic Stress—Duke University
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www.NCTSN.org

Impact of High-Conflict Divorce on Children

Neil S. Grossman, Ph.D.

There continues to be much concern about the affect divorce has on children. The research in this area originally indicated that children whose parents divorced had more problems. With additional studies we now have a clearer picture about the impact of divorce on children. This research indicates:

1. Divorce creates stress in families. The ending of a marital relationship is stressful for couples and children. Stress occurs whether or not couples divorce through divorce mediation, collaborative divorce or through litigation. The impact of the stress on children is usually temporary and is caused by a reduction of parenting capacity and the dislocation or economic instability that goes along with divorce.
2. The negative effect of divorce on children is largely due to the conflict between the parents and appears to be transmitted by a poor relationship between the parents and children. Stress, insecurity and agitation are found in these children as a result of chronic conflict. The negative effect is greater when the conflict is open and attacking and the children are caught in the middle.
3. Parental emotional stability, warmth and consistency are important factors that are related to children having a better adjustment to divorce. This is most important in the primary custodial parent.
4. On the whole children adjust better to the divorce when both parents are actively involved with them.
5. The remarriage of a parent increases children's stress when it triggers parental conflict.

While divorce causes stress which has an adverse affect on couples and children the most important negative factor is high parental conflict. This variable is not limited to families in which a divorce occurs. Children living in any household with parents who are in high conflict are adversely affected. Furthermore, research is indicating that children whose parents divorce do better than children whose parents are in chronic conflict and do not divorce.

Studying families with high parental conflict we find that the conflict usually begins before the divorce, and continues during and after the divorce. The parental conflict typically heightens just before the divorce and during the divorce. The conflict usually lessens (dissipates) in the years following a divorce. One or two years are average in a high-conflict divorce but in some cases the animosity between the parents can last for years. The post-divorce conflict is often overlooked unless parents continue to re-litigate.

While we know that the high conflict of parents in a divorce results in a negative impact on children, to understand this impact on any individual child we need to consider several other variables:

- Age of the child, meaning of the divorce for the child and the child's circumstances - other things being equal, a 6 year old child is likely to be impacted differently by a divorce than a 14 year old child. In one case, the 6 year old child may be more dependent on the parents and feel a greater loss than the 14 year old child. In another case the opposite may be true. The 6 year old child may have an easier time while the 14 year old child might feel a greater loss since established attachment to peers and community may be disrupted by the divorce.
- Developmental level of the child – a 15 year old child may function at a 12 year old developmental level. In looking at the child's behavior we must consider the developmental level to understand what is expected for this child and whether the child's behavior is deviating from the norm.
- Psychological adjustment of the child - children with a better pre-divorce adjustment will be more resilient during a divorce.
- Relationship of child to each parent – a child who was closest to one parent but now lives with the other parent may have a harder time
- Psychological adjustment of the parents (including narcissism, anger and psychological developmental level/primitivism) - children whose parents have poorer psychological adjustment will probably have a harder time because the parents will not be as capable of "good parenting".
- The family system - our understanding of family systems tells us that children may play a role in the conflict of the parents. For example, for years before a divorce a child may be aligned, over-involved or in conflict with one parent. The other parent may try to rescue the child or compensate for the perceived threat from the first parent. A conflict

between the parents ensues with the child being allied with one parent and in conflict with the other parent. The family system's view suggests that the interaction of all the members creates this dynamic not just the actions of one parent.

- Presence of family violence may increase the negative impact of high conflict on children – this is an important variable but there is a need to differentiate the type and level of violence, e.g., Common Intimate Partner Violence as compared to Battered Woman Syndrome. The incidence of Common Intimate Partner Violence is frequent at the time of separation/divorce and is not equivalent to an ongoing battering relationship.

With knowledge of the research in this area we can identify stressors and protective factors regarding the impact of a high-conflict divorce on children and create interventions that are designed to reduce stressors and enhance protective factors.

Age-Related Reactions to a Traumatic Event

A fundamental goal of parenting is to help children grow and thrive to the best of their potential. Parents anticipate protecting their children from danger whenever possible, but sometimes serious danger threatens, whether it is manmade, such as a school shooting or domestic violence, or natural, such as a flood or earthquake. And when a danger is life-threatening or poses a threat of serious injury, it becomes a potentially traumatic event for children.

By understanding how children experience traumatic events and how these children express their lingering distress over the experience, parents, physicians, communities, and schools can respond to their children and help them through this challenging time. The goal is to restore balance to these children's lives and the lives of their families.

How Children May React

How children experience traumatic events and how they express their lingering distress depends, in large part, on the children's age and level of development.

Preschool and young school-age children exposed to a traumatic event may experience a feeling of helplessness, uncertainty about whether there is continued danger, a general fear that extends beyond the traumatic event and into other aspects of their lives, and difficulty describing in words what is bothering them or what they are experiencing emotionally.

This feeling of helplessness and anxiety is often expressed as a loss of previously acquired developmental skills. Children who experience traumatic events might not be able to fall asleep on their own or might not be able to separate from parents at school. Children who might have ventured out to play in the yard prior to a traumatic event now might not be willing to play in the absence of a family member. Often, children lose some speech and toileting skills, or their sleep is disturbed by nightmares, night terrors, or fear of going to sleep. In many cases, children may engage in traumatic play—a repetitive and less imaginative form of play that may represent children's continued focus on the traumatic event or an attempt to change a negative outcome of a traumatic event.

For school-age children, a traumatic experience may elicit feelings of persistent concern over their own safety and the safety of others in their school or family. These children may be preoccupied with their own actions during the event. Often they experience guilt or shame over what they did or did not do during a traumatic event. School-age children might engage in constant retelling of the traumatic event, or they may describe being overwhelmed by their feelings of fear or sadness.

A traumatic experience may compromise the developmental tasks of school-age children as well. Children of this age may display sleep disturbances, which might include difficulty falling asleep, fear of sleeping alone, or frequent nightmares. Teachers often comment that these children are having

greater difficulties concentrating and learning at school. Children of this age, following a traumatic event, may complain of headaches and stomach aches without obvious cause, and some children engage in unusually reckless or aggressive behavior.

Adolescents exposed to a traumatic event feel self-conscious about their emotional responses to the event. Feelings of fear, vulnerability, and concern over being labeled “abnormal” or different from their peers may cause adolescents to withdraw from family and friends. Adolescents often experience feelings of shame and guilt about the traumatic event and may express fantasies about revenge and retribution. A traumatic event for adolescents may foster a radical shift in the way these children think about the world. Some adolescents engage in self-destructive or accident-prone behaviors.

How to Help

The involvement of family, physicians, school, and community is critical in supporting children through the emotional and physical challenges they face after exposure to a traumatic event.

For young children, parents can offer invaluable support, by providing comfort, rest, and an opportunity to play or draw. Parents can be available to provide reassurance that the traumatic event is over and that the children are safe. It is helpful for parents, family, and teachers to help children verbalize their feelings so that they don't feel alone with their emotions. Providing consistent caretaking by ensuring that children are picked up from school at the anticipated time and by informing children of parents' whereabouts can provide a sense of security for children who have recently experienced a traumatic event. Parents, family, caregivers, and teachers may need to tolerate regression in developmental tasks for a period of time following a traumatic event.

Older children will also need encouragement to express fears, sadness, and anger in the supportive environment of the family. These school-age children may need to be encouraged to discuss their worries with family members. It is important to acknowledge the normality of their feelings and to correct any distortions of the traumatic events that they express. Parents can be invaluable in supporting their children in reporting to teachers when their thoughts and feelings are getting in the way of their concentrating and learning.

For adolescents who have experienced a traumatic event, the family can encourage discussion of the event and feelings about it and expectations of what could have been done to prevent the event. Parents can discuss the expectable strain on relationships with family and peers, and offer support in these challenges. It may be important to help adolescents understand “acting out” behavior as an effort to voice anger about traumatic events. It may also be important to discuss thoughts of revenge following an act of violence, address realistic consequences of actions, and help formulate constructive alternatives that lessen the sense of helplessness the adolescents may be experiencing. When children experience a traumatic event, the entire family is affected. Often, family members have different experiences around the event and different emotional responses to the traumatic event. Recognizing each others' experience of the event, and helping each other cope with possible feelings of fear, helplessness, anger, or even guilt in not being able to protect children from a traumatic experience, is an important component of a family's emotional recovery.

For more information about child traumatic stress and the National Child Traumatic Stress Network, visit www.NCTSN.net or e-mail info@NCTSN.net.

Long Term Effects of Conflict on Children

- Parental conflict, regardless of divorce, can have a long term effect on children, including an increased likelihood that children will experience relationship failure and divorce themselves.
- Research shows that the highest occurrence of divorce is among those whose parents were classified as having high conflict relationship and who also divorced.
- The second highest divorce rate was found among adult children whose parents did not divorce, but were classified as having a high conflict relationship
- The second lowest divorce rate was found among adult children whose parents divorced, but had a low conflict relationship.
- The lowest rate of divorce was found among the adult children whose parents remained married and had a low conflict relationship
- Children who observe high amounts of parent conflict, especially when the conflict is not resolved, develop poor communication and conflict resolution skills themselves, resulting in a higher likelihood that their future marriage will fail.
- Even though children still observe some conflict, the act of seeing their parents effectively resolve conflict teaches children positive relationship behaviors.
- A couple's ability to resolve conflict is not only determinative of whether their marriage will survive, but also whether their children will be more likely to have a successful marriage.

The 12 Core Concepts: Concepts for Understanding Traumatic Stress Responses in Children and Families

The 12 Core Concepts, developed by the NCTSN Core Curriculum Task Force during an expert consensus meeting in 2007, serve as the conceptual foundation of the Core Curriculum on Childhood Trauma and provide a rationale for trauma-informed assessment and intervention. The Concepts cover a broad range of points that practitioners and agencies should consider as they strive to assess, understand, and assist trauma-exposed children, families, and communities in trauma-informed ways.

Concepts for Understanding Traumatic Stress Responses in Children and Families

- 1

Traumatic experiences are inherently complex.

Every traumatic event—even events that are relatively circumscribed—is made up of different traumatic moments. These moments may include varying degrees of objective life threat, physical violation, and witnessing of injury or death. Trauma-exposed children experience subjective reactions to these different moments that include changes in feelings, thoughts, and physiological responses; and concerns for the safety of others. Children may consider a range of possible protective actions during different moments, not all of which they can or do act on. Children's thoughts and actions (or inaction) during various moments may lead to feelings of conflict at the time, and to feelings of confusion, guilt, regret, and/or anger afterward. The nature of children's moment-to-moment reactions is strongly influenced by their prior experience and developmental level. Events (both beneficial and adverse) that occur in the aftermath of the traumatic event introduce additional layers of complexity. The degree of complexity often increases in cases of multiple or recurrent trauma exposure, and in situations where a primary caregiver is a perpetrator of the trauma.
- 2

Trauma occurs within a broad context that includes children's personal characteristics, life experiences, and current circumstances.

Childhood trauma occurs within the broad ecology of a child's life that is composed of both child-intrinsic and child-extrinsic factors. Child-intrinsic factors include temperament, prior exposure to trauma, and prior history of psychopathology. Child-extrinsic factors include the surrounding physical, familial, community, and cultural environments. Both child-intrinsic and child-extrinsic factors influence children's experience and appraisal of traumatic events; expectations regarding danger, protection, and safety; and course of posttrauma adjustment. For example, both child-intrinsic factors such as prior history of loss, and child-extrinsic factors such as poverty may act as vulnerability factors by exacerbating the adverse effects of trauma on children's adjustment.
- 3

Traumatic events often generate secondary adversities, life changes, and distressing reminders in children's daily lives.

Traumatic events often generate secondary adversities such as family separations, financial hardship, relocations to a new residence and school, social stigma, ongoing treatment for injuries and/or physical rehabilitation, and legal proceedings. The cascade of changes produced by trauma and loss can tax the coping resources of the child, family, and broader community. These adversities and life changes can be sources of distress in their own right and can create challenges to adjustment and recovery. Children's exposure to trauma reminders and loss reminders can serve as additional sources of distress. Secondary adversities, trauma reminders, and loss reminders may produce significant fluctuations in trauma survivors' posttrauma emotional and behavioral functioning.
- 4

Children can exhibit a wide range of reactions to trauma and loss.

Trauma-exposed children can exhibit a wide range of posttrauma reactions that vary in their nature, onset, intensity, frequency, and duration. The pattern and course of children's posttrauma reactions are influenced by the type of traumatic experience and its consequences, child-intrinsic factors including prior trauma or loss, and the posttrauma physical and social environments. Posttraumatic stress and grief reactions can develop over time into psychiatric disorders, including posttraumatic stress disorder (PTSD), separation anxiety, and depression. Posttraumatic stress and grief reactions can also disrupt major domains of child development, including attachment relationships, peer relationships, and emotional regulation, and can reduce children's level of functioning at home, at school, and in the community. Children's posttrauma distress reactions can also exacerbate preexisting mental health problems including depression and anxiety. Awareness of the broad range of children's potential reactions to trauma and loss is essential to competent assessment, accurate diagnosis, and effective intervention.
- 5

Danger and safety are core concerns in the lives of traumatized children.

Traumatic experiences can undermine children's sense of protection and safety, and can magnify their concerns about dangers to themselves and others. Ensuring children's physical safety is critically important to restoring the sense of a protective shield. However, even placing children in physically safe circumstances may not be sufficient to alleviate their

fears or restore their disrupted sense of safety and security. Exposure to trauma can make it more difficult for children to distinguish between safe and unsafe situations, and may lead to significant changes in their own protective and risk-taking behavior. Children who continue to live in dangerous family and/or community circumstances may have greater difficulty recovering from a traumatic experience.

6 **Traumatic experiences affect the family and broader caregiving systems.**

Children are embedded within broader caregiving systems including their families, schools, and communities. Traumatic experiences, losses, and ongoing danger can significantly impact these caregiving systems, leading to serious disruptions in caregiver-child interactions and attachment relationships. Caregivers' own distress and concerns may impair their ability to support traumatized children. In turn, children's reduced sense of protection and security may interfere with their ability to respond positively to their parents' and other caregivers' efforts to provide support. Traumatic events—and their impact on children, parents, and other caregivers—also affect the overall functioning of schools and other community institutions. The ability of caregiving systems to provide the types of support that children and their families need is an important contributor to children's and families' posttrauma adjustment. Assessing and enhancing the level of functioning of caregivers and caregiving systems are essential to effective intervention with traumatized youths, families, and communities.

7 **Protective and promotive factors can reduce the adverse impact of trauma.**

Protective factors buffer the adverse effects of trauma and its stressful aftermath, whereas promotive factors generally enhance children's positive adjustment regardless of whether risk factors are present. Promotive and protective factors may include child-intrinsic factors such as high self-esteem, self-efficacy, and possessing a repertoire of adaptive coping skills. Promotive and protective factors may also include child-extrinsic factors such as positive attachment with a primary caregiver, possessing a strong social support network, the presence of reliable adult mentors, and a supportive school and community environment. The presence and strength of promotive and protective factors—both before and after traumatic events—can enhance children's ability to resist, or to quickly recover (by resiliently "bouncing back") from the harmful effects of trauma, loss, and other adversities.

8 **Trauma and posttrauma adversities can strongly influence development.**

Trauma and posttrauma adversities can profoundly influence children's acquisition of developmental competencies and their capacity to reach important developmental milestones in such domains as cognitive functioning, emotional regulation, and interpersonal relationships. Trauma exposure and its aftermath can lead to developmental disruptions in the form of regressive behavior, reluctance, or inability to participate in developmentally appropriate activities, and developmental accelerations such as leaving home at an early age and engagement in precocious sexual behavior. In turn, age, gender, and developmental period are linked to risk for exposure to specific types of trauma (e.g., sexual abuse, motor vehicle accidents, peer suicide).

9 **Developmental neurobiology underlies children's reactions to traumatic experiences.**

Children's capacities to appraise and respond to danger are linked to an evolving neurobiology that consists of brain structures, neurophysiological pathways, and neuroendocrine systems. This "danger apparatus" underlies appraisals of dangerous situations, emotional and physical reactions, and protective actions. Traumatic experiences evoke strong biological responses that can persist and that can alter the normal course of neurobiological maturation. The neurobiological impact of traumatic experiences depends in part on the developmental stage in which they occur. Exposure to multiple traumatic experiences carries a greater risk for significant neurobiological disturbances including impairments in memory, emotional regulation, and behavioral regulation. Conversely, ongoing neurobiological maturation and neural plasticity also create continuing opportunities for recovery and adaptive developmental progression.

10 **Culture is closely interwoven with traumatic experiences, response, and recovery.**

Culture can profoundly affect the meaning that a child or family attributes to specific types of traumatic events such as sexual abuse, physical abuse, and suicide. Culture may also powerfully influence the ways in which children and their families respond to traumatic events including the ways in which they experience and express distress, disclose personal information to others, exchange support, and seek help. A cultural group's experiences with historical or multigenerational trauma can also affect their responses to trauma and loss, their world view, and their expectations regarding the self, others, and social institutions. Culture also strongly influences the rituals and other ways through which children and families grieve over and mourn their losses.

11 **Challenges to the social contract, including legal and ethical issues, affect trauma response and recovery.**

Traumatic experiences often constitute a major violation of the expectations of the child, family, community, and society regarding the primary social roles and responsibilities of influential figures in the child's life. These life figures may include family members, teachers, peers, adult mentors, and agents of social institutions such as judges, police officers, and child welfare workers. Children and their caregivers frequently contend with issues involving justice, obtaining legal redress, and seeking protection against further harm. They are often acutely aware of whether justice is properly served and the social contract is upheld. The ways in which social institutions respond to breaches of the social contract may vary widely and often take months or years to carry out. The perceived success or failure of these institutional responses may exert a profound influence on the course of children's posttrauma adjustment, and on their evolving beliefs, attitudes, and values regarding family, work, and civic life.

12

Working with trauma-exposed children can evoke distress in providers that makes it more difficult for them to provide good care.

Mental healthcare providers must deal with many personal and professional challenges as they confront details of children's traumatic experiences and life adversities, witness children's and caregivers' distress, and attempt to strengthen children's and families' belief in the social contract. Engaging in clinical work may also evoke strong memories of personal trauma- and loss-related experiences. Proper self-care is an important part of providing quality care and of sustaining personal and professional resources and capacities over time.

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For a printable PDF version of *The 12 Core Concepts* and more information on the *Core Curriculum on Childhood Trauma* click here to access the files through our Learning Center for Child and Adolescent Trauma.



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Tips for Finding Help: Recommendations from the National Child Traumatic Stress Network

Information

Because children and adolescents go through many normal changes as they mature into young adults, it is not always easy to tell whether they are bothered by traumatic stress, grief, or depression. Families can be most helpful if they learn as much as they can about child traumatic stress. Helpful sources of information include:

The National Child Traumatic Stress Network, www.NCTSN.net

The New York Child Study Center, www.aboutourkids.org

The National Center for Children Exposed to Violence at the Yale Child Study Center, www.nccev.org

The National Center for PTSD, www.ncptsd.org

The Office for Victims of Crime – US Dept. of Justice, www.ojp.usdoj.gov/ovc

The International Society for Traumatic Stress Studies, www.istss.org

National Center for Victims of Crime, www.ncvc.org

Professional Help

There are many routes to finding a qualified mental health professional. Families can:

- Look on the website of the National Child Traumatic Stress Network to see if one of its member centers exists in your city or state. The list of members may be found at http://www.nctsn.net/nccts/nav.do?pid=abt_ntwk.
- Ask a pediatrician, family physician, school counselor, or clergy member for a referral to a professional with expertise in traumatic stress.
- Talk to close family members and friends for their recommendations, especially if their child or adolescent had a good experience with psychotherapy.
- Contact a community hospital, state or county medical society, state or county psychological association, or the division of child and adolescent psychiatry or department of psychology in any medical school or university.
- Contact agencies in the community that specialize in trauma and/or victimization. These might include sexual assault or rape programs, victims' advocacy agencies, the local crime victims' compensation program, the children's advocacy center, or local domestic violence programs.
- Contact local community mental health centers, mental health associations, and support groups such as chapters of the Federation for Families for Children's Mental Health (www.ffcmh.org) and NAMI (National Alliance for the Mentally Ill (www.nami.org), which often keep lists of mental health professionals willing to see new clients or patients.
- Call the American Psychological Association (www.apa.org) toll-free number, which will connect you to the state or local referral service for your area. The number is 1-800-964-2000.



Children's Responses to Crises and Tragic Events¹



Infants, toddlers, preschoolers, and young children who experience a tragic event may show changes in their behaviors. They may also be indirectly affected by a crisis by what they see on the TV or hear.

The most important role you can play as a parent in an emergency situation is to stay calm. Children of all ages easily pick up on their parents or other's fears and anxieties. This may cause changes in behaviors.

Children, no matter what their age, do not always have the words to tell you how they are feeling. They may not know how to talk about what has happened. Their behavior can be a better sign. Sudden changes in behavior can mean they have been exposed to trauma or a crisis.

What you might see:

- Problems sleeping, including not wanting to sleep alone, having a hard time at naptime or bedtime, not wanting to sleep or repeatedly waking up, nightmares
- Separation anxiety, including not wanting to be away from you, not wanting to go to school, and crying or complaining when you leave
- Not eating
- Not being able to do things they used to do
- Being scared by new things
- More cranky behaviors
- Being more stubborn than usual

¹Material adapted from:

National Child Traumatic Stress Network Schools Committee. (October 2008). *Child Trauma Toolkit for Educators*. Los Angeles, CA & Durham, NC: National Center for Child Traumatic Stress

National Child Traumatic Stress Network. Parent Tips for Helping Infants and Toddlers after Disasters. Available at http://www.nctsn.org/sites/default/files/pfa/english/appendix_e4_tips_for_parents_with_infants_and_toddlers.pdf

HealthyChildren.org. What to tell your children about disasters. <http://www.healthychildren.org/English/safety-prevention/at-home/Pages/Getting-Your-Family-Prepared-for-a-Disaster.aspx>

Federal Emergency Response Agency. Helping Children Cope with Disaster <http://www.fema.gov/news-release/2005/10/14/helping-children-cope-disaster>

School readiness begins with health!

- Wanting things only done his/her way
- Social regression
- Increased complaints (headaches, stomachaches)
- Intense preoccupation with the details of the event
- Wanting to always talk about what happened
- Fear that the event might happen again
- Not paying attention, being restless
- Moody, depressed, or irritable
- Playing in violent ways
- Hitting you or others
- More tantrums
- Clinginess with teachers, caregivers, or yourself
- Regression, or going back to an earlier stage of development
- Bedwetting or other toileting issues
 - Baby talk
 - Wanting to be carried or rocked
- Re-creating the event, without prompting by staff or mental health consultant
 - Playing out or drawing the event
 - Repeatedly talking about it
- Overreacting to minor bumps or falls
- Changes in behavior (not wanting to eat, angry outbursts, decreased attention, withdrawal, wetting the bed, having bad dreams)
- Over- or under-reacting to physical contact, sudden movements, or loud sounds such as sirens and slamming doors
- Anxiety and worry
- New fears and/or fears about safety
- Asking questions and making statements about the event

What you might see (in addition to those listed above) in your older children

- Strong angry or sad feelings
- Acting out in school
- Poor grades
- Fighting with friends
- Wanting to be alone
- Behaving as if he or she has no feelings
- Disobeying, talking back, or getting into fights
- Drinking or using drugs, hanging out in groups and getting into trouble



Additional information about children's responses to trauma and disasters is available from the following resources:

- American Academy of Pediatrics Promoting Adjustment and Helping Children Cope <http://www.aap.org/disasters/adjustment>
- The Youngest Victims: Disaster Preparedness to Meet Children's Needs <http://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/Children-and-Disasters/Documents/Youngest-Victims-Final.pdf>
- Office of the Administration for Children & Families Early Childhood Disaster-Related Resources <http://www.acf.hhs.gov/programs/ohsepr/early-childhood>
- The National Child Traumatic Stress Network <http://www.nctsn.org>

If you see changes in your child, tell your child's teacher or home visitor. It is important that you and your child get the support. Your Head Start/Early Head Start teacher and/or mental health consultant can help you find resources that can help.

School readiness begins with health!

Trauma-Informed Approach and Trauma-Specific Interventions

samhsa.gov/nctic/trauma-interventions

Trauma-Informed Approach

According to SAMHSA's concept of a trauma-informed approach, "A program, organization, or system that is trauma-informed:

1. *Realizes* the widespread impact of trauma and understands potential paths for recovery;
2. *Recognizes* the signs and symptoms of trauma in clients, families, staff, and others involved with the system;
3. *Responds* by fully integrating knowledge about trauma into policies, procedures, and practices; and
4. *Seeks to actively resist re-traumatization.*"

A trauma-informed approach can be implemented in any type of service setting or organization and is distinct from trauma-specific interventions or treatments that are designed specifically to address the consequences of trauma and to facilitate healing.

SAMHSA's Six Key Principles of a Trauma-Informed Approach

A trauma-informed approach reflects adherence to six key principles rather than a prescribed set of practices or procedures. These principles may be generalizable across multiple types of settings, although terminology and application may be setting- or sector-specific:

1. Safety
2. Trustworthiness and Transparency
3. Peer support
4. Collaboration and mutuality
5. Empowerment, voice and choice
6. Cultural, Historical, and Gender Issues

From SAMHSA's perspective, it is critical to promote the linkage to recovery and resilience for those individuals and families impacted by trauma. Consistent with SAMHSA's definition of recovery, services and supports that are trauma-informed build on the best evidence available and consumer and family engagement, empowerment, and collaboration.

Trauma-Specific Interventions

Trauma-specific intervention programs generally recognize the following:

- The survivor's need to be respected, informed, connected, and hopeful regarding their own recovery
- The interrelation between trauma and symptoms of trauma such as substance abuse, eating disorders, depression, and anxiety
- The need to work in a collaborative way with survivors, family and friends of the survivor, and other human services agencies in a manner that will empower survivors and consumers

Known Trauma-Specific Interventions

Information for Parents and Caregivers

Helping Young Children Exposed to Trauma: For Families and Caregivers

When young children experience a traumatic stressor, their first response is usually to look for reassurance from the adults who care for them. The most important adults in a young child's life are his/her caregivers and relatives. These adults can help reestablish security and stability for children who have experienced trauma by:

- Answering children's questions in language they can understand, so that they can develop an understanding of the events and changes in their life
- Developing family safety plans
- Engaging in age-appropriate activities that stimulate the mind and body
- Finding ways to have fun and relax together
- Helping children expand their "feelings" vocabulary
- Honoring family traditions that bring them close to the people they love, e.g., storytelling, holiday celebrations, reunions, trips
- Looking for changes in behaviors
- Helping children to get back on track
- Setting and adhering to routines and schedules
- Setting boundaries and limits with consistency and patience
- Showing love and affection

Caregivers and relatives are the most important adults in children's lives. They can help reestablish security and stability for children who have experienced trauma.

Resources for Family and Caregivers	
Online resources	
After the Injury (http://aftertheinjury.org/)	<i>Find Ways to Help Your Child Recover</i> (http://aftertheinjury.org/findWhat.html)
Center on the Social and Emotional Foundations for Early Learning (http://csefel.vanderbilt.edu/about.html)	<i>Family Tools</i> (http://csefel.vanderbilt.edu/resources/family.html)
National Child Traumatic Stress Network (http://www.nctsn.org)	<i>After the Hurricane: Helping Young Children Heal</i> (http://www.nctsn.org/nctsn_assets/pdfs/edu_materials/Helping_Young_Children_Heal.pdf) <i>Helping Young Children and Families Cope with Trauma</i> (http://www.nctsn.org/nctsn_assets/pdfs/Helping_Young_Children_and_Families_Cope_with_Trauma.pdf)
Scholastic.com (http://www2.scholastic.com/browse/home.jsp)	Brodin A. M. (2005). Talking with children about natural disasters. <i>Scholastic Early Childhood Today</i>

Trauma and Your Family

What is trauma?

A trauma is a scary, dangerous, or violent event that can happen to any or all members of a family. Some types of trauma that families go through are:

- Accidents or injuries
- Serious illness
- House fires
- Crimes
- Community violence
- School violence
- Sudden loss of a loved one
- Combat injuries or death of a family member
- Violence within the family
- Abuse
- Neglect
- Homelessness
- Natural disasters
- Acts of terrorism
- Living in or escaping from a war zone

What is traumatic stress?

Everyone gets stressed out once in a while. At any time, a member of any family may worry about staying safe or getting very sick. But when “bad things happen,” such as a trauma event, some family members may become very upset and show signs of traumatic stress. They may:

- Feel numb or shock
- Avoid people and places that remind them of the event
- Have nightmares or strong memories of the event, as if re-living it
- Be very afraid, angry, or sad
- Have trouble sleeping or paying attention
- Feel helpless and hopeless
- Be very tired and worn out
- Have aches and pains

*“Sitting around worrying about what happened makes it worse.”
A mother who experienced domestic violence*

How common is trauma?

Unfortunately, trauma events happen pretty often. Some families have more than one trauma event. Others do not. When there is trauma, at first people feel more shocked, upset, and unable to cope. When families have many traumas, they can find it hard to support each other or meet the needs of the children.

How does trauma impact the family?

Trauma can affect every member of the family. Each family goes through trauma differently. Some family members may get closer to each other and find comfort in wise words of family elders. Some families may not do as well as they did before. Some families might feel more alone or be in shock or believe no one will be there for them. Others may end up cutting ties with members who hurt them.

“When my children hurt, I hurt.”

A mother whose children were beaten at school

Can my family get over traumatic stress?

Yes. When families are safe and can care for and support each other, they often can overcome the fears and stress of trauma. Some families grow stronger after a trauma event and even are able to help others in need. Of the many ways to cope and heal from traumatic stress, many families count on:

- Community support
- Spiritual beliefs
- Friends and other families

For families having ongoing distress, crises, or trouble meeting their children’s needs, trauma treatment is available to help your family seek safety, grow stronger, and heal.

“You can’t change the past, but you can do something with the present and prepare for the future. This is what really kept me going.”

A grandmother raising grandchildren who were abused

Things families can do to cope with traumatic stress

It is natural to want to “put the past behind you” and not to think or talk about the bad things that happened. While each person in the family may behave differently, families can manage fear and stress and feel safer when they spend time together talking about their feelings, return to everyday routines, respect family rules, and honor family traditions.

Some families get better with time and the support of others, while other families may need help from trauma treatments. When seeking help, your family can:

- Talk to a doctor, school counselor, or spiritual leader about the family’s trauma event
- Find a mental health provider who has helped families overcome traumatic stress
- Look for trauma treatments that help all members of the family:
 - Feel safe
 - Learn about trauma and its effects
 - Cope with difficulties caused by the trauma
 - Recognize and build on the family’s strengths
 - Talk about ways to get the family back on track

“It helps to talk about it versus keeping it bottled up.”

A father who witnessed domestic violence as a child

Go to nctsn.org to learn more about how to help your family grow stronger.

What is Child Traumatic Stress?

Child traumatic stress is when children and adolescents are exposed to traumatic events or traumatic situations, and when this exposure overwhelms their ability to cope.

When children have been exposed to situations where they feared for their lives, believed they could have been injured, witnessed violence, or tragically lost a loved one, they may show signs of traumatic stress. The impact on any given child depends partly on the objective danger, partly on his or her subjective reaction to the events, and partly on his or her age and developmental level.



If your child is experiencing traumatic stress you might notice the following signs:

- Difficulty sleeping and nightmares
- Refusing to go to school
- Lack of appetite
- Bed-wetting or other regression in behavior
- Interference with developmental milestones
- Anger
- Getting into fights at school or fighting more with siblings
- Difficulty paying attention to teachers at school and to parents at home
- Avoidance of scary situations
- Withdrawal from friends or activities
- Nervousness or jumpiness
- Intrusive memories of what happened
- Play that includes recreating the event

What is the best way to treat child traumatic stress?

There are effective ways to treat child traumatic stress.

Many treatments include cognitive behavioral principles:

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

For more information see the NCTSN website: www.nctsn.org.

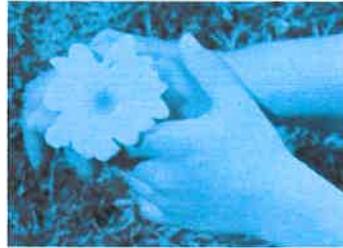
What can I do for my child at home?

Parents never want their child to go through trauma or suffer its after effects.

Having someone you can talk to about your own feelings will help you to better help your child.

Follow these steps to help your child at home:

1. Learn about the common reactions that children have to traumatic events.
2. Consult a qualified mental health professional if your child's distress continues for several weeks. Ask your child's school for an appropriate referral.
3. Assure your child of his or her safety at home and at school. Talk with him or her about what you've done to make him or her safe at home and what the school is doing to keep students safe.
4. Reassure your child that he or she is not responsible. Children may blame themselves for events, even those completely out of their control.
5. Allow your child to express his or her fears and fantasies verbally or through play. That is a normal part of the recovery process.
6. Maintain regular home and school routines to support the process of recovery, but make sure your child continues going to school and stays in school.
7. Be patient. **There is no correct timetable for healing. Some children will recover quickly. Other children recover more slowly.** Try not to push him or her to "just get over it," and let him or her know that he or she should not feel guilty or bad about any of his or her feelings.

**How can I make sure my child receives help at school?**

If your child is staying home from school, depressed, angry, acting out in class, having difficulty concentrating, not completing homework, or failing tests, there are several ways to get help at school. Talk with your child's school counselor, social worker, or psychologist. Usually, these professionals understand child traumatic stress and should be able to assist you to obtain help.

Ask at school about services through Federal legislation including:

1. Special Education—the Individuals with Disabilities Education Act (IDEA) which, in some schools, includes trauma services; and
2. Section 504—which protects people from discrimination based on disabilities and may include provisions for services that will help your child in the classroom.

Check with your school's psychologist, school counselor, principal, or special education director for information about whether your child might be eligible for help with trauma under IDEA.

The good news is that there are services that can help your child get better. Knowing who to ask and where to look is the first step.

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For Early Childhood Professionals

Support Social and Emotional Development

Adapted from

U.S. Dept. of Health and Human Services
Publication CA-0037, 1999

As an early childhood professional, you play a major role in the development of the infants, toddlers, and preschool children in your care. Research shows that the way you talk and play with children during these early years impacts a child's:

- Social and emotional development (mental health)
- Learning abilities
- Functioning later in life

Mental Health Matters

Children learn from their families, culture, friends, and communities and from all the people who nurture them. As an early childhood provider, you help children to:

- Cope with stress
- Build Self-confidence
- Develop self-worth
- Learn and master new skills
- Develop self-regulation and learn to control their impulses
- Develop trusting relationships with adults and other children

To grow and learn, children need these mental health abilities as much as they need good physical health.



Promote Mental Health and Well-Being in All Children

1. Learn the developmental stages of social and emotional development
2. Learn about and respect the cultures of children and their families
3. Talk with children about their feelings—help them put words to their feelings
4. Smile and laugh often—express joy
5. Encourage friendship and play among children
6. Help children learn to respect the feelings and possessions of others
7. Use a variety of positive guidance methods, e.g. listening, redirecting, (offering another activity), and reinforcing (praising good behavior)
8. Never threaten to harm, shake, or shame children, and
9. Teach problem solving and conflict resolution skills

Special Considerations for Infant Mental Health and Well-Being

- Hold, carry, rock, and touch babies often
- Respond promptly and calmly to crying or fussing
- Make caregiving routines enjoyable
- Repeat back the sounds a baby makes—take turns singing, listening, and talking
- Have schedules that respond to individual needs for sleeping, feeding, and active play
- Provide a variety of opportunities, places, and positions for active movement
- Never spank, threaten to harm, shake or shame infants

What Behaviors Indicate that a Child's Mental Health May Be "at Risk"?

Infants and Toddlers

- Displays very little emotion
- Does not show interest in sights sounds or touch
- Rejects or avoids being touched or held or playing with others
- Unusually difficult to soothe or console
- Unable to comfort or calm self
- Extremely fearful or on-guard
- Does not turn to familiar adults for comfort or help
- Exhibits sudden behavior changes

Preschool Children

- Cannot play with others or objects
- Absence of language or communication
- Frequently fights with others
- Very sad
- Extreme mood swings
- Unusually fearful
- Inappropriate responses to situations, e.g. laughs instead of cries
- Withdrawn
- Extremely active
- Loss of earlier skills (e.g. toileting, language, motor)
- Sudden behavior changes
- Very accident prone
- Destructive to self and/or others
- Extremely immature



Always Consider:

- How severe is the behavior?
- How many weeks or months has the behavior been occurring?
- How long does the behavior last (e.g. minutes, hours)?
- How does the behavior compare with the behavior of other children of the same age?
- Are there events in the early childhood education setting, or at home, that make the behavior better or worse?

If a child displays any of the behaviors described above and the answers to the questions make you think the behavior could be problematic, then:

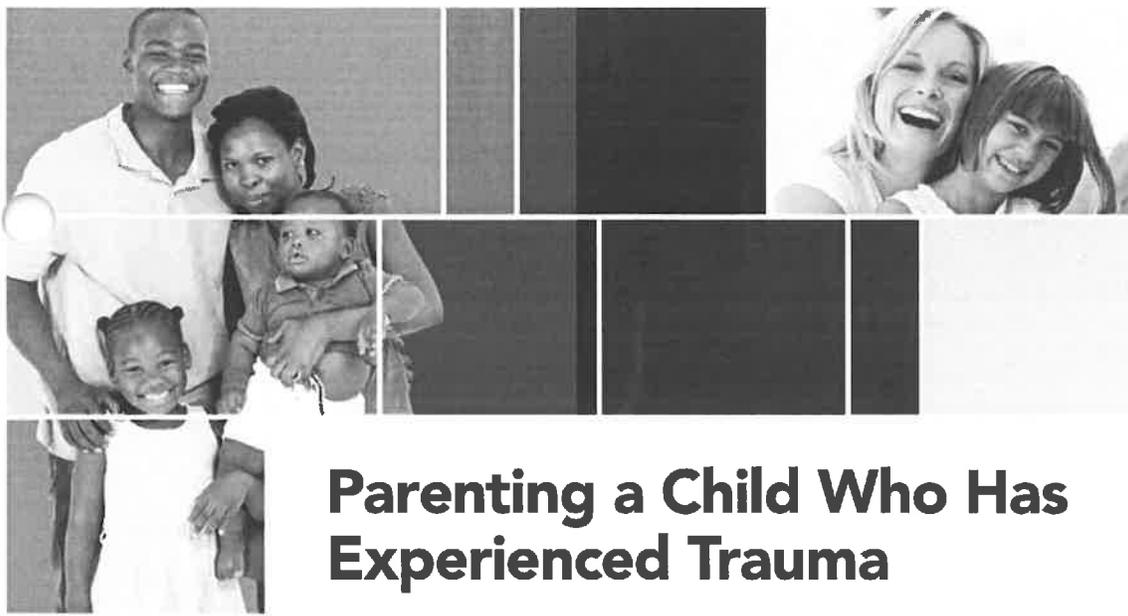
- Talk with a colleague or supervisor
- Talk with the child's family
- Recognize cultural differences
- Get more information
- Seek professional help

Remember, it is always better to get more information and help when you notice behaviors that might be a risk to a child's healthy development.

Two other very important points!

Communicate with families
and work together.

Take good care of your own physical
and mental health.



Parenting a Child Who Has Experienced Trauma

Children who have experienced traumatic events need to feel safe and loved. All parents want to provide this kind of nurturing home for their children. However, when parents do not have an understanding of the effects of trauma, they may misinterpret their child's behavior and end up feeling frustrated or resentful. Their attempts to address troubling behavior may be ineffective or, in some cases, even harmful.

This factsheet discusses the nature of trauma, its effects on children and youth, and ways to help your child. By increasing your understanding of trauma, you can help support your child's healing, your relationship with him or her, and your family as a whole.

WHAT'S INSIDE

What is trauma?

The impact of untreated trauma

Understanding your child's behavior

Helping your child

Conclusion

Resources

What Is Trauma?

Trauma is an emotional response to an intense event that threatens or causes harm. The harm can be physical or emotional, real or perceived, and it can threaten the child or someone close to him or her. Trauma can be the result of a single event, or it can result from exposure to multiple events over time.

Potentially traumatic events may include:

- Abuse (physical, sexual, or emotional)
- Neglect
- Effects of poverty (such as homelessness or not having enough to eat)
- Being separated from loved ones
- Bullying
- Witnessing harm to a loved one or pet (e.g., domestic or community violence)
- Natural disasters or accidents
- Unpredictable parental behavior due to addiction or mental illness

For many children, being in the child welfare system becomes another traumatic event. This is true of the child's first separation from his or her home and family, as well as any additional placements.

The Impact of Untreated Trauma

Children are resilient. Some stress in their lives (e.g., leaving caregivers for a day at school, riding a bike for the first time, feeling nervous before a game or performance) helps their brains to grow and new skills to develop. However, by definition, trauma occurs when a stressful experience (such as being abused, neglected, or bullied) overwhelms the child's natural ability to cope. These events cause a "fight, flight, or freeze" response, resulting in changes in the body—such as faster heart rate and higher blood pressure—as well as changes in how the brain perceives and responds to the world.

In many cases, a child's body and brain recover quickly from a potentially traumatic experience with no lasting harm. However, for other children, trauma interferes with normal development and can have long-lasting effects.

Table 1. Effects of Trauma on Children

Trauma may affect children's ...	In the following ways
Bodies	<ul style="list-style-type: none"> • Inability to control physical responses to stress • Chronic illness, even into adulthood (heart disease, obesity)
Brains (thinking)	<ul style="list-style-type: none"> • Difficulty thinking, learning, and concentrating • Impaired memory • Difficulty switching from one thought or activity to another
Emotions (feeling)	<ul style="list-style-type: none"> • Low self-esteem • Feeling unsafe • Inability to regulate emotions • Difficulty forming attachments to caregivers • Trouble with friendships • Trust issues • Depression, anxiety
Behavior	<ul style="list-style-type: none"> • Lack of impulse control • Fighting, aggression, running away • Substance abuse • Suicide

Factors that determine the impact of traumatic events include the following:

- **Age.** Younger children are more vulnerable. Even infants and toddlers who are too young to talk about what happened retain lasting "sense memories" of traumatic events that can affect their well-being into adulthood.
- **Frequency.** Experiencing the same type of traumatic event multiple times, or multiple types of traumatic events, is more harmful than a single event.
- **Relationships.** Children with positive relationships with healthy caregivers are more likely to recover.
- **Coping skills.** Intelligence, physical health, and self-esteem help children cope.

- **Perception.** How much danger the child thinks he or she is in, or the amount of fear the child feels at the time, is a significant factor.
- **Sensitivity.** Every child is different—some are naturally more sensitive than others.

The effects of trauma vary depending on the child and type of traumatic events experienced. Table 1 shows some of the ways that trauma can affect children.

This list of potential consequences shows why it is so important for parents to understand trauma. The right kind of help can reduce or even eliminate many of these negative consequences.

Understanding Your Child's Behavior

When children have experienced trauma, particularly multiple traumatic events over an extended period of time, their bodies, brains, and nervous systems adapt in an effort to protect them. This might result in behaviors such as increased aggression, distrusting or disobeying adults, or even dissociation (feeling disconnected from reality). When children are in danger, these behaviors may be important for their survival. However, once children are moved to a safer environment, their brains and bodies may not recognize that the danger has passed. These protective behaviors, or habits, have grown strong from frequent use (just as a muscle that is used regularly grows bigger and stronger). It takes time and retraining to help those "survival muscles" learn that they are not needed in their new situation (your home), and that they can relax.

It might be helpful to remember that your child's troublesome behavior may be a learned response to stress—it may even be what kept your child alive in a very unsafe situation. It will take time and patience for your child's body and brain to learn to respond in ways that are more appropriate for his or her current, safe environment.

Parenting a traumatized child may require a shift from seeing a "bad kid" to seeing a kid who has had bad things happen.

Trauma Triggers

When your child is behaving in a way that is unexpected and seems irrational or extreme, he or she may be experiencing a trauma trigger. A trigger is some aspect of a traumatic event that occurs in a completely different situation but reminds the child of the original event. Examples may be sounds, smells, feelings, places, postures, tones of voice, or even emotions.

Youth who have experienced traumatic events may reenact past patterns when they feel unsafe or encounter a trigger. Depending on whether the child has a "fight," "flight," or "freeze" response, the child may appear to be throwing a tantrum, willfully not listening, or defying you. However, responses to triggers are best thought of as reflexes—they are not deliberate or planned. When children's bodies and brains are overwhelmed by a traumatic memory, they are not able to consider the consequences of their behavior or its effect on others.

Symptoms by Age

Table 2 shows symptoms and behaviors that children who have experienced trauma might exhibit at different stages of development. The age ranges are merely guidelines. For many children who have experienced trauma, their development lags behind their age in calendar years. It may be normal for your child to exhibit behaviors that are more common in younger children.

Table 2. Signs of Trauma in Children of Different Ages¹

Young Children (Ages 0–5)	School-Age Children (Ages 6–12)	Teens (Ages 13–18)
<ul style="list-style-type: none"> • Irritability, “fussiness” • Startling easily or being difficult to calm • Frequent tantrums • Clinginess, reluctance to explore the world • Activity levels that are much higher or lower than peers • Repeating traumatic events over and over in dramatic play or conversation • Delays in reaching physical, language, or other milestones 	<ul style="list-style-type: none"> • Difficulty paying attention • Being quiet or withdrawn • Frequent tears or sadness • Talking often about scary feelings and ideas • Difficulty transitioning from one activity to the next • Fighting with peers or adults • Changes in school performance • Wanting to be left alone • Eating much more or less than peers • Getting into trouble at home or school • Frequent headaches or stomachaches with no apparent cause • Behaviors common to younger children (thumb sucking, bed wetting, fear of the dark) 	<ul style="list-style-type: none"> • Talking about the trauma constantly, or denying that it happened • Refusal to follow rules, or talking back frequently • Being tired all the time, sleeping much more (or less) than peers, nightmares • Risky behaviors • Fighting • Not wanting to spend time with friends • Using drugs or alcohol, running away from home, or getting into trouble with the law

¹ Content in the table is adapted from Safe Start Center. (n.d.). *Tips for Staff and Advocates Working With Children: Polyvictimization*. Washington, DC: Office of Juvenile Justice and Delinquency Prevention, available at http://ojjdp.gov/programs/safestart/TipSheetFor_Polyvictimization.pdf.

These signs alone do not necessarily indicate that your child has experienced trauma. However, if symptoms are more severe or longer lasting than is typical for children the same age, or if they interfere with your child’s ability to succeed at home or in school, it is important to seek help. (See the Helping Your Child section below.)

Trauma and Mental Health

Trauma symptoms that are more severe or disruptive to a child’s ability to function at home or at school may overlap with specific mental health diagnoses. This may be one reason why nearly 80 percent of children aging out of foster care have received a mental health diagnosis.² For example:³

- Children who have difficulty concentrating may be diagnosed with ADHD (attention deficit hyperactivity disorder).
- Children who appear anxious or easily overwhelmed by emotions may be diagnosed with anxiety or depression.
- Children who have trouble with the unexpected may respond by trying to control every situation or by showing extreme reactions to change. In some cases, these behaviors may be labeled ODD (oppositional defiant disorder) or intermittent explosive disorder (IED).
- Dissociation in response to a trauma trigger may be viewed as defiance of authority, or it may be diagnosed as depression, ADHD (inattentive type), or even a developmental delay.

It may be necessary to treat these diagnoses with traditional mental health approaches (including the use of medications, where indicated) in the short term. However, treating the underlying cause by addressing the child’s experience of trauma will be more effective in the long run.

² American Academy of Pediatrics. (2013). *Helping Foster and Adoptive Families Cope With Trauma*. Elk Grove Village, IL: AAP and Dave Thomas Foundation for Adoption. Retrieved from <http://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/healthy-foster-care-america/Documents/Guide.pdf>

³ Examples adapted from American Academy of Pediatrics. (2013). *Parenting After Trauma: Understanding Your Child’s Needs. A Guide for Foster and Adoptive Parents*. Elk Grove Village, IL: AAP and Dave Thomas Foundation for Adoption. Retrieved from <http://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/healthy-foster-care-america/Documents/FamilyHandout.pdf>

Posttraumatic Stress Disorder

About one in four children and youth in foster care will experience a specific set of symptoms known as posttraumatic stress disorder (PTSD).⁴ It includes four types of symptoms:⁵

- Reexperiencing/remembering (flashbacks or nightmares)
- Avoidance (distressing memories and reminders about the event)
- Negative cognitions and mood (feeling alienated, persistent negative beliefs)
- Alterations in arousal (reckless behavior, persistent sleep disturbance)

It is important to realize that if your child does not exhibit all of the symptoms of PTSD, it does not mean that he or she has not been affected by trauma.

⁴ AAP, *Helping Foster and Adoptive Families Cope With Trauma*. Retrieved from <http://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/healthy-foster-care-america/Documents/Guide.pdf>

⁵ American Psychiatric Association, *Posttraumatic Stress Disorder* (2013). Retrieved from <http://www.dsm5.org/Documents/PTSD%20Fact%20Sheet.pdf>

Helping Your Child

Although childhood trauma can have serious, lasting effects, there is hope. With the help of supportive, caring adults, children can and do recover. Consider the following tips:

- **Identify trauma triggers.** Something you are doing or saying, or something harmless in your home, may be triggering your child without either of you realizing it. It is important to watch for patterns of behavior and reactions that do not seem to "fit" the situation. What distracts your child, makes him or her anxious, or results in a tantrum or outburst? Help your child avoid situations that trigger traumatic memories, at least until more healing has occurred.
- **Be emotionally and physically available.** Some traumatized children act in ways that keep adults at a distance (whether they mean to or not). Provide attention, comfort, and encouragement in ways your child will accept. Younger children may want extra hugs or cuddling; for older youth, this might just mean spending time together as a family. Follow their lead and be patient if children seem needy.
- **Respond, don't react.** Your reactions may trigger a child or youth who is already feeling overwhelmed. (Some children are even uncomfortable being looked at directly for too long.) When your child is upset, do what you can to keep calm: Lower your voice, acknowledge your child's feelings, and be reassuring and honest.
- **Avoid physical punishment.** This may make an abused child's stress or feeling of panic even worse. Parents need to set reasonable and consistent limits and expectations and use praise for desirable behaviors.
- **Don't take behavior personally.** Allow the child to feel his or her feelings without judgment. Help him or her find words and other acceptable ways of expressing feelings, and offer praise when these are used.
- **Listen.** Don't avoid difficult topics or uncomfortable conversations. (But don't force children to talk before they are ready.) Let children know that it's normal to have many feelings after a traumatic experience. Take their reactions seriously, correct any misinformation about the traumatic event, and reassure them that what happened was not their fault.
- **Help your child learn to relax.** Encourage your child to practice slow breathing, listen to calming music, or say positive things ("I am safe now.").
- **Be consistent and predictable.** Develop a regular routine for meals, play time, and bedtime. Prepare your child in advance for changes or new experiences.
- **Be patient.** Everyone heals differently from trauma, and trust does not develop overnight. Respecting each child's own course of recovery is important.
- **Allow some control.** Reasonable, age-appropriate choices encourage a child or youth's sense of having control of his or her own life.
- **Encourage self-esteem.** Positive experiences can help children recover from trauma and increase resilience.

Examples include mastering a new skill; feeling a sense of belonging to a community, group, or cause; setting and achieving goals; and being of service to others.

Seeking Treatment

If your child's symptoms last more than a few weeks, or if they are getting worse rather than better, it is time to ask for help. Mental health counseling or therapy by a professional trained to recognize and treat trauma in children can help address the root cause of your child's behavior and promote healing. A therapist or behavioral specialist might be able to help you understand your child and respond more effectively. At times, medications may be necessary to control symptoms and improve your child's ability to learn new skills.

Begin by asking your caseworker or agency whether your child has been screened for trauma. If you know that your child experienced trauma, ask whether he or she has had a formal mental health assessment by a professional who is aware of trauma's effects. Ideally, this assessment (including both strengths and needs) should be repeated periodically to help you and your child's therapist monitor progress.

Once your child has been assessed and it has been determined that treatment is needed, ask about treatment options. A number of effective trauma treatments have been developed.⁶ However, they are not all available in every community. Consult with your child's caseworker about the availability of trauma-focused treatment where you live.

Timely, effective mental and behavioral health interventions may help in the following ways:

- Increase your child's feelings of safety
- Teach your child how to manage emotions, particularly when faced with trauma triggers
- Help your child develop a positive view of him- or herself
- Give your child a greater sense of control over his/her own life

⁶ See for example the National Child Traumatic Stress Network's list, Empirically Supported Treatments and Promising Practices, at <http://www.nctsn.org/resources/topics/treatments-that-work/promising-practices>.

- Improve your child's relationships—with family members and others

It is important to look for a provider who understands and has specific training in trauma (see box). Most providers will agree to a brief interview in their office or over the phone, to determine whether they are a good fit for your needs.

Questions to ask a mental health provider before starting treatment:

- Are you familiar with research about the effects of trauma on children?
- Can you tell me about your experience working with children and youth who have experienced trauma?
- How do you determine whether a child's symptoms may be caused by trauma?
- How does a child's trauma history influence your treatment approach?

Helping Yourself and Your Family

Parenting a child or youth who has experienced trauma can be difficult. Families can sometimes feel isolated, as if no one else understands what they are going through. This can put a strain not only on your relationship with your child, but with other family members, as well (including your spouse or partner).

Learning about what your child experienced may even act as a trigger for you, if you have your own trauma history that is not fully healed. Being affected by someone else's trauma is sometimes called "secondary trauma." Table 3 lists signs that you may be experiencing secondary trauma.

Table 3. Signs of Secondary Trauma

Physical Symptoms	<ul style="list-style-type: none"> • Headaches • Stomach problems • Sleep problems • Weight gain or loss • Lack of energy
Behavioral Symptoms	<ul style="list-style-type: none"> • Increased drinking or smoking • Procrastination • Feeling overly critical • Avoiding other people
Emotional Symptoms	<ul style="list-style-type: none"> • Anxiety • Frequent crying • Irritability • Loneliness • Depression
Cognitive symptoms	<ul style="list-style-type: none"> • Inability to concentrate • Forgetfulness • Loss of humor/fun • Inability to make decisions

The best cure for secondary trauma is prevention. In order to take good care of your child, you must take good care of yourself. Here are some things you can do:

- **Be honest about your expectations for your child and your relationship.** Having realistic expectations about parenting a child with a history of trauma increases the chances for a healthy relationship.
- **Celebrate small victories.** Take note of the improvements your child has made.
- **Don't take your child's difficulties personally.** Your child's struggles are a result of the trauma he or she experienced; they are not a sign of your failure as a parent.
- **Take care of yourself.** Make time for things you enjoy doing that support your physical, emotional, and spiritual health.
- **Focus on your own healing.** If you have experienced trauma, it will be important for you to pursue your own healing, separate from your child.
- **Seek support.** Your circle of support may include friends, family, and professional support if needed. Don't be afraid to ask about resources available from the child welfare system, such as a caseworker or support groups.

In order to take good care of your child, you must take good care of yourself.

Conclusion

Trauma can affect children's behavior in ways that may be confusing or distressing for caregivers. It can impact the long-term health and well-being of the child and his or her family members. However, with understanding, care, and proper treatment (when necessary), all members of the family can heal and thrive after a traumatic event.

Resources

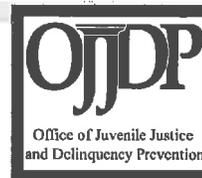
American Academy of Pediatrics. (2013). *Parenting after trauma: Understanding your child's needs. A guide for foster and adoptive parents.* Elk Grove Village, IL: AAP and Dave Thomas Foundation for Adoption. Retrieved from <http://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/healthy-foster-care-america/Documents/FamilyHandout.pdf>

Child Welfare Information Gateway. Resources on Trauma for Caregivers and Families [Webpage]: <https://www.childwelfare.gov/topics/responding/trauma/caregivers>.

Children's Bureau. (2012). *Making healthy choices: A guide on psychotropic medications for youth in foster care.* Retrieved from the Child Welfare Information Gateway website at <https://www.childwelfare.gov/pubPDFs/makinghealthychoices.pdf>

Children's Bureau. (coming in 2015). *Supporting youth in foster care in making healthy choices: A guide for caregivers and caseworkers on trauma, treatment, and psychotropic medications.* Find this on the Child Welfare Information Gateway website in 2015.

National Child Traumatic Stress Network. Resources for Parents and Caregivers [Webpage]: <http://www.nctsn.org/resources/audiences/parents-caregivers>



Trauma-Informed Care for Children Exposed to Violence

Tips for Parents and Other Caregivers

What happens when children are exposed to violence?

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

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

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

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

Young Children (5 and younger)

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

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



Elementary School-Age Children (6–12 years)

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

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

Teenagers (13–18 years)

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

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



What can you do?

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

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

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

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

With a younger child, it is helpful to provide comfort with frequent hugging and cuddling, following the child's lead (for example, wanting to be held, being clingy, or wanting to talk). You should also correct misinformation and

answer questions without giving more information than what was asked for.

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

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

How do you know if more help is needed?

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

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

Mandated Reporting

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

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

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

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

<http://www.safestartcenter.org>

1-800-865-0965

info@safestartcenter.org

Additional Resources

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

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Family Violence Prevention Fund. (2009). *Connect: Supporting Children Exposed to Domestic Violence, In-Service Training for Resource Families*. San Francisco: Family Violence Prevention Fund. <http://www.endabuse.org/content/features/detail/1314/>

National Child Traumatic Stress Network. (2011). *Parenting in a Challenging World*. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services. <http://www.nctsn.org/print/72>

Safe Start Center. (2009). *Healing the Invisible Wounds: Children's Exposure to Violence, A Guide for Families*. North Bethesda, MD: Office of Juvenile Justice and Delinquency Prevention, Office of Justice Programs, U.S. Department of Justice. <http://www.safestartcenter.org/pdf/caregiver.pdf>

A Guide to Caregiving Following a Stressful Event



1. **Take Care of Yourself:** In order to help your child during or following a stressful event, you need to help yourself first. Children learn how to respond and cope by watching others. If you are calm in the face of stress, this may help your child learn how to handle the same event in a more healthy way.

What does this mean?

1. Tune into your own emotions. Monitor how you handle daily interactions with your child, especially times that might increase your stress (e.g., your child tantruming in the grocery store). If you are feeling too stressed or upset, take a break or calm yourself in the moment in a healthy way.
 2. Identify potential triggers for your stress: For example, can you easily handle when your child is aggressive but struggle when your child is crying? Identifying your “hot buttons” and adjusting your way of handling these situations will help you react in a more healthy way. List an example of one of your “hot buttons” below:
 1. _____
 3. Identify and practice healthy coping skills: When you are upset, what do you do to feel better? Many people find that **Taking a Few Slow Breaths** helps them cope when stressed. **Calling a friend/neighbor** or **Taking a 5-minute Break** in another room may also help. Identify 3 ways you can help yourself feel better when you are upset below:
 1. _____
 2. _____
 3. _____
2. **Ask for Help:** If you realize that you are having a hard time following a stressful event, it’s ok to ask for help. Knowing when you need help and asking for it is a sure sign that you are giving your child the best care possible. Resources such as **The Disaster Distress Helpline (1-800-985-5990)** provides immediate crisis support to people affected by stressful events in the community. Please feel free to also call our clinic at **(410) 328-5881** with any additional referral needs (e.g., crisis response, therapy).

Helping Young Children Cope with Upsetting Events

- ✓ Young children can be affected by upsetting events, even if they seem unaware.
- ✓ Children of the same age, exposed to the same event, may show very different reactions.
- ✓ Reconnecting children with familiar adults and routines helps them manage their feelings about scary events.
- ✓ Most children will recover on their own without needing any services.

What should I say? What can I do to help my child?

<i>When I act this way, I want you to know that:</i>	<i>You can help me when you:</i>
I might try to get your attention because I am scared or worried that something might happen to us. Sometimes I worry that scary things will happen in my neighborhood again. Sometimes I cry and cling to people I love because I worry that they will not come back if they leave. I don't like to do some things that remind me of the scary things I saw or heard about.	Spend a little more time with me. Remember that I am not trying to bother you or make you mad. You can help me by telling me that you are doing everything you can to keep me safe. You can help me say "good bye" and tell me that you will always come back. Be patient with me, and if you can, don't make me do things that remind me of what happened if it still makes me too upset or scared.
I am confused about what happened in my neighborhood, so I ask a lot of questions.	Remember that I am curious and trying to learn. Tell me honestly what happened, using words I can understand, but do not provide complicated or gory details. Notice my cues if I'm getting upset. Help me express myself by drawing a picture about what I know and how I feel.
I try to make sense of what happened when I play over and over or talk a lot about things I saw or heard, such as fires, police, weapons, or people hitting each other.	Understand that I need help making sense of what happened. Do not let me see it on TV or other media if the story is in the news. Reassure me that you are doing everything you can to keep me safe.
I might have physical reactions like stomach aches and headaches.	Help me do things that make me feel calm, and spend time doing fun things with me. Help me relax at bedtime by reading stories, listening to music and reminding me that you will keep me safe.
I might show you that I am feeling scared by crying, hitting, or biting.	Understand that I may be acting out because I am scared or confused about what happened. Please stay calm and be patient with me while setting limits.

When should I seek additional support? Below is a more complete list of common reactions in young children. After several weeks, if you notice any of these behaviors are not improving, or if you are concerned about your child at any time, you may need some additional support.

- ✓ Physical complaints, like upset stomach or headache
- ✓ Repeatedly talking about or playing about what they saw or heard
- ✓ Nightmares or distressing memories during the day
- ✓ Startling easily to loud noises, being jumpy
- ✓ Separation anxiety, clinginess, fussiness, or other new fears (the dark, monsters, going to the bathroom alone)
- ✓ Regression in development (loss of toilet training skills, baby talk) or new difficulties sleeping or eating
- ✓ Fighting, biting, or hitting

If you have concerns about your child, please talk to your child's teacher, school mental health consultant, school principal/director, or counselor/therapist to obtain information and referrals.



Tips for Parents & Caregivers of Children who have Experienced Trauma

By Bruce D. Perry, MD, Ph.D.

- 1. Nurture these children.** Be physical, caring and loving while being mindful that in some children touch may be associated with pain, torture or sexual abuse. In such cases, carefully monitor how they respond and act accordingly. Provide replacement experiences that should have taken place during their infancy, realizing that their brains are now harder to modify, requiring a more in-depth bonding experience to help develop attachment.
- 2. Try to understand the behaviors before punishment or consequences.** Learn about attachment, bonding, normal and abnormal development in order to develop useful behavioral and social interventions. Hoarding food, for instance, should not be viewed as stealing but as a predictable result of being food deprived during early childhood. Punishing this behavior will increase the child's sense of insecurity and ultimately the need to hoard food. Get help from professionals in order to implement a practical, useful approach to such behaviors.
- 3. Parent these children based on emotional age.** Abused and neglected children often are socially and emotionally delayed. When frustrated or fearful, they will regress so that a ten-year-old child may emotionally act as a two-year-old. Interact with them at their emotional level, parenting them as if they were two if they are tearful, frustrated and overwhelmed. Use soothing, non-verbal interactions, holding and rocking them while singing quietly.
- 4. Be consistent, predictable and repetitive.** Maltreated children are sensitive to changes in schedule, transitions, surprises and any new situation. Birthday parties, sleepovers, the start or end of a school year can be overwhelming. Be consistent, predictable and repetitive to increase feelings of safety and security.
- 5. Model and teach appropriate social behaviors.** Both model and narrate appropriate behavior with a play by play description, "I am going to the sink to wash my hands before dinner because..." Coach on ways to play and interact, explaining why another child might be upset if you take an object from them during a game. In cases of inappropriate physical contact behavior, gently guide with few words, relying on nonverbal cues.
- 6. Listen to and talk with these children.** Find and make time to stop, sit, listen and play with a child so that they will sense that you are there just for them. Use such moment to reach and teach about feelings. Instill the principles that all feelings are okay to feel, modeling healthy ways to act, exploring how others may feel and how they show their feelings. Help children to put words and labels to their feelings.
- 7. Have realistic expectations of the children.** A comprehensive evaluation by skilled clinicians can be helpful to define the skill areas of a child and areas where progress will be slower. Limit expectations accordingly.
- 8. Be patient with the child's progress and with yourself.** Adoptive parents may feel inadequate when love, time and efforts seem not to have any effect. Don't be hard on yourself, allotting patience for yourself as well as for your child.

9. Take care of yourself. Parents and caregivers cannot provide the consistent, predictable, enriching and nurturing care needed by traumatized children if they are depleted. Get rest and support. Respite care can be crucial.

10. Take advantage of other resources. Look for support groups for adoptive or foster families. Professionals with experience in attachment problems or with maltreated children can be very helpful. The earlier and more aggressive the interventions, the better.

RESOURCES

This information is used by permission in an excerpt from his article, "Bonding and Attachment in Maltreated Children: Consequences of Emotional Neglect in Childhood." A full copy of Dr. Bruce Perry's article is available at www.ChildTrauma.org

Tips for Parents and Caregivers Of Children who have Experienced Trauma
by Bruce D. Perry, MD, Ph.D.

Seven Tips For Minimizing Your Children's Trauma in Divorce

Posted on May 17, 2014 by attorney Rachel Elovitz (</attorneys/30342-ga-rachel-elovitz-446071.html>)

01

Keep your conflict to yourself

You're angry, scared, and your sadness hangs off you like wet sandbags. You feel your husband's infidelity was an abandonment of you and your children. You want them to know what he's done. They should know the truth, you tell yourself. But your need for a catharsis will not help you or your children. All they will hear is that their father is a bad person - and they will assume that they did something wrong to make him want to abandon them (a suggestion you will have planted in their heads and one they will nurture for years). You will be shoving a wedge between the children and their father - one that they will recognize when they get older, and which may spawn significant resentment toward you. How do I know this? It's axiomatic - and it's my experience after 18 years of family law practice and 13 years of representing the interests of children, but don't take my word for it - consult with a child specialist, a cooperative parenting expert, or a family therapist. And no, my example notwithstanding, betrayal is gender neutral. It knows just as many wives as it does husbands (but thankfully, many parents out there are committed to each other - they're just not the subject of this paper).

02

Attend to your emotional and psychological needs

Your feelings of rejection, your uneasiness, your grief - they're all a normal part of the divorce process, but if you do not address them, they can persist long after the marriage is dissolved. When you get into a funk, it's easier to stay in fetal position and to pull a blanket over your head than it is to get out of bed, but do it. Get up. Call that friend who always manages to push you back into reality. Do whatever it takes to step out of the fog that you've been wearing like a heatsheet. Instead of spending your lunch hour ruminating, give yourself permission to cease the self-flagellation. Try on vintage dresses at a consignment shop or hunt for some fabulous flea market finds that you can repurpose. And instead of venting to your colleagues (not a great idea), consider speaking to a therapist, ideally someone with some expertise in dealing with families in transition.

03

Be respectful of your child's other parent

It's not enough to abstain from demeaning your spouse in your child's presence. You have to make a concerted effort to speak well (or not at all) of your child's other parent to third parties, unless you want your child to suffer the consequences when those third parties repeat what you've said to their children and their children repeat it to your child. Your child sees himself or herself as an extension of you and your spouse, so when you badmouth the child's other parent, your child is likely to internalize your insults.

04

Share the news with your children together

You are, G-d willing, going to be parents of the same children for a long time. You will be at doctor visits, parent-teacher conferences, birthday parties, soccer games, tennis tournaments, swim meets, ballet recitals, drama productions, and graduations together...and eventually weddings, baby showers, baptisms, confirmations, barmitzvot.... If you want to minimize your children's discomfort, present a united front, starting with telling them about the divorce together. If one parent tries to beat the other to the proverbial punch, the children might perceive the divorce as being one sided. They may even perceive (however wrongly) that the other parent doesn't care about them. Forget your need to claim superiority in the marital commitment category. Make your children's psychological wellbeing your priority. Let them know that you and their other parent will continue to parent as a team.

05

Consider the consequences - make empathetic decisions

When making decisions that impact your children, start by imagining what it would be like to be on the receiving end of whatever decision you are making. How would you feel if your mother uprooted you from the only home you'd known and moved you into her boyfriend's apartment before your parents' divorce was final? How would you feel if your father's girlfriend started picking you up from school and spending his parenting time with you? When your children grow up and speak to their respective therapists about their childhood, what will they say about how you safeguarded them in divorce? Will they be thankful that you road the moral high ground, or will they bemoan the myriad of ways in which you and their father used them as pawns in your conflict? Will they blame you for their endless string of failed relationships and inability to trust?

06

Invest in your family, not in litigation

A judge doesn't know you and your family (and if he or she does, then he or she should probably be recusing himself or herself from hearing your divorce case). So, unless you want a stranger deciding what kind of custody and parenting time arrangement is best suited for you and your children, talk to your attorney about potential avenues for reaching an amicable resolution: negotiation, mediation, a collaborative process, judicially hosted settlement conference, etc. You might also speak jointly to a child specialist who can help you understand what kind of parenting time schedule would be best for your child depending on his or her age and stage of development, your family dynamic, proximity of you and your spouse to each other, and any other relevant factors - including your desire that each of your children be able to maintain a quality relationship with each parent. Ask about equal parenting, co-parenting, parallel parenting - the names are less important than the kind of parenting arrangement they represent, and what may be best for your family may not be best for another. So, instead of engaging in legal warfare in the hope of ending up with the same custodial arrangement as your neighbor, colleague, or best friend's cousin's nephew, do your research and find out what kind of arrangement is best for your family - for your children.

07

Always let them know they're loved

Children crave security, stability, consistency. Divorce upsets the balance with which they are familiar, even if that "balance" has been less than steady. They will be apprehensive about how the divorce will disrupt that to which they've become accustomed. They will want to know where they will live, whether they will attend the same school, how often they will see each parent,

whether they will live with their siblings, and whether the dog they love will share their home. You may not have all the answers yet, but what's most important is that when you answer them, you do so in a patient, loving, and truthful way. You and your spouse should have at least an agreed upon temporary parenting plan before you break the news of the divorce to the children.

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[Divorce and family \(/topics/divorce-and-family\)](/topics/divorce-and-family)

[Filing a lawsuit \(/topics/litigation\)](/topics/litigation)

[Family law \(/topics/family-law\)](/topics/family-law)

[Mediation \(/topics/mediation\)](/topics/mediation)

Avvo divorce email series

Sign up to receive a 10-part series of useful information and legal advice about the divorce process.

Quick Tips for Kids to Nurture Resilience



Resilience is being able to thrive in both good times and hard times. We can grow our resilience at any age.



Self-care

Sleep, exercise and healthy foods are important ways we care for ourselves.



Attachment

Time with friends and family is good for our growing minds and bodies.



Self-worth

We are important not for what we do but for who we are.



Feelings

Recognizing and naming our feelings helps us to talk about them.



Soothe

Taking care of ourselves when we are upset helps. Five deep breaths are always great!

Relationships Matter

Friends, family and caring adults including parents, coaches and teachers help us to grow our resilience.



Rules

Understanding and talking about rules helps us to be safe.



Choices

Having and making safe choices teaches us about the world.



Accountability

Mistakes are part of life. Finding the lessons in them helps us to learn.



Empathy

Thinking about how others feel helps us to have trust and respect for everyone.



Belonging

Including others builds friendship and community.

For more information:

(541) 682-8786 • aces@co.lane.or.us
Adverse Childhood Experiences Project
Lane County Health & Human Services

lanecounty.org/aces



Feelings Feelings Games and Activities



Circle Time Activity

Pass The Apple

Play this game like "Hot Potato." Ask the children to sit in a circle and give one child an apple. When the music starts, have the children pass the apple around the circle. But when the music stops, the child who is holding the apple in his hand 'becomes' Alex and yells, "Aaaaaaaaaaaaaa!!!!" just like Alex does when he's feeling angry. Then ask him, "What makes you feel angry?" Play until everyone gets a chance to be Alex. You may want to mention that the letter A makes the same sound that Alex makes when he's feeling angry.

Magic Word Book

Before the children arrive, staple some paper together and label it, "MAGIC WORD BOOK." Put Mr. Turtle's magic words on the first three pages. After the children have heard the story, let them think up magic words to add to the book. When somebody is having a difficult time expressing anger appropriately, let him or her carry the book around for a while.

Letter Badge

The children will be making a letter badge for each 'Letter Friend.' Tell the children, "Each friend you meet will have a name that begins with a different letter. At Creative Pre-K Preschool the students don't wear name tags. Instead, they wear letter badges. Alex Apple's name begins with the letter A so he will need a badge with the letter An on it." Give each child a piece of paper with a capital A drawn boldly with a black marker. Collect items that begin with the letter An and let the children glue the items onto the lines. (Remember, the letter badges are being done to introduce the children to the capital letter. This project is not the same as 'Creative Art' so it is OK to encourage the children to stay on the letter lines).

Simon Says "Feelings"

Play Simon says with the children substituting feeling phrases for the usual directions. For example, say: "Simon says, look happy." In between commands you can ask them questions about those feelings, such as "What makes you feel happy?"

Feely Faces

Make enough happy, sad, and mad faces for the children in your class. When doing circle, you can ask them how they are feeling that day. They would take the appropriate face and put it next to their name on a board.

Flannelboard activity

Cut out several circles to represent faces and draw on different emotions - happy, sad, scared, angry, sleepy, surprised. Put up first face (ex. Happy) and say, Happy face, happy face, what do you see? I see a _____ face looking at me. Put up next face and continue.

The Gift Of Friendship

Remind the children how good people feel when they give someone a gift and the person shows their appreciation. What are some ways to show your appreciation? "Thank you," "it's beautiful!", "It's just what I wanted," "I love it!" Have the children draw names and make a gift (picture) for the name they drew. Give their friend the gift. Then have the children make thank you cards with markers or crayons for the picture.

"Put-ups" Time

Go around the circle and ask each child if there is anyone they want to give a "put-up" to. (Put UP instead of down). Has anyone done something especially nice for you? Shared?, Etc. The teacher and helpers contribute too so you can make sure everyone hears his/her name mentioned. You can also write the comments down and send them home for the parents to read. It does encourage the children to remember the "good" interactions they have with others.

Faces Discussion

Put faces on flannel board: grumpy, sleepy, happy, crying, singing, startled, mad, sly and silly face. Use this story as a lead in to a discussion on how the children feel when they wake up in the morning or after a nap.

Gather a collection of pictures (cut from magazines) showing children or adults experiencing one of the emotions. Glue to identical sizes of heavy construction paper or card stock. Number pictures on the back), laminate. Use them for these activities:

Activity 1: During circle time, hold up one of the pictures and ask the children how this person feels. (If they do not know, tell them.) Ask the children to talk about what they see that makes them think the person feels that way. Point out facial expressions or other features which suggest the emotion.

Activity 2: Stack at least three pictures of each emotion on a table in your daycare. Mix up the order of the pictures. Hand the stack to a child and ask him to group all the sad pictures together, then all the happy ones and so on.

Activity 3: Either at a table or during circle time, show several pictures portraying the same emotion and ask the children to identify how all the people feel.

More:

You can show illustrations from children's books that visually represent emotions.

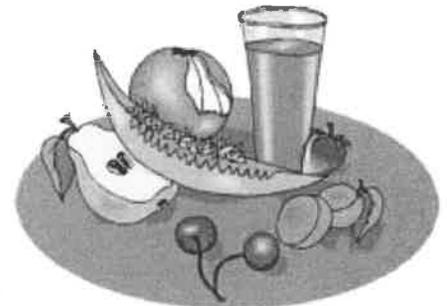
Mirror Anatomy (game)

Children can practice naming the parts of their bodies while looking in a mirror. They will also enjoy practicing different facial expressions. Observing how they look when they have different feelings inside helps children to understand the body language of others.

Feelings Recipes and Snacks

Rice Cake Faces

Spread with peanut butter, use raisins, red hots, chocolate chips, nuts, etc. to make own face for snacks. Have the children choose an emotion to convey. A similar idea could be used for English muffin pizzas.

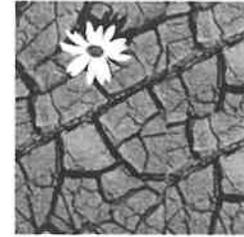


Feelings Songs, Poems and Finger

Resources for More Information



USFSP
 UNIVERSITY OF
 SOUTH FLORIDA
 ST. PETERSBURG
 Family Study Center



"Resiliency"

Pinellas County Supports for Trauma and Traumatic Stress:

If you have experienced trauma and toxic stress in your life and are looking for support, contact the resources below for assistance or treatment. Call the 2-1-1 resource line for other needed services.

2-1-1 Tampa Bay Cares, Inc.- 14155 58th St, Suite 211, Clearwater, FL 33760
211 Pinellas: 727-210-4211 / www.211tampabay.org Admin Phone: **727-210-4241**

Adoption Related Services of Pinellas/Family Enrichment Services - 3941 68th Ave. N, Pin. Park, FL
727-657-7761 / www.arsponline.org

Provides emotional/behavioral screening & interventions, counseling, focus on strengthening child-caregiver dyad, promote positive attachment & parenting skills, address trauma and developmt. concerns.

Directions for Living- 1437 South Belcher Road, Clearwater, FL 33764
727-524-4464 / www.directionsmh.org

Offering behavioral health services for adults and children in need of mental healthcare or substance abuse treatment, and prevention, wellness and recovery.

Operation Par- 6150 150th Ave. N, Clearwater, FL 33760
(727) 507-4673 / www.operationpar.org Drug Addiction Treatment Center

Personal Enrichment through Mental Health (PEHMS) - 11254 58th St. N. Pinellas Park, FL 33782
727-545-6477 / www.pemhs.org

Provides mental health services for children & adults. Emergency crisis intervention, inpatient and outpatient, residential treatment, emergency shelter, community-based programs, including therapeutic foster care, crisis intervention for children, Family Emergency Treatment Center.

Suncoast Center- 2960 Roosevelt Boulevard, Clearwater, FL 33760, 4024 Central Ave St. Petersburg
727-388-1220 / www.suncoastcenter.org

Provides services for children , adults & families exposed to trauma, sexual abuse and assault.

24-Hour Domestic Violence Support:

Community Action Stops Violence (CASA)- St. Petersburg- **(727) 895-4912**

The Haven Domestic Violence Shelter- Clearwater- **(727) 442-4128**

Florida [FCADV]: **(800) 500-1119** National Hotline: **(800) 799-SAFE (7233)**

24-Hour Suicide Hotline:
727-791-3131

24-Hour Mental Health Assistance:
727-541-4628

24-Hour Rape Crisis Hotline:
727-530-RAPE (7273)

Peace for Tarpon- Trauma Informed Community Initiative to support Tarpon Springs residents and organizations. www.peace4tarpon.org

Web Resources for further information:

- National Child Traumatic Stress Network- www.nctsn.org, or <http://www.nctsn.net>
- National Institute of Mental Health- www.nimh.nih.gov, Veterans Administration- www.ptsd.va.gov
- Florida Association for Infant Mental Health- www.faimh.org , Zero To Three- www.zerotothree.org
- American Psychological Association- www.apa.org/topics/trauma
- Boston Witness to Violence Project- www.childwitnessstoviolence.org
- Trauma Informed Child Welfare Practice Toolkit
<http://www.chadwickcenter.org/CTISP/images/TICWPracticeToolkit.pdf>
- Trauma-sensitive schools - <http://traumasensitiveschools.org/>
- Harvard Center for the Developing Child- www.developingchild.harvard.edu/

Purchase or download a free copy of “Helping Traumatized Children Learn at:

<http://traumasensitiveschools.org/tlpi-publications/download-a-free-copy-of-helping-traumatized-children-learn/>

Purchase or download a free copy of “A Guide to Creating Trauma-Sensitive Schools at:

<http://traumasensitiveschools.org/tlpi-publications/download-a-free-copy-of-a-guide-to-creating-trauma-sensitive-schools/>

Watch a free video: “Five Core Ideas of Helping Traumatized Children Learn” by Michael Gregory, a Senior Attorney on the staff of the Trauma and Learning Policy Initiative and an Assistant Clinical Professor at Harvard Law School shares the five core ideas of *Helping Traumatized Children Learn Volumes One and Two* at

<http://traumasensitiveschools.org/tlpi-publications/>

Purchase or download a free copy of the “Educational Rights of Children” at:

<http://traumasensitiveschools.org/tlpi-publications/download-a-free-copy-of-educational-rights-of-children-affected-by-homelessness-and-domestic-violence/>

Center for Disease Control ACE Study:

<http://www.cdc.gov/violenceprevention/acestudy/>

The Adverse Childhood Experiences Study Website:

<http://acestudy.org/>

BOOK: A Terrible Thing Happened: A Story for Children Who Have Witnessed Violence or Trauma

<http://www.apa.org/pubs/magination/4417017.aspx>

BOOK: Child Protection: A Guide for Teachers and Child Care Professionals

http://www.bookdepository.com/Child-Protection-Freda-Briggs/9781864482218?a_aid=traumabooks

BOOK: Trauma-Through a Childs Eyes: Awakening the Ordinary Miracle of Healing

http://www.bookdepository.com/Trauma-Through-Childs-Eyes-Peter-Levine/9781556436307?a_aid=traumabooks

BOOK: The Healing Power of Play: Working with Abused Children

http://www.bookdepository.com/Healing-Power-Play-Eliana-Gil/9780898624670?a_aid=traumabooks

Briefs/Articles/Reports:

This policy brief discusses the need for high quality child care for infants and toddlers. It outlines research showing the benefits of high quality care and the effectiveness of various quality improvement strategies. It also offers policy recommendations for ensuring all young children have access to child care that meets their needs

http://www.zerotothree.org/public-policy/policy-toolkit/child_caremar5singles.pdf

This report presents the compelling evidence for addressing the needs of infants and toddlers in the child welfare system and outlines the important steps that can be taken in policies, programs, and practices to address the needs of this vulnerable population.

<http://www.zerotothree.org/public-policy/federal-policy/childwelfareweb.pdf>

This policy brief explains why healthy social and emotional development is critical for all children. It outlines research linking infant early childhood mental health with success in school and adulthood and offers policy recommendations for promoting infants’ and toddlers’ healthy social and emotional development

<http://www.zerotothree.org/public-policy/policy-toolkit/mentalhealthbriefweb1-13-13.pdf>

This publication prepared for the Substance Abuse and Mental Health Services Administration (SAMHSA) presents resources that service providers, advocates, and practitioners can use to better understand and engage their communities in responding to children whose caregivers are negatively impacted by mental illness, substance abuse, or trauma:

<http://store.samhsa.gov/shin/content/SMA12-4726/SMA12-4726.pdf>

Associations Between Adverse Childhood Experiences, High-Risk Behaviors, and Morbidity in Adulthood

Adverse Childhood Experiences and Prescribed Psychotropic Medications in Adults

Adverse Childhood Experiences, Military Service, and Adult Health

Adverse Childhood Experiences and Chronic Obstructive Pulmonary Disease in Adults

Adverse Childhood Experiences and the Risk of Premature Mortality

Adverse Childhood Experiences

Childhood Adversity and Adult Chronic Disease

Adverse Outcomes to Early Middle Age Linked With Childhood Residential Mobility

Childhood family violence history and women's risk for intimate partner violence and poor health

Abuse in Childhood and Adolescence As a Predictor of Type 2 Diabetes in Adult Women

Adulthood Stressors, History of Childhood Adversity, and Risk of Perpetration of Intimate Partner Violence

Relationship of Childhood Abuse and Household Dysfunction to Many of the Leading Causes of Death in Adults

Women's Experience of Abuse in Childhood and Their Children's Smoking and Overweight

Adverse Childhood Experiences and Chronic Obstructive Pulmonary Disease in Adults

Childhood Adversity and Combat as Predictors of Depression and Post-Traumatic Stress in Deployed Troops

Risky Driving Among Regular Armed Forces Personnel from the United Kingdom

Adverse childhood exposures and alcohol dependence among seven Native American tribes

Child Maltreatment's Heavy Toll

Long-Term Consequences of Childhood Sexual Abuse by Gender of Victim

Building a Framework for Global Surveillance of the Public Health Implications of Adverse Childhood Experiences

Adverse Childhood Experiences, Military Service, and Adult Health

Childhood Adversity and Adult Reports of Food Insecurity Among Households With Children

Child Abuse and Epigenetic Mechanisms of Disease Risk

Trauma Informed Care Toolkit

RESOURCES

GENERAL INFORMATION ABOUT TRAUMA AND TRAUMA-INFORMED CARE:

- ❖ **ACE Connections:** Community of practice website providing a wide range of information and resources including articles, blog, media library etc.

<http://www.acesconnection.com/home>

- ❖ **Adolescent Health Working Group-“Trauma and Resilience”:** Thorough overview of trauma and its impact on adolescents, resilience and trauma informed care.

<http://rodriguezgsarah.wordpress.com/about/>

- ❖ **Child Trauma Academy- “Surviving Childhood: An Introduction to the Impact of Trauma”:** Online course about trauma and its impact on children.

http://www.childtraumaacademy.com/surviving_childhood/lesson01/page01.html

- ❖ **Crisis Prevention Institute-“Top 10 Recommended Trauma-Informed Care Online Resources”:** Links to 10 websites with many resources for training, screening, etc.

<http://www.crisisprevention.com/Blogs-CPI/Blog/April-2012/Top-10-Recommended-Trauma-Informed-Care-Online-Res>

- ❖ **Find Youth Info:** Provides information, strategies, tools, and resources for youth, families, schools and community organizations related to a variety of cross-cutting topics that affect youth

<http://www.findyouthinfo.gov/youth-topics>

- ❖ **JBS International, Inc. and Georgetown University National Technical Assistance Center for Children’s Mental Health, Trauma Informed Care: Perspectives and Resources:** A comprehensive, video-enhanced website regarding trauma informed care in many settings.

<http://trauma.jbsinternational.com/Traumatool/index.html>

- ❖ **The National Center on Family Homelessness-“Trauma-Informed Organizational Toolkit”:** Comprehensive guidance for developing a trauma-informed organization including an organizational self-assessment.

<http://www.familyhomelessness.org/media/90.pdf>

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- ❖ **National Child Traumatic Stress Network:** Comprehensive website about childhood trauma across the age span. Information is available for parents/caregivers, professional, educators, the media, etc.
<http://www.nctsn.org/>
- ❖ **National Council for Community Behavioral Health Care, “How to Manage Trauma”** User friendly infographic explaining trauma, its impact and coping strategies.
<http://www.thenationalcouncil.org/wp-content/uploads/2013/05/Trauma-infographic.pdf>
- ❖ **National Institute for Trauma and Loss Center:** Training resources for clinicians and organizations including trauma certification.
<https://www.starr.org/training/tlc>
- ❖ **Raising of America, Wounded Places:** Documentary series to be released in Spring 2015 about the importance of early childhood, “Wounded Places” addresses the impact of community violence on children of all ages.
http://www.raisingofamerica.org/wounded-places?utm_source=+RA+List%3A+3+DVDs%2C+updated+temp+site%2C+etc.&utm_campaign=RA+List%3A+Three+DVDs%2C+Updated+Website%2C+and+more%21&utm_medium=email
- ❖ **SAMHSA, Trauma and Justice-Trauma Definition:** Overview of trauma and trauma-informed approach.
<http://www.samhsa.gov/traumajustice/traumadefinition/index.aspx>
- ❖ **SAMHSA, Concept of Trauma and Guidance for a Trauma Informed Approach:** A summary of key assumptions, principles and domains of trauma informed care.
<http://store.samhsa.gov/shin/content//SMA14-4884/SMA14-4884.pdf>
- ❖ **SAMHSA-HRSA Center for Integrated Health Solutions:** Includes a section on trauma informed care in health care settings.
<https://www.integration.samhsa.gov>
- ❖ **Trauma Informed Care Project:** Resources and training for developing trauma informed care organizations and communities.
<https://www.traumainformedcareproject.org/index.php>

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- ❖ **University of Iowa, Community Connections – “Creating Cultures of Trauma-Informed Care: A Self-Assessment and Planning Protocol”:** Detailed assessment and protocol for creating trauma-informed organizations.

<http://www.healthcare.uiowa.edu/icmh/documents/CCTICSelf-AssessmentandPlanningProtocol0709.pdf>

- ❖ **VA National Center for PTSD:** Resources for identification and treatment of PTSD, extends beyond military veterans.

<http://www.ptsd.va.gov/>

NEUROSCIENCE AND TRAUMA:

- ❖ **CNS Forum Lundbeck Institute:** Provides images of brain anatomy and physiology as well as brain changes associated with various mental and physical health problems.

<https://www.cnsforum.com/educationalresources/imagebank>

- ❖ **LDOnline:** The symptoms of ADD/ADHD often overlap with symptoms of traumatic stress. This website provides information & resources for parents & teachers.

www.ldonline.org

- ❖ **The Leadership Council on Child Abuse and Interpersonal Violence:** Articles about the effects of childhood trauma on brain development.

<http://www.leadershipcouncil.org/1/res/brain.html>

- ❖ **Understood for Learning and Attention Issues:** The symptoms of ADD/ADHD often overlap with symptoms of traumatic stress. This website provides information & resources for parents.

www.understood.org

CREATING TRAUMA INFORMED SCHOOLS:

- ❖ **CBITS-Cognitive Behavioral Intervention for Trauma in Schools:** School-based group and individual intervention. Information and training offered.

<http://cbitsprogram.org/>

- ❖ **Center for School Mental Health- “Tools for Clinicians”:** List of resources related to school crisis response, many other resources related to mental health services in schools.

<http://csmh.umaryland.edu/Resources/ClinicianTools/index.html>

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- ❖ **Mulloy, Maura, Ph.D. “Resilience-Building Schools for At-Risk Youth: Developing the Social, Emotional, and Motivational Foundations of Academic Success”:** Provides a model/framework for resilience building in schools.

info@civicrosearchinstitute.com

- ❖ **National Child Traumatic Stress Network-“Resources for School Personnel”:** A comprehensive array of resources for schools regarding trauma.

<http://www.nctsn.org/resources/audiences/school-personnel>

- ❖ **Treatment and Services Adaptation Center-“Support for Trauma-Informed Schools & Resources for Traumatic Stress”:** Offers info about trauma-specific interventions for schools, including Psychological First Aid (PFA); Cognitive Behavioral Intervention for Trauma in Schools (CBITS); Support for Students Exposed to Trauma (SSET) and general info about trauma and school populations and secondary traumatic stress.

<http://traumaawareschools.org/>

- ❖ **Wisconsin Dept. of Public Instruction – “Creating Trauma-Sensitive Schools to Improve Learning”:** Comprehensive toolkit including webcasts, videos, articles, presentation materials, and links to other websites.

http://ssp.wi.gov/ssp_wi_mhtrauma

TRAUMA-SPECIFIC SCREENING, ASSESSMENT & INTERVENTIONS:

- ❖ **Act for Youth: “Trauma Screening and Assessment Tools for Children and Adolescents”:** Overview of trauma screening and assessment tools including domains assessed, age, format, and information about training and costs.

<http://www.actforyouth.net/resources/pd/trauma-assess-tools.pdf>

- ❖ **Child Welfare Information Gateway-Screening and Assessment for Child Trauma:** Provides information regarding screening and assessment tools.

https://www.childwelfare.gov/systemwide/assessment/family_assess/childneeds/trauma.cfm

- ❖ **National Child Traumatic Stress Network- “Measures Review Database”:** Detailed review of evidenced-based measures regarding children’s experiences of trauma, their reactions and other mental health and trauma-related issues.

<http://www.nctsn.org/resources/online-research/measures-review>

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- ❖ **National Registry of Evidence-based Programs and Practices-“Interventions with outcomes related to PTSD”:** Provides overview of a wide range of interventions related to traumatic stress, notes those that are for school-aged and adolescents.

<http://www.nrepp.samhsa.gov/SearchResultsNew.aspx?s=b&q=PTSD>

- ❖ **Polaris Project-National Human Trafficking Resource Center:** Provides information and resources for identifying and intervening on behalf of children and adults who are victims of human trafficking.

www.polarisproject.org

- ❖ **Starr Commonwealth-“Resources for Parents & Professionals-Activities”:** Activities for children and adolescents to support trauma recovery.

<https://www.starr.org/research/activities>

- ❖ **RAAPS:** Website for screening tool used by many CAHC sites.

<https://www.raaps.org>

- ❖ **US Dept. of Veterans Affairs PTSD: National Center for PTSD- “Child Measures of trauma and PTSD”:** A list of child and adolescent trauma and PTSD measures.

<http://www.ptsd.va.gov/professional/assessment/child/index.asp>

- ❖ **WMU Children’s Trauma Assessment Center:** Resource for comprehensive assessment of children exposed to trauma; also provides extensive training for a variety of organizations.

<https://www.wmich.edu/traumacenter>

RESILIENCE:

- ❖ **Center for the Study of Social Policy-Strengthening Families –** Information about strengthening families’ framework and protective factors for families, youth and communities.

<http://www.cssp.org/reform/strengthening-families/the-basics/protective-factors>

- ❖ **Children’s Resilience Initiative: “Resilience Trumps ACEs”:** Card game and other teaching tools for promoting the development of resilience strategies.

<http://resiliencetrumpsaces.org/>

- ❖ **National Institutes of Health, US National Library of Medicine-“Use of the Revised Posttraumatic Growth Inventory for Children”:** Article regarding tool that assesses resilience in children.

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<http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2827205/>

SECONDARY TRAUMATIC STRESS:

- ❖ **Professional Quality of Life:** Provides theory related to compassion satisfaction and fatigue as well as ProQOL tool, presentation materials available.

http://proqol.org/Home_Page.php

- ❖ **Trauma Stewardship Institute:** Website describing book – “Trauma Stewardship: An Everyday Guide to Caring for Self While Caring for Others”.

<http://traumastewardship.com/the-book/inside-the-book/>

ONLINE TRAINING OPPORTUNITIES:

- ❖ **Cognitive Behavioral Intervention for Trauma in Schools:**

www.cbitsprogram.org

- ❖ **Structured Sensory Interventions for Children, Adolescents and Parents (SITCAPS) (AKA TLC-National Institute for Trauma and Loss | Children):**

www.starr.org/training/tlc

- ❖ **Trauma Focused Cognitive Behavioral Therapy (TF-CBT):**

www.tfcbt.musc.edu

- ❖ **Trauma Affect Regulation: Guide for Education and Therapy (TARGET):**

www.advancedtrauma.com

- ❖ **Mindfulness Fundamentals:**

www.mindfulschools.org/training/mindfulness-fundamentals

SPANISH LANGUAGE RESOURCES

- ❖ **National Child Traumatic Stress Network:** several of their publications/pages are available in Spanish, look at resources and audiences.

www.nctsn.org

- ❖ **Trauma Focused Cognitive Behavioral Therapy:** Spanish language materials available.

www.tfcbt.musc.edu

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- ❖ **Center for Health and Health Care in School:** Has a section on addressing the needs of immigrant and refugee communities.

www.healthinschools.org

- ❖ **Mental Health.Gov:** Has a section of materials in Spanish.

www.mentalhealth.gov



**September 16,
2016**

**8:00 - 5:00 pm
Continental Breakfast,
Lunch and
Reception**

**LOCATION:
USF St. Petersburg
USC 200 6th Ave S.
St. Petersburg, 33701**



**Thank You
Sponsors!**

Adverse Childhood Experiences: Recognized and Addressed in Family Court

Participants:

USF St. Petersburg, Judges,
General Magistrates, Child
Support Hearing Officers,
and Case Managers of the
6th Circuit Family Law Division;
Family Law Attorneys; and the
Mental Health & Medical Community



Training Content: Understand Trauma, Toxic Stress and ACEs and their effect on Children and Families. Develop a collaborative partnership with The Family Court, Family Attorneys, and Mental Health Community to Effectively address the trauma and toxic stress in high conflict Family Law cases

