

FOCUS

Newsletter of the Foster Family-based Treatment Association



Implementing the Neurosequential Model of Therapeutics™

by Kathleen Ayala, MSW and Tim Grove, MSW

SaintA has been committed to implementing the Neurosequential Model of Therapeutics™ (NMT™) since 2008, working closely with Dr. Bruce Perry and the ChildTrauma Academy staff, as well as its NMT™ partners and colleagues. Our journey has been demanding and yet remarkably rewarding, teaching all of us about children, their families and the communities in which they grow up. We have learned a few lessons along the way:

- Trauma is important but not all-inclusive. Neglect, relational interactions, neurobiological capability and other developmental opportunities are also very salient
- Resilience is primarily fostered by the strength of a child's connection to his core groups (family, community, system)
- The capability of parents/care-givers is the most significant variable in child well-being
- The children and families we serve are our best teachers and resources for their own healing
- Hope is indeed possible

H's story below illustrates the unique perspective that the NMT™ process

offers. It is a story of hurt and hope, and how dedication and compassion created opportunities to heal and grow.

H came to his current SaintA treatment foster home after multiple placements and disruptions. This home was H's fourth foster home, following removal from his birth parent's custody for the second time. At only seven years old, H had spent the majority of his life in foster care. Throughout his life, H experienced significant adverse events without the buffering of a stable, healthy adult. His parents struggled with mental health disorders diagnosed as schizophrenia and depression, ADOA and their own chaotic/neglectful childhood experiences, all of which impeded their ability to respond to H's needs and provide an optimal environment for development. In addition, H witnessed domestic violence, experienced the loss of his father's involvement in his life, homelessness, medical trauma, and several transitions, such as the removal from his family of origin. With this lack of consistency and predictability in his life, H displayed many challenging behaviors when placed with SaintA. These behaviors created

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— by Gretchen Test, MSW

Trauma-informed Care

This issue of *FOCUS* explores a theme that, just a few years ago, seemed like a “hot topic” and has now become integrated into our everyday lexicon — trauma-informed care.

According to the National Child Traumatic Stress Network, “child traumatic stress occurs when children and adolescents are exposed to traumatic events or traumatic situations, and when this exposure overwhelms their ability to cope with what they have experienced.”¹ It can be the results of acute traumatic events (such as sudden loss of a loved one or physical assault) or due to chronic traumatic situations (such as long-standing sexual abuse). Children can react differently to trauma depending on many factors, and healing approaches that are tailored to a child’s age, experience, culture, gender, etc. are critical. Thanks to a growing body of brain science and child development research, as well as emergence of more evidence-based programs, we know much more about how to help kids who’ve experience trauma to heal, grow and thrive.

In this *FOCUS* you’ll learn just what trauma-informed care looks like for an organization, its staff, families and youth. We begin with a wonderful and hopeful story by Kathleen Ayala and Tim Grove of SaintA in Wisconsin about “H”, a young boy who had experienced many traumas. Using an approach called *Neurosequential Model of Therapeutics™* (NMT™) “H” improved significantly and, well, you have to read the article for the happy ending!

In *Kasserian Ingera* we learn about FFTA member PATH’s trauma-informed care for a young child who has experienced multiple and severe traumas including witnessing domestic violence and experiencing sexual

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significant difficulty in stabilizing and maintaining him safely in the home and community. His diagnoses included ADHD, reactive attachment disorder (RAD) and post-traumatic stress disorder (PTSD). He was having multiple explosive tantrums each week that involved property destruction as well as verbal and physical aggression. In addition, H had put himself at significant risk for harm, which required the foster parent to provide line-of-sight supervision. If she needed to be away from the home, alternate programming had to be arranged for H, because he was not able to be safely maintained with another adult for periods of more than 30 minutes. H’s biggest triggers appeared to be transitions and intimacy. It was very difficult to prevent H’s tantrums; however, the foster parent had set up the home in a way that allowed H to be safe during the tantrums. He destroyed property with his tantrums, but he had become accustomed to using his bedroom as a more appropriate place to release his physical aggression. The foster mother had developed a process within her home that, to ensure safety, required all other children to leave the area when H started to escalate. H’s explosive behavior also continued to be dangerous when he was in the community. The combination of his intense behaviors (themselves the result of a very sensitized stress response system) and a poorly matched medication regiment from his pediatrician resulted in a hospitalization stay. He had lost 30% of his body weight and was officially labeled with failure to thrive. The team had run the traditional course: individual therapy, medication management, day treatment services, etc. H was very much at risk for a residential stay. The silver lining of H’s hospitalization was that it brought the opportunity for H’s team to re-group and consider a different approach.

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Client (7 years, 3 months)

Report Date: 11/29/2012

4	7	3	3	7	2
9	9	6	3	3	8
4	5	5	3	6	9
	6	7	2	2	
	9	10	6	8	
		9	3		
		4	9		
		10	9		

Age Typical - 6 to 7

7	7	7	7	7	7
9	10	9	7	7	8
8	9	10	10	8	10
	10	9	9	10	
	9	11	10	8	
		12	10		
		12	12		
		11	12		

Table 1 (left) represents H’s (Client) brain “map” at the beginning of services. The “map” is a part of the NMT process that approximates developmental capability across 32 functional items like cardiovascular/ANS, temperature regulation/metabolism, attention/tracking, sleep-sensory integration, attunement/empathy, speech/articulation, reading/verbal, etc. A numerical score is given by the clinician in collaboration with the team for each of the 32 items with 1 being the lowest score and up to 12 being the highest score. When you compare H’s “map” to an age typical map, the effect of H’s developmental experiences is evident.

abuse. This story highlights the role of trauma expert Dr. Bruce Perry in working with the team of clinicians and foster parents to help Cheyenne build a set of six core strengths in her path to wellness.

J. Kellie Evans and Ronnie Gehring of The Up Center in Virginia describe a deliberate process of *organizational transformation*, with a specific focus on what changed for resource parents, from recruitment and assessment, to the home study and training, to improved foster family supports and services and involvement in quality improvement.

Kimberley Bradley of Seneca Family of Agencies in California discusses *practice approaches and principles for supporting caregivers and birth parents*, including parenting unconditionally, understanding and acknowledging their own emotional or traumatic experiences. By better understanding themselves, Bradley argues, parents can better help the children in their care.

Christine Bowlby of Right Turn of Nebraska stresses the *importance of vicarious trauma* and its impact on staff well-being, behavior and job performance, and offers practical tips for supervisors and agency leaders to recognize that "it's there" and to create a supportive environment that will help staff and strengthen the agency.

These articles are just a sampling of the expertise of our members. Thanks to all of our authors for giving of their valuable time and writing skills. Do you want to learn more about trauma-informed care? We have also included some online resources for you to explore. Hope you enjoy...

¹ National Child Traumatic Stress Network, Defining Trauma and Child Traumatic Stress, <http://www.nctsn.org/content/defining-trauma-and-child-traumatic-stress>

Gretchen Test, MSW, is a Senior Associate at the Annie E. Casey Foundation, located in Baltimore, MD. She serves on the FFTA Board of Directors and is the Chair of the Editorial Committee.

Implementing the Neurosequential Model of Therapeutics™ | continued from pg. 2

Using the NMT™ core principles and H's NMT™ metric as a guide for understanding the challenges H faced, the team began to create their sequential priorities. The first priority was to figure out how to engage H's foster parent, recognizing that she was going to be the difference-maker. She committed to a 30-day plan that involved working with an occupational therapist and treatment foster care specialist to enhance H's regulatory capacity through exposure to a variety of somatosensory activities. Such activities included whole-body activities (riding bikes, playing basketball, swimming); oral activities (chewing gum, blowing bubbles, using a vibrating toothbrush); cognitive and fine motor activities (doing crossword puzzles, building Legos, playing chess). This process also involved the larger Wraparound Milwaukee team, which included seven formal supports and one informal support — H's mom. All of these team members agreed to learn all of the regulatory activities and used them during their time with H. Ongoing psycho-education happened with the foster parent, as she started to make the connection between H's adverse history and the importance of regulation.

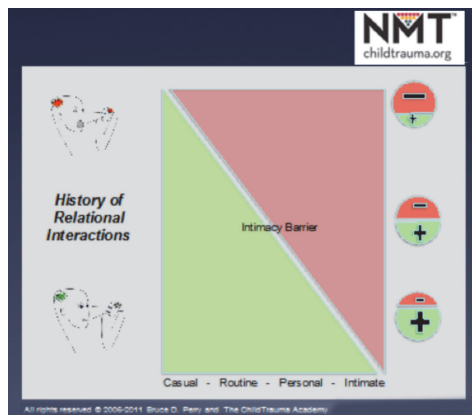


Table 2 (left) represents The Intimacy Barrier. The general premise is that children who have early experiences that are positive, safe & nurturing develop a broader capacity for engaging in interactions that range from casual to intimate and respond accordingly. Children with early experiences that are marked by fear, threat and insecurity often prioritize safety which restricts the risk they are willing to take in the same relational contexts. Like H, these children require patience, repetition and attuned caregiving so that their capacity for more intimate interactions can be gradually enhanced.

As H started to show small signs of progress, he also began to have moments where he would allow relational interactions to pass through the protective barrier he had erected. This was a remarkable NMT™-related discovery — that some kids have such a high degree of relational sensitivity that the focus must be on enhancing their regulation before attempts are made at relational connection. The foster parent was taught about H's "intimacy barrier" and learned ways to benefit from his regulatory capacity and interact with him to help him feel safe. These activities were completed the majority of the time in the context of a relationship. At first, the foster mom and other team members conducted the activities in parallel, with H slowly working to close the intimacy barrier. As time went on, the team remained committed to utilizing these activities as a way to reduce negative behaviors and increase H's ability to appropriately interact with others.

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Client (8 years, 10 months) Report Date: 6/10/2014

5	7	6	5	8	4
9	9	8	6	5	8
7	6	6	7	6	10
	8	7	5	6	
	9	10	8	7	
		10	5		
		9	10		
		11	11		

Age Typical - 8 to 10

8	8	8	8	8	8
10	11	10	8	8	9
9	10	11	10	9	11
	10	10	10	11	
	10	11	11	9	
		12	11		
		12	12		
		12	12		

Table 3 (above) represents H's brain "map" as scored by his clinician and team 18 months later, again compared to an age typical child. Notice the absence of red items compared to his first "map" and also a significant reduction in pink items. These changes suggest that the collective efforts of H's team contributed to significant gains in developmental capacity, which usually translates to positive changes in behavioral outcomes.

H's progress now moved forward at a much quicker pace. H's stress response system began to experience some much-needed regulation. This resulted in a reduction of the intensity and frequency of his aggressive episodes, from several times a week to once or twice a month. H no longer destroyed property. H began to learn to trust adults and seek out affection. He made improvements with listening to rules both at home and in the community (i.e., previously he had tried to run into the streets or leave the adults he was with, but he was now no longer considered a flight risk). His school also accepted the recommended adaptations, and sensory activities were added to his functional behavioral plan. He was able to successfully discharge from day treatment, remain on a minimal amount of medications and be described as a model student. He stabilized and is now placed with a pre-adoptive family, where he will be able to achieve permanency in several months.

H's story is one of many that are taking place in our community. A group of dedicated foster parents, professionals and teams are learning how to apply core developmental concepts to create hope and healing for the people we serve.

Kathleen Ayala, MSW, has been a social worker in the Treatment Foster Care Program with SaintA, Inc. for last 5 years.

Tim Grove, MSW, is the Chief Clinical Officer at SaintA. He spearheaded SaintA's trauma-informed care philosophy and practices, including implementing Dr. Bruce Perry's Neurosequential Model of Therapeutics™.



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“Kasserian Ingera”

—by Hank Marotske,
BSW, MBA

The mighty Masai warriors are among the most fabled tribes in Africa. They were considered the most fearsome and intelligent. The traditional greeting passed between warriors was, “Kasserian ingera,” which means in Swahili, “And how are the children?” All warriors looked for the response, “All the children are well.” This response told the warriors that life was good and all was right in the world; proper care for village children was of the highest priority.

Children come into Treatment Foster Care for many reasons, often having experienced complex traumatic life experiences. PATH’s treatment model is built around nine core components that ensure our children are well. Trauma-informed practice is a foundational component of the PATH model. It is PATH’s goal to ensure that all the children who come into our care receive the best evidence-based services available and leave care better than when they entered.

Trauma-Informed Practice and the PATH Model

PATH firmly believes our focus on evidence-based practices and trauma-informed practices has led to shortened lengths of stay in out-of-home placement (our average placement lasts 9

months) and contributed to a 79% permanency rate across our three-state organization (our most intensive programs are seeing over 80%). Children with the highest levels of severity are often referred to PATH. Often the youth placed with PATH homes have multiple diagnoses.

The PATH Family Institute has ongoing trauma-informed trainings for staff, foster parents, and our community partners. These trainings are provided by our experienced personnel, our partnership with the Neuropsychiatric Research Institute in Fargo, North Dakota, and an ongoing relationship with the ChildTrauma Academy and Dr. Bruce Perry. PATH has engaged Dr. Perry for periodic case consultation and, most recently, for a targeted, agency-wide

training in 2014 and a statewide training for professionals in health, human services, and education. Supplemental trauma-informed trainings include PRIDE, Nurtured Heart, wraparound training, Family Inclusion, and Systemic Assessment and Intervention. Primary initial treatment foster parent training is built on the National Child Traumatic Stress Network curriculum.

“Cheyenne”—A Case Example

Recently PATH consulted Dr. Bruce Perry about a particular child who has significantly stabilized under an intensively supported treatment plan. In the past year we’ve seen extraordinary progress while keeping this child in a family setting. “Cheyenne” came to PATH after a very stressful and chaotic

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residential treatment. Many members of her treatment team believed living in a family setting and in the community would never be an option for her.

Cheyenne experienced a very traumatic early childhood. The following adverse early childhood experiences greatly impacted Cheyenne's ability to organize and reflect on her environment. As we know, her brain would adapt uniquely to the stimuli within her early childhood environment:

- Her early trauma started with the umbilical cord wrapped around her neck;
- She witnessed domestic violence against her mom by her mom's numerous boyfriends;
- When Cheyenne was just 1 year old, she was brought to the emergency room with pain and swelling in her wrist. The hospital reported excoriation in the genital area, and it is believed that sexual abuse was occurring;
- Cheyenne experienced severe head trauma from falling out of a shopping cart;
- Cheyenne was reported to be sexually abused by numerous adult males over a prolonged period;

At age 5 Cheyenne was removed from her home, and her mom's parental rights were terminated at age 6. Since then Cheyenne has

- Experienced 13 out-of-home placements, including multiple psychiatric hospitalizations;
- Made numerous threats to harm adults;
- Engaged in self-harm actions, including biting, scratching, slapping, eye-gouging, head banging, and swallowing inanimate objects;
- Made several attempts to jump out of fast-moving vehicles;
- Destroyed property;
- Reported experiencing auditory and visual hallucinations; and
- Run away multiple times.

Every child coming into PATH care undergoes an initial CASII (Child and Adolescent Service Intensity Instrument) and systemic assessment of trauma to help the case manager and foster parents gain insight into early traumatic experiences, to help determine the appropriate level of service intensity, and to set a standardized baseline for behavior measurement and outcomes. PATH assesses continuously, typically every 3 months, to measure areas of change and the treatment planning impact on targeted interventions.

Cheyenne and Her Journey Along Dr. Perry's Six Core Strengths for Children

With the baseline established and an initial treatment plan set, we moved forward on the journey of helping Cheyenne build upon the Six Core Strengths.

Dr. Bruce Perry's Six Core Strengths for Children

Attachment

Cheyenne entered our program deprived of relationships. She remained emotionally connected to her birth mother despite not having had contact with her since parental rights were terminated over 4 years ago. The treatment team focused on building the child's ability to attach so that further healing could begin. Cheyenne's treatment relationships specifically focused on increasing her emotional, social, and cognitive interactions and opportunities.

Last spring PATH introduced Cheyenne to a team of staff and community professionals with the intent of creating a relation-rich environment. One team member was Cheyenne's former case manager from the Department of Health and Welfare, now working with PATH. This ensured some consis-

tency and provided a past connection to build upon. An adult male worker was able to establish a relationship in which Cheyenne tolerated his authority. PATH also ensured that all members of the treatment team were committed for the long run—case manager, support staff, and foster parents.

PATH's first priority was to make Cheyenne feel safe. When Cheyenne senses fear or uncertainty, her fight-or-flight response is initiated, and she escalates in order to protect herself. However, setting expectations and exercising parental authority calm her and help her feel safe. It is important we tell her what's going to happen and set clear expectations and boundaries before introducing any controlled stimulus.

The team also agreed to be persistent and consistent. Other components of building her trust and attachment include never trying to control her behavior as long as she's safe, staying with her during violent episodes, and allowing her to move forward once she's ready emotionally and physically.

Last, the team established procedures whereby foster parents would not restrain her. Only the treatment team members would execute a child safety hold and only in severe situations. Holds have reduced significantly over time and have evolved into inviting her to receive a hug.

Establishing this foundation of solid relationships allowed us to move on to work on self-regulation. Ongoing work will be done with Cheyenne to continue to build trusting relationships with other adults outside her core treatment team.



Self-Regulation

As Cheyenne's emotional connection to the core treatment team has increased, the team has been able to work on her self-regulation.

Because we know that the cognitive part of Cheyenne's brain is going off-line as a defense mechanism, the team is purposeful about activating this part of her brain with controlled exposure to various external stimuli including group engagement, social interaction and introduction to new people. PATH limits overexposure to social and group stimuli as that leads to feelings of intimacy for Cheyenne, and intimacy ignites her defense mechanisms. A strategy the treatment team uses to monitor her response and to control her exposure to stimulus is mirroring neurobiology.

When it comes to social exposure, the treatment team controls how often it occurs, who participates, ensuring that someone she trusts is in control, and when and how long it is allowed to continue. The more we activate her neural system in a controlled situation where she feels safe, the more that system changes to reflect that pattern of activation. We use novelty to activate the arousal system, telling her ahead of time what is going to happen next. It's important to ensure her stress is predictable, moderate, and controlled to increase her resilience. To do this, we focus primarily on somatosensory regulation techniques.

Through this process the team has been able to help Cheyenne recognize when she's escalating and identify triggers.

As a result we've noticed significantly

increased self-regulation and the ability for Cheyenne to identify and communicate when she's getting upset. She is starting to demonstrate the ability to contain impulses and to control primary urges and frustrations when the adults she's built an attachment to are present.

Affiliation

The treatment team is currently working on helping Cheyenne affiliate and be able to join and contribute to the group. Cheyenne presents significant language difficulties as she hesitates before answering questions and “talks around” target words (circumlocution). She struggles with both receptive and expressive languages, often getting frustrated when people do not understand what she is trying to say or correct her for using the wrong word.

As a result she continues to have difficulty interacting with peers and prefers to engage adults who understand her developmental level. In small-group situations, she tries to monopolize conversations and teacher attention or refuses to complete tasks. During group discussions Cheyenne will participate; however, she takes longer than average to complete her thought. Her response is a way to control the situation and is a result of her language difficulties. Her defense mechanisms make her very demanding of control in situations, and she appears argumentative and defiant.

The treatment team understands that Cheyenne thinks linearly and that whenever the environment takes her away from her linear train of thought, she needs to be pulled back and reset. It's important to understand that correcting her is threatening and invokes her defense mechanism. Staff will correct with affirmation, allow her the time she needs to finish her thoughts, and

Cheyenne has demonstrated particularly acute awareness of the needs of others at times. She just hasn't developed the social and communication skills to react and respond in real time.

possibly reframe the situation for her understanding. She has also been encouraged to write her thoughts and to journal. She is in control of sharing her journal if and when she wants. Although the team members vary, they remain consistent in their approach, which helps Cheyenne understand the expectations.

Awareness

When Cheyenne enters a heightened state of mind, her behavior can easily be interpreted as not being aware of others. Her baseline for awareness of threat is already higher than the average, healthy developed person. So when her fight-or-flight response is triggered, it looks impulsive. During this time her state of mind is no different than a healthy person's in a life-threatening situation, and she won't remember details or understand why she responded in the way she did.

The treatment team purposefully reestablishes her sense of safety before moving on and doesn't try to understand why she responded the way she did. Rather, the team identifies which of her basic needs were unmet and determines how to get her and the adults around her to recognize the triggers that preceded her heightened state and impulsive reactions.

In fact, Cheyenne has demonstrated particularly acute awareness of the needs of others at times. She just hasn't developed the social and communication skills to react and respond in real time.

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“Kasserian Ingera”™

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Tolerance

Staff believe Cheyenne is capable of understanding and accepting the differences in others; however, progress in this area will require consistency. As Dr. Perry articulated in our consultation, Cheyenne experienced 5 years of substantial traumatic abuse and another 4 years of traumatic instability. She is a 10-year-old girl who has had consistency and trauma-informed care for only 1 year. Her development of tolerance has been slow but is steady at present.

Respect

As stated previously, Cheyenne has demonstrated the ability to be aware of and have empathy for the needs of others. She also can be respectful, and she sees value in the adults in her life when she feels safe. Learning how to express respect for others will be an ongoing process as she establishes the ability to trust and develops cognitively, socially, and emotionally.

Permanency

PATH values permanency with all children we serve. With Cheyenne we've done an extensive genogram and approached family members in hopes of finding her a connection within her own family. As Cheyenne progresses through treatment we communicate openly about her progress and readiness for a permanent and stable home. The treatment team has also approached the adoptive parents of her sibling group and conducted supervised visits. Lastly, PATH is always looking for community members and friends of Cheyenne that might already have a trusting and emotional connection with her. At this point in time the treatment team has yet to find a home that is a good fit for where

Cheyenne is at in her journey. As of the writing of this article she is going to be featured on Wednesdays Child and have a profile online so others might find her and fall in love with her beautiful soul.

Looking Forward

Dr. Perry has stated that the most severe outcomes of traumatic events are permanent cognitive, social, and physical dysfunctions. In our most recent consultation, he noted that Cheyenne may never be able to function without support systems. At this time, Cheyenne is safe and doing well. However, with patience and consistency from her caretakers and support systems, she is capable of healing and progress. Kasserian ingera.

Hank Marotske, BSW, MBA, is the Director of Corporate Communications and Development at PATH Administrative Services, located in Fargo, North Dakota. He serves on the FFTA Editorial Committee. Mr. Marotske will present on foster care's image problem and how to improve community engagement at the FFTA Conference in Denver this August.



Foster Family-based Treatment Association



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“Fire can warm or consume,
water can quench or drown,
wind can caress or cut.
And so it is with human relationships:
we can both create and destroy,
nurture and terrorize, traumatize
and heal each other.”

—Bruce D. Perry, MD, PhD and Maia Szalavitz, *The Boy Who Was Raised As a Dog* as quoted in *Wounded Children Healing Home* by Jayne E. Schooler, Betsy Keefer Smalley, LSW and Timothy J. Callahan, PsyD

ORGANIZATIONAL TRANSFORMATION

—by J. Kellie Evans, LCSW, CSOTP and Ronnie Gehring, MSW

Therapeutic or Treatment Foster Care (TFC), at its very core, relies on the caregiver as its most vital resource. The impact of the relationship between child and caregiver cannot be denied. It is our duty as child welfare professionals to understand this and make our most diligent effort to assess and train caregivers so that they can provide foster children with a safe place to land AND heal. Training and assessment of this critical resource requires intense energy and ongoing attention so that foster children can receive the best possible outcome.

This article will focus on the journey of one agency, The Up Center, to improve and elevate the assessment, pre-service and ongoing training of resource parents as a critical component of TFC. Understanding that best practice has moved the field of human services to recognize the benefit of using a trauma-informed care (TIC) approach to serving those in need, The Up Center began this transformation over three years ago. As a multi-program non-profit human service agency that serves over 10,000 people annually in the Hampton Roads, Virginia region, The Up Center embarked on this transformation initially through clinical service delivery. As research, outcomes and best practice pushed this approach to the forefront, the agency began to look at ways to change “how we were doing what we were doing” in order to achieve consistency of the TIC movement across all programs, staff and stakeholders.

TIC is certainly an industry “buzz word” these days. As defined by SAMHSA (NCTIC, 2012), trauma-informed care is an approach to engaging people with histories of trauma. It recognizes the presence of trauma symptoms and acknowledges the role that trauma has played in their lives. The definition

seems simple enough, however to operationalize this, understanding the principles supporting the approach is required.

KEY PRINCIPLES ARE:

- Safety – environment promotes a sense of safety both physically and psychologically
- Trustworthiness and transparency – operations and decisions are clear and not secretive with the goal of building and maintaining trust among staff, clients and family members of people served
- Collaboration and mutuality – true partnering and leveling of power differences between staff and people served and between operations to direct care staff to management
- Empowerment – model is applied across personnel and people served
- Voice and choice – individualized approach to serving people strengthens choice
- Peer support and mutual self-help – key to organizational functioning and service delivery
- Resilience and strengths-based – belief in resilience and the ability of the collective “us” to heal and promote recovery by building on client strengths, not weaknesses
- Inclusiveness and shared purpose – recognizing that EVERYONE has a role to play in a TIC approach, as in “you don’t have to be a therapist to be therapeutic” (Gillece, 2013).

As these principles began to take shape within the agency, the TFC program began to look specifically at ways to achieve model fidelity. By attending on-site and off-site training, reading

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The basic tenet of the agency's TIC training is to shift the resource parent's thinking of the child's behavior from "what is wrong with you?" to "what happened to you?"

relevant research, analyzing program outcomes and processing all the data gathered as a team, the program staff created action plans to move this transformation forward.

Action 1: Begin to include more TIC education in our current foster parent pre-service training.

Principles of trauma-informed care are encompassed throughout all 12 pre-service training sessions, and the facilitators highlight how trauma plays a role in every topic that is discussed. Adding an entire session devoted solely to the principles and concepts of TIC has been critical. The basic tenet of the agency's TIC training is to shift the resource parent's thinking of the child's behavior from "what is wrong with you?" to "what happened to you?" Initially the TIC session was one of the last sessions held. However, prospective resource parents informed staff that having TIC principles presented to them earlier in training would have made them view the session on discipline from a different perspective.

Action 2: Begin the mutual assessment process BEFORE pre-service training begins.

This method allows for staff to continuously assess the prospective parents, while allowing for a more individualized training experience as staff is able to follow up on some of the concepts discussed in the prior classes. Not only does this model help parents get a better grasp on TIC, but it allows staff to screen out parents who are not ready or appropriate for TFC without wasting the parent's time or agency resources.

Action 3: Give each newly approved resource home a copy of *Wounded Children Healing Home* by Jayne E. Schooler, Betsy Keefer Smalley, LSW and Timothy J. Callahan, PsyD as a mandatory read.

In addition, staff is beginning to include many of the key concepts in this book into the pre-service training. All staff is required to read this book as well.

Action 4: Revamp our home study questionnaire to elicit information that is required to better assess the prospective foster parents. We used Jane Schooler and The Ohio Trauma Consortium Team's *Trauma-Informed Assessment and Preparation Toolkit* as a guide.

This revised assessment tool allows for more focus on how the prospective parent views stress, conflict and trauma in their own lives. It is also a helpful springboard into conversations that can lead to a better understanding of the family, which ultimately supports better matching.

Action 5: Enhance ongoing training for current resource parents during our monthly support group.

Small groups are formed and a topic (discipline, attachment, placement disruptions, etc.) is briefly presented, and the remainder of the time is spent having a true discussion of the topic, facilitated by agency staff. With TIC in mind, facilitators bring the child's behavior back to their trauma and teach the resource parents how to parent these children in a more trauma-informed manner.

Action 6: Offer more clinically focused interventions with foster families that take into consideration the foster family's trauma history and vicarious trauma responses to the child's functioning within the home.

Efforts are made by agency staff to connect with resource parents who are struggling with a child placed in their home, are on the verge of having a disruption, and/or had experienced an unplanned disruption. Increasing the home visits made to these families is designed to provide them with more support, and to help them realize the role of trauma in their current situation.

Action 7: Create a quality improvement committee that includes current and former resource parents.

This allows resource parents to play an active role in how the program is run, and to have voice and choice.

Action 8: Support staff in their professional development as they address the vicarious trauma that is inherent in the work of child welfare.

Through effective use of supervision, training and improved self-care skills, staff report enhanced productivity and work satisfaction, which leads to improved client outcomes in the long term.

Lessons learned along the way have let us know that there is no finish line here. The commitment to creating healing homes will always be evolving.

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J. Kellie Evans, LCSW, CSOTP is the VP of Child Welfare Services at The Up Center in Virginia. Ronnie Gehring, MSW, is the Director of Resource Home Development at The Up Center in Virginia. Ms. Evans will present "Strategies for Placing Children and Adolescents with Sexual Behavior Problems in Treatment Foster Homes" at the FFTA Conference in Denver this August.

Supporting Caregivers and Birth Parents with Building Capacity for Trauma- informed Care

—by Kimberly Bradley, PsyD

The Trauma-informed care movement has begun! There is currently an enormous amount of information and training available on developing trauma-informed care, treatment, services and service delivery within health, mental health and social service agencies. For child welfare systems nationwide, there are considerable federal and state efforts/projects aimed at providing education about the intersection of trauma and the child welfare system, as well as providing information about the elements of a trauma-informed child welfare system and practical ways to integrate these elements into child welfare practice. One such resource is the Child Welfare Trauma Training Toolkit, located on the website on the National Child Traumatic Stress Network, www.NCTSN.org. The site includes The Essential Elements of Child Welfare Practice and Creating Trauma-informed Child Welfare Systems.

With these tools, many child welfare and mental health practitioners working with children and families involved with the child welfare system have become more informed about integrating trauma-informed principles into actual practice. While it is absolutely essential for the professionals working in and partnering with child welfare systems to be trauma-informed, it is also quite necessary for the foster parents, kinship caregivers, adoptive and birth parents to be brought into the loop for training and coaching in trauma-related issues. In this way, the entire caregiving system creates a full circle of trauma-informed care that will allow these traumatized children to heal.

If you do an online search for “trauma-informed principles,” you will find there are several different variations presented. While different principles of trauma-informed care are identified based on the different populations being served, they all emphasize increasing trauma awareness, physical and psychological safety and avoiding re-traumatization of those providing and receiving services and care. Trauma-informed care seeks to avoid re-traumatization and provide a space for permanency, healing and recovery for all children in the foster care system. Therefore, it is critically important to recognize the primary role of all caregivers in a child’s caregiving system as the facilitators and advocates for that healing and trauma recovery, and to prepare them for the journey by building their capacity for providing trauma-informed care along with unconditional and conscious parenting. Becoming trauma-informed opens up a new way of thinking about and responding to the emotional, behavioral, educational, and social challenges experienced by traumatized children in foster care.

There is a quote from Maya Angelou, “Do the best you can until you know better; then when you know better, do better.” Most caregivers and birth parents are doing the best they can with what they know. It is well known that we often parent based on how we were parented. In addition, many foster children come from families with histories of multigenerational trauma that has been transmitted to them through their parents and families, thereby making it complex trauma. In order for foster parents, caregivers and birth parents to “do better,” and therefore avoid re-traumatization, and create emotionally and physically safe caregiving environments, they have to be given the tools to gain knowledge, awareness, understanding and skills on how to provide trauma-informed caregiving using an unconditional parenting approach. Trauma-informed caregiving is based on trauma awareness and an understanding of the impact trauma has had on a child’s well-being and life, as well as their own. Trauma-informed caregiving requires an approach

Trauma-informed care seeks to avoid re-traumatization and provide a space for permanency, healing and recovery for all children in the foster care system.

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Supporting Caregivers and Birth Parents with Building Capacity for Trauma-informed Care

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that prioritizes the child's experiences of trauma and its impact by shifting ideas about childhood development, discipline and parenting from "What is wrong with my child?" to "What has happened to my child?" Trauma-informed caregiving shifts how caregivers communicate with, and provide support for, the child in their care. It recognizes that traditional parenting practices often will not work, and that their child may perceive and respond to the world in ways that are very different from what they are used to due to the vulnerabilities and triggers of trauma. More can be learned about trauma-informed caregiving at www.nctsn.org where there is access to a workshop series designed for caregivers called "Caring for Youth Who Have Experienced Trauma."

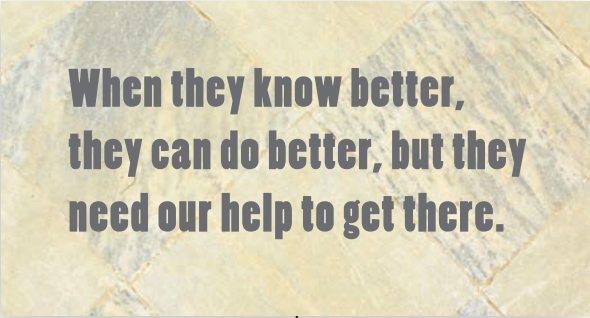
An unconditional parenting approach is also essential when providing trauma-informed caregiving. Unconditional parenting is about shifting the focus from, "How do I get my child to do what I want?" to "What does my child need right now? And how can I meet that need?" An unconditional parenting approach is a shift away from the traditional paradigm of parenting as a punitive model that uses power and consequences to change behaviors, towards building a more respectful and empathic connection with children by focusing on the relationship with the child. The emphasis of an unconditional parenting approach is on making sure that children not only know that they are loved but also feel loved; that children need to be loved for who they are and not for what they do; and for children to know and feel they are loved even when they make mistakes or misbehave. Parenting unconditionally starts with the caregivers rather than the children or their behavior. It is about the caregivers making a conscious decision about how they relate to their children and deciding to show unconditional love and support for their children no matter what they do or say. It means not giving up on children when things get difficult and constantly reassuring them of that as often as they need.

Parenting unconditionally involves caregivers re-framing their view of their child's behavior and intentionally changing how they think about and experience their child. Essential to this approach are emotionally aware and empathic caregivers and birth parents who have acknowledged their own emotional experiences and unresolved past emotional wounds so that

they can effectively support the building of emotional awareness and appropriate expression in their children. The caregivers' acknowledgement of their own emotional experience and wounds can also help them show more empathy for their child. This acknowledgement can also help caregivers better understand the connection between their experience and behavior, as well as the connection between their child's experiences and behavior. This makes it very important for practitioners, agencies and systems to treat foster parents, birth parents, adoptive parents and kinship caregivers with respect, cultural humility, empathy and compassion in a way that validates their experience, role and significance in the child's life.

As key components of trauma-informed and unconditional caregiving/parenting, it is essential that birth/foster/adoptive parents and kinship caregivers receive ongoing support for building empathy and increased emotional awareness, as well as with developing their trauma awareness in general and as it pertains to their children. Practitioners, agencies and systems

must ensure that caregivers get the support they need to build and strengthen their capacity for trauma-informed care. When they know better, they can do better, but they need our help to get there. This may mean assessing birth parent trauma, multi-generational trauma within the child's family as well as the trauma histories of kinship caregivers and foster and adoptive parents. This also indicates a



**When they know better,
they can do better, but they
need our help to get there.**

strong need for more training specific to trauma-related issues, trauma-informed parenting, unconditional parenting, culturally responsive parenting and practice, interrupting the cycle of multigenerational trauma and the intersection between culture, trauma, child welfare and mental health. There are certainly more training topics to consider here but the main point is that many more services, training, supports and resources are needed for caregivers, foster parents, birth parents and adoptive parents to help with building and strengthening their capacity for trauma-informed care. The more we work together in making sure that parents and caregivers of traumatized youth know about and practice trauma-informed care, the better they will be at helping their children, and perhaps themselves, to heal.

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THE

OF VICARIOUS TRAUMA: IT'S THERE; WE JUST NEED TO RECOGNIZE IT

—by Christine Bowlby, LMHP, RPT

So, you may be asking yourself, "What is vicarious trauma?" Sometimes it is confused with our other nemesis, *compassion fatigue*. They are different. Compassion fatigue "refers to the deep emotional and physical wearing down that takes place when helping professionals are unable to refuel and renew" (Figley, 1995). Vicarious trauma is the residual effect helping professionals may succumb to when they are assisting clients who have experienced trauma. 'Vicarious' means the trauma was not experienced first hand by the professional; however, physical ailments, nightmares, emotional disturbances, etc... may be just as present as they are in the victim. Furthermore, it should be noted that vicarious trauma is not burnout, which has to do with "stress and frustration caused by the workplace" (Lipsky & Burk, 1996).

Vicarious trauma can affect our personal and professional lives. The helping professional is superbly vulnerable to undergoing distressing symptoms that his or her clients have encountered. It is a "state of tension and preoccupation of the stories/trauma experiences described by clients," (American Counseling Association). Are we unconsciously living vicariously through their trauma? And if we are, what are we doing to prevent, monitor and address this?

Let's take a look at some of the symptoms that may be present. The American Counseling Association offers a list of behaviors and symptoms. Here is just a sampling of what vicarious trauma may look like (American Counseling Association).

Signs and Symptoms

- Losing sleep over clients
- Worrying that you are not doing enough for your clients
- Dreaming about clients/ clients' trauma experiences
- Feeling diminished joy toward things you once enjoyed

Behavior

- Irresponsibility
- Tardiness
- Absenteeism
- Exhaustion

Interpersonal

- Staff conflict
- Blaming others
- Lack of collaboration
- Withdrawal and isolation from colleagues
- Avoidance of working with clients with trauma histories
- Change in relationship with colleagues

Personal values/beliefs

- Apathy
- Worry about not doing enough
- Lack of appreciation
- Questioning your frame of reference — identity, world view, and/or spirituality

Job Performance

- Low motivation
- Increased errors
- Decreased quality
- Lack of flexibility
- Over-involvement in details/perfectionism
- Avoidance of job responsibilities

Now that we have a working perspective of what behaviors we may see, how can we — as colleagues, as supervisors and as an agency — facilitate a healthy plan to move forward?

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THE IMPACT OF VICARIOUS TRAUMA: IT'S THERE; WE JUST NEED TO RECOGNIZE IT | continued from pg. 13

How can we help alleviate the harmful and destructive consequences that plague those performing their jobs on a day-to-day basis? Researchers in this field have formulated beneficial suggestions that may decrease the risk of vicarious trauma.

Pearlman and McKay propose "sufficient orientation, professional training, and management supervision for staff to feel competent and supported in their jobs." Pearlman and McKay also indicate the need for confidential counseling and support to those who may encounter troubling child care issues.

Let's start at the very beginning — the job interview. It's at this time when we can begin the dialogue of the potential risks that are associated with this line of work. The most vulnerable are the less seasoned workers, those that are brand new, have a considerable amount of energy and are ready to take on the world. If you are a manager, you may want to ask yourself, "is there time built into the work week for supervision?" Individual supervision with a supervisor or other designated staff is extremely important and may prove to be invaluable. An additional possibility is group supervision or group debriefing.

For those who are in supervisory positions, it's a good idea to have random check-ins. Keep in mind that there are individuals who will not take it upon themselves to approach his/her supervisor. Incidentally, they may not even be aware that what they're experiencing is in direct correlation to the job they once loved.

The opportunity for ongoing trainings, as well as offering employees the ability to have a diverse caseload is advantageous for all involved. In addition, ask yourself:

- Am I a good role model for my co-workers and staff?
- Do I maintain a healthy balance between my personal life and professional life?
- What kind of vibes do our office surroundings send?
- Can we display more kindhearted pictures and memorable quotes than rules and regulations?

Social support within the agency is crucial. Scheduled get-togethers among co-workers, such as "celebrating birthdays or other events as well as organized team-building



activities and staff retreats, can increase workers' feeling of group cohesion and mutual support" (Bell, Kulkarni, & Dalton). Longevity is much more likely when an employee feels valued, safe and secure.

Unfortunately, as a result of vicarious trauma, very qualified and committed staff members vacate positions on a regular basis. Personal self care is vital,

but taking the initiative to anticipate the negative side effects working with trauma may have on their employees, can only strengthen an agency. Let's equip them with the appropriate tools. It's a win-win pay off for everyone!

Christine Bowlby, LMHP, RPT, is the Training and Education Coordinator for Right Turn of Nebraska. Right Turn is a collaboration between Lutheran Family Services and Nebraska Children's Home Society, and serves the post adoption community.

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Resource:

Transforming the Pain: A Workbook on Vicarious Traumatization; by Laurie Anne Pearlman and Karen W. Saakvitne. This workbook provides tools for self-assessment, guidelines and activities for addressing vicarious traumatization, and exercises to use with groups of helpers.



Resources on Trauma-Informed Care:

Child Welfare Information Gateway

<https://www.childwelfare.gov/topics/responding/trauma/>

National Child Traumatic Stress Network

<http://www.nctsn.org/>

Safe Spaces. Safe Places: Creating Welcoming and Inclusive Environments for Traumatized LGBTQ Youth (New in 2015)

<http://www.nctsn.org/products/nctsn-safe-places-video>

Indian Country Child Trauma Center

<http://www.icctc.org/>

Culture Counts – Culture and Trauma

<http://www.nctsn.org/resources/topics/culture-and-trauma>

Military and Veteran Families and Children

<http://www.nctsn.org/resources/topics/military-children-and-families>

A Social Worker's Tool Kit for Working With Immigrant Families–Healing the Damage: Trauma and Immigrant Families in the Child Welfare System

<http://cimmcw.org/wp-content/uploads/2015/03/CICW-toolkit-trauma-immigrant-families-March-2015.pdf>

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