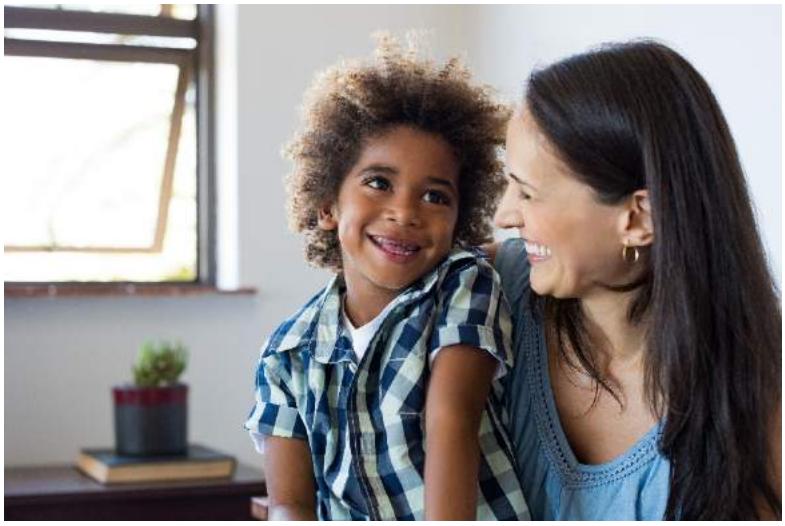
Clearinghouse on Supervised Visitation E-Press

October 2018



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Phone Conferences for the Remainder of 2018:

October 17, 2018 @ 12pm/11CT
November 28, 2018 @ 12pm/11CT
December 19, 2018 @ 12pm/11CT

LAST CHANCE to get your program narrative published. Send it to koehme@fsu.edu. All programs in the state are eligible.

LAST CALL for A and V DATA!

Remember, all cases should be in the database by Sept ember 30th for the annual roll up. Call the Clearinghouse for help (850-644-6303). **Time's UP!**

QUESTIONS FROM DIRECTORS

Can you help me figure out how to convince a client to relax at my program? I have a mother who is so negative that she makes the visit experience unnecessarily difficult. When I try to talk to her, she just assumes I am her enemy.

Two reminders: Many clients are suspicious of social service providers, and you should not take this personally.

Let's imagine for a moment what this client has been through: she is a survivor of domestic violence, and she was raised in a home where she was victimized. She has been to jail, and she had her child removed from her home. That's a very difficult set of circumstances. Imagine if you yourself had experienced such adversity. How do you think you might act toward people who say they are trying to help you?

Now for the tough reality: This client may never be comfortable with you. She may never trust you. She may never thank you for working so hard to ensure that she spends quality time with her child. But if you treat her with respect, if you provide her with a safe environment, and if you stay positive and helpful, you may truly give this client a chance to develop better parenting skills and get the resources she needs to move forward.

That should always be enough for you. Thank you for everything you are doing.

Is it okay for us to keep parents' car keys during the visit? We hate to be responsible for losing anything of value.

Yes, but don't just throw them in a drawer. Have some system that keeps them clearly marked and safe. For example, have a plastic bag with the parent's name marked on the outside. On the inside, include a piece of paper with the parent's name. Incorporate some way to indicate that you returned the keys to the parent. It
doesn't have to be a very formal system, but you should spend some time troubleshooting whatever system you create.

Examples of Program Narratives

1. Beyond Barriers Inc

3677 Central Ave, Suite I, Fort Myers, FL 33901
Program Director: Charity Williams 239-839-3907
Contact Email: beyondbarriersfl@gmail.com

Number of Sites: 1 Counties Served: Lee, Charlotte, Hendry and Glades

Beyond Barriers Inc is a newly opened visitation center. We operate as a full service approach to our clients by also offering many of the services that they will need to complete to be reunited with their children. All of our "Supervisors" are also certified as parenting instructors and are able to provide feedback during the visitation to facilitate a better visit for both parent and child. We offer home like settings in our office for the visits so that the visit can be more relaxed for all parties. Our rooms include couches, tv's with family friendly movies, games and some toys for the families to use during their visit. We offer visits seven days a week so that there are no barriers to a parent visiting a child.

2. Family Visitation Center of Alachua, Children's Home Society

1409 NW 36th PL Gainesville, FL 32605
Program Director: Eric Losciale 386-740-3839x226
Contact E-mail: Eric.Losciale@chsfl.org
Program on-site contact: Beverly Jones 352-334-0882
Contact E-mail: Beverly.Jones@chsfl.org

Number of Sites: 2 Counties Served: Alachua, Suwanee

The Family Visitation Center of Alachua County continues to provide supervised visitation to families in both the dependency and family courts. More than 150 families visited in the last year. In addition, a monthly average of 8 volunteers and interns from the community and the University of Florida provided over 3,250 hours towards supervising visits.

2nd Site: Family Visitation Center of Suwanee (Circuit 8), Children's Home Society

620 SW Arlington Blvd., Lake City, FL
Program Director: Eric Losciale 386-740-3839x226
Contact E-mail: Eric.Losciale@chsfl.org
Program on-site contact: Pamela Gill 386-758-0591
Contact E-mail: Pamela.Gill@chsfl.org

The center is fully a part of the community's help for families. The Rotary Club continues to provide volunteers for the maintenance of the facility and grounds. The program is a vital part of the community and provides a safe place for families to spend time together in a nurturing, caring, and child-friendly environment.

Again, this is the LAST CHANCE to get your program narrative published. Send it to koehme@fsu.edu. All programs in the state are eligible.

Resources on Trauma-Informed Care

The Clearinghouse on Supervised Visitation has provided much information about trauma-informed care through various training manuals and E-presses. For ease of use, these resources have been compiled into the following document.

Resources for Supervised Visitation Monitors

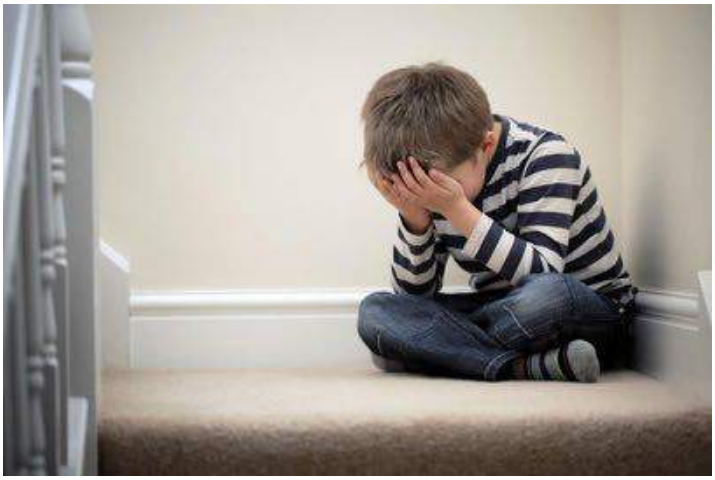
Resources for Organizations

Why Trauma –Informed Care?[1]

- Being trauma informed can allow visitation monitors to create an understanding and supportive environment for clients.
- Monitors who are educated about trauma are more sensitive to client's needs.

Background Information on Trauma-Informed Approaches[2]

Trauma-informed care is a strengths-based service delivery approach that is grounded in an understanding of, and responsiveness to, the impact of trauma. It emphasizes physical, psychological, and emotional safety for both providers and survivors, and creates opportunities for survivors to rebuild a sense of control and empowerment in their lives. A trauma-informed approach to the delivery of services includes an understanding of trauma and an awareness of the impact it can have across settings, services, and populations. It involves viewing trauma through an ecological and cultural lens and recognizing that context plays a significant role in how individuals perceive and process traumatic events. It involves four key elements of a trauma-informed approach:



1. Realizing the prevalence of trauma;
2. Recognizing how trauma affects all individuals involved with the program, organization, or system, including its own workforce;
3. Responding by putting this knowledge into practice; and
4. Resisting re-traumatization.

Key Principles of a Trauma-Informed Approach

Trauma is experienced in a different way for all clients and monitors should

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[1] Adapted from Supervised Visitation Manual, Chapter 13, https://familyvio.csw.fsu.edu/wp-content/uploads/2017/07/Supervised-Visitation-Manual-2017-Edition.pdf

[2] From Supervised Visitation Manual, Chapter 5, https://familyvio.csw.fsu.edu/wp-content/uploads/2017/07/Supervised-Visitation-Manual-2017-Edition.pdf

be aware that it is better to adhere to principles in responding to traumatized clients rather than adhere to strict actions. The six principles include:

1. Safety
2. Trustworthiness and transparency
3. Peer support
4. Collaboration and mutuality
5. Empowerment, voice, and choice
6. Cultural, historical, and gender issues

These principles are generalizable across multiple settings and can be used as specifically or broad as monitors see fit.

Connecting Theory to Practice: Trauma-Informed Care

The theory of trauma-informed care advances the idea that social service providers will not always be able to identify trauma but should assume that all clients have experienced some traumatic event(s). With this theory, providers are expected to work through service delivery without re-traumatizing a client.

Trauma-informed care suggests that most people have experienced trauma and it is the job of social service providers to learn about the effects of trauma to deliver the most effective services.

The Basics of Trauma

The word "trauma" describes experiences or situations that are emotionally painful and distressing, and can be often pervasive and disabling to an individual's everyday functioning. Trauma overwhelms the individual's ability to cope with difficult situations, leaving him or her feeling powerless.

There are different forms of trauma; some forms include violence, rape, and assault. This can also include an overseas soldier's experience in war or an individual witnessing violent acts in the community. Trauma also results from the effects of neglect, abject poverty, discrimination, and oppression.

The impact of trauma can be radically life-altering. Trauma can lead to depression, substance abuse, Post-Traumatic Stress Disorder, and/or anxiety disorders.

Supervised visitation professionals who interact with clients who have experienced trauma should be understanding and sensitive to those experiences. Visitation providers should be knowledgeable about the individual's history in order to know how to properly empathize and respond.

The Short and Long Term Effects of Trauma

Trauma's effect on an individual depends on many things: his or her life experiences before the trauma, his or her natural ability to cope with stress, the severity of the trauma, and the level of support offered by friends, family, and professionals (promptly after the trauma occurs).

Short-term

Individuals experiencing the short-term effects of trauma may:

- Turn away from loved ones initially because their support systems don't seem to understand their situations.
- Have trouble falling or staying asleep.
- Feel agitated and constantly be on the lookout for danger.
- Be startled by loud noises or something/someone behind them when they don't expect it.

Long-term

Individuals experiencing the long-term effects of trauma may:

- Re-experience the trauma though memories.
- Self-medicate with drugs or alcohol to numb the pain.
- Become upset or anxious when reminded about the trauma (by something the person sees, hears, feels, smells, or tastes).
- Feel anxious or fearful of being in danger again.

- Become angry, aggressive, and/or defensive.
- Have trouble managing emotions because reminders may lead to anger and/or anxiety.
- Have difficulty concentrating, focusing, or thinking clearly.
- Have a lasting effect on mental and emotional health.

For Trauma Survivors

In order to provide trauma-informed care to adults and children, service providers need to understand the following:

Trauma experiences can be dehumanizing, brutal experiences that rob someone of any human emotion or experience.

• Trauma-informed care should exist in all human services.

• Trauma-informed care shifts the perception from "what's wrong with you?" to "what has happened to you?" This shows a move away from victim-blaming.

• There is a correlation between trauma and mental health issues and chronic conditions

For adult clients, it is important to look at any past trauma and determine how to provide treatment that addresses both past trauma experiences and present issues, like substance abuse or chronic illness.

Adults may experience trauma due to:

- Serving overseas in the military and developing PTSD.
- Physical, sexual, verbal abuse (either in child- or adulthood).
- Being a victim of domestic violence.
- Being a victim of rape or assault.
- The lasting effects of a natural disaster (fire, hurricane, etc.).
- Loss of a significant other, parent, or child.
- Prolonged experience of poverty, oppression, or discrimination.

Children may experience trauma due to:

- The loss of a parent, friend, or pet.
- Physical, sexual, or verbal abuse.
- Neglect or maltreatment.
- An unstable or unsafe environment.
- Bullying.
- Surviving a natural disaster (fire, hurricane, etc.)
- Separation from a parent.
- Witnessing domestic violence.

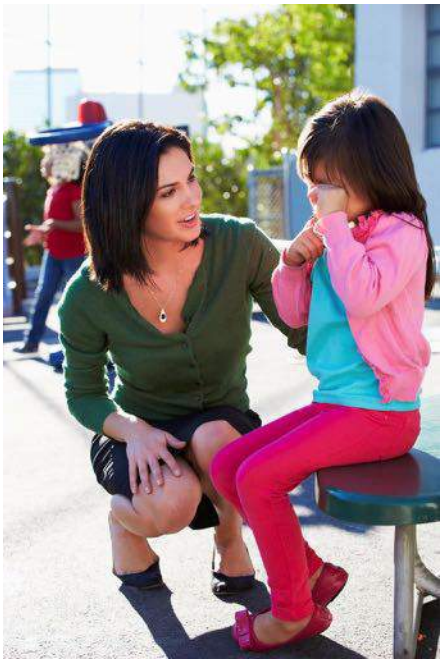
Trauma-Informed Approaches in Supervised Visitation

Parents experiencing trauma may seem distracted, frustrated, angry, depressed, or anxious. Children experiencing trauma may seem distant, scared, or depressed. It is important to recognize that trauma can happen to competent, healthy, and strong, people and that no one can completely protect him- or herself from a traumatic event. Visitation monitors should be sensitive to the issues that the child may be facing, as well as to the issues a visiting parent may be experiencing.

Visitation monitors should look for ways that they can improve the interaction and bonding between parent and child positively. While looking for ways to establish a safe place for the child, supervised visitation staff should watch for behaviors that may signal anxiety or re-traumatization.

Keys to Trauma-Informed Care

1. Many of the clients in social services have suffered trauma.
2. Survivors need to be respected, informed, connected, and hopeful regarding their own recovery.
3. Trauma and traumatic reactions are often inter-related (e.g., substance abuse, disordered eating and sleeping, depression, anxiety).
4. Social service providers need to work collaboratively with survivors, family and friends of the survivor, and other human services agencies in a manner that will empower survivors.



Provider Competence

"Trauma-informed approaches" involve the provision of care that, borrowing from the field of cultural competence, is "trauma-competent." Individuals and services providing trauma-informed approaches should

cater to the individual needs of each child to best promote empowerment and effective treatment. These can include ethnic or cultural differences, mental or physical disabilities, or language barriers.

Safety

Trauma-informed care must begin with the provision of safety, both physical andemotional, by adult caregivers to the traumatized child. In the absence of safety, the child will be unable and often unwilling to alter behavior, consider new ideas, or accept help. Children concerned about their survival cannot broaden their focus, engage in self-reflection, or allow themselves to be emotionally vulnerable. Trauma- informed organizations, programs, and services attempt to understand the vulnerabilities or triggers of trauma survivors that traditional service delivery approaches may exacerbate. Therefore, these services and programs can be more supportive and avoid re-traumatization.

Safety Skill

As part of trauma-informed visitation, monitors can help children feel safe by asking children how they feel about visitation and establish a word or sign to use if the child feels unsafe.

As a supervised visitation monitor, you will encounter and work with many families who have suffered some sort of trauma. It is important for you to understand what trauma is, what trauma-informed care entails, and to understand what trauma is, what trauma-informed care entails, and to understand the principals to deliver services in an effective manner. As a visitation monitor you can help families feel safe and give them back control and empowerment over their lives.

Applying a Trauma-Informed Lens to Practice

As social service providers become more and more aware of the impact of trauma on clients and client systems, it is important to take the initiative to recognize the existence of trauma and how to best work with clients affected by traumatic events. In addition to the recognition of the unique impact trauma has on the supervised visitation realm, programs can work to change their culture to ensure the safety and comfort of all clients within the program. Programs can use the following guidelines and recommendations to help place trauma in the focus of all client serving activities.

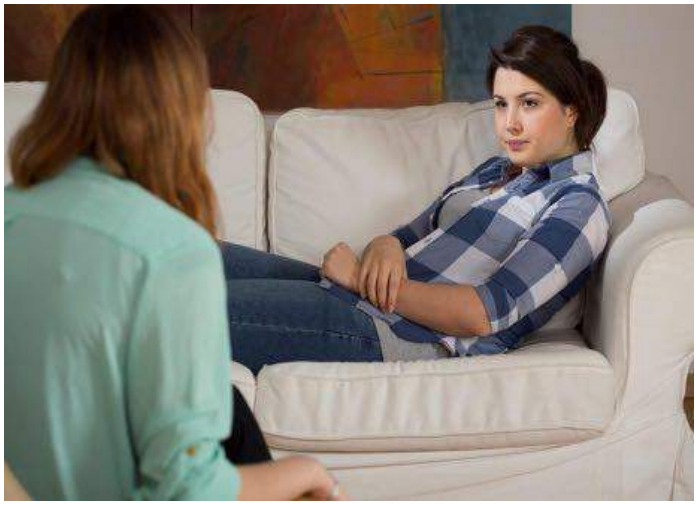
- *Incorporate trauma knowledge into new intake paperwork* – Programs can use intake as a time to discover unforeseen trauma and include questions to understand the client's needs in regard to coping with that trauma.
- *Evaluate existing practice models and organizational structure* – Programs should think about what their current process and system feels like to the client. Monitors should try to evaluate the process from referral to termination

and see what it may feel like from the client's perspective. Monitors can then ask questions such as:

- Is this sensitive to the client's needs?
- Could this process be harmful in any way?
- How can I be more accommodating while still prioritizing safety?
- What might be triggering about this situation?

- *Keep visits calm and eliminate stressful events or people* – While it can be difficult to predict when a parent or child will become angry or out of control, it is in the best interest of the monitor to keep situations as calm as possible, and when there is any sign of anger, stress, or triggers, attempt to divert their impact on the clients.

- *Seek to talk with clients in a safe and secure setting* – Avoid busy and loud offices, consider emphasizing the value of privacy and respect for the client.
- *Explain what is going to occur during intake and visitation* – Ask client if he or she feels concerned about any part of the process and also ask what would make him or her feel safe. Most importantly, try to follow through as much as possible.



- *Give the client some control or choice* – Ask clients what will make them feel the most comfortable. Maybe this includes using a certain monitor, or a certain room for visitation. Some children may prefer to do specific activities that will help calm them or may want to avoid other stressful activities.

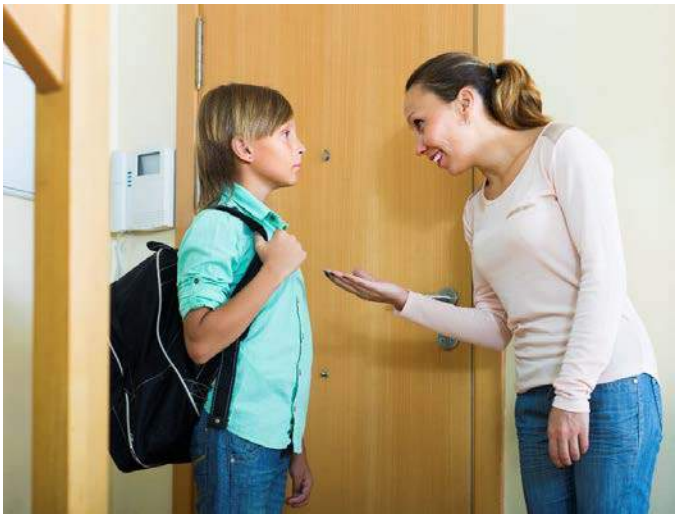
Addressing Children's Concerns During Visits[3]

Many children in supervised visitation may have experienced trauma, such as abuse or neglect. It is essential that you keep this in mind while communicating and interacting with children at visits.

Children who have experienced trauma will have unique needs, which you can help meet by practicing trauma-informed care to best promote empowerment and effective treatment. These can include ethnic or cultural differences, mental or physical disabilities, or language barriers.

In cases where the abuse has been confirmed, as well as in cases where there is "some indication" of child abuse, the child should be allowed to signal when the visit needs to end or break for a period of time. This is a perfect time to remind children of the **safety signal** you chose together during your initial safety planning. If the child leaves the visit for a break or asks that the visit be terminated, staff should conduct a risk assessment to determine how the child is being affected by the contact.

When child abuse has been alleged or proven, a child should be reassured that the supervised visitation staff wants to make sure he or she is safe at visits. It may be confusing for a child victim if staff remains silent about what happened or may have happened to the child. On the other hand, a program must not begin advocating for one parent, or treating a parent with disdain or contempt.



Supervised visitation staff do not need to be specific about the allegations with a child. The following examples are statements that monitors can use to alleviate a child's fears prior to visits. Make sure to give the child assurances that let the child know that staff will be vigilant, such as: "You are here because the judge cares about you."

- "We care about you, too."
- "You have not done anything wrong."
- "We are here so you can have a safe visit."

[3] From Supervised Visitation Manual, Chapter 3, https://familyvio.csw.fsu.edu/wp-content/uploads/2017/07/Supervised-Visitation-Manual-2017-Edition.pdf

- “Tell us if there is anything we can do to make your time here better.”
- “Tell us how we can help you feel more comfortable.”

Always remember the trauma the child may have experienced when interacting with them at visits. If a child starts to become upset or overly withdrawn, stop the visit and talk with them one-on-one to make sure everything is okay before moving forward with the visit. Make a note of any child behaviors or statements that may indicate past trauma in your case notes, and make sure to address these concerns in your safety plan.

Common Child Responses to Trauma[4]

After experiencing trauma, a child's response is affected by multiple factors and situations. While trauma is unique to the individual, there are still some common age-related patterns of response to trauma.

Table 5.1 Common Responses to Trauma

Age of Child	Child's Response	
Toddlers and Preschool – *18 months to Age 5*	• Crying, whimpering, screaming • Moving aimlessly • Trembling • Speech difficulties	• Irritability • Repetitive reenactment of trauma themes in play • Fearful avoidance and phobic reactions
School Age – *Ages Six to Twelve Years of Age*	• Sadness or crying • Poor concentration • Irritability • Fear of personal harm, or other anxieties • Nightmares and/or sleep disruption	• Bedwetting • Eating difficulties • Attention-seeking behaviors • Trauma themes in play/art/conversation
Adolescence – *Ages Thirteen to Eighteen Years of Age*	• Feelings of extreme guilt • Reluctance to discuss feelings about traumatic event • Flashbacks • Nightmares • Emotional numbing • Depression	• Delinquent or self-destructive behaviors • Changes in school performance • Detachment and denial • Shame about feeling afraid and vulnerable • Abrupt changes in or abandonment of former friendships

[4] From Supervised Visitation Manual, Chapter 5, https://familyvio.csw.fsu.edu/wp-content/uploads/2017/07/Supervised-Visitation-Manual-2017-Edition.pdf

Shame in Trauma-Informed Care[5]

Introduction

Child Maltreatment has many detrimental effects on a child. In this section, we will focus specifically on a child's development of **shame** following maltreatment. Shame is a universal, internal belief that the entire self is bad, unworthy, or unlovable that many children experience after the trauma of child abuse or maltreatment. Children are particularly susceptible to shame because their view of self is not fully formed. It is important that shame is understood as a process that leads to maladaptive outcomes, not as a single feeling. Naturally, visitation providers must be able to recognize shame and its inner workings in order to help the children with whom they interact.

Objectives

After completing this section/training, you should be able to:

1. Define shame and other related concepts.
2. Recognize what shame looks like and how it manifests.
3. Discuss how shame mediates maladaptive behavior.
4. Understand why it is important to address shame in cases of maltreatment.
5. Identify measures that can be taken to reduce shame.

What is Shame?

As mentioned at the beginning of this section, shame is a belief that oneself is wholly bad, unworthy, diseased, or unlovable. It is important to distinguish between shame and guilt. Although the terms are often used interchangeably- they are quite different. Shame focuses on the entire self; guilt focuses on specific behaviors. Someone who is feeling ashamed will think "I am bad," while someone who feels guilty focuses on "what I did was wrong." While these thoughts do not sound very different, they impact a person in very different ways. Ultimately, shame results in maladaptive outcomes.

[5] From January 2013 E-press, https://familyvio.csw.fsu.edu/wp-content/uploads/2012/12/Jan13EPress_MB.pdf

Shame	Guilt
global	**action-specific**
incapacitating (nonproductive/counterproductive)	**can motivate change (may be productive)**
persistent	**often temporary**
damaging	**can be protective**
Involves cognitive/behavioral avoidance	**involves cognitive/behavioral attentiveness**
unhealthy	**sometimes healthy**

What causes shame?

Shame in children is often caused by maltreatment, harsh or punitive parenting, as well as domestic violence. It is also important to remember that some children will experience many of these different factors rather than just one specifically.

Many elements of child maltreatment contribute to shame. These include:

• Being forced into behaviors considered taboo by society

• Stigma - the fear it could make the child or the child's family look bad • Messages communicated by the perpetrator of the abuse

• Secrecy surrounding abuse

• Fear of discovery

• Discovery process- the process through which others, significant others and professional workers, learn of the abuse; including those person's reactions to the abuse

Often children will not talk about what they have experienced. A child may believe if he or she do not talk about it, he or she doesn't have to think about it. This nondisclosure is an attempt to avoid what has happened. This avoidance intensifies shameful feelings, making the child feel more isolated and putting him or her at risk for behavior problems, cognitive issues, and other obstacles in the future.

Parenting that is harsh or punitive often contributes to shame-proneness, the individual's disposition to be engulfed by shame. Many of these behaviors are reflective of abuse. Punitive parenting behaviors include:

- constant criticism
- neglect
- hostile rejection
- severe punishment

Children with parents who exhibit such behaviors are more likely to feel shame as they enter adolescence. It is likely that these children have received a message that they are unworthy, unwanted, or unlovable - their entire self is inadequate. This may be an intentional or unintentional. Regardless, it damages a child's self-image.

Additionally, domestic violence can increase feelings of shame in children. Children with mothers who are abused have similarities to those children who are physically abused. Children living in a house with violence may believe they are to blame for the abuse. This contributes to shame.

Recognizing Shame

Because children often cannot or will not disclose shame through verbal reports, it is important that visitation staff be able to recognize the non-verbal forms in which shame manifests. This includes knowing what shame looks like and feels like, as well as being able to recognize the behaviors that relate to feelings of shame.

Research acknowledges that it is normal for children who have experienced maltreatment to feel shame right after the abuse was discovered, but that shame is expected to decrease over a year's time in normatively functioning children and families. If shame is not decreasing, it is important that someone intervenes on the child's behalf, as children with high levels of shame after more than a year's time face more obstacles in the future.

What does shame look like?

Shame can be expressed numerous ways, including:

• Verbal reports of shameful feelings

• Facial expressions - characterized by downward gaze/gaze aversion, "sad" or sorrowful frown, and downward eyebrows

• Body posture - displayed by hanging of the head/ hiding of face and shoulders slumping; person seems to be hiding, shrinks body

It is important for visitation monitors to be sensitive to nonverbal displays of shame. Children do not typically verbally communicate shameful feelings until about eight years of age, but shame can be observed in children as young as three years old.

Visualizing Shame/ Building Empathy

Shame weighs a person down.

1. Think about the last time you had an X-ray done at the doctor or dentist.
2. Close your eyes. Think about what it felt like to have the weighted vest surrounding you.
3. Think about all the activities you do during a typical day. What would it feel like to be wearing a Wight, like that vest, all day, every day?

How Does Shame Manifest?

Children tend to avoid their feelings of shame. They hope that if they do not think about these feelings, they will go away. This, unfortunately, is not the case. Eventually shame manifests in one way or another - either through internalizing or externalizing behaviors. Keep in mind that each individual's symptoms depend on their perception of the shaming interaction, or the event that caused the shame.

Internalizing Behaviors

Internalizing behaviors occur when a person suppresses aversive feelings and directs problematic behaviors at the self, rather than outward. Internalizing behaviors impact a child's self-esteem, emotional coherence, and happiness. It is not uncommon for a child internalizing shameful feelings to develop situational depression. Furthermore, prolonged shame relates to numerous types of psychopathology, including:

- Post-Traumatic Stress Disorder (PTSD)
- Obsessive Compulsive Disorder (OCD)
- Psychoticism
- Anxiety
- Depression

Additionally, bodily shame, which occurs when an individual view's his/her body as diseased or traitorous in some way, may mediate abuse experiences and problems such as bulimia and low self-esteem.

Externalizing Behaviors

Externalizing behaviors are those behaviors children use to externalize the blame for what has happened to them. These behaviors relate to anger. When anger and

shame combine, it is a catalyst for maladaptive behaviors, often characterized by rage, an unfocused, hostile form of anger. Ultimately, a chain reaction occurs:

Maltreatment→ Shame→Anger→Behavior Problems
(externalizing behaviors)

As you can see, the behavior problems result from maltreatment. Shame and anger mediate maltreatment and behavior problems! Anger as a response to maltreatment is a key predictor of behavior problems.

Externalizing behaviors:

- are more likely in male survivors of child abuse.
- are more likely in children who were maltreated prior to age 5.
- correlate to adolescent delinquency.
- affect adjustment.
- are less likely when shame has been expressed.
- may be indicative of shame-fury, when one strikes back in anger to regain some amount control over life.
- predict future behavior problems, particularly in adolescence, but are not linked to antisocial disorders.

Key Terms Review

Please match each term to its appropriate definition! All terms are related to shame and will further your understanding of the subject.

Terms	Definitions
Shaming Interaction	*a. the individual who maltreats the child*
Discovery Process	*b. directing problematic behaviors at others, at society*
Shame Proneness	*c. occurs when an individual strikes out in anger in order to regain some form of control over their life*
Rage	*d. directing problematic behaviors toward oneself*
Perpetrator	*e. unfocused, hostile anger*
Externalizing Behaviors	*f. the process through which others, significant others and professional workers, learn of the abuse*

Non-offending Caregiver	*g. the event that caused the burden of shame*
Shame-fury	*h. an individual's predisposition, because of environmental factors, to become engulfed in shame*
Bodily Shame	*i. any caregiver who was not involved in the abuse*
Internalizing Behaviors	*j. belief or feeling that one's body is diseased or has betrayed them in some way*

Answer Key:

A: Perpetrator, B: Externalizing Behaviors, C: Shame Fury, D: Internalizing Behaviors, E: Rage, F: Discovery Process, G: Shaming Interaction, H: Shame-Proneness, I: Non-Offending Caregiver, J: Bodily Shame

What can be done?

Shame itself serves as a barrier to recovery - it keeps children from exposing their dysfunctional beliefs about themselves and the abuse, thereby inhibiting processing and healing. Children stuck in shame are at risk of persistently processing events through the lens of this shame, which is likely to prolong symptoms of posttraumatic stress. There is much to be done for and with these children so they can recover!

Impact of the Parent/ Caregiver

- Evidence shows that interventions including both parent/caregiver and child are more effective than those that only involve the child survivor.
- It is not uncommon for caregivers to accidentally communicate negative messages to children at the time of abuse discovery. For instance, children misinterpret a parent's anger at the perpetrator as anger at them.
- Caregivers who are unsure of how to react to the abuse are often silent because of a hope to provide normalcy or because of feelings of helplessness or failure. This only prolongs shame in children who have experienced abuse.
- Even well-meaning adults can perpetuate shame in a child if they do not have the appropriate supportive and communicative skills.
- One of the most important elements in a child's recovery after maltreatment is the support of a non-offending parent/caregiver.
- Parents are the primary avenue through which children understand the abuse.

- It is not uncommon for a non-offending parent/caregiver to be experiencing shame because of the abuse of their child.
- Both the parent and the child need to be offered treatment from a social worker, psychologist, psychiatrist etc.
- Parents need opportunities to work on any parenting deficits. This could include improving coping skills, stress reduction and anger management, as well as problem solving skills and nonviolent disciplining strategies.
- Parents and caregivers must be encouraged to talk with their children openly about the abuse and questions surrounding it. This is key to the child's and the family's recovery. It may require the visitation worker to help the parent/caregiver practice talking about the abuse in the absence of the child.

What the Child Survivor Needs

Children who have experienced maltreatment need to confront the shame, fear, and confusion they are experiencing. This should be done by creating a safe space for facilitating cognitive and behavioral processing, as well as by addressing complaints, confusion, and bodily shame openly.

Cognitive and Behavioral Processing

Children weighed down by shame have been coping by avoiding processing the abusive event, or by ineffective attempts at trying to make sense of what has happened.

- Children need supportive responses from people involved in the investigation of their abuse and the recovery period following before they can begin processing.
- Children need the people working with them to be confident and professional, while exhibiting compassion and sensitivity at the same time. Eye contact and calm, normal tones of voice are integral.
- The most effective way for children to process would be through professional counseling, likely using cognitive behavioral techniques, including:
    - Education
        - correct terminology and psychoeducation
        - diminishes confusion and builds comfort
    - Skill- building
        - coping, relaxation techniques, stress management, assertiveness training
        - increases self-efficacy and empowers
    - Trauma Narrative and Processing
        - gradual, repeated telling of experience

        - diminishes emotional responses and reveals distortions/dysfunctional thoughts, as well as decreasing PTSD symptoms
    - Safety Planning
        - teaching children to recognize dangerous situations
        - reinforces the most important step, telling someone, and praises the child for their courage
    - Open Communication with Non-Offending Parent/ Caregiver
        - practice personal safety skills with child and discuss sexuality openly
        - dysfunctional parental beliefs need to be addressed prior to joint work – otherwise, joint work can undermine the child's progress
        - statements should empower, rather than warn
        - very important for optimal recovery from abuse-related shame
- Disclosure of dysfunctional thoughts should be met with gentle corrective feedback providing cognitive restructuring.
- Children should never be forced to talk about the abusive experience. Any forced sharing can increase feelings of shame.

Openly Addressing Complaints, Confusion, and Bodily Shame

- Sometimes psychological distress manifests physiologically. It is okay to let the child go to the doctor, even if the symptoms are believed to be a result of the abuse.
- Children may be confused about things that happened during the abuse. For instance, survivors of sexual abuse may be confused and humiliated that the sexual touching was pleasurable.
- Because discussing sexuality is taboo in our society (especially concerning children), openly talking about it can reduce feelings of shame in child survivors of sexual abuse.
- Therapeutic medical examinations can be used to address bodily shame. In this context, the child's physical concerns are addressed directly in a thoughtful manner. An examination can disconfirm misguided beliefs about diseased or traitorous body parts (i.e. genitals).
- Children are trying to figure out what they did wrong that caused the abuse. This needs to be addressed honestly and openly, sending the clear message that they are not to blame.

Ultimately, the key to healthy parent-child interactions following abuse is positive, open communication. Children who have survived abuse must be praised for their strength, as well as all of the other great things about them. It is important to help these children regain their self-worth. Reminding children they are worthy helps negate feelings of shame, mediating feelings and behaviors that may lead to non-acceptance by peers and unhealthy friendships and romantic relationships in the future.

Case Example

Freddie has been put in foster care because he was being sexually abused by his mother's boyfriend. Freddie is visiting with non-offending mother and 10-year-old sister. His mother is disassociated from the shame of letting her boyfriend hurt her child. His sister is assuming the role of parent, but she was abused herself. Freddie is acting out during supervised visitation - yelling when his mother doesn't do what he wants and hitting his sister.

1. What type of behaviors is Freddie exhibiting? What are the feelings underlying these behaviors?
2. What are the supportive services and experiences Freddie needs?
3. What referrals might the case manager give this family?

Summary

A child should never be blamed for abuse, nor should he or she feel ashamed because of something he or she could not control. In this section, we have discussed what shame is, what causes shame, how to recognize shame, concepts related to shame, and important aspects of a child recovering from abuse-related shame. Always remember that children are resilient and possess protective factors from developmental level to gender or ethnic background, as well as coping style and family or community support. It is of utmost importance to look at their strengths as well as their challenges!

References

Bonanno, G. A., Negrao, C., Noll, J.G., Putnam, F.W., & Trickett, P. K. (2005). Shame, humiliation, and childhood sexual abuse: distinct contributions and emotional coherence. *Child Maltreatment*, 10(350).

Bennett, D. S., Sullivan, M.W., & Lewis, M. (2005). Young children's adjustment as a function of maltreatment, shame and anger. *Child Maltreatment*, 10(311).

Deblinger, E. & Runyon, M.K. (2005). Understanding and treating feelings of shame in children who have experienced maltreatment. *Child Maltreatment*, 10(364).

Feiring, C. (2005). Emotional development, shame, and adaption to child maltreatment. *Child Maltreatment*, 10(307).

Feiring, C & Taska, L.S. (2005). The persistence of shame following sexual abuse: a longitudinal look at risk and recovery. *Child Maltreatment*, 10(337).

McCloskey, L. A. & Stuewig, J. (2005). The relation of child maltreatment to shame and guilt among adolescents: psychological routes to depression and delinquency. *Child Maltreatment*, 10(324).

(n.d). Facial expressions- the basics. Retrieved from http://www.reading-bodylanguage.co.uk/facial_expression_basics.html

Resources on Trauma-Informed Care[6]

- Administration for Children and Families: Resource Guide to Trauma-Informed Human Services. https://www.acf.hhs.gov/trauma-toolkit
- The National Child Traumatic Stress Network (NCTSN): Creating Trauma-Informed Systems. https://www.nctsn.org/trauma-informed-care/creating-traumainformed-systems
- Center for Health Care Strategies, Inc: Resource List for Trauma-Informed Care. http://www.chcs.org/media/TIC-Resource-List-_September-2015.pdf
- Video: Trauma-Informed Care Counseling Role Play. https://www.youtube.com/watch?v=boOWboUehHA
- Video: What is Trauma-Informed Care? https://www.youtube.com/watch?v=AnBEROaeiak
- Video: Trauma Informed Starts with You. https://www.youtube.com/watch?v=-876Zw-NA94

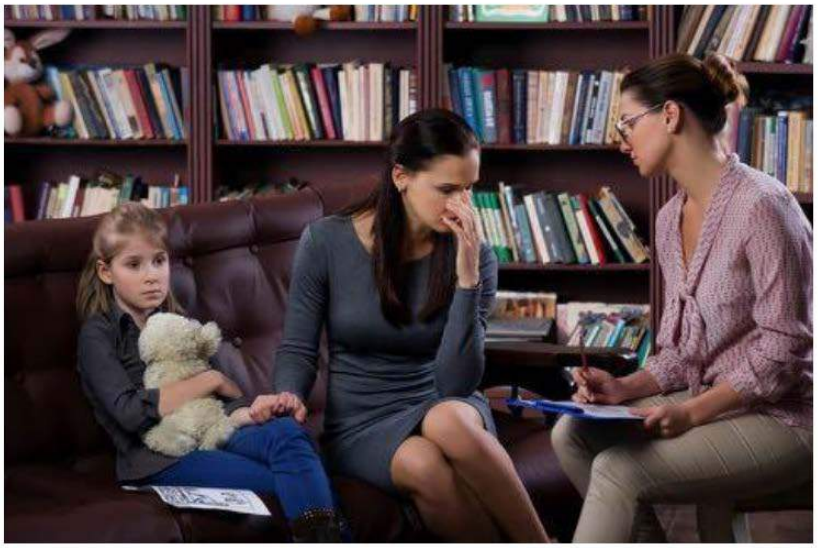
[6] From May 2018 E-press, https://familyvio.csw.fsu.edu/wp-content/uploads/2018/05/May-2018-E-Press-Part-1.pdf

The Trauma-Informed Environment[7]

Trauma-informed care traditionally is viewed in light of its impact the development of programs and staff interactions with clients. Given the nature of those who are in need of supervised visitation programs, it is important to understand the prevalence of trauma as a part of clients' lives. The mere event of losing custody of a child is traumatizing for a non-custodial parent, and being removed from a parent is traumatizing to children. In addition to this, domestic violence, child abuse, substance abuse, neglect, and many other potential traumas may have occurred in the lives of the parents and children who use supervised visitation programs. Trauma-informed care extends far beyond the interpersonal interactions of the 116 visitation but also include the environment and culture of the organization. Survivors of trauma are likely to be hyperaware of anything that may be potentially triggering to them. It becomes important to develop an appropriate environment so that those being served are able to feel safe and receive the maximum benefit from services. Cultivating an environment where a client feels valued will allow for more helpful environment. A healthy, trauma-informed environment will allow an organization and staff to effectively provide care.

The Trauma-Informed Environment: Supervised Visitation

In the supervised visitation setting, the culture of the organization will either help or harm the organizations ability to provide care. The trauma-informed environment extends far beyond the visitation monitor working with families. Rather, it is the whole organizational culture that creates a more helpful environment. The trauma-informed environment



[7] From Supervised Visitation Manual, Chapter 5, https://familyvio.csw.fsu.edu/wp-content/uploads/2017/07/Supervised-Visitation-Manual-2017-Edition.pdf

demonstrates the following characteristics. The trauma-informed environment emphasizes all of the following qualities:

Safe, calm, and secure.
The trauma-informed environment promotes feelings of safety and decreases potential stressors or traumatizing experiences for clients. The environment is aesthetically pleasing. Organization policies and practices are designed to avoid re-traumatization. Privacy is respected, and the physical layout is easy to navigate.

Understanding of the prevalence of trauma.
All staff has been trained on the prevalence of trauma in the populations served. This training should be universal to all domains, whether they have direct contact with clients or not. This should increase the responsiveness of the entire workforce to the populations served to better provide services. The trauma-informed environment should understand that service providers also have histories of trauma. Emerging best practices is disseminated to all staff and updated training takes place regularly.

Culturally competent.
All domains of an organization are sensitive to the cultural influence on the families served and how an individual's culture may influence how he or she responds to trauma. Additionally, the organization and the client are able to communicate appropriately and understand one another. Translators and materials in different languages are used as necessary.

Gives clients a voice, choice, and advocacy.
Populations served have a say in the planning, implementation, and evaluation of program's efforts to improve services. Regular evaluation of the organization by consumers is used. When appropriate, the consumer has a say in their own services.

Recovery and consumer driven.
Emerging best practices are continually used and the organization updates regularly to provide the best standards of services.

Healing, hopeful, honest, and facilitates development of trusting relationships. Staff in an organization work together and speak positively of one another at all times. The culture of the staff is to support one another and work towards greater collaboration. Care is taken to not betray the trust of the clients, who may feel that they cannot trust others.

Practices

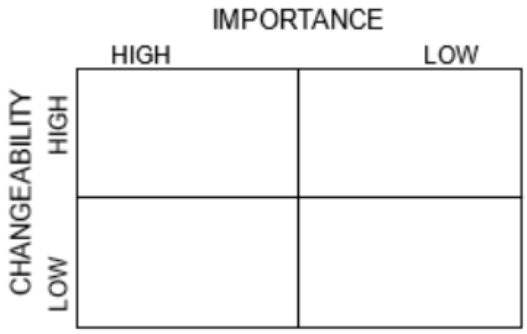
There are a number of best and worst practices an organization can highlight. It is important for supervised visitation programs to consider the impact the organization has on the clients through the existing practices. The following matrix has been adapted from the National Council for Behavioral Health.

Table 5.2 Program Practices		
Domain	What Hurts	What Helps
Relationships	…interactions that are humiliating, harsh, impersonal, disrespectful, critical, demanding, or judgmental.	Interactions that express kindness, patience, reassurance, acceptance, and listening help clients.
Physical Environment	…congested areas that are noisy, poor or confusing signage, uncomfortable furniture, and non-inviting paint on the walls.	The setting is comfortable and calm, furniture is clean and comfortable, wall coverings and posters are pleasant and convey hope.
Policies and Procedures	…rules that are commonly broken, policies focus more on organization's needs rather than client, policies that make the client "jump through hoops" to get the care they need, and language and cultural barriers.	Rules are fairly explained, emphasis is on what the organization can do, there is transparency in documentation and service planning, materials and communication are available in native language of the client, and the client is allowed provide feedback into the organization.
Attitudes and Beliefs	…asking questions that convey the idea that something is "wrong" with the parent or child, regarding difficulties as a result of some other issue, such as mental health.	Asking questions for the purpose of understanding what harmful events may contribute to the current problem; Recognizing that some non-constructive behaviors are used as a coping mechanism for trauma.

Implementing Changes to Become a Trauma- Informed Organization

The following steps are suggested to organization leaders to develop more trauma-informed practices within their organization.

1. Form a trauma-informed change team
    a. Identify persons in the organization that desire to become trauma-informed and wish to implement change in the organization. At least one member should be in a role to implement system wide change (supervisor or director level).
    b. Keep the team limited to no more than 10 people, have as many departments represented as possible.
2. Distribute the Trauma-Informed Agency Assessment (see below). All staff or strategic positions can take this assessment. Consider using an online survey tool for easy dissemination.
3. Review the results of the Trauma-Informed Agency Assessment and flag any areas that are consistently rated low.
4. Prioritize the need by using the Prioritization matrix. Chart each domain in the two by two matrix by changeability (capacity as in resources and readiness) and importance (how much will this impact/affect the issue or the agency).
    a. The domains that score highest on importance and changeability should take first priority.



5. Develop a plan to address the needs of your own organization.
6. Disseminate the new plan and training to implement the desired changes. The change team becomes the facilitators of change that takes place within the organization.
7. Develop ways to adequately train all staff on the basics of trauma-informed care. Consider hiring a consultant to lead the training or have staff attend a training webinar.
8. The change team should continually evaluate the needs of the organization and formulate ways to improve the organization culture.

This is a continual process and requires continued evaluation and dissemination of new ideas for the organization. The Trauma-Informed Agency Assessment should be redistributed at regular intervals.

The Trauma-Informed Agency Assessment can be accessed at http://www.traumainformedcareproject.org/resources/Trauam%20Informed%20Organizational%20Survey_9_13.pdf

Additional Online Resources[8]

1. **The National Council for Behavioral Health** offers a number of trainings and resources to help organizations implement the most recent best practices. The website is www.thenationalcouncil.org.
2. **Thrive Initiative** is the Maine-based organization for leading organizations to become trauma-informed. The Trauma-Informed Agency Assessment can be accessed here. The website is thriveinitiative.org.
3. **Trauma Informed Care Project** is available at traumainformedcareproject.org
4. **The Chadwick Trauma-Informed Systems Project** is part of *The National Child Traumatic Stress Network* and has created a guide for administrators in child welfare systems. Website at http://www.chadwickcenter.org/CTISP/images/CTISPTICWAdmin Guide2ndEd2013.pdf
5. **Healing the Damage: Trauma and Immigrant Families in the Child Welfare System** is a toolkit made for social service providers to help with addressing trauma of immigrant families. Culture plays a prominent role in this toolkit. Website at http://www.americanhumane.org/assets/pdfs/children/pc-toolkit- trauma-immigrant-families.pdf
6. **Trauma-Informed Approach and Trauma-Specific Interventions** is a site by SAMHSA. This site provides users with an overview of trauma-informed care and plenty of resources for different populations and professionals. Website at http://www.samhsa.gov/nctic/trauma-interventions
7. **The Child Welfare Information Gateway** provides resources on building trauma-informed systems and policies. Website at https://www.childwelfare.gov/topics/responding/trauma/building/

[8] Adapted from Supervised Visitation Manual, Chapter 5, https://familyvio.csw.fsu.edu/wp-content/uploads/2017/07/Supervised-Visitation-Manual-2017-Edition.pdf

Resources for Practicing Trauma-Informed Care in Cases of Domestic Violence[9]

- **Resources for Advocates- Trauma-Informed Domestic Violence Advocacy.** http://www.nationalcenterdvtraumamh.org/trainingta/resource s-for-advocates-trauma-informed-dv-advocacy/ Provides links to webinars and tip sheets that provide a comprehensive view of how to create culturally competent, accessible, and trauma- informed services and organizations.
- **Tips for Creating a Welcoming Environment.** http://www.fcadv.org/sites/default/files/Tipsheet_Welcoming%20Environment_NCDVTMH_Aug2011.pdf. Offers different ways that social service programs can provide a welcoming environment for victims of domestic violence.
- **Tips for Enhancing Emotional Safety.** http://www.fcadv.org/sites/default/files/Tipsheet_Emotional%20Safety_NCDVTMH_Aug2011.pdf. This resource identifies seven tips to promote and increase emotional safety within programs.
- **A Trauma-Informed Approach to Domestic Violence Advocacy.** http://www.fcadv.org/sites/default/files/Tipsheet_TI%20DV%20Advocacy_NCDVTMH_Aug2011.pdf. Discusses the five core components necessary for a trauma-informed approach to domestic violence advocacy and helping survivors strengthen their psychological capacity to work through multiple issues associated with domestic violence.

[9] From Supervised Visitation Manual, Chapter 13, https://familyvio.csw.fsu.edu/wp-content/uploads/2017/07/Supervised-Visitation-Manual-2017-Edition.pdf

Promising Practices: Trauma-Informed Approaches to Working with Survivors of Domestic and Sexual Violence and Other Trauma, and How This May be Applied to Supervised Visitation[10]

Written by Lisa S. Panisch

Individual supervised visitation monitors can enhance the quality of their work by adopting the following trauma-informed principles and practices:

- Learning about the effects of vicarious trauma, and how to recognize it within themselves and others.
- Maintaining consistent habits of self-care in order to minimize the impact of vicarious trauma.
- Making a commitment to seek appropriate help if the effects of vicarious trauma begin to interfere with a monitor's work and/or personal life.
- If a family member is willing to share, monitors can deeply listen to their stories and experiences, as well as to what those family members feel has been helpful and/or supportive to them.
- Refining their approach to working with families so that it is as individualized, adaptable, and trauma-informed as is possible.
- Becoming informed about and practicing culturally relevant responses to trauma as well as to the related issues that these families may be facing.
- Educating themselves about collective and historical trauma.
- Acknowledging that the effects of historical and collective trauma amongst different cultures may impact the relationship between the family and the monitor.
- Recognizing the importance of building trust with families.
- Actively working to build trust by:
    - Avoiding power-based hierarchical dynamics that may re-traumatize family members.
    - When possible, avoiding overly rigid rules, while still maintaining consistency.
    - Being clear with families about the role of the monitor, the limitations of this role, and outlining specific expectations about what the monitor and their agency is and is not able to offer.
    - Providing as much information to families about all of their available options, as well as the risks and benefits of each, and letting families know that additional information may also exist.
    - Prioritizing the confidentiality of all members of the family.

[10] From July 2016 E-Press, https://familyvio.csw.fsu.edu/wp-content/uploads/2016/07/July-Epress.pdf

    - Understanding the effects of trauma and how it impacts family dynamics. Understanding that perplexing and even self-destructive behaviors of some family members may be the result of survival reflexes. Using this understanding to work with family members in a non-judgmental way in order to help them learn behaviors and skills that will be more beneficial in meeting their needs.

Agencies offering supervised visitation can enhance the quality of their services by adopting the following trauma-informed principles and practices:

- Commitment across the agency to create a more trauma-informed organization. Recognizing that this is an ongoing and reflective process that involves a deeper understanding about the effects of trauma, as opposed to a checklist of services and changes to be implemented.
- Making a commitment to staff well-being.
    - Providing health and wellness incentives such as gym membership discounts, in house fitness facilities or classes, etc.
    - Ensuring that monitors are provided with scheduling flexibility to meet personal and family needs.
    - Deeply listening to the experiences, feedback, and suggestions shared by monitors.
- Learning about the effects of vicarious trauma, and how to recognize it within their monitors.
    - Providing specific training for supervisors on how to educate workers about vicarious trauma and how to manage its impact.
    - Partnering with monitors to support their personal commitment to recognize and address their own vicarious trauma.
    - Creating a safe emotional environment for monitors and families receiving services.
- Utilizing a universal-design approach, so that services can be offered to meet the largest amount of people experiencing a variety of situations.
- Providing on-going training for staff in areas such as:
    - Trauma-informed principles, policies, stages of healing from trauma, historical and collective trauma, and vicarious trauma.
    - Cultural competency and relevant approaches.
    - Evidence-based interventions and approaches for working with families who have experienced trauma.
- Providing and participating in opportunities where other agencies in the field can share their innovative work, services, and/or approaches.
- Becoming involved in policy, advocacy, and community engagement activities that will address integrating a trauma-informed social justice approach for dealing with issues related to trauma and supervised visitation.

Are you Trauma-Informed?

Trauma Informed

Trauma Responsive

Trauma Sensitive

Trauma Aware

The Principles of Trauma Informed Care

For child welfare services to actually help families where there has been trauma, we need to attend to the five core principles of Trauma Informed Care:

- Safety: Ensuring physical and emotional safety
- Trustworthiness: Maximizing trustworthiness, making tasks clear and maintaining appropriate boundaries
- Choice: Prioritizing developmentally appropriate choice and control for children, youth, families and adults
- Collaboration: Maximizing collaboration and sharing of power with children, youth, families, and adults
- Empowerment: Prioritizing child, youth, family and adult empowerment and skill-building

SOLUTION-FOCUSED TRAUMA-INFORMED CARE (SF-TIC): AN INTEGRATION OF MODELS

Denise J. Krause, LCSW-R
Clinical Professor
University at Buffalo, School of Social Work

Solution-Focused -TIC Concepts and Skills (Koury, Green & Krause, 2016)

	Trauma-Informed Care (TIC)	Solution-Focused Approach	SF Skill/Examples
Safety	Both physical and emotional dimensions—includes considerations around where and when services are being offered, what security measures are in place, the physical appearance of waiting rooms and other parts of the agency, etc. Interactions between staff and clients and staff and colleagues are welcoming, respectful and engaging. Staff recognize and are attentive to the discomfort and unease of clients.	**Creates emotional safety by:** 1. "leading from one step behind," which allows the other to drive the conversation/session at their own pace 2. Taking the position of "not knowing," by being respectfully curious and non-judgmental about the other's perceptions and experiences **Can be used to create physical safety by:** Inquiring about what the other would need to see/experience in order to feel an increased sense of safety	**Goal formation questions** *"What needs to happen here today in order for this meeting to be helpful to you?"* *"What is your best hope for our time together today?"* **Difference questions** *"What difference will that make for you?"* *"What would you need to see different that would let you know you are safe?"* **Competency questions** *"What tells you that… will be useful?"* *"You must have a good reason to…Tell me more."*
Trustworthiness	Information and expectations for clients and staff are provided clearly (who, what, when, where, under what circumstances).	The solution-focused approach always starts with building a shared understanding of what the other wants, which involves clarification and being respectfully curious.	**Goal formation questions** *"What would you like to be different as a result of these sessions?"*

	The staff and agency are consistent and uphold interpersonal boundaries with each other and clients.	Focusing on what the other wants and what is important to them, especially in mandated situations, also enhances engagement and thus builds trust.	*"How will you know when you reach your goal?"* **Relationship questions** *"What do you suppose…would have to see that would let them know you don't need to come here anymore?"* **Coping questions** *"How have you managed to…?"* *"How did you know…?"*
Choice	Clients have control and choice over the services they receive. Client priorities and goals are incorporated into service delivery. Staff also have some autonomy and choice in their work and factors impacting their job (i.e. caseload, vacation time, etc.)	The position of "leading from one step behind" and inquiring what the other wants gives them choice in what the focus of the session/conversation /meeting is. The goal and the next small step to get there stem from the other, thus they have choice in where they want to go and how they get there.	**Miracle question** *"Suppose you are asleep tonight and a miracle happens […] What would be the first thing you would notice when you woke up that would let you know things were different?"* **Exception questions** *"What have you already tried that's been helpful, even if only a little?"* *"What is already working?"* *"How could you make that happen more often?"* **Scaling questions** "*What will you be doing differently when you are one point higher on the scale?"* *"What do you suppose is the next small step to get one point higher?"*

			"At what number do you need to be so you don't have to come back here anymore?"
Collaboration	The agency embodies a model of doing "with" rather than "to" or "for" in staff interactions with clients and leadership interactions with staff. All individuals in the agency are treated as the expert of their own experiences and history.	Solution building, the core process in the solution-focused approach, is the co-construction of what the other wants to be different, what's important to them and what capacities/strengths they have for change. The other is the expert of their own experiences and knows what they want and what is helpful—thus the approach takes a position of "not knowing," and explores the other's perceptions and past successes.	**Miracle/goal formation questions** *"What are your best hopes for our time together?"* *"What has to happen to make this session worthwhile to you?"* *"Suppose you are asleep tonight and a miracle happens […] What would be the first thing you might notice when you wake up that would let you know things were different?"* **Exception questions** *"Have there been times in the last couple of weeks when the problem didn't happen, or was less of a problem?"* *"What do you think you did to make that happen?"* *"What have you already tried, and which of those things helped, even if only a little?"*
Empowerment	Interactions and procedures recognize and build on growth, skills and strengths. Interactions are validating and affirming, and communicate a	Empowerment is key to the solution-focused approach through building on strengths/capacities, increasing hope, and helping the other to find and create their own solutions.	**Coping/competency questions** *"How do you manage to…?"* *"How did you know you were able to…?"* *"How come things aren't worse?"*

	realistic sense of hope for the future.		*"What gives you hope that things will be different?"* **Exception questions** *"What did you think you did to make that happen?"* *"What's already going better since you made the appointment for this session?"* *"At what times do you already see parts of the miracle happening?"* **Scaling questions** *"What are you already doing that helps you be at a…?"* *"What are you already doing that's on track to being [one number higher]?"*
Shift of Perspective	An approach that asks "what has happened to this person" rather than "what is wrong with this person?"	An approach that focuses on what a person wants to see different rather than what is wrong/the problem.	*"What will you be doing instead?"* *"What will be different when… is no longer a problem?"*

Language	The use of "everyday" language as opposed to clinical or legal jargon. There is a focus on what someone is allowed to do/what is expected instead of what is not allowed. There is awareness and sensitivity to the negative cognitions those with trauma histories often have and how language can trigger them.	An individual using a solution-focused approach will adopt the other's words and build questions from their answers to the last question. Solution-focused language is positive—focused on the presence of behavior, strengths, solutions and hope. Acknowledges the power of language through the use of tentative language, avoiding "why" questions, the difference between "if" and "when," using indirect compliments, etc.	**Tentative language** *"What do you suppose…?"* *"It seems like…"* *"Imagine things do get better…"* **Avoiding "why"** "*How is it helpful for you to…?*" instead of "*Why do you you…?*" **Using "when"** *"When you finish the program…"* instead of *"If you finish the program…"* **Indirect compliments** *"How did you manage to come in today despite not wanting to get out of bed?"* instead of *"I'm glad you made it in today!"*

Special thanks to the Missouri team that created this chart.

Trauma Aware

Definition	Processes	Indicators	Resources
Key Task: Awareness and attitudes **Trauma aware** organizations have become aware of how prevalent trauma is and have begun to consider that it might impact their clientele and staff.	Leadership understands that knowledge about trauma could potentially enhance their ability to fulfill their mission and begins to seek out additional information on the prevalence of trauma for the population served. Awareness training is offered (including definitions, causes, prevalence, impact, values and terminology of trauma- informed care.) People are made aware of how and where to find additional information, and are supported in further learning.	Most staff: 1) know what the term trauma refers to; and 2) are aware that knowledge about the impact of trauma can change the way they see (and interact with) others. The impact of trauma is referenced in informal conversations among staff. **The organization explores what this new information might mean for them and what next**	**Websites:** National Child Traumatic Stress Network (NCTSN) http://www.nctsn.org/ National Center on Domestic Violence, Trauma and Mental Health (trauma-aware) http://www.nationalcenterdvtraumamh.org/The Anna Institutehttp://www.theannainstitute.org/ National Center for PTSD, U.S Department of Veterans Affairs http://www.ptsd.va.gov/ Resource Center on Violence Towards Women http://www.vawnet.org/news/2013/04/trauma-informed/ ACE Study www.cdc.gov/violenceprevention/acestudy/ http://acestudy.org/home http://acestoohigh.com/resources/ http://www.acesconnection.com/ **Documents:** SAMHSA's TIP 57: Trauma Informed Care in Behavioral Health Services– Chapter 2 Trauma

		steps may need to be taken.	Awareness. http://store.samhsa.gov/shin/content//SMA14-4816/SMA14-4816.pdf SAMHSA concept paper (trauma-aware) http://store.samhsa.gov/shin/content//SMA14-4884/SMA14-4884.pdf Children, violence and trauma video https://www.youtube.com/watch?v=z8vZxDa2KPM

Trauma Sensitive

Definition	Processes	Indicators	Resources
Key Task: Knowledge, application, and skill development **Trauma sensitive** organizations have begun to: 1) explore the principles of trauma-informed care (safety, choice, collaboration, trustworthiness, and empowerment) within their environment and daily work; 2) build consensus around the principles; 3) consider the implications of adopting the principles within the organization; and 4) prepare for change.	Values of a trauma-informed approach are processed with staff. Through a self-assessment process, the organization identifies existing strengths, resources and barriers to change as well as practices that are consistent or inconsistent with trauma informed care. Leadership prepares the organization for change and leads a process of reflection to determine readiness for change. The organization begins to identify internal trauma champions and finds	The organization values and prioritizes the trauma lens; a shift in perspective happens. Trauma is identified in the mission statement or other policy documents. Trauma training for all staff is institutionalized, including within new staff orientation. Basic information on trauma is available and visible to both clients and staff, through posters, flyers, handouts, Web sites, etc.	**Websites:** NCTSN http://www.nctsn.org/ National Center on Trauma Informed Care (NCTIC) www.nasmhpd.org/TA/nctic.aspx Child Trauma Academy http://childtrauma.org/ International Society for Traumatic Stress Studies **Toolkits and Videos:** Healing Neen (DVD) http://healingneen.com/ Fallot and Harris Organization Self-Assessment Tool http://www.theannainstitute.org/TIPSASCORESHEET.pdf Risking Connection organizational assessment http://www.traumainformedresponse.com/uploads/Sec_03-TReSIA-Assessment.pdf Institute for Health and Recovery http://healthrecovery.org/images/products/30_inside.pdf

	ways to hire people who reflect in their attitudes and behavior alignment with the trauma informed principles. The organization examines its commitment to consumer involvement and what next steps could be taken. The organization begins to review tools and processes for universal screening of trauma. The organization begins to identify potential resources for trauma specific treatment.	Direct care workers begin to seek out opportunities to learn new trauma skills. Management recognizes and responds to compassion fatigue and vicarious trauma in staff.	**Documents:** A Long Journey Home: A Guide for Creating Trauma–Informed Services for Mothers and Children Experiencing Homelessness http://www.familyhomelessness.org/media/89.pdf Trauma-sensitive schools. http://traumasensitiveschools.org

Trauma Responsive

Definition	Processes	Indicators	Resources
Key Task: Change and integration **Trauma responsive organizations** have begun to change their organizational culture to highlight the role of trauma. At all levels of the organization, staff begins re-thinking the routines and infrastructure of the organization.	Planning and taking action. Begin integration of principles into staff behaviors and practices. Begin integration of principles into staff supports: • Addressing staff trauma • Self-care • Supervision models • Staff development • Staff performance evaluations Begin integration of principles into organizational structures: • Environmental review	Staff applies new knowledge about trauma to their specific work. Language is introduced throughout the organization that supports safety, choice, collaboration, trustworthiness and empowerment. The organization has policies that support addressing staff's initial and secondary trauma. All clients are screened for trauma and/or a "universal precautions" approach is used.	**Website:** National Child Traumatic Stress Network (NCTSN) http://www.nctsn.org/ **Documents:** SAMHSA's TIP 57: Trauma Informed Care in Behavioral Health Services http://store.samhsa.gov/shin/content//SMA14-4816/SMA14-4816.pdf Healing the Hurt – Rich et al (men of color) http://www.dcf.state.fl.us/programs/samh/docs/Healing-the-Hurt.pdf Trauma Stewardship: An Everyday Guide to Caring for Self While Caring for Others, van Dernoot, Lipsky & Burk, http://traumastewardship.com/ Engaging Women In Trauma Informed Peer Support: A Guidebook http://www.nasmhpd.org/docs/publications/EngagingWomen/PeerEngagementGuide_Color_UP_FRONT_P AGES.pdf

	• Record-keeping revised • Policies and procedures re-examined • Self-help and peer advocacy incorporated	People with lived experience are engaged to play meaningful roles throughout the agency (employees, board members, volunteers, etc.)	Assaulted Staff Action Program http://americanmentalhealthfoundation.org/2012/04/the-assaulted-staff-action-program-asap-psychological-counseling-for-victims-of-violence/ **Training:** DMH Trauma Responsive Training – 6 hours, no cost contact patsy.carter@dmh.mo.gov Child Welfare Trauma Toolkit (NCTSN) http://nctsn.org/products/child-welfare-trauma-training-toolkit-2008 Juvenile Detention Trauma Toolkit "Think Trauma" NCTSN http://learn.nctsn.org/enrol/index.php?id=92 Partnering with Youth and Families Toolkit (NCTSN) http://www.nctsn.org/nctsn_assets/pdfs/Pathways_ver_finished.pdf Changes to environments are made. Trauma-specific assessment and treatment models are available for those who need them (either directly or through a referral process). Organization has a ready response for crisis management that reflects trauma informed values.

Trauma Informed

Definition	Processes	Indicators	Resources
Key Task: Leadership **Trauma informed** organizations have made trauma- responsive practices the organizational norm. The trauma model has become so accepted and so thoroughly embedded that it no longer depends on a few leaders. The organization works with other partners to strengthen collaboration around being trauma informed.	Measuring impact on clients Revision of policies and procedures Implementation of the agency's model/values is measured for fidelity to a trauma informed model and appropriate corrective actions taken. Practice patterns of staff Program assessments Interventions to address the impact	Leadership including hiring of new leaders demonstrates a commitment to trauma informed values (safety, choice, collaboration, trustworthiness and empowerment). All staff are skilled in using trauma-informed practices, whether they work directly with clients or with other staff. All aspects of the organization have been reviewed and revised to reflect a trauma approach. People outside the agency (from the Board to the community) understand the	**Websites:** National Child Traumatic Stress Network (NCTSN) http://www.nctsn.org/Healthcaretoolbox.org https://www.healthcaretoolbox.org/ National Technical Assistance Center for Children's Mental Health http://gucchdtacenter.georgetown.edu/TraumaInformedCare/ Anna Institute video -Important Souls http://www.theannainstitute.org/a-bio.html Men and boys as sexual abuse survivors https://www.youtube.com/watch?v=Wx-JqBdwdAA **Documents:** SAMHSA's TIP 57: Trauma Informed Care in Behavioral Health Organizationshttp://store.samhsa.gov/shin/content//SMA14-4816/SMA14-4816.pdf Trauma Informed Supervision Guide – Institute for Health and Recovery

	of secondary trauma on staff is monitored Focus on reduction of stigma of trauma Human resource policies support hiring staff with knowledge and expertise in trauma The organization and staff become advocates and champions of trauma within their community Advocacy at a macro level with payors and policy- makers for systemic changes that support trauma informed approaches	organization's mission to be trauma-related. People from other agencies and from the community routinely turn to the organization for expertise and leadership in trauma-informed care. The organization uses data to inform decision making at all levels. A variety of sustainable training is promoted and made accessible to staff, including at new staff orientation.	http://healthrecovery.org/publications/detail.php?p=30 How Schools Can Help Students Recover from Traumatic Experiences – Rand Gulf State Policy Institute http://www.rand.org/content/dam/rand/pubs/technical_reports/2006/RAND_TR413.pdf Helping Traumatized Children Learn –Massachusetts Advocates for Children in Association with Harvard Law School http://traumasensitiveschools.org/ **Toolkits** Trauma Informed Organizational Toolkit for Homeless National Center on Family Homelessness http://www.familyhomelessness.org/media/90.pdf **Working with Partners** Trauma informed community building manual http://bridgehousing.com/PDFs/TICB.Paper5.14.pdf Collective Impact http://www.ssireview.org/articles/entry/collective_impact Creating Culture: Promising Practices of Successful Movement Networks https://nonprofitquarterly.org/governancevoice/234

			39-creating-culture-promising-practices-of-successful- movement-networks.html Prevention Institute – Cross Sector Collaboration http://www.preventioninstitute.org/ **Disaster Preparedness and Response** SAMHSA's disaster TA center http://beta.samhsa.gov/dtac Public Health Emergency http://www.phe.gov/Preparedness/planning/abc/Pages/homeless-trauma-informed.aspx U.S. Department of Health and Human Services Office, Disaster Response for Homeless Individuals and Families: A Trauma-Informed Approach http://www.phe.gov/Preparedness/planning/abc/Documents/homeless-trauma-informed.pdf The business model including fiscal structures works to meet the need to address trauma.

Fun and Games: 3-5 Years Old

WHAT KIDS LEARN

- **Large Motor Skills**: using large body parts like arms and legs to complete tasks
- **Fine Motor Skills:** using small body parts like hands and fingers to complete tasks
- **Speech and Language Development:** learning words and how to talk to others

SAMPLE ACTIVITY

"Froot Loops" Jewelry:

Skills: Fine Motor

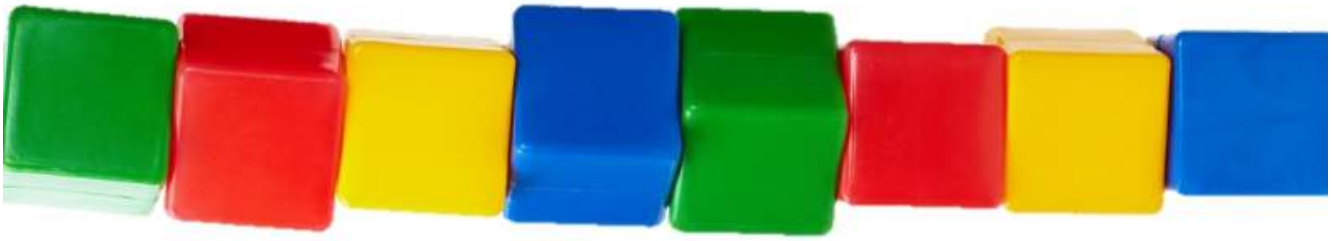
Materials: Yarn or String, a box of "Froot Loops", a clothespin

What to Do:

1. Measure the size of your child(ren)'s wrist and/or neck.
2. Cut out a piece of string.
3. Place the clothespin at the end of the string.
4. Have your child(ren) slide the "Froot Loops" onto the yarn.
5. Measure the jewelry to make sure it fits your child(ren) and cut the yarn!
6. Tie the two ends of the jewelry and wear it!

KEEP PLAYING!

- Playing house
- Hopscotch
- Coloring books
- Catch
- Hide and Seek



FUN AND GAMES: 5-7 YEARS OLD

What Kids Learn from Play:

- **Large Motor Skills:** using large body parts like arms and legs to complete tasks
- **Fine Motor Skills:** using small body parts like hands, fingers, and toes to complete tasks
- **Speech and Language Development:** learning words and how to talk to others
- **Self-Regulation:** the ability to control emotions and behaviors according to the setting.

  Example: Smiling when you're happy

Sample Activity

Skills: Fine Motor, Gross Motor, Speech, Language Comprehension, Self-Regulation

Materials: Dry erase board or poster paper on an easel, marker, cutouts of shapes, numbers, words, faces, pictures with magnet or tape strips on the back.

What to do:

1. Have the child(ren) stand 5 feet from the easel.
2. Place the cut out on the board, explain what the cut out is. Example: “This is the number 3, let’s count to 3 with me."
3. The child(ren) will run to the easel and copy or trace the cutout as best as they can.
4. Ask them to review what the picture is. Example: “Do you remember what number you just traced? Good job, that is the number 3, can we count to it?”

Keep Playing!

I Spy
Simon Says
Hot Potato
Scavenger Hunt
Hide and Seek
Musical Chairs

Contact the Clearinghouse at 850-644-1715

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