

LEARNER HANDOUTS

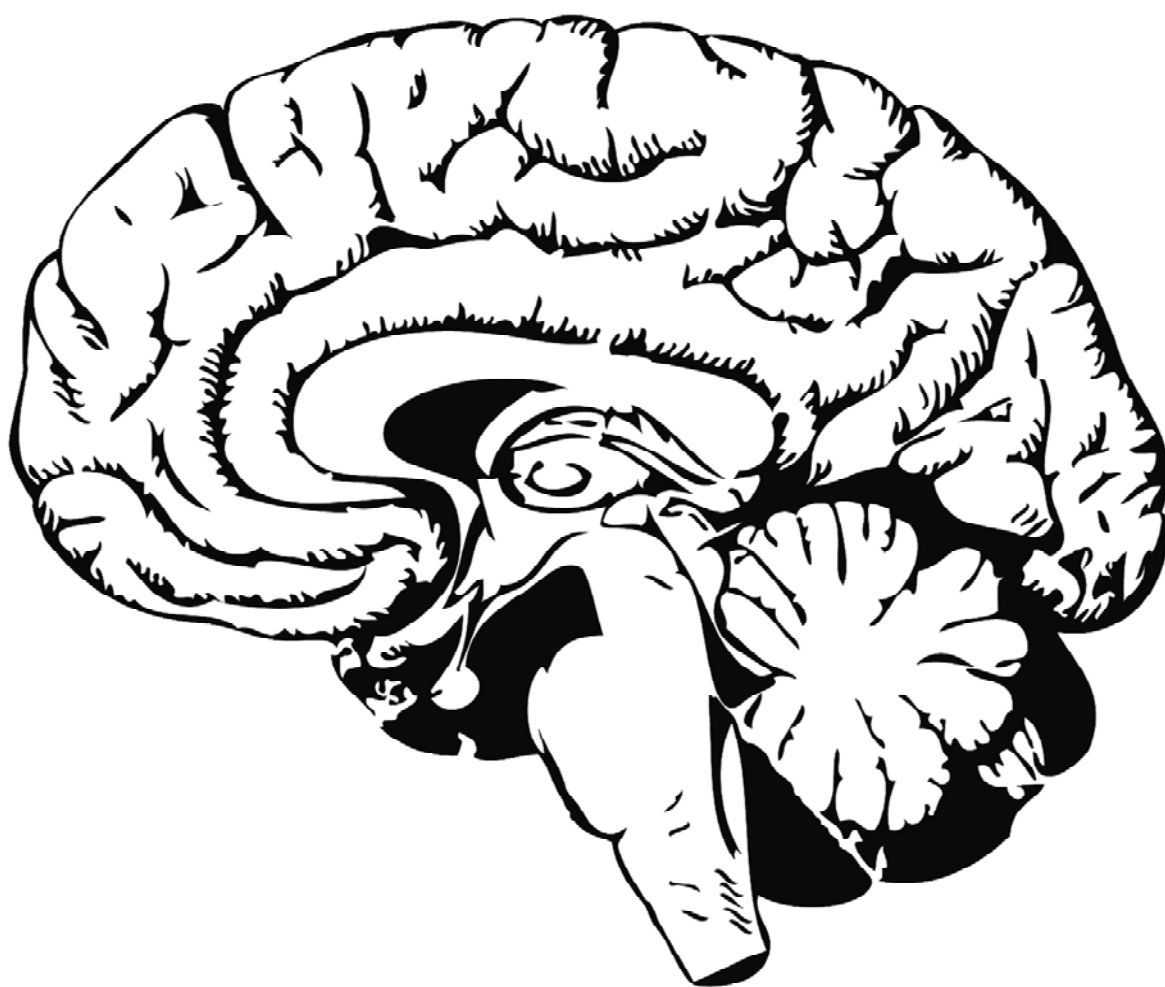
CWS4015W: TRAUMA-INFORMED CHILD WELFARE PRACTICE



VIRGINIA DEPARTMENT OF
SOCIAL SERVICES

WDS Workforce Development
and Support

TRAUMA AND THE BRAIN



Breakout Room: Operationalizing SAFETY (10 minutes)

You have been assigned the following scenario, based on your breakout room:

Room 1: A young child being interviewed about allegations of sexual abuse

Room 2: A parent accused of neglecting their child

Room 3: A mother fleeing domestic violence with her three children

Room 4: A parent and child at the point of removal

1. Review the trauma-informed practices for SAFETY on Page 8 in your *Being Trauma-Informed* workbook.
2. As a group, discuss a trauma-informed approach to your scenario.
3. What are some potential threats to a sense of safety for the person(s) in your scenario?
4. Document specific practices to increase physical and psychological safety for your scenario on Page 9 in your workbook.
5. Choose a spokesperson to report 2-3 of your group's practices when you return to the main platform.

LOW IMPACT DEBRIEFING: THE STEPS



1. SELF AWARENESS

Have you ever shocked or horrified friends or family with a work story that you thought was benign or even funny? Helping Professionals can become desensitized to the trauma and loss that they are exposed to daily. Be aware of the stories you tell and the level of detail you provide when telling a story. Are all the details really necessary? Can you give a "Coles notes" or abbreviated version?



2. FAIR WARNING

If you had to call your sister to tell her that your grandfather has passed away, you would likely start the phone call with "I have some bad news" or "You better sit down". This allows the listener to brace themselves to hear the story. Allow your listener to prepare and brace themselves by starting with "I would like to debrief a difficult situation with you and the story involves traumatic content."



3. CONSENT

Once you have warned the listener, then ask for consent. This can be as simple as something like: "I would like to debrief something with you, is this a good time?" or "I heard something really hard today, could I talk to you about it?"

The listener then has a chance to decline, or to qualify what they are able/ready to hear.



4. LIMITED DISCLOSURE

Once you have received consent from your colleague, decide how much to share, starting with the least traumatic information, and gradually progressing as needed. You may end up not needing to share the most graphic details.

"When Helping Professionals hear and see difficult things, a normal reaction is to want to debrief with someone, the problem is that we are often debriefing ourselves all over each other..."

*Françoise Mathieu,
M.Ed., CCC., RP,
Co-Executive Director,
TEND*

As Helping Professionals, we have made a decision to do the work we do which can include hearing and seeing very difficult things. At TEND, we believe that it is important to understand and practice self-care techniques like Low Impact Debriefing. We also believe It is equally important to be good stewards of the stories we hear, and responsibly practice Low Impact Debriefing to protect our colleagues, friends and families.

SYMPTOMS THAT OVERLAP WITH CHILD TRAUMA AND MENTAL ILLNESS

<u>MENTAL ILLNESS</u>	<u>OVERLAPPING SYMPTOMS</u>	<u>TRAUMA</u>
1. Bipolar Disorder	hyperarousal and other anxiety symptoms mimicking hypomania; traumatic reenactment mimicking aggressive or hypersexual behavior; and maladaptive attempts at cognitive coping mimicking pseudo-manic statements	Child Trauma
2. Attention Deficit / Hyperactivity Disorder	restless, hyperactive, disorganized, and/or agitated activity; difficulty sleeping, poor concentration, and hypervigilant motor activity	Child Trauma
3. Oppositional Defiant Disorder	a predominance of angry outbursts and irritability	Child Trauma
4. Panic Disorder	striking anxiety and psychological and physiologic distress upon exposure to trauma reminders and avoidance of talking about the trauma	Child Trauma
5. Anxiety Disorder including Social Anxiety, Obsessive-Compulsive Disorder, Generalized Anxiety Disorder, or Phobia	avoidance of feared stimuli, physiologic and psychological hyperarousal upon exposure to feared stimuli, sleep problems, hypervigilance, and increased startle reaction	Child Trauma

6. Major Depressive Disorder	self-injurious behaviors as avoidant coping with trauma reminders, social withdrawal, affective numbing, and/or sleep difficulties	Child Trauma
7. Substance Abuse Disorder	drugs and/or alcohol used to numb or avoid trauma reminders	Child Trauma
8. Psychotic Disorder	severely agitated, hypervigilance, flashbacks, sleep disturbance, numbing, and/or social withdrawal, unusual perceptions, impairment of sensorium and fluctuating levels of consciousness	Child Trauma

SOURCE: Griffin, G., McClelland, G., Holzberg, M., Stolbach, B., Maj, N., & Kisiel, C. (2012) Addressing the Impact of Trauma before Diagnosing Mental Illness in Child Welfare, *Child Welfare*, 90, (6), 69 – 89. Retrieved from <http://ccfs.sc.edu/resources/pdf/overlap.pdf>

QUESTIONS TO ASK MENTAL HEALTH PROVIDERS

1. Does the individual/agency that provides therapy conduct a comprehensive trauma assessment?
 - What specific standardized measures are given?
 - What did your assessment show?
 - What were some of the major strengths and/or areas of concern?
2. Is the clinician/agency familiar with evidenced-based treatment models?
3. Have clinicians had specific training in an evidenced-based model (when, where, by whom, how much)?
4. Does the individual/agency provide ongoing clinical supervision and consultation to its staff, including how model fidelity is monitored?
5. Which approach(es) does the clinician/agency use with children and families?
6. How are parent support, conjoint therapy, parent training, and/or psychoeducation offered?
7. Which techniques are used for assisting with the following:
 - Building a strong therapeutic relationship
 - Affect expression and regulation skills
 - Anxiety management
 - Relaxation skills
 - Cognitive processing/reframing
 - Construction of a coherent trauma narrative
 - Strategies that allow exposure to traumatic memories and feelings in tolerable doses so that they can be mastered and integrated into the child's experience
 - Personal safety/empowerment activities
 - Resiliency and closure
8. How are cultural competency and special needs issues addressed?
9. Is the clinician or agency willing to participate in the multidisciplinary team (MDT) meetings and in the court process, as appropriate?

SOURCE: The National Child Traumatic Stress Network (2013). *Child Welfare Trauma Training Toolkit: Questions for Mental Health Providers*. Retrieved from www.NCTSN.org

Breakout Room: Operationalizing Trauma-Informed Practices for

CULTURAL AND HISTORICAL TRAUMA

(10 minutes)

You have been assigned the following scenario, based on your breakout room:

Room 1: Mother accuses the worker of racism.

Room 2: Transgender youth on caseload wishes to dress and live as a gender different than that assigned at birth.

Room 3: Parents are undocumented immigrants who are fearful of authorities.

Room 4: Parent was previously in foster care.

1. Review the trauma-informed practices for CULTURAL AND HISTORICAL TRAUMA on Page 22-24 in your *Being Trauma-Informed* workbook.
2. As a group, discuss a trauma-informed approach to your scenario.
3. What are some potential threats to empowerment, voice, and choice for the person(s) in your scenario?
4. Document specific ways to increase physical and psychological safety on Page 25 in your workbook.
5. Choose a spokesperson to report 2-3 of your group's practices when you return to the main platform.