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Building Resilience in Foster Children: The Role of the Child's Advocate

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I. Introduction

Children who enter the foster care system often suffer from the effects of traumatic stress. The sources of their trauma[1] may vary: they may be the victims of physical abuse, sexual abuse, or neglect—or they may be exposed to violence in their homes or communities.[2] Similarly, many children who enter the child welfare system have experienced the loss of one or more significant adults in their lives, often through death or abandonment.[3] Although the removal of a child from an abusive or neglectful home may be necessary to ensure the child's safety and wellbeing, the child may experience that removal as traumatic.[4] Because so many children entering the child welfare system are impacted by trauma, it is essential that children's advocates understand trauma, its impacts upon children's development, and steps they can take to enhance their clients' resilience.[5]

Researchers and some mental health professionals have been aware of trauma and its impacts on children for years,[6] although focused research began only in the 1980s.[7] More recently, courts have begun to recognize and address the impact of trauma on children in various legal contexts.[8] Unless a foster child's trauma has been addressed, he or she will be at heightened risk for adverse outcomes[9] such as placement or school failure, delinquency, poor physical health, and emotional/behavioral dysregulation (i.e., out-of-balance emotions that lead to out-of-control behavior).[10]

This Article provides an introduction to, and brief overview of trauma, its impact upon foster children, and steps children's advocates[11] can take to lessen or ameliorate the impact of trauma upon their clients. This Article begins in Part II by defining relevant terms. Part III addresses the prevalence of trauma among children entering the child welfare system. Part IV considers the neurodevelopmental (i.e., the developing brain) impact of trauma on children and will explore how that trauma may manifest emotionally and behaviorally. With this foundation in place, Part V discusses the need for a comprehensive trauma assessment including a thorough review of the child's history of potentially traumatic experiences and the impact those experiences have had and are continuing to have on the child. This Article argues that a more complete understanding of the number and severity of potentially traumatic events a child has experienced, as well as knowledge of the various traumatic impacts on the child's developing brain are essential to begin addressing the needs of children in the child welfare system. Next, in Part VI, this Article explores ways in which a child's resilience can be enhanced, specifically the importance of connectedness/relatedness, mastery, and affect regulation. Finally, Part VII discusses implications of this information for children's advocates.

II. Definitions

In discussing trauma, its impact upon children, and the role of children's advocates in addressing the needs of traumatized children, it is important to begin with a common understanding of various terms. This segment of this Article will provide that common understanding.

In this Article, "trauma" refers to an overwhelming event that renders a child helpless or powerless, thereby creating a threat of harm to the child coupled with the internalization of that experience, which continues to impact the child's perception of self, others, his or her development, and the world.[12] Trauma in this sense generally refers to being a victim of violence, witnessing violence, or experiencing stressful life events.[13] As Bessel van der Kolk, a leading researcher and theorist of childhood trauma, has written, "at the core of traumatic stress is the breakdown in the capacity to regulate internal states."[14]

A related concept is "complex trauma." Complex trauma refers to "the problem of children's exposure to multiple or prolonged traumatic events and the impact of this exposure on their development."[15] When referring to complex trauma, mental health professionals typically mean that a child has been exposed to multiple potentially traumatic events, either simultaneously or sequentially.[16] Specific to child welfare, complex trauma refers to children who have experienced more than one of the following: physical abuse, psychological abuse, sexual abuse, neglect, or exposure to violence within the home.[17] Consider, for example, a child who resides with a drug-addicted mother who physically assaults the child when she is irritable because she does not have access to her drug of choice. This mother has lived with a series of abusive boyfriends, and at least one has sexually abused the child. As a result, the child becomes depressed, dissociates,[18] or otherwise acts out. This child has experienced complex trauma. Researchers and mental health professionals may sometimes refer to this as a comorbidity; that is, there are multiple traumatic factors

that impinge—either simultaneously or sequentially—upon the child's safety, security, and well-being and which have impacted her functioning.

Another term to be aware of is "early childhood trauma," which typically refers to trauma experienced by a child age 0–6 years.[19] Exposure to traumatic experiences in early childhood can be particularly harmful because it is during this critical time that children are forming the basic attachments to their primary caregivers and other significant adults that will provide them with a path to healthy growth as well as relational and emotional adjustment.[20] Additionally during these all-important early years, the child's rapidly developing brain is especially vulnerable to the impacts of complex trauma.[21] As this Article later discusses, exposure to trauma can interrupt neurodevelopment and can actually alter children's brain architecture.[22]

"Resilience" has been defined as "the capacity to maintain or regain adaptive functioning in the face of adverse conditions."[23] In other words, this concept refers, basically, to the child's "ability to bounce back" or "manage the stress" from a potentially traumatic event.[24] Consider a child from a supportive family, who lives in a safe neighborhood, and who enjoys the benefits of access to various professionals to address his physical and psychological needs. If such a child were to be assaulted physically or sexually—that is, if he were to experience a potentially traumatic event—this child has in place the building blocks for resilience that include relatedness with an adult caregiver and affect regulation skills.[25] Equipped with these building blocks the child is better able to "bounce back" from the potentially traumatic event. Now consider the same event experienced by a child from a dysfunctional family where the adults are not able to provide adequate support and the community where the family resides is riddled with violence and lacking necessary resources, including concerned and competent professionals to address this child's trauma and assist in his recovery. This child's ability to "bounce back" from a potentially traumatic experience is diminished.[26] Such a child lacks many essential resources necessary to be resilient. Resilience in the context of this Article is sometimes referred to as "protective factors," which are external (e.g., supportive parents, parental employment) and internal (e.g., effective social skills) resources available to the child that buffer potential traumatic stress.[27]

This Article will frequently refer to "trauma-informed services," which are services rooted in a thorough understanding of traumatic experiences and their potential impact on children, that are evidence-based or evidence-supported, and that are culturally competent.[28]

With these basic terms defined in order to provide a common understanding, this Article will now turn to a consideration of the prevalence of experienced trauma among children who enter the nation's child welfare system.

III. Prevalence of Trauma Among the Child Welfare Population

It should now be quite clear that given the nature of the foster care system and the social maladies it addresses, many or most children entering the child welfare system have experienced some form of trauma.[29] Generally, children enter foster care because of pervasive neglect or as a result of physical, sexual, or psychological maltreatment by their parents or legally responsible caregivers. Very often, children have experienced more than one of these trauma-inducing life events in combination.[30] Results of a recent study conducted by the National Child Traumatic Stress Network of 2,251 children entering the foster care system found that these children "typically have experienced at least one caregiver-related trauma (e.g., abuse or neglect)."[31] This same study found that seventy percent of these children had experienced at least two of the traumas that contribute to complex trauma, with an average of five traumatic exposures.[32] Among children who were experiencing complex trauma, the average number of traumatic events was six.[33] Thus, virtually every child who is removed from his or her family or legal guardian, and then placed into the foster care system has experienced some level of trauma within the home. Moreover, although necessary to protect the child in some instances, removing a child from the home she has known, even a home that is violent and threatens the child's wellbeing, may itself be a traumatic experience for that child.[34] The Administration for Children, Youth and Families ("ACYF"), which aims to promote the well-being of children in the child welfare system states: "To focus on social and emotional well-being is to attend to children's behavioral, emotional, and social functioning—those skills, capacities, and characteristics that enable young people to understand and navigate their world in healthy, positive ways."[35] When a child is removed from his or her family of origin and placed in foster care, that child is often unmoored from other supportive elements within the extended family and community such as school, church, and friends, which may have helped the child to cope with the situation. Safe and healthy relationships communicate to children that they are valued and loved, that they can trust others, and that they are not alone, which in turn serves to mitigate the potential harmful effects of trauma. Additionally, a child's sense of self is threatened with the loss of key adults who provide the child with a sense of value, which is essential to the development of mastery/efficacy,[36] another key protective factor in resilience.[37]

Accordingly, the next section will examine more closely the impact of trauma on children.

IV. Impact of Trauma

Each child experiences potentially traumatic events differently. Abuse or neglect that will traumatize one child, leaving him or her severely impacted, may not be trauma-inducing in another. The impact of trauma on the individual child depends on a variety of factors such as the child's temperament, the accumulated number and type of experienced traumatic events, the child's support network of family and friends, and the child's access to professional assistance to cope with the trauma.[38] Generally, the overall impact of trauma is divided into three categories: physical impacts, neurodevelopmental impacts, and psychosocial impacts. Each of these categories of impact will be addressed in turn.

A. Physical Impacts

Children exposed to trauma are at risk for a variety of physical ailments and health-related impairments. For over fifteen years the National Centers for Disease Control and Kaiser Permanente have been collaborating to conduct an on-going study of Adverse Childhood Experiences ("ACE") and their impact over the life course.[39] To date, this study has included more than 17,000 participants.[40] The profound ACE study findings reveal that adverse childhood experiences such as abuse and neglect have a significant direct relationship to adult health even a half-century after the traumatic event occurred.[41] The researchers found:

> A highly significant relationship between adverse childhood experiences and depression, suicide attempts, alcoholism, drug abuse, sexual promiscuity, domestic violence, cigarette smoking, obesity, physical inactivity, and sexually transmitted diseases. In addition, the more adverse childhood experiences reported, the more likely that person was to develop heart disease, cancer, stroke, diabetes, skeletal fractures, and liver disease.[42]

It is thus not surprising that recent research found that eighty percent of children in the foster care system suffer from at least one chronic medical condition, while twenty-five percent have at least three chronic medical problems.[43]

An example from one of the author's[44] recent practice may help to illustrate how general health is impacted by earlier trauma. At this writing, the author represents an infant who was diagnosed with neonatal abstinence syndrome at birth.[45] The infant-client's mother had illegally used the prescription drug Vicodin while pregnant. After his birth, this drug-addicted infant remained in the hospital for a month as he was slowly weaned from the opiate medication. Despite the termination of the parents' rights to four other children only a year earlier, Child Protective Services ("CPS") decided court action was not necessary to protect the infant. Approximately one month after his release from the hospital to the parents, the child was again brought to the hospital due to repeated physical abuse. He was suffering from a freshly broken leg, a healing fracture of a rib, and a torn frenulum.[46] Since being placed in foster care, he has continued to be especially vulnerable to colds and has twice been hospitalized for pneumonia. He also has significant feeding problems and thus has subsequently gained only a few ounces in three months. The doctors explained that the child's vulnerabilities were largely because of his *in utero* exposure to opiates.[47] Children who experience pre-natal trauma are at risk for numerous poor physical outcomes, including low birth weight and infant mortality.[48]

B. Neurodevelopmental Impact

To understand the impact of trauma on children, it is important to have a basic understanding of human brain development.[49] The human brain "develops in a predictable fashion—from most primitive to most complex."[50] The brainstem, which connects to the spinal cord, is the most primitive portion of the brain and is responsible for basic bodily functions such as regulation of respiration and heart rate.[51] Brainstem impairment can be life threatening if the brain is unable to properly and automatically regulate heartbeat or breathing.[52]

The limbic system, located in the central part of the brain (the mid-brain) is responsible for functions such as the regulation of mood, perception of fear or anxiety, and arousal regulation (e.g., in states of fear or anger).[53] It is essential to human survival to experience and process fear or anger, because of the chemical results of these experiences.[54] When this process is triggered, the brain secretes certain chemicals that increase heart rate and respiration and in other ways prepares the body to either flee from or confront the perceived danger:[55] the fight or flight response.[56] But living in a persistent state of fear, such as when a child lives with the constant fear of being physically assaulted by his caretakers or constant exposure to domestic violence, means that those stress-related neurochemicals are constantly being secreted. These neurochemicals are secreted in an experience-dependant way, meaning these "disruptions of experience-dependent neurochemical signals during [critical or sensitive] periods (e.g., the prenatal period and the first three years of life) may lead to major abnormalities or deficits in neurodevelopment—some of which may not be reversible."[57]

The prefrontal cortex, located behind the forehead, is responsible for higher-level cognition, abstract thought, and logical reasoning.[58] The cortex is the final system of the brain to develop, and its development continues through adolescence and into young adulthood.[59] The failure of healthy brain development in the early stages of development (that is, in the regions of the brain that control more primitive functions) impairs later development of those regions of the brain that are responsible for more complex functions such as abstract thinking.[60]

Experience changes the brain throughout the lifespan. For example, one may learn to speak a foreign language in adulthood, which creates new neural pathways and literally changes the physical makeup of the brain as new neuronal connections are created. However, "experience during the critical periods of early childhood *organizes* the brain systems."[61] Thus, as Dr. Bruce Perry, a leading expert in the field of child trauma, and his colleagues have observed, "trauma during infancy and childhood . . . has the potential effect of influencing the permanent organization—and all future functional capabilities—of the child."[62] This is why child maltreatment, particularly child neglect, early in life can have such devastating consequences for children; the traumatic stress that results from neglect may literally change the architecture of the child's brain systems in ways that may permanently impair the child's functioning in every domain of development—sensory, emotional, cognitive, and social.[63]

i. Hyperarousal and Dissociation

When humans are relaxed and happy (i.e., in an optimally regulated state), the brain tends to mainly function under the influence of the cerebral cortex. The cerebral cortex allows humans to carefully think things through, reason, and debate the best approach to a problem. When threatened by fear, however, the level of arousal is increased and brain functioning moves from cortical (cortex) control to mid-brain,[64] which is the more primitive, faster-acting region of the brain. This is a good thing as it can help to keep humans alive in an emergency by giving them the ability to either flee from or confront danger.

When threats are constant and ongoing, this "life-preserving" brain function can become damaging because the brain remains in this aroused, high-energy state. This constant state of high-energy arousal is termed "hyperarousal."[65] Traumatized children often function in a state of chronic hyperarousal, which can result in symptoms that may "include difficulty falling or staying asleep; irritability or outbursts of anger; difficulty concentrating; hypervigilance; and an exaggerated startle response."[66] Dr. Perry has written, "with prolonged fear there can be chronic or near-permanent changes in the brain. The brain alternations that result from lingering terror, especially early in life, may cause an enduring shift to a more impulsive, more aggressive, less thoughtful and less empathic way of responding to the world."[67] Consequently, the capacity for relatedness, a protective factor in resiliency, is compromised, which can have significant negative ramifications not only in childhood, but also in adulthood.

Traumatic stress physically alters the brains of infants and young children during development. The fight or flight response is not of much practical use to infants and young children, as they cannot run away and they cannot stand and fight.[68] Therefore, when increased arousal is not a viable coping mechanism for dealing with trauma-inducing experiences, the body may move into a state of dissociation. Like hyperarousal, dissociation takes place at a chemical level in the brain (i.e., neurobiological).[69] When a child is overwhelmed with danger and fear, her brain secretes chemicals that allow her to neurologically remove herself from the situation resulting in hyperarousal or dissociation. Hyperarousal results in the release of neurochemicals in the brain (via the sympathetic nervous system) that increase blood pressure, respiratory rate, heart rate, and prepares the organism to flee or fight.[70] Different stress-related neurochemicals are released in an episode of dissociation, which slow the heart rate and respiratory rate and lower blood pressure (via the parasympathetic nervous system).[71] Children who disassociate experience numbing, use compliance or avoidance, and experience a restricted range of affect.[72] These children sometimes describe "going to another place," becoming a superhero, or floating above the event and watching it as a means of coping with the trauma-inducing event.[73]

Often children's neurological reactions to trauma differ depending on their sex. In general, as children grow and age, traumatized boys are more likely to be hyperaroused; they frequently are diagnosed with ADHD, oppositional-defiant disorder, and often display symptoms of aggression.[74] They may grow up to be aggressive and hostile, and violate the rules of society. In contrast, young girls who have experienced similar trauma tend to dissociate; they become quiet, withdrawn, or depressed.[75] The results of their history of unaddressed trauma are likely to be turned inward against themselves.[76] Because of their different reactions to their experienced trauma, boys tend to come to the attention of authority figures such as teachers, parents, and law enforcement officers more readily than girls. As Bruce Perry and his colleagues have written poignantly, "[t]he potential homicide threatens; the potential suicide inconveniences."[77]

ii. Cognition

Maltreatment may impact a child's neurodevelopment and can result in cognitive delays.[78] For example, infants that experience pervasive neglect have been found to have significantly smaller brains than non-neglected children of the same age.[79] One impact of this maltreatment is that children who experience it have lower IQ scores than comparable non-maltreated children.[80] Generally speaking, the longer the child remains in an abusive or neglectful environment, the greater the negative impact is on her intellectual functioning.[81] The use of in-home services such as infant mental health involvement with the family may improve a child's home environment.[82] When the child's family of origin cannot be sufficiently assisted via in-home services to become safe and nurturing, the younger the child is moved to a safe, nurturing, and adequately stimulating environment, the more likely the child will achieve normal intellectual functioning.[83]

The cognitive impairment resulting from maltreatment may also include language delays.[84] As Dr. Bruce Perry has observed, "if a child is not exposed to language during his early life, he may never be able to speak or understand speech normally."[85] If children do not have sufficient opportunities to listen and speak, they will have diminished language capabilities because language is "use-dependent."[86] That is, if language is not used and experienced adequately, a child's ability to speak fluently may ultimately be lost.

Language consists of two major components: receptive language and expressive language. Receptive language is the ability to hear and understand what others are saying, while expressive language refers to the ability of a person to use spoken words.[87] Deprivation early in life may impact both expressive and receptive language. A child's failure to develop either of these critical language skills will have obvious and far-reaching consequences, including a significant impact on social communication. Therefore, abused and neglected children simply may not have the language capability to adequately explain what has happened to them. Additionally, these traumatized children may not understand what is being said to them. The more difficult and technical the language presented, of course, the less likely a child with language deficits will be able to understand what is being communicated. In a study of 274 maltreated children assessed for the impact of trauma at Western Michigan University's Southwest Michigan Children's Trauma Assessment Center ("CTAC"), approximately seventy percent of these children had moderate to major receptive language problems, with sixty-six percent having moderate to major expressive language delays.[88] Additionally, over eighty-two percent of these traumatized children had moderate to major attention problems.[89]

As these data suggest, traumatized children may exhibit cognitive impairments. In addition to such cognitive impairments, traumatized children may experience impairments in psychosocial functioning.

C. Psychosocial Impacts

There is a growing body of evidence that children who have experienced maltreatment see the world differently from children who have not experienced abuse or neglect.[90] A critical understanding of the psychosocial impacts of child trauma involves having a basic appreciation for attachment and bonding.[91] Under normal circumstances, a young child develops an emotional connection to one or a small circle of primary caregivers.[92] Once the child has established this relationship, called an "attachment," the child views these individuals as safe because they provide safety and comfort.[93] However, when this person is not consistently available to the child because the caregiver is either physically or emotionally absent, the child experiences distress.[94] It is through attachment relationships that the child learns about the world, begins to explore it, and learns to manage and regulate emotion.

Whether abuse, neglect, abandonment, or exposure to violence in the home, maltreatment may result in a failure of the child to adequately attach to a caregiver.[95] The lack of proper attachment portends a number of negative outcomes for the child, the most prominent of which is later aggressive and violent behavior.[96]

D. Delinquency, Violence and Criminality

Experiences of childhood trauma are strongly linked with delinquent, violent, and criminal behavior later in life.[97] James Gilligan, former medical director of the Bridgewater State Hospital for the criminally insane in Massachusetts and the director of Harvard Medical School's Center for the Study of Violence, has written about this connection. Of that experience, he wrote:

> In the course of my work with the most violent men in maximum-security settings, not a day goes by that I do not hear reports—often confirmed by independent sources—of how these men were victimized during childhood. Physical violence, neglect, abandonment, rejection, sexual exploitation and violation occurred on a scale so extreme, so bizarre, and so frequent that one cannot fail to see that the men who occupy the extreme end of the continuum of violent behavior in adulthood occupied an equally extreme end of the continuum of violent child abuse earlier in life.[98]

Almost half of the criminal justice population is made up of persons with histories of childhood trauma.[99] Physical abuse and neglect in childhood is associated with very high rates of arrest in adolescence and adulthood.[100] Seventy-five percent of perpetrators of child sexual abuse report that they were sexually abused during childhood.[101]

An enormous body of research has documented the link between childhood maltreatment and later violent behavior.[102] One compelling example of this research looked at the life histories of fourteen boys who had been sentenced to death as a result of violent criminal acts.[103] In that study, Dorothy Otnow Lewis and her colleagues found that twelve of those boys had been "brutally physically abused, five had been sodomized by relatives, and eleven exposed to chronic and severe domestic violence in their home."[104]

Similarly, Dorothy Van Soest and her colleagues studied the records of thirty-seven men convicted of murder and executed by the state of Texas in 1997.[105] The researchers, based upon the particular characteristics of each case, divided each man into one of two groups: 1) those "who committed murders characterized by extreme rage and brutality"; and 2) those who "committed less heinous, albeit violent, murders."[106] After studying the men's histories, the researchers concluded:

> The most striking portrayal that emerges of the men in this study is the early prevalence of violence in many of their childhoods. Violence seems to be a particularly predominant theme in the lives of the men who committed the most heinous crimes. . . . [T]he men for whom there is evidence of childhood sexual abuse and emotional or physical neglect, all of them were among the group that committed the most heinous crimes.[107]

As these examples of the extensive research into the correlation between child maltreatment and later delinquency/criminality suggest, foster children's histories of trauma, and the failure to adequately and effectively address those traumatic experiences, are likely a major contributing factor in "crossover kids," those foster youth who matriculate from the child welfare system into the delinquency and adult criminal systems.[108] Moreover, only very recently, the United States Supreme Court implicitly linked a history of childhood maltreatment with later violent behavior. In *Miller v Alabama*,[109] the Court held that a juvenile's history of maltreatment must be considered before a juvenile may be sentenced to life in prison without the possibility of parole.[110]

Why does delinquency and criminality so often follow child maltreatment? One possible explanation is linked to this Article's earlier discussion of neurodevelopment.[111] Dr. Perry and his colleagues have observed that "[d]eprivation of critical experience during development may be the most destructive yet least understood area of child maltreatment. Unlike broken bones, irreversible maldevelopment of the brain areas mediating empathy resulting from emotional neglect in infancy and childhood is not readily observable."[112] Such deprivation may result in children with severe attachment disorders, which in turn may result in violent children and violent adults.[113] These difficulties can be exacerbated when combined with other developmental problems, such as prenatal exposure to alcohol.

Maltreated children with concomitant Fetal Alcohol Spectrum Disorders ("FASD") carry even more risk for criminal behavior (including aggression and sexual offending).[114] Recently, legal and judicial thought leaders have published important information regarding FASD and its legal impact.[115] All too often, published accounts of FASD's legal impact do not appreciate that many FASD children are also traumatized. These accounts also fail to critically mention the additive neurodevelopmental/neurobehavioral impact of the co-occurrence of trauma and FASD. Unfortunately, careful longitudinal studies of FASD children without maltreatment (i.e., FASD infants adopted to loving and nurturing parents at birth) are sorely needed, but are not currently available, preventing a careful analysis of which component (trauma or FASD) is more influential for the development of criminal behavior. All concerned stakeholders must now address this critical research question.[116]

V. Need for Assessment[117]

As noted above, children entering the child welfare system may have been exposed to numerous and various potentially traumatic experiences. Appropriate *early* intervention to address the child's history of trauma can "ameliorate the intensity and severity of the response to trauma."[118] Yet, a comprehensive assessment[119] of these children's experiences is almost never completed before or after they enter the system. Nor are parents' experiences of trauma carefully assessed before or after their children enter the system. At best, CPS may have screened the parents for risk factors and the children for risk and safety factors.[120]

In its 2005 Child and Family Services Review ("CFSR"), the Department of Health and Human Services noted that "'agency risk and safety assessments are often not sufficiently comprehensive to capture underlying family issues that may contribute to maltreatment, such as substance abuse, mental illness, and domestic violence.'"[121] Similarly, the CFSR process identified

the lack of timely and comprehensive assessment of children's mental health needs as a major problem among states.[122] Thus, the allegations in a petition filed by CPS should be considered merely the tip of the proverbial iceberg of the reality of the family members' experience. Moreover, because every child is different and may react to traumatic experiences differently (one may emerge apparently unscathed from experiences that would have deeply scarred another child)[123] it is essential that the family and each of its individual members receive a careful comprehensive trauma-informed assessment.[124] Assessment should focus on functional capacities and not merely psychological conditions.[125] To maximize that assessment's utility, it should be done as early in the case as possible, and should also be comprehensive, multidisciplinary, and trauma-informed.

A. The Need for Early Assessment

While CPS or foster care workers may screen children and families for co-occurring problems, they may not be qualified or skilled in identifying attendant problems (such as attentional/executive dysfunction, language problems, and regulatory issues) or may not understand their importance. By obtaining a comprehensive evaluation by a highly skilled team of evaluators at the earliest possible point in the case, it is more likely that problems in individual and family functioning will be identified. Early identification will provide a better understanding of the risks the child faced while at home and the problems that must be addressed before the child may be returned.

Early evaluation may help to safely maintain the child in the parental home obviating the need for removal, while early assessment can more accurately identify risk factors and parenting deficits, thereby providing an opportunity to arrange for in-home services. Consider research of CPS-involved families by Dr. Kathleen Coulborn Faller and her colleagues at the University of Michigan School of Social Work.[126] The families were provided a comprehensive, multidisciplinary assessment soon after CPS substantiated that child maltreatment had taken place in the home.[127] Because a careful assessment was done, more appropriate services were provided to the family.[128] One year later, children in the families that received the early assessment were more likely to remain at home safely than a comparison group of children who did not receive such assessment.[129] Indeed, at the one year follow-up more than three-quarters of the children whose family received an in-depth early assessment were still at home with their parents.[130] By comparison, children whose families did not receive that early and detailed assessment were twice as likely to be living with relatives, four times more likely to be in foster care, and twice as likely to be in an adoptive home one year after the initial intervention.[131] This study suggests that early assessment of the family can be useful in preserving families—a goal consistent with federal and state mandates for child safety.[132] Because any removal from the familial home is a traumatic experience for most children, early assessment may reduce children's accumulated trauma.

An additional reason to pursue an early assessment is that the child or parent is likely to have experienced more and different trauma-inducing experiences than is known to investigators. It is common occurrence in child welfare practice to encounter a family that enters the system based upon one type of allegation, only to learn sometime after the children are removed that there is other maltreatment and trauma that were not disclosed in the initial investigation. For instance, a child may be originally removed from the parental home as a result of neglect, later to disclose sexual abuse only after feeling safe in a nurturing and supportive foster home.[133] Additionally, without an early assessment, it is common that parenting problems are not discovered until after the children have been in foster care for months, therefore leaving the parents with insufficient notice of the need to address the issue and without the services needed to do so. Therefore, it is important to identify as many of these concerns as possible early in the case in order to develop adequate treatment plans for the parents and the children. Doing so will provide the parent the best opportunity to obtain and benefit from services that are of the necessary type, intensity, and duration to address the parent's needs. It will also go far in ensuring decision-making that will serve the child's interests in safety, permanency, and wellbeing.

Additionally, an early assessment will help to establish a baseline from which to measure parental progress. Too often in the child welfare system, individuals are sent for treatment when it is not clear what is to be treated or how treatment success will be measured. That is, child welfare workers, advocates, and courts prescribe remedies before the malady to be addressed has been diagnosed. Imagine for a moment going to the emergency room because you injured yourself when you fell off your roof while cleaning the gutters. If the emergency room personnel functioned like the child welfare system, they would test your vital signs then immediately put a cast on your leg. At some later date, after you had not healed, they would do x-rays only to discover that it was your arm rather than your leg that was broken. Absurd, isn't it? Yet the child welfare system routinely functions in an analogous way as a matter of course.

Parents and children are mandated to "go to counseling" or "go to parenting classes" without first

determining what the problem is, whether that particular counseling or parenting class, the treatment, is of the correct type, intensity, and duration. Because parents and children are prescribed treatment before proper diagnosis, it is common to find out later that the parents and children have problems that were never imagined.[134] The assessment process will aid in properly identifying the relevant problems and in more precisely prescribing services to address those problems. In part because the child welfare system fails to properly diagnose problems, it fails to provide timely services and children remain for unnecessarily long periods of time in the temporary foster care system.

Finally, such an assessment may identify cases that should be fast tracked for early permanency. The Adoption and Safe Families Act included provisions, codified in Title IV-E of the Social Security Act, that permit child welfare agencies to seek and courts to grant early termination of parental rights or to pursue other alternative permanency plans.[135] This is possible in any case in which it is unlikely that the child can be returned to the parent in a timely fashion, within the 12 to 15 month timeframe provided by federal law.[136] That is, Congress recognized that there are some cases, although not defined in the federal law or by the state as an "aggravated circumstances" case, which may warrant immediate decisions not to pursue family reunification. In such cases, Congress made clear that state authorities may move immediately to alternative permanency plans.[137] Pursuant to this recognition, some states (e.g., Illinois) have made it clear in their child welfare statutes that the child welfare agency may seek early permanency, and may obviate the need to make "reasonable efforts" in any appropriate case.[138] Making children wait in temporary foster care while their parents are provided services that we can reasonably predict will be futile, is not only contrary to the child's interests, it may further exacerbate the trauma and continue to derail development.[139]

B. The Case for Comprehensive Assessments

The need to assess children entering the foster care system across a number of domains has been widely advocated.[140] Numerous commentators have recognized the need to evaluate various aspects of a child's or parent's functioning when they come into contact with child protective authorities or enter the foster care system.[141] These have included discipline-specific medical assessments, education assessments, and mental health assessments.[142] A comprehensive, trauma-informed assessment of each individual, as well as their functioning as a family unit, however, will enhance legal decision-making. It has been observed that a "lack of in-depth assessment plays a role in . . . inconsistency in assuring child safety and insufficient or inappropriate services to reduce risk of harm to children" in the child welfare system.[143] Comprehensive evaluations are conducted in order to identify functional problems, the services necessary to address those problems, as well as the strengths possessed by members of the family.[144] Tina Maschi, an expert in trauma's impact upon children and youth, has observed "[c]omprehensive trauma assessment necessitates a broad assessment tool that measures minor to severe stressors that negatively affect youth."[145] As Maschi's assertion suggests, in the child protection context, comprehensive assessments examine all aspects of functioning and seek to identify maltreatment risk factors. Additionally, these assessments seek to design a case plan that is case-specific and carefully tailored to the individual needs of the particular family and its constituent members, rather than the generic plans often utilized in the child welfare system.

At a minimum, a comprehensive assessment would consider the following: mental functioning; history of child maltreatment; exposure to violence in the home, in the form of domestic violence, or in the community; loss of significant relationships; other potential sources of trauma (e.g., natural disasters); medical needs; and educational status and needs of each child and parent. Additionally, as previously discussed, when considering a child's experience of trauma, it is important to consider the prenatal environment. A child's prenatal experience may profoundly affect that child's functioning across the life span. Recent research has discovered a much higher rate of Fetal Alcohol Syndrome ("FAS") and Fetal Alcohol Spectrum Disorder ("FASD") than was previously reported.[146] FAS or FASD also may profoundly impact a child's development.[147] As mentioned above, research done at the Southwest Michigan Children's Trauma Assessment Center has discovered that forty percent of the 274 children they assessed as suffering from moderate to major trauma effects also suffered FASD.[148] This combination of risk factors interacts to impair children's functioning across many functional domains.[149] Thus, every comprehensive trauma assessment should include screening for FASD.

Not only are assessments that cover an array of domains essential, assessment by professionals from various disciplines is necessary. As should be clear from this discussion, a truly comprehensive trauma-informed assessment, where trauma history and symptomology is a key component, necessitates a multidisciplinary[150] approach.

C. The Case for a Multidisciplinary Assessment

No single discipline "owns" the problem of child maltreatment or has the expertise to respond to it in a comprehensive way.[151] Rather, in order to address the multifaceted challenges presented by the phenomena of child abuse and neglect, it is essential that various disciplines truly collaborate in order to fully understand and properly respond to all needs of the children and families that enter the child welfare system.[152] The composition of multidisciplinary teams may vary, but typically include social workers, psychologists, medical professionals, occupational therapists, speech-language pathologists, and lawyers. Utilizing a multidisciplinary process develops a much deeper understanding of the individual and his or her interaction with other family members. An important strength of using a multidisciplinary team is that it balances the natural bias of individual evaluators and provides a more objective picture of the functioning of each individual and the family as a unit.[153] There is a natural process of critical analysis and critique that occurs as individuals with differing perspectives weigh in on what they see happening within the family and its constituent members. Finally, having professionals from varying disciplines involved, allows the team to view individuals and families and consider the family's problems and strengths from differing professional perspectives. This allows for more creativity in thinking about needs of the family and the resources available to best meet those needs.

For these reasons, professionals from numerous disciplines have argued for their involvement in assessing child maltreatment cases.[154] Consequently, federal law has long recognized the value of multidisciplinary assessment of children and families and provides financial support to establish and operate multidisciplinary teams composed of professionals from various disciplines to assist CPS in responding to child maltreatment.[155] In response to federal encouragement, a number of states have enacted statutory provisions that permit or require the establishment and use of multidisciplinary teams to respond to child maltreatment.[156]

It may be challenging to maintain such teams despite their significant value due to cost, time, and a lack of genuine collaboration that transcends turf issues. However, a commitment to viewing the child from a holistic perspective is essential. Therefore, professionals must be willing to learn from each other to better understand and match children's needs with the appropriate interventions, which is essential if such advances are to be successfully made.

D. Trauma-Informed Assessment

Over the past fifteen years, scientists have learned a great deal about the impact of traumatic experiences on children during their development.[157] As previously discussed, exposure to traumatic events can compromise how the brain functions, commonly resulting in a constellation of symptoms and behaviors often diagnosed as Post-traumatic Stress Disorder ("PTSD").[158] PTSD results from exposure to a traumatic event or events that alter chemical secretions in the brain and may ultimately result in architectural changes to the human brain.[159] A truly comprehensive trauma-informed assessment of a child and family should carefully consider how the trauma experience has impacted the brain function of both the child and parent as well as the resulting problematic behaviors (the brain-behavior connection) of all parties.

When a child is assessed and found to be reacting to traumatic events, it is important to connect that child with trauma-informed treatment. Traditional treatments such as talk therapy and psychopharmacology may help with some of the symptoms of trauma. Until the underlying trauma has been addressed in the treatment process, however, a child's emotional and behavioral problems will likely persist or, at best, may temporarily dissipate only to return later. Research has shown that many forms of evidence-based treatment are helpful to traumatized children.[160]

Two of the most prominent of these treatments are Trauma-Focused Cognitive Behavioral Therapy ("TF-CBT") for children five years of age or older, and Child-Parent Psychotherapy for children birth to eight years.[161] These are evidence-based, structured, and manualized treatment modalities that research has confirmed to be effective. They are increasingly available in communities across the United States. In the authors' home state of Michigan, for example, a community health trauma-informed initiative has trained and provided ongoing consultations to over 200 therapists in TF-CBT. It is important that the child's advocate directly ask a treatment provider about the provider's credentials and experience with these and similar evidence-based, trauma-informed treatments. The Substance Abuse and Mental Health Services Administration ("SAMHSA") maintains an easy-to-use website of evidence-based practices that the advocate should review to assist the advocate in obtaining the appropriate treatment programs for clients.[162]

While this Article focuses on the impact of trauma on children who enter the foster care system, they are rarely the only members of their families who have experienced trauma.[163] It is common that the parents of the children entering the foster care system have also

been victims of trauma, which has never been adequately addressed.[164] A history of childhood physical and sexual abuse is associated with various psychiatric disorders including substance abuse, borderline personality disorder, antisocial personality disorder, eating disorders such as anorexia and bulimia, dissociative disorder, and affective and somatoform[165] disorders. In addition, research demonstrates "a strong relationship between violent victimization history [and] abuse of drugs and alcohol."[166] As Bessel van der Kolk has observed, "most interpersonal trauma on children is perpetrated by victims who grow up to become perpetrators or repeat victims of violence."[167]

For instance, many young women whose children are in the child welfare system engage in substance abuse as a means of coping with multiple life stressors.[168] In 2009, the Pennsylvania Coalition Against Rape published a monograph, which summarizes the research that links substance abuse by women to their earlier traumatic victimization and provides guidance to counselors in responding to these complex cases.[169] The report found that "[v]ictims of sexual assault, including childhood sexual abuse, may use alcohol or drugs to numb or escape from painful memories or PTSD symptoms. When they attempt to stop using the drug, symptoms reappear and the likelihood of relapse increases."[170] The report continues by stating:

> The relationship between sexual violence and addiction is complex and often reciprocal in that sexual violence may be a precursor to or consequence of substance use, abuse, or addiction.
>
> A prior history of victimization may predispose someone to drug and alcohol use, abuse and addiction, while drug and alcohol problems may be a risk factor for victimization.[171]

Because of the strong link between sexual victimization and substance abuse, it is reasonable to screen each mother whose child enters the child welfare system.[172] Men, too, should be screened for sexual victimization. Estimates suggest that one in every nine males has a history of sexual abuse.[173] Failure to identify the parent's history of sexual victimization early in the case and provide proper services sets the stage for relapse. The failure and likely relapse deprives the parent of a meaningful opportunity to stabilize her or his life and regain custody of her or his children, by making the possibility of reunification more unlikely.

In short, a comprehensive trauma-informed assessment of each family member, and the relationship between those traumatic experiences and current functioning, is essential to fully understanding the family's needs and identifying the services necessary to address the reasons the children came to the attention of the child welfare system. As the research suggests, trauma is cyclical; when a child experiences trauma during her childhood that is not addressed, it is likely that she may display behaviors and suffer from disorders that create a traumatic environment for her own children. As this Article suggests, parents involved in the child welfare system may have a significant need for trauma-informed services, to end this cycle. A child's advocate should press for such an evaluation and subsequent trauma treatment in each case to aid in case planning.

VI. Building Resilience

Many adults assume that children who have experienced trauma are naturally resilient.[174] This sentiment is expressed when an adult says of a traumatized infant, "she is too young to remember what happened," or when adults tell a child to "just get over it." Unfortunately, children are not naturally or automatically resilient.[175] Children who have lived through trauma-inducing experiences need specific types of support to build protective factors and reduce risk factors in order to better cope with their impact.[176] What then can the child's advocate do to help the child "bounce back" from her or his experience of trauma? The research suggests three key factors that enhance a child's ability to rebound from trauma: 1) connectedness/relatedness; 2) mastery/efficacy; and 3) affect regulation.

A. Connectedness/Relatedness

Sometimes referred to as "relational security," connectedness means that children's efforts to cope with and overcome their experiences of trauma are enhanced when they have strong, long-lasting connections to stable, nurturing adults.[177] Most naturally, children, particularly young children, are most connected to their birth families, including parents, grandparents, aunts, and uncles. The importance of these connections for children forms the foundation of the entire child welfare system. The policy choice to preserve families consistent with the child's safety is also rooted in the cultural belief, reflected in law, that parents are the natural guardians of their children and it is parents to whom most children are naturally emotionally connected.[178] Of course, law and policy recognize the reality that a small sub-set of parents are unable or unwilling to act in their children's best interests.[179] Only when parents cannot safely care for their children does the law permit the state to step in.

When a child must be removed from the home, it is important that that relationship between the child and her parent be maintained or that an alternative relationship be offered and potentially established. This is because

in overcoming the impact of trauma, "the availability of a healthy and responsive caretaker to provide some support and nurturance for the child following the trauma" is perhaps the most important element in the child's resilience.[180]

When a child enters the foster care system, the connection to her parent is usually maintained through visitation between the child and the parent.[181] The court should order visitation as is consistent with the child's needs. For example, for young children involved in cases in which the permanency goal is reunification, it is important that visitation be frequent, several times per week at a minimum, and perhaps daily.[182] Unfortunately, all too often visitation is dictated not by the child's needs, but by the needs of the agencies or professionals involved, for instance, when visitation is limited to normal weekday business hours. Therefore, it is important that the child's advocate press for visitation that is most conducive to the child's need for connectedness to the parent, if the plan is to reunify the child with the parent. While traditional visits are viewed as giving parents and children time together, such visits ignore the dysfunctional relational patterns, how the child's trauma may be retriggered or reenacted, during this time. Parent-child visitation should be seen as an opportunity to provide rehabilitative treatment to both child and parent through therapeutic visitation.

Therapeutic visitation utilizes the visitation process to facilitate positive interaction and build the capacity for relatedness within both parent and child. Coaching the parent, who often has compromised abilities to engage and attune to the child's underlying needs, rather than "judging" or passively observing during visits, provides opportunities for relational growth. This relational growth is essential to minimizing future maltreatment and fostering developmental progress in the child. Visits are a potential laboratory for healthy change and trauma recovery.[183] Typically, children are reared and connected to extended family members or other individuals. Therefore, regardless of the permanency plan, it will help children to remain connected to those who are important to them. Fostering relations not only with the child's parents but her grandparents, aunts and uncles, and teachers may provide a sense of connectedness for the child and that sense of connection will assist the child in overcoming the impact of trauma. Again, this may place the child's interests in a position that is at odds with agency's interests because, in practice, agencies routinely assert that they do not provide for visitation between children and extended relatives. Caseworkers often express concern, given their high caseloads and competing demands on their time, about their ability to arrange for sufficient visitation time for parents, let alone aunts and uncles.

On this point, CTAC recently assessed a boy who had been badly burned in a fire. His aunt had been a great emotional support to him, in part because she herself had been badly burned. The boy made it clear that he wanted to see and maintain a relationship with his aunt. CTAC recommended in a written report that the boy should have the opportunity to stay connected with this family member who held such an important place in his life. In such circumstances, it may be important to remind the agency that it is the needs of the child that must be the central focus of the case planning and casework rather than the system's needs.

When the plan in child abuse and neglect proceedings is not to return the child to the parent, it is imperative that the child either remain connected to extended family members or that the child make new connections because it is through such connections that children overcome trauma and return to a more normal developmental trajectory.[184] Children should be invited to engage in new, safe relationships. Dr. Bruce Perry has succinctly made the case for traumatized children's need for safe and nurturing relationships with supportive adults; "the research on the most effective treatment to help trauma victims might be accurately summed up this way: what works best is anything that increases the quality and number of relationships in the child's life."[185] Building connections with a traumatized child takes time because of their underlying distrust. Adults must honor the child's fears without disengaging themselves. This is extremely challenging yet critical in order to help the child develop connectedness again.

In addition to maintaining relationships, the traumatized child's ability to connect and socially communicate with adults and peers, generally, is important. The ability to connect and communicate is an extremely complex and insufficiently researched area that involves three main components: language skills (expressive and receptive), social cognition (the inherent capacity that each individual possesses that is highly compromised in individuals with autism), and affect regulation.[186] Therefore, assessment of these specific areas should be completed and then efficiently and effectively treated in order to optimize social communication potential, which will be instrumental in building overall resiliency.

B. Mastery/Efficacy

A keystone to development and resiliency are the internal beliefs about "self" that are formed in childhood.[187] When children experience success in affecting and influencing their environment, their brain wiring can be altered and they grow to believe that they can achieve goals.[188] They are willing to take risks, fail, and struggle

believing that ultimately they can overcome the obstacles or barriers that prevent them from being successful. In order to wire this belief into the brain, children need the support and affirmation from adults who provide reasonable opportunities for them to be successful and communicate their belief that the child can be successful.[189] Parents provide the "relational security," which means "no matter whether you are successful or not you are lovable and valuable."[190] When this does not occur, children view failure as an "all or nothing for a parent's love," doubting their personal value if they are not successful. The child also may internalize the labels that parents give them, thereby believing the truth in labels such as "good girl" or "bad girl."

It is not uncommon for children who have experienced maltreatment, to view the maltreatment as their fault.[191] They perceive themselves as responsible for the maltreatment believing that they have done something wrong or that there is something inherently wrong with them, otherwise the neglect, physical abuse, or sexual abuse would not have happened. This is both an artifact of normal child development[192] and a product of a culture, which communicates to children through television and advertisements that "good things happen to good children."[193] Such a cultural myth reinforces for maltreated children their perception that they are "bad" and no matter what they do good things are not going to be available to them. Consequently, these children often form a "victim" belief that they do not deserve success, and if they do experience success it will be only temporary. The locus of control becomes external, rather than internal. They expect to fail, which results in a loss of motivation to try again because they, like most individuals, wants to keep risking failure if there is no chance for success. The loss of efficacy is accompanied by a pervasive powerlessness that manifests in self-protective behaviors ranging from apathy to aggression. These behaviors are an abreaction to a world viewed as rejecting and unaccepting of them.

Conversely, maltreated children who do experience success in some area of life, such as through academics, sports, music, or similar activities, are much more likely to overcome the effects of traumatic stress or adversity that they have experienced.[194] These children experience efficacy through their successes, which is internalized as positive beliefs about themselves.[195] They begin to believe that they can achieve as well as experience the rewards of success including affirmation from adults who communicate that they are valuable and acceptable to others. Such external messages serve as an antidote to harmful and toxic messages that they have received from adults as well as their own negative statements about themselves. Success provides hope for the future that goals are achievable and that they can overcome despite failures that occur along the way. This mindset is empowering and serves to mitigate perceptions of helpless and ongoing victimization.

C. Affect Regulation

The third area for resiliency is considered to be a risk factor, in contrast to connectedness and mastery/efficacy that are protective factors. The inability to regulate affect is the most consistent primary impact of ongoing exposure to trauma and complex traumatization.[196] Traumatic experiences, as detailed earlier, affect brain physiology and functioning.[197] Regulating affect (emotions) is, most often, extremely difficult given the impact of the complex trauma to the corpus callosum and executive functioning.[198] Simply put, as a result of trauma, the left side of the brain, which involves logic and self talk, cannot communicate to the right side of the brain, which is more creative, conceptual, and impulsive. Further, children who are traumatized are frequently retriggered into "fight/flight/freeze" behaviors (including reactive anger, explosiveness, and aggression) that short circuit normal, well-regulated brain functioning by disrupting right side-left side brain communication.[199] When a child is triggered into survival behaviors (via an overactive amygdala) he cannot access his thinking centers.[200] A child emotionally overreacts and cannot access his higher-level thinking skills (essential for optimal affect regulation) when he is under extreme stress.[201] Problem-solving abilities of a child who is highly stressed, maltreated, or traumatized are severely compromised and therefore she cannot anticipate consequences for her actions. Later, when this child is not stressed and is calm and regulated, she then can access the thinking center of the brain (i.e., the prefrontal cortex), which allows her to think through the situation and anticipate consequences. This phenomenon can be illustrated by a child recently seen at CTAC. The case involved an eleven-year-old adopted boy who was severely abused until five years of age and extremely prone to rapid-onset affect dysregulation (because of brain dysfunction due to chronic traumatic stress) resulting in frequent explosive episodes. He described this process, "How come when I am upset my brain becomes dead, but when I am not upset anymore my brain comes back?"

Traumatized children who are dysregulated continually incur negative responses by both adults and other children. They are frequently seen as explosive, out of control, and manipulative.[202] The adult and peer reactivity to their behaviors communicates to traumatized children rejection and further harms their connectedness to others. Others view these children as "willfully

disobedient" and respond to them accordingly, because there is no recognition of what and how trauma has negatively affected brain development. These children get multiple negative labels (i.e. bipolar) from the Diagnostic and Statistical Manual of Mental Disorders, which is the mental health diagnostic manual from which clinicians determine specific diagnoses based on client symptoms. There are also negative school labels (e.g., 'Emotionally Impaired') that convey that these children are "bad," which seriously undermines mastery/efficacy. Adults assume that all children should be able to regulate their emotions and behaviors, not recognizing that affect regulation is a skill that is developed through "relational security" and "ongoing acceptance," which maltreated and traumatized children lack in their experience (and thus have not developed this critical skill).

In contrast to traumatized children who have overt affect dysregulation are those children who have experienced trauma but are "internalizers."[203] These children do not explode, have emotional outbursts, or become aggressive. Instead they regulate their affect in ways that produce adult and peer acceptance regardless of what is occurring within these children. In school these placative ("have-to-please") children are typically liked by teachers and therefore receive positive affirmation. They can manage their sadness and anger externally while simultaneously often experiencing severe anxiety or depression. Their ability to externally manage their affect masks their traumatic stress and need for services. These "non-squeaky-wheel" children are particularly vulnerable to chronic depression, dissociation, and self-induced harm such as cutting themselves.[204] Often adults perceive cutting as a sign of potential suicide, but most often children who cut are not suicidal, but numb to both feeling and their own bodies, and cutting provides experiences to feel.[205]

Being aware of trauma, how it is experienced by children entering the child welfare system, how it may impact children's behavior, and the ways in which its effects may be ameliorated will better prepare children's advocates to bring their skills to bear on behalf of their child-clients. The next section of this Article addresses specific implications of this knowledge for child advocates' day-to-day work on behalf of their clients.

VII. Implications for Advocates

Foster children's exposure to trauma and the deleterious effects of that exposure has numerous implications for children's advocates. This section first addresses a number of generalized implications, and then each of the three previously discussed elements of building children's resilience.

A. The Importance of Psychoeducation

Because child protection work involves numerous disciplines and because the knowledge base of each of those disciplines is constantly evolving, it is important that children's advocates are consistently making concerted efforts to stay abreast of developments in the allied disciplines.[206] Children's advocates who are not familiar with trauma and its impact on children cannot provide professionally competent service to their clients without a basic understanding of these issues.[207] But once advocates are aware of the dynamics of trauma and its impact on children, then they are duty-bound to act on that knowledge. That is, as the understanding of the impact of child maltreatment broadens and deepens, advocates have an ethical duty to act on the knowledge[208] due to their responsibility toward the child.

B. Interviewing the Child

Children who have been the victims of trauma, including prenatal alcohol exposure, may suffer from either receptive or expressive language deficits.[209] As the names suggest, a receptive language deficit impairs the child's ability to understand language that may be used in communication. Deficits in expressive language limit the child's use of language and impair, at the most basic level, their ability to tell their stories. Therefore, while lawyers' use of jargon may confuse even non-traumatized children, for the traumatized child with a receptive language deficit, that problem may be magnified.

Additionally, while it is common complaint and unfortunate reality that lawyers are not good listeners, the child with impaired expressive language capacities demands even more focused attentiveness on the part of the lawyer. More time, patience, listening, and careful explanation is required for the advocate working with a child who suffers either of these forms of language deficit in order to ensure even basic communication. Because children are likely to retain only a small portion of the information received during the interview, writing down for them the key points will allow them to have available what was shared at a later time when they are confused about what was said. This is empowering to children as knowledge provides power through predictability.

C. Investigating the Case

Frequently, the parents of children entering the foster care system will minimize their maltreatment of their children. They may do this because, blinded by their own histories of abuse, they do not understand the seriousness of their own behavior or its impact on their children. Additionally, there are powerful incentives for

abusive or neglectful parents to minimize their behavior. Admitting their conduct and its consequences to their children could cause them to lose custody of children they love and may subject them to criminal charges.

Traumatized children are often reluctant to discuss their trauma-inducing experiences.[210] Like their parents, traumatized children will also commonly minimize their experiences of abuse.[211] They may do so because they blame themselves for what happened, because they love their parents, are hurt by being removed from the only home they have known, or do not thoroughly understand what they have been through and its impact on them.[212]

When a child's advocate understands these dynamics of child maltreatment, this knowledge challenges the child's advocate to minimize neither the presenting maltreatment nor the potential trauma that the children have experienced. Often children who have been the most severely traumatized are the most likely to minimize the impact, due to the fear of future harm.[213]

D. Counseling Clients and Position Formation

Whether one is assigned the role of attorney in the traditional sense, the role of guardian *ad litem*, or fulfills another advocacy role within the system, one cannot provide the client professionally competent advice or wise counsel without an understanding of the subject about which they are counseling the client. Because of the interdisciplinary nature of child welfare practice, counseling a client rarely involves only purely legal issues. It is simply not possible for an advocate to advise a client without a basic understanding of the options and the potential consequences of available options.

Consider this example of an advocate for two brothers, ages three and thirteen. The boys entered the child welfare system following a head-on car collision involving their mother, her boyfriend, and the three-year-old. The collision occurred in large part due to the fact that the boyfriend, who was driving, was under the influence of alcohol, illicit drugs, and medications that were not prescribed to him, but to mother. Through investigation, CPS learned that the mother also abused substances and that the she was the victim of domestic violence perpetrated by the boyfriend, which sometimes took place in the presence of one or both of the children. Eighteen months into the case, the thirteen-year-old wished to have contact with his mother's boyfriend. The boys resided in their mother's home under court supervision after being returned from a relative's care when the mother substantially completed a treatment plan. Several months earlier, the boyfriend, after completing an outpatient substance abuse treatment program and a domestic violence counseling program, had perpetrated a serious assault upon the boys' mother in the presence of the three-year-old, for which the boyfriend was being prosecuted. Understanding the dynamics of domestic violence, that men who assault their wives or girlfriends are at a heightened risk to perpetrate child abuse,[214] the potential consequences to the three-year-old and the thirteen-year-old (including that he may step in to try to protect his mother[215]), and the impact of this upon the boys' continued placement in the mother's home, is essential to wise, professionally competent counseling for the teenager.

For those lawyers charged with the duty of advocating a child's best interests, it is impossible to come to a reasoned and thoughtful position regarding the best interests of the child without a basic understanding of the dynamics of trauma and when it is necessary to seek evaluation or expert advice from a trauma-informed mental health provider. Similarly, for those charged with advocating in a traditional, client-directed role, it is essential to understand these matters in order to counsel clients in the process of assisting them in setting the goals of the representation.[216] Moreover, even those who advocate within child-directed, client-centered systems, the advocacy is not typically limited to a mere assertion of the child's expressed wishes. Rather, these advocates routinely seek court orders to address conditions that exist in the family and that impact the child's goals in the case.

E. Negotiation and Treatment Planning

Child welfare cases, like most civil cases, are typically resolved not through trial or courtroom litigation, but through negotiation and settlement.[217] Knowledge of trauma and its impact on children will inform the advocate's assessment of the issues in a case, educate the advocate regarding the services necessary to address those issues, and inform the advocate as to when those issues have been adequately addressed. In addition to understanding the dynamics of trauma, it is important that children's advocates know what trauma-informed services are available in their community to address the concerns presented by the child and the child's family. Where there is a dearth of trauma-informed services, it may be important that children's advocates press the system to engage in capacity building.[218] One way of doing this is to present to the court the case for ordering such services, even if the agency says they are not available. By pressing the court and then the agency, lawyers for children can, through individual case advocacy, have systemic impact. Another way to achieve this goal is to organize local bar associations, including judicial officers, to take a leadership role in driving systems change.[219]

Previously, this Article discussed the need for a trauma-informed evaluation. It is critical that children's advocates press the system to provide such an assessment at the earliest possible point in the proceeding. For example, in Michigan, the relevant court rules provide that the court may begin to order the agency to provide, and the parent and child to engage in services at the conclusion of the initial hearing at which the petition in authorized, even if the case is to be set for trial.[220] In such a jurisdiction, it is important to press the court to enter an order for an assessment at that first hearing. Some jurisdictions may not permit the court to order that services be provided until the petition has actually been adjudicated or the parent has made an admission and submitted to the court's jurisdiction. In such a case, it may be helpful to seek the agreement of all the parties, through negotiation, to undertake such an assessment.

In addition to the general phases of a case discussed in this section, which are familiar to lawyers, trauma-informed lawyering will have specific implications for enhancing the child's sense of connectedness, mastery/efficacy, and affect regulation. It is to these subjects that this Article now turns.

F. Enhancing a Child's Connectedness

The law's recognition that children are best served through the preservation of their families when this can be safely accomplished is fully consonant with the child's need for connectedness. Children's lawyers in child welfare proceedings have been encouraged to ask whether the danger can be removed, rather than the child.[221] As previously discussed, the law requires that reasonable efforts be made to prevent removals,[222] and children's advocates should monitor cases to ensure that these efforts are in fact being provided or that the circumstances of the individual case merit dispensing with those efforts.[223]

When children must be removed and the plan is reunification, their advocates should focus on ways in which to keep them connected to their parents. The primary way in which this is accomplished is through parent-child visitation while in the foster care system. The importance of parent-child visitation to reunification has been known to the child welfare system for decades.[224] Its importance has recently been revisited.[225] Frequency, location, duration, and whether visits must be supervised (and by whom) are all issues that children's advocates should consider when advocating to maintain connections between children and their parents. Whether or not the long-term plan is for family reunification, the child's advocate should also consider that there may be others beyond the child's parents to whom the child has significant connections that should be maintained. Making a recommendation to preserve these relationships is entirely consistent with federal child welfare law. The Fostering Connections to Success and Increasing Adoptions Act provides that the agency undertake aggressive efforts to locate relatives of children entering the foster care system.[226] In this regard, a pilot study of a family-finding project in Santa Clara County, California is of considerable interest. Staff members of that project located over 220 relatives for 8 young people in residential care in only 9 hours.[227] Agencies will often assert that they do not have the resources necessary to maintain children's relationships with significant relatives beyond the parents, and children's advocates should be prepared to press the case for them to do so, both because the law requires it and because the child's welfare demands it. Such a position may cut a child off from valuable interpersonal resources and injure the child's ability to overcome the trauma he or she has experienced.

Beyond relatives, children's advocates should seek other adults who have a nurturing, supportive relationship with foster children and pursue ways to keep these children and these adults connected. These natural mentors may prove to be an important source of support and nurturance to foster children.[228] Finally, although less efficacious than either relatives or natural mentors, some children and youth in the foster care system may benefit from involvement in formal (i.e., programs where the mentor is matched with the child through a program such as the Boys and Girls Club) mentoring programs.[229]

Children's advocates should assess each child to determine what significant adult relationships that child had before entering the foster care system and how to keep each child connected with those significant adults. As a number of commentators have pointed out, keeping children connected to these important persons is the most valuable thing we can do as advocates for traumatized children.[230]

G. Enhancing Mastery/Efficacy

Children's advocates can enhance their clients' sense of mastery and efficacy. Too often sports and music are taken away from children as a punishment because of "bad behaviors" or "poor academics," yet these are the very activities that facilitate the development of self-esteem, motivation, and value to maltreated children. For example, in one recent case in which CTAC was involved, a judge threatened to take away the trumpet of a 14-year-old youth, who was exceptionally talented and had the goal of playing in a band at a state college, if his behavior did not improve. Yet, trumpet playing was the one area of efficacy that provided affirmation and

motivation to this child. Taking the trumpet away would only reinforce the child's victimization perception that no matter how talented he is someone would prohibit him from utilizing his talent. The role of the child's advocate in such a case is to recognize the value of the activity for the child, to educate the court (and the other parties) as to the importance of the trumpet as a therapeutic tool, and to press the system to find a more appropriate way to impose consequences on the child's unacceptable behavior.

As this example illustrates, children's advocates will need to take the time to inquire of their clients what activities they may be good at and what pass times they enjoy. It also may require that the advocate locate community-based enrichment programs for the child to engage in after school or during summer breaks.

H. Fostering Affect Regulation

Child advocates play a critical role in ensuring that children receive psychotherapy that includes skill-building strategies that enhance the development of affect regulation (self-control especially when the child is under duress) skills. Most trauma-informed treatments contain this critical component.[231] The traditional method of talk therapy does not adequately address affect regulation skill building, which must be practiced daily with the primary caregiver following therapy. Educating the court and other system professionals, that should know but often do not, that most behaviors of traumatized children are not "willful disobedience" but an inability to regulate affect, is essential in preventing a punitive approach that most often just exacerbates children's behaviors, robs them of connections with others, and reinforces to them that they are "bad." Demanding that therapists' reports specifically identify the area of affect regulation as a target goal[232] will provide opportunities for children to develop affect regulation skills, which are necessary for resiliency.[233]

i. Secondary Trauma

Working with traumatized children, hearing their stories about the harm they have experienced, and the frustrations of trying to get a bureaucratic system to respond to the needs of an individual child can be emotionally challenging for professionals. These experiences can lead child advocates to experience secondary trauma, which is defined as "[t]he natural and consequent behaviors and emotions resulting from knowing about a traumatized event from a significant other, the stress from helping or wanting to help a traumatized or stressed person."[234] Acknowledging and addressing secondary trauma has been ignored within the child serving systems resulting in increased burnout, professional negativism, and a multitude of other symptoms that compromise child advocates willingness and ability to listen to children's stories and to then actively pursue what is in the best interest for the child despite system obstacles. Professionals with secondary traumatic stress become task focused rather than being centered on advocating for the needs of each individual child.

Children's advocates, like CPS workers and other professionals in the child welfare system, will best be able to serve their clients when they are aware of their own emotions and their reactions to secondary trauma.

VIII. Conclusion

Most children entering the foster care system have experienced trauma. To effectively advocate for these children, their advocates must be familiar with trauma and its impact on children. In order to build resilience in these children which, contrary to many people's beliefs, is not naturally occurring, children's advocates should focus on the three core considerations of resiliency: connectedness to/relatedness with supportive adults, the development of mastery/efficacy, and assuring that children receive, when necessary, trauma-focused treatments that can help them to develop affect regulation. By focusing on these three areas of need, children's advocates will best serve their client's interests and provide them the best opportunity to maximize their potential over the long-term.

Endnotes

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[1] For a definition of trauma, *see infra* Part II.

[2] Like all children, children entering foster care may also experience trauma as a result of natural disasters, but for the purposes of this Article, the discussion will focus on those sources of trauma that are most likely to impact the children in the child welfare system.

[3] For purposes of this Article, the child welfare system refers to the American foster care system into which children are placed based upon a finding by a court that the child has suffered maltreatment at the hands of his or her caretakers.

[4] *See generally* Delilah Bruskas, *Children in Foster Care: A Vulnerable Population at Risk*, 21 J. CHILD & ADOLESCENT PSYCHIATRIC NURSING 70 (2008).

[5] Marty Beyer, *Developmentally-Sound Practice in Family and Juvenile Court*, 6 Nev. L.J. 1215, 1216 (2006).

[6] *See* James Garbarino et al., Children in Danger: Coping with the Consequences of Community Violence 71–74 (1992) (discussing, in part, the history of the study of trauma).

[7] *Id.*

[8] *See, e.g.*, *In re* Nunez, 173 Cal. App. 4th 709 (2009) (in this case, in which a juvenile was tried as an adult and sentenced to life without parole, the court discussed the juvenile's extensive history of trauma, which included being shot, observing his brother be shot in the head and murdered, long-standing domestic violence in the family home, and prevalent violence in his community.

[9] *See* Frank W. Putnam, *The Impact of Trauma on Child Development*, 57 Juv. & Fam. Ct. J. 1 (2006).

[10] *Id.* at 2.

[11] The term "advocates" or "advocate" in this Article is used advisedly. The authors believe that a basic understanding of trauma, its impact upon children in the nation's foster care system, and holding the system accountable to address it, is relevant whether the advocate fulfills the role of an attorney in a client-centered model of representation, a guardian *ad litem*, or some hybrid of the two. The authors also use the term because it is broad enough to encompass Court Appointed Special Advocates and other lay advocates, in addition to those licensed to practice law.

[12] Nat'l Child Traumatic Stress Network, *What is Child Traumatic Stress?* http://www.nctsnet.org/sites/default/files/assets/pdfs/what_is_child_traumatic_stress_0.pdf (last visited June 18, 2012); *see also* Jenifer Maze, et al., *An Overview of the Special Issue*, 59 Juv. & Fam. Ct. J. 3, 3 (2008) ("Trauma, or traumatic stress . . . is psychological and biological distress experienced by an individual exposed to an event that overwhelms the individual's ability to cope. Trauma is marked by a sense of horror and helplessness or the threat of serious injury or death.").

[13] Tina Maschi, *Unraveling the Link between Trauma and Male Delinquency: The Cumulative Versus Differential Risk Perspectives*, 51 Soc. Work 59, 59 (2006).

[14] Bessel A. van der Kolk, *Developmental Trauma Disorder: Towards a rational diagnosis for children with complex trauma histories*, 35 Psychiatric Annals 401, 403 (2005).

[15] *See Types of Traumatic Stress*, Nat'l Child Traumatic Stress Network, http://www.nctsn.org/trauma-types (last visited Oct. 6, 2012) [hereinafter *Types of Traumatic Stress*].

[16] *Id.*

[17] *Id.*

[18] As used in this context, to dissociate means that the individual enters an "altered state of consciousness in the face of overwhelming stress." *See* Jon G. Allen, Coping With Trauma: Hope Through Understanding 187 (2d ed. 2005). It has been referred to as "a form of mental flight when physical flight is impossible." *Id.*

[19] *Types of Traumatic Stress, supra* note 15.

[20] Child Welfare Info. Gateway, Understanding the Effects of Maltreatment on Brain Development 4, 7 (2009).

[21] *See generally* Bruce D. Perry, et al., *Childhood Trauma, the Neurobiology of Adaptation, and "Use-dependent" Development of the Brain: How "States" Become "Traits,"* 16 Infant Mental Health J. 271 (1995) (noting the importance of brain development in the early years of life).

[22] *See infra* Part III.B.

[23] Mark W. Fraser & Mary A. Terzian, *Risk and Resilience in Child Development Principles and Strategies of Practice, in* Child Welfare for the 21st Century: A Handbook of Practices, Policies, and Programs 55 (Gerald P. Mallon & Peg McCartt Hess eds., 2005).

[24] *See* Robin H. Gurwitch et al., Terrorism and Disaster Ctr. at the Univ. of Okla. Health Sci. Ctr. & Nat'l Child Traumatic Stress Network, Building Community Resilience for Children and Families (2007).

[25] Affect regulations means, in general, one's ability to control emotions and to express their emotions in a socially appropriate manner.

[26] New South Wales Dep't of Cmty. Servs. NSW Center for Parenting and Research, *Risk, protection and resilience in children and families*, Research to Practice Notes (2007), http://www.community.nsw.gov.au/docswr/_assets/main/documents/researchnotes_resilience.pdf.

[27] *Id.*

[28] *See* Nat'l Child Traumatic Stress Network, Trauma-Informed Interventions: Clinical and Research Evidence and Culture Specific Information Project (2008) [hereinafter Trauma-Informed Interventions].

[29] *See* Nat'l Child Traumatic Stress Network, Facts for Policymakers: Complex Trauma and Mental Health of Children Placed in Foster Care: Highlights from the National Center for Child Traumatic Stress Core Data Set (2011) [hereinafter Facts for Policymakers].

[30] Valerie J. Edwards, et al., *Relationship Between Multiple Forms of Childhood Maltreatment and Adult Mental Health in Community Respondents: Results from the Adverse Childhood Experiences Study*, 160 Am. J. Psychiatry 1453 (2003) (finding that more than one-third of individuals who were maltreated as children actually experienced multiple forms of maltreatment).

[31] Facts for Policymakers, *supra* note 29, at 1.

[32] *Id.*

[33] *Id.*

[34] Beyer, *supra* note 5, at 1218 ("Children who are separated from their families are traumatized by disrupted attachments (removal from home)."); Bruskas, *supra* note 5, at 76 (discussing the impact of foster care placement on maltreated children and suggesting that "In some ways,

the loss of a parent through foster care is worse than by death because child welfare creates a 'divorce' type of loss of a child's parents in addition to the loss of their family, friends, and environment with no sense of closure.").

[35] Information Memorandum from U.S. Dep't of Health & Human Serv., Admin. on Children, Youth & Families to State, Tribal & Territorial Agencies Administering or Supervising the Admin. of Titles IV-B & IV-E of the Soc. Sec. Act, Indian Tribes & Indian Tribal Orgs., Log No. ACYF-CB-IM-12-04 (Apr. 17, 2012) [hereinafter ACYF Information Memorandum], http://www.acf.hhs.gov/programs/cb/laws_policies/policy/im/2012/im1204.pdf.

[36] For a discussion of what mastery/efficacy means, *see infra* Part VI.B.

[37] Sandra Prince-Embury, *Resiliency Factors in Children* at Child Abuse Research Educ. & Serv. Inst. at Univ. Med. & Dentistry N.J. (2007).

[38] *See generally* Perry et al., *supra* note 21, at 285–86.

[39] See The Adverse Childhood Experiences Study, www.acestudy.org (last visited June 6, 2012).

[40] *Id.*

[41] *Id.*

[42] van der Kolk, *supra* note 14, at 402 (internal citations omitted).

[43] Judith Silver et al., *Starting Young: Improving the Health and Developmental Outcomes of Infants and Toddlers in the Child Welfare System*, LXXVIII Child Welfare 148, 156 (1999) (finding that 60.3% of 308 children studied had at least one chronic medical illness and 43.1% had acute illness when entering the foster care system); Neal Halfon, et al., *Heath Status of Children in Foster Care: The Experience of the Center for the Vulnerable Child*, 149 Archives of Pediatric & Adolescent Med. 386, 389 (1995) (finding that 82% of the children studied had a chronic illness).

[44] This example derives from the practice of author, Frank E. Vandervort.

[45] Researchers have documented recent, dramatic increases in the incidences of babies being born with neonatal abstinence syndrome (a medical condition relating to newborn infants that are chronically exposed *in utero* to opiates—e.g., heroin, morphine, narcotic pain medications, etc., and exhibit obvious clinical signs/symptoms of drug withdrawal—sensory hypersensitivity, excessive irritability, feeding difficulties, and potential life-threatening alterations to cardiac and respiratory systems—after birth). *See* Stephen W. Patrick, et al., *Neonatal Abstinence Syndrome and Associated Health Care Expenditures United States*, 2000–2009, 307 J. Am. Med. Ass'n 1934 (2012), http://jama.jamanetwork.com/article.aspx?articleid=1151530.

[46] The frenulum is the small piece of skin that connects the upper lip to the gums. *See Frenulum,* The Free Dictionary, http://medical-dictionary.thefreedictionary.com/frenulum (last visited Oct. 6, 2012).

[47] Frank E. Vandervort, *Legal Rights of Fetuses and Young Children, in* Principles of Addictions and the Law: Applications in Forensic, Mental Health, and Medical Practice, 229, 230–31 (Norman S. Miller ed., 2010) It should be noted that pre-natal exposure to opiates may affect different children differently. Not every child who is exposed to opiates *in utero* will suffer these same effects.

[48] *Id.*

[49] Unless otherwise indicated, the information contained in this segment of the article is summarized and adapted from Perry et al., *supra* note 21 and Bruce D. Perry & Maia Szalavitz, The Boy Who Was Raised As A Dog and Other Stories From A Child Psychiatrist's Notebook: What Traumatized Children Can Teach Us About Loss, Love, And Healing 86 (2006) [hereinafter Perry & Szalavitz, The Boy Who Was Raised As A Dog].

[50] Perry et al., *supra* note 21, at 290.

[51] *Id.*

[52] *Id.*

[53] *Id.*

[54] *Id.*

[55] *Id.*

[56] *Id.* at 291.

[57] *Id.* at 276.

[58] *Id.*

[59] It is the normal functioning of the prefrontal cortex which has been referred to by the Supreme Court is its decisions in *Roper v. Simmons*, 543 U.S. 551 (2005), and *Graham v. Florida*, 130 S. Ct. 2011 (2010).

[60] Perry et al., *supra* note 21, at 276.

[61] *Id.* at 290 (emphasis in original).

[62] *Id.*

[63] Michael D. De Bellis, *The Psychobiology of Neglect*, 10 Child Maltreatment 150 (2005); Putnam, *supra* note 10, at 4. Child neglect has been extensively researched by pre-eminent neuroscientists in the past 20 years and is now widely considered by trauma experts as the single most deleterious form of traumatic stress. *Id.*

[64] Bruce D. Perry, Understanding Traumatized and Maltreated Children: The Core Concepts 10 (2004).

[65] *Hyperarousal*, The Free Dictionary, http://medical-dictionary.thefreedictionary.com/hyperarousal (citing Marie T. O'Toole, Miller-Keane Encyclopedia and Dictionary of Medicine, Nursing and Allied Health (7th ed. 2003)) (last visited Oct. 22, 2012) (defining "hyperarousal" as "a state of increased psychological and physiological tension marked by such effects as reduced pain tolerance, anxiety, exaggerated startle responses, insomnia, fatigue, and accentuation of personality traits").

[66] Allen, *supra* note 18, at 177.

[67] *Id.* at 65–66.

[68] Perry et al., *supra* note 21, at 277.

[69] *Id.* at 281.

[70] *Id.*

[71] *Id.*

[72] *Id.*

[73] *Id.*

[74] *Id.* at 283.

[75] *Id.*

[76] *Id.*

[77] *Id.*

[78] Putnam, *supra* note 9, at 4.

[79] *Id.*

[80] *Id.*

[81] *Id.*

[82] *See* Kathleen Baltman & Nichole Paradis, *Infant Mental Health: What Judges and Lawyers Should Know About Relationship-Based Assessment and Intervention*, XIV MICH. CHILD WELFARE L.J. 11 (2012).

[83] Putnam, *supra* note 9, at 4.

[84] *Types of Traumatic Stress, supra* note 15.

[85] PERRY & SZALAVITZ, THE BOY WHO WAS RAISED AS A DOG, *supra* note 49, at 86.

[86] *Id.* at 85, 218–19.

[87] *See Language Disorder—Children*, MEDLINEPLUS MED. ENCYCLOPEDIA, http://www.nlm.nih.gov/medlineplus/ency/article/001545.htm (last visited Oct. 22, 2012).

[88] Jim Henry et al., *Neurobiology and Neurodevelopmental Impact of Childhood Traumatic Stress and Prenatal Alcohol Exposure*, 38 LANGUAGE, SPEECH, AND HEARING SERVICES IN SCHOOLS 99 (2007).

[89] *Id.*

[90] Putnam, *supra* note 9, at 5.

[91] *Id.* at 5–6.

[92] *Id.* at 5.

[93] *Id.*

[94] *Id.*

[95] *Id.* at 6.

[96] *Id.*

[97] van der Kolk, *supra* note 14, at 402; *see generally* Kimberly Bender et al., *Internalizing Symptoms Linking Youths' Maltreatment and Delinquent Behavior*, 90 CHILD WELFARE 69, 73 (2011); Tina Maschi et al., *Releasing Their Stories: A Qualitative Study of Juvenile Justice-Involved Youth with Histories of Mental Health Issues and Violence*, 1 J. FORENSIC SOC. WORK 132, 135 (2011).

[98] JAMES GILLIGAN, VIOLENCE: OUR DEADLY EPIDEMIC AND ITS CAUSES 45 (1996).

[99] *Id.*

[100] *Id.*

[101] *Id.*

[102] *See generally* JAMES GARBARINO, LOST BOYS: WHY OUR SONS TURN VIOLENT AND HOW WE CAN SAVE THEM, (1999); Dorothy Otnow Lewis et al., *Ethics Questions Raised by the Neuropsychiatric, Neuropsychological, Educational, Developmental, and Family Characteristics of 18 Juveniles Awaiting Execution in Texas*, 32 J. AM. ACAD. PSYCHIATRY & L. 408, 409 (2004) (Lewis and her colleagues conducted research on juveniles sentenced to death before the United States Supreme Court barred the practice in *Roper v. Simmons* in 2004). The articles detailing this connection are beyond the scope of the paper, however, this Article provides a brief summary of the research.

[103] Dorothy Otnow Lewis et al., *Neuropsychiatric, Psychoeducational, and Family Characteristics of 14 Juveniles Condemned to Death in the United States*, 145 AM. J. PSYCHIATRY 584, 587–88 (1988).

[104] *Id.*

[105] Dorothy Van Soest et al., *Different Paths to Death Row: A Comparison of Men Who Committed Heinous and Less Heinous Crimes*, 18 VIOLENCE AND VICTIMS 15 (2003).

[106] *Id.*

[107] *Id.* at 27.

[108] Katharine W. Scrivner, Student Essay, *Crossover Kids: The Dilemma of the Abused Delinquent*, 40 FAM. CT. REV. 135, 136 (2002); Ann Reyes Robbins, *Troubled Children and Children in Trouble: Redefining the Role of the Juvenile Court in the Lives of Children*, 41 U. MICH. J.L. REFORM 243, 245 (2007).

[109] Miller v. Alabama, 132 S. Ct. 2455, 2455 (2012).

[110] *Id.* at 2456; *see also* Wiggins v. Smith, 539 U.S. 510, 517 (2003) (holding that failure of counsel to present a death penalty defendant's history of childhood victimization as mitigating evidence in the sentencing phase constituted ineffective assistance of counsel).

[111] *See supra* Part III.B.

[112] Perry et al., *supra* note 21, at 276.

[113] *Id.* at 277.

[114] Ann P. Streissguth et al., *Risk Factors for Adverse Life Outcomes in Fetal Alcohol Syndrome & Fetal Alcohol Effects*, 25 J. DEVELOPMENTAL & BEHAV. PEDIATRICS 228, 233 (2004).

[115] *Fetal Alcohol Spectrum Disorders: Legal Issues*, A.B.A. CENTER ON CHILD. & L., http://www.americanbar.org/groups/child_law/what_we_do/projects/child_and_adolescent_health/fasd.html (last visited Oct. 22, 2012).

[116] *See* Henry et al., *supra* note 88.

[117] Part V of this Article is adapted from Frank E. Vandervort, *Child Welfare Cases Involving Mental Illness: Reflections on the Role and Responsibilities of the Lawyer-Guardian ad Litem*, XIV MICH. CHILD WELFARE L.J. 31 (2012) [hereinafter Vandervort, *Child Welfare Cases Involving Mental Illness*].

[118] Streissguth, *supra* note 114, at 236.

[119] For purposes of this section of this Article, the terms "assessment" and "evaluation" are used interchangeably.

[120] *See* Michael W. Weber, *The Assessment of Child Abuse: A Primary Function of Child Protective Services, in* THE BATTERED CHILD 120, 130–31 (Mary Edna Helfer et al. eds., 5th ed. 1997) (discussing CPS's use of risk assessment tools).

[121] Kathleen Coulborn Faller et al., *Can Early Assessment Make a Difference in Child Protection? Results from a Pilot Study*, 2 J. PUB. CHILD WELFARE 71, 84 (2008) (internal citation omitted).

[122] Jennifer Huber & Bill Grimm, *Child and Family Services Review, Part V: Most States Fail to Meet the Mental Health Needs of Foster Children*, XXV J. NAT'L CENTER FOR YOUTH L. 1 (2004).

[123] Putnam, *supra* note 9, at 3; Tiffany Watts-English et al., *The Psychobiology of Maltreatment in Childhood*, 62 J. SOC. ISSUES 717, 728 (2006) (noting that "not all children who are maltreated are adversely affected. In fact, many children have good outcomes despite high risk and stressful circumstances.").

[124] *See generally* Vandervort, *Child Welfare Cases Involving Mental Illness, supra* note 117, at 32–36.

[125] The Children's Bureau has recently issued guidance about the importance of functional assessments rather than traditional, point-in-time psychological assessments. *See* ACYF Information Memorandum, *supra* note 36. ("Traditionally, child welfare systems use assessment as a point-in-time diagnostic activity to determine if a child has a particular set of symptoms or requires a specific intervention. Functional assessment, however, provides a more holistic evaluation of children's well-being and can also be used to measure improvement in skill and competencies that contribute to well-being. Functional assessment—assessment of multiple aspects of a child's social-emotional functioning—involves sets of measures that account for the major domains of well-being. Rather than using a 'one size fits all' assessment for children and youth in foster care, systems serving children receiving child welfare services should have an array of assessment tools available. This allows systems to appropriately evaluate functioning across the domains of social-emotional well-being for children across age groups. They capture children's strengths, including skills and capacities, as well as potential difficulties in a developmentally-appropriate manner, accounting for the trauma- and mental health-related challenges faced by children and youth who have experienced abuse or neglect. Similarly, some assessment tools can be used to measure parenting capacities and improvements over time.") (internal citations omitted).

[126] Faller et al., *supra* note 121, at 71.

[127] *Id.*

[128] *See generally id.*

[129] *Id.*

[130] *Id.*

[131] *Id.*

[132] *See generally* 42 U.S.C.A. § 621 (West 2012) (providing for family preservation services); CAL. WELF. & INST. CODE § 16500.5 (West 2012).

[133] *See In re* Snyder, 566 N.W.2d 18, 20 (Mich. Ct. App. 1997) (children were removed from parental home due to unsafe and unsanitary conditions then, after being in foster care for a period of time, disclosed that they had been sexually abused by both parents); *In re* Gilliam, 613 N.W.2d 748, 749 (Mich. Ct. App. 2000) (children entered care because of neglect and it was later discovered that the father had substance abuse and anger management problems).

[134] *See, e.g., In re Snyder,* 566 N.W.2d 18; *In re Gilliam*, 613 N.W.2d 748.

[135] *See* Adoption and Safe Families Act of 1997, Pub. L. No. 105-89, 111 Stat. 2115 § 103(d) (codified as a Rule of Construction following 42 U.S.C.A. § 675 (West 2012)) ("Nothing in this section or in part E of title IV of the Social Security Act (42 U.S.C. § 670), as amended by this Act, shall be construed as precluding State courts or State agencies from initiating the termination of parental rights for reasons other than, or for timelines earlier than, those specified in part E of title IV of such Act, when such actions are determined to be in the best interests of the child, including cases where the child has experienced multiple foster care placements of varying durations."); *see also* 42 U.S.C.A. § 678 (West 2012) (permitting state courts to make any decision that will protect the health and safety of children).

[136] *See* 42 U.S.C.A. § 675.

[137] *Id.*

[138] *See generally* 705 ILL. COMP. STAT. ANN. 405/1–2(1)(c) (West 2012) (noting that "it may be appropriate to expedite termination of parental rights . . . in those extreme cases in which the parent's incapacity to care for the child, combined with an extremely poor prognosis for treatment or rehabilitation, justifies expedited termination of parental rights").

[139] Although not central to the argument, it would be remiss of the authors if they did not note that such a practice also wastes the child welfare system's very limited resources, resources that may make the difference in whether another family receives needed services.

[140] *See, e.g.*, Diane E. Elze et al., *Educational Needs of Youth in Foster Care, in* CHILD WELFARE FOR THE 21ST CENTURY: A HANDBOOK OF PRACTICES, POLICIES, AND PROGRAMS 185 (Gerald P. Mallon & Peg McCartt Hess eds., 2005) (advocating assessment of foster children's educational needs); Jan McCarthy & Maria Woolverton, *Healthcare Needs of Children and Youth in Foster Care, in* CHILD WELFARE FOR THE 21ST CENTURY: A HANDBOOK OF PRACTICES, POLICIES, AND PROGRAMS 129, 134 (Gerald P. Mallon & Peg McCartt Hess eds., 2005) (advocating for medical assessments of children entering foster care).

[141] *See generally* Elena Cohen et al., *Assessment of Children, Youth and Families in the Child Welfare System, in* CHILD WELFARE FOR THE 21ST CENTURY: A HANDBOOK OF PRACTICES, POLICIES, AND PROGRAMS 87, 87–101 (Gerald P. Mallon & Peg McCartt Hess eds., 2005).

[142] *Id.*

[143] Faller et al., *supra* note 121, at 85.

[144] *Id.* at 88.

[145] Maschi, *Unraveling the Link Between Trauma and Male Delinquency, supra* note 13, at 68. (Maschi discusses this connection in the delinqeuncy context, but the need to

utilize assessment tools capable of capturing the full range of trauma-inducing stressors is equally present in the child protection context).

[146] Phillip A. May & J. Phillip Gossage, *Estimating the Prevalence of Fetal Alcohol Syndrome: A Summary*, NAT'L INST. ON ALCOHOL ABUSE AND ALCOHOLISM, http://pubs.niaaa.nih.gov/publications/arh25-3/159-167.htm (last visited Oct. 6, 2012).

[147] *Id.*

[148] Henry et al., *supra* note 88, at 102.

[149] *Id.*

[150] We use the term "multidisciplinary" here because it is the term most often used in legislation and in discussions of this sort. However, we recognize that others may refer to "transdisciplinary" or "interdisciplinary" when discussing these issues.

[151] *See* Donald N. Duquette et al., *We Know Better Than We Do: A Policy Framework for Child Welfare Reform*, 31 U. MICH. J.L. REFORM 93, 101 (1997–1998).

[152] For a discussion of the value of multidisciplinary teams and the way in which one team works, see generally Faller et al., *supra* note 121, at 91.

[153] Personal communication with Dr. Kathleen Coulborn Faller, Ph.D (Sept. 23, 2012).

[154] *See* Marina Lalayants & Irwin Epstein, *Evaluating Multidisciplinary Child Abuse and Neglect Teams: A Research Agenda*, 84 CHILD WELFARE 433, 439 (2005).

[155] *See* 42 U.S.C.A. § 5106 (a)(2)(A) (West 2012).

[156] *See, e.g.*, CAL. WELF. & INST. CODE § 18961.7 (West 2012); MICH. COMP. LAWS ANN. § 722.629 (West 2012); VA. CODE ANN. § 63.2-1503(J) (West 2012); WASH. REV. CODE ANN. § 74.14B.030 (West 2012); WYO. STAT. ANN. § 14-3-212 (West 2012).

[157] *See generally* PERRY & SZALAVITZ, THE BOY WHO WAS RAISED AS A DOG, *supra* note 49.

[158] PTSD is not a diagnosis that fits children all that well. At the present time, there is a great deal of discussion in mental health circles about the need for a new diagnosis that more accurately reflects the impact of trauma on children's development. There is a movement to add a developmental trauma disorder to the Diagnostic and Statistical Manual of Mental Disorders. *See* van der Kolk, *supra* note 14.

[159] *See* ALLEN, supra note 18, at 171–186.

[160] See TRAUMA-INFORMED INTERVENTIONS, *supra* note 29, for a more detailed consideration of trauma-informed, evidence-based treatment.

[161] *Id.*

[162] *Trauma-Informed Care and Trauma Services,* SUBSTANCE ABUSE AND MENTAL HEALTH SERV. ADMIN., http://www.samhsa.gov/nctic/trauma.asp (last visited Oct. 6, 2012).

[163] Kathryn S. Collins et al., *Trauma Adapted Family Connections: Reducing Developmental and Complex Trauma Symptomatology to Prevent Child Abuse and Neglect*, 90 CHILD WELFARE 29 (2011).

[164] *Id.* at 30 ("Increased exposure to stressful life events and chronic traumas such as multigenerational family, school, and community violence, victimization, and traumatic loss often leads to the development and escalation of trauma symptoms among parents and children."); NAT'L CHILD TRAUMATIC STRESS NETWORK, BIRTH PARENTS WITH TRAUMA HISTORIES AND THE CHILD WELFARE SYSTEM: A GUIDE FOR CHILD WELFARE STAFF, http://www.nctsn.org/sites/default/files/assets/pdfs/birth_parents_trauma_history_fact_sheet_final.pdf; *see* Leslie Doty Hollingsworth, *Birth Mothers Whose Parental Rights Have Been Terminated: Implications for Services, in* CHILD WELFARE FOR THE 21ST CENTURY: A HANDBOOK OF PRACTICES, POLICIES, AND PROGRAMS 469 (Gerald P. Mallon & Peg McCartt Hess eds., 2005)

[165] AM. PSYCHIATRIC ASS'N, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS, TEXT REVISION 485 (4th ed. 2000) ("The common feature of the Somatoform Disorders is the presence of physical symptoms that suggest a general medical condition . . . and are not fully explained by a general medical condition, but the direct effects of a substance, or by another mental disorder . . . ."); van der Kolk, *supra* note 14, at 405.

[166] Videotape: National Victim Assistance Academy Videotape Series: Substance Abuse and Victimization (U.S. Dep't. of Justice 2005).

[167] van der Kolk, *supra* note 14, at 402.

[168] Judy Fenster, *Substance Abuse Issues in the Family, in* CHILD WELFARE FOR THE 21ST CENTURY: A HANDBOOK OF PRACTICES, POLICIES, AND PROGRAMS 335, 336 (Gerald P. Mallon & Peg McCartt Hess, eds., 2005).

[169] SARAH DAWGERT, SUBSTANCE USE AND SEXUAL VIOLENCE: BUILDING PREVENTION AND INTERVENTION REPONSES: A GUIDE FOR COUNSELORS AND ADVOCATES 1 (2009), http://www.ncdsv.org/images/PCAR_SubUseAndSVBldgPrevAndIntervenResp_2009.pdf.

[170] *Id.*

[171] *Id.* at 21–22.

[172] *See* David Finkelhor, *Current Information on the Scope and Nature of Child Sexual Abuse*, 4 FUTURE CHILD. 31, 37 (1994) (noting that the most reliable estimates are that 27% – 34% of women were sexually victimized during childhood, roughly 1 in 3).

[173] DAVID FINKELHOR, SEXUALLY VICTIMIZED CHILDREN 83 (1979).

[174] *See* Fraser & Terzian, *supra* note 23, at 55–56 (discussing the outdated idea that some children are naturally resilient and noting that nearly all children who experience traumatic events also experience negative effects from those occurrences).

[175] PERRY & SZALAVITZ, THE BOY WHO WAS RAISED AS A DOG, *supra* note 49, at 38 ("Resilient children are made, not born.").

[176] *See generally* van der Kolk, *supra* note 14, at 407–08.

[177] *Id.* at 231–33; *see also* GINA MIRANDA SAMUELS, A REASON, A SEASON, OR A LIFETIME: RELATIONAL PERMANENCE AMONG YOUNG ADULTS WITH FOSTER CARE BACKGROUNDS, (2008), https://docs.google.com/gview?url=http://jimcaseyyouth.org/sites/default/files/documents/reason_season_lifetime.pdf.

[178] *Id.* at 3; *see also* Parham v. J.R., 442 U.S. 584, 602 (1979) (noting that typically the "natural bonds of affection lead parents to act in the best interests of their children").

[179] *Parham,* 442 U.S. at 602–03; Lassiter v. Dep't of Soc. Servs. of Durham Cnty, N.C., 452 U.S. 18, 27 (1981) (noting that the state in a child protective proceeding has "an urgent interest in the welfare of the child").

[180] Perry et al., *supra* note 21, at 285.

[181] This discussion of maintaining the parent-child relationship through visitation assumes that such contact is not harmful to the child. If, for instance, the parent has perpetrated significant abuse upon the child, the child may be actively harmed psychologically by contact with the parent even if the contact is supervised. In such circumstances contact between the parent and child may need to be limited, supervised, or discontinued.

[182] *See* James P. Gleeson, *What Works in Kinship Care, in* WHAT WORKS IN CHILD WELFARE 193, 195 (Miriam P. Kluger et al. eds., 2000) (discussing the importance of parental visitation to reunification).

[183] *See* MICH. SUPREME COURT & STATE COURT ADMIN. OFFICE, MICHIGAN FOSTER CARE REVIEW BOARD 2011 ANNUAL REPORT: PARENT-CHILD VISITATION, (2012), http://courts.michigan.gov/administration/scao/resources/documents/publications/reports/fcrb/fcrb_ar11.pdf [hereinafter MICH. 2011 ANNUAL REPORT] (discussing the use of visitation as a therapeutic tool rather than merely a requirement to be fulfilled and citing numerous studies and reports outlining the need for improved performance by the child welfare system in the area of parent-child visitation).

[184] *See* PERRY & SZALAVITZ, THE BOY WHO WAS RAISED AS A DOG, *supra* note 49, at 66–68, 79–80 (discussing the importance of relationships for children who have suffered trauma).

[185] *Id.* at 80.

[186] Truman E. Coggins et al., *A State of Double Jeopardy: Impact of Prenatal Alcohol Exposure and Maltreatment on the Social Communication Abilities of School-Age Children With Fetal Alcohol Spectrum Disorders*, 38 LANGUAGE, SPEECH & HEARING SERVICES IN SCHS. 117 (2007); Yvette D. Hyter, *Complex Trauma & Parental Alcohol Exposure: Clinical Implications*, 13 PERSP. ON SCH.-BASED ISSUES 32 (2012).

[187] Ann S. Masten, *Risk and Resilience in Development, in* OXFORD HANDBOOK OF DEVELOPMENTAL PSYCHOLOGY (Philip David Zelaso ed.) (forthcoming Jan. 2013).

[188] van der Kolk, *supra* note 14.

[189] *See generally* PERRY & SZALAVITZ, THE BOY WHO WAS RAISED AS A DOG, *supra* note 49, at 230 (discussing the benefits of positive relationships on traumatized children).

[190] *See* Kristine Jentoft Kinniburgh et al., *Attachment, Self-Regulation, and Competency: A Comprehensive Intervention Framework for Children with Complex Trauma*, 35 PSYCHIATRIC ANNALS 424 (2005).

[191] ALLEN, *supra* note 18, at 105 ("Those who are traumatized by other persons almost always blame themselves. Abused children feel that they deserved it, that they brought it on—or at least that they should have been able to prevent it, stop it, or minimize it.").

[192] *Id.* at 104–05; DIANE E. PAPALIA ET AL., A CHILD'S WORLD: INFANCY THROUGH ADOLESCENCE 241 (9th ed. 2002) (discussing egocentrism in children).

[193] *See, e.g.*, JOHN FREDRICK COOTS & HAVEN GILLESPIE, *Santa Claus is Coming To Town* (1934) ("You better watch out/You better not cry/Better not pout/I'm tellin' you why/Santa Claus is coming to town. . . He's makin' a list/Checkin' it twice/Gonna find out whose naughty and nice . . . He knows if you've been bad or good/So you better be good for goodness sake"). The definitive performance of this classic children's Christmas song was, of course, performed and recorded by Bruce Springsteen and the E Street Band December 12, 1975. *See* MasterB1001, *Bruce Springsteen - Santa Claus in Coming to Town*, YOUTUBE (Feb. 22, 2009), http://www.youtube.com/watch?v=eAEBdP_4aog.

[194] Joshua Arvidson, et al., *Treatment of Complex Trauma in Young Children: Developmental and Cultural Considerations in Application of the ARC Intervention Model* 4 J. CHILD & ADOLESCENT TRAUMA 34, 44–45 (2011) (discussing how children develop "mastery over themselves and their environment").

[195] *Id.*

[196] van der Kolk, *supra* note 14, at 405.

[197] *See supra* Part III.B.

[198] ALLAN N. SCHORE, THE SCIENCE OF THE ART OF PSYCHOTHERAPY 88–92 (2012).

[199] *Id.* at 82.

[200] *Id.* at 87.

[201] *Id.* at 83–84.

[202] Henry et al., *supra* note 88, at 105.

[203] Perry et al., *supra* note 21, at 279–282 (discussing dissociation).

[204] *See generally*, NAT'L INST. OF MENTAL HEALTH, HELPING CHILDREN AND ADOLESCENTS COPE WITH VIOLENCE AND DISASTERS: WHAT PARENTS CAN DO (2006), http://www.nimh.nih.gov/health/publications/helping-children-and-adolescents-cope-with-violence-and-disasters-parents/complete-index.shtml#pub1 (discussing the different ways that children react to trauma and noting that these include isolation, depression, and emotional numbing).

[205] PERRY & SZALAVITZ, THE BOY WHO WAS RAISED AS A DOG, *supra* note 49, at 181–82.

[206] Major publications addressing the needs of children in the child welfare system contain numerous articles or chapters representing a variety of disciplines. *See* CHILD WELFARE LAW AND PRACTICE: REPRESENTING CHILDREN, PARENTS, AND STATE AGENCIES IN ABUSE, NEGLECT, AND DEPENDENCY CASES (Donald N. Duquette & Ann M. Haralambie, eds., 2d ed. 2010); THE APSAC HANDBOOK ON CHILD MALTREATMENT (John E.B. Meyers, et al. eds., 2d ed. 2001); CHILD WELFARE FOR THE 21ST CENTURY: A HANDBOOK OF PRACTICES, POLICIES, AND PROGRAMS (Gerald P. Mallon & Peg McCartt Hess eds., 2005); THE BATTERED CHILD (Mary Edna Helfer et al. eds., 5th ed. 1997).

[207] There are two on-line resources that the authors strongly recommend. First, the website of the National Child Traumatic Stress Network, www.nctsn.org, contains a wealth of information regarding trauma and its impact on children and families. Secondly, The Child Trauma Academy, which is a rich source of information: www.childtrauma.org. *See also* PERRY & SZALAVITZ, THE BOY WHO WAS RAISED AS A DOG, *supra* note 49. This book is written for a lay audience and provides a very helpful introduction to the topic. It provides basic information about children's brain development, the impact of trauma on that development, and a number of helpful tips for addressing children's trauma. Another basic resource is the Fall 2008 issue of the Juvenile & Family Court Journal, which is a special issue addressing child trauma.

[208] *See* MODEL RULES OF PROF'L CONDUCT PREAMBLE (2002) ("As advocate, a lawyer zealously asserts the client's position under the rules of the adversary system.").

[209] Beyer, *supra* note 5, at 1223.

[210] van der Kolk, *supra* note 14, at 405.

[211] *See, e.g.*, Dorothy Otnow Lewis, *Objective Documentation of Child Abuse and Dissociation in 12 Murderers With Dissociative Identity Disorder*, 154 AM. J. PSYCHIATRY 1703, 1707 (1997) (noting that most of the subjects in her study continued to deny or minimize abuse even as adults).

[212] *Id.*

[213] *See, e.g.*, *supra* Part IV.D., and the accompanying discussion of death row inmates.

[214] *See, e.g.*, Naomi Cahn, *Child Witnessing of Domestic Violence*, *in* HANDBOOK OF CHILDREN, CULTURE, AND VIOLENCE 3, 4 (Nancy E. Dowd et al. eds. 2006) ("The children of fathers who are abusive to their partners are 30 to 60% more likely to be physically abused.").

[215] The lead author of this Article has twice represented adolescents charged with crimes when they stepped into incidences of domestic violence: a 12-year-old boy charged with murder after he stabbed his mother's boyfriend as he was beating the mother's head against the floor and a 15-year-old girl charged with assault with intent to murder when she shot her mother's boyfriend, who was attacking her mother with a shovel.

[216] *See* ABA STANDARDS OF PRACTICE FOR LAWYERS WHO REPRESENT CHILDREN IN ABUSE AND NEGLECT CASES (1996) [hereinafter ABA STANDARDS].

[217] Patricia Lee Refo, *The Vanishing Trial*, 30 LITIG., no. 2, Winter 2004 at 2 (discussing the fact that the vast majority of civil and criminal cases in both the federal and state justice systems end without a trial); Pat Vaughn Tremmel, *Much Celebrated American Trial is Dying in Real Life*, NW. U. NEWS, March 3, 2009, http://www.northwestern.edu/newscenter/stories/2009/03/burnstrial.html (noting that only 2 percent of civil cases actually go to trial).

[218] *See generally* James Henry, et al., *A Grassroots Prototype for Trauma-Informed Child Welfare System Change*, 90 *CHILD WELFARE* 169 (2011).

[219] *See* Judge Michael L. Howard & Robin R. Tener, *Children Who Have Been Traumatized: One Court's Response*, 59 JUV. & FAM. CT. J. 21, 29–32 (2008) (discussing the juvenile court judge as a community leader and some of the challenges in building the capacity of the child welfare system to deliver trauma-informed child welfare services).

[220] *See* MICH. COMP. LAWS ANN. § 3.965(E)(2) (West 2012) (providing that participation in the initial services plan is voluntary unless ordered by the court). In such a circumstance, counsel for either the child or the parent may wish to advocate for a protective order that would disallow the petitioner from using the results of the assessment until the dispositional phase of the proceeding. This would protect the child and parent from cooperating with an assessment and then facing additional allegations of maltreatment.

[221] *See* Donald N. Duquette, Protecting Our Children—And Our Liberty: Striking the Balance in Child Protection Removals (June 11, 2008) (unpublished manuscript), *available at* http://www.law.umich.edu/centersandprograms/ccl/courseofferings/Documents/Protect%20our%20Children%206-11-08.pdf.

[222] *See* 42 U.S.C.A. §§ 621 – 628(b) (West 2012); 42 U.S.C.A. §§ 670 – 679(c) (West 2012); CHILD WELFARE INFO. GATEWAY, REASONABLE EFFORTS TO PRESERVE OR REUNIFY FAMILIES AND ACHIEVE PERMANENCY FOR CHILDREN: SUMMARY OF STATE LAWS (2009), http://www.childwelfare.gov/systemwide/laws_policies/statutes/reunifyall.pdf.

[223] *See* ABA STANDARDS, *supra* note 216.

[224] *See* DAVID FANSHEL & EUGENE B. SHINN, CHILDREN IN FOSTER CARE: A LONGITUDINAL INVESTIGATION (1978) (noting that frequent parental visitation was significantly related to children's leaving foster care to return home).

[225] MICH. 2011 ANNUAL REPORT, *supra* note 183.

[226] 42 U.S.C.A. § 627 (West 2012).

[227] Rosemary J. Avery, *The Potential Contribution of Mentor Programs to Relational Permanency for Youth Aging Out of Foster Care*, 90 CHILD WELFARE 9, 20 (2011) (internal citations omitted).

[228] *Id.* at 15 (discussing research findings regarding natural mentors and noting that the research supports the conclusion that there are moderate positive benefits to children involved in natural mentoring relationships).

[229] *Id.* at 17.

[230] *See, e.g.*, PERRY & SZALAVITZ, THE BOY WHO WAS RAISED AS A DOG, *supra* note 49, at 80 (discussing "the research on the most effective treatment to help child trauma victims might be accurately summed up this way: what works best is anything that increases the quality and number of relationships in the child's life"); Perry et al., *supra* note 21, at 285 ("The intensity and duration of response to trauma in children is dependent on a wide variety of factors. One of the most important appears to be the availability of a healthy and responsive caretaker to provide some support and nurturance for the child following the trauma.").

[231] JUDITH A. COHEN ET AL., TREATING TRAUMA AND TRAUMATIC GRIEF IN CHILDREN AND ADOLESCENTS (2006).

[232] *See, e.g.*, Connie Black-Pond, Margaret Richardson & Jim Henry, Trauma Informed Therapist Report (2011) (on file with the authors).

[233] Ann S. Masten & Angela J. Narayn, *Child Development in the Context of Disaster, War, and Terrorism: Pathways of Risk and Resilience*, 63 ANN. REV. PSYCHOL. 227 (2012).

[234] *See* COMPASSION FATIGUE: COPING WITH SECONDARY TRAUMATIC STRESS DISORDER IN THOSE WHO TREAT THE TRAUMATIZED (Charles R. Figley ed., 1995).