



# North Carolina Department of Health and Human Services CPS Assessment in Child Welfare Track Training

# Participant's Workbook Day Two

September 2025



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## Instructions

This course was designed to guide child welfare professionals through the knowledge, skills, and behaviors needed to engage with families in need of child protection services. The workbook is structured to help you engage in the lesson through reflection and analysis throughout each week of training. Have this workbook readily available as you go through each session to create a long-lasting resource you can reference in the future.

If you are using this workbook electronically: Workbook pages have text boxes for you to add notes and reflections. Due to formatting, if you are typing in these boxes, blank lines will be "pushed" forward onto the next page. To correct this when you are done typing in the text box, you may use delete to remove extra lines.

## **Course Themes**

The central themes of the CPS Assessment Track Training are divided across several course topics.

- Purpose and Legal Basis for Child Protection Services in North Carolina
- Essential Function: Communicating
- Diversity, Equity, Inclusion, and Belonging
- Trauma-Informed Care
- Family-Centered Practice
- Essential Function: Engaging
- Safety Focused
- Essential Function: Assessing
- Interviewing Learning Lab
- The Role of Observation in Assessing for Safety
- Structured Decision-Making: Safety Assessment
- Assessment Learning Lab
- Safety Planning
- Safety Planning Learning Lab
- Trauma-Informed Practice
- Considerations for Cases Involving Special Circumstances
- Social Worker Safety
- Engaging the Family in Child Protection Services
- Risk Assessment
- Crucial Conversations
- Quality Contacts
- Assessing Family Strengths and Needs
- Secondary Traumatic Stress and Vicarious Traumatization
- Ongoing Assessment
- Family Engagement and Ongoing Assessment Learning Lab
- Documentation
- Well-Being as an Outcome
- Reasonable Efforts and Removals

- Reasonable Efforts and Removals Learning Lab
- Decision-Making
- Decision-Making and Case Closure Learning Lab

## **Training Overview**

Training begins at 9:00 a.m. and ends at 4:00 p.m. If a holiday falls on the Monday of training, the training will begin on Tuesday at 9:00 a.m. This schedule is subject to change if a holiday falls during the training week or other circumstances occur. The time for ending training on Fridays may vary and trainees need to be prepared to stay the entire day.

Attendance is mandatory. If there is an emergency, the trainee must contact the classroom trainer and their supervisor as soon as they realize they will not be able to attend training or if they will be late to training. If a trainee must miss training time in the classroom, it is the trainee's responsibility to develop a plan to make up missed material.

## **Pre-Work Online e-Learning Modules**

There is required pre-work for the CPS Assessment Track Training in the form of online e-Learning modules. Completion of the e-Learnings is required prior to attendance at the classroom-based training. The following are the online e-Learning modules:

- 1. North Carolina Worker Practice Standards
- 2. Safety Organized Practice
- 3. Understanding and Assessing Safety and Risk
- 4. Understanding and Screening for Trauma

## **Transfer of Learning**

The CPS Assessment Track Training Transfer of Learning (ToL) tool is a comprehensive and collaborative activity for workers and supervisors to work together in identifying worker goals, knowledge gain, and priorities for further development throughout the training process. In four distinct steps, the worker and supervisor will highlight their goals and action plan related to participating in training, reflect on lessons and outstanding questions, and create an action plan to support worker growth. The tool should be started prior to beginning the CPS Assessment Track Training and re-visited on an ongoing basis to assess growth and re-prioritize actions for development.

- Part A: Training Preparation: Prior to completing any eLearning and in-person
  Track Training sessions, the worker and supervisor should meet to complete Part
  A: Training Preparation. In this step, the worker and supervisor will discuss their
  goals for participation in training and develop a plan to meet those goals through
  pre-work, other opportunities for learning, and support for addressing anticipated
  barriers.
- Part B: Worker Reflections During Training: The worker will document their thoughts, top takeaways, and outstanding questions regarding each section. This level of reflection serves two purposes. First, the practice of distilling down a full section of training into three takeaways and three remaining questions requires

the worker to actively engage with the material, subsequently forming cognitive cues related to the information for future use in case practice. Second, prioritizing takeaways and questions by section allows workers to continually review information to determine if questions are answered in future sessions and supports the development of an action plan by requiring workers to highlight the questions they find most important.

- Part C: Planning for Post-Training Debrief with Supervisor: The worker considers
  the takeaways and questions they identified in each section and creates a
  framework to transfer those takeaways and questions into an action plan.
- Part D: Post-Training Debrief with Supervisor: Provides an opportunity for the supervisor and worker to determine a specific plan of action to answer outstanding questions and to further support worker training.

While this ToL is specific to the Track Training in North Carolina, workers and supervisors can review the takeaways and questions highlighted by the worker in each section of training on an ongoing basis, revising action steps when prior actions are completed, and celebrating worker growth and success along the way.

## **Training Evaluations**

At the conclusion of each training, learners will complete a training evaluation tool to measure satisfaction with training content and methods. The training evaluation tool is required to complete the training course. Training evaluations will be evaluated and assessed to determine the need for revisions to the training curriculum.

All matters as stated above are subject to change due to unforeseen circumstances and with approval.

## **Learning Objectives**

#### **Day Two**

#### **Family-Centered Practice**

 Learners will be able to explain how family-centered practice increases family engagement.

#### **Essential Function: Engaging**

- Learners will be able to include children and youth in decisions made about their placements and services.
- Learners will be able to demonstrate strategies for engaging families in the assessment process.
- Learners will be able to explain policy requirements and interview protocols for different types of assessments.
- Learners will be able to formulate different types of interview questions.
- Learners will be able to demonstrate narrative interviewing techniques.
- Learners will be able to describe strategies for interviewing children.
- Learners will be able to describe strategies for interviewing adults.
- Learners will be able to outline how to integrate active listening skills into their interviewing techniques.

#### Safety Focused

#### **Essential Function: Assessing**

- Learners will be able to identify strategies to help elicit family voice when conducting interviews.
- Learners will be able to describe the benefit of developing harm and worry statements to communicate concerns related to child maltreatment.
- Learners will be able to describe how caregiver behavior impacts child safety.

## Day Two Agenda

## **CPS Assessment Track Training**

Welcome

**Family-Centered Practice** 

Family-Centered Practice

Meet the Anchor Families

**Essential Function: Engaging** 

**Engaging Overview** 

Interviewing

**Engagement Skills Practice** 

**Safety Focused** 

North Carolina Core Value: Safety Focused

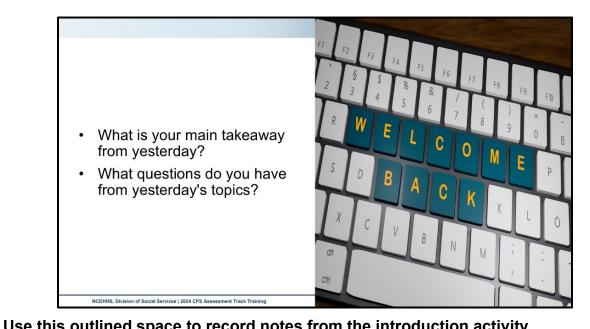
Safety, Protective Capacities, and Risk

**Essential Function: Assessing** 

Assessing

**End-of-Day Values Reflection** 

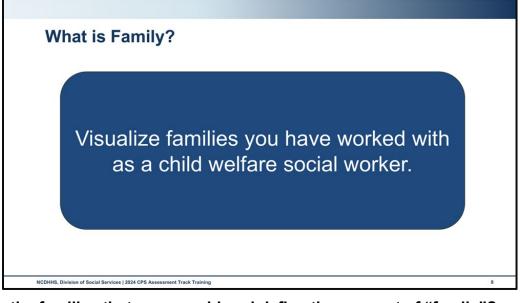
## Welcome



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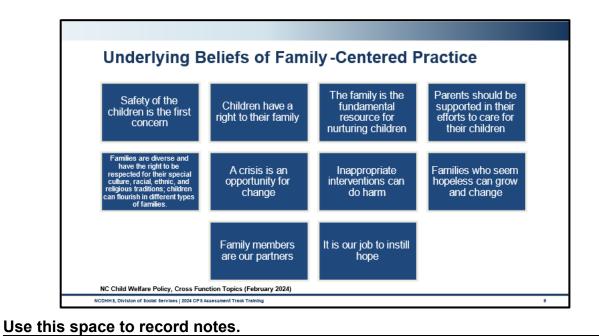
# **Family-Centered Practice**

Family-Centered Practice



How do the families that you considered define the concept of "family"?
What definition of family do you use when working with families?

What are we missing when we make assumptions or limitations on the definition of family?					



## Handout: Underlying Beliefs of Family-Centered Practice and Principles of Partnership

Underlying Beliefs of Family-Centered Practice
Safety of the children is the first concern.
Children have a right to their family.
The family is the fundamental resource for nurturing children.
Parents should be supported in their efforts to care for their children.
Families are diverse and have the right to be respected for their special culture, racial, ethnic, and religious traditions; children can flourish in different types of families.
A crisis is an opportunity for change.
Inappropriate interventions can do harm.
Families who seem hopeless can grow and change.
Family members are our partners.
It is our job to instill hope.
Principles of Partnership
Everyone desires respect.
Everyone needs to be heard.
Everyone has strengths.
Judgments can wait.
Partners share power.
Partnership is a process.
Inappropriate interventions can do harm.
Families who seem hopeless can grow and change.
Family members are our partners.
It is our job to instill hope.

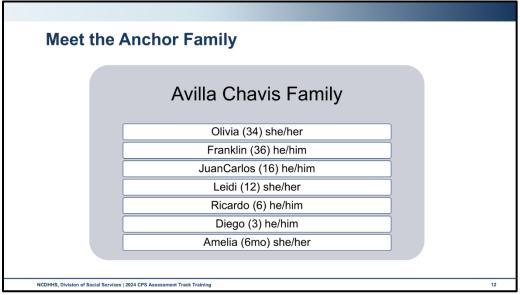
Use the space below as you consider the tasks and activities you do with families and on behalf of families that demonstrate each belief and principle.



	NCDHH8, Division of Boolal Services   2024 CPS Assessment Track Training 10					
What difference does it make for families when you spend time engaging an building rapport?						
Share a "family-	ew examples of when our practice may be centered on the familiendly.	y and not				

What are some techniques you use to build relationships with families?					
How do y	ou elevate f	amilies' voi	ces?		

## Meet the Anchor Families



U	Use this space to record notes.						

### Worksheet: Meet the Anchor Family

#### **Meet the Anchor Family**

#### **Avilla Chavis Family**

T
Olivia Avilla Chavis, she/her, 34-year-old, Hispanic, radiology technician at a hospital
Franklin Morelos Esquivel, he/him, 36-year-old, Hispanic, mechanic at an auto repair shop
Amelia Morelos Avilla, female, 6 months, Hispanic, at home
Diego Morelos Avilla, male, 3-year-old, Hispanic, at home
Ricardo Morelos Avilla, he/him, 6-year-old, Hispanic, 1st grade Pineville Elementary
Leidi Morelos Avilla, she/her 12-year-old, Hispanic, 6th grade, Williams Middle School
JuanCarlos Morelos Garcia, he/him, 16-year-old, Hispanic, 11 <sup>th</sup> grade, Williams High School

## **CPS History**

11 years ago: CPS Assessment finding: Services provided; child protective services no longer needed. Report alleged chronic diaper rash and no supplies at daycare for 5-month-old Leidi. Infant was observed with red and raw diaper rash and mother, Olivia, was diagnosed with post-partum depression, with little support from father, Franklin. Interviews and collateral information indicated that this is an isolated incident for the family. Olivia was referred for mental health services and both parents were referred to parenting classes/birth to age 5.

2 years ago: CPS Assessment finding: Services Provided, child protective services no longer needed. Report alleged Diego and Ricardo were found alone in the neighborhood by a neighbor. Law enforcement and CPS responded to the scene and returned the children to the home, where they found the mother asleep and seemingly intoxicated. Interviews and collateral information indicated that this is an isolated incident for the family. Olivia was referred to behavioral health services.

#### **Intake Report**

The report was made by a neighbor, Tammy Kirby.

Report alleged that Ricardo, age 6, was at the park with his brother, Diego, age 3. Diego was running around on the playground and Ricardo was sitting on the swing when Reporter found them. Ricardo told Reporter that he "often" takes Diego to the park when he babysits for his mom. Reporter walked Ricardo and Diego home and when they entered the home, the Reporter observed that the children were home alone, with Leidi, age 12, left in charge. Leidi was putting Amelia, age 6mo down to nap and knew

the children were at the park and did not think this was a problem. Reporter also observed that the home was very cluttered and had trash and spoiled food strewn about the living room.

The report was screened in for neglect, unsafe supervision, Family Assessment, immediate response time.

<u>Provisional Harm</u>: The parents leave Leidi (12) to supervise three children, Amelia (6mo), Ricardo (6), and Diego (3) which is more responsibility than a 12-year-old can manage. Ricardo took Diego to the park without an adult, which is dangerous as Ricardo is not old enough to supervise himself or babysit a younger child.

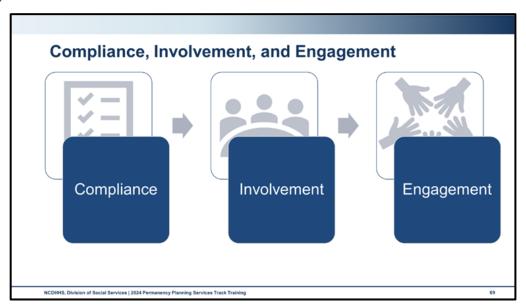
<u>Provisional Worry</u>: The reporter is worried Amelia, Diego, and Ricardo could be seriously hurt or injured or something bad might happen to them if they go to the park alone or are at home without an adult.

Ketie	ction							
What	were you	ur initial ı	reactions	to what y	ou read a	bout the A	villa Chav	es family?

What are some	hypotheses	for what may	be going on	or not goin	g on

# **Essential Function: Engaging**

## Family-Centered Practice



lse the space below to draft the definition for the concept assigned to yo	ur
roup:	

## Fist to Five Consensus Building Model:

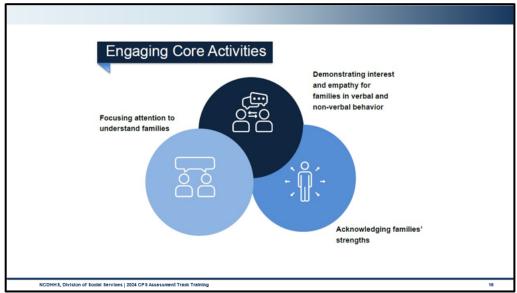
Once a definition is given, rate your agreement of that definition by holding up your hand with vote, using the scale below:

0	1	2	3	4	5
Fist	One finger	Two fingers	Three fingers	Four fingers	Spread hand
I don't agree at all with this definition and cannot move on	I have strong reservations and cannot move on until further work is done	I have some reservations and minor concerns to discuss before moving on	I am not in full agreement although feel comfortable enough to move on	I agree that this definition is good enough and am ready to move on	I am in full agreement with this definition

If you vote with fist, one or two, be prepared to state what you feel needs to change about the definition before moving on.

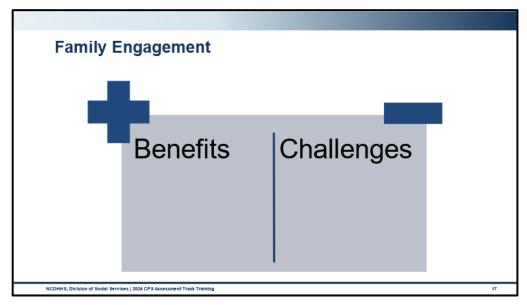
The goal is consensus and having a good enough definition. Definitions may be imperfect to move on.

Compliance – Collaborated Definition
Involvement – Collaborated Definition
Engagement – Collaborated Definition



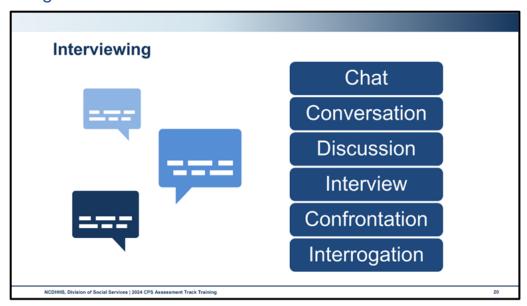
NCDHH 8, Division of Social Services   2024 CP 8 Assessment Track Training	
Were you aware of all the strategies that you employ to engage with children an families?	d
Are there activities, standards, or strategies that come more easily to you?	
Are there activities, standards, or strategies that feel more challenging?	

What do you need to grow your skill across all these areas?						



What are the benefits of family engagement?	
What are the challenges of family angagemen	42
What are the challenges of family engagemer	ıı,

## Interviewing



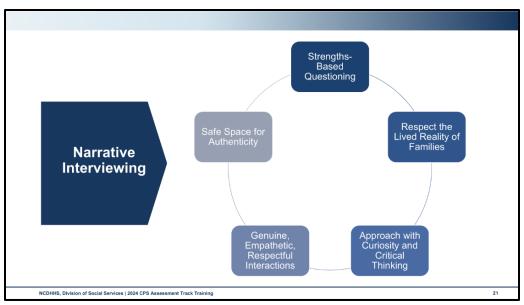
In what ways would you consider an interview practicing the engagement function?

What could happen if we rush through introductions and rapport building and move straight to discussions of the allegations?

	e miss plannir cus on inform		

As we delve into the skill of interviewing, keep in mind our role in CPS-Assessments is to ensure child safety.

The tools, concepts, and frameworks we are about to cover support us to engage families, build relationships, and support the fullest understanding of a family's functioning, all of which support us in having a clear picture of a child's safety within the home.



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Strength-Based and Solution-Focused Approach	
Identifying strengths in problem situations	
Exploring the past	
Finding and using expectations to the problem	
Facilitating a positive vision of the future	
Scaling questions	
Encouraging commitment	
Developing action steps	
https://www.pacwrc.pitt.edu/Curriculum/301EngggCintsFrmAnSBSFPrspctv/Hndts/HO_9_Solution_focused_skills_and_questions.pdf NCDHHS, Division of Social Services   2024 CPS Assessment Track Training	2

Use this space to record notes.						

Handout: Solution-Focused Interviewing Skills and Questions

Open Ended Questions					
Questions that encourage the client to use their own words and to elaborate on a topic.	Can you tell me about your relationship with your parents?				
	Tell me about your parenting experience.				
	Who are your supports and how do they help you?				
	Note: identify and reflect to clients any strengths or positive qualities clients may reveal in their responses to the open-ended questions.				
Summarizing					
Periodically state back to the client his/her thoughts, actions, and feelings.	So, what I hear you say is				
	If I understand you correctly, you are saying that				
	So, what you are saying is				
	Right?				
Tolerating/Using Silence					
Allow 10, 15, 20 seconds or so to allow clients to come up with their own responses. Avoid the temptation to fill in silence with advice.					
Complimenting					
Acknowledging client strengths and past success.	As you were talking, I noticed that you have many strengths. You have,				
	In the past, you have had successes evident by your ability to				
Affirming Client's Perception					
Perception is some aspect of a person's self-awareness or awareness of their life. They include a person's thoughts, feelings, behaviors, and experiences. Affirmation of the client's perceptions is similar to reflective listening in form but does not isolate and focus on the feeling component per se, but on the client's larger awareness.	would you like to use this information to move forward				

## Working with Client's Negative or Inaccurate Perceptions

Perceptions, even negative ones like suicide or assaultive behaviors should be explored to understand the full context.

Some perceptions may be obviously inaccurate and reflect a person's denial of a problem. Avoid an immediate educative or dissuading response to negative or inaccurate perceptions. Listening and understanding are the social worker's first obligations.

What's happening in your life that tells you that hitting or suicide might be helpful in this situation? How does it feel to say, "I don't want to do this anymore?"

How might your life be different if you did hit him?
What are the pros and cons of your reaction?

## Returning the Focus to the Client

Clients tend to focus on the problem and/or what they would like others to do differently. In the Solution-Focused approach, the client is encouraged to return the focus to themselves and to possible solutions.

"My kids are lazy. They don't realize that I need help sometimes." Response: "What gives you hope that this problem can be solved?" "I wish my parents would get with it. A 10:00 pm curfew on weekends is ridiculous." Response: "When things are going better, what will your parents notice you doing differently?"

"My teachers are too hard. If they would back off all the homework and give more help my grades would improve." Response "What is it going to take to make things even a little bit better?"

"If my boss would stop criticizing me and treating me like a child, I could be more productive." Response "If your boss was here and I asked him what you could do differently to make it just a little easier for him not to be so critical, what do you think he would say?"

## **Exception Questions**

Exception questions help clients think about times when their problems could have occurred but did not or at least were less severe. Exception questions focus on who, what, when, and where (the conditions that helped the exception to occur) NOT WHY; should be related to client goals.

Are there times when the problem does not happen or is less serious? When? How does this happen?

Have there been times in the last couple of weeks when the problem did not happen or was less severe?

How was it that you were able to make this exception happen?

What was different about that day?

If your friend (teacher, relative, spouse, partner, etc.) were here and I were to ask him what he noticed you doing differently on that day, what would he say? What else?

## Coping Questions

Coping questions attempt to help the client shift his/her focus away from the problem elements and toward what the client is doing to survive the painful or stressful circumstances. They are related in a way to exploring for exceptions.

Coping questions attempt to help the client What have you found that is helpful in managing shift his/her focus away from the problem this situation?

Considering how depressed and overwhelmed you feel, how is it that you were able to get out of bed this morning and make it to our appointment (or make it to work)?

You say that you're not sure that you want to continue working on your goals. What is it that has helped you to work on them up to now?

## Scaling Questions

Scaling questions invite clients to put their observations, impressions, and predictions on a scale from 0 to 10, with 0 being no chance, and 10 being every chance. Questions need to be specific, citing specific times and circumstances.

Scaling questions invite clients to put their On a scale of 0 to 10, with 0 being not serious at observations, impressions, and predictions all and 10 being the most serious, how serious do on a scale from 0 to 10, with 0 being no you think the problem is now?

On a scale of 0 to 10, what number would it take for you to consider the problem to be sufficiently solved?

On a scale of 0 to 10, with 0 being no confidence and 10 being very confident, how confident are you that this problem can be solved?

On a scale of 0 to 10, with 0 being no chance and 10 being every chance, how likely is it that you will be able to say "No" to your boyfriend when he offers you drugs?

What would it take for you to increase, by just one point, your likelihood of saying "No"?

What's the most important thing you have to do to keep things at a 7 or 8?

## Indirect Relationship Questions

Indirect questions invite the client to consider how others might feel or respond to some aspect of the client's life, behavior, or future changes. Indirect questions can be useful in asking the client to reflect on narrow or faulty perceptions without the worker directly challenging those perceptions or behaviors.

How is it that someone might think that you are neglecting or mistreating your children?

Has anyone ever told you that they think you have a drinking problem?

If your children were here (and could talk, if the children are infants or toddlers) what might they say about how they feel when you and your wife have one of those serious arguments?

At the upcoming court hearing, what changes do you think the judge will expect from you to consider returning your children?

How do you think your children (spouse, relative, caseworker, employer) will react when you make the changes we talked about?

#### Miracle Questions

The Miracle Question is a special type of preferred future question that can help people get clarity on how the problem impacts their daily life and what life would look like without the problem happening.

Imagine you woke up tomorrow and a miracle had happened overnight, and all the trouble was gone. How would you know it was over? What would be different that would tell you the problem was no longer happening? What is the first thing you would be doing to start the day? What would the rest of your day look like? What would things look like for your children?

If you could wave a magic wand and things, be different, what would that new state of being look like? What would it take to get there without the magic wand?

## Trauma-Responsive and Shame-Sensitive Interviewing

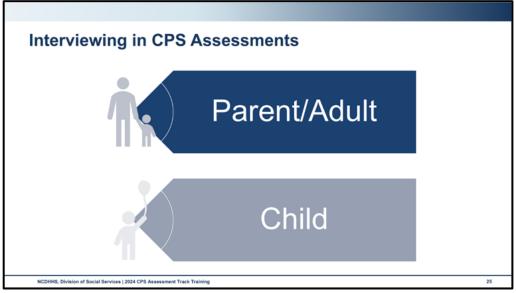
"The safer a person feels, the more likely they are to fully or partially reveal their interpersonal trauma and make us aware of their need for support."

- Interviews can be overwhelming and shame-inducing
- Understand how trauma impacts behavior
- Acknowledge feelings of shame
- Believe families when they share their story

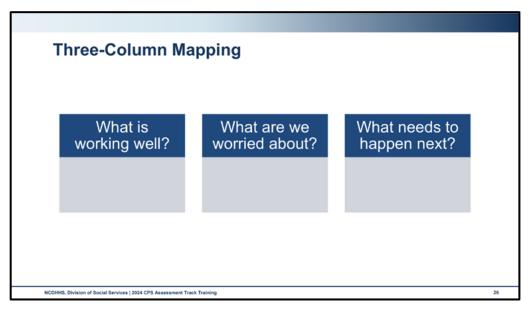
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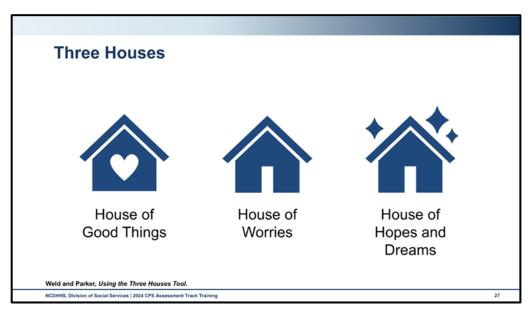
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What is the definition of child development?
•
What are the key tasks in early childhood development?
What do children learn about the world from having secure, safe relationships
with caregivers?



Use this space to record notes.



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### **Engagement Skills Practice**

Skills Practice: Initial Engagement with Parent

Handout: Observation and Feedback

### **Observation Quick Tips:**

- Clear your mind and practice area of distractions
- Listen and observe intently and with purpose
- Look for strengths and opportunities for growth

### Feedback Quick Tips:

- Ask your partner what they felt most comfortable doing and what was more difficult for them.
- Actively listen to your partner.
- Provide feedback building upon their self-assessment.
- Be clear, concise, and behaviorally specific.
- Be open and honest
- Start by identifying their strengths.
- Provide feedback on opportunities for improvement.
- Maintain their self-esteem without diminishing attention to the opportunities.
- Provide tips and suggestion
- Guide them in brainstorming and selecting the next steps.

**Note**: Apply SMART to feedback: Specific, Measurable, Achievable, Realistic., and Timely with feedback.

### **Receiving Feedback Tips:**

- Be open
- Understand that growth is a constant process.
- We all learn from each other no matter what our role.
- Accept positive feedback.
- Have grace for yourself.
- The classroom is a safe place to practice and make mistakes.
- Strategize the next steps.
- Be clear about what works for you and what doesn't in the learning process so the next steps are tailored to your needs.

### Activity: Communicating Engagement

### **Scenario Updates**

### **Avilla Chavis Family**

### Initial phone call:

Social Worker contacted Olivia via phone call. Immediately upon hearing Social Worker introduction, Olivia indicated she was on her way home because Leidi had called her and told her DSS was on their way. Olivia shared that Leidi is a good girl and that she watches the other children carefully. Olivia indicated that the social worker will see this when the social worker comes to the home. Olivia agreed to have all household members, including JuanCarlos and Franklin home as soon as possible, as social worker was leaving the office immediately and about fifteen minutes away from the home.

### Entry into the home:

Franklin answered the door and told Social Worker that everything is fine. He indicated that there was no need for the Social Worker to enter the home or to check on everyone, as his family is okay; he makes sure of that. Olivia then came to the door and told Franklin that he needed to let the social worker in, that the social worker was just doing their job. Franklin sat on the couch and Olivia granted permission for the social worker to enter the home.

### Observations of tour of the home:

- The family resides in a three-bedroom manufactured home. No concerns regarding sleeping space were noted.
  - Ricardo and JuanCarlos share one bedroom, with bunk beds and a desk in the room.
  - Diego and Amelia share a bedroom, with Diego in a toddler bed and Amelia sleeping in a crib. Crib was observed to have several stuffed animals and a blanket. Safe sleeping was discussed with parents, and items were removed before completion of the home visit.
  - Leidi sleeps in a small room off the living room that used to be Olivia's office for privacy.
  - Olivia and Franklin share a bedroom.
- The home has working smoke detectors. Fire safety discussed with family.
- One shotgun reported and observed in the home. The shotgun with trigger lock stored separately from bullets in a locked closet of the parents' bedroom. Firearm safety discussed with family with no concerns noted regarding firearm access.
- Adequate food was observed in the cabinets, pantry, and refrigerator.
- Home is free of hazards on initial walk through although kitchen requires further assessment, as bags of trash, food in various stages of preparedness, dirty dishes, etc. were observed piled on the counter and kitchen table.

Use the space below to create a few narrative statements and open-ended questions to utilize in your interview with the parent.					
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# **Safety Focused**

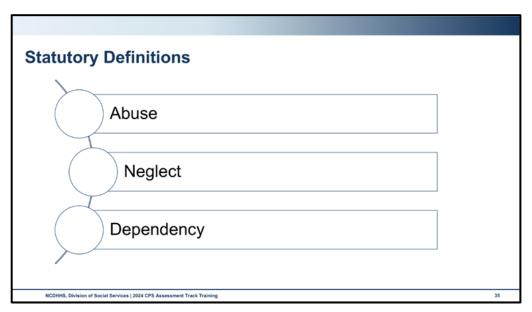
North Carolina Core Value: Safety Focused



What role d	lo you play in ned to vou?	assuring a ch	ild's safety wh	ose CPS Asse	essment has
What role o	lo you play in ned to you?	assuring a ch	ild's safety wh	nose CPS Asse	essment has
What role o	lo you play in ned to you?	assuring a ch	ild's safety wh	nose CPS Asse	essment has
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What role o	lo you play in ned to you?	assuring a ch	ild's safety wh	nose CPS Asse	essment has
What role o	lo you play in ned to you?	assuring a ch	ild's safety wh	nose CPS Asse	essment has

How do you prepare for this role?
How do you fulfill this role?
What is the likelihood that you will encounter domestic violence in your work with families?

ou play when ary team respo		?



Definitions for Abused, Neglected, and Dependent Juvenile can be found in NCGS § 7B-101. Definitions and in CPS Intake Policy, Protocol, and Guidance.

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### Activity: Family Accessible Language and Maltreatment Definitions

Create a poster with your group that includes:

- The definition as outlined in policy (for sexual abuse, it is okay to summarize)
- A list of behaviors or conditions that may be present in a home or family where this form of maltreatment is or has occurred
- A list of ways in which children are impacted by this form of maltreatment
- A revised definition in language you could use with a family

How was this activity?
What was the most challenging part?
After looking at each of the posters, are there any questions that came up for you?

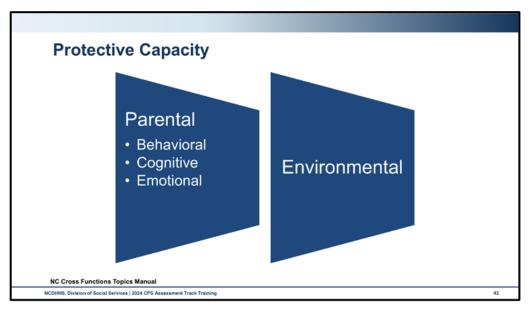
Safety, Protective Capacities, and Risk



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### **Handout: Protective Capacity**

**Protective capacity** is defined as the ability and willingness to mitigate or ameliorate the identified safety and risk concerns. Protective capacity can be demonstrated by a parent through their statements, actions, and reactions. Protective capacity exists both within the parent/caretaker and within the family environment.

Parent/caretaker protective capacity should be assessed in three domains:

- Behavior characteristics
- Cognitive characteristics
- Emotional characteristics

**Behavioral** characteristics are defined as specific actions and activities consistent with and resulting in parenting and protective vigilance. Questions to consider include:

- Does the parent/caretaker have the capacity to care for the child? If the parent/caretaker has a disability(ies) (e.g., blindness, deafness, paraplegia, chronic illness), how has the parent/caretaker addressed the disability in parenting the child?
- Has the parent/caretaker acknowledged and acted to provide the needed support to effectively parent and protect the child?
- Does the parent/caretaker demonstrate activities that indicate putting aside one's own needs in favor of the child's needs (if appropriate)?
- Does the parent/caretaker demonstrate adaptability in a changing environment or during a crisis?
- Does the parent/caretaker demonstrate actions to protect the child?
- Does the parent/caretaker demonstrate impulse control related to a risk factor?
- Does the parent/caretaker have a history of protecting the child given any threats to the safety of the child?

**Cognitive** characteristics are defined as the parent/caretaker's specific intellect, knowledge,

understanding, and perception that contributes to protective vigilance. Questions to consider include:

- Is the parent/caretaker oriented to time, place, and space? (i.e., reality orientation)
- Does the parent/caretaker have an accurate perception of the child? Does the parent/caretaker see the child as having strengths and weaknesses, or do they see the child as "all good" or "all bad"?
- Can the parent/caretaker recognize the child's developmental needs or if the child has special needs?
- How does the parent/caretaker process the external stimuli? (e.g., a battered woman who believes she deserves to be beaten, because of something she has done)
- Does the parent/caretaker understand their role to provide protection to the child?
- Does the parent/caretaker have the intellectual ability to understand what is needed to raise and protect a child?
- Does the parent/caretaker accurately assess potential threats to the child?

Emotional characteristics are defined as the parent/caretaker's specific feelings, attitudes, and identification with the child and motivation that results in parenting and protective vigilance. Questions to consider include:

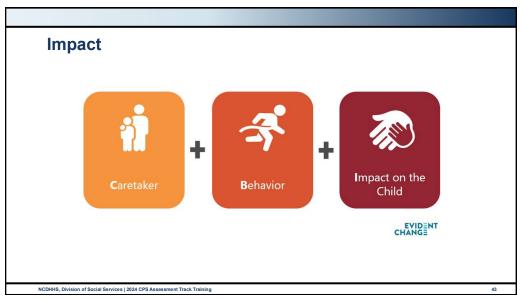
- Does the parent/caretaker have an emotional bond with the child? Is there a
  reciprocal connectedness between the parent/caretaker and the child? Is there
  a positive connection to the child?
- Does the parent/caretaker have empathy for the child when the child is hurt or afraid?
- Is the parent/caretaker flexible under stress? Can the parent/caretaker manage adversity?
- Is the parent/caretaker able to control their emotions? If emotionally overwhelmed, does the parent/caretaker reach out to others or expect the child to meet the parent/caretaker's emotional needs?
- Does the parent/caretaker consistently meet their own emotional needs via other adults, services?

### **Environmental Protective Capacities**

While the assessment of the parent/caretaker's protective capacities is critical, an assessment of **environmental capacities** may also mitigate the safety concerns/risk of harm to a child. Below are several categories of environmental protective capacities to be considered.

- Family/kinship relationships that contribute to the protection of the child;
   Informal relationships
- Agency supports
- Community supports
- Financial status
- Spiritual supports
- For American Indians, the tribe
- Concrete needs being met (e.g., for food, clothing, shelter).

Citation: Cross Function Topics



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### Worksheet: Distinguishing Safety and Risk

Read the scenario below. For each, decide if the scenario represents a safety threat or a risk factor. If a risk factor is decided, write one way that a parent or caregiver might mitigate or eliminate the risk.

# Scenario One A father was arrested for DWI after he was seen swerving and crossing the center line of the road. The three-year-old was in the car with him, as they were on the way to school. Circle One: Safety Threat Risk Factor If Risk Factor, one idea to mitigate or eliminate the risk:

### Scenario Two

The mother is a single mother of five children. Two of the children are under 2 years old. She has limited support and inconsistently takes her medication for depression.. Her 12-year-old daughter takes on a parenting role when the mother has a mental health crisis.

Circle One: Safety Threat Risk Factor

If Risk Factor, one idea to mitigate or eliminate the risk:

### Scenario Three

The mother and father are young parents of a toddler and an infant. They have unrealistic expectations of a two-year-old. They use physical discipline when their toddler does not listen to their directions. The toddler has no marks or bruises. The parents are tired and often have the infant sleep in the bed with them. The infant's crib has stuffed animals and cute blankets in it.

Circle One: Safety Threat Risk Factor

If Risk Factor, one idea to mitigate or eliminate the risk:

### Scenario Four

A mother has a history of substance use disorder involving alcohol. She has several past DWIs, the most recent 6 months ago. She is the only adult in the household and the 6-year-old has been suspended from the bus for the next two weeks due to aggressive behavior.

Circle One: Safety Threat Risk Factor

If Risk Factor, one idea to mitigate or eliminate the risk:

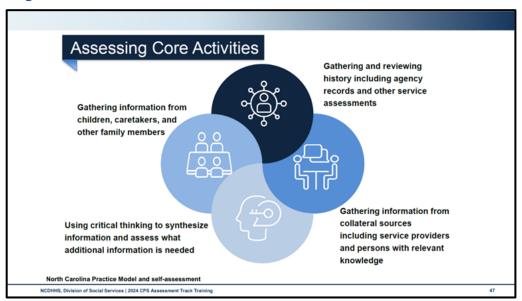
### Scenario Five

The father is a person with Schizophrenia. He is a single father of five children. Two of the children are under 2 years old. He recently moved to North Carolina from Florida and has limited support. His 12-year-old daughter called 911 when her father had a psychosis episode and attempted to drown his 4-year-old son stating that he was the devil. Emergency technicians verified that the daughter had successfully resuscitated her brother.

Circle One:	Safety Threat	Risk Factor
If Risk Factor, one ic	dea to mitigate or eliminate the	e risk:

# **Essential Function: Assessing**

## Assessing



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Handout: Assessing Self-Assessment

### NC DEPARTMENT OF HEALTH AND HUMAN SERVICES

# North Carolina Worker Assessment: Assessing

### Introduction

Assessing is defined as gathering and synthesizing information from children, families, support systems, agency records, and persons with knowledge to determine the need for child protective services and to inform planning for safety, permanency, and well-being. Assessing occurs throughout child welfare services and includes learning from families about their strengths and preferences.

There are four Assessing core activities: (1) gathering information from children, caretakers, and other family members, (2) gathering and reviewing history, including agency records and other service assessments, (3) gathering information from collateral sources including service providers and persons with relevant knowledge, and (4) using critical thinking to synthesize information, assess what additional information is needed, and inform decision making.

Table 1. Core Activity: Gathering information from children, caretakers, and other family members

Practice Standard 1: Differentiates between information and positions								
	Α	s	N	Notes				
I moderate information gathering sessions	(1)	(2)	(3)					
I gather information that supports all positions	(1)	(2)	(3)					
I understand my own biases that may cloud positions	(1)	(2)	(3)					
Practice Standard 2: Takes time to get to	know	famili	es an	d explain the assessment process				
	Α	S	N	Notes				
I take time to conversationally gather the family's story	(1)	(2)	(3)					
I use engagement to build family participation in assessment process	(1)	(2)	(3)					
I get a picture of the family's hopes, aspirations, challenges, and worries	(1)	(2)	(3)					
I explain the assessment process, reiterating purpose	(1)	(2)	(3)					
I authentically share with the family about the process	(1)	(2)	(3)					

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### NC DEPARTMENT OF HEALTH AND HUMAN SERVICES

I keep in mind the culture of the family when gathering information	(1)	(2) (3)			
Practice Standard 3: Asks questions bas	sed on	informati	ion need	ded and at ease asking uncomfortable questions	
	A	s	N	Notes	
l ask open-ended, strengths-based questions	1 1 1	(2)	(3)		
I understand what type of questions elicit the best type of answers		(2)	(3)		
I have the ability to hear difficult information without reaction		(2)	(3)		
I engage in crucial conversations	(1)	(2)	(3)		
I utilize a narrative approach to gather perspectives on historical information		(2)	(3)		

Table 2. Core Activity: Gathering and reviewing history, including agency records and other service assessments

Practice Standard 4: Stays open to different explanations of events in the record, keeping biases in check							
	Α	S	N	Notes			
I continuously gather information	(1)	(2)	(3)				
I am diligent in pursuing information	(1)	(2)	(3)				
I understand how to factor historical information into current situation	(1)	(2)	(3)				
l keep an open mind	(1)	(2)	(3)				
Practice Standard 5: Balances what is rea	ad in t	he rec	ord a	and what families share			
	Α	s	N	Notes			
I review information ahead of meeting the family, but ask them to share their perspective	(1)	(2)	(3)				

**Division of Social Services** 

### NC DEPARTMENT OF HEALTH AND HUMAN SERVICES

I identify in the record what has historically worked well for the family	(1)	(2)	(3)
I have an understanding of what biases I hold when reviewing history	(1)	(2)	(3)

Table 3. Core Activity: Gathering information from collateral sources including service providers and persons with relevant knowledge

Practice Standard 6: Obtains all sides if there are differing positions among collaterals, engaging families in the process Α S N Notes I seek out wide number of collaterals (1) (2) (3) and balance collateral sources I obtain information from as many (1) (2) (3) collaterals as time permits I consider all relevant collateral sources (1) (2) (3) I am honest with families when I must reach out to collaterals the family is (1) (2) (3) unhappy with and explain why I let the family help identify collaterals and ask their permission before (1) (2) (3) contacting

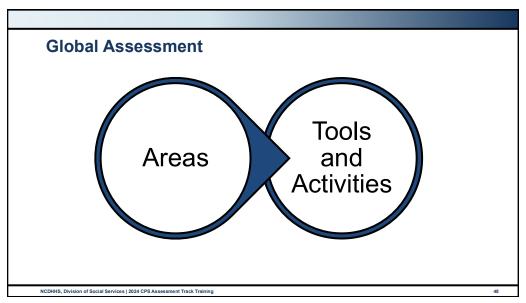
Table 4. Core Activity: Using critical thinking to synthesize information, assess what additional information is needed, and inform decision making

Practice Standard 7: Synthesizes information and considers sources, prioritization, and timelines								
	Α	S	N	Notes				
I continually gather information	(1)	(2)	(3)					
I understand assessment is ongoing process in determining needs	(1)	(2)	(3)					
I rank information received based on relevance and priority	(1)	(2)	(3)					

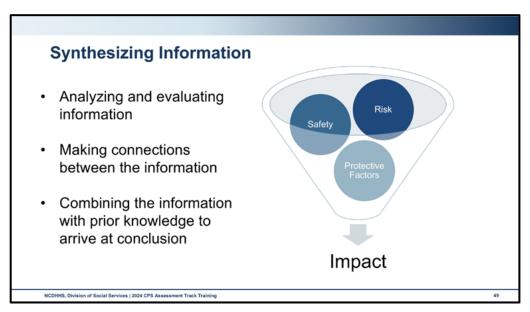
**Division of Social Services** 

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I prioritize information that negatively impacts children to address first	(1)	(2)	(3)					
Practice Standard 8: Remains non-judgmental when processing information								
	Α	S	N	Notes				
I am inquisitive from the beginning of assessment process	(1)	(2)	(3)					
I understand the family's community as they define it	(1)	(2)	(3)					
I operate with cultural humility	(1)	(2)	(3)					
I persevere in gathering information, follow the information	(1)	(2)	(3)					
l understand not all information is relevant	(1)	(2)	(3)					
I normalize reactions family has to information and assessment results	(1)	(2)	(3)					
I understand fight, flight, or freeze response	(1)	(2)	(3)					



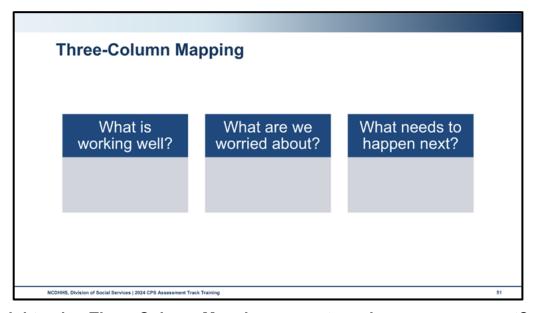
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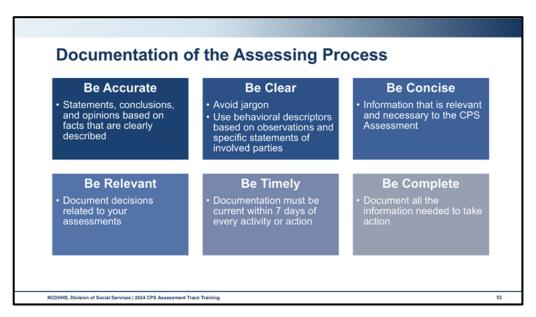
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SDM Tool	Description of Tool
North Carolina Safety Assessment (DSS-5231)	<ul> <li>Assessment of whether a child is likely to be in immediate danger of serious harm which may require protective intervention and to determine what safety interventions should be maintained or initiated to provide appropriate protection</li> </ul>
Temporary Parental Safety Agreement (Part E of the Safety Assessment)	<ul> <li>When specific threats to a child's immediate or foreseeable future have been identified, this portion is created with the family to address risks with practical, action-oriented plan</li> </ul>
Family Risk Assessment of Abuse/Neglect (DSS- 5230)	<ul> <li>Assessment estimates the likelihood of future child welfare system involvement, and assists in determining which cases should be continued for ongoing services and which may be closed at the end of an investigation</li> </ul>
Family Strengths and Needs (DSS-5229)	<ul> <li>Structures the assessment of family caregivers and all children across a common set of domains of family functioning. Identifies priority areas of need for ongoing case planning to focus efforts to improve family functioning and child safety.</li> </ul>

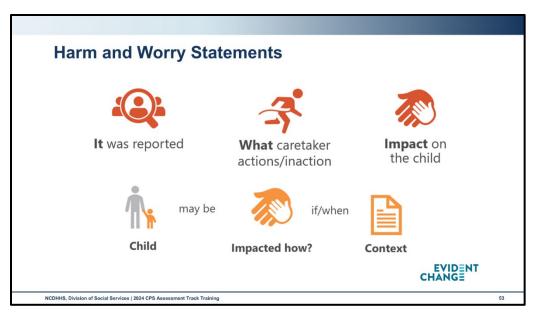
why is it best practice to complete the SDM tools in collaboration wi	ui uie iaiiiiy ?



low might using Three-Column Mapping support you in your assessment?



What are some of the ways you demonstrate non-judgmental and respectful documentation?



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# **End-of-Day Values Reflection**

Questions and Reflections.

Use this space to record questions and reflections about what you have learned.

# **Bibliography of References**

### **Day Two**

Adverse childhood experiences study. (2024). *Acestudy.org*. [Website]. www.acestudy.org

Alliance for Child Welfare Excellence. (2020, October 1). Regional Core Training – Interviewing Adults Handouts. *Rise with the Alliance*.

https://risewiththealliance.org/home/regional-core-training-interviewing-adults-handouts/

CalSWEC Online, (2019, April 29) Child Welfare Worker Realistic Job Preview. [Video]. YouTube.com.https://www.youtube.com/watch?v=2aoOYAwgp2o&list=PLNYfSDZN2XUpWQ62KzijZDZ g2VEjlSGD&index=1

Casey Family Programs, (2019, January 18) *Jeremiah Donier: Birth dad winner.* [Video]. YouTube.com. <a href="https://www.youtube.com/watch?v=yxBeN5-Rq">https://www.youtube.com/watch?v=yxBeN5-Rq</a> E&t=249s

Child Welfare Information Gateway. (n.d.). *Separating poverty from neglect*. Washington, DC: U.S. Department of Health and Human Services, Administration for Children and Families, Children's Bureau.

https://www.childwelfare.gov/topics/prevention/separating-poverty-neglect/?top=89

Child Welfare Information Gateway. (2020, October) *How the Child Welfare system works*. Washington, DC: U.S. Department of Health and Human Services, Administration for Children and Families, Children's Bureau. <a href="https://www.childwelfare.gov/pubPDFs/cpswork.pdf">https://www.childwelfare.gov/pubPDFs/cpswork.pdf</a>

Child Welfare Information Gateway. (2021, March). *The use of safety and risk assessments in Child Protection cases*. Washington, DC: U.S. Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth, and Families, Children's Bureau. (March 2021). https://cwig-prod-prod-drupal-s3fs-us-east-

1.s3.amazonaws.com/public/documents/safety\_risk.pdf?VersionId=ssUjM9eGAF05e9Y AiAkm8zjJ AibAyRS

Child Welfare Information Gateway. (2021). Family engagement: Partnering with families to improve child welfare outcomes. Washington, DC: U.S. Department of Health and Human Services, Administration for Children and Families, Children's Bureau. https://www.childwelfare.gov/pubs/f-fam-engagement/

Child Welfare Information Gateway. (2014, July 23) *Child and family services reviews quick reference items list*. Washington, DC: U.S. Department of Health and Human Services, Administration for Children and Families, Children's Bureau. https://www.acf.hhs.gov/sites/default/files/documents/cb/cfsr\_quick\_reference\_list.pdf.

Child Welfare Information Gateway. (2023). *Child Welfare Policy Manual*. Washington, DC: United States Department of Health and Human Services, Administration for Children and Families, Children's Bureau. Retrieved from https://www.acf.hhs.gov/ on 12 Nov 2023.

D'Aunno, L.E., Boel-Studt, S., & Landsman, M.J. (2014). Evidence-based elements of Child Welfare in-home services. *Journal of Family Strengths* 14(1): Article 3. DOI: https://doi.org/10.58464/2168-670X.1247

Dolezal, L., & Gibson, M. (2022). Beyond a trauma-informed approach and towards shame-sensitive practice. *Humanities & social science communities* 9: 214. https://doi.org/10.1057/s41599-022-01227-z

Evident Change. (2022, March 30). *Back To Basics-Safety and Risk Webinar #2/Safety and Risk Assessment Key Elements*. Family & Children's Resource Program. https://fcrp.unc.edu/resources/back-to-basics-safety-and-risk-webinar-2-safety-and-risk-assessment-key-elements/

Evident Change. (2024). Three Questions: Making a Rigorous and Balanced Assessment eLearning. *Safety-Organized Practice*.

Gerald R. Sherratt Library. (2024). *Information Synthesis*. Cedar City, Utah: Southern Utah University. https://library.suu.edu/LibraryResearch/information-synthesis

Juvenile Code, Article 1 – Abuse, Neglect, Dependency Definitions. North Carolina Stat. §7B-101. (1979, rev. 2021).

https://www.ncleg.net/EnactedLegislation/Statutes/HTML/ByChapter/Chapter\_7B.html

Kezelman C., & Stavropoulos P. (2017) *Talking about Trauma: Guide to Everyday Conversations for the General Public*. Milsons Point, NSW, Australia: Blue Knot Foundation. https://www.tfec.org/wp-content/uploads/Talking-About-Trauma-in-Public.pdf

Lund, T.R. & Renne, J. (2009). *Child safety: A guide for judges and attorneys.* Washington, DC: American Bar Association.

https://www.americanbar.org/content/dam/aba/administrative/child\_law/child-safety-guide.pdf

National Council of Juvenile and Family Court Judges. (2018). *Distinguishing Poverty Experienced by Families from Child Neglect*. Linking Systems of Care for Children and Youth Project. https://www.ncjfcj.org/wp-content/uploads/2021/11/Distinguishing-Poverty.pdf

Newlin, C., Cordisco Steele, L., Chamberlin, A., Anderson, J., Kenniston, J., Russell, A., Stewart, H., & Vaughan-Eden, V. (2015). *Child forensic interviewing: Best practices*. (2015). Retrieved from https://www.ojjdp.gov/pubs/248749.pdf on 30 January 2024.

North Carolina Department of Health and Human Services, Division of Social Services. (2002). What is forensic interviewing? *Children's services practice notes* 8(2). https://practicenotes.org/vol8\_no1/what\_is.htm

North Carolina Department of Health and Human Services, Division of Social Services, Child Welfare Services. (2017). *North Carolina Safety Assessment.* https://policies.ncdhhs.gov/wp-content/uploads/dss-5231-ia.pdf

North Carolina Department of Health and Human Services, Division of Social Services. (2019). Assessing safety and risk. *Children's services practice notes* 24(2). https://practicenotes.org/v24n2.htm

North Carolina Department of Health and Human Services, Division of Social Services. (2020, May). CPS Purpose & Philosophy, Legal Basis, Administration: NC Child Welfare manual, 9. https://policies.ncdhhs.gov/wp-content/uploads/purpose.pdf

North Carolina Department of Health and Human Services, Division of Social Services. (2021). *North Carolina practice standards worker assessment*.

https://www.ncdhhs.gov/cw-worker-north-carolina-worker-assessment-all-practice-standards/open

North Carolina Department of Health and Human Services, Division of Social Services. (2021). *Worker practice standards desk guide*. https://www.ncdhhs.gov/cw-worker-north-carolina-worker-practice-standards-desk-guide/open

North Carolina Department of Health and Human Services, Division of Social Services. (2024, April). *Cross function topics: NC Child Welfare manual*. https://policies.ncdhhs.gov/wp-content/uploads/In-Home April-2024 2.pdf

North Carolina Department of Health and Human Services, Division of Social Services. (2024, August). *CPS Assessments Policy, Protocol, and Guidance: NC Child Welfare manual.* https://policies.ncdhhs.gov/wp-content/uploads/CPS-Assessments-Aug-2024.pdf

North Carolina Department of Health and Human Services, Division of Social Services. (2024, August). *CPS Intake Policy, Protocol, and Guidance: NC Child Welfare manual.* https://policies.ncdhhs.gov/wp-content/uploads/CPS-Intake Aug-2024.pdf

The Pennsylvania Child Welfare Resource Center. (n.d.). *Engaging Clients from a Strength-Based, Solution-Focused Perspective, Handout #9, Page 1 of 4*. Pittsburgh, PA: University of Pittsburgh.

https://www.pacwrc.pitt.edu/Curriculum/301EngggClntsFrmAnSBSFPrspctv/Hndts/HO\_9\_Solution\_focused\_skills\_and\_questions.pdf

Platt, D. (2012, May). Understanding parental engagement with child welfare services: An integrated model, *Child and family social work 17*(2): 138-148. https://doi.org/10.1111/j.1365-2206.2012.00828.x

Roose, R., Roets, G., Van Houte, W., Vandenhole, W., & Reynaert, D. (2013). From parental engagement to the engagement of social work services: Discussing reductionist and democratic forms of partnership with families. *Child & Family Social Work 18*(4): 449-457.

Toros, K., DiNitto, D.M., & Tiko, A. (2018, May). Family Engagement in the child welfare system: A scoping review. *Children and youth services review 88*: 598-607. https://doi.org/10.1016/j.childyouth.2018.03.011.

Weld, N. & Parker, S. (n.d.). *Using the Three Houses Tool. Partnering for Safety*. https://www.partneringforsafety.com/uploads/2/2/3/9/22399958/three\_houses\_booklet\_updated.pdf

Wessells, M.G. (2015). Bottom-up approaches to strengthening child protection systems: Placing children, families, and communities at the center. *Child abuse & neglect 43*: 8-21.

Yordy, J. (2023, February 1). *Poverty and Child Neglect: How did we get it wrong?* Washington, DC: National Conference of State Legislatures. https://www.ncsl.org/state-legislatures-news/details/poverty-and-child-neglect-how-did-we-get-it-wrong

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#### Underlying Beliefs of Family-Centered Practice and Principles of Partnership

# Underlying Beliefs of Family-Centered Practice Safety of the children is the first concern. Children have a right to their family. The family is the fundamental resource for nurturing children. Parents should be supported in their efforts to care for their children. Families are diverse and have the right to be respected for their special culture, racial, ethnic, and religious traditions; children can flourish in different types of families. A crisis is an opportunity for change. Inappropriate interventions can do harm. Families who seem hopeless can grow and change. Family members are our partners. It is our job to instill hope. Principles of Partnership Everyone desires respect. Everyone needs to be heard. Everyone has strengths. Judgments can wait. Partners share power. Partnership is a process. Inappropriate interventions can do harm. Families who seem hopeless can grow and change. Family members are our partners. It is our job to instill hope.

#### Family Engagement: Partnering With Families to Improve Child Welfare Outcomes



# Family Engagement: Partnering With Families to Improve Child Welfare Outcomes

Engaging families in the casework process promotes the safety, permanency, and wellbeing of children and families in the child welfare system and is central to successful practice. Effective family engagement occurs when child welfare practitioners actively collaborate and partner with the family network, including maternal and paternal relatives and fictive kin, throughout their involvement with the child welfare system and recognizing them as the experts on their respective situations and empowering them in the process.

#### WHAT'S INSIDE

The benefits of family engagement

Challenges to family engagement

Strategies for engaging families at the practice level

Family engagement at the system, program, and community levels

Family engagement across disciplines

Conclusion

Additional resources





Children's Bureau/ACYF/ACF/HHS | 800.394.3366 | Email: info@childwelfare.gov | https://www.childwelfare.gov

1

Family engagement is a family-centered and strengths-based approach to making decisions, setting goals, and achieving desired outcomes for children and families. At its best, family engagement encourages and empowers families to be their own champions and to work toward goals that they developed, with the support of their caseworker, based on their strengths, protective factors, and needs. This partnership between caseworkers and families is founded on the principle of communicating openly and honestly in a way that supports disclosure of culture, family dynamics, and personal experiences to meet the individual needs of every family and child. Additionally, family engagement is recognized as essential to success across the human services and education fields and is considered a core competency in the Council on Social Work Education's accreditation standards.

This bulletin for professionals provides an overview of the foundational elements of the family engagement approach, followed by strategies and promising practices for implementing it. While this publication is intended to provide information for frontline caseworkers who directly engage families, it also provides information about family engagement at the system, program, and community levels, as best practices are grounded in these higher levels of the child welfare system.

#### THE BENEFITS OF FAMILY ENGAGEMENT

In child welfare practice, families are recognized as experts in determining what is best for themselves and their children. A family engagement approach to casework involves supporting families in developing solutions to their unique challenges. Using this strengths-based approach, caseworkers work to create a safe space and build trust with a family network, then empower and encourage them to partner with caseworkers in developing plans and goals to ensure child safety and, in turn, improve outcomes for children and families. Prioritizing family voice in decision—making and planning processes enhances the fit between family needs and services and increases the likelihood that families will access services that will result in case plan completion.

Rather than being a single tool, family engagement represents a mindset and approach that can reap extensive benefits, including the following:

- Family preservation. Involving family members early in the casework process may eliminate the
  need for a child to be placed outside of the home (Children's Bureau, 2019).
- Improved interpersonal relationships. A family's belief that all its members are respected—and
  that its strengths, challenges, concerns, and cultural differences are recognized and accepted—
  strengthens the relationship with the caseworker. This creates confidence in the process that
  increases the chances for a successful intervention (Horwitz & Marshall, 2015).
- Increased family buy-in. Families are more likely to commit to achieving goals when they help
  make decisions about a plan that will affect them and their children (Horwitz & Marshall, 2015).

- Creating a sense of belonging and family connectedness. The inclusion of kin and extended family members in case planning expands placement and permanency options for children when in-home care is not feasible and can nurture children's sense of belonging during what is oftentimes a tumultuous, unsettling time. Some people who play an important role may be "fictive kin"—those who may not be related, but who have an emotionally significant relationship with the family or child.
- Improved quality of caseworker visits. The engagement of families through empathy, genuineness, and respect leads to quality, purposeful interactions between families and caseworkers. In turn, quality contacts provide opportunities for caseworkers to make an improved assessment of the child's safety, risk, and needs so they can better support the family (Capacity Building Center for States, 2017b).
- Youth empowerment. There are also tangible benefits to engaging youth. These include supporting adolescent brain development, encouraging development of leadership skills, improving self-esteem, and helping form critical social connections (Children's Bureau, 2019).

#### Family Engagement During a Public Health Crisis

A public health crisis, such as a pandemic, can have major implications on the ways in which caseworkers can engage with families. Agencies may need to adapt their processes and services, e.g., shift to virtual caseworker and family visits. It is important that caseworkers are flexible and supportive as they engage with families during such crises. This could involve helping a family access technology or the internet so they can continue to participate in the case planning process (Children's Bureau, 2021). Caseworkers should also be aware and sensitive of financial difficulties and other family stressors that may be caused or exacerbated by public health crises. For more information on engaging families during times of hardship, see the following resources:

- Supporting Child, Caregiver, and Family Well-Being in Times of Crisis: Strategies to Promote Effective Virtual and Phone Engagement (Child Welfare Information Gateway)
- Responding to Disasters (Child Welfare Information Gateway)
- ACYF-CB-IM-21-03: <u>Lessons From the COVID-19 Pandemic: Supporting Families Through</u>
   More Just, Equitable, Proactive, and Integrated Approaches (Children's Bureau)
- Virtual Case Management Considerations and Resources for Human Services Programs
   (U.S. Department of Health and Human Services [HHS], Office of the Assistant Secretary for Planning and Evaluation)

#### CHALLENGES TO FAMILY ENGAGEMENT

Caseworkers regularly face challenges to engaging parents and extended family members. Common barriers to engagement include the following:

- Vulnerable and worried families. Involvement with the child welfare system often results in
  vulnerability and stress that is difficult to cope with. It is important that caseworkers establish a
  foundation of trust to address these challenges (G. Pilarski, personal communication, May 19, 2021).
- Unreceptive or mistrusting families. Parents who become involved in the child welfare system often
  mistrust child welfare services (Mirick, 2014). Their mistrust may be conveyed through a range of
  emotions, such as anger, frustration, confusion, skepticism, and questioning.
- An inherent power imbalance. There is an inherent power imbalance in the roles of parents, other family members, and social workers in child protection processes (Toros et al., 2018). The nature of the relationship is often involuntary on the parents' part and investigative and punitive on the workers' part, which can make forming a partnership challenging.
- The duality of the caseworkers' role. On top of the power imbalance, practitioners are required to play multiple—and oftentimes contradicting—roles in the casework process. On one hand, they provide support and assistance, while on the other, they have the authority and ability to make recommendations that remove children from their homes (Horwitz & Marshall, 2015).
- Caseworker turnover and/or high caseload. Caseworker turnover adds an element of instability
  that can hinder the engagement process and take away from time needed to build trust (Cheng & Lo,
  2020). In addition, a caseworker with a high caseload may not have sufficient time to build strong
  relationships with families (Toros et al., 2018).
- Logistical challenges. Transportation costs, scheduling conflicts, and other logistical challenges that
  both families and caseworkers face can impede engagement. Utilizing active and joint problem-solving
  around these barriers can support family buy-in (Stephens et al., 2018).
- Family stressors. Problems including substance use, mental illness, and intimate partner violence can
  hinder a caseworker's efforts to build a productive, engaging relationship (Cheng & Lo, 2020). Some
  families facing these stressors benefit from intentional collaboration across service sectors, such as
  behavioral health and the education system.
- Implicit bias. Child welfare agencies should be aware of the implicit biases held by caseworkers, supervisors, and others about the families they work with, as these can impede effective engagement. Common biases include "Individuals can't or won't change" or "If parents loved their children, they would make different choices" (Children's Bureau, 2019). Caseworkers may be particularly biased towards fathers and unwilling or unprepared to engage them (Arroyo et al., 2019). This can result in caseworkers engaging only mothers, despite evidence that father involvement can have beneficial impacts on case outcomes.
- Interpretation of confidentiality statutes. Caseworkers can be hamstrung by conservative
  interpretations of confidentiality laws, precluding them from sharing critical information with the
  family network.

#### **Engaging Fathers and Paternal Relatives**

Engaging fathers and paternal relatives is a crucial component of family engagement, but these family members have been historically overlooked. The findings from round 3 of the Federal Child and Family Services Reviews show fathers were engaged in less than half (49 percent) of the reviewed cases, while mothers were engaged in 64 percent of cases (JBS International, Inc., 2020). Child welfare agencies should provide training for their staff on how to effectively engage fathers and work to create greater opportunities to partner with fathers and paternal relatives whose children are involved in the child welfare system.

The benefits of involved fathers include the following (National Fatherhood Initiative, n.d.):

- Improved emotional and social well-being of children
- Fewer maltreatment incidents
- Better school performance
- · Fewer behavioral problems for boys and fewer psychological problems for girls

For more information, refer to the following resources:

- Engaging Fathers and Paternal Family Members (Child Welfare Information Gateway)
- "Tips & Tools to Help Your Organization Learn to Better Engage Fathers" (National Fatherhood Initiative)
- ACF-ACF-IM-18-01: <u>Integrating Approaches That Prioritize and Enhance Father</u> <u>Engagement</u> (HHS, Office of Family Assistance)
- "Engaging Participants and Facilitating Groups" (National Responsible Fatherhood Clearinghouse)

#### STRATEGIES FOR ENGAGING FAMILIES AT THE PRACTICE LEVEL

Quality family engagement occurs at the practice level between the caseworker and the family. Effective, collaborative case planning relies on the caseworker's transparent efforts to continuously engage family members and others as appropriate, including utilizing the following activities:

- · Visualizing the family system through developing genograms and network maps
- Engaging the family as key decision-making partners
- Identifying behaviors and conditions that need to change
- Matching strengths and needs with solutions and services
- Reviewing, tracking, and acknowledging progress regularly

**Appendix: Handouts** 

- Determining readiness for key case transition points, such as reunification
- Marshaling supports for relapse prevention as needed
- Preparing for case closure

The following sections describe approaches caseworkers can use to promote family engagement in daily practice.

#### **USING SUPPORTIVE BEHAVIORS**

Being supportive can go a long way with a family that is involuntarily involved in the child welfare system. Caseworkers should use the following supporting behaviors:

- Considering the socioeconomic stressors and institutional and societal biases associated with class, race, gender, and culture
- Balancing discussions of problems with the identification of strengths and resources
- Listening to the family's concerns with empathy
- Helping families meet concrete needs (e.g., housing, food, utilities, child care) by connecting them
  with appropriate supports and services
- Setting goals that are mutually agreed upon and may be generated primarily by the family and stated in their language
- · Focusing on improving family members' skills rather than providing insights
- Providing family members with choices whenever possible
- · Obtaining commitment from the family that they will engage in mutually identified tasks
- Sharing openly and transparently with family members about agency and court expectations and timelines
- Conducting frequent and substantive caseworker visits with the parents, caregivers, children, and other members of the family network
- Providing <u>virtual alternatives to parent-child visits</u> when face-to-face meetings cannot occur
- Recognizing and praising progress
- Embracing family meetings with the widest family network possible by inviting fictive kin and other members of the family's support system to participate
- Incorporating the child or youth in case planning and family meetings, including helping them be
  physically present, encouraging them to participate by sending letters and videos, or suggesting
  participation through other methods
- · Holding meetings at times and in locations that are most convenient for family members
- Providing a welcoming physical environment for the meetings

#### SUPPORTING PARTNERSHIPS BETWEEN BIRTH AND FOSTER PARENTS

A strong relationship between a child or youth's birth parents and foster parents can help improve family engagement and child welfare outcomes (Birth and Foster Parent Partnership, 2020). These relationships work best when caseworkers support and facilitate early and ongoing communication between the parties.

The Quality Parenting Initiative (QPI) is a strategy developed by the Youth Law Center that emphasizes the importance of developing a robust relationship between birth and foster families. As of January 2021, 75 jurisdictions in eight States had implemented the QPI approach (Quality Parenting Initiative, 2021). Rather than being a standalone program, QPI is a philosophical approach that communities use to design policies and practices that suit their individual needs (Casey Family Programs, 2020a). The QPI approach in Louisiana, the first State to adopt QPI statewide, involves two core strategies to facilitate shared parenting between foster and birth families: initial calls and icebreakers.

An initial call between the families takes place as soon as possible following the removal of a child from their family. These calls serve to confirm that the child has arrived at the foster home, to introduce the birth family to the foster family, and to exchange information about the child. Caseworkers facilitate this early conversation by preparing both parties for the call, providing topics for discussion, and offering support and guidance if the call does not go well.

An icebreaker meeting is a short meeting between birth and foster families that is facilitated by the caseworker in the foster family's home within 3 to 5 days of placement. This meeting focuses on initiating a relationship between caregivers and serves several purposes:

- The resource parent can learn about the child's needs.
- · The birth parent can meet the person caring for their child.
- The child can see their caregivers collaborate.

#### INSTITUTING FAMILY MEETING MODELS

The hallmark of family engagement practice is convening the family network to support and plan for its children and family members. When it comes to putting together the family network, child welfare agencies have implemented different types of family meetings, including models such as family group decision–making, family team conferencing, permanency teaming, and team decision–making meetings. For a detailed description of these four approaches, visit the <a href="Annie E. Casev Foundation website">Annie E. Casev Foundation website</a>.

The various family meeting models involve different structures and procedures, but common threads across these approaches include teamwork and family engagement (Kim et al., 2019). Family meeting approaches bring together a group of family members, caseworkers, and other significant stakeholders to develop, implement, and evaluate individualized case plans. Service selection is often a part of these family meetings, which can help build trust between the family members and caseworker. When family members feel safe and can meaningfully participate in assessing their situation, they are able to guide the caseworker on what services and supports will help them.

Such approaches can strengthen family relationships, help identify and nurture a system of family supports, intentionally involve fathers and paternal relatives, and prevent unnecessary placement and placement disruption. For example, a study in Texas found that after controlling for demographic variables, family team meetings reduced the odds of removal by 51 percent (Lambert et al., 2017).

#### INCORPORATING FAMILY FINDING

In agencies that implement <u>family finding</u>, child welfare professionals cast a wide net to identify and search for family members and other important people in the lives of children in foster care. Once identified, the professionals make them aware that children have entered care and ask them to become part of the family circle that is engaged in the case decision-making process. This process intentionally creates a lifetime network for children, which fosters a sense of belonging and create meaningful connections with maternal and paternal family members as well as fictive kin. Family finding was initially viewed as a tool to enhance permanency for youth aging out of foster care. However, the practice became more widely used following passage of the Fostering Connections to Success and Increasing Adoptions Act of 2008, which requires State agencies to identify and notify family members within 30 days of removing a child from their home.

Family finding can be time intensive. Since caseworkers have limited time, it is most common for family findings to be carried out by relative search units. Recognizing this, the Fostering Connections Act authorized \$75 million over 5 years for grants that enable agencies to implement programs to increase permanency for children and youth, including intensive family finding programs.

#### The Illinois Recruitment and Kin Connection Project

One family finding program funded by the Fostering Connections Act grants was the Illinois Recruitment and Kin Connection Project (RKCP), which was funded by the Children's Bureau from 2010 to 2015. This project sparked policy and practice changes that continued after the project's conclusion (Illinois Department of Children and Family Services & Illinois Center for Adoption and Permanency, 2015).

The RKCP program model included a kin connection specialist who began family finding outreach the same day temporary custody was granted, actively engaging the birth family and case management team in the process. After conducting the search for 40 days, the specialist documented their findings in Illinois' statewide automated child welfare information system.

At the project's conclusion, project leaders determined that RKCP services improved concurrent planning, increased the likelihood that future placements would be with relatives or fictive kin, and succeeded in locating more family members and kin who could serve as alternative placement options and positive attachment figures (Illinois Department of Children and Family Services & Illinois Center for Adoption and Permanency, 2015). Ultimately, the project was successful in catalyzing systems change at the legislative level, the State policy level, and the professional development level. The project's impact exceeded expectations, and front-end family finding is now considered a best practice in the Illinois child welfare system.

More information is available in the RKCP final report.

#### **EMPLOYING SAFETY ORGANIZED PRACTICE**

Safety Organized Practice (SOP) is a collaborative practice approach designed to enhance family participation and encourage equitable decision-making (Northern California Training Academy, 2018). The practice emphasizes the importance of teamwork and aims to strengthen partnerships within a family by involving a network of family, friends, service providers, and the child welfare agency. A core belief of SOP is that all families have strengths.

SOP is both a framework for practice and a set of tools and strategies that caseworkers can utilize. These tools and strategies are informed by several solution-focused techniques used in child welfare practice. These three questions offer a guiding framework for SOP:

- What are we worried about?
- What is working well?
- What needs to happen?

For more information about SOP, check out the California Social Work Education Center's <u>Safety Organized Practice toolkit</u>.

#### USING MOTIVATIONAL INTERVIEWING

Motivational interviewing is a nonconfrontational engagement practice that can help families work toward potential changes. It may be particularly useful in encouraging parents to recognize the benefits of participating in a home-based family support program. The approach was originally designed to help adults with substance-use issues but has since been adapted as an effective model for working with involuntary or reluctant families to help resolve their ambivalence toward change (Casey Family Programs, 2021).

When skillfully employed, this technique helps an individual see the possibilities for—and merit in—positive change and then encourages and supports them in this effort. The practice requires a caseworker to listen empathetically and build trust with the family before encouraging them to consider possible changes. A traditional approach to family engagement may involve a caseworker telling a parent they are at risk of losing custody of their child and directing them to participate in services. Using motivational interviewing, the caseworker listens to the parent's concerns about the allegations, encourages them to look at the positives and negatives of engaging in services, and helps them decide what changes are consistent with their goals and values (Hall et al., 2020).

For additional information, see Information Gateway's <u>Motivational Interviewing</u>: A <u>Primer for Child Welfare Professionals</u>.

#### **Engaging Families Affected by Parental Incarceration**

The intersection of child welfare and parental incarceration is a growing concern for child welfare caseworkers. Engaging incarcerated parents may be difficult for caseworkers due to a lack of clear agency policies and insufficient training on working with this population. However, incarcerated parents typically have the same rights as other parents regarding visitation, engagement in case planning, and reunification efforts.

Caseworkers should engage incarcerated parents early and often, from the time of arrest until release. When working with families affected by parental incarceration, caseworkers should consider the following engagement practices:

- Become familiar with the rules and procedures for visitation and other forms of contact at the facility in which a parent is incarcerated in order to facilitate parent/child contact.
- Seek out ways for incarcerated parents to participate in case-planning meetings, dependency hearings, family decision-making meetings, and other appointments.
- Revisit discussions about case and visit plans as incarcerated parents near their release dates.

For more information about working with incarcerated parents, read Information Gateway's <u>Child Welfare Practice With Families Affected by Parental Incarceration</u>.

#### PRACTICING CULTURAL HUMILITY

Caseworkers who partake in cultural and diversity training have reported higher success rates in engaging families (Cheng & Lo, 2018). This suggests that when a caseworker demonstrates sensitivity about a family's ethnicity and culture, they can build trust and rapport with that family.

Many of these cultural trainings are labeled and designed to achieve "cultural competency." However, many social work professionals have suggested shifting from the term "cultural competency" to "cultural humility." While competency suggests mastery, humility involves admitting that one does not know everything there is to know about another culture but that they are willing to learn from their clients and address their inherent biases and embedded perceptions (Lekas et al., 2020). Cultural humility is described as a lifelong learning process involving self-reflection and self-critique.

Child welfare caseworkers should seek to apply cultural humility in any instance when one is working with people different from oneself in terms of race, ethnicity, gender, religion, sexual orientation, gender identity expression, socioeconomic status, or geographic location (Mallon, 2020). A lack of sensitivity to the cultural needs, values, and strengths of an at-risk population may undermine the quality of a family's case plan and provided services. It could also lead to assumptions and misconceptions that can result in limited family engagement, frustrated efforts, and misguided resources.

The <u>National Child Welfare Workforce Institute</u> (NCWWI) suggests that caseworkers integrate the following cultural humility strategies into their practice (NCWWI, 2019):

- Embrace the complexity of diversity.
- Be open to individual differences and different social experiences.
- Reserve judgement.
- · Communicate with others in ways that are most understandable to them.
- View cultural humility as an ongoing effort to become more familiar with the worldviews of others.
- Promote collaboration.
- Demonstrate familiarity with children's and families' living environments.
- Self-reflect on the ways in which biases interfere with the ability to objectively listen to others.

Use the following resources for more information on culturally sensitive child welfare practice:

- "Seeking Equity Calls Us to Cultural Humility" (Children's Bureau Express)
- Racial Equity Resources for Child Welfare Professionals (Child Welfare Information Gateway)
- <u>National Center for Cultural Competence</u> (Georgetown University Center for Child and Human Development)

## FAMILY ENGAGEMENT AT THE SYSTEM, PROGRAM, AND COMMUNITY LEVELS

While this bulletin is intended for caseworkers who work directly with families, child welfare agencies play an important role in family engagement by implementing programs and supporting their workers in executing best practices for engagement. Community groups and organizations also play a critical role in partnering with agencies to provide tailored services and supports for families involved with the child welfare system.

#### INVOLVING FAMILIES IN SYSTEM-LEVEL CHANGE

The experiences that families have with all levels of the child welfare system begin at the system level. One of the strongest ways to promote more positive interactions with the system is to have family and youth voices involved in how it is designed and operated (Children's Bureau, 2019). System-level family engagement occurs when family members who were formerly involved with child welfare services actively collaborate with child welfare agencies in effecting practice and systems change. Providing the opportunity for families with lived experience to have a voice in policy and program development, serve on decision-making bodies, and help train agency staff on family engagement can have many benefits in the child welfare system (Capacity Building Center for States, 2019).

Even when States and jurisdictions understand the value of stakeholder engagement, many still struggle to engage families and youth authentically and sustainably in the development and implementation of programs, policies, and training. Pitfalls for family engagement include not giving family members an explicit role or involving them as an afterthought (Capacity Building Center for States, 2019). This often results in the families feeling as though they are involved in a process only to "check a box" or fulfill a requirement. Authentic engagement occurs when child welfare agencies actively work with families and youth early and throughout a process or project and recognize them as equal partners.

Agencies can increase the prominence and impact of family and youth voice in the child welfare system by implementing the following principles (Children's Bureau, 2019):

- Prioritize family and youth voice.
- · Work with families and youth to create a vision for how to implement family and youth voice
- Challenge the inherent power imbalance between agencies and families.
- Use mindful and empowering language to describe parents, youth, and caregivers. (For example, use "child" instead of "foster child," "parent" instead of "birth parent," and "resource family" instead of "foster family.")
- Ensure parents and youth have high-quality legal representation.
- Implement peer-led and supported services.
- Establish feedback loops for continuous quality improvement.

Recognizing the benefits of agencies, families, and community partners working together, the Children's Bureau Capacity Building Center for States developed the <u>Family Empowerment Leadership Academy</u>, a collection of resources designed to help agencies improve collaboration with families.

#### ENGAGING PARENTS AS PEER MENTORS AT THE PROGRAM LEVEL

One of the most commonly used practices for engaging families at the program level is the <u>parent</u> <u>partner program</u>, which enlists individuals who were once involved with child welfare services to help parents currently involved with the system meet case plan goals and navigate the system. Parent and caregiver mentors assist current parents through mutual sharing, support, and advocacy. Parent partner programs are founded on the premise that these experienced parents and caregivers are uniquely qualified to help by serving as empathetic peers, mentors, guides, and advocates.

Studies show that parent partner programs in child welfare have resulted in higher rates of reunification, lower rates of reentry, and increased family participation in services and court hearings (Casey Family Programs, 2019). They can also be beneficial to the parents who serve as mentors (Casey Family Programs, 2020b). As former clients of the child welfare system take on leadership roles and responsibility, they build workplace skills and self-esteem and are compensated for their efforts. In addition, many who take on roles as parent partners go on to pursue careers in child welfare or degrees in higher education.

To be successful, parent partner programs need strong leaders who can work collaboratively with multiple agency and community partners. Because some agency staff are not accustomed to treating their former child welfare clients as paraprofessionals, leadership should communicate clearly that parent partner programs can be a powerful strategy to improve family engagement in child welfare cases (Casey Family Programs, 2020b). These programs can also influence the culture of child welfare agencies by shifting the perception of caregivers from clients to partners. It is also important that the leadership implementing parent partner programs include diverse representatives so that the diversity of the parent partners reflects the diversity of the population served by the agency (Casey Family Programs, 2020b).

#### COMMUNITY ENGAGEMENT IN CHILD WELFARE

Community engagement in child welfare involves partnering with community members who have firsthand knowledge of the strengths their neighborhoods possesses and the challenges they face. Communities are also home to independent organizations that offer specialized programs and services that can support families served by the child welfare system. Integrating community voice into child welfare systems can improve family engagement and increase the efficacy of services.

Agencies can use the following strategies to engage communities:

- Recognizing promising practices and partnering with programs and services that are highly valued within a community
- Hiring staff that represent the race, ethnicity, and cultural makeup of the community
- Encouraging agency staff to attend community events to build relationships and learn about community strengths and concerns
- Involving community members and organizations in assessment and evaluation activities

The Children's Bureau funded a series of Community Collaborations grantees in Federal fiscal years 2018 and 2019 that encouraged collaboration between child welfare agencies and communities. The grantees were awarded funds to develop, implement, and evaluate community-based primary prevention strategies and activities for strengthening families, preventing maltreatment, and reducing entry into the child welfare system. Read about lessons learned from these grantees in the Children's Bureau's *Primary Prevention: Themes From Fiscal Year 2018 Grantee Site Visits*.

Use the following resources for more information about community engagement:

- Building Agency/Community Partnerships (Child Welfare Information Gateway)
- <u>Building and Sustaining Collaborative Community Relationships</u> (Capacity Building Center for States)
- "Embracing Community and the Wisdom of Lived Experience" (HHS, Administration for Children and Families, Children's Bureau; Information Gateway; & FRIENDS National Center for Community-Based Child Abuse Prevention)

#### FAMILY ENGAGEMENT ACROSS DISCIPLINES

Families involved in the child welfare system often have multiple and complex needs across different human services sectors, such as mental health issues and juvenile justice involvement (Capacity Building Center for States, 2017a). Effective collaboration across human services systems can help agencies achieve better outcomes related to safety, permanency, family preservation, and reunification.

For example, interdisciplinary family engagement has proven successful when there is overlap between the child welfare and juvenile court systems (Olson, 2020). When families, caseworkers, legal personnel, extended families, and other stakeholders work collaboratively—sometimes with the help of a facilitator—the benefits can include parental empowerment, strengths-based decision-making, and the focused exchange of information. Visit the Information Gateway website for resources about how child welfare agencies can collaborate with the courts, behavioral health and wellness professionals, and domestic violence service providers.

#### CONCLUSION

There are many ways in which child welfare caseworkers and agencies can engage families, ranging from large-scale policy changes to simple changes in daily practice. Fundamentally, though, it requires a paradigm shift in attitude where the family is treated as the expert on its unique situation and encouraged to draw on its specific strengths and resources to ensure more positive long-term outcomes. By reviewing the concepts presented in this issue brief, child welfare professionals can assess how well their own agencies engage families and initiate changes to improve their work in this area.

#### **Appendix: Handouts**

#### ADDITIONAL RESOURCES

<u>Family-Centered Practice</u> (Information Gateway) provides resources on family-centered practice approaches, including information on engaging families in case planning.

<u>Quality Worker-Parent Visits: A Tip Sheet for Supervisors and Managers</u> (Capacity Building Center for States) provides guidance to support caseworkers through three phases of quality worker-parent visits: before the visit, during the visit, and after the visit.

Applying the Science of Child Development in Child Welfare Systems (Center on the Developing Child at Harvard University) provides information on how science-based principles can inform child welfare policy and practice development, including strategies caseworkers can apply to their work engaging families.

#### REFERENCES

- Arroyo, J., Zsembik, B., & Peek, C. W. (2019). Ain't nobody got time for dad? Racial-ethnic disproportionalities in child welfare casework practice with nonresident fathers. *Child Abuse & Neglect*, 93, 182–196. https://doi.org/10.1016/j.chiabu.2019.03.014
- Baginsky, M., Hickman, B., Moriarty, J., & Manthorpe, J. (2020). Working with Signs of Safety: Parents' perception of change. Child & Family Social Work, 25, 154–164. https://doi.org/10.1111/cfs.12673
- Birth and Foster Parent Partnership. (2020). Birth and foster parent partnership: A relationship building guide. https://ctfalliance.sharefile.com/share/view/sfbf4965b0cb04a4cb3aee4a034aa2042
- Capacity Building Center for States. (2017a). Creating and sustaining cross-system collaboration to support families in child welfare with co-occurring issues: An administrator's handbook. <a href="https://capacity.childwelfare.gov/pubPDFs/cbc/cross-system-collaboration-cp-00071.pdf">https://capacity.childwelfare.gov/pubPDFs/cbc/cross-system-collaboration-cp-00071.pdf</a>
- Capacity Building Center for States. (2017b). *Defining quality contacts*. <a href="https://capacity.childwelfare.gov/states/resources/defining-quality-contacts/">https://capacity.childwelfare.gov/states/resources/defining-quality-contacts/</a>
- Capacity Building Center for States. (2019). Strategies for authentic integration of family and youth voice in child welfare. <a href="https://capacity.childwelfare.gov/states/focus-areas/foster-care-permanency/integration-youth-family/">https://capacity.childwelfare.gov/states/focus-areas/foster-care-permanency/integration-youth-family/</a>
- Casey Family Programs. (2019). How do parent partner programs instill hope and support prevention and reunification? <a href="https://www.casey.org/parent-partner-program/">https://www.casey.org/parent-partner-program/</a>
- Casey Family Programs. (2020a). How do initial calls and icebreakers support shared parenting? <a href="https://www.casey.org/initial-calls-icebreakers/">https://www.casey.org/initial-calls-icebreakers/</a>
- Casey Family Programs. (2020b). What are the key elements for sustaining, expanding, and spreading parent partner programs? <a href="https://www.casey.org/parent-partner-program-themes/">https://www.casey.org/parent-partner-program-themes/</a>
- Casey Family Programs. (2021). How can motivational interviewing be used in child protection? <a href="https://www.casey.org/motivational-interviewing/">https://www.casey.org/motivational-interviewing/</a>

- Cheng, T. C., & Lo, C. C. (2018). Do social work education, job description, and cultural competence foster child-welfare caseworkers' therapeutic alliances? *Child & Family Social Work*, 23, 435–442. https://doi.org/10.1111/cfs.12434
- Cheng, T. C. & Lo, C. C. (2020). Collaborative alliance of parent and child welfare caseworker. *Child Maltreatment*, 25, 152–161. <a href="https://doi.org/10.1177%2F1077559519865616">https://doi.org/10.1177%2F1077559519865616</a>
- Children's Bureau. (2019). Engaging, empowering, and utilizing family and youth voice in all aspects of child welfare to drive case planning and system improvement (ACYF-CB-IM-19-03). U.S. Department of Health and Human Services, Administration for Children and Families. <a href="https://www.acf.hhs.gov/media/9347">https://www.acf.hhs.gov/media/9347</a>
- Children's Bureau. (2021). Emerging transformed: Taking lessons from the COVID-19 pandemic to create more just, equitable, proactive, and integrated approaches to supporting families and ensuring child and family health and well-being (ACYF-CB-IM-21-03). U.S. Department of Health and Human Services, Administration for Children and Families. <a href="https://www.acf.hhs.gov/cb/policy-guidance/im-21-03">https://www.acf.hhs.gov/cb/policy-guidance/im-21-03</a>
- Hall, M. T., Sears, J., & Walton, M. T. (2020). Motivational interviewing in child welfare services: A systematic review. Child Maltreatment, 25, 263–276. https://doi.org/10.1177/1077559519893471
- Horwitz, M., & Marshall, T. (2015). Family engagement in child protection social work. Journal of Family Social Work, 18, 288–301. https://dx.doi.org/10.1080/10522158.2015.1079584
- Illinois Department of Children and Family Services, & Illinois Center for Adoption and Permanency. (2015). Illinois Recruitment and Kin Connection Project: Federal fiscal years 2010–2015: Final report: Grant #90-CO-5013. https://library.childwelfare.gov/cwig/ws/library/docs/gateway/Blob/112000.pdf?w=+NATIVE%28%27recno%3D112000%27%29&upp=0&rpp=10&r=1&m=1
- JBS International, Inc. (2020). Child and Family Services Reviews aggregate report: Round 3: Fiscal years 2015–2018. U.S. Department of Health and Human Services, Administration for Children and Families, Children's Bureau. <a href="https://www.acf.hhs.gov/media/13907">https://www.acf.hhs.gov/media/13907</a>
- Kim, J., Trahan, M., Bellamy, J., & Hall, J. A. (2019). Advancing the innovation of family meeting models: The role of teamwork and parent engagement in improving permanency. *Children and Youth Services Review*, 100, 147–155. <a href="https://doi.org/10.1016/j.childyouth.2019.02.039">https://doi.org/10.1016/j.childyouth.2019.02.039</a>
- Lambert, M. C., Johnson, L. E., & Wang, E. W. (2017). The impact of family group decision-making on preventing removals. *Children and Youth Services Review*, 78, 89–92. <a href="https://doi.org/10.1016/j.childyouth.2017.05.005">https://doi.org/10.1016/j.childyouth.2017.05.005</a>
- Lekas, H., Pahl, K., & Lewis, C. F. (2020). Rethinking cultural competence: Shifting to cultural humility. Health Services Insights, 13, 1–4. https://doi.org/10.1177%2F1178632920970580

- Mallon, G. P. (2020). From the editor: The impact of trauma-informed care and cultural humility in child welfare systems. Child Welfare, 98(4), v-vii.
- Mirick, R. G. (2014). The relationship between reactance and engagement in a child welfare sample. Child & Family Social Work, 19, 333–342. https://doi.org/10.1111/cfs.12022
- National Child Welfare Workforce Institute. (2019). Cultural humility practice principles. <a href="https://ncwwi.org/index.php/resourcemenu/resource-library/inclusivity-racial-equity/cultural-responsiveness/1415-cultural-humility-practice-principles/file">https://ncwwi.org/index.php/resourcemenu/resource-library/inclusivity-racial-equity/cultural-responsiveness/1415-cultural-humility-practice-principles/file</a>
- National Fatherhood Initiative. (n.d.) The proof is in: Father absence harms children. <a href="https://www.fatherhood.org/father-absence-statistic">https://www.fatherhood.org/father-absence-statistic</a>
- Northern California Training Academy. (2018). Safety Organized Practice quick guide: Introduction to SOP. https://oercommons.s3.amazonaws.com/media/editor/92375/Intro\_to\_SOP\_- SOP\_Quick\_Guide.pdf
- Olson, K. B. (2020). Family engagement and collaborative decision-making processes provide multiple benefits in child welfare cases. *Family Court Review*, 58, 937–954. <a href="https://doi.org/10.1111/fcre.12527">https://doi.org/10.1111/fcre.12527</a>
- Quality Parenting Initiative. (2021). What is QPI? https://www.qpi4kids.org/what-is-qpi/
- Stephens, T., Gopalan, G., Acri, M. C., Bowman, M., & McKay, M. M. (2018). Culturally relevant, trauma-informed engagement strategies for child welfare workers: Moving beyond compliance to engagement with families experiencing high levels of exposure to trauma and stress. In V. C. Strand & G. Sprang (Eds.), Trauma responsive child welfare systems (pp. 67–86). Springer International Publishing. <a href="https://doi.org/10.1007/978-3-319-64602-2">https://doi.org/10.1007/978-3-319-64602-2</a>
- Toros, K., DiNitto, D. M., & Tiko, A. (2018). Family engagement in the child welfare system: A scoping review. Children and Youth Services Review, 88, 598–607. <a href="https://doi.org/10.1016/j.childyouth.2018.03.011">https://doi.org/10.1016/j.childyouth.2018.03.011</a>

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#### Beyond a Trauma-Informed Approach and Towards Shame-Sensitive Practice

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#### **ARTICLE**

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# Beyond a trauma-informed approach and towards shame-sensitive practice

In this article, we outline and define for the first time the concept of shame-sensitivity and principles for shame-sensitive practice. We argue that shame-sensitive practice is essential for the trauma-informed approach. Experiences of trauma are widespread, and there exists a wealth of evidence directly correlating trauma to a range of poor social and health outcomes which incur substantial costs to individuals and to society. As such, trauma has been positioned as a significant public health issue which many argue necessitates a trauma-informed approach to health, care and social services along with public health. Shame is key emotional after effect of experiences of trauma, and an emerging literature argues that we may 'have failed to see the obvious' by neglecting to acknowledge the influence of shame on posttrauma states. We argue that the trauma-informed approach fails to adequately theorise and address shame, and that many of the aims of the trauma-informed are more effectively addressed through the concept and practice of shame-sensitivity. We begin by giving an overview of the trauma-informed paradigm, then consider shame as part of trauma, looking particularly at how shame manifests in post-trauma states in a chronic form. We explore how shame becomes a barrier to successful engagement with services, and finally conclude with a definition of the shame-sensitive concept and the principles for its practice.

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#### Introduction

"Shame has ruled my whole life" - Anonymous, trauma survivor

"Trauma leads to shame. Trauma determines the content of shame. Shame pushes the body into a traumatic response. The more I learn about the two, the more I am convinced of their deep connection to one another." – Lucia Osborne-Crowley (Osborne-Crowley, 2020)

xperiences of trauma are widespread, and there exists a wealth of evidence directly correlating trauma to a range of poor social and health outcomes which incur substantial costs to individuals and to society. As such, trauma has been positioned as a significant public health issue which, as Magruder et al. (2017) argue, necessitates a 'trauma-informed approach' (TIA) to public health policy agendas. Shame is key emotional aftereffect of trauma, and an emerging literature argues that we may "have failed to see the obvious" by neglecting to acknowledge the influence of shame on post-trauma disorders (Taylor, 2015). In this article, we argue that effectively addressing the posttraumatic state necessitates a clear understanding of shame, its phenomenology and its effects. We demonstrate that shame is a core aftereffect of traumatic experiences and argue that being sensitive to shame addresses many issues related to trauma, while also supporting good practice for all that come into contact with human services. We outline and define for the first time the concept of shame-sensitivity and the principles for shamesensitive practice. We begin by giving an overview of the trauma-informed paradigm, then consider shame as part of trauma, looking particularly at how shame manifests in the posttraumatic state in a chronic form. We explore how shame becomes a barrier to successful engagement with services, and finally conclude with a definition of the shame-sensitive concept and the principles for its practice. Offering strategies for shamesensitive practice, this article highlights the need for shame competence in health, care and social services.

#### The trauma-informed approach

While trauma has been studied for over one hundred years it was not until the 1980s and 1990s that the topic had sufficient interdisciplinary support to develop into a field of research and produce a theory of trauma. While there is no unified approach or understanding of trauma, most agree that it entails an event that involves "threats to life or bodily integrity, or a close personal encounter with violence and death" (Herman, 1992, p. 33), and that the experience of this event is overwhelming, resulting in long lasting effects which can encompass significant alterations to one's experience of self, others and the world (SAMHSA, 2014). Particularly significant are experiences of trauma in early life, or Adverse Childhood Experiences (ACEs), such as abuse, deprivation, violence, witnessing of violence, neglect and disrupted attachment, among others (Poole and Greaves, 2012). Also significant are experiences of trauma in later life, such as interpersonal violence, sexual assault, warfare, tyranny under oppressive regimes, natural disasters, domestic abuse, among many others (Pattison, 2000, p. 96). While trauma can lead to post-traumatic stress disorder (PTSD) or other trauma or stressorrelated disorders, which are classified as psychopathologies in the Diagnostic and Statistical Manual 5<sup>th</sup> Edition (DSM-V), not all post-trauma states or experiences warrant being classified as pathological or fall under the umbrella of a disorder. Nonetheless, research demonstrates that individuals who have experienced trauma can have adverse outcomes in all areas of life, and that these effects can endure across a lifetime.

The interest in trauma, and its links to health and social outcomes, increased following the publication of the Felitti et al. (1998) paper on ACEs. With a sample of close to ten thousand, it is one of the largest investigations of childhood abuse and neglect, concluding that there is a strong relationship between "the breadth of exposure to abuse or household dysfunction during childhood and multiple risk factors for several of the leading causes of death in adults" (Felitti et al., 1998, p. 245). This study has been influential in subsequent research into trauma and the development of policy for services that seek to address issues related to adversity and trauma. There is now a large body of research that demonstrates that individuals who have experienced trauma can have adverse outcomes in all areas of life, and that these effects can endure across a lifetime. These individuals are significantly more likely to suffer from a range of "social, psychiatric, psychological, behavioural and physical problems" (Knight, 2019, p. 80), such as chronic health issues, mental health problems and substance use problems, as well as being correlated with social outcomes such as homelessness, violence, marital problems and incarceration, among others (Banaj and Pellicano, 2020).

The term "trauma-informed" was introduced by Harris and Fallot in 2001 as a means to integrate an understanding of trauma and its aftereffects into mental health services, following the evidence that a significant number of individuals accessing mental health services were survivors of physical and sexual abuse (Harris and Fallot, 2001). Adopting a TIA attempts to embed an understanding of how experiences of trauma can become central to an individual's life course and life outcomes, having a profound negative effect on social outcomes, emotional wellbeing, mental and physical health, along with health-relevant behaviour (Poole and Greaves, 2012), impeding an individual's ability to seek out and engage with health and social services that are designed to help them (Barrett, 2019). TIAs involve a paradigm shift in how services and professionals respond to patients and clients, attempting to address root causes rather than surface symptoms, reframing the core diagnostic question from enquiring, "What is wrong with you?" to understanding, "What happened to you?" (Kimbery and Wheeler, 2019, p. 42; SAMHSA, 2014). This approach recognises that "any person seeking services or support might be a trauma survivor" and that "systems of care need to recognise, understand and counter the sequelae of trauma to facilitate recovery" (Goodman et al., 2016, p. 748).

Central to the TIA is an understanding that typical emotional, psychological and social aftereffects of trauma directly impede an individual's ability to seek out and engage with the human services that are designed to help them (Barrett, 2019). In addition, when trauma survivors do manage to engage with the services that may help them, the interactions they have with organisations, staff and care providers, who do not recognise and understand their trauma and its aftereffects, may inadvertently lead to a further disengagement and entrenchment of the problems (e.g., substance use, mental ill health) that these services are designed to diagnose and treat. The central contention of the TIA is that applying a 'trauma lens' can powerfully elucidate the root causes of ill health, health-related behaviours and social difficulties, leading to more effective interventions, support, diagnoses and treatments. This has led to the redesigning and reconceptualization of some health, care and social services, using the TIA paradigm as a way to structure the way that care is delivered (Gerber, 2019; SAMHSA, 2014; Wilson et al., 2013).

In a Western context, TIA has gained influence in international policy making circles. For example, in the United States there are many programmes designed to integrate the TIA at federal, state and community levels (Melz et al., 2019). Within the United Kingdom, the Scottish and Welsh Government are seeking to

**Appendix: Handouts** 

develop and integrate the TIA into a range of public services. (Scottish Government, 2020; Welsh Government, 2021). This is equally the case in England, with Plymouth leading the way by seeking to become the United Kingdom's first 'trauma informed city' (Plymouth City Council, n.d.). The TIA is not only being advanced geographically but also practically, being applied to an ever-greater range of public services including children and youth, education, and health services, probation, and policing.

#### **Critiques and limitations**

The TIA is not without criticism. Conceptually, 'trauma' is a farranging concept that covers a wide range of experiences, and also a broad spectrum of outcomes. In considering how the concept of 'trauma' has been advanced in the TIA, Wastell and White (2017) argue that there are fundamental problems with how original research on trauma experiences has been interpreted for policy and practice. They argue that the original science underpinning our understanding of trauma expresses uncertainty and tentative conclusions, but that this inconclusiveness has been removed in the translation to practice in the TIA, resulting in definitive answers and concepts that are no longer consistent with the foundations of trauma research. Their concerns raise important conceptual and philosophical questions regarding how trauma is defined and understood, and how this is translated into practice.

Equally, there are conceptual implications as a result of the link between trauma and the original ACEs study. As the concept of trauma was boosted by the publication and promotion of the ACEs study, the case for the TIA is often justified by the research on ACEs. However, as Berliner and Kolko (2016) argue, not all harmful or stressful life experiences that the ACEs study examined were traumas; the two are not synonymous. Furthermore, there are those who have criticised the concept of adversity used in the original ACEs study to argue that not only do the components fail to identify adverse experiences (a parental separation is considered an adverse experience when this could be a protective one, for example) but that it is also a very narrow concept that misses many other forms of adversity, particularly wider individual, social and community forms of adversity such as chronic illness, or on-going social harms like poverty, deprivation or discrimination (White et al., 2019). There are on-going academic and practical debates relating to how to address the effects of trauma and ACEs. For example, Steptoe et al. (2019) argue there is a need for more information on approaches that address ACEs, while Asmussen et al. (2019) review a range of interventions that seek to address ACE-related trauma. To address such criticisms, some policy makers have included broader forms of adversity in the conceptualisation of the TIA, such as the Trauma Informed Plymouth Network who discuss 'Adverse Community Environments' (Trauma Informed Plymouth Network, n.d.). While such acknowledgements help the policy to address a wider range of experiences, it takes the conceptualisation of the TIA further away from the original idea of addressing 'trauma' per se.

Moreover, there are some criticisms regarding some TIA practices. Within the TIA, there is typically some form of screening used to identify trauma and refer for treatment, and that the screening tool is usually the ACE checklist or an adaptation of it (Schulman and Maul, 2019). Notwithstanding the issues of what the ACEs checklist actually measures (as discussed above), one of the authors of the original ACEs study has since argued that it has been misappropriated and misapplied to service delivery and professional practice, cautioning against its use in such a way (Anda et al., 2020). Furthermore, there is evidence that this medicalised model of screening, referring and treating does not sit well with more socially oriented services, with Kerns et al. (2016) finding practitioners feeling uneasy about the use of

screening tools to identify trauma. Joy and Beddoe (2019), meanwhile, criticise the ACE tool for not being sensitive to culture, race, poverty and wider issues of power, while Kelly-Irving and Delpierre (2019) argue the ACE tool is not appropriate for individual level assessment.

Linked to these conceptual and operational issues have been criticisms of how a trauma perspective has been implemented into policy and practice (UK Parliament, 2018). Despite existing guidance that has been given on the TIA (e.g., SAMHSA), Donisch et al.'s (2016) research into the opinions and experiences of professionals involved in working in a trauma-informed way found uncertainty about how to actually implement the TIA in practice. Their research found substantial variation in how the TIA was defined and understood among practitioners, and highly idiosyncratic implementations of practices across systems. As they note, there are "varying terms, [a] lack of common lexicon, and differences across systems in knowledge and skills" related to the TIA, and what is lacking is a unified conceptualisation and operationalisation of the approach (Donisch, 2016, p. 131).

The TIA was developed within a specific context to work with people who had most likely experienced trauma. The wider application of this approach to different contexts and more diverse populations, for whom trauma may not be the main issue, inevitably brings complexities and challenges. Conceptual questions are raised about whether 'trauma' is the most appropriate lens through which to organise practice and services. Furthermore, there are operational and implementational questions regarding how the TIA is successfully put into practice in a consistent manner that is supported by a robust evidence base. The point is not that the TIA is not a useful way to frame policy and practice, but that it may not be the most effective way to frame all policy and practice for all groups. The question is not just what do we gain by using the TIA, but also what is left out?

In what follows, we discuss how a consideration of shame, along with its impacts and effects, is missing in the TIA. We argue that this omission will be detrimental, leading to the potential ineffectiveness of trauma-informed interventions. As a necessary supplement to any TIA, we argue for the concept and practice of shame-sensitivity.

#### Shame

Shame has recently been included in the diagnostic criteria for PTSD in the DSM-V under the umbrella of "persistent negative emotional states" (Taylor, 2015). Hence, shame has recently come to be identified in the trauma literature as part of a constellation of negative emotions (along with fear, horror, anger, guilt) that are common for trauma survivors in post-trauma states. Understanding shame and its role in post-trauma states is, as shall be discussed below, central to the success of the TIA.

Shame is a defining and central feature of human experience and all human relationships, intimately linked to one's self-perception, social worth, identity, relationships and position within a social group, while also being connected to social control and power through the normative boundaries which determine what is shameful and what is not in a particular society or culture (Dolezal, 2015a, p. 107). Because of its significance and prominence in both personal experience and within social life, shame is considered by many to be the "master emotion" (Scheff, 2004). Shame is commonly characterised as a negative self-conscious emotion; it is an experience that arises when we are concerned about how we are seen and judged by others. We feel shame when we are seen by another or others (whether they are present, imagined or simply a viewpoint that has been internalised) to be flawed in some crucial way, or when some part of our core self is perceived to be inadequate, inappropriate, or immoral.

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The term 'shame' should be considered an umbrella term that refers to a whole range of experiences, including cognate emotions such as embarrassment, chagrin, mortification and humiliation. As James Gilligan usefully notes, in the same way "that we use the term 'flower' as a generic term to refer to a wide variety of different but related plants" then the term 'shame' encompasses a wide range of experiences including: "feelings of being slighted, insulted, disrespected, dishonoured, disgraced ... demeaned ... treated with contempt, ridiculed ... mocked, rejected ... feelings of inferiority, inadequacy ... of being a failure, 'losing face', and being treated as if [one is] insignificant, unimportant or worthless' (Gilligan, 2003, p. 1155). What is common to all of these experiences is a sense of being judged negatively by others, and a feeling of being worth less than others.

During a shame experience, we can feel deeply and often irreparably flawed, unworthy and unlovable, and that our social position and our social bonds are under threat. Shame can provoke powerful feelings of despair, inferiority, powerlessness, defectiveness and self-contempt, to name a few. In addition, shame itself is shameful and taboo. As such, shame is an "iterated emotion," (Dolezal and Lyons, 2017, p. 258); its experience can lead to an intensification or multiplication of itself, leading to a "feeling trap" (Herman, 2011, p. 266) where "one can become ashamed because one is ashamed" (Taylor, 2015). For these reasons shame is usually avoided, shunned or kept secret at all costs, both individually and collectively.

While shame is a negative experience for an individual, it is an inevitable and necessary part of human life. Healthy shame can lead to the expression of positive attributes such as modesty, humility and gratitude, along with respect for oneself and for others. It can also be a powerful motivating force for personal growth and change, and in forging harmonious and meaningful relationships with others (Ng, 2020; Sanderson, 2015). However, healthy shame is very easily distorted and can become 'unhealthy', "maladaptive" or "destructive" (Sanderson, 2015, p. 22). As John Bradshaw notes, "shame as a healthy human emotion can be transformed into shame as a state of being... [which] is to believe that one's being is flawed, that one is defective as a human being. [Shame] becomes toxic and dehumanising" (Bradshaw, 2005, p. xvii). Toxic shame, Sanderson notes, "paradoxically severs connections, destroys social bonds and can lead to antisocial behaviour" (Sanderson, 2015, p. 22). Toxic shame is corrosive and pernicious, and can lead to a pervasive and enduring sense of inferiority, inadequacy, defectiveness, along with a sense of not being worthy of respect, love or connection. It is an experience that can be organise one's self, life and world, having a deep significance and impact on an individual and their life chances.

A typical shame response involves being overwhelmed with an intense feeling of conspicuousness and a strong sense of being judged by others, along with painful and negative emotions centred around one's feelings of inadequacy, all triggered by a mishap, mistake or transgression which has been 'witnessed' by others (whether they are present, imagined or internalised). This sort of shame response is commonly called "acute shame" (Dolezal, 2015a), insofar as it is a discrete emotional reaction in response to a trigger or event. In contrast, the toxic or pathological shame described above has a very different phenomenological profile, usually occurring in a chronic form. While chronic shame shares many of the painful features of acute shame, such as emotional pain, self-consciousness, a sense of visibility, it is not experienced as a discrete reaction of emotional torment and hyper-self-consciousness. Nor, as the term might imply, is it a state of perpetually feeling shame. Instead, chronic shame is frequently characterised, firstly, by the nagging and persistent possibility of shame, and secondly by a persistent sense of inadequacy, defilement, failure and lesser self-worth. Chronic shame can be characterised by what Leon Wurmser terms a "shame attitude" (Pattison, 2000, p. 85), where one's entire personality and character is structured around shame and shame avoidance.

Chronic shame is an elusive experience for several reasons. First, while 'chronic shame' is a term that appears in psychological, psychiatric and psychotherapeutic literatures, there is no clear definition of what constitutes chronic shame and it has been described through a variety of terms including "dispositional shame," (Leeming and Boyle, 2004) "shame-proneness" (Harris-Perry, 2011), "toxic shame," (Bradshaw, 2005) and being "shame-based" (Lloyd and Sieff, 2015), among others. There is no clear epidemiological data regarding the prevalence of chronic shame, nor is there any clear diagnostic criteria through which individuals can be 'diagnosed' as suffering from chronic shame, or understand their 'symptoms' to be mild, moderate, serious or severe (Pattison, 2000, p. 96).

Second, chronic shame is commonly characterised by the nagging and persistent possibility of shame, where, for the most part, shame itself is not necessarily realised in experience. Instead, what comes to dominate experience is a pernicious form of anticipated shame, or a persistent and heightened "shame anxiety," of which an individual may, or may not, be aware (Dolezal, 2021; Pattison, 2000). Shame anxiety appears in experience as a corrosive, undermining and persistent fear or anxiety about being objectified, judged, labelled and rejected by others; it is a persistent "fear of disgrace and being looked at by others with contempt" (Wilson et al., 2006, p. 125). This shame anxiety ultimately becomes connected to negative self-beliefs and selfconceptions; one comes to believe that the "core-self is defective, inadequate and unacceptable to others" (Sanderson, 2015, p. 24). It is important to note that shame anxiety may not be experienced as shame. Instead, it may be dominated by shame avoidance and, as such, characterised by emotions such as fear, anxiety, selfconsciousness, stress or powerful impulses to hide, avoid or escape, along with negative feelings about the self, characterised by a sense of inadequacy, defilement or deficiency in relation to others.

While chronic shame has many causes (e.g., societal expectations, stigma and discrimination, psychopathology), it is clear that a significant cause of persistent chronic shame is trauma, where childhood relational trauma and traumatic experiences in later life are strongly correlated with experiences of chronic shame and shame anxiety (DeYoung, 2015; Kalsched and Sieff, 2015; Pattison, 2000). There is also evidence that chronic shame plays a role in PTSD symptom severity (Cunningham, 2020; La Bash and Papa, 2014; Lee et al., 2001). In fact, common defensive scripts or shame-avoidant behaviours seen among those who live with maladaptive chronic shame "bear a strong resemblance," as Taylor notes, "to the prominent symptoms and behaviours" associated with PTSD (Taylor, 2015). And many experiences related to shame, such as chronic rumination, flashbacks, emotional avoidance, intrusions, hyper-arousal, dissociation and fragmented states of mind are similar to experiences associated with trauma and post-trauma states (Budden, 2009, pp. 1035–1036; Theisen-Womersley, 2021, pp. 210–211).

#### Shame and trauma

There is a growing literature that explores the centrality of shame for individuals who have experienced trauma (Budden, 2009; Cunningham, 2020; DeYoung, 2015; Goldblatt, 2013; Herman, 2011; Lee et al., 2001; Øktedalen et al., 2014; Plante et al., 2022; Saraiya and Lopez-Castro, 2016; Sieff, 2015; Taylor, 2015; Theisen-Womersley, 2021; Wilson et al., 2006). Trauma research has seen the recent development of the idea that "shame and trauma

are inextricably linked" (Theisen-Womersley, 2021, p. 211), where some argue that "post-traumatic shame" is a key experience that shapes post-trauma states (Theisen-Womersley, 2021), while others have come to theorise and describe PTSD as a "shame disorder" (Herman, 2011; Salter and Hall, 2020), with evidence demonstrating that chronic shame plays a role in PTSD symptom severity (Cunningham, 2020; Lee et al., 2001). Overall, this body of research argues that shame is a world-organising affect for many trauma survivors and that shame is behind much of the maladaptive behaviour associated with trauma, PTSD and other post-trauma states.

The cause of shame in post-trauma states is complex, but there seem to be a multitude of overlapping factors which render shame a predominant, if not the dominant, emotional experience following trauma. Research demonstrates that shame can brought on by: the traumatic experience itself (Budden, 2009; Lloyd and Sieff, 2015); incorrect or inaccurate feelings of blame or responsibility for what happened in the traumatic event (e.g., "it was my fault...", "this wouldn't have happened if I had just...") (Bhuptani and Messman, 2021; Kalsched and Sieff, 2015; Wilson et al., 2006); feelings of defilement and unlovability as a result of neglect or abuse, particularly in childhood (Pattison, 2000); rumination about one's behaviours, actions and reactions at the time of the trauma (Lee et al., 2001); the sense of being damaged or defiled as a result of having experienced trauma or having a trauma diagnosis, such as PTSD (Herman, 2011); the symptoms of PTSD or a post-trauma state (Lee et al., 2001); the labels attached to one's identity as a result of trauma and post-trauma outcomes (e.g., "victim", "survivor", "addict", "homeless") (DeYoung, 2015; Theisen-Womersley, 2021); the coping mechanisms one engages in to cope with trauma (Herman, 2011; Taylor, 2015); fear of judgement by others if they discover one's trauma (Øktedalen et al., 2014); the social taboos associated with the trauma that one has experienced (e.g., childhood sexual abuse by a family member) (Banaj and Pellicano, 2020); revealing trauma in clinical and psychotherapeutic encounters (DeYoung, 2015; Goldblatt, 2013; Lanksy, 2000); falling short of one's own ideals and standards (Goldblatt, 2013; Kalsched and Sieff, 2015); and because of the taboo and shameful nature of shame itself (Herman, 2011; Taylor, 2015; Wilson et al., 2006). Hence, in addressing the impact of emotions for trauma survivors, for the treatment of PTSD, and within the TIA, Taylor's question "have we failed to see the obvious?" with respect to "the influence of shame on posttrauma disorders" seems particularly pertinent (Taylor, 2015).

Understanding shame, and in particular chronic shame, as a keystone sequela of trauma experiences has the potential to elucidate the root cause of a range of maladaptive behaviours associated with trauma. The lack of trust and empathy within intersubjective encounters suggested by some to be characteristic of trauma survivors (Wilde, 2019) are accounted for affectively through understanding shame as central to post-trauma states. However, as noted above, chronic shame is difficult to identify and 'diagnose'; it is an elusive experience that is often 'disguised' or 'camouflaged' by other experiences and feelings. The relational psychotherapist Patricia DeYoung notes that what those who suffer from chronic shame, "may not daily or consciously expect to be annihilated by shame. However, the threat is always around somewhere, just out of awareness, kept at bay" (DeYoung, 2015, p. 19). DeYoung describes chronic shame as "silent," where some of her clients who suffer from chronic shame do not even know that they are anticipating shame (and related strategies to avoid shame) with debilitating frequency. What they live with is not shame, but "what it costs them to keep from falling into shame" (DeYoung, 2015, p. 19). Bradshaw concurs writing that for those living with toxic shame, "everything is organised around preventing exposure" (Bradshaw, 2005, p. 139). As a result, what characterises the experience of chronic shame in post-trauma states is not enduring or repetitive experiences of shame but rather an atmosphere of anticipated shame, or shame anxiety, that leads to compensatory behaviours or experiences.

In this way, in experiences of chronic shame, shame *itself* often becomes invisible and what dominates experience is other behaviour or feelings which are used to help circumvent or avoid shame, or to mask or cope with the pain of shame. As Pattison notes, individuals who experience chronic shame "live their lives trying to avoid occasions and relationships that might provoke painful shame experiences" (Pattison, 2000, p. 83). DeYoung concurs: "the pain [of shame] can be unbearable. To save ourselves, we push shame away as fast as we can, covering for it with more tolerable states of being" (DeYoung, 2015, p. xii). Helen Block Lewis discusses this experience as "bypassed shame" (Lewis, 1971), where the self is not conscious of feeling shame directly, and instead bypasses or 'displaces' shame for other emotions, states or experiences (Brown, 1998, p. 146).

As a result, living with chronic shame can lead to a range of compensatory behaviours; these are powerful "defensive scripts" (Kaufman, 1993, p. 113; Pattison, 2000, p. 111), "strategies" (Sanderson, 2015, p. 24) or patterns and habits of interaction, which make it possible for an individual to avoid the social threat, pain and emotional anguish that comes with shame and its chronic anticipation. Lanksy links these to the experience of living with trauma, stating the "posttraumatic state gives rise to shame and to defences that keep shame arousing awareness from consciousness" (Lanksy, 2000, p. 133). Wilson et al. concur, noting that, "the powerful emotions of posttraumatic shame ... are associated with a broad range of avoidance behaviours: isolation, detachment, withdrawal, hiding, nonappearance, self-imposed exile, cancellation of appointments, surrender of responsibilities, emotional constriction, psychic numbing, emotional flatness, and non-confrontation with others" (Wilson et al. 2006, p. 138). These avoidance behaviours help an individual protect themselves from shame through avoidance, or "by placing it outside of conscious awareness" (Sanderson, 2015, p. 24). In this way, shame can, as Wilson et al. note, "operate unconsciously in trauma complexes and initiate self-destructive and self-defeating modalities of behaviour" (Wilson et al., 2006, p. 129). Hence, instead of shame, what is seen externally are other reactions, responses and behaviours that "mask the shame" (Ng, 2020, p. 30).

The psychiatrist Donald Nathanson theorises "the compass of shame", where shame-avoidance behaviours follow four common patterns: withdrawal, avoidance, attack other and attack self (Nathanson, 1992, pp. 305-377). Common defensive behaviours include a variety of different reactions, all of which are damaging both to oneself and to one's social bonds, such as anger, aggression, hostility, violence, narcissism, depression, perfectionism, apathy, withdrawal, avoidance, excessive deference, among others (Nathanson, 1992; Pattison, 2000). These common defensive reactions to shame are, as Taylor notes, "consistent with many of the symptoms and comorbidities of PTSD" and posttrauma states, including anger, violence, addiction, isolation, feelings of hopelessness and helplessness which can progress to depression and even suicide ideation (Taylor, 2015). What becomes problematic in understanding and treating trauma and the post-trauma states is that these avoidance behaviours for shame are "easily misread" (Theisen-Womersley, 2021, p. 212) and shame often becomes invisiblized and, consequently unacknowledged, in efforts to provide care, treatment and support.

In fact, it has been demonstrated that shame is a "potent treatment barrier" for trauma survivors (Saraiya and Lopez-Castro, 2016), leading to outright avoidance, and to dropping out and attrition once engaged with care and services. As Plante et al. note, shame "generates an urgent need to hide and conceal the

defective self from exposure" (Plante et al., 2022). Indeed, there is ample evidence that the 'necessity' to avoid shame or shameful exposure can interfere with individuals accessing healthcare (Dolezal, 2015b; Dolezal and Lyons, 2017; Lazare, 1987), and also prevent individuals from reporting traumatic incidents such as abuse, sexual assault and violence (Hlavka, 2017; Weiss, 2010). In addition, shame prevents the reporting of shame itself, as individuals "in clinical settings are sometimes reluctant to disclose feelings of shame out of fear from being exposed and rejected" (Øktedalen et al., 2014, p. 600). In these complex and overlapping ways, shame experiences lead to concealment and avoidance, consistent with the "hallmark symptoms" of PTSD and post-trauma states (Saraiya and Lopez-Castro, 2016).

Hence, in the context of seeking help through health, care or social services, individuals who are chronically anxious about shameful exposure may avoid seeking help in the first place, may regularly miss appointments, may avoid disclosing honest details about traumatic events, lifestyle or circumstances, may fail to follow through with treatments, and may conceal diagnoses and coping behaviours from friends, family and professionals (Dolezal and Lyons, 2017). In fact, not only is shame a barrier to accessing services, it is very easily exacerbated and incited in the context of seeking help from professionals; professional practice and public policy are frequently "vectors of shame, humiliation, and inequality" (Salter and Hall, 2020, p. 10). Moreover, shame is a relational emotion that is frequently present in clinical and care encounters (Dolezal, 2015b; Lazare, 1987). Interactions with care professionals can compound feelings of shame, as these interactions often involve unequal power relationships, a fear of being judged, the scrutiny and exposure of one's potentially 'shameful' past, circumstances, lifestyle, coping behaviours, body, illnesses, along with other vulnerabilities. Despite shame's ubiquity and its obvious impact in encounters with health and care professionals, there is evidence that addressing shame is routinely avoided in clinical and therapeutic encounters, as practitioners themselves are reluctant to acknowledge shame or address experiences which may lead to shame or embarrassment (Lewis, 1971).

It seems clear that being attuned to experiences of shame and chronic shame, along with the common 'scripts' and 'strategies' deployed to avoid shame and shameful exposure, becomes central to achieving trauma-informed practice, and in fact central to facilitating individuals to seek help and engage with health, care and social services. However, a consideration of shame, along with its impacts and effects, has not been part of the conceptualisation of the TIA, nor an explicit focus in its practice. Indeed, shame is rarely even mentioned in the academic and grey literature about the TIA.

To address this lacuna, we argue for shame-sensitivity to be central to the theory, policy and practice of any TIA. However, the relevance of shame-sensitivity is by no means limited to the TIA. As everyone experiences shame or is vulnerable to shame, shame-sensitivity is of general benefit to all populations and provides a unified framework for good care when working with people more humanely. We do not argue that shame-sensitivity should replace a 'trauma lens'. Rather we argue that shame-sensitivity, and using a 'shame lens', is both necessary for, and has wider application than, the TIA.

#### Shame-sensitivity

Shame-sensitivity is a concept and practice for health and human services. There are three central components to the concept. The first is that shame is inevitable. We all have the capacity to experience shame (with a debate about a very small number of individuals (Kosson et al., 2015)), while many vulnerable people live with chronic shame. Interactions with services can, and often

do, evoke shame in the people who engage with those services. Second, because shame is a highly unpleasant experience, humans have evolved and developed strategies to avoid shame, and these strategies influence an individual's thoughts, behaviours and social interactions, usually for the worse. Third, it is incumbent upon services that work with people to acknowledge and respond appropriately to people's shame in order to mitigate its potential negative effects and impacts. In other words, services need to be shame-sensitive.

While there are a variety of ways to implement shame-sensitivity in practice, and these should be tailored to the specificity of the service provision in question, we outline three key principles for shame-sensitive practice, which we refer to as the 3As: acknowledging shame, avoiding shaming, and addressing shame.

#### Acknowledging shame.

Individual understanding of shame: Practitioners working in human services must have 'shame competence'. They must have a theoretical and practical understanding of what shame is, how it operates, how it is evoked, how it can be hidden, and understand the behaviours that are used to cope with shame. Not only must individual practitioners be sensitive to the experience of shame in others, but they must also be sensitive to shame within themselves, understanding how shame experiences can affect their own thinking, actions, behaviour and attitudes towards others. Practitioners must also have an understanding of how shame circulates between individuals and within organisations, and also be able to understand when shaming is present in policy and practice.

Organisational understanding of shame: Individual shame competence cannot take place without a system of support that accepts the existence, importance, and significance of shame; both for the practitioners themselves and for patients/ clients/service users. This involves the fostering of emotional communication within professional practice, where speaking about and understanding emotions, and their effects, within professional practice becomes commonplace (Gibson, 2014). In particular, the taboo regarding shame, and shameful or stigmatised states and experiences, must be directly addressed. An organisational perspective not only recognises the possibility for the evocation of shame by individuals but also the possibility that organisational policies and procedures can evoke shame in staff and patients/clients/service users.

Appreciating the differential experience of shame: A significant part of individual acknowledgement of shame is understanding how people come to experience shame, knowing that the boundaries for what is considered shameful can vary for individuals and for different groups. There are variable pressures, standards, contexts, histories and expectations placed on individuals and groups, which can result in shifting signification of what is considered 'shaming' or 'shameful'. By ensuring there is meaningful engagement and collaboration with different communities and groups to understand their particular sensitivities to shame, along with common behavioural responses to avoid the experience of shame, organisations can support individual and collective knowledge and understanding.

Recognising shame and shaming: Acknowledging shame moves beyond knowledge of shame theory to also include being able to recognise shame and shaming in experience and practice. Not only is shame frequently hidden and notoriously difficult to admit to, but it is also taboo and shameful. People go to great lengths to hide shame and what they consider to be shameful. Practitioners and organisations must become adept at using a 'shame lens' to identify shame through both

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**Appendix: Handouts** 

physiological, psychological and social indicators. Practitioners must become aware of common verbal, paralinguistic, and nonverbal cues that may indicate a shame state (Gibson, 2015; Herman, 2011; Retzinger, 1995). These include postural and embodied cues (e.g., covering the face, blushing, downcast eyes, etc.), common terms used instead of shame (e.g., 'selfconscious', 'embarrassed', 'foolish', 'worthless', 'inept', 'inferior', etc.), paralinguistic cues (e.g., stammering, silence, long pauses, etc.). Practitioners must also become adept at recognising bypassed shame, through knowledge and recognition of common avoidance behaviours for shame (cf. 'the compass of shame'). Practitioners must also become alert to shame dynamics within interpersonal encounters, recognising that shame is a "two-way street" and "contagious" (Theisen-Womersley, 2021, p. 212). This means it can transfer from client, patient or service user to the practitioner, infecting an entire interaction. Practitioners must also have an understanding of how shame circulates within professional organisations and institutions and be able to identify, and also address, implicit and explicit shaming in policy and practice.

#### Avoiding shaming.

- · Avoiding individual shaming: Any individual can explicitly seek to shame another person, whether this is a manager to manager, manager to employee, employee to manager, employee to employee, employee to patient/client/service user. With knowledge and understanding of shame and shame dynamics, individuals within a shame-sensitive organisation, practising shame-sensitivity, would actively seek to avoid shaming others. However, they should also be sensitive to the potential for implicit shaming, recognising that any relationship where there are power differences can be inherently shame-inducing (Dolezal, 2015b; Lazare, 1987; Ng, 2020). Individuals engaging with services are expected to expose their vulnerabilities (including their physical bodies, their lifestyle, their illnesses, mental health status, and potentially share intimate details about their past, their families, their feelings etc.), which are then the subject of scrutiny and professional assessment. Practitioners must remain alert to, and continuously assess, how the language they use, their demeanour, questioning style, emotional expression and other interpersonal dynamics may inadvertently produce a shame response (Ford et al., 2021). Furthermore, consideration must be given to interpersonal dynamics, based on gender, race, ethnicity, language-spoken, disability, age, religious identification, along with other factors in particular situations (e.g., a female police officer may be the most 'shame appropriate' practitioner to interact with a female victim of sexual assault). Practitioners should also avoid stereotyping, labelling and other stigmatising ways of engaging with individuals. It is imperative to remain responsive to individuals and their unique circumstances and to genuinely acknowledge distress.
- Avoiding collective shaming: Many initiatives rely on shame
  as the affective driver of the change they hope to promote
  (e.g., shame is frequently used in public health campaigns,
  for example, to combat obesity or improve hygiene (Brewis
  and Wutich, 2019)). Such shaming attempts are examples
  of how whole groups of people can be targets for shame.
  While there are some initiatives that have an explicit aim to
  shame groups of people, there are many other initiatives,
  policies and procedures that have the effect of shaming

- groups of people, even when this is not intended. Avoiding collective shaming involves being alert to how shaming may become implicit within policy and practice, for instance through the use of stigmatising language, or through creating dynamics of blame and individual responsibility for circumstances or conditions that may be resulting from structural conditions (e.g., poverty, obesity) or that may stem from a post-trauma coping behaviour (e.g., addiction, mental ill health).
- Evaluating impact of practice for shaming: Not all proactive attempts to avoid shaming will be successful. To ensure that there is a reflexive feedback system to inform the proactive shaming avoidance attempts, organisations and practitioners must conduct and engage in a process of ongoing evaluation of the impact of their practice, policies, and procedures on the people they come into contact with; both within (employees) and without (patients/clients/ service users) of the organisation (Dolezal et al., 2021). This involves vulnerability, and requires critical reflection on past and future practice. There must be willingness to admit mistakes, openness to critical reflection and flexibility to make responsive changes in policy and practice. Furthermore, organisations must create and systematise nuanced and collaborative understandings of how shaming is produced, and how shame is experienced, as a result of their policies and practices, avoiding attributing blame and shame to individuals where there is a disconnect between policy and operational capacity, especially in cases of chronic underfunding. Collective accountability for shame-sensitive or shame-reducing practice begins with mutually-agreed goals and frames of reference; such as an institutional code of conduct, or a shame-proofing toolkit (Dolezal et al., 2021). Cultures and practices of shaming and blaming must be avoided within organisations (Creed et al., 2014). Cultures of dignity, openness, learning and emotional intelligence should be

#### Addressing shame.

Addressing individual shame: Being able to address individual experiences of shame requires an understanding of how and why a person experiences their shame and finding ways to work through or around it. This, firstly, means understanding the person in their context and personal history, which will highlight the reasons for the shame experience. Secondly, it necessitates creating a sense of emotional safety (Gibson, 2019), where individuals feel able to talk about their experiences without fear of judgement, criticism, or ridicule, and also with a belief they will be understood and accepted for sharing their feelings. Thirdly, issues related to the experience of shame must be directly discussed in an empathetic and sensitive manner. Language and terminology must be carefully chosen, as the term 'shame' can itself be shame-inducing. Alternative phrasing might be more appropriate (e.g., 'feeling judged', 'feeling self-conscious', 'embarrassment', etc.). Unacknowledged and unspoken shame can give the "toxic beliefs that are inherent in shame" some legitimacy (Gibson, 2015, p. 339) and bringing these beliefs out in the open provides the opportunity to unburden the person from shame and reduce the influence it has on interactions. Furthermore, such sensitive discussion of shame requires attentiveness to the person's needs for support and connection after sensitive disclosures of shame or shame-inducing states, events or circumstances.

Supporting shame resilience: While attempts to address shame can occur in any interaction, the effects of shame and disclosing shame can have longer term consequences (Dearing and Tangney, 2011). The experience of shame can leave individuals to "feel isolated ... and shy away from reaching out to people who may be able to offer help for fear of rejection and further shame" (Gibson, 2015, pp. 339-340). Shamesensitive practice, organisations, and systems, therefore, need to embed shame resilience into the ways they address shame. At the heart of shame resilience is the development and deepening of social bonds (Brown, 2006). It is imperative that practitioners engage in practice that creates and promotes sustainable relationships with and within any organisation (Gibson, 2015). Organisations and services need to ensure continuity with individual practitioners so meaningful relationships grounded in familiarity, trust and empathy can be developed. Practitioners and services need to be proactive in reaching out to individuals, especially when they disengage. Individuals should not be made to feel cut off, disconnected or discarded from services. Structural factors such as the availability of appointment times, accessibility of clinical spaces, ease through which one can contact the service, length of waiting lists, duration of service, continuity between services, must be continually assessed to ensure that individuals feel supported and a sense of connection is maintained. Furthermore, friend and family networks must be supported so that individuals have sustainable networks of support. In addition, practitioners must be supported by their organisations and institutions to have the time, support and resources to engage in genuinely relational practice, fostering connection, empathy and trust with the individuals they are working with and supporting.

Actively fostering the conditions for shame-sensitive practice: Organisations must actively work to create the conditions, policy and practices that promote shame-sensitivity, where relationships based on dignity, respect, empathy and trust are the first priority within workplaces and when delivering services. Practitioners must be supported within organisations to have the personal, professional and operational capacity to work in a shame-sensitive manner.

Combating the systemic causes of shame: The systemic forces which shape and define what is considered shameful or stigmatised are not immutable. In addition, many causes of trauma (e.g., social deprivation, domestic abuse) have their roots in societal and structural conditions which can be changed and improved. Practitioners, along with leaders and managers within organisations, must be given the resources and encouraged to be engaged in making meaningful changes. This will happen through creating cultures of engaged practice and political activity, where individuals are encouraged to write to local councillors or Members of Parliament, carry out research, engage with academic partners, become involved in local and national political campaigns, engage with media outlets, etc., with the overall aim of advocating and agitating for more humane and shame-sensitive changes in law, policy and practice (Gibson, 2019, p. 199).

#### Conclusions

Having the capacity, on the levels of policy, organisations and individual practitioners, to address shame directly is imperative considering the how impactful shame can be for those who have experienced trauma and post-trauma states. Being attentive to shame, and acknowledging its significance for individuals, in health and social care contexts, can improve both engagement

and outcomes. Using a 'shame lens' alongside a 'trauma lens' is necessary for TIAs to achieve the goal of redesigning services to be more sensitive and supportive, with the ultimate aim of avoiding retraumatisation and any additional harm. As a result, TIAs must begin to integrate shame-sensitive practice. There are obvious overlaps and synergies with the main principles which guide TIAs, however focusing through a 'shame lens' will reveal significant affective dynamics that are otherwise occluded, overlooked or ignored.

Shame-sensitivity and using the 'shame lens' within organisations will enable more humane services which address and acknowledge a significant affective dimension of seeking help, namely shame and self-consciousness. Following the evidence that shame is a significant force within encounters with professionals within health, care and social services, introducing a 'shame lens' to the way these services are conceptualised and conducted, has the potential to transform interactions between professionals and patients/clients/service users, as well as among colleagues within services and organisations. The emotional intelligence that shame-competence affords will give practitioners greater awareness of social dynamics which will help manage interactions and relationships within encounters with more empathy, humanity and sensitivity. Having more awareness of emotions and emotional dynamics within workplaces has been linked to a range of positive outcomes, such as ability to handle stress, improved job performance, job satisfaction and leadership skills (Magny and Todak, 2021, p. 958). Understanding shame, in particular, can uncover and unlock a range of usually occluded dynamics between individuals and within institutions that have negative or damaging effects (Creed et al., 2014).

While shame-sensitive practice is essential for the TIA, it should be acknowledged that shame is a universal experience, and that shame-sensitive practice should be integrated into all service delivery, and not just seen as an accompaniment to trauma-informed care. All individuals experience shame, and this can be easily exacerbated in contexts where there are unequal power relations, such as in encounters with doctors, social workers, police and other health and care professionals. In addition, shame-sensitive practice is not intended to be a solution for the social ills that lead individuals to need to engage with services. The integration of this approach must be within broader societal efforts to reduce conditions that produce chronic shame, stigma and trauma, such as poverty, destitution, deprivation, long-term unemployment, violence, sexual assault, domestic abuse, displacement, etc. These principles for practice will be most effective in environments that have long-term viability and also are also well-resourced, where there is also widespread public confidence in services and organisations.

Offering an outline of the concept and the practice of shamesensitivity, this article has highlighted what is needed for human services to effectively face shame and shaming and mitigate their negative impacts and effects. We argue that principles of shamesensitivity, and the practice that goes along with it, are the starting point for any interactions, organisational changes, and policy developments. The corollary of this is that these principles and practices should precede a TIA, that they will address many of the issues that people face following trauma, but where additional care and support is needed these principles should be integrated into the TIA.

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#### References

- Anda RF, Porter LE, Brown DW (2020) Inside the adverse childhood experience score: strengths, limitations, and misapplications. Am J Prev Med 59(2):293-295. https://doi.org/10.1016/j.amepre.2020.01.009
- Asmussen K, McBride T, Waddell S (2019) The potential of early intervention for preventing and reducing ACE-related trauma. Soc Policy Soc 18(3):425-434. https://doi.org/10.1017/S1474746419000071
- Banaj N, Pellicano C (2020) Childhood trauma and stigma. In: Spalletta G, Janiri D, Piras F, Sani G (eds) Childhood trauma in mental disorders. Springer, Cham, Switzerland, pp. 413-430
- Barrett JE (2019) Trauma-informed nursing care. In: Gerber MR (ed) Traumainformed healthcare approaches. Springer, Cham, Switzerland, pp. 181-193
- Berliner L, Kolko DJ (2016) Trauma informed care: a commentary and critique. Child Maltreat 21(2):168-172. https://doi.org/10.1177/1077559516643785
- Bhuptani PH, Messman TL (2021) Self-compassion and shame among rape survivors. J Interpers Violence https://doi.org/10.1177/08862605211021994
- Bradshaw J (2005) Healing the shame that binds you. Health Communications, Inc., Deerfield Beach, FL
- Brewis A, Wutich A (2019) Lazy, crazy and disgusting: stigma and the undoing of global health. Johns Hopkins University Press, Baltimore
- Brown B (2006) Shame resiliene theory: a grounded theory study on women and shame. Fam Soc 87(1):43–52. https://doi.org/10.1606/1044-3894.3483
  Brown NW (1998) The destructive Narcissistic pattern. Praeger, Westport, CN and
- Budden A (2009) The role of shame in posttraumatic stress disorder: a proposal for a socio-emotional model for DSM-V. Soc Sci Med 69:1032–1039. https://doi. org/10.1016/j.socscimed.2009.07.032
- Creed WED, Hudson BA, Okhuysen GA, Smith-Crowe K (2014) Swimming in a sea of shame: incorporating emotion into explanations of institutional reproduction and change. Acad Manag Rev 39(3):275–301. https://doi.org/10. 5465/amr.2012.0074
- Cunningham KC (2020) Shame and guilt in PTSD. In: Tull MT, Kimbrel NA (eds) Emotion in posttraumatic stress disorder: etiology, assessment, neurobiology, and treatment. Academic Press, pp. 145-171
- Dearing RL, Tangney JP (2011) Shame in the therapy hour. American Psychological Association
- DeYoung PA (2015) Understanding and treating chronic shame: a relational/ neurobiological approach. Routledge, London
- Dolezal L (2015a) The body and shame: phenomenology, feminism and the socially shaped body. Lexington Books, Lanham, MD
- Dolezal L (2015b) The phenomenology of shame in the clinical encounter. Med Healthc Philos 18(4):567-576. https://doi.org/10.1007/s11019-015-9654-5
- Dolezal L (2021) Shame, stigma and HIV: considering affective climates and the phenomenology of shame anxiety. Lambda Nordica 2-3:47-75. https://doi. org/10.34041/ln.v27.741
- Dolezal L, Lyons B (2017) Health-related shame: an affective determinant of health. Med Humanit 43(4):257-263. https://doi.org/10.1136/medhum-2017-011186
- Dolezal L, Rose A, Cooper F (2021) Shame-sensitive practice and COVID-19: evidence and recommendations for scenes of shame and stigma in COVID-19. Policy at Exeter, University of Exeter. https://www.exeter.ac.uk/media/ universityofexeter/research/policy/briefs/Shame-Sensitive\_Practice\_and\_ Covid-19.pdf, Accessed 1 Dec 2021
- Donisch K, Bray C, Gewirtz A (2016) Child welfare, juvenile justice, mental health, and education providers' conceptualizations of trauma-informed practice. Child Maltreat 21(2):125-134. https://doi.org/10.1177/1077559516633304
- Felitti VJ, Anda RF, Nordenberg D, Williamson DF, Spitz AM, Edwards V, Marks JS (1998) Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults: the Adverse Childhood Experiences (ACE) Study. Am J Prev Med 14(4):245-258. https://doi.org/10. 1016/s0749-3797(98)00017-8
- Ford J, Thomas F, Byng R, McCabe R (2021) Asking about self-harm and suicide in primary care: moral and practical dimensions. Patient Educ Couns
- 104:826-835. https://doi.org/10.1016/j.pec.2020.09.037 Gerber MR (ed) (2019) Trauma-informed healthcare approaches. Springer, Cham-
- Gibson M (2014) Social worker shame in child and family social work: inadequacy, failure, and the struggle to practise humanely. J Soc Work Pract 28(4):417-431. https://doi.org/10.1080/02650533.2014.913237
- Gibson M (2015) Shame and guilt in child protection social work. Child Fam Soc Work 20:333-343. https://doi.org/10.1111/cfs.12081
- Gibson M (2019) Pride and shame in child and family social work. Policy Press, Bristol, UK
- Gilligan J (2003) Shame, guilt and violence. Soc Res 70(4):1149-1180. https://www. jstor.org/stable/40971965
- Goldblatt MJ (2013) Shame in psychodynamic psychotherapy of post-traumatic states. Scand Psychoanal Rev 36(2):104-111. https://doi.org/10.1080/ 01062301.2013.852877

- Goodman LA, Sullivan CM, Serrata J, Perilla J, Wilson JM, Fauci JE, DiGiovanni CD (2016) Development and validation of the Trauma-Informed Practice Scales. J Community Psychol 44(6):747-764. https://doi.org/10.1002/jcop.
- Harris M, Fallot RD (2001) Using trauma theory to design service systems: new directions for mental health services. Jossey-Bass, San Francisco, CA
- Harris-Perry M (2011) Sister Citizen: Shame, Stereotypes and Black Women in America. Yale University Press, New Haven and London
- Herman JL (1992) Trauma and recovery. Basic Books/Hachette Book Group
- Herman JL (2011) Posttraumatic stress disorder as a shame disorder. In: Dearing RL, Tangney JP (eds) Shame in the therapy hour. American Psychological Association, pp. 261-275
- Hlavka HR (2017) Speaking of stigma and the silence of shame: young men and sexual victimization. Men Masculinities 20(4):482-505. https://doi.org/10. 1177/1097184X16652656
- E, Beddoe L (2019) ACEs, cultural considerations and 'common sense' in Aotearoa New Zealand. Soc Policy Society 18(3):491-497. https://doi.org/10. 1017/S1474746419000046
- Kalsched DE, Sieff DF (2015) Uncovering the secrets of the traumatised psyche: the life-saving inner protector who is also a persecutor. In: Sieff DF (ed) Understanding and healing emotional trauma: conversations with pioneering
- clinicians and researchers. Routledge, London and New York, pp. 11-24 Kaufman G (1993) The Psychology of Shame: Theory and Treatment of Shame Based Syndromes. Routledge, London
- Kelly-Irving M, Delpierre C (2019) A critique of the adverse childhood experiences framework in epidemiology and public health: uses and misuses. Social Policy and Society 18(3):445-456. https://doi.org/10.1017/S1474746419000101
- Kerns SE, Pullmann MD, Negrete A, Uomoto JA, Berliner L, Shogren D, Putnam B (2016) Development and implementation of a child welfare workforce strategy to build a trauma-informed system of support for foster care. Child maltreatment 21(2):135-146. https://doi.org/10.1177/1077559516633307
- Kimbery L, Wheeler M (2019) Trauma and Trauma-Informed Care. In: Gerber MR (ed) Trauma-Informed Healthcare Approaches: A Guide for Primary Care. Springer, Cham, Switzerland, pp. 25-56
- Knight C (2019) Trauma Informed Practice and Care: Implications for Field Instrcution. Clinical Social Work Journal 47:79-89. https://doi.org/10.1007/ s10615-018-0661-x
- Kosson DS, Vitacco MJ, Swogger MT, Steuerwald BL (2015) Emotional experiences of the psychopath. In: Gacono CB (ed) The clinical and forensic assessment
- of psychopathy. Routledge, London, pp. 73–96
  Bash H, Papa A (2014) Shame and PTSD symptoms. Psychol Trauma 6(2):159–166. https://doi.org/10.1037/a0032637
- Lanksy MR (2000) Shame dynamics in the psychotherapy of the patient with PTSD: a viewpoint. J Am Acad Psychoanal 28(1):133-147. https://doi.org/10. 1521/jaap.1.2000.28.1.133
- Lazare A (1987) Shame and humiliation in the medical encounter. Arch Intern Med 147:1653-1658. https://doi.org/10.1001/archinte.1987.00370090129021
- Lee DA, Scragg P, Turner S (2001) The role of shame and guilt in traumatic events: a clinical model of shame-based and guilt-based PTSD. Br J Medial Psychol 74:451-466. https://doi.org/10.1348/000711201161109
- Leeming D, Boyle M (2004) Shame as a social phenomenon: a critical analysis of the concept of dispositional shame. Psychol Psychother 77:375-396. https:// doi.org/10.1348/1476083041839312
- Lewis HB (1971) Shame and guilt in neurosis. International Universities Press, Inc, New York
- Lloyd JB, Sieff DF (2015) Return from exile: beyond self-alienation, shame and addiction to reconnect with ourselves. In: Sieff DF (ed) Understanding and healing emotional trauma: conversations with pioneering clinicians and researchers. Routledge, London and New York, pp. 25-45
- Magny O, Todak N (2021) Emotional intelligence in policing: a state-of-the-art review. Policing 44(6):957-969. https://doi.org/10.1108/PIJPSM-01-2021-
- Magruder KM, McLaughlin KA, Borbon DLE (2017) Trauma is a public health issue. Eur J Psychotraumatol 8(1). https://doi.org/10.1080/20008198.2017.
- Melz H, Morrison C, Ingoldsby E, Cairone K, Mackrain M (2019) Review of trauma-informed initiatives at the systems level. US Department of Health and Human Services, Arlington, VA. https://aspe.hhs.gov/sites/default/files/private/pdf/262051/TI\_Approaches\_Research\_Review.pdf
- Nathanson D (1992) Shame and pride: affect, sex and the birth of the self. W. W. Norton & Company, New York
- Ng E (2020) Shame-informed counselling and psychotherapy: eastern and western perspectives. Routledge, London
- Øktedalen T, Hagtvet KA, Hoffart A, Langkaas TF, Smucker M (2014) The Trauma Related Shame Inventory: measuring trauma-related shame among patients with PTSD. J Psychopathol Behav Asess 36:600–615. https://doi.org/10.1007/ s10862-014-9422-5

#### **ARTICLE**

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Osborne-Crowley L (2020) How shame makes us sick. Wellcome Collection. https://wellcomecollection.org/articles/XoR36xIAAPzSyP9D. Accessed 23

Pattison S (2000) Shame: theory, therapy, theology. Cambridge University Press, Cambridge

Plante W, Tufford L, Shute T (2022) Interventions with survivors of interpersonal trauma: addressing the role of shame. Clin Soc Work J https://doi.org/10. 1007/s10615-021-00832-w

Plymoth City Council (n.d.) Trauma Informed Practice, n.d. https://www. plymouth.gov.uk/adultsandchildrenssocialcare/childrenssocialcare/academys ocialworkplymouth/informationandresourcespractitioners/traumainformedp ractice. Accessed 26 Nov 2021

Poole N, Greaves L (2012) Introduction. In: Poole N, Greaves L (eds) Becoming trauma informed. Centre for Addiction and Mental Health, Canada, pp.

Retzinger SM (1995) Identifying shame and anger in disourse. Am Behav Sci 38:1104-1113. https://doi.org/10.1177/0002764295038008006

Salter M, Hall H (2020) Reducing shame, promoting dignity: a model for the primary prevention of complex post-traumatic stress disorder. Trauma, Violence Abuse 23(3):906–919. https://doi.org/10.1177/1524838020979667

SAMHSA (2014) Substance abuse and mental health services administration's concept of trauma and guidance for a trauma-informed approach. SAMHSA, Rockville, MD

Sanderson C (2015) Counselling skills for working with shame. Jessica Kingsley Publishers, London and Philadelphia

Saraiya T, Lopez-Castro T (2016) Ashamed and afraid: a scoping review of the role of shame in post-traumatic stress disorder (PTSD). J Clin Med 5(94) https:// doi.org/10.3390/jcm5110094

Scheff TJ (2004) Elias, Freud and Goffman: shame as the master emotion. In: Quilley SLAS (ed) The sociology of Norbert Elias. Cambridge University Press, Cambridge, pp. 229-242

Schulman M, Maul A (2019) Screening for adverse childhood experiences and trauma TraumaInformedCare.chcs.org. Accessed 3 Dec 2021

Scottish Government (2020) Adverse childhood experiences (ACEs) and trauma. https://www.gov.scot/publications/adverse-childhood-experiences-aces/ pages/trauma-informed-workforce/. Accessed 26 Nov 2021

Sieff DF (2015) Understanding and healing emotional trauma: conversations with

pioneering clinicians and researchers. Routledge, London and New York Steptoe A, Marteau T, Fonagy P, Abel K (2019) ACEs: evidence, gaps, evaluation and future priorities. Soc Policy Society 18(3):415–424. https://doi.org/10. 1017/S1474746419000149

Taylor TF (2015) The influence of shame on posttrauma disorders: have we failed to see the obvious? Eur J Psychotraumatol 6:28847. https://doi.org/10.3402/ ejpt.v6.28847

Theisen-Womersley G (2021) Working with shame and trauma, trauma and resisliance among displaced populations: a socio-cultural exploration. Springer, Cham, Switzerland, pp. 209-232

Trauma Informed Plymouth Network (n.d.) Envisioning Plymouth as a Trauma Informed City (n.d.) https://www.plymouthoctopus.org/wp-content/uploads/ 2021/05/Trauma-Informed-Plymouth-Approach-.pdf. Accessed 1 Dec 2021

UK Parliament (2018) The evidence behind early intervention: Adverse Childhood Experiences. https://publications.parliament.uk/pa/cm201719/cmselect/cmsctech/ 506/50605.htm. Accessed 1 Dec 2021

Wastell D, White S (2017) Blinded by Science: The social implications of epigenetics and neuroscience. Policy Press, Bristol

Weiss KG (2010) Too ashamed to report: deconstructing the shame of sexual victimization. Feminist Criminol 5(3):286-310. https://doi.org/10.1177/ 1557085110376343

Welsh Government (2021) Review of Adverse Childhood Experiences (ACE)
Policy: Report. https://gov.wales/review-adverse-childhood-experiences-acepolicy-report-html. Accessed 26 Nov 2021

White S, Edwards R, Gillies V, Wastell D (2019) All the ACEs: a chaotic concept for family policy and decision-making. Soc Policy Society 18(3):457–466. https://doi.org/10.1017/S147474641900006X

Wilde L (2019) Trauma and intersubjectivity: the phenomenology of empathy in PTSD. Med Healthc Philos 22:141–145. https://doi.org/10.1007/s11019-018-9854-x

Wilson C, Pence DM, Conradi L (2013) Trauma-informed care. Encyclopedia of social work. Oxford University Press. Retrieved from https://oxfordre.com/ socialwork/view/10.1093/acrefore/9780199975839.001.0001/acrefore-978019

Wilson JP, Droždek B, Turkovic S (2006) Posttraumatic shame and guilt. Trauma Violence Abuse 7(2):122-141. https://doi.org/10.1177/1524838005285914

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The research in this article did not require ethical approval.

#### Informed consent

The article does not contain any studies with human participants performed by any of

#### Additional information

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### Solution-Focused Interviewing Skills and Questions

Open Ended Questions		
their own words and to elaborate on a topic.	Can you tell me about your relationship with your parents?	
	Tell me about your parenting experience.	
	Who are your supports and how do they help you?	
	Note: identify and reflect to clients any strengths or positive qualities clients may reveal in their responses to the open-ended questions.	
Summarizing		
thoughts, actions, and feelings.	So, what I hear you say is	
	If I understand you correctly, you are saying that	
	So, what you are saying is	
	Right?	
Tolerating/Using Silence		
Allow 10, 15, 20 seconds or so to allow clients to come up with their own responses. Avoid the temptation to fill in silence with advice.		
Complimenting		
success.	As you were talking, I noticed that you have many strengths. You have,	
	In the past, you have had successes evident by your ability to	
Affirming Client's Perception		
· · · · · · · · · · · · · · · · · · ·	That is very smart of you, let us explore this further	
self-awareness or awareness of their life. They include a person's thoughts, feelings, behaviors, and experiences. Affirmation of the client's perceptions is similar to reflective listening in form but does not isolate and focus on the feeling component per se, but on the client's larger awareness.	You have a high-level of self-awareness, how would you like to use this information to move forward	

#### Working with Client's Negative or Inaccurate Perceptions

Perceptions, even negative ones like suicide or assaultive behaviors should be explored to understand the full context.

Some perceptions may be obviously inaccurate and reflect a person's denial of a problem. Avoid an immediate educative or dissuading response to negative or inaccurate perceptions. Listening and understanding are the social worker's first obligations.

What's happening in your life that tells you that hitting or suicide might be helpful in this situation?

**Appendix: Handouts** 

How does it feel to say, "I don't want to do this anymore?"

How might your life be different if you did hit him?

What are the pros and cons of your reaction?

#### Returning the Focus to the Client

Clients tend to focus on the problem and/or what they would like others to do differently. In the Solution-Focused approach, the client is encouraged to return the focus to themselves and to possible solutions.

"My kids are lazy. They don't realize that I need help sometimes." Response: "What gives you hope that this problem can be solved?" "I wish my parents would get with it. A 10:00 pm curfew on weekends is ridiculous." Response: "When things are going better, what will your parents notice you doing differently?"

"My teachers are too hard. If they would back off all the homework and give more help my grades would improve." Response "What is it going to take to make things even a little bit better?"

"If my boss would stop criticizing me and treating me like a child, I could be more productive." Response "If your boss was here and I asked him what you could do differently to make it just a little easier for him not to be so critical, what do you think he would say?"

#### **Exception Questions**

Exception questions help clients think about times when their problems could have occurred but did not or at least were less severe. Exception questions focus on who, what, when, and where (the conditions that helped the exception to occur) NOT WHY; should be related to client goals.

Are there times when the problem does not happen or is less serious? When? How does this happen?

Have there been times in the last couple of weeks when the problem did not happen or was less severe?

How was it that you were able to make this exception happen?

What was different about that day?

If your friend (teacher, relative, spouse, partner, etc.) were here and I were to ask him what he noticed you doing differently on that day, what would he say? What else?

#### Coping Questions

Coping questions attempt to help the client shift his/her focus away from the problem elements and toward what the client is doing to survive the painful or stressful circumstances. They are related in a way to exploring for exceptions.

Coping questions attempt to help the client What have you found that is helpful in managing this shift his/her focus away from the problem situation?

Considering how depressed and overwhelmed you feel, how is it that you were able to get out of bed this morning and make it to our appointment (or make it to work)?

**Appendix: Handouts** 

You say that you're not sure that you want to continue working on your goals. What is it that has helped you to work on them up to now?

#### Scaling Questions

Scaling questions invite clients to put their observations, impressions, and predictions on a scale from 0 to 10, with 0 being no chance, and 10 being every chance. Questions need to be specific, citing specific times and circumstances.

Scaling questions invite clients to put their On a scale of 0 to 10, with 0 being not serious at all and observations, impressions, and predictions 10 being the most serious, how serious do you think the on a scale from 0 to 10, with 0 being no problem is now?

On a scale of 0 to 10, what number would it take for you to consider the problem to be sufficiently solved?

On a scale of 0 to 10, with 0 being no confidence and 10 being very confident, how confident are you that this problem can be solved?

On a scale of 0 to 10, with 0 being no chance and 10 being every chance, how likely is it that you will be able to say "No" to your boyfriend when he offers you drugs?

What would it take for you to increase, by just one point, your likelihood of saying "No"?

What's the most important thing you have to do to keep things at a 7 or 8?

#### Indirect Relationship Questions

Indirect questions invite the client to consider how others might feel or respond to some aspect of the client's life, behavior, or future changes. Indirect questions can be useful in asking the client to reflect on narrow or faulty perceptions without the worker directly challenging those perceptions or behaviors.

How is it that someone might think that you are neglecting or mistreating your children?

**Appendix: Handouts** 

Has anyone ever told you that they think you have a drinking problem?

If your children were here (and could talk, if the children are infants or toddlers) what might they say about how they feel when you and your wife have one of those serious arguments?

At the upcoming court hearing, what changes do you think the judge will expect from you to consider returning your children?

How do you think your children (spouse, relative, caseworker, employer) will react when you make the changes we talked about?

#### Miracle Questions

The Miracle Question is a special type of preferred future question that can help people get clarity on how the problem impacts their daily life and what life would look like without the problem happening.

Imagine you woke up tomorrow and a miracle had happened overnight, and all the trouble was gone. How would you know it was over? What would be different that would tell you the problem was no longer happening? What is the first thing you would be doing to start the day? What would the rest of your day look like? What would things look like for your children?

If you could wave a magic wand and things, be different, what would that new state of being look like? What would it take to get there without the magic wand?

#### Affirming Client's Perception

Perception is some aspect of a person's self-awareness or awareness of their life. They include a person's thoughts, feelings, behaviors, and experiences. Affirmation of the client's perceptions is similar to reflective listening in form but does not isolate and focus on the feeling component per se, but on the client's larger awareness.

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#### **Protective Capacity**

**Protective capacity** is defined as the ability and willingness to mitigate or ameliorate the identified safety and risk concerns. Protective capacity can be demonstrated by a parent through their statements, actions, and reactions. Protective capacity exists both within the parent/caretaker and within the family environment.

Parent/caretaker protective capacity should be assessed in three domains:

- Behavior characteristics
- Cognitive characteristics
- Emotional characteristics

**Behavioral** characteristics are defined as specific actions and activities consistent with and resulting in parenting and protective vigilance. Questions to consider include:

- Does the parent/caretaker have the capacity to care for the child? If the parent/caretaker has a disability(ies) (e.g., blindness, deafness, paraplegia, chronic illness), how has the parent/caretaker addressed the disability in parenting the child?
- Has the parent/caretaker acknowledged and acted to provide the needed support to effectively parent and protect the child?
- Does the parent/caretaker demonstrate activities that indicate putting aside one's own needs in favor of the child's needs (if appropriate)?
- Does the parent/caretaker demonstrate adaptability in a changing environment or during a crisis?
- Does the parent/caretaker demonstrate actions to protect the child?
- Does the parent/caretaker demonstrate impulse control related to a risk factor?
- Does the parent/caretaker have a history of protecting the child given any threats to the safety of the child?

**Cognitive** characteristics are defined as the parent/caretaker's specific intellect, knowledge,

understanding, and perception that contributes to protective vigilance. Questions to consider include:

- Is the parent/caretaker oriented to time, place, and space? (i.e., reality orientation)
- Does the parent/caretaker have an accurate perception of the child? Does the parent/caretaker see the child as having strengths and weaknesses, or do they see the child as "all good" or "all bad"?
- Can the parent/caretaker recognize the child's developmental needs or if the child has special needs?
- How does the parent/caretaker process the external stimuli? (e.g., a battered woman who believes she deserves to be beaten, because of something she has done)
- Does the parent/caretaker understand their role to provide protection to the child?
- Does the parent/caretaker have the intellectual ability to understand what is needed to raise and protect a child?
- Does the parent/caretaker accurately assess potential threats to the child?

Emotional characteristics are defined as the parent/caretaker's specific feelings, attitudes, and identification with the child and motivation that results in parenting and protective vigilance. Questions to consider include:

- Does the parent/caretaker have an emotional bond with the child? Is there a
  reciprocal connectedness between the parent/caretaker and the child? Is there
  a positive connection to the child?
- Does the parent/caretaker have empathy for the child when the child is hurt or afraid?
- Is the parent/caretaker flexible under stress? Can the parent/caretaker manage adversity?
- Is the parent/caretaker able to control their emotions? If emotionally overwhelmed, does the parent/caretaker reach out to others or expect the child to meet the parent/caretaker's emotional needs?
- Does the parent/caretaker consistently meet their own emotional needs via other adults, services?

#### **Appendix: Handouts**

#### **Environmental Protective Capacities**

While the assessment of the parent/caretaker's protective capacities is critical, an assessment of **environmental capacities** may also mitigate the safety concerns/risk of harm to a child. Below are several categories of environmental protective capacities to be considered.

- Family/kinship relationships that contribute to the protection of the child;
   Informal relationships
- Agency supports
- Community supports
- Financial status
- Spiritual supports
- For American Indians, the tribe
- Concrete needs being met (e.g., for food, clothing, shelter).

Citation: Cross Function Topics