

RESPONDING EFFECTIVELY TO TRAUMA MANIFESTATIONS IN CHILD WELFARE CASES

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This article defines trauma and how it manifests in the dependency court system. Trauma is prevalent in child welfare cases and all of the professionals on these cases can respond to the trauma they see and experience more effectively through a better understanding of how to regulate the nervous system and the body. Trauma often manifests as difficult behaviors in the dependency court world, but there is a lack of information for effective strategies to deal with it. This article discusses how families and professionals experience trauma in dependency court and provides tools rooted in a physiological understanding of trauma. It will help professionals notice and respond to trauma in themselves and others.

Key Points for the Family Court Community:

- There are many ways to define trauma, and using a broader definition of trauma helps put people's actions into context.
- The discussion about the implications of trauma on family court parties and professionals helps inform every family law decision.
- Trauma manifests in recognizable ways, and learning to recognize trauma manifestations can help professionals interact with clients and each other better.
- Learning the skills to respond to trauma manifestations is important for family law professionals.

Keywords: *Child Welfare; Dependency; Nervous System; Trauma.*

I. INTRODUCTION

In the past ten years, the word trauma has entered mainstream discussions in all types of family law, including private dispute resolution, state-involved child welfare cases, and delinquency cases. There are several definitions of trauma and numerous studies on how the impact of trauma affects people differently. This article, as part of this special edition of Family Court Review on child welfare related issues, focuses on the unique impacts of trauma in state-involved, child welfare cases. The issues here can be extrapolated to other family cases, but dependency cases often exacerbate the underlying trauma issues in families and the professionals.

It is important to define the parameters of this article. I refer to these cases as dependency cases. This is not the only word used to describe state-involved child welfare cases, elsewhere they are called child protection or child welfare cases. This article discusses the underlying trauma that exists in dependency actions generally. While the focus is on the United States, the issues addressed can be extrapolated to dependency cases worldwide. I use "they" as a singular pronoun.¹ In order to be inclusive, I will not use gender-specific pronouns except in actual quotations.

This article focuses on trauma and how dependency professionals can respond to trauma more effectively, when they have a better understanding of how to regulate the body and the nervous

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system. It is impossible to discuss trauma without first discussing systemic and institutional trauma, particularly because these issues affect children and families in the dependency system disproportionately.² This article focuses on changing individual responses and on bias and nonjudgment in all contexts.

This article proceeds in the following manner: Part II of this article addresses the varying definitions of trauma and how they relate to dependency. Part III addresses what makes trauma in dependency unique, including a look at systemic trauma. Part IV focuses on trauma's impact on professionals in the dependency system, and Part V discusses how to respond to trauma manifestations when they arise in families and professionals.

II. DEFINING TRAUMA BROADLY IMPACTS HOW PROFESSIONALS CAN RESPOND

Trauma in dependency cannot be observed in a vacuum. As we will see, the impact of the dependency system can and usually does exacerbate any other trauma that occurs in someone's life, in the families and the professionals in the system. When trauma is defined narrowly or objectively, as through the Diagnostic and Statistical Manual, the options for responding are limited. When trauma is defined broadly as nervous system dysregulation, the opportunities to respond to trauma manifestations increase, and professionals can help themselves or their clients. In this context, narrow and broad are similar to the difference between objective and subjective. When trauma is defined by objective criteria the responses available are limited but when trauma is defined by subjective, internal experiences, there are multiple responses available. I examine various ways to define trauma as background for describing these responses outlined in later sections.

This article was written between March and May 2020, during a time when the novel coronavirus pandemic affected the entire world. Any article about trauma cannot ignore the effect COVID-19 is having and will continue to have on the world, and as related here, on the dependency system. Other articles in this edition address COVID's specific effect on dependency,³ but I want to mention the piling on effect. The impact of social isolation, a decimated economy, and the uncertainty of how life will look in the future, has had a yet-unquantified effect on the mental health of people around the world. We already know that COVID-19 has worsened prior mental health issues and the mental health system is overrun with new issues.⁴ COVID-19 will have lasting influence on people's mental health long after it is safe to go back into public because, as will be discussed below, it will likely reduce people's tolerance for additional trauma.

A. TRAUMA DEFINED BY AN EVENT

Defining trauma by an event is the most objective but also the narrowest way to define trauma. The word trauma is derived from the Greek word for wound.⁵ Multiple aspects of dependency participants' lives can be traumatic. For example, they may face bullying in school, a car accident, or a family member's cancer diagnosis. While it is important to focus on the trauma that brought a child into the dependency system, or the trauma of being in the dependency system itself, it is equally important to pay attention to how events external to the case affect a child.

For many professionals in the legal field, trauma begins and ends with the Diagnostic and Statistical Manual of Mental Disorders (DSM).⁶ Now in its 5th edition (DSM-5), the DSM is the preeminent way to classify mental health disorders in the United States. Insurance companies use the DSM to provide or to deny treatment.⁷ The DSM-5 defines trauma through the circumstances that can result in a diagnosis of post-traumatic stress disorder (PTSD), including:⁸

The person was exposed to: death, threatened death, actual or threatened serious injury, or actual or threatened sexual violence, in the following way(s):

Direct exposure

Witnessing the trauma

Learning that a relative or close friend was exposed to a trauma
 Indirect exposure to aversive details of the trauma, usually in the course of professional duties (e.g., first responders, medics).

The DSM-5 requires there be a specific incident or incidents that result in specific behaviors for a diagnosis of PTSD. The DSM limits the definition of trauma to objective, external situations where a person experiences specified symptoms. These symptoms must last for at least a month and include, “at least one re-experiencing symptom, at least one avoidance symptom, at least two arousal and reactivity symptoms, [and] at least two cognition and mood swings.”⁹ These experiences are not the only instances that can cause trauma. Even without meeting the diagnostic criteria, some people experience significant trauma in their lives that affect their behaviors.

The DSM-5 did make one significant improvement. It was the first edition to allow indirect exposure, or vicarious trauma, to be a basis for a PTSD diagnosis.¹⁰ Vicarious trauma affects all healing professionals, including lawyers, court personnel, and other dependency professionals.

B. TRAUMA: DEFINED BY LONG TERM EFFECTS

There is a growing recognition that adverse childhood experiences (ACEs) can be traumatic and affect someone’s long-term mental and physical health. Dr. Nadine Burke Harris, a pediatrician, ACEs researcher, and the first Surgeon General of CA, discusses the need for a diagnosis of toxic stress in her book, *The Deepest Well: Healing the Long-term Effects of Childhood Adversity*.¹¹ She bases much of her discussion throughout the book on the original ACE study.¹² What Dr. Harris describes as toxic stress impacts long-term mental and physical health and can provide a foundation for a discussion about how trauma manifests and how to respond to it when it manifests behaviorally and mentally.

The original ACE study has significantly contributed to our understanding of childhood adversity and its effect on emotional and physical health. Drs. Vincent Felitti and Robert Anda conducted the study in San Diego, California from 1995–1997 through Kaiser Permanente.¹³ The ACE study found that the more adverse childhood experiences someone has the higher their rate of physical ailments later in life including, heart disease, pulmonary diseases, etc.

The ACE questionnaire is simple to take.¹⁴ The original ACE study consisted of only ten questions. For yes responses, the participant tallied one point.¹⁵ A person with an ACE score of four is twelve times more likely to have attempted suicide than someone with an ACE score of zero.¹⁶ An ACE score of six lowers someone’s life expectancy by an average of twentyyears.¹⁷

While the ACE study provides a causal connection between childhood adversity and adverse health conditions experienced later in life, it also grossly understates the problem. “[T]he specific questions that measured ACEs in previous studies, although universally important, might not reflect all of the salient stressors encountered by children and families living in poor urban communities, [which] might have significant contributions to suboptimal outcomes.”¹⁸

A Philadelphia ACE task force did an expanded study where they asked more questions related to both adversity and resilience. They also asked questions both in writing and by reading to participants to aid participants’ understanding.¹⁹ In addition to the original ACE items, the adversity questions included “witnessing violence, experiencing racism/discrimination, living in unsafe and unsupporting neighborhoods, experiencing bullying, and being in foster care.”²⁰

Research on the long-term impacts of adverse childhood experiences helps put both parent and child behaviors in the dependency system into context. Substance use remains one of the common reasons parents enter the dependency system.²¹ People with an ACE score of four or more are “twelve times more likely to have attempted suicide, seven times more likely to be alcoholic, and ten times more likely to have injected street drugs.”²² Further, children with an ACE score of four or more are “thirty-two times as likely to have learning or behavior problems”²³ and higher rates of headaches than children with no measurable ACEs.²⁴ Many of my child clients reported frequent

headaches when asked. ACEs as a measurement of long-term health consequences are a way to measure the amount of toxic stress a person has experienced, but they are not sufficient to tell a professional in the dependency system how to respond to trauma as it manifests in the moment.

C. TRAUMA: IMPACTS ON LONG-TERM DEVELOPMENT AND BEHAVIORS

ACEs also show up as trauma and have an impact on long-term development and behaviors.²⁵ Dependency court professionals should notice and respond to these in their cases. Children exposed to trauma and chronic stress have been shown to have smaller brains.²⁶ When children live in high stress or traumatic environments, the increased cortisol “inhibits cognition (clear thinking).”²⁷ These issues are tied together, but the smaller brain volume and the increased cortisol interrupting cognition are two key factors specifically affecting brain development. Removal from the home is also traumatic.²⁸ When a child welfare agency becomes involved with a family, they must take immediate appropriate measures to both address the trauma before state intervention and the trauma caused by state intervention.

Further, chronic stress and trauma affect a person’s ability to regulate their stress response later in life.²⁹ The amygdala and the hypothalamus govern the brain’s stress response and repeated exposure to toxic stress and trauma rewire the brain to expect more trauma in the future, making it difficult for someone who has been exposed to toxic stress to feel safe in the future. Dr. Harris says, “But the stress response can do its job a little too well sometimes. This happens when the response to stimuli goes from adaptive and lifesaving to maladaptive and health-damaging.”³⁰ The overreaction becomes a survival response that may become maladaptive in healthy relationships.

Similarly, long-term stress and trauma inhibit sleep, “which makes a lot of sense if you are living in a forest full of bears—better to be a light sleeper.”³¹ The problem is that a lack of sleep perpetuates the cycle, never allowing the brain to rest and rejuvenate, potentially leading to cognitive deficits.³² Without intervention, foster youth generally sleep less than non-foster youth, which can lead to more cognitive and behavioral problems.³³ The dependency cycle is a toxic stress environment, which causes the brain to respond as though most interactions are a threat, and a lack of sleep that never allows the brain to rejuvenate, increasing the likelihood of cognitive impairment.

Stress and trauma can also affect decision-making. For example, people have a tendency to make more egocentric decisions while under increased stress.³⁴ The research suggests people become more self-focused when they are under high levels of stress with high emotions, which is exactly the situation a dependency case creates.³⁵ Stress can also cause people to feel more anger, act more aggressively, and have reduced behavioral control that manifests as “reduced self-control and increased impulsive behavior.”³⁶ These behaviors frequently manifest in parent clients, and also in the children and professionals in the dependency system.

The research on the impact of stress on decision-making is particularly relevant in dependency cases, which usually require that parents remedy the circumstances that brought their children to the state’s attention and behave safely and appropriately as a condition precedent to reunification with their children. We know that removing children from the home is traumatic for both parents and children, and many parents in these cases have experienced trauma and chronic stress before their children are removed. Parents’ nervous systems are likely ill-equipped to respond immediately to dependency case requirements, including parenting classes, substance use classes, domestic violence classes, visitation, and therapy, among others. Parents in dependency cases are often viewed negatively when it appears as if they choose drugs, a partner, or some other life experience over caring for their children. As a result, if the trauma is not addressed, and the parent is unable to cope, the parent’s ability to reunify with their children is diminished.³⁷

D. TRAUMA: DEFINED THROUGH ITS EFFECT ON THE NERVOUS SYSTEM

Trauma can also be defined as that which overwhelms the nervous system to such a degree that the nervous system can no longer function correctly.³⁸ When a person has sufficient resiliency the nervous system can handle even excessive amounts of stress.³⁹ When the nervous system becomes overwhelmed and lacks resiliency, it can get stuck in fight, flight, or freeze responses, or a combination of any of the three together.⁴⁰

The fight-flight response is governed by the hypothalamic–pituitary–adrenal (HPA) axis.⁴¹ In addition to the HPA axis, there is the Sympatho-adrenomedullary (SAM) axis.⁴² Together, the hypothalamus, pituitary, and adrenal glands respond to the amygdala’s fear warning system. They cause the body to release cortisol, the longer-lasting stress response hormone and adrenaline and noradrenaline, the shorter-acting stress hormones.⁴³ These hormones activate the fight-or-flight response and allow the person to either fight the stressor or flee from it.

Generally, fight-or-flight responses shut down certain aspects of the body’s functioning, while amplifying others. For example, it becomes more difficult to digest food and sleep because these functions are unnecessary if someone is fleeing from a threat. By contrast, muscles tense, heart rate increases, and pupils dilate to improve vision when the fight-or-flight system activates.⁴⁴ While these are not the only responses activated, they are the most noticeable.

Many people, including those in the dependency system, are familiar with the term “fight-or-flight.” Fewer people discuss the freeze response as a trauma response, but it is not without its common usage. When people describe a “deer in headlights” or a possum “playing dead,” they are referring to the freeze response. Physiologically, the freeze response happens when fight and flight are no longer an option, so the system freezes to hide from a threat.⁴⁵ Fight-or-flight activation remains beneath the freeze response, so when the freeze response lifts, the animal, in our case a human, can flee.⁴⁶ The human freeze response is slightly different than that of other mammals. “Rather than being a last-ditch reaction to inescapable threat, paralysis becomes a ‘default’ response to a wide variety of situations in which one’s feelings are highly aroused.”⁴⁷ Humans often go into a freeze response when it would not be expected and when it may not be physiologically warranted.

When stress is encountered as a one-time occurrence, once a person leaves the stressful situation, the “feedback inhibition” response activates, and the SAM and HPA axes shut down.⁴⁸ For many families involved in the dependency system, however, their stress does not abate and this response does not shut down. In a 2009 study of foster youth, researchers found dysregulated cortisol levels in the foster youth as compared to non-maltreated children.⁴⁹ When stressors occur too frequently or too intensely, the body can no longer shut down the HPA and SAM axes.⁵⁰ When this happens, the nervous system remains in fight, flight, or freeze mode. These physiological responses are survival responses, meaning the nervous system activates because the brain thinks the person is in danger. If the nervous system never down regulates, the aspects that were shut down, including sleep and digestion, are unable to function properly.

Behavioral indicators of fight, flight, and freeze happen throughout the dependency system. I have observed many child clients run away from their foster placements, and children and adults who scream and yell at judges in court or sit slouched in their chairs unable to hear or understand what is happening around them. Professionals are not immune either. They may send inappropriate emails, yell at each other, or miss deadlines. All of these can be trauma responses.

E. MANIFESTATIONS OF TRAUMA

There are very specific behavioral and physiological responses to trauma that professionals may see in themselves or their clients. Once professionals understand them, they can use this knowledge to respond more effectively when clients exhibit these behaviors. Fight, flight, and freeze manifest in different ways, and the response to each should be different. They all share one similar characteristic – when the nervous system is in a fight, flight, or freeze response, the executive brain function

decreases and sometimes shuts down entirely.⁵¹ Trauma activation limits a person's ability to think rationally. The nervous system must down-regulate before having a meaningful conversation with someone when they are triggered.

This section is not specific to participants or professionals in the dependency system. I have seen these manifestations in biological parents, foster caregivers, relative caregivers, children, and professionals. The overview here will help professionals recognize where they have noticed these manifestations, in others or themselves, and help them contemplate how to respond. The first requirement of responding is to notice, and this section describes what you may see when someone, including yourself, is in a fight, flight, or freeze response.

When someone is in a fight response, they look as though they are getting ready to fight.⁵² People in this nervous system state tend to lean forward, and their eyes tend to be sharp and focused. Their muscles are tense, particularly their arms and facial muscles, and their neck is usually forward from the chest and very tense. In addition, their breath is shallow and short, meaning it looks like it is in the upper chest near the throat. Often people will look like they are speaking through clenched teeth. This is a very focused state of awareness, and people can be loud in this state, sometimes even screaming. They may use words that indicate fighting. Easy irritability and frustration are emotional indicators of the fight response.

The flight response, at first, can look very similar, but instead of the laser focus of the fight response, there is a sense of movement. This is not a regulated sense of movement; it looks much more like someone is looking for an escape route. People will often look around the room, shake their leg, and fidget like they cannot stop energy from moving in their bodies. People's eyes may still be piercing, but they will likely not be focused on one spot. People who often go to a flight response will talk about hiding or running away, and it may be difficult to get them to focus on a consistent train of thought.

Freeze is much more difficult to recognize because it generally results in people telling you they are "fine," and using words like "whatever." Physiologically, the freeze response is actually the highest state of activation in the nervous system, but the brain believes the danger is so grave, the person must freeze, or hide, from the danger. This leaves the viewer with a confusing picture. The person looks tense but unfocused. In this space people tend to slouch, look at the floor, and often ask for information to be repeated. When speaking to someone in a freeze response, it can feel similar to speaking to a wall.

In addition to these very specific fight, flight, freeze responses, trauma manifestations can be physical, emotional, mental, behavioral, social, and spiritual.⁵³ There are lists of these manifestations all over the internet and in many books. I list several here from Gina Ross's book, but this list is not exhaustive. This list is based on my experience of the most common manifestations I saw in participants and professionals in the dependency system. As you read these, think about clients and professionals you know, perhaps including yourself, who exhibit these trauma manifestations.

Physical symptoms include chronic pain, tension, backaches, headaches, hyper-alertness (jumping at loud noises), panic attacks, and sensitivity to senses.⁵⁴ Emotional manifestations include intense and unpredictable emotions, profound helplessness, loss of sense of adequacy, loneliness and isolation from others, and uncontrollable fear after an event has ended.⁵⁵ Mental manifestations include confusion and disorientation, forgetfulness and loss of skills, paranoid beliefs, inability to reason, tendency to blame or judge oneself or others, and "projection of difficult feelings and thoughts onto others."⁵⁶ Behavioral manifestations include inability to sit still, tapping feet uncontrollably (I have seen many lawyers who do this constantly), acting out with risky behaviors, addictive behavior, dysfunctional communication, "fear of loss of control, leading to perfectionist or obsessive-compulsive behavior."⁵⁷ Over the course of thirteen years in the dependency system, I saw these manifestations in clients, parents, caregivers, and professionals on a daily basis. When we think about trauma as these broader definitions, we see that manifestations are not unique to any type of person, and they are not indicators that someone is weak. They may be signs that someone has experienced too much trauma and needs to find healing.

F. HEALING FROM TRAUMA

The nervous system can heal and improve from trauma and its manifestations. Resilience research is slowly emerging. The most important aspect of resilience is to have a loving, caring adult in a child's life.⁵⁸ For adults, social engagement is one of the key avenues for healing.

Dr. Stephen Porges writes⁵⁹:

it is my hope to highlight the important role of feeling safe as an important component of the healing process. . . . [D]eficits in feeling safe form the core biobehavioral feature that leads to mental and physical illness. It is my sincere hope that furthering an understanding of our need to feel safe will lead to new social, educational, and clinical strategies that will enable us to become more welcoming as we invite others to co-regulate on a quest for safety.

Several years ago, I asked a group of trauma healing professionals what they would teach a group of lawyers regarding trauma-sensitive interviewing. The most common response, by far, was "learn to regulate their own nervous system first." Learning to regulate your own nervous system is important because of what Dr. Porges says here; it is when we are regulated that someone with us can feel safe. Safety is the key component because the lack of safety "leads to mental and physical illness."

Other people are more likely to feel safe around you when your own nervous system is regulated because of "co-regulation." Co-regulation is "a bidirectional linkage of oscillating emotional channels between partners, which contributes to emotional stability for both [parties]."⁶⁰ Essentially, co-regulation means that one person's nervous system affects another person's nervous system. Therefore, if one person is regulated, the other person can begin to regulate through co-regulation.⁶¹ If children or adults in the dependency system are surrounded by people with dysregulated nervous systems, they cannot regulate themselves.

III. DEPENDENCY ISSUES THAT EXACERBATE TRAUMA AND ITS MANIFESTATIONS

There are aspects of the dependency system that impact families and professionals differently than other types of family law. Specifically, there are mandatory federal and state case timelines, children in the dependency system are more heavily medicated than other children, and the dependency court system and processes can be traumatizing.

Dependency cases are unique among family law cases because of their compressed timelines. In the United States, federal law requires a permanency hearing within twelve months of a child being removed from a parent's home.⁶² A permanency hearing is where the court determines the permanent plan for a child such as family reunification, permanent guardianship, or termination of parental rights, and adoption. For children under the age of three, parents may have only six months to advance in a case plan before courts can change the case plan to terminate their parental rights or place their children in a permanent guardianship.⁶³ Children need not be returned in that time period, but parents must be making enough of a shift and change that return is imminent. If not returned to their biological parents, children can be adopted or placed into a guardianship.

Parents, therefore, have six to twelve months to address their underlying trauma, obtain a legal form of income or employment, and secure a stable and appropriate home. Frequently, parents are required to attend multiple classes, often without transportation, while making time to visit their child, regardless of their distance from the child. Distance can be a significant impediment to visitation and maintenance of an ongoing relationship between parent and child.

Why not allow more time? The need for permanency drives child welfare policy.⁶⁴ Research clearly demonstrates that children have a different sense of time than adults and that permanency helps children. Living life in limbo can be disorienting for children, and as discussed earlier, safety and stability are vital to resolving the child's trauma (and the parent's). Problems are not solved

overnight, however, and even the initial trauma of having children removed from their care can cause parents to go into shock for part, or all, of the reunification time period. Research also clearly demonstrates that children do best in biological families and when they can continue to have contact with their biological families while in care.⁶⁵ The goal of dependency cases is always to reunify families unless there is a statutorily allowed reason not to attempt reunification.⁶⁶ This creates an inherent tension between giving parents the time to heal and address their own trauma, and to create the stability and safety that their children need, while also addressing the children's need to be in their family of origin and in a permanent situation in a timely manner.

In addition to the strict time constraints seen in dependency cases, an added problem is the rampant use of psychotropic medication in the foster care system. This occurs because of a lack of understanding regarding trauma and toxic stress. Children in foster care receive psychotropic medication at a rate much higher than children on non-foster children on Medicaid.⁶⁷ In one study, more than forty percent of foster youth were on three or more psychotropic medications.⁶⁸ As noted above, children with ACE scores of four or more are more than thirty-two times as likely to have behavioral issues. These children are "told that they [have] ADHD or a 'behavior problem' when these problems were directly correlated with toxic doses of adversity."⁶⁹ Dr. Harris states:⁷⁰

Currently, ADHD is a diagnosis based entirely on symptoms. . . . [T]he criteria include inattention, impulsiveness, and hyperactivity, but the Diagnostic and Statistical Manual of Mental Disorders doesn't say a word about the underlying biology. What it does say is that if these same symptoms are associated with a different mental disorder, like schizophrenia, then it's no longer ADHD. Similarly, if we see impulsivity and hyperactivity but discover that those symptoms are caused by a brain tumor, we can't diagnose ADHD.

By recognizing that ADHD is a symptom diagnosis and the effects of trauma can manifest in ways similar to ADHD, professionals working with foster youth should get appropriate treatment for these youth, rather than accept a simple diagnosis that ignores the underlying biology of chronic stress. "[T]he diagnosis of toxic stress doesn't yet exist in the medical literature,"⁷¹ but the research on children in the foster care system and psychotropic medication indicates doctors are too quick to make an ADHD diagnosis, when the problem is really "toxic stress."

Being in court, itself, is traumatic. The National Center for State Courts recognizes the importance of moving cases quickly through the system, particularly when they involve issues of children and families,⁷² but of course that also adds stress to the process. Simply going to court can be scary and overwhelming for families and children. As the Philadelphia ACE study found, experiencing foster care is an adverse childhood experience that can lead to multiple mental and physical problems.⁷³ And while in court, participants often feel that no one explains what is happening to them. Court can move quickly, lawyers and judges have multiple cases per day, and the trauma of the situation itself makes it difficult for many parents to retain the information they are given. Families are confused and scared. They are trying to get back together, yet trauma makes it difficult to hear and understand what is happening.

This raises a rarely discussed problem in the dependency system; trauma manifestations themselves are often used to "support" an assertion that a parent cannot parent. The inability to get to classes, the inability to change behaviors, and the outbursts in court stemming from a lack of understanding what is happening are all trauma manifestations. They are also often the reasons cited for why parents should not have their children returned to them. While these behaviors may not be safe, the answer should not be to misdiagnose the problem but to acknowledge that the family is experiencing toxic stress and address the trauma.

IV. TRAUMA AND ITS IMPACT ON PROFESSIONALS

Understanding trauma's impact on dependency professionals is not only important for professionals' own sakes. As anyone who has ever traveled on a plane knows, "you have to put your own

mask on before helping others.” Another way to say this is that the heart pumps blood to itself first. It is necessary for professionals to take care of themselves in order to be the best professionals they can be. In order to do that, professionals must first understand the impact of trauma on themselves and how the trauma and stress shows up in their world.

In recent years, there has been a push to discuss burnout, compassion fatigue, and vicarious trauma within the legal profession, particularly within the dependency system. While they are often described as similar issues, they can also be described as stepping-stones to a state of overwhelm that must be addressed differently. I separate them out below to help professionals manage their response to each one.

Before discussing stress and vicarious trauma, it is important to discuss primary trauma among professionals. Incivility in courts has become commonplace. California now requires new attorneys to take an oath to be civil to one another, stating, “[a]s an officer of the court, I will strive to conduct myself at all times with dignity, courtesy, and integrity.”⁷⁴ Notwithstanding the administration of this oath, many lawyers still treat each other as well as mental health professionals, witnesses, and social workers with high levels of incivility. Dependency cases are difficult and can cause people to act worse than they otherwise might, perhaps by yelling at colleagues/adversarial attorneys or by sending reactionary emails. In my experience professionals treat each other poorly because of our own vicarious trauma.

Burnout is a condition that was commonly discussed in the legal profession long before the words such as compassion fatigue and vicarious trauma entered the lexicon.⁷⁵ Burnout is working too hard and not getting enough rest, which causes the sympathetic nervous system hormones described above to become commonplace.⁷⁶ Burnout can lead to potentially debilitating health conditions, although it can be addressed by getting enough rest, reducing workload, and taking adequate care of oneself.⁷⁷ Unfortunately, in most jurisdictions, professionals in the dependency system are overworked, underpaid, and struggle to address burnout effectively.

Compassion fatigue is unique to healing professionals. Anyone who works in the dependency system is in a healing profession. Compassion fatigue is a shift in mental perspective that affects how someone views the world, when so much of their daily life is consumed reading about and hearing about other people’s trauma.⁷⁸ Compassion fatigue has less to do with exhaustion, although that plays a part, and more to do with an overwhelming sense that the world is not the place one once believed it to be.⁷⁹ For example, it is easy for people who work with dependency cases to forget that the majority of families are mostly functional, and domestic violence is not the predominant form of interaction between intimate partners.

Similar to primary trauma, vicarious trauma occurs in the nervous system and can have the same results discussed regarding fight, flight, and freeze.⁸⁰ Vicarious trauma is when the nervous system becomes overwhelmed from what happens to other people. As noted above, the DSM-5 now recognizes that vicarious trauma can be an underlying cause for PTSD, and when someone experiences vicarious trauma, they can experience all of the trauma responses discussed earlier, including nervous system dysregulation and behavioral health, mental health, and physical health shifts.

V. WHAT DO WE DO WHEN TRAUMA MANIFESTS?

A. ADDRESSING BIAS

Human brains are wired to find the simplest answer. These biases, or labels, help humans make sense of the world. They also cause people to potentially believe something about someone that is not true for that individual. It is therefore important, in being trauma-responsive professionals, that we examine and address our own personal biases.

There are different kinds of bias/labels. Sometimes bias can be neutral. For example, think to yourself what happens around June 20th of every year. If you pay attention to the seasons, and you

live in the northern hemisphere, you likely think that it is the summer solstice. If you live in the southern hemisphere, however, it is the winter solstice.

Why does it matter how you view the solstice? It is simple to believe that our own way of seeing the world is the correct way.⁸¹ As dependency professionals, however, our job is to see the world from our clients' points of view. I cannot understand a client if I can only see their world from a metaphorical northern hemisphere perspective. There is no meaningful social engagement without trust. There is no trust without someone feeling seen and heard. There is no feeling seen and heard without a lack of judgment.

As dependency professionals, therefore, we must start by slowing down and utilizing Type 2 thinking as described by Daniel Kahneman.⁸² Kahneman describes Type 1 thinking as automatic thinking; it is what our brains do quickly to get to an answer.⁸³ Type 2 thinking is slower and more methodical and takes the brain out of "automatic."⁸⁴ The first step is to listen to someone and their story. The next step is to believe them, even if their story does not fit within the confines of your world view. What might seem impossible to fathom for you might be a daily occurrence for someone else. Professionals cannot define other people's stories. The law and circumstances may define whether their experience is sufficient for a child to be removed from parents, but your job is to let them tell their story.

For example, consider the situation where someone says the police planted evidence that led to the removal of a child. Many people are raised to believe that police tell the truth. However, stories have emerged about police misconduct, including planting evidence. In Chicago, more than eighty people were exonerated after a police officer was convicted of planting evidence that led to their convictions.⁸⁵ Professionals must listen to the entire story and not revert to bias about any group.⁸⁶

Similar to bias, the words we use matter. It is important that we choose our words carefully when referring to clients either directly or indirectly. For example, saying someone is "autistic" is very different from saying that someone has "autism." In the former, you are letting the characterization define the person. In the latter, the term is just one characteristic that is part of that person. We do not say that someone is cancerous; we say they have cancer. Similarly, when referring to mental health conditions, while it is easy to say that someone "is borderline," it is preferable to say they "have borderline personality disorder." Why does it matter? Ask yourself, is it easier to return a child to "a borderline," or to someone "who has borderline personality disorder." Of course, using people's correct pronouns and names is important as well, regardless of whether you believe in their gender identity or expression. For some people, the use of proper pronouns and names as validation of their gender identity is a matter of life and death.⁸⁷

These examples offer just a brief glimpse at the most basic ways to address bias overall. Incorporating them into your practice will help your clients feel safe enough around you to speak with you and share their stories.⁸⁸

B. SUGGESTIONS FOR DEPENDENCY COURT PROFESSIONALS

Peter Levine, one of the foremost experts on trauma, says that "[t]rauma is not what happens to us, but what we hold inside in the absence of an empathetic witness."⁸⁹ Being an empathetic witness is one of the simplest, albeit not the easiest, ways anyone can help address trauma daily in the dependency system. What does it mean to be an empathetic witness? Although there are many ways to learn to act as an empathetic witness, we will cover some of the easier ones to implement in this section.

First, and this might be the most difficult, to be an empathetic witness, you must be able to regulate your own nervous system. Nervous system regulation happens both over time and in the moment. Over time it happens through your own self-care. In individual moments, it occurs by utilizing the techniques described in this section.

There are many different types of self-care. Only you can know what works for you, although connecting to loved ones (e.g., friends, family, partners) is key. Social engagement happens when

we emerge from trauma responses. Face-to-face contact helps regulate the fight-flight response according to Dr. Stephen Porges.⁹⁰ Social engagement can also be the very thing that brings us out of a trauma response.⁹¹ Spending time with friends and family, particularly if there is laughter involved, is one of the best ways to take care of yourself. One of the challenges of social distancing during the COVID-19 experience is that people are increasingly stressed because they are lacking face-to-face social engagement, and the effect on mental health issues has been profound. Other ways to regulate the fight-flight response include yoga or meditation, walks in nature, interacting with pets, hobbies, volunteering, listening to music, getting a massage, and going to therapy. Whatever you enjoy, that does not involve excessive substance use, can be key to your own self-care.

And why is self-care so important? If your nervous system is too dysregulated, you are unable to respond to someone else's dysregulated nervous system in a healthy way. Further, because of co-regulation, your ability to stay regulated can help the other person's nervous system regulate. Even as humans get older, we can still regulate through other people.⁹² While there remains debate about the role of mirror neurons,⁹³ there is evidence to suggest "the actions, emotions, and sensations of others are mapped by the same neural mechanisms that are normally activated when we act or experience similar emotions and sensations."⁹⁴ The second person's body "maps" the emotions of the first person and embodies at least some of the first person's emotional state.⁹⁵

In addition to regulating your own nervous system, there are simple steps and tools you can use to help the person you may be interviewing, sitting next to in a courtroom as an attorney or as a party or witness, etc. It is always important to recognize the trauma manifestations in the person with whom you are interacting. Notice if the person is exhibiting fight characteristics, flight characteristics, or freeze characteristics as described in Part II.

There are also techniques that work to down-regulate the nervous system when it is over-activated. I would suggest you try these while reading them and try to notice if any changes occur in your own nervous system or body.⁹⁶

- Orienting – Orienting means slowly looking around the room while allowing your eyes to guide you to anything that draws their attention. Allow your eyes to rest on various objects for at least a moment and then continue looking until your head has moved back and forth at least a couple of times. It is often helpful to let your eyes rest on images or objects that evoke more of a pleasant feeling rather than those that are less pleasant.
- Grounding – Grounding is about noticing wherever in your body you feel grounded or anchored. Some people feel grounded in their feet, others in their backs, others in the back of their legs. Take a moment right now to notice where in your body you feel most grounded or connected and notice if there is a shift in how your body feels.
- Noticing the breath – Noticing the breath is exactly as it sounds, simply noticing. There is no intent to change the breath here, only to notice where it is. As you notice it, pay attention to whether it changes or shifts in any way.
- Centering – Everyone's body has a center, and for some people, just bringing awareness to the vertical center of the body can down-regulate the nervous system. Imagine a line parallel to the spine between the front and back of the body going down through the ground and up through the crown of your head. Notice if there is a change in your body sensations as you imagine this line.
- Tap into your senses – Noticing the five senses can bring our awareness back to the body and help down-regulate. One of the simplest ways to do this is to notice five things you see, four things you can touch, three things you hear, two things you can smell, and one thing you can taste.⁹⁷
- Soothing movements/touch – Most people have self-soothing techniques where they hold their hands a certain way, stroke their arms, play with their hair, or something similar. Chances are good you have noticed these in yourself or in your closest friends and family. Think about how you self-soothe and actively do it.

- Sensory/fidget tools – Do you remember the fidget spinner phase? There was a reason they worked so well. Sensory toys and fidget spinners bring awareness and sensation back into the body and give the nervous system something to feel other than the underlying fight, flight, freeze symptoms.

These techniques help you down regulate your own nervous system, which is the first step toward helping your clients feel safe. When noticing shifts in your body and nervous system, you can also often notice whether another person is going from a fight, flight, or freeze response back into a rest and digest state, by noticing a few simple characteristics of the body. The easiest way to notice this is when the person's eyes meet yours in a comfortable gaze. True social engagement occurs when we can be with someone and look them in the eyes without it feeling overwhelming for either party.⁹⁸ If eye contact is not appropriate, you can notice the lack of fight, flight, freeze responses in yourself and your clients.

Other avenues for engaging in a trauma-responsive way include slowing down and taking time with other people. This is particularly difficult in the dependency system when lawyers consistently have more than 200 clients, judges have more than 1,000 cases, and social workers and other mental health providers have double or triple what is considered to be an acceptable case load. Despite excessive caseloads, slowing down is one of the most important ways professionals can help themselves and others. The nervous system cannot be regulated when it is rushed moving from case to case. This is as important for the professional's nervous system as it is for the client's nervous system. Slowing down gives you the time to see and hear your clients and for social engagement.

It is important to be nonjudgmental when interacting with people in the dependency system. A key aspect to being trauma responsive is helping people feel safe. It is impossible for someone to feel safe if they feel judged, particularly by the people who are supposed to support them. We do this by listening to listen, not by listening to respond. Giving people an opportunity to tell their story is, in some ways, the greatest gift we can offer and the best way to help them navigate the dependency system.

One way to address the specific trauma manifestations is through a technique called pendulation. Pendulation, as defined by Peter Levine, is the body's natural rhythm between overwhelm and safety.⁹⁹ He describes it as when a child falls and scrapes their knee, begins crying, and then runs to their caregiver to be consoled.¹⁰⁰ Pendulation allows the nervous system to recognize that it will not always be stuck in one place, be that fight, flight, or freeze.¹⁰¹ While Levine describes it as a therapy technique, it can be used by anyone. Pendulation only requires the willingness to think outside the box and, sometimes, to interrupt a story someone is telling. Interrupting to say something you want to say can be traumatizing but interrupting when someone appears to be overwhelmed can be trauma responsive. Recognizing the difference, and acknowledging that difference with clients, is important.

Here are two examples of using pendulation in two opposite scenarios – one involving an overly activated sympathetic response and another involving such a child who has gone into a freeze state. Client A is a fifteen-year-old girl who has experienced significant domestic violence in her parents' relationship. When recounting this particular domestic violence incident, Client A's speech sped up, her shoulders crept closer to her ears, her breath became faster, she sat forward in her seat, and her eyes began to get laser focused.

The following exchange occurred:

Lawyer, interrupting client's story: "May I stop you for just a second? It looks as though telling this story is very difficult for you. Is that true?"

Client: "Yes."

Lawyer: "I really want you to have the opportunity to tell your story, and I really want to hear it, but it looks like it might be too much right now. Would it be okay if we stopped for a moment? I will remember exactly where we are in the story, and we can talk about something else until you feel a little better?"

Client: "Yes."

Lawyer and client talk about the client's favorite movies. While that conversation happens, Client's shoulders begin to drop, she sits back in her chair, her head is able to move on her neck, and her eyes begin to soften into a more natural gaze.

Lawyer: "It looks as though you are feeling better. Is that true?"

Client: "Yes."

Lawyer: "Would you like to continue telling the story?"

Client: "Yes."

Client finishes telling the story, and this time, her nervous system remains regulated, and she does not become overly activated.

This story illustrates a couple of important points about being trauma-responsive. The first is entirely contrary to what is generally considered appropriate. Sometimes it is okay, even necessary, to interrupt someone. This is different than interrupting because you want to say something or because you are not actually listening. This interruption comes from a place of compassion. It inhibits the nervous system from becoming so activated that it is difficult for the person to come back. Notice too that the lawyer offered to remember where they were in the story. It would not be appropriate to expect the person whose nervous system is becoming overwhelmed to have that kind of memory. The lawyer could even write it down to ensure memory of the place in the story. It is very important to express the want and need to continue the story, but just to give space to allow the person to feel more comfortable. As soon as the professional mentions it, the person will likely notice they are not feeling well. The most difficult piece here is knowing that it is okay to interrupt and doing it before the overwhelm sets in, particularly because when the sympathetic nervous system is activated like this, people tend to speak more quickly.

In another example, Client B is a fifteen-year-old child who is nonbinary and who is not saying much to the lawyer. The lawyer can see that Client B is slouching in their chair, shoulders hunched forward, their breath is barely visible and then only in the uppermost part of his chest, and Client B's eyes are focused in one spot but not looking at the lawyer. The lawyer also notices that Client B's arms are just hanging by their side.

The following exchange occurred:

Lawyer: "This may sound like a strange question, but can you feel your arms right now?"

Client: "Actually, no."

Lawyer: "Are you willing to try something with me?"

Client: "I guess."

Lawyer places their palms together with elbows pointing out and pushes their hands together asking the client to do the same, for about three seconds. Both put their hands down. Both of them take an involuntary deep breath.

After this moment, the lawyer and the client were able to have a more involved conversation. The client was not quite as stuck or absent-looking, and they could talk about the case. There are multiple options in a scenario like this other than the one described here. One approach would have been to just stand up and walk around, if that is an option where the lawyer and client are talking. Another approach would have been trying to talk to the client about something the lawyer knows the client enjoys doing. The difficulty with this approach is that the more stuck or absent the client is, the harder it is to find something to talk about that can bring them out of this kind of response.

A third approach is to use sensory toys or spinners or anything tactile, like playdoh or even drawing. Just touching something that has a texture can help the nervous system come back online when it has shut down. It is very important when doing this to refrain from immediately going into a discussion of something traumatic. The freeze response happens because the sympathetic nervous system is overly activated so the system has to shut down. It is important to allow someone time to come back from the freeze state to talk about something enjoyable. This gives the nervous system time to settle before you discuss something too activating again. Then, if the person becomes too activated, you can use the pendulation technique described for Client A.

These techniques can seem very daunting and tend to contradict much of what we are taught. Our natural biases about working with people experiencing trauma manifestations are not always

helpful or correct. These tools help us to slow down the process, give people time, and allow you to not feel overwhelmed by clients whose systems are so dysregulated that they cannot listen or interact with you.

Learning these techniques can help you take care of your own burnout, compassion fatigue, and vicarious trauma. Importantly, taking care of yourself allows your clients to begin to feel safe in your presence and provides the space for their own nervous systems to down regulate. These skills cannot solve every aspect of the trauma in the dependency system, but what they can do is give people enough space so that they have the ability to engage in the rest of the system. In my experience, taking this extra time and showing up regulated to conversations with clients helps the case move forward because the brain's executive function works better, and people are better prepared to work together.

I would argue there is no other way to survive in the dependency system. If a person does not feel safe, they cannot participate in the process. Every single professional in the dependency system has the potential to offer a different type of presence, one that focuses on listening without judgment and navigating the nervous system with thoughtful care and appreciation for the harm that can arise in dependency court.

VI. CONCLUSION

Working in the dependency court system can feel overwhelming and hopeless. The overwhelm and trauma, whether primary or vicarious, often result in behaviors and actions that cause ongoing trauma between professionals and the failure of the system to reunify families. There are ways to respond that begin to interrupt the trauma responses and bring the body and nervous system back into a natural state of regulation. Techniques that are based in the nervous system can have profound impacts on everyone involved. I hope this article has provided a first step for noticing, slowing down, and responding differently in your practice going forward.

ENDNOTES

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²Issue Brief, CHILD WELFARE INFORMATION GATEWAY, 3 (2016), https://www.childwelfare.gov/pubpdfs/racial_disproportionality.pdf (hereinafter “Issue Brief”).

³Kristen Pisani-Jaques, *A Crisis for a System in Crisis: Forecasting from the Short- and Long-Term Impacts of COVID-19 on the Child Welfare System*, ___ FAM. CT. REV. ____ (forthcoming 2020).

⁴Paige Winfield Cunningham, “The Health 202: Texts to Federal Government Mental Health Hotline Up Roughly 1,000 Percent,” THE WASHINGTON POST (May 4, 2020), <https://www.washingtonpost.com/news/powerpost/paloma/the-health-202/2020/05/04/the-health-202-texts-to-federal-government-mental-health-hotline-up-roughly-1-000-percent/5eaae16c602ff15fb0021568/>.

⁵MERRIAM-WEBSTER, <https://www.merriam-webster.com/dictionary/trauma>.

⁶American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders: Diagnostic and Statistical Manual of Mental Disorders, (AMERICAN PSYCHIATRIC ASSOCIATION 5th ed. 2013).

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⁸U.S. Dep’t of Veterans Affairs, PTSD: National Center for PTSD, https://www.ptsd.va.gov/professional/treat/essentials/dsm5_ptsd.asp.

⁹*Id.*

¹⁰*Id.*

¹¹NADINE BURKE HARRIS, *THE DEEPEST WELL: HEALING THE LONG-TERM EFFECTS OF CHILDHOOD ADVERSITY* 60 (Houghton Mifflin Harcourt 2018).

¹²*Adverse Childhood Experiences (ACE)*, CENTERS FOR DISEASE CONTROL AND PREVENTION, <https://www.cdc.gov/violenceprevention/childabuseandneglect/acestudy/index.html> (hereinafter “ACE CDC”).

¹³Jane E. Stevens, *The Adverse Childhood Experiences Study — The Largest, Most Important Public Health Study You Never Heard of — Began in an Obesity Clinic*, ACES TOO HIGH NEWS (Oct. 3, 2012) <https://acestoohigh.com/2012/10/03/the-adverse-childhood-experiences-study-the-largest-most-important-public-health-study-you-never-heard-of-began-in-an-obesity-clinic/> (hereinafter “ACE Public Health Study”).

¹⁴<https://www.cdc.gov/violenceprevention/childabuseandneglect/acestudy/index.html>.

¹⁵The 10 questions were limited in scope to incidents or situations that occurred before the participant turned 18 years of age. Participants were asked whether they had ever experienced: 1) emotional abuse by a parent or adult in the house, 2) physical abuse by a parent or adult in the house, 3) sexual abuse by anyone more than five years older, 4) feelings that the family was not supportive of participant or each other, 5) neglect through lack of food or cleanliness or parents'/caregivers' substance use, 6) parents ever separated or divorced, 7) physical abuse against a female adult/caregiver in the home, 8) lived with anyone who was a problem drinker or used illicit substances, 9) a household member had significant mental health issues or attempted suicide, and 10) whether a household member had gone to prison. *Got Your ACE Score?*, ACES TOO HIGH NEWS <https://acestoohigh.com/got-your-ace-score/>.

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¹⁷David W. Brown et al., *Adverse Childhood Experiences and the Risk of Premature Mortality*, 37 AM. J. PED. MED. 389 (2009).

¹⁸Lee Pachter et al., *Developing a Community-Wide Initiative to Address Childhood Adversity and Toxic Stress: A Case Study of The Philadelphia ACE Task Force*, 17 ACADEMIC PEDIATRICS 130 (2017).

¹⁹*Id.*

²⁰*Id.* at 131.

²¹Child Welfare Information Gateway, *Parental substance use and the child welfare system*, U.S. DEP'T OF HEALTH AND HUMAN SERVS., CHILDREN'S Bureau (2014) <https://www.childwelfare.gov/pubs/factsheets/parentalsubabuse/>.

²²ACE Public Health Study, *supra* note 13.

²³Harris, *supra* note 11, at 61.

²⁴Fahad Mansuri, MPH et al., *Adverse Childhood Experiences (ACEs) and Headaches Among Children: A Cross-Sectional Analysis*, 0 HEADACHE 1 (2020).

²⁵See generally, Michael D. De Bellis & Abigail Zisk, *The Biological Effects of Childhood Trauma*, 23 CHILD ADOLESCENT PSYCHIATRIC CLINICS N. AM. 185 (2015) (discussing a complete overview of the effects of childhood trauma and biology).

²⁶James Douglas Bremner, *Traumatic Stress: effects on the brain*, 8 DIALOGUES IN CLINICAL NEUROSCIENCE 445, 451 (2006).

²⁷Harris, *supra* note 11, at 56.

²⁸Vivek Sankaran et al., *A Cure Worse than the Disease? The Impact of Removal on Children and Their Families*, 102 MARQUETTE L. REV. 1161 (2019).

²⁹One way to discuss this would be through attachment theory. This article cannot go into all the nuances of attachment theory. For a great overview of attachment and its effect on family courts, please refer to the *July 2011* edition of *Family Court Review*. 49 FAM. CT. REV. 415 (2011).

³⁰Harris, *supra* note 11, at 47.

³¹*Id.* at 51.

³²Paula Alhola & Päivi Polo-Kantola, *Sleep Deprivation: Impact on Cognitive Performance*, 3 NEUROPSYCHIATRIC DISEASE & TREATMENT 553 (2007); Jennifer R. Tininenko et al., *Sleep Disruption in Young Foster Children*, 41 CHILD PSYCHIATRY & HUMAN DEVELOPMENT 409 (2010).

³³Tininenko, *supra* note 32, at 416.

³⁴Nikolaus Steinbeis et al., *The Effects of Stress and Affiliation on Social Decision-Making: Investigating the Tend-and-Befriend Pattern*, 62 PSYCHONEUROENDOCRINOLOGY 138, 138 (2015).

³⁵Katrin Starcke et al., *Does Stress Alter Everyday Moral Decision-Making?*, 36 PSYCHONEUROENDOCRINOLOGY 210 (2011).

³⁶Steinbeis, *supra* note 34, at 146–47.

³⁷Katherine Markey and Vivek Sankaran, *Compassion: The Foundation For All Efforts To Reunify Children With Their Parents*, ___ FAM. CT. REV. ___ (Forthcoming 2020).

³⁸Peter Levine & Maggie Kline, *TRAUMA THROUGH A CHILD'S EYES* 4 (North Atlantic Books 2005).

³⁹Harris, *supra* note 11, at 53.

⁴⁰Some would argue, there is also a “tend and befriend” pattern, sometimes called a fawn response. That is, however, an emotional response and not a physiological response. There remains much debate about the “tend and befriend” pattern, so it will not be addressed in this article. Steinbeis, *supra* note 34.

⁴¹Harris, *supra* note 11, at 49. As Dr. Harris mentions in her book, the stress response cycle is much more complex than the HPA axis. This article focuses on this small part as a primer for the information in the next section.

⁴²*Id.*

⁴³*Id.*

⁴⁴*Id.* at 51.

⁴⁵Karin Roelofs, *Freeze For Action: Neurobiological Mechanisms in Animal and Human Freezing*, 372 PHILOSOPHICAL TRANSACTIONS OF THE ROYAL SOCIETY B: BIOLOGICAL SCIENCES 1718 (2017).

⁴⁶*Id.*

⁴⁷Peter A. Levine, *IN AN UNSPOKEN VOICE: HOW THE BODY RELEASES TRAUMA AND RESTORES GOODNESS* 24 (North Atlantic Books 2012).

⁴⁸Harris, *supra* note 11 at 51.

⁴⁹Jacqueline Bruce et al., *Morning Cortisol Levels in Preschool-Aged Foster Children: Differential Effects of Maltreatment Type*, 51 *DEVELOPMENTAL PSYCHOBIOLOGY* 14 (2009).

⁵⁰Harris, *supra* note 11 at 52.

⁵¹*Id.* at 49–50.

⁵²The information here and in the following few paragraphs stems from my training in Somatic Experiencing™ (SE). SE is a trauma healing modality originated by Dr. Peter Levine and implemented now by the Somatic Experiencing Trauma Institute (SETI). Somatic Experiencing, *Beginning 2 Manual*, 11 (on file with author).

⁵³Gina Ross, *BEYOND THE TRAUMA VORTEX INTO THE HEALING VORTEX: A GUIDE FOR YOU*, (The Int'l Trauma Healing Inst. ed., 2010).

⁵⁴*Id.* at location 518 in Kindle ed.

⁵⁵*Id.* at location 527 in Kindle ed.

⁵⁶*Id.* at 536, Kindle ed.

⁵⁷*Id.* at 545, Kindle ed.

⁵⁸Harris, *supra* note 11 at 53.

⁵⁹Stephen W. Porges, *THE POCKET GUIDE TO THE POLYVAGAL THEORY: THE TRANSFORMATIVE POWER OF FEELING SAFE* (W.W. Norton & Co. 2011).

⁶⁰Emily A. Butler & Ashley K. Randall, *Emotional Coregulation in Close Relationships*, 5 *EMOTION REV.* 202 (2013).

⁶¹Tools for how to coregulate are discussed in Part V.

⁶²42 U.S.C. § 675(5)(c) (2018).

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⁶⁴Kele Stewart, *The Connection Between Permanency and Education in Child Welfare Policy*, 9 *HASTINGS RACE & POVERTY L. J.* 511, 512 (2012).

⁶⁵Lenore M. McWey et al., *The Impact of Continued Contact with Biological Parents upon the Mental Health of Children in Foster Care*, 32 *CHILD YOUTH SERVS. REV.* 1338 (2010).

⁶⁶42 U.S.C. § 671(a)(15) (2019).

⁶⁷Julie M. Zito, et al., *Psychotropic Medication Patterns Among Youth in Foster Care*, 121 *PEDIATRICS* 157 (2008).

⁶⁸*Id.*

⁶⁹Harris, *supra* note 11 at 59–60.

⁷⁰*Id.* at 60.

⁷¹*Id.*

⁷²Deborah Smith, *Trends in State Courts*, National Center for State Courts (2018) <http://niwaplibrary.wcl.american.edu/wp-content/uploads/Trends-in-State-Courts-Survey-Findings.pdf>.

⁷³Philadelphia ACE Survey, *THE PHILADELPHIA ACE PROJECT* (2019), <https://www.philadelphiaaces.org/philadelphia-ace-survey>.

⁷⁴CAL. BUS. & PROF. CODE §6067 (West 2018).

⁷⁵*What is Compassion Fatigue*, TEND, <https://www.tendacademy.ca/what-is-compassion-fatigue/>.

⁷⁶*Id.*

⁷⁷*Id.*

⁷⁸*Id.*

⁷⁹*Id.*

⁸⁰Erin Clements, et al., *Secondary Trauma in the Workplace: Tools for Awareness, Self-Care, and Organizational Response in Montana*, MONT. STATE UNIV. CTR. FOR AM. INDIAN & RURAL HEALTH EQUITY, <https://traumahealing.org/wp-content/uploads/2018/10/Secondary-Trauma-Manual-.pdf>.

⁸¹Katherine Markey & Vivek Sankaran, *Compassion: The Foundation For All Efforts To Reunify Children With Their Parents*, ___ *FAM. CT. REV.* ____ (forthcoming 2020).

⁸²Daniel Kahneman, *THINKING, FAST AND SLOW* 20 (Farrar et al. eds., 2011).

⁸³*Id.*

⁸⁴*Id.*

⁸⁵Amir Vera & Eric Levenson, *Dozens of Convictions Tied to a Corrupt Chicago Cop are Being Tossed*, CNN, Feb. 11, 2019, 1:09 PM, <https://www.cnn.com/2019/02/11/us/chicago-convictions-dismissed-corrupt-cop/index.html>.

⁸⁶See Rebecca Stahl & Philip Stahl, *REPRESENTING CHILDREN IN DEPENDENCY AND FAMILY COURT: BEYOND THE LAW* 219–231 (ABA Family Law Section 2018).

⁸⁷Greta R. Bauer, Ayden I. Scheim, et al., *Intervenable factors associated with suicide risk in transgender persons: a respondent driven sampling study in Ontario, Canada*, 15 *BMC PUBLIC HEALTH* 525 (2015).

⁸⁸See Robert Simon & Philip Stahl, *FORENSIC PSYCHOLOGY CONSULTATION IN CHILD CUSTODY LITIGATION: A HANDBOOK FOR WORK PRODUCT REVIEW, CASE PREPARATION, AND EXPERT TESTIMONY* (Am. Bar Ass'n 2d ed. 2014).

⁸⁹Levine, *supra* note 47.

⁹⁰Dr. Stephen Porges, *Face to Face Social Engagement*, YOUTUBE (Apr. 23, 2018), <https://www.youtube.com/watch?v=1xS3bv32-UY>.

⁹¹*Id.*

⁹²Vittorio Gallese, *Mirror Neurons, Embodied Simulation, and the Neural Basis of Social Identification*, 19 PSYCHOANALYTIC DIALOGUES 519 (2009).

⁹³Gregory Hickock, THE MYTH OF MIRROR NEURONS: THE REAL NEUROSCIENCE OF COMMUNICATION AND COGNITION (W.W. Norton and Co. ed., 2014).

⁹⁴Gallese, *supra* note 92 at 520.

⁹⁵*Id.* at 519.

⁹⁶All of these techniques come from a variety of somatic experiencing and other body-based healing modalities; *see generally* Levine, *supra* note 47.

⁹⁷Sara Smith, *5-4-3-2-1 Coping Techniques for Anxiety*, BEHAVIORAL HEALTH PARTNERS BLOG (2018), <https://www.urmc.rochester.edu/behavioral-health-partners/bhp-blog/april-2018/5-4-3-2-1-coping-technique-for-anxiety.aspx>.

⁹⁸There are certain characteristics that can make eye contact difficult for someone, including autism spectrum disorder or being from a culture that does not believe eye contact, especially with strangers, is appropriate.

⁹⁹Levine, *supra* note 47 at 77–81.

¹⁰⁰*Id.* at 81.

¹⁰¹*Id.* at 79.

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