

# **ATTENTION:**

THE FIRST PART OF THIS BOOKLET CONTAINS:

**HANDOUTS** FOR THE  
TRAUMA TELECONFERENCE / WEBCAST

**PRINT THESE 31 PAGES (which includes this page)**  
**TO HAVE FOR THE PROGRAM**

THE SECOND PART OF THIS BOOKLET CONTAINS:

**OPTIONAL** RELEVANT RESOURCE MATERIAL

This section is 135 pages total – PRINT AS NEEDED

Effects

Focal Point Articles

Interventions

What Happened to this Child – Introduction

Resources

# **Trauma Informed Care for Children and Adolescents: Understanding Trauma and Mental Health**

*Tuesday, March 31, 2009*

**Handout Materials**



**New York State  
Office of  
Children & Family  
Services**

New York State  
Office of Children and Family Services,  
PDP Distance Learning Project,  
CDHS/Research Foundation of SUNY/BSC  
and SUNY Stony Brook

**TRAUMA INFORMED CARE FOR CHILDREN AND  
ADOLESCENTS:  
UNDERSTANDING TRAUMA AND MENTAL HEALTH**  
March 31, 2009

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**OPTIONAL MATERIALS**  
**(print as needed)**

# **Clinical Considerations**

**Handout material adapted from these sources:**

Bowers, Duane T., L.P.C. July 9, 2008.

Conference title: Trauma, PTSD, & Traumatic Grief. Erie, PA.

Jacobs, Selby C. (1999). *Traumatic Grief: Diagnosis, Treatment, and Prevention*. Brunner/Mazel, a member of the Taylor & Francis Group. Philadelphia.

Lerner, Mark D. (2002). The National Center for Crisis Management, in collaboration with the American Academy of Experts in Traumatic Stress.

Ogden, P. & Kekuni, M. (2000). "Sensorimotor Psychotherapy: One Method for Processing Traumatic Memory." *Traumatology* Vol. VI, Issue 3, Article 3, Boulder, CO: Sensorimotor. Psychotherapy Institute and Naropa University.

Schupp, Linda J., Ph.D., (2004). *Assessing and Treating Trauma and PTSD*, PESI, LLC, Eau Claire, WI.

Stamm, B Hudnall & Figley, Charles R. TSRG, 1995-1999  
<http://www.isu.edu/~bhstamm>.

# Etiology of Stress

- Stress is the nonspecific response of the body to any demand placed upon it to adapt, whether that demand produced pleasure or pain.

~ Hans Selye (1976)

- Stress is the inability to cope with a perceived (real or imagined) threat to one's physical, mental, emotional, and spiritual well-being.

~ Brian Luke Seaward (1999)

- Traumatic stress is the emotional, cognitive, behavioral and physiological experience of those exposed to events that overwhelm their coping abilities.

~ Mark Lerner (2001)

- Trauma is a psychologically distressing event outside the range of usual human experiences. In traumatic situations, the child experiences or witnesses an immediate threat to self or others, often followed by serious injury or harm. Trauma often involves a sense of fear, terror, and helplessness

~ Dr. Bruce Perry (2004)

- Complex trauma describes children's experience when exposed to traumatic events that occur within their care-giving systems and the impact of this exposure on their development.

~ Richard Kagan, Ph.D. (2009)

Vicarious trauma is the most severe form of compassion fatigue. It is experienced by helpers whose clients have experienced trauma.

***Traumatization occurs when both internal and external resources are inadequate to cope with a perceived threat.***

# Characteristics of the Crisis

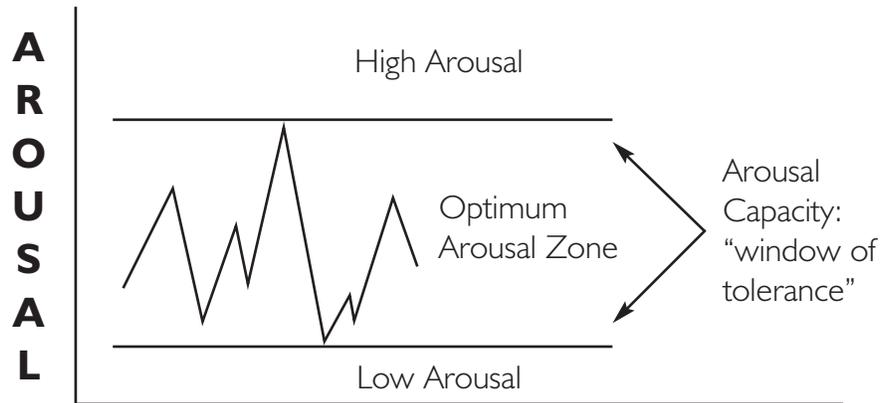
- Warning?
- Time of day (most powerful)
- Duration
- Natural vs. man-made
- Intentional vs. accidental
- Scope of the impact
- Post-crisis environment
- Preventability
- Suffering (subjective)

**Source:** Bowers, Duane T., L.P.C. July 9, 2008. Conference title: Trauma, PTSD, & Traumatic Grief. Erie PA. (Used with permission.)

# The Modulation Model

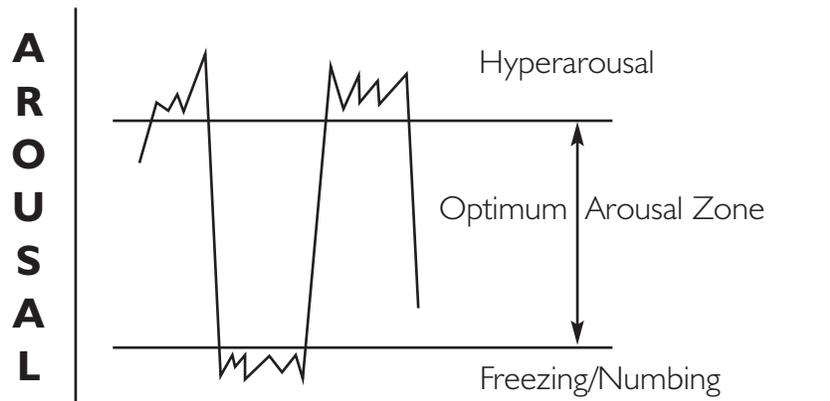
## Optimum Arousal Zone

Figure 1



## The Bi-Phasic Response to Trauma

Figure 2



Reprinted by permission of: Ogden, P. & Kekuni, M. (2000). "Sensorimotor Psychotherapy: One Method for Processing Traumatic Memory." *Traumatology* Vol. VI, Issue 3, Article 3, Boulder, CO: Sensorimotor Psychotherapy Institute and Naropa University.

# Stress-Related Disorders (DO)

## Trauma-Based Concerns

- Adjustment DO
- Post-traumatic stress DO (PTSD)
- Acute stress DO
- DESNOS
- Complex PTSD
- Generalized anxiety DO
- Panic DO
- Phobic DO
- Bereavement
- Major depressive episode
- Traumatic grief
- Brief psychotic DO
- Depersonalization
- Compulsive personality DO
- Borderline personality DO
- Substance-induced DO
- Somatization DO
- Eating DO
- Traumatic neurosis
- Derealization
- Dissociative DO
- Dissociation

**Source:** Schupp, Linda J. 2004, *Assessing and Treating Trauma and PTSD*. PESI Healthcare LLC. Eau Claire, WI. (Used with permission.)

## **Disorders Worth Considering as Trauma-based Conditions**

- Conduct DO
- Obsessive-compulsive DO
- AOD abuse
- Learning disabilities
- Severely emotionally disturbed
- Malingering
- Affective DO
- Schizophrenia
- Bipolar DO
- ADD/ADHD

**Source:** Schupp, Linda J. 2004, *Assessing and Treating Trauma and PTSD*. PESI Healthcare LLC. Eau Claire, WI. (Used with permission.)

# Trauma Intake Interview

## Additional Screens

- Symptoms of PTSD
- Dissociative responses
- Somatic disturbance
- Sexual disturbance
- Trauma-related cognitive disturbance
- Tension reduction activities
- Transient post-traumatic psychotic reactions
- Symptoms of grief

**Source:** Schupp, Linda J. 2004, *Assessing and Treating Trauma and PTSD*. PESI Healthcare LLC. Eau Claire, WI. (Used with permission.)

# Predicting PTSD

## Primary influences:

1. Pre-trauma vulnerability
2. Magnitude of the stressor
3. Preparedness for the event
4. Quality of the immediate and short term responses
5. Post-event “recovery” factors

**Source:** Ariel Y. Shalev 1996. In Schupp, Linda J. 2004, *Assessing and Treating Trauma and PTSD*. PESI Healthcare LLC. Eau Claire, WI. (Used with permission.)

# High Risk Indicators for PTSD

- Close proximity to the event
- Extended exposure to danger
- Pre-trauma anxiety and depression
- Chronic medical condition
- Substance involvement
- History of trouble with authority (e.g., stealing, vandalism, etc.)
- Mental illness
- Lack of familial/social support
- Lack of opportunity to vent (i.e., unable to tell one's story)
- Strong emotional reactions upon exposure to the event; prior exposure to severe adverse life events (e.g., combat)
- Significant losses
- Prior victimization (e.g., childhood sexual and physical abuse)
- Physically injured by event

**Source:** Lerner, Mark D. 2002. The National Center for Crisis Management in collaboration with the American Academy of Experts in Traumatic Stress. (Used with permission.)

# Loss/Grief Inventory

## Common Losses

Loved Ones

Health

Appearance

Status

Amputation of body part

Image

Security

Material possessions

Meaning in life

Faith

Dignity

Home

Life style

Mobility

Animal companions

Potential of self

Safety

Finances

Dreams

Confidence

Love

Identity

## Factors Complicating Grief/Trauma Resolution

### Emotional

- Unexpressed hostility
- Prolonged duration of grief
- Delayed and insufficient responses
- Repressed emotions or absence of emotion
- Unresolved previous losses
- Concomitant losses

### Relational

- Narcissistic relationship
- Overly dependent relationship
- Child abuse or childhood trauma
- Insecure childhood attachments
- Ambivalent relationship with deceased
- Death following a lingering illness
- Uncertain death or MIA
- Holding onto false hopes
- Sudden unexpected death or loss

### Personal

- Self-blame for abuse
- History of depressive illness
- Personality factors
- Self concept roles
- Belief that loss was avoidable
- Social problems

**Source:** Schupp, Linda J. 2004, *Assessing and Treating Trauma and PTSD*. PESI Healthcare LLC. Eau Claire, WI. (Used with permission.)

# Clinical Treatment Issues

- Re-experiencing
- Avoidance
- Arousal
- Energy shift (track the trauma)
- Obsessive behaviors
- Compulsive re-exposure
- Emotional repercussions
- Information processing
- Fragmentation of self
- Loss and separation

**Source:** Schupp, Linda J. 2004, *Assessing and Treating Trauma and PTSD*. PESI Healthcare LLC. Eau Claire, WI. (Used with permission.)

# Trauma-Focused Treatment Techniques

## Working the Mind-Body-Brain Connection

### Physiological Interventions

- Sleep
- Massage
- Meditation/relaxation
- Exercise, esp. expressive forms (e.g., dance, some martial arts, nature walks, rock climbing, ropes course, etc.).
- Breathwork
- Mindfulness
- Stress inoculation training
- Sensorimotor psychotherapy
- Trauma touch therapy
- Vitamin and mineral therapies
- Psychopharmacology

### Additional Interventions for Trauma

- The therapeutic relationship
- Cognitive Behavioral Therapy (CBT)
- Dialectic Behavioral Therapy (DBT)
- Identity clues
- Nonverbal approaches
- Eye Movement Desensitization and Reprocessing (EMDR)
- Client-directed eye movement technique
- Emotional Freedom Techniques (EFT)
- EMDR and EFT
- Resource development and installation
- Visual imagery
- Visual/Kinesthetic Dissociation (V/KD)
- Traumatic Incident Reduction (TIR)
- Basic TIR
- Exposure Therapy
- Gestalt
- Sanctuary Model tools
- Art and music therapy
- Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)

**Source:** Schupp, Linda J. 2004, *Assessing and Treating Trauma and PTSD*. PESI Healthcare LLC. Eau Claire, WI. (Used with permission.)

# Descriptions: Trauma Focused Treatment Techniques

**Stress Inoculation Training (SIT)** an individually-tailored, multifaceted form of CBT. SIT has been used on a treatment basis to help clients cope with the aftermath of exposure to stressful events and on a preventative basis to “inoculate” the client to current and future stressors.

**Sensorimotor Psychotherapy** somatic psychology—a body-centered psychotherapy that helps clients discover habitual and automatic attitudes (physical and psychological) by which they generate patterns of experience. Through the use of simple experiments, unconscious attitudes are brought to consciousness where they can be examined, understood, and changed.

**Trauma Touch Therapy** a variety of non-touch modalities that create safe space and help the client prepare to experience touch. Clients learn to pace themselves to avoid reliving traumatic events and to create experiences in which they're helped to take care of themselves (in ways not possible at the time of trauma).

**Psychopharmacology** in conjunction with other therapeutic techniques, when medically required.

**Identity clues** agreeing when possible, paraphrasing, matching verbal energy and mirroring body language.

**Emotional Freedom Techniques (EFT)** a therapy with roots in ancient Chinese medicine and in the modern science of applied kinesiology (muscle testing). EFT uses acupuncture points and the theory that all disease, physical or emotional, comes from blockage in the energy system; tapping or massaging these points frees up the blockage.

**Traumatic Incident Reduction (TIR)** a procedure that intends to make benign the consequences of past traumatic events. It requires flexibility, as sessions routinely go 1 ½ hours; 2-3 hour sessions are common.

**Exposure Therapy** a form of desensitization; the client is systematically exposed to fearful memories, objects or situations.

**Visual/Kinesthetic Dissociation (V/KD)** a positive, therapeutic form of dissociation with roots in neurolinguistic programming. It uses a “distancing” effect for visual and kinesthetic stimulants. V/KD helps clients to process traumatic material that otherwise could move them to dissociate in order to try to handle it.

# Compassion Satisfaction and Fatigue (CSF) Test\*

Helping others puts you in direct contact with other people's lives. As you probably have experienced, your compassion for those you help has both positive and negative aspects. This self-test helps you estimate your compassion status: How much at risk you are of burnout and compassion fatigue and also the degree of satisfaction with your helping others. Consider each of the following characteristics about you and your current situation. Write in the number that honestly reflects how frequently you experienced these characteristics in the last week. Then follow the scoring directions at the end of the self-test.

<b>0</b> = Never	<b>1</b> = Rarely	<b>2</b> = A few times	<b>3</b> = Somewhat often
<b>4</b> = Often	<b>5</b> = Very often		

## Items About You

- 1. I am happy.
- 2. I find my life satisfying.
- 3. I have beliefs that sustain me.
- 4. I feel estranged from others.
- 5. I find that I learn new things from those I care for.
- 6. I force myself to avoid certain thoughts or feelings that remind me of a frightening experience.
- 7. I find myself avoiding certain activities or situations because they remind me of a frightening experience.
- 8. I have gaps in my memory about frightening events.
- 9. I feel connected to others.
- 10. I feel calm.
- 11. I believe I have a good balance between my work and my free time.
- 12. I have difficulty falling or staying asleep.
- 13. I have outbursts of anger or irritability with little provocation.
- 14. I am the person I always wanted to be.
- 15. I startle easily.
- 16. While working with a victim, I thought about violence against the perpetrator.
- 17. I am a sensitive person.
- 18. I have flashbacks connected to those I help.
- 19. I have good peer support when I need to work through a highly stressful experience.

- 20. I have had first-hand experience with traumatic events in my adult life.
- 21. I have had first-hand experience with traumatic events in my childhood.
- 22. I think I need to “work through” a traumatic experience in my life.
- 23. I think I need more close friends.
- 24. I think there is no one to talk with about highly stressful experiences.
- 25. I have concluded that I work too hard for my own good.
- 26. Working with those I help brings me a great deal of satisfaction.
- 27. I feel invigorated after working with those I help.
- 28. I am frightened of things a person I helped has said or done to me.
- 29. I experience troubling dreams similar to those I help.
- 30. I have happy thoughts about those I help and how I could help them.
- 31. I have experienced intrusive thoughts of times with especially difficult people I have helped.
- 32. I have suddenly and involuntarily recalled a frightening experience while working with a person I helped.
- 33. I am preoccupied with more than one person I help.
- 34. I am losing sleep over a person I help's traumatic experiences.
- 35. I have joyful feelings about how I can help the victims with whom I work.
- 36. I think that I might have been “infected” by the traumatic stress of those I help.
- 37. I think that I might be positively “inoculated” by the traumatic stress of those I help.
- 38. I remind myself to be less concerned about the well being of those I help.
- 39. I have felt trapped by my work as a helper.
- 40. I have a sense of hopelessness associated with working with those I help.
- 41. I have felt “on edge” about various things, and I attribute this to working with certain people I help.
- 42. I wish I could avoid working with some people I help.
- 43. Some people I help are particularly enjoyable to work with.
- 44. I have been in danger working with people I help.
- 45. I feel that some people I help dislike me personally.

### Items About Being a Helper and Your Helping Environment

- 46. I like my work as a helper.
- 47. I feel I have the tools and resources that I need to do my work as a helper.
- 48. I have felt weak, tired, and run down as a result of my work as helper.
- 49. I have felt depressed as a result of my work as a helper.
- 50. I have thoughts that I am a “success” as a helper.
- 51. I am unsuccessful at separating helping from my personal life.
- 52. I enjoy my coworkers.
- 53. I depend on my coworkers to help me when I need it.
- 54. My coworkers can depend on me for help when they need it.
- 55. I trust my coworkers.
- 56. I feel little compassion toward most of my coworkers.
- 57. I am pleased with how I am able to keep up with helping technology.
- 58. I feel I am working more for the money or prestige than for personal fulfillment.
- 59. Although I have to do paperwork that I don't like, I still have time to work with those I help.
- 60. I find it difficult separating my personal life from my helper life.
- 61. I am pleased with how I am able to keep up with helping techniques and protocols.
- 62. I have a sense of worthlessness/disillusionment/resentment associated with my role as a helper.
- 63. I have thoughts that I am a “failure” as a helper.
- 64. I have thoughts that I am not succeeding at achieving my life goals.
- 65. I have to deal with bureaucratic, unimportant tasks in my work as a helper.
- 66. I plan to be a helper for a long time.

## Scoring Instructions

Please note that research is ongoing on this scale, and the following scores are theoretically derived and should be used only as a guide, not as confirmatory information.

**1. Be certain to respond to all items.**

**2. Mark the items for scoring:**

- a. Put an x by the following 26 items: 1-3, 5, 9-11, 14, 19, 26-27, 30, 35, 37, 43, 46-47, 50, 52-55, 57, 59, 61, and 66.
- b. Put a check by the following 16 items: 17, 23-25, 41, 42, 45, 48, 49, 51, 56, 58, 60, and 62-65.
- c. Circle the following 23 items: 4, 6-8, 12, 13, 15, 16, 18, 20-22, 28, 29, 31-34, 36, 38-40, and 44.

**3. Add the numbers you wrote next to the items for each set of items and note:**

- a. *Your potential for compassion satisfaction (x):* 118 and above = extremely high potential; 100–117 = high potential; 82–99 = good potential; 64–81 = modest potential; below 63 = low potential.
- b. *Your risk for burnout (check):* 36 or less = extremely low risk; 37-50 = moderate risk; 51–75 = high risk; 76–85 = extremely high risk.
- c. *Your risk for compassion fatigue (circle):* 26 or less = extremely low risk; 27–30 = low risk; 31–35 = moderate risk; 36–40 = high risk; 41 or more = extremely high risk.

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## **My Personal Self-Care Plan**

### **Personal Physical**

- Engage in self-care behaviors
- Physical activity – exercise, dance, strenuous manual labor
- Reconnecting with one’s body – massage, yoga
- Take care of oneself physically; use physical means to find adrenalin highs
- Maintain a high-energy level through proper diet, sleep, exercise

**List the Personal Physical components of your self-care plan:**

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### **Personal Psychological**

- Identify those triggers which may cause one to experience vicarious traumatization
- Get therapy if personal issues and past traumas get in the way
- Use one’s own self-soothing capacities in a positive manner
- Know one’s own limitations
- Keep the boundaries one sets for self and others
- Maintain an ability to see gray
- Know one’s own level of tolerance
- Engage in healing activities that renew meaning of life both in therapy and out of therapy settings.
- Listen to music
- Spend time in nature
- Take a vacation
- Read for pleasure
- Balance work, play, and rest
- Engage in practices that renew a cherished sense of identity or extend one’s identity beyond that of someone who works with trauma
- Engage in activities that allow one to feel particularly like a man/woman or that allow one to be in a dependent or receiving role

- Engage in creative endeavors
- Play and laugh
- Develop personal rituals to ensure safety and empowerment
- Dream
- Journal
- Modify one's own work schedule to fit one's life
- Consider joining a creative therapy group<sup>[1]</sup>

**List the Personal Psychological components of your self-care plan:**

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**Personal Social**

- Identify one's own personal and social resources and supports and then plan strategies for their use.
- Engage in social activities outside of work
- Garner emotional support from colleagues
- Garner emotional support from family and friends
- Spend time with children, pets

**List the Personal Social components of your self-care plan:**

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**Personal Moral**

- Adopt a philosophical or religious outlook and remind oneself that he/she cannot take responsibility for the client's healing but rather must act as a midwife, guide, coach, mentor
- Clarify one's own sense of meaning and purpose in life
- Develop one's spiritual side as a grounding tool

- Connect with the larger sociopolitical framework and develop social activism skills

**List the Personal Moral components of your self-care plan:**

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**Professional**

- Become knowledgeable about the effects of trauma on self and others
- Attend workshop/conference
- Attempt to monitor or diversify case load
- Seek consultation on difficult cases
- Get supervision from someone who understands the dynamics and treatment of PTSD
- Join supervision/study group
- Use – don't ignore - case consultation and supervision that you get
- Read relevant professional literature
- Take breaks during workday
- Have hope in the ability of people to change, heal, grow
- Admit it when one does not know an answer or makes a mistake
- Develop strategies to stay present during therapy sessions, even when hearing or seeing the horrors others have experienced
- If one feels overwhelmed in a therapy-related matter, break the task(s) down into manageable components; apply case management strategies
- Diversify interests to include balance, including materials read or workshops attended and between personal and professional lives.
- Modify one's own work schedule to fit one's life
- Develop strategies to stay present during therapy sessions, even when hearing or seeing the horrors others have experienced
- Know one's own level of tolerance
- Recognize emotional, cognitive, and physical signs of incipient stress reactions in self and in colleagues and respond appropriately
- Do not limit clinical practice to only PTSD clients – balance victim and nonvictims case loads
- Limit overall case loads.
- Recognize you are not alone in facing the stress of working with traumatized clients – normalize your reactions.
- Remind oneself of the health in the person's story

- Use a team for support
- Where indicated, use debriefing
- Consider time-limited group approach with clinicians who have a history of trauma.
- Become knowledgeable about PTSD – seek professional training
- Join a network of others who work with PTSD population
- Maintain collegial on the job support thus limiting the sense of isolation
- Understand dynamics of traumatic reenactment

**List the Professional components of your self-care plan:**

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**Organizational / Work Setting**

- Accept stressors as real and legitimate, impacting individuals and group-as-a-whole
- Work in a team
- Create a culture to counteract the effects of trauma
- Consider developing Assaulted Staff Action Program<sup>[iii]</sup>
- Alter physical setting to be more secure, safe, and soothing
- Establish a clear value system within your organization
- Develop clarity about job tasks and personnel guidelines
- Obtain supervisory/management support
- Maximize collegiality
- Encourage democratic processes in decision-making and conflict resolution<sup>[iiii]</sup>
- Emphasize a leveled hierarchy
- View problem as a problem for the entire group, not just an individual problem
- The general approach to the problem is to seek solutions, not assign blame
- Expect high level of tolerance for individual disturbance
- Express support clearly, directly and abundantly and through tangible behavioral response like providing resources – helping with paperwork, making phone calls, providing back-up
- Communicate openly and effectively
- Expect a high degree of cohesion
- Expect considerable flexibility of roles
- Join with others to deal with organizational bullies
- Eliminate any subculture of violence and abuse
- Create a culture of nonviolence

**List the Organizational components of your self-care plan:**

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**Societal**

- General public and professional education about PTSD and secondary traumatic stress
- Find a mission – become politically and socially engaged
- Encourage local, state, and national organizational to education professionals and nonprofessionals about trauma
- Community involvement
- Coalition building
- Legislative reform
- Social action
- Rescuing efforts directed at any oppressed or traumatized group
- Bearing witness and seek justice.
- Share and transform suffering through the use of the arts
- Political action

**List the Social/political components of your self-care plan:**

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## Refs for Self-

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<sup>[i]</sup> Riley S. An art psychotherapy stress reduction group: for therapists dealing with a severely abused client population. *Arts in Psychotherap*, 1997, 23:407-415

<sup>[ii]</sup> Flannery, R. B. *Becoming Stress-Resistant: Through the Project SMART Program*. New York: Continuum, 1990; Flannery, R. B., P. Fulton, J. Tausch, A.Y. DeLoffi. A program to help staff cope with psychological sequelae of assaults by patients. *Hospital and Community Psychiatry*, 1991., 42(9): 935-938; Flannery, R. B. *Violence in the Workplace*. New York: Crossroad, 1995; Flannery, R. B. *The Assaulted Staff Action Program: Coping With The Psychological Aftermath Of Violence*. Ellicott City, MD: Chevron Publishing Co, 1998.

<sup>[iii]</sup> Bloom, SL. *Practicing Sanctuary: Creating and Maintaining Safe Environments*. Unpublished manuscript.

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## Case Study

### Background

Terrance is a 15-year-old African American boy placed in residential treatment eight months ago, following a year in a foster home. He initially came to the attention of service providers when a PINS petition was filed by the school for excessive truancy. While in the foster care system Terrance experienced a disrupted placement, and the second placement was only for a few weeks as a “hold-over” until a bed opened in a residential treatment facility.

Terrance is the oldest of three boys raised in his father’s custody. Terrance’s mother’s whereabouts are unknown. Terrance has little memory of his mother. While not on probation or parole himself, Terrance’s father is known to have violent encounters within the community and is known to local law enforcement officers. He made no attempt to control his behavior within the family either: e.g., he roughly shaved all the boys’ heads because he “was tired of telling them to comb their hair.” Terrance’s caseworker would schedule family conferences and meetings at the local library as a way to control the father’s angry outbursts.

Like his father, Terrance shows little respect for authority or for females. His foster care placement was disrupted due to Terrance’s aggressive behavior toward the foster mother. In an act of defiance, he destroyed her prized handmade crafts. He frequently uses vulgar language around very young children, girls and women; this behavior is less pronounced when Terrance is in the company of males.

Terrance is mainstreamed in the eighth grade, having failed sixth grade. His grades are marginal, with his best performance in shop and computer studies. He says he’ll quit school as soon as he turns 16. He is athletically built and enjoys playing “pick-up” football and hockey. He is not involved in organized sports; he was removed from Pee Wee teams due to inappropriate behavior--fighting in one situation and vandalism in the other.

Terrance looks forward to visits with his siblings, who remain in their father’s custody. Even with visits at his father’s home, any substantial contact between Terrance and his father was lacking and the LDSS successfully petitioned to terminate the father’s parental rights to Terrance. Visits with his siblings became less frequent and more secretive.

### Current Situation

Within the last month, Terrance did or said something that enraged his father. Terrance refuses to share what that was. His father is now actively preventing visits between Terrance and his siblings. There may be safety concerns as his father is still raging to his neighbors about wanting to “get” Terrance.

Meanwhile, Terrance’s behavior is increasingly difficult to manage in the living unit, the classroom, and he has recently been restricted to facility grounds. According to facility staff, Terrance “flies off the handle” very easily. He is argumentative and combative

when given any kind of directive. He is bullying others on a daily basis, including facility staff.

Last week he threw his dinner plate across the dining area while others were eating and yelled, "THIS SHIT ISN'T FIT FOR A DOG!" The scene caused a very chaotic evening in the living unit and reinforcements needed to be called in to assist with the situation.

**Assessment and Treatment Planning Ideas**

**Please write your assessment and treatment planning ideas in the spaces below.**

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**Questions**

**Please write your answers to the following questions in the spaces below.**

What signs of reenactment, avoidance and/or hyper-arousal are evident in Terrance's behavior?

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What everyday activities might trigger Terrance's traumatic reminders?

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What suggestions do you have for team members to help Terrance heal?

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What questions should the team members ask the clinician?

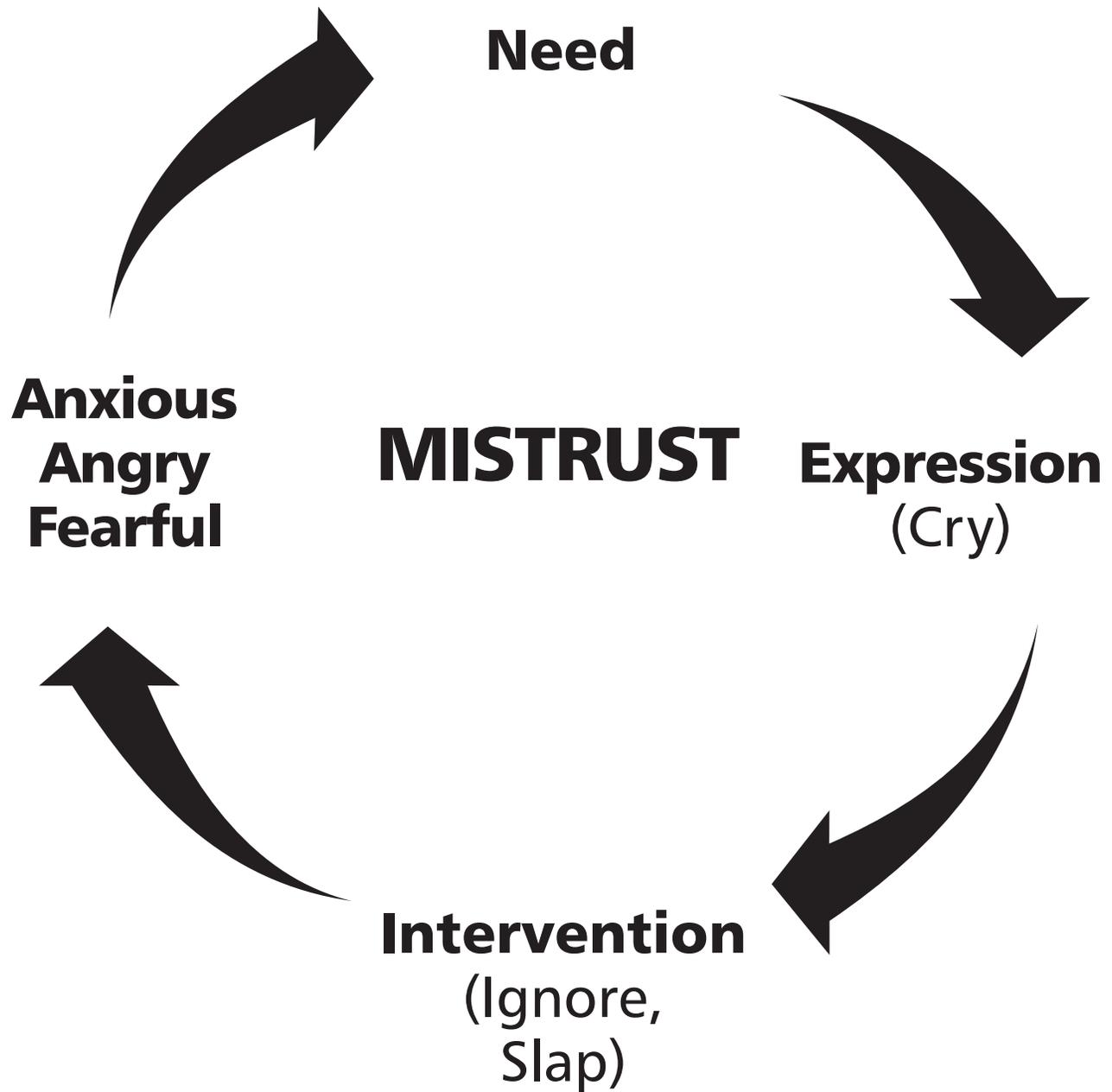
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**OPTIONAL  
RELEVANT RESOURCE  
MATERIAL**

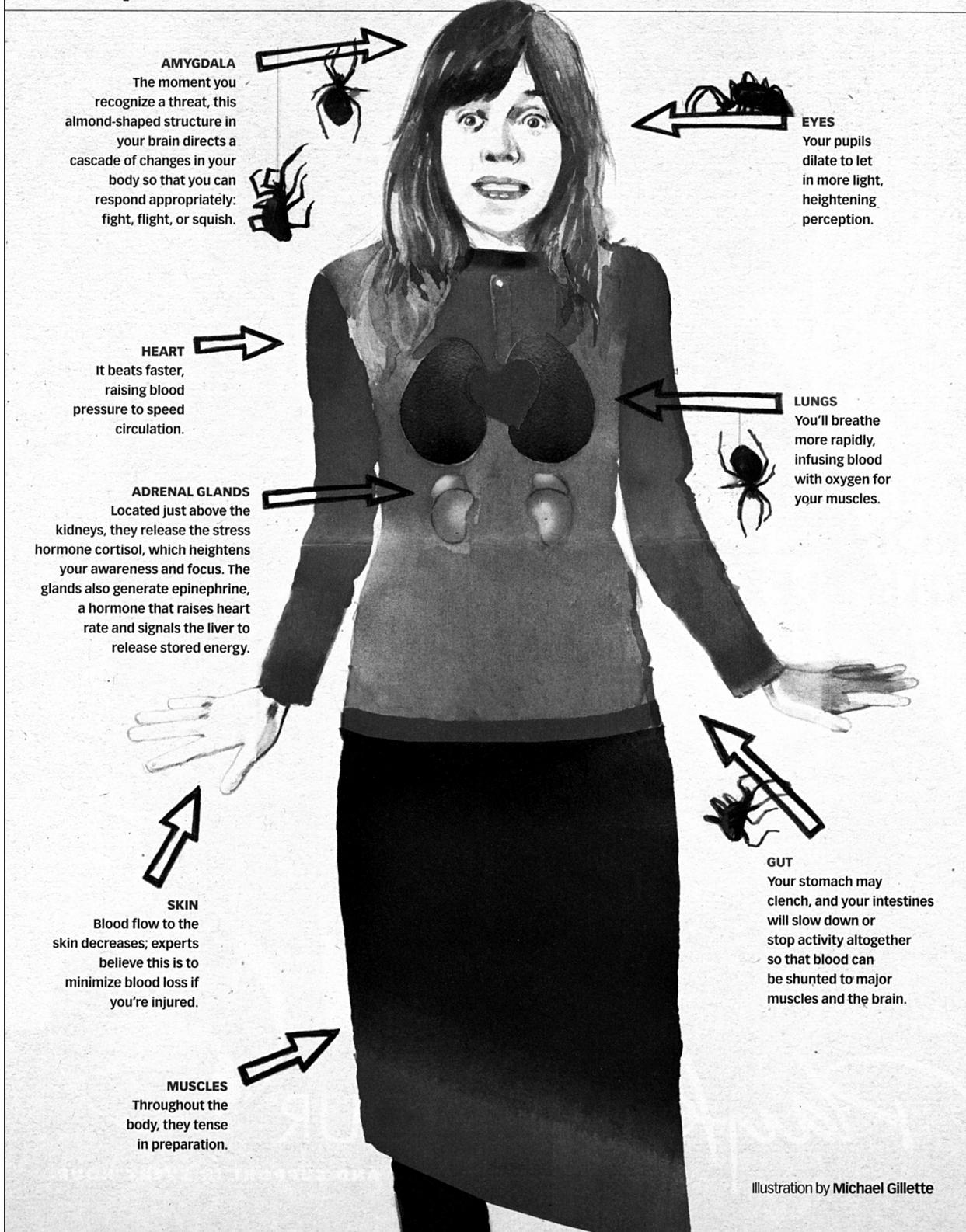
# Effects

## The Cycle of Need: Mistrust



# A Spider Beside Her

How the body reacts to fear



**AMYGDALA**

The moment you recognize a threat, this almond-shaped structure in your brain directs a cascade of changes in your body so that you can respond appropriately: fight, flight, or squish.

**EYES**

Your pupils dilate to let in more light, heightening perception.

**HEART**

It beats faster, raising blood pressure to speed circulation.

**LUNGS**

You'll breathe more rapidly, infusing blood with oxygen for your muscles.

**ADRENAL GLANDS**

Located just above the kidneys, they release the stress hormone cortisol, which heightens your awareness and focus. The glands also generate epinephrine, a hormone that raises heart rate and signals the liver to release stored energy.

**SKIN**

Blood flow to the skin decreases; experts believe this is to minimize blood loss if you're injured.

**GUT**

Your stomach may clench, and your intestines will slow down or stop activity altogether so that blood can be shunted to major muscles and the brain.

**MUSCLES**

Throughout the body, they tense in preparation.

Illustration by Michael Gillette

# Impact of Physical Abuse, Sexual Abuse, Emotional Maltreatment, and Neglect on a Child's Development\*

Following is a partial list of behaviors that may signal a problem in a child's development. If you notice one or more of these behaviors in a child, consider referring the child for further assessment.

Remember, children grow at their own special rate. Children of the same age develop differently. Be careful not to jump to conclusions after a single incident. If the behavior continues for several days or weeks, you should seek help.

Recognizing and being familiar with the signs of illness are also necessary to prevent permanent damage to a child's development. Be careful, however, not to confuse simple illness with more serious problems. For example, before referring a child with watery eyes for an eye examination, find out if the child simply has a cold.

## The Infant:

- ◆ does not cry or cries very weakly
- ◆ cries at a very high pitch
- ◆ screams all the time
- ◆ does not react to pain, noise, lights, or attention
- ◆ has trouble breathing (noisy, raspy, gurgling sounds)
- ◆ has a hard time sucking, eating, swallowing
- ◆ vomits frequently and has a hard time keeping food down
- ◆ has eyes that are often red or watery
- ◆ at six months of age, is still cross-eyed, rolls the eyes around, or does not follow things with both eyes
- ◆ does not turn toward sounds
- ◆ has earaches and shows this by crying or putting hand near the ear (there may be a runny fluid coming from the ear)
- ◆ cannot focus on caretaker's eyes or face
- ◆ often has a high temperature
- ◆ has skin rashes often
- ◆ does not lie in different positions at six months
- ◆ rocks constantly in corner, playpen, or crib
- ◆ does not smile when familiar people approach

\* Adapted from Martin, H. (1979) *Treatment for abused and neglected children*. Washington, DC: User Manual Series, National Center on Child Abuse and Neglect.

- ◆ bumps head on pillow while trying to get to sleep
- ◆ always bumps into things
- ◆ squints to see things, holds objects close to the eyes or doesn't try to reach for objects
- ◆ rocks back and forth for long periods of time, waving fingers in front of eyes
- ◆ sleeps for a very long time
- ◆ at six months of age, does not hold head steady when supported
- ◆ at nine months of age, cannot balance head
- ◆ at nine months of age, cannot sit alone when placed in a sitting position
- ◆ at nine months of age, cannot pick up small objects
- ◆ at nine months of age, does not vocalize with expression
- ◆ at one year of age, never points to anything or responds to people or toys

### **The Child (toddlers, preschoolers, and kindergartners):**

- ◆ has trouble controlling arms and legs
- ◆ falls often, walks poorly, or can't walk at all by 2 years of age
- ◆ holds one hand at side and never uses it for picking up or holding toys
- ◆ has stiff arms, legs, or neck
- ◆ drools all the time
- ◆ may sleep often during the day
- ◆ shows signs of seizures – often faints; wets and soils pants even though toilet trained; lies on the floor with arms and legs stiff, then jerks arms and legs around with back arched, then sleeps
- ◆ has many skin rashes, lumps, or sores
- ◆ refuses to eat for three or more days
- ◆ coughs constantly
- ◆ has continual diarrhea
- ◆ is unusually pale and skin is cold
- ◆ suddenly becomes dizzy, vomits, sleeps, wets, or has a headache
- ◆ squints or holds objects close to see them
- ◆ rolls eyes around, is cross-eyed, or doesn't use both eyes to follow objects
- ◆ doesn't point to, wave back to, or imitate others
- ◆ doesn't look at colorful, eye-catching objects

- ◆ often waves fingers in front of eyes
- ◆ often rubs eyes
- ◆ complains of itching or burning eyes or of seeing double
- ◆ frequently complains of headaches or dizziness
- ◆ does not react to sudden loud sounds
- ◆ has many earaches or has a runny fluid coming from the ear
- ◆ has little voice control
- ◆ bumps head on pillow in bed to go to sleep
- ◆ does not walk or talk by three years of age
- ◆ has trouble understanding or remembering simple directions
- ◆ has trouble doing many skills which require eye-hand coordination, such as scribbling on paper with a crayon
- ◆ does not respond to simple questions or directions
- ◆ does not seem to enjoy being held or touched
- ◆ does not know body parts
- ◆ often hurts own self by hitting or biting
- ◆ rocks back and forth for long periods of time
- ◆ does the same movement over and over, such as waving arms and legs
- ◆ says the same thing over and over, or only repeats words after hearing them from another person
- ◆ at three or four years of age, does not play with other children and prefers to be alone in the corner or in bed
- ◆ at three or four years of age, cannot run, jump, or balance on one foot
- ◆ at three or four years of age, cannot throw or kick a ball

School-aged children who show any of the same warning signs as infants, toddlers, preschoolers, or kindergartners may need your special attention. Other signs of possible problems for school-aged children follow.

### **The School-Aged Child:**

- ◆ is overweight or underweight
- ◆ has consistent bad breath and a severe sore throat
- ◆ has an injury that leads to dizziness, vomiting, headache, or sleepiness
- ◆ is not able to see objects or books clearly
- ◆ is easily distracted
- ◆ speaks very little and uses only a few words
- ◆ asks for words to be repeated or stays near you and frequently watches your lips when you speak
- ◆ leans toward a sound or requires voices or music to be louder than normal
- ◆ appears confused or frustrated when asked to try something new
- ◆ by age six, cannot dress self
- ◆ by age six, cannot identify shapes or colors
- ◆ by age six, cannot follow simple rules or directions
- ◆ by age seven, cannot print own name without help
- ◆ by age seven, cannot count from one to 100
- ◆ needs to have new ideas repeated often and in many different ways
- ◆ fights often with other children
- ◆ is unusually shy or withdrawn
- ◆ fears new experiences and people
- ◆ is unable to handle changes
- ◆ is often depressed and unhappy
- ◆ is unable to receive or show affection
- ◆ refuses to eat for a long period of time
- ◆ lies, cheats, or steals frequently
- ◆ is constantly negative about self, school, day care, or home

## **The Adolescent:**

- ◆ misses school on a regular basis but is not ill
- ◆ has not developed signs of puberty by age 16
- ◆ at age 16, is markedly shorter than peers
- ◆ is very quick to show anger and has a violent temper
- ◆ stays away from home for days at a time without word of whereabouts
- ◆ is frequently disciplined at school for misbehavior
- ◆ has been arrested
- ◆ stays alone most of the time
- ◆ has few friends
- ◆ has poor relationships with peers
- ◆ has no appetite or prolonged loss of appetite
- ◆ is generally sluggish, tired, and has little energy
- ◆ mutilates self by cutting, burning, and/or branding
- ◆ abuses drugs and/or alcohol
- ◆ has excessive need to control others
- ◆ engages in risky behaviors such as high-speed driving, unprotected sex, binge drinking
- ◆ verbally or physically hurts boyfriends or girlfriends
- ◆ bullies his or her friends or others
- ◆ is cruel to younger children or to animals
- ◆ has very low self-esteem or very negative self-image
- ◆ has very poor hygiene
- ◆ hoards food
- ◆ binges and purges
- ◆ starves self
- ◆ is sexually promiscuous (especially a younger teen)

# Long-Range Effects of Lack of Normal Attachment

## Psychological or Behavioral Problems

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### Conscience Development

1. May not show normal anxiety following aggressive or cruel behavior.
2. May not show guilt about breaking laws or rules.
3. May project blame onto others.

### Impulse Control

1. Exhibits poor control; depends upon others to provide external controls on behavior.
2. Exhibits lack of foresight.
3. Has a poor attention span.

### Self-Esteem

1. Is unable to get satisfaction from tasks well done.
2. Sees self as undeserving.
3. Sees self as incapable of change.
4. Has difficulty having fun.

### Interpersonal Interactions

1. Lacks trust in others.
2. Demands affection but lacks depth in relationships.
3. Exhibits hostile dependency.
4. Needs to be in control of all situations.
5. Has impaired social maturity.

**Source:** Armand Lauffer, director of Project Craft, *Training in the Adoption of Children with Special Needs*, Ann Arbor, MI: University of Michigan, School of Social Work, 1980. Permission granted by Dr. Lauffer.

## **Emotions**

1. Has trouble recognizing own feelings.
2. Has difficulty expressing feelings appropriately, especially anger, sadness, and frustration.
3. Has difficulty recognizing feelings in others.

## **Cognitive Problems**

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1. Has trouble with basic cause and effect.
2. Experiences problems with logical thinking.
3. Appears to have confused thought processes.
4. Has difficulty thinking ahead.
5. May have an impaired sense of time.
6. Has difficulties with abstract thinking.

## **Developmental Problems**

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1. May have difficulty with auditory processing.
2. May have difficulty expressing self well verbally.
3. May have gross motor problems.
4. May experience delays in personal-social development.
5. May have inconsistent levels of skill in all of these areas.

## **“Red Flag” Behaviors**

If any of these behaviors are observed, discuss them with the child's caseworker and other members of the permanency team. It is important for caregivers to ensure child safety while working to identify possible unmet needs behind any particular behavior(s).

Attempts to control everything and everyone

Lacks guilt or anxiety after doing something wrong

Refuses to accept responsibility for own actions

Bullies or hurts smaller or younger children

Hurts house pets or other small animals

Starts fires

Resists affection and comfort, even when hurt or ill

Does not think logically

Has difficulty in expressing or understanding personal feelings

Has difficulty in expressing or understanding the feelings of others

Has difficulty in experiencing fun, feelings of accomplishment, and/or pride in jobs well done

Steals, lies, and “uses” other people

# Impact of Placement on Children's Self-Concept\*

**Self-Concept:** The set of beliefs which a person has about himself or herself, which evolves out of relationships with others over a period of time. These beliefs shape the way one feels, thinks, and behaves in relation to oneself and others. Self-concept has four primary characteristics:

lovable

capable

worthwhile

responsible

**Lovable:** What makes you feel lovable? What makes children feel lovable? When children feel lovable, how do they show it? How do children let you know they feel unlovable? How might foster care placement make a child feel unlovable? What can caretakers and social workers do to help children feel more lovable?

**Capable:** When do you feel capable? What makes children feel capable? How do children demonstrate that they feel capable? How do they behave when they do not feel capable? How might placement make a child feel not capable? What can we do to help children feel more capable?

**Worthwhile:** What makes you feel worthwhile? What makes children feel worthwhile? How do children demonstrate that they feel worthwhile? How do they behave when they do not feel worthwhile? How might foster care placement make a child feel not worthwhile? What can caretakers and social workers do to help youth in foster care feel more worthwhile?

**Responsible:** When do you feel responsible? What makes children feel responsible? Why would children in foster care not feel responsible or even want to be responsible? How does placement make a child feel not responsible? What can we do to help youth in foster care feel more responsible?

Which of the above four characteristics might be the easiest to instill? Which might be the most difficult? As a caretaker, where would you begin?

\* Adapted from **Foster Parent Training: A Curriculum and Resource Manual**, by Michael E. Polowy, Daniel Wasson, and Mary Wolf. New York State Child Welfare Training Institute. State University College at Buffalo, ©1985.

# The Double Trauma of Sexual Abuse and Placement

## Abandonment

### Sexual Abuse Trauma

The child experiences emotional abandonment, especially if the child is not believed about the sexual abuse.

The child experiences loss of normalcy. The child feels different and abnormal; the taboo of sexual abuse has been broken, and others know about it.

### Placement Trauma

The child feels abandonment or loss. The child feels lost, alone, and isolated.

## Rejection

### Sexual Abuse Trauma

The child experiences *actual* rejection. The child may not be believed by family members or may be blamed for the family's difficulties.

### Placement Trauma

The child *perceives* rejection; in other words, the child may feel rejected even if he or she is living with caretakers who want him or her to be with them. The child feels alone and believes he or she is not wanted by the foster family.

## Shame

### Sexual Abuse Trauma

The child feels ashamed because others know about the sexual abuse. The child has to talk about the abuse many times and has to go through physical examination.

### Placement Trauma

The child feels ashamed at being different and at being a foster child. The child feels everyone will know because his or her last name is not the same as the caretaker's name.

## **Guilt**

### **Sexual Abuse Trauma**

The child takes responsibility for the abuse. The child believes himself or herself to be defective in some way and believes others can tell he or she has been sexually abused just by looking at him or her. The child feels “dirty.”

The child may experience guilt about not having stopped the abuse sooner, about “breaking up the family,” or about reporting the abuse. The child may actually believe that he or she betrayed the abuser.

### **Placement Trauma**

The child believes himself or herself to be somehow responsible for placement.

The child who is placed in foster care may feel he or she caused the placement and so may feel responsible for the pain of others.

## **Anger**

### **Sexual Abuse Trauma**

In incest cases, the child may feel anger toward both the abusive parent and the non-abusive parent, who may be seen as not having been protective. This anger often goes unexpressed, however, and the child blames himself or herself for what has happened.

### **Placement Trauma**

The child often holds inside or hides his or her anger toward family members for their role in the child's being placed in foster care. The child may instead feel angry with himself or herself for placement. The child may believe that he or she did something to cause placement and is unable to see the family's role.

## **Denial**

### **Sexual Abuse Trauma**

The child may recant by saying, “I was kidding. It didn't really happen.” The child may claim that the abuse never really occurred or may stop discussing the abuse. Often this occurs when the family is pressuring the child to keep the abuse a secret or is threatening the child.

### **Placement Trauma**

*Denial* means to hide feelings. The child may not be willing or able to discuss how he or she is feeling. The child may deny any feelings of sadness, anger, or other emotions.

## **Fear**

### **Sexual Abuse Trauma**

Sexually abused children may develop very specific, unrealistic fears (phobias) related to the abuse. For example, the child may be fearful of the bath, of being read to in bed, or of particular objects. The normal fears that many young children have, such as fear of dogs, may be heightened in an insecure child. A key issue to consider when evaluating a child's fear is whether the fear interferes with daily life. Is the child unable to form relationships or go about daily activities because of the intensity of the fear?

Some children have an extreme fear of another loss of a person with whom they have a significant attachment. They may anticipate such a separation after the loss of a birth family or even after the loss of a sexual abuser to whom they felt overly close. The term “existential terror” is used when discussing the impact upon a child of sexual abuse by a family member. The child may experience extreme separation dread to the point that the child's ability to survive is questionable. This is not something the child is able to express verbally or perhaps even to think about. However, the child's feelings are very strong and may be similar to the way an adult might feel when imagining his or her own death during the night. These feelings may persist for children who suddenly feel they have no one at all to count on.

Children within a dysfunctional family may be unable to develop a sense of self or of wholeness. The child becomes less able to develop a separate identity. Individuation is the process of becoming an individual with a distinct personality and the ability to think for oneself. It is important for young people during adolescence to develop identities separate from their parents or caregivers. Teenagers often express their own uniqueness through their style of dress, hair, and language. They begin to assert themselves as people separate from their parents and their parents' generation. This process is very important if one is to grow and become a productive and confident member of society; however, children who have been sexually abused often have difficulty in carrying out this stage of development.

### **Placement Trauma**

The child feels generalized fearfulness because in any loss, the child fears additional loss. Fear the child already feels is made worse by placement into foster care. The child will often display an increase in symptoms after the “honeymoon” (the early period of foster care placement) is over. The child may experience nightmares or night terrors, generalized anxiety or specific fears.

A child feels tension when faced with separating from a person to whom the child is attached. The child, particularly younger children, may experience intense fear or worry about further separations. Studies seem to indicate that many phobias among children are related to separation issues. Some examples of phobias are fear of certain types of people (white men), places (dark rooms), or things (the smell of alcohol, tobacco, body odor, or cologne). Such specific situations as these may act as triggers for the child to experience flashbacks of the abuse.

## **Thoughts of Death**

### **Sexual Abuse Trauma**

The child may consider suicide as a way out of a bad situation. The child may make comments about life not being worth living or may threaten to commit suicide. Caretakers should take such comments very seriously and should immediately report them to the caseworker, health provider, or mental health provider.

### **Placement Trauma**

When a child is placed into foster care, he or she experiences intense separation issues; in other words, the child feels extreme emotions when separated from family and home. Many children may experience these intense separation issues as a kind of death. They may actually have death fantasies or wishes at the time of placement and for quite a while thereafter. A child may in fact believe he or she will be unable to survive outside the birth family.

## **Helplessness**

### **Sexual Abuse Trauma**

The child had no control or choice about the abuse. Yet at times the child may believe that he or she did have some choice or control and might have been able to stop it. The child may feel that he or she participated in the abuse (or others may accuse him or her of this), especially if the child accepted bribes, special treats, or favors as part of the abuse. Although the child is helpless against the adult's power to force, threaten, influence, or manipulate him or her, the child holds himself or herself responsible for the abuse.

### **Placement Trauma**

Children may feel they have no control over their fate. The placement is beyond the child's control; in most cases the child is not consulted, rather the child is simply told the placement will occur. The child has no idea if or when he or she will be able to return home. The future is unclear and frightening. Even in an adoptive situation, the child must adjust to the idea of a "new family" and must struggle to fit in.

## Repeating Familiar Pain

### Sexual Abuse Trauma

The word *counterphobic* means that sometimes people will behave in a way that helps them counteract a fear. Thus, sometimes a person will attempt to recreate or repeat a painful situation in order to ward off fear or to cope with or accept something difficult. For example, adults sometimes replay in their minds a painful mistake they made. By thinking about it and “reliving” it over and over, they may be able to dull these feelings or even resolve them. Sometimes, however, this is not an effective way to overcome fear. Sexually abused children sometimes recreate the abuse scene in an attempt to deal with what has happened to them. They may interact with other children in a sexual way, masturbate frequently, or even attempt to recreate the abuse with another adult. The child has been taught to interact sexually, so the child continues to carry out those learned behaviors.

### Placement Trauma

Children in placement often have a need to recreate the atmosphere in their birth family or family of origin. Thus, some children may actively seek rejection or may attempt to provoke negative responses from the adults around them. Although children may fear these reactions, they are familiar with them and, therefore, find them comfortable and predictable.

## Expecting Punishment

### Sexual Abuse Trauma

Some older children with a religious background may be very concerned about having sinned. They believe themselves to be responsible for the abuse and, therefore, believe they will be punished by God or adults and will never find happiness. They believe they will never be loved by their parents again and will never go home.

### Placement Trauma

The child may expect to be punished because of the anger he or she feels toward the birth parents.

## **Effects of Sexual Abuse**

- ◆ Guilt
- ◆ Fear and betrayal
- ◆ Low self-esteem and poor social skills
- ◆ Being shocked by the sexual abuse (traumatic sexualization)
- ◆ Acting older (pseudomaturity) and not being able to grow up and develop as most children do (failure to complete developmental tasks)

# Emotions and Behaviors of Children Who Have Been Sexually Abused\*

## Emotions

- ◆ Sadness
- ◆ Anger
- ◆ Anxiety
- ◆ Fear
- ◆ Confusion
- ◆ Guilt
- ◆ Mistrust
- ◆ Worthlessness (“damaged goods”)
- ◆ Powerlessness
- ◆ Helplessness
- ◆ Denial\*
- ◆ Loneliness
- ◆ Shame\*

## Behaviors

- ◆ Running away
- ◆ Substance abuse\*
- ◆ Suicide
- ◆ Immature behavior (such as thumb sucking, soiling, wetting)
- ◆ Sexual behavior beyond the child's age
- ◆ School problems or fears
- ◆ Afraid of people of the same sex and age as the person who abused
- ◆ Nightmares and night terrors
- ◆ Sleep difficulties
- ◆ Excessively active
- ◆ Afraid of places similar to where the abuse occurred

\* These emotions and behaviors are also very common in children where there is addiction in the family.

# The Grieving Process

## Stage 1: Shock/Denial

### Feelings

Disbelief  
Confusion  
Silliness  
Vulnerability  
Numbness  
Anxiety  
Panic  
Guilt

### Behaviors

Shows few reactions  
Becomes silent, withdrawn  
Appears confused and in a trance  
Seems “robot like,” even when playing  
Acts silly  
Refuses to eat  
Has night terrors and/or sleep disruptions  
Refuses to talk about anything to do with the placement (covers ears, etc.)  
May create a fantasy about the reason(s) for being in care  
Engages in repetitive, rhythmic behaviors (bouncing a ball over and over, etc.)



## Stage 2: Anger

### Feelings

Anger  
Rage  
Powerlessness  
Being out of control

### Behaviors

Runs away  
Becomes physically ill (vomits, has headaches, etc.)  
Becomes hyperactive  
Has tantrums and destroys property  
Attempts to hurt self or others  
Begins/resumes bedwetting  
Tries to hurt self  
Changes personal care habits (does not bathe, brush teeth, etc.)  
Acts out sexually and/or engages in high-risk behaviors such as drug and/or alcohol abuse



## Stage 3: Bargaining

### Feelings

Hopefulness

### Behaviors

Does everything the caretaker or caseworker asks

May get sick and refuse to get well unless allowed to go home

Seeks or returns to religious beliefs (older children)



## Stage 4: Despair

### Feelings

Hopelessness

Helplessness

Abandonment

Loneliness

### Behaviors

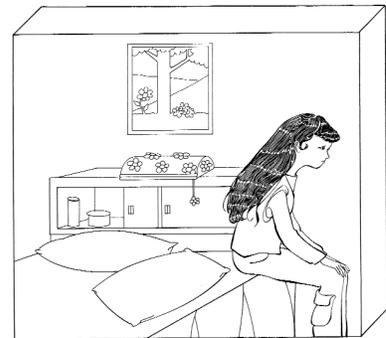
Gives up or stops trying

Shows signs of depression

Has no energy

Increases or loses appetite and/or sleep

Fails or falls off in schoolwork



## Stage 5: Acceptance/Understanding

### Feelings

Lovable

Worthwhile

Capable

Responsible

### Behaviors

Forms new friendships and attachments, particularly with adults

Accepts new situations more easily

Participates in placement setting life more readily and comfortably

Talks about parents and siblings without being overwhelmed by powerful feelings

Shows energy and enthusiasm for school, sports, outside interests, and or hobbies (older children)



## Child Sexual Abuse Accommodation Syndrome

Children caught up in sexual abuse are too overwhelmed to know what is happening. They find ways to adjust, however. Their immediate survival requires that they make adjustments, which can often be predicted, but which also often can be misinterpreted. These often predictable adjustments, called Child Sexual Abuse Accommodation Syndrome, are recognized by clinicians and by courts in many states.

Stage	Statements, Behaviors of Adult Who Abused	Emotions the Child Feels	Child's Behavior	Common Myths About Child
<b>1. Secrecy</b>	<p>"What we are doing is good, but other people would not understand."</p> <p>"Your parents would be angry with us if you told."</p> <p>"You'll destroy the family if you tell."</p>	<p>Child is dependent on adult for definition of experience.</p> <p>Most consistent and meaningful impression—one of anger and secrecy.</p> <p>Secrecy carries both threat and promise of safety.</p>	<p>Most children tell no one during childhood.</p>	<p>Many people might expect a child's "normal" reaction would be to tell caregivers.</p>
<b>2. Helplessness</b>	<p>Adult explores body while child is alone or asleep.</p> <p>Adult seeks opportunity when child is unprotected.</p>	<p>Child is helpless, faced with loss of love or family security.</p> <p>Child has no way to make sense of this and no acceptable way to describe it to others.</p>	<p>Most children play possum, roll over or pull up the covers, but do not cry out for help.</p>	<p>Many might expect a child's "normal" reaction would be to resist, escape, or cry out.</p>
<b>3. Entrapment and accommodation</b>	<p>Adult repeats behaviors and falls into pattern of guilt, followed by inability to stop.</p> <p>"This does no harm."</p>	<p>The option to stop the abuse gets more remote. Child must adjust to increasing sexual demands and long-term betrayal by trusted adult.</p> <p>Sex is a "normal" way to relate to people.</p>	<p>Child adjusts to a profoundly painful adult environment.</p> <p>Deep daydreams (dissociation).</p> <p>Child becomes caretaker of the adult's needs.</p>	<p>Many might expect a "normal" child would eventually say "no" or report the situation.</p>
<b>4. Delayed, conflicted, and unconvincing disclosure</b>	<p>Adult ignores or denies child's efforts to disclose.</p> <p>As child reaches adolescence, abuser becomes jealous and possessive.</p>	<p>The younger child is eager to please—an achiever.</p> <p>As child enters adolescence, increasingly feels angry.</p>	<p>A younger child may disclose if he or she feels trust in a safe attachment.</p> <p>Child discloses in anger or out of an increasing sense of independence as enters adolescence.</p>	<p>Many may believe the fact that the child disclosed in anger makes him or her less credible. If it is true, the disclosure should be convincing.</p>
<b>5. Retraction</b>	<p>Child's unconvincing disclosure is met with increased anger, blame, and punishment. Child is blamed for the whole situation.</p> <p>"You shouldn't have lied!"</p>	<p>Child's worst fears about disclosure are confirmed. Ambivalence and guilt increase.</p>	<p>Child retracts complaint with a lie about why he or she made up the accusation.</p>	<p>Rebellious children use false allegations to destroy well-meaning parents. Children cannot be trusted to tell the truth.</p>

\* Adapted from Summit, Roland. "Child Sexual Abuse Accommodation Syndrome." *Child Abuse and Neglect*, 7, 1983, pp. 177-193; and from Tilley, Betty. *Judicial Desk Reference on Child Sexual Abuse*. The Bridge Family Center of Atlanta, GA, 1987.

# **Most Frequent and Bothersome Behaviors\***

## **Most Frequent Problems for Caretakers**

- ◆ Child's exposure of private parts in public
- ◆ Harassment by the person who abused child
- ◆ Child's compulsive or public masturbation
- ◆ Child's suicide attempts
- ◆ Child's self-mutilation

## **Most Bothersome Problems for Caretakers**

- ◆ Child's seductive behavior with caretaker
- ◆ Child's seductive behavior with peers
- ◆ Child's promiscuous behavior with peers
- ◆ Child's school problems

## **Behaviors Most Likely to Result in a Change of Placement**

- ◆ Seductive behavior
- ◆ Aggressive behavior
- ◆ Alcohol and drug abuse
- ◆ Suicide attempts
- ◆ Running away

\* Thompson, Ronald and Authier, Karen. *Behavior Problems of Sexually Abused Children in Foster Care*. Boys Town, Nebraska, 1990.

## **Most Frequent Behavior Problems by Age Group**

### **Preschool**

- ◆ Compulsive masturbation
- ◆ Aggressive behavior
- ◆ Clinging behavior

### **School Age**

- ◆ Bed-wetting
- ◆ Aggressive behavior
- ◆ School problems
- ◆ Clinging behavior

### **Adolescence**

- ◆ Suicide threats
- ◆ Promiscuous behavior
- ◆ Alcohol and drug abuse
- ◆ School problems

# focal. point

research, policy, & practice  
in children's mental health

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## Traumatic Stress/ Child Welfare



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# Traumatic Stress and the Child Welfare System

**T**raumatic events cause overwhelming feelings of terror, horror, or hopelessness. These kinds of feelings often occur when a person experiences or witnesses a serious injury, or witnesses a death. A person may also be traumatized by threats of injury or death, or by experiencing other forms of attack or violation. Child traumatic stress occurs when exposure to traumatic events overwhelms the child's ability to cope.



This issue of *Focal Point* focuses on child traumatic stress, particularly the kinds of stress most commonly found among children and adolescents who are involved with the child welfare system. We (the RTC on Family Support and Children's Mental Health at Portland State University) and the National Child Traumatic Stress Network (NCTSN) have worked together to provide this summary of what is currently known about the effects of child traumatic stress and the most effective treatments.

Traumatic stress can arise in the context of war, endemic community violence, or natural disaster. In this issue, however, we focus on traumatic stress that arises in the context of families and within the systems that are designed to protect children when their families cannot. Children who enter the child welfare system are typically affected by abuse, neglect, and/or domestic violence. If they are removed from their homes, they often face further traumas that are caused by efforts to remedy the situation. Children's relationships with caregivers and other family members are ruptured, they are uprooted from friendships and familiar surroundings, and their daily routines are destroyed. Often, children face ongoing uncertainty and instability that can

continue for years.

We know that a strong relationship with a caregiver is by far the most potent buffer against child traumatic stress. This is precisely the asset that children involved with child welfare typically lack. When children lack a secure bond with a caregiver, they are highly vulnerable to the immediate effects of trauma. Additionally, when traumatic stress is left untreated—or when it is compounded by ongoing experiences of instability and uncertainty in the absence of a strong attachment to a caregiver—problems begin to multiply and can impact every area of a child's functioning. Cognitive, attentional, and emotional resources that are normally devoted to learning, exploring, and developing are instead devoted to coping and survival strategies. While these strategies may work to protect the child in the short run, they are often maladaptive in the long run, resulting in problems with forming healthy attachments, regulating attention and emotion, and learning. In turn, these cascading problems leave children vulnerable to further traumas and victimization, and increase the likelihood of school failure, substance abuse, and involvement in antisocial activity.

Later on in their lives, we may encounter these young people as "multi-system kids": runaways, delinquents,

substance abusers, and dropouts, often carrying labels like "oppositional defiant" or "conduct disordered." We also encounter other youth with similar problems, many of whom experienced abuse, neglect, domestic violence, or other traumatic stressors but who did not come to the attention of child protective services. As adolescents, these young people may appear undeserving of sympathy. It is easy to

see them as willfully "bad" kids, and often they are not particularly receptive to our efforts to help.

Intervening early and effectively can help traumatized children recover. Even severely traumatized children like Aaron Weaver (page 9 in this issue) can thrive when they find safety and love, and when they have opportunities to learn how to manage the enduring aftereffects of trauma. Understanding the ways that traumatic experiences impact young people can make us more alert to possible traumas that lurk in the life histories of "bad" and highly troubled adolescents we encounter in human service settings. Being knowledgeable about child traumatic stress can help us respond more sympathetically and responsively to their needs. The goal of this *Focal Point* issue is to help build the knowledge and understanding that supports effective efforts to help young people recover from the effects of trauma.

*By Janet S. Walker and Aaron Weaver*

*Special thanks to Susan Ko of the NCTSN for helping make this issue possible.*

# Complex Trauma in Children and Adolescents

The term *complex trauma* describes the dual problem of children's exposure to multiple traumatic events and the impact of this exposure on immediate and long-term outcomes. Typically, complex trauma exposure results when a child is abused or neglected, but it can also be caused by other kinds of events such as witnessing domestic violence, ethnic cleansing, or war. Many children involved in the child welfare system have experienced complex trauma.

Often, the consequences of complex trauma exposure are devastating for a child. This is because complex trauma exposure typically interferes with the formation of a secure attachment bond between a child and her caregiver. Normally, the attachment between a child and caregiver is the primary source of safety and stability in a child's life. Lack of a secure attachment can result in a loss of core capacities for self-regulation and interpersonal relatedness. Children exposed to complex trauma often experience lifelong problems that place them at risk for additional trauma exposure and other difficulties, including psychiatric and addictive disorders, chronic medical illness, and legal, vocational, and family problems. These difficulties may extend from childhood through adolescence and into adulthood.

The diagnosis of posttraumatic stress disorder (PTSD) does not cap-



ture the full range of developmental difficulties that traumatized children experience. Children exposed to maltreatment, family violence, or loss of their caregivers often meet diagnostic criteria for depression, attention-deficit/hyperactivity disorder (ADHD), oppositional defiant disorder (ODD), conduct disorder, anxiety disorders, eating disorders, sleep disorders, communication disorders, separation anxiety disorder, and/or reactive attachment disorder. Yet each of these diagnoses captures only a limited aspect of the traumatized child's complex self-regulatory and relational difficulties. A more comprehensive view of the impact of complex trauma

can be gained by examining trauma's impact on a child's growth and development.

## Impact on Development

A comprehensive review of the literature suggests seven primary domains of impairment observed in children exposed to complex trauma. Each of the seven domains is discussed below.

### Attachment

Complex trauma is most likely to develop if an infant or child is exposed to danger that is unpredictable or uncontrollable, because the child's body must devote resources that are normally dedicated to growth and development instead to survival. The greatest source of danger and unpredictability is the absence of a caregiver who reliably and responsively protects and nurtures the child. The early caregiving relationship provides the primary context within which children learn about themselves, their emotions, and their relationships with others. A secure attachment supports a child's development in many essential areas, including his capacity for regulating physical and emotional states, his sense of safety (without which he will be reluctant to explore his environment), his early knowledge of how to exert an influence on the world, and his early capacity for communication.

When the child-caregiver relationship is the source of trauma, the at-

tachment relationship is severely compromised. Caregiving that is erratic, rejecting, hostile, or abusive leaves a child feeling helpless and abandoned. In order to cope, the child attempts to exert some control, often by disconnecting from social relationships or by acting coercively towards others. Children exposed to unpredictable violence or repeated abandonment often learn to cope with threatening events and emotions by restricting their processing of what is happening around them. As a result, when they confront challenging situations, they cannot formulate a coherent, organized response. These children often have great difficulty regulating their emotions, managing stress, developing concern for others, and using language to solve problems. Over the long term, the child is placed at high risk for ongoing physical and social difficulties due to:

1. Increased susceptibility to stress (e.g., difficulty focusing attention and controlling arousal),
2. Inability to regulate emotions without outside help or support (e.g., feeling and acting overwhelmed by intense emotions), and
3. Inappropriate help-seeking (e.g., excessive help-seeking and dependency or social isolation and disengagement).

### *Biology*

Toddlers or preschool-aged children with complex trauma histories are at risk for failing to develop brain capacities necessary for regulating emotions in response to stress. Trauma interferes with the integration of left and right hemisphere brain functioning, such that a child cannot access rational thought in the face of overwhelming emotion. Abused and neglected children are then prone to react with extreme helplessness, confusion, withdrawal, or rage when stressed.

In middle childhood and adolescence, the most rapidly developing brain areas are those that are crucial for success in forming interpersonal relationships and solving problems. Traumatic stressors or deficits in self-regulatory abilities impede this development, and can lead to difficulties in

emotional regulation, behavior, consciousness, cognition, and identity formation.

It is important to note that supportive and sustaining relationships with adults—or, for adolescents, with peers—can protect children and adolescents from many of the consequences of traumatic stress. When interpersonal support is available, and when stressors are predictable, escapable, or controllable, children and adolescents can become highly resilient in the face of stress.

### *Affect Regulation*

Exposure to complex trauma can lead to severe problems with affect regulation. Affect regulation begins with the accurate identification of internal emotional experiences. This requires the ability to differentiate among states of arousal, interpret these states, and apply appropriate labels (e.g. “happy,” “frightened”). When children are provided with inconsistent models of affect and behavior (e.g., a smiling expression paired with rejecting behavior) or with inconsistent responses to affective display (e.g., child distress is met inconsistently with anger, rejection, nurturance, or neutrality), no coherent framework is provided through which to interpret experience.

Following the identification of an

abuse).

The existence of a strong relationship between early childhood trauma and subsequent depression is well-established. Recent twin studies, considered one of the highest forms of clinical scientific evidence because they can control for genetic and family factors, have conclusively documented that early childhood trauma, especially sexual abuse, dramatically increases risk for major depression, as well as many other negative outcomes. Not only does childhood trauma appear to increase the risk for major depression, it also appears to predispose toward earlier onset of depression, as well as longer duration, and poorer response to standard treatments.

### *Dissociation*

Dissociation is one of the key features of complex trauma in children. In essence, dissociation is the failure to take in or integrate information and experiences. Thus, thoughts and emotions are disconnected, physical sensations are outside conscious awareness, and repetitive behavior takes place without conscious choice, planning, or self-awareness. Although dissociation begins as a protective mechanism in the face of overwhelming trauma, it can develop into a problematic disorder. Chronic trauma exposure may

*The early caregiving relationship provides the primary context within which children learn about themselves, their emotions, and their relationships with others.*

emotional state, a child must be able to express emotions safely and to adjust or regulate internal experience. Complexly traumatized children show impairment in both of these skills. Because they have difficulty in both self-regulating and self-soothing, these children may display dissociation, chronic numbing of emotional experience, dysphoria and avoidance of emotional situations (including positive experiences), and maladaptive coping strategies (e.g., substance

lead to an over-reliance on dissociation as a coping mechanism that, in turn, can exacerbate difficulties with behavioral management, affect regulation, and self-concept.

### *Behavioral Regulation*

Complex childhood trauma is associated with both under-controlled and over-controlled behavior patterns. As early as the second year of life, abused children may demonstrate rig-

idly controlled behavior patterns, including compulsive compliance with adult requests, resistance to changes in routine, inflexible bathroom rituals, and rigid control of food intake. Childhood victimization also has been shown to be associated with the development of aggressive behavior and oppositional defiant disorder.

An alternative way of understanding the behavioral patterns of chronically traumatized children is that they represent children's defensive adaptations to overwhelming stress. Children may reenact behavioral aspects of their trauma (e.g., through aggression, or self-injurious or sexualized behaviors) as automatic behavioral reactions to trauma reminders or as attempts to gain mastery or control over their experiences. In the absence of more advanced coping strategies, traumatized children may use drugs or alcohol in order to avoid experiencing intolerable levels of emotional arousal. Similarly, in the absence of knowledge of how to form healthy interpersonal relationships, sexually abused children may engage in sexual behaviors in order to achieve acceptance and intimacy.

### Cognition

Prospective studies have shown that children of abusive and neglectful parents demonstrate impaired cognitive functioning by late infancy when compared with nonabused children. The sensory and emotional deprivation associated with neglect appears to be particularly detrimental to cognitive development; neglected infants and toddlers demonstrate delays in expressive and receptive language development, as well as deficits in overall IQ. By early childhood, maltreated children demonstrate less flexibility and creativity in problem-solving tasks than same-age peers. Children and adolescents with a diagnosis of PTSD secondary to abuse or witnessing violence demonstrate deficits in attention, abstract reasoning, and problem solving.

By early elementary school, maltreated children are more frequently referred for special education services. A history of maltreatment is asso-

ciated with lower grades and poorer scores on standardized tests and other indices of academic achievement. Maltreated children have three times the dropout rate of the general population. These findings have been demonstrated across a variety of trauma exposures (e.g., physical abuse, sexual abuse, neglect, and exposure to domestic violence) and cannot be accounted for by the effects of other psychosocial stressors such as poverty.



### Self-Concept

The early caregiver relationship has a profound effect on a child's development of a coherent sense of self. Responsive, sensitive caretaking and positive early life experiences allow a child to develop a model of self as generally worthy and competent. In contrast, repetitive experiences of harm and/or rejection by significant others and the associated failure to develop age-appropriate competencies are likely to lead to a sense of self as ineffective, helpless, deficient, and unlovable. Children who perceive themselves as powerless or incompetent and who expect others to reject and despise them are more likely to blame themselves for negative experiences and have problems eliciting and responding to social support.

By 18 months, maltreated toddlers already are more likely to respond to self-recognition with neutral or

negative affect than nontraumatized children. In preschool, traumatized children are more resistant to talking about internal states, particularly those they perceive as negative. Traumatized children have problems estimating their own competence. Early exaggerations of competence in preschool shift to significantly lowered estimates of self-competence by late elementary school. By adulthood, they tend to suffer from a high degree of self-blame.

### Family Context

The family, particularly the child's mother, plays a crucial role in determining how the child adapts to experiencing trauma. In the aftermath of trauma, family support and parents' emotional functioning strongly mitigate the development of PTSD symptoms and enhance a child's capacity to resolve the symptoms.

There are three main elements in caregivers' supportive responses to their children's trauma:

1. Believing and validating the child's experience,
2. Tolerating the child's affect, and
3. Managing the caregiver's own emotional response.

When a caregiver denies the child's experiences, the child is forced to act as if the trauma did not occur. The child also learns she cannot trust the primary caregiver and does not learn to use language to deal with adversity. It is important to note that it is not caregiver distress per se that is necessarily detrimental to the child. Instead, when the caregiver's distress overrides or diverts attention away from the needs of the child, the child may be adversely affected. Children may respond to their caregiver's distress by avoiding or suppressing their own feelings or behaviors, by avoiding the caregiver altogether, or by becoming "parentified" and attempting to reduce the distress of the caregiver.

Caregivers who have had impaired relationships with attachment figures in their own lives are especially vulnerable to problems in raising their own children. Caregivers with histories of childhood complex trauma

may avoid experiencing their own emotions, which may make it difficult for them to respond appropriately to their child's emotional state. Parents and guardians may see a child's behavioral responses to trauma as a personal threat or provocation, rather than as a reenactment of what happened to the child or a behavioral representation of what the child cannot express verbally. The victimized child's simultaneous need for and fear of closeness also can trigger a caregiver's own memories of loss, rejection, or abuse, and thus diminish parenting abilities.

### Ethnocultural Issues

Children's risk of exposure to complex trauma, as well as child and family responses to exposure, can also be affected by where they live and by their ethnocultural heritage and traditions. For example, war and genocide are prevalent in some parts of the world, and inner cities are frequently plagued with high levels of violence and racial tension. Children, parents, teachers, religious leaders, and the media from different cultural, national, linguistic, spiritual, and ethnic backgrounds define key trauma-related constructs in many different ways and with different expressions. For example, flashbacks may be "visions," hyperarousal may be "un ataque de nervios," and dissociation may be "spirit possession." These factors become important when considering how to treat the child.

### Resilience Factors

While exposure to complex trauma has a potentially devastating impact on the developing child, there is also the possibility that a victimized child may function well in certain domains while exhibiting distress in others. Areas of competence also can shift as children are faced with new stressors and developmental challenges. Several factors have been shown to be linked to children's resilience in the face of stress: positive attachment and connections to emotionally supportive and competent adults within the family or community, development of cognitive and self-regulation abilities, and positive beliefs about oneself and

motivation to act effectively in one's environment. Additional individual factors associated with resilience include an easygoing disposition, positive temperament, and sociable demeanor; internal locus of control and external attributions for blame; effective coping strategies; a high degree of mastery and autonomy; special talents; creativity; and spirituality.

The greatest threats to resilience appear to follow the breakdown of protective systems. This results in damage to brain development and associated cognitive and self-regulatory capacities, compromised caregiver-child relationships, and loss of motivation to interact with one's environment.

### Assessment and Treatment

Regardless of the type of trauma that leads to a referral for services, the first step in care is a comprehensive assessment. A comprehensive assessment of complex trauma includes information from a number of sources, including the child's or adolescent's own disclosures, collateral reports from caregivers and other providers, the therapist's observations, and standardized assessment measures that have been completed by the child, caregiver, and, if possible, by the child's teacher. Assessments should be culturally sensitive and language-appropriate. Court evaluations, where required, must be conducted in a forensically sound and clinically rigorous manner.

The National Child Traumatic Stress Network is a partnership of organizations and individuals committed to raising the standard of care for traumatized children nationwide. The Complex Trauma Workgroup of the National Child Traumatic Stress Network has identified six core components of complex trauma intervention:

1. *Safety*: Creating a home, school, and community environment in which the child feels safe and cared for.

2. *Self-regulation*: Enhancing a child's capacity to modulate arousal and restore equilibrium following dysregulation of affect, behavior, physiology, cognition, interpersonal relatedness and self-attribution.

3. *Self-reflective information processing*: Helping the child construct self-narratives, reflect on past and present experience, and develop skills in planning and decision making.

4. *Traumatic experiences integration*: Enabling the child to transform or resolve traumatic reminders and memories using such therapeutic strategies as meaning-making, traumatic memory containment or processing, remembrance and mourning of the traumatic loss, symptom management and development of coping skills, and cultivation of present-oriented thinking and behavior.

5. *Relational engagement*: Teaching the child to form appropriate attachments and to apply this knowledge to current interpersonal relationships, including the therapeutic alliance, with emphasis on development of such critical interpersonal skills as assertiveness, cooperation, perspective-taking, boundaries and limit-setting, reciprocity, social em-



pathy, and the capacity for physical and emotional intimacy.

6. *Positive affect enhancement*: Enhancing a child's sense of self-worth, esteem and positive self-appraisal through the cultivation of personal creativity, imagination, future orientation, achievement, competence, mastery-seeking, community-building and the capacity to experience pleasure.

In light of the many individual and contextual differences in the lives of children and adolescents affected by complex trauma, good treatment requires the flexible adaptation of treatment strategies in response to such factors as patient age and developmental stage, gender, culture and ethnicity, socioeconomic status, and religious or community affiliation. However, in general, it is recommended that treatment proceed through a series of phases that focus on different goals. This can help avoid overloading children—who may well already have cognitive difficulties—with too much information at one time. A phase-based approach begins with a focus on providing safety, typically followed by teaching self-regulation. As children's capacity to identify, modulate and express their emotions stabilizes, treatment focus increasingly incorporates self-reflective information processing, relational engagement, and positive affect enhancement. These addition-

al components play a critical role in helping children to develop in positive, healthy ways, and to avoid future trauma and victimization.

While it may be beneficial for some children affected by complex trauma to process their traumatic memories, this typically can only be successfully undertaken after a substantial period of stabilization in which internal and external resources have been established. Notably, several of the leading interventions for child complex trauma do not include revisiting traumatic memories but instead foster integration of traumatic experiences through a focus on recognizing and coping with present triggers within a trauma framework.

Best practice with this population typically involves adoption of a systems approach to intervention, which might involve working with child protective services, the court system, the schools, and social service agencies. Finally, there is a consensus that interventions should build strengths as well as reduce symptoms. In this way, treatment for children and adolescents also serves to protect against poor outcomes in adulthood.

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This article has been adapted from the following sources:  
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# Building on Family Strengths: Research and Services in Support of Children and their Families conference

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## A Real Mother's Embrace: Reflections on Abuse and Recovery

A warm breeze gently blew across my face as I was swinging on my porch, thinking of the visit I was about to endure. I had to face the same uncomfortable wait for my caseworker every Tuesday. Just thinking about what was to come made my eyes feel fuzzy and my head spin as fast as a tornado. I closed my eyes and tried to make that feeling go away, but fear of my biological mother just made the spinning faster. At that moment the front door swung open and my foster mom appeared. She gave me a toothy grin as she walked towards me and asked if the spot next to me on the swing was taken.

"No."

"Well, I think I'll sit down next to ya', good lookin'." With these words she sat down beside me, swinging her arm around my shoulder. We sat there in silence together for about five minutes, although a day's worth of thoughts passed through my mind. Why did I have to go see the person who had made me fear almost all women for the first six years of my life?

I saw the car coming from about a block away. The sun was shining brightly off the silver paint. In my mind the car was coming towards us very slowly, like a hearse carrying someone's remembered relative and friend. I felt very alone, and very much like I might soon be the person in the back of the hearse.

The car finally arrived, pulling up into the long drive and honking while the driver waved enthusiastically at us through the window. I gave a fake smile and waved back, slowly getting up. I liked my caseworker, who



by then I simply called Aunt K, but I would be lying if I said that I enjoyed seeing her on those terrible Tuesdays. She opened her car door, and walked up the six concrete steps before stepping onto the light blue wood of the porch that creaked and moaned even under the petite frame of Aunt K.

"Hello sweetheart, how are you doing today? Are you a little uneasy about having to see Mama Cathie for the last time?" I was excited that this would be the last time I would ever see my bio-mom Mama Cathie, but very nervous about having to see her at all.

"Yes, but I don't want to go." I said this in a very meek voice, and then looked down as I smoothed my blonde hair out with my left hand. As I stood there, water began to swell in my eyes.

My foster mom brought her mouth close to my ear, and said, "Sweetie, I will be right here waiting for you when you get back." She accompanied these calming words with an embrace that was bursting with love. After my foster mom released me, Aunt K took hold of my hand and led me from the porch, away from my soon-to-be-legal family, and to the passen-

ger side of her car.

"I love you Aaron. I will be standing right here when you get back." My foster mother said these words as I lowered myself into the form-fitting seat. As we began to back out of the driveway I gave my soon-to-be adopted mom a last glance, and an emotion swelled inside of me the likes of which I had never before known. I did not want to leave my foster mom. I pushed the foreign feeling to the back of my thoughts, focusing instead on rolling the window up and

down as many times as were possible in one minute. A block away from the only true home I had ever known, I quickly looked out the back window hoping I would get to see my foster mom just one last time.

The ride to my biological mother's apartment was quiet. I stared non-stop out the window at nothing in particular. Honestly, I only remember seeing one sight, and that is a little boy about two or three riding his tricycle while his mother stood watching and smiling. I felt anger towards the little boy that he had a mom and I might never know what having a real mom would feel like.

I do not really remember the car pulling into the building parking lot, or the walk into the building, up the stairs and to the door with the number five hanging from a nail. What I do remember is the look on the face of my bio-mom as she gazed through me.

Her exceptionally plump face was framed with her stringy strawberry blonde hair. Her already tight mouth was now a hardly visible line above her four chins. Her usually very pale complexion was a beautiful shade of

scarlet, and her eyes scanned me with a lack of interest.

"How many times have I told you to call me before you come!?! You know I never remember these visits, and I just called your aunt to come take me to get some fast food. Now I have to call her back and tell her to forget about picking me up for an hour!" My bio-mom roared these words at Aunt K, who kept a pleasant smile on her face until Mama Cathie was done with her tantrum.

"Cathie, we have these visits the same time every Tuesday, and the fact that you can never remember is exactly why this is the last time you will ever have with your son." Aunt K was a woman with a big and very powerful heart, which oftentimes made her forget about what she should and should not say.

"I am sorry Cathie, but you should know better than to say something like that in front of Aaron." For the first time my bio-mom actually looked at me.

"That is right, this is the last time I will get to see him, isn't it? Well, might as well get this going." She said this in a very different tone from her previous comment, a tone lacking any emotion.

Mama Cathie stepped aside and allowed us to come into her very untidy apartment. There were boxes everywhere. This apartment was her fifth in about a year, and quite noticeably she was about to make the change to number six. The odor of cleaning solutions and air freshener made this more obvious, since Mama Cathie's apartment usually smelled musty with a lingering trace of french-fries.

Mama Cathie planted herself on her stained loveseat. Aunt K took her usual spot in an antique rocking chair positioned in a corner so that she was out of sight but not out of ear-shot. I sat myself on the floor in front of the loveseat and began playing with a frayed string of carpeting.

"I think the reason I forget about these visits is because they are so boring. I need to call my sister. Aaron, bring me the phone!" I slumped myself onto my feet, and retrieved and handed the phone to Mama Cathie.

"May I please use the bathroom?"

Mama Cathie huffed as she said, "I suppose, but don' make a mess,

I just got the thing clean." I quickly walked to the bathroom, and shutting the door behind me allowed my six year-old heart to release the emotions that had been swelling inside of me. The tears streaked down my face, some going down my nose, others dripping into my silently sobbing mouth. I stood there quietly, with the only sound to be heard the constant running of water in the broken sink. My face was burning, especially the scar on the bridge of my nose where Mama Cathie had once hammered in a nail as a punishment. I had similar

scars all over my body, but this one was different. This scar becomes deep red whenever I am very sad or angry. At that moment I had no idea of what I felt. I wanted my bio-mom to love me, but I also wanted her to never want to see me again. I sat down on the toilet lid, and tried to make the drops stop from streaming over my face. At last, I dried my face with the newly washed but vomit-stained yellow hand towel. I flushed the toilet, walked out of the bathroom and down the sparsely lit hallway, and found myself again face to face with Mama Cathie.

Mama Cathie stayed on the couch as Aunt K and I walked out the door. We said goodbye the way two people do who have just met, but will never see one another again. I was finally free of those terrible Tuesdays.

The ride to my foster home was a long one. I was anxious to see my only real family. The emotion that I had felt before leaving my home was very strong now. My heart was beating a little faster than usual, and all I could think of was needing someone to squeeze.

We finally pulled up into my driveway and there she was, exactly where she said she would be standing. Next to my mother was my father, both smiling at me as I emerged from the car. My two brothers came running from around the house, and greeted me with an atomic wedgie. I walked up the six concrete steps, and was

greeted by my mom and dad. My dad put his hand on my head, and messed up my hair. I gave my mom a hug, and she held me tight. As we stood there, the unknown emotion finally gave me a name—love. In that split second, my young heart began to let go of the pain. I now allowed myself to feel what a real family felt like. I finally allowed myself to let in the love they had been trying to give me. My mom squeezed me harder as the tears poured down my face and my body trembled. In that embrace, I let myself have my real mom.

*I wanted my bio-mom to love me, but I also wanted her to never want to see me again.*

Tragedy and trauma walk hand-in-hand in the lives of so many youth today, particularly those who are involved in the child welfare system. A pressing question is how to help a young person overcome that trauma and lead a successful and happy life. That answer is as varied as the forms of trauma the youth must face. All people have some form of trauma in their lives: No single person is immune to tragedy. The challenge in life is overcoming the tragedy and facing the trauma in a way that allows us to resolve the conflict within ourselves. Here are some of the ways that I was able to overcome the tragedy that I faced so early in my life, and more importantly, the ways that other people helped me to face and overcome the trauma.

The first event that allowed me to have a chance was when my biological mother saved me from an even more abusive situation than I had to endure when living with her. After I was removed from my mother's care, I was sent to stay with her parents in Montana. That soon escalated into a very volatile placement. I was beaten every day in addition to being sexually molested by my grandfather. My biological sisters learned these behaviors and soon started to physically abuse me as well. My biological mother came to visit and, realizing the severity of the situation, had my sisters and me removed. The woman who tormented me in one form or an-

other for much of my childhood was also the woman who gave me my first real chance at hope.

The second string of events that helped me have a fighting chance was being accepted into a very loving family, and the court's decision to look for adoption to be my permanency rather than reunification. The story above details my internal struggle to find a real mom and family, but the true reason I was able to let in my new family's love was the support that they had set up around me. Having a stable and reliable support system is absolutely a necessity for any child and especially for a child with a traumatic history.

The first of those supports was simple but very effective. I always got into trouble when I had the time to think of a way to cause mischief, so my parents got me heavily involved in sports and other activities. I played soccer, football, baseball, basketball; I wrestled, and was in Cub Scouts. When I became a little older I realized the importance of staying busy and with the backing of my parents I began to volunteer and try to give back to the system that had given me a second chance.

Another support that my parents found for me was a therapist. Carol was her name, and she was one of the biggest influences in my life. She was the one who started having me write down or draw my feelings. I had a terrible temper as a child, and I would fight for no reason in school. Carol helped me not only to recognize what made me angry, but also to identify why I was angry. She was one of the first to make me face my past trauma and realize that the pain did not define me. I saw Carol for several periods over the years. At first, she helped me deal with the adoption and the feelings that those terrible Tuesdays would stir. Then she helped me to overcome my anger and violent outbursts. The last times I saw Carol were when I was fourteen and fifteen. I started to have flashbacks of the abuse and neglect I endured as a toddler. Even before the flashbacks I remembered events from when I was just barely two. I would always have the memory of making my grandfather angry, but the memory always stopped when he would grab me.

When the flashbacks started they were more like continuations of those memories. I started to remember the room my grandfather would use to beat me; to remember my sisters spinning me by my hair until chunks would rip out. When I went to live with my parents at the age of three, I had several bald spots on my head, and my hair was partially stained red from all the blood. Carol gave me the insight into my own emotions that allowed me to break down the feelings



and deal with the specific emotions associated with the memories. This skill is one that I use today.

Possibly the most important aspect of what made my situation a success was the fact that my adopted parents were so supportive and consistent in my life. Rick and Cheryl Weaver did not back down from any challenge I would throw their way. I tested those expectations every day and in the most extreme ways I could think up. They were consistent with what the expectations they had of me were and even more consistent with the punishments when I did not follow those expectations.

My parents also pushed me every day to be a better person, whether by signing me up for sports at an early age or making me sit down and fill out applications for volunteer and leadership positions when I would have rather been out playing football. They always had my best intentions in mind. They were great models for me to learn from about being a responsible and caring adult. I am the

person I am today because of their guidance, acceptance, and love.

None of these traits my parents instilled in me would have been helpful had my parents ever given up on me. One of the most detrimental parts of foster care is the way that children are passed around. A young person does not know where they fit in or who they are, and without a stable home this often leads to more serious problems. My parents made a commitment to me the minute I became their foster child to provide for me what every young person deserves.

Another part of the healing process for me was being allowed to just be a kid. I knew abuse and hate when I was placed into foster care and had no idea that a hug could feel so right. In my grandparents' home I would be beaten for being too loud or for not sitting completely still. The first time I played with my adopted brothers they screamed and yelled and fell down all over. I expected at any minute someone would come running in and beat them severely. The longer that did not happen the more fun I started to have and before I knew what I was doing I was also screaming and jumping around.

The most important factor that I have detailed about how to overcome trauma is that I had help. I would not have been able to do any healing on my own and thus I would have become a negative statistic about foster care and adoption. The more supports we have around youth and the more outlets the youth have, the better their chances for being successful. Internally I had to make the decision to let people help me, and that decision took time and patience on everyone's part. Looking at my life now I understand the worth every child has and the potential that could be unlocked just with a little understanding and patience, and a whole lot of caring. I now try to make a difference every day in a life, and I would not have that opportunity had I not had the support and love I needed.

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*Aaron Weaver* is guest editor of this issue of *Focal Point*.

# Evidence-Based Treatment for Children in Child Welfare

Many children in the child welfare system exhibit behavioral or social competency problems warranting mental health care. Studies of children in foster care suggest at least 50% meet criteria for a mental health diagnosis. Often, these difficulties are related to trauma they have experienced. This paper presents a review of the research evidence for trauma-focused interventions for children and adolescents. The goal is to provide guidance about effective strategies for addressing emotional and behavioral problems associated with trauma.

Children with posttraumatic stress disorder (PTSD) or symptoms related to trauma often exhibit other mental health disorders as well. Although interventions for these other disorders are not addressed in this review, trauma-affected children and adolescents may also need diagnosis-specific treatment for co-occurring conditions such as attention deficit hyperactivity disorder (ADHD) and depression. They may also require intensive home- and community-based services (e.g., wraparound, therapeutic foster care, Multisystemic Therapy) for persisting difficulties.

## Evidence-Based Treatments for Child Trauma

In the last decade, a number of organizations have created lists of “evidence-based” practices for treating children and youth who experience emotional and behavioral difficulties.



However, the standards required for a treatment to be “evidence-based” vary from list to list. This proliferation of standards and lists of evidence-based practices may have created confusion around how to determine what is effective for children and youth with emotional and behavioral problems. For this review, our goal was to highlight treatments that have been evaluated according to the criteria proposed by the Division of Clinical Psychology of the American Psychological Association.<sup>12,4</sup>

Four reviews of treatment for child abuse and neglect, completed in the last three years, provide the basis for this paper.<sup>13,10,2,3</sup> These reviews rated the extent to which interventions meet criteria that have been deemed essential for a treatment to be labelled as an “evidence based practice.” Essential criteria include use of a treatment manual, positive findings from at least two rigorous studies, evidence of long-term outcomes beyond treatment termination, and use of standardized therapist training and adherence monitoring.

Two of the four reviews aimed

to identify the leading treatment candidates with the most controlled research, while the other two aimed to review the evidence for some of the most commonly provided treatments for child trauma. Our goal was to determine where these reviews converged to identify some exemplary candidates for treatment dissemination. Seven treatment models

emerged as the most-supported interventions for children with histories of trauma. All are evidence-based, meeting criteria for either “well-established” or “probably efficacious” (see Table 1). Each treatment model is described briefly below.

### *Trauma Focused Cognitive Behavior Therapy (TF-CBT)*

TF-CBT<sup>5</sup> addresses behavioral and emotional symptoms as well as the negative thought patterns associated with childhood trauma. Treatment is targeted at both the parent and the child. For example, the therapist teaches the child how to regulate his or her emotions stemming from the trauma, and how to cope when experiencing reminders of the trauma. Parents are taught how to encourage these skills in the child. In joint sessions, parents and their children practice these skills with live feedback from the therapist. A PTSD diagnosis is not necessary; TF-CBT treatment is appropriate for any child who exhibits behavioral or emotional problems related to past trauma, such as nightmares, clinging

to caregivers, or an increased startle response to loud or unusual noises. The model is clinic-based and short-term (12-16 weeks). In randomized trials TF-CBT has been linked to improvements in PTSD symptoms, depression, anxiety, behavioral problems, and feelings of shame and mistrust. Moreover, these improvements have been maintained for a year following treatment completion. When parents are also involved in TF-CBT, the positive effects for children increase. This occurs through improvement of parental depression, increased support of the child, decreased emotional distress about the child's abuse, and more effective parenting practices.

### *TF-CBT for Childhood Traumatic Grief*

TF-CBT for Childhood Traumatic Grief,<sup>1</sup> a revised form of TF-CBT, is designed specifically to help children suffering from traumatic grief after experiencing the loss of a loved one in traumatic circumstances. These children often have PTSD symptoms that prevent them from successfully grieving their loss. The therapy model is calibrated for two age groups: children up to six years old, and children and adolescents over age six. Treatment is provided to both child and caregiver (together and alone) over 12-16 sessions, focused at first on trauma and then on grief. The treatment pays special attention to cognitive, behavioral, and physiological reactions to the combination of trauma and bereavement, most notably sadness and fear. The components of the model are similar to those for TF-CBT, but with added focus on fear and sadness resulting from bereavement. The evidence base for TF-CBT for Childhood Traumatic Grief is emerging because the treatment is relatively new. Two studies have linked specific components of treatment to targeted changes in symptoms over time.

### *Abuse-Focused Cognitive Behavior Therapy (AF-CBT)*

AF-CBT<sup>10</sup> is delivered in an outpatient

setting to physically abusive parents and their school-age children. Treatment is brief (12-18 hours) and can be applied in the clinic or the home. The model incorporates aspects of learning/behavioral theory, family systems, and cognitive therapy. Individual child and parent characteristics, as well as the larger family context, are targeted. AF-CBT addressed both the risks for abuse in the parent and the consequences of abuse in the child. For example, the therapist may work with the parent on relaxation training and anger management, while discouraging aggressive behavior in the child and teaching positive social



interaction skills. Experimental studies suggest that AF-CBT can decrease parental anger and use of physical discipline and force.

### *Parent Child Interaction Therapy (PCIT)*

PCIT<sup>8</sup> is a highly structured treatment model involving both parent and child. Originally developed by Eyberg in the 1970s for children with behavioral problems, PCIT has been adapted for physically abusive parents with children ages 4 to 12. The overarching goal of PCIT is to change negative parent-child interaction patterns. Treatment is brief (12-20 sessions) and involves live-coached sessions where the parent/caregiver learns skills while engaging in specific play with the child. The time in each session is usually divided among enhancing the relationship between the parent and child, teaching the parent how to use positive discipline tech-

niques, and working with the child to improve his or her compliance with parent directions. Specific parent and child behaviors are tracked and charted on a graph during each session, and the therapist provides feedback to the parent on his/her mastery of skills. Parents and children are given daily homework assignments to reinforce the skills learned in therapy. Experimental and quasi-experimental findings have shown that abusive parents and their children participating in PCIT reported declines in physical abuse, child behavior problems, and parental stress, as well as increased positive parent-child interactions.

### *Cognitive Behavioral Intervention for Trauma in Schools (CBITS)*

CBITS<sup>9</sup> is a group intervention intended to build coping skills for children suffering from symptoms of PTSD, depression, and anxiety related to trauma. CBITS is commonly used for children ages 10 to 15 that have experienced or directly witnessed a traumatic event, including violence. Briefly, during group sessions, children express their feelings through drawings and group discussion. This serves as the context for building skills with guidance from the therapist. Some of the skills taught include relaxation, social problem solving, challenging upsetting thoughts, and processing traumatic memories and grief. Children are then given homework assignments to practice the skills learned in each session. Research shows that CBITS is effective, particularly in cases where trauma was more recent. Emerging findings also suggest that CBITS is effective for Latino immigrant children.

### *Child-Parent Psychotherapy for Family Violence (CPP-FV)*

CPP-FV<sup>11</sup> is an individual psychotherapy model for infants, toddlers, and preschoolers who have witnessed domestic violence or display symptoms of violence-related trauma such as PTSD, defiance, aggression, mul-

TABLE 1. WELL-ESTABLISHED\* AND PROBABLY EFFICACIOUS\*\* INTERVENTIONS FOR CHILD TRAUMA

Intervention	Age Group	Research Design	Main Findings
<i>Adapted CBT models for physical and sexual abuse (TF-CBT, AF-CBT, CBT for child traumatic grief)*</i>	4-18 years	10 randomized trials 4 quasi-experimental	<ul style="list-style-type: none"> <li>• Improvement in child PTSD, depression, anxiety, behavior problems, sexualized behaviors, and feelings of shame &amp; mistrust</li> <li>• Decreased parental PTSD, depression and emotional distress about the child's abuse</li> <li>• Decreased parent use of physical discipline and parent anger problems</li> <li>• Decreased family conflict</li> </ul>
<i>Parent-Child Interaction Therapy (PCIT)*</i>	4-12 years	1 randomized trial 4 quasi-experimental	<ul style="list-style-type: none"> <li>• Decreased parent physical abuse</li> <li>• Reduced negative parent-child interactions</li> <li>• Maintained effects at long term follow-up (3-6 years after treatment)</li> </ul>
<i>Child-Parent Psychotherapy for Family Violence*</i>	Up to 5 years	4 randomized trials	<ul style="list-style-type: none"> <li>• Decreased PTSD symptoms and behavior problems</li> <li>• Decreased maternal avoidance</li> </ul>
<i>Cognitive Behavioral Intervention for Trauma in Schools**</i>	10-15 years	1 randomized trial 1 quasi-experimental	<ul style="list-style-type: none"> <li>• Improvement in PTSD and depressive symptoms</li> <li>• Maintained improvements at 6-month follow up</li> </ul>
<i>Project 12-Ways/Safe Care for Child Neglect**</i>	Young children	4 quasi-experimental	<ul style="list-style-type: none"> <li>• Improved skills in assertiveness and home management</li> <li>• Improved job skills</li> </ul>

\*Meets criteria for "well-established" as defined by Lonigan, Elbert & Johnson, 1998. Efficacy results from at least two group-design studies in which the intervention was either superior to another intervention or equivalent to another evidence-based treatment; Treatment manuals preferred; Sample characteristics clearly specified.

\*\*Meets criteria for "probably efficacious" as defined by Lonigan, Elbert & Johnson, 1998. Two studies showing superior results when compared to no-treatment control, or two group-design studies conducted by the same investigator; Treatment manuals preferred; Sample characteristics clearly specified.

multiple fears, and/or difficulty sleeping. The treatment incorporates aspects of psychodynamic, attachment, trauma, cognitive-behavioral, and social-learning theories. The parent and child attend therapy sessions together. The therapist targets the child-parent relationship and the individual child's functioning, helping the child to gain a sense of security and self-esteem. Typically, treatment is delivered for one hour per week for approximately 12 months. Randomized trials have shown better outcomes in areas including behavior problems, symptoms of traumatic stress, and maternal avoidance of the child for children who received CPP-FV compared to children receiving other control or comparison treatments.

#### *Project 12-Ways/Safe Care for Child Neglect*

Project 12-Ways/Safe Care<sup>6</sup> is focused on child neglect and is included in this review because neglect is a form of maltreatment that places children at risk for mental health problems. The intervention targets the various

contexts in which the child and family live, and is based on behavioral principles. Parents are taught skills in safety, bonding, and health care. The intervention often incorporates video modeling, and is used for both prevention and treatment. The evidence consists of as many as 60 program evaluations and quasi-experimental studies, showing improvement in both interpersonal (social interactions, assertion skills) and functional (job training, home management skills) domains for parents.

#### Disseminating Evidence-Based Practice

Many efforts are underway to spread evidence-based practice across the country. Some of these initiatives are being undertaken directly within child welfare/foster care service settings and therefore provide a direct application to a foster care population.

The State of Oklahoma has partnered with Mark Chaffin and his colleagues at the University of Oklahoma School of Medicine to test and

disseminate evidence-based interventions in child welfare populations and foster care settings. Their work to date has included initiatives with a strong federally-funded research component that seek to implement PCIT and Project Safe Care across the state.

The State of California recently funded the development of a clearinghouse for evidence-based practice in child welfare that is being implemented under contract by the Chadwick Center for Children and Families at Children's Hospital, San Diego. This initiative will post reviews of the evidence for interventions in numerous areas, including mental health treatment for children and adolescents involved with child welfare.

The Oregon Social Learning Center in Eugene, Oregon has recently partnered with the County of San Diego child welfare system and the Child and Adolescent Services Research Center at Children's Hospital to test a parent management training intervention for foster parents that is modeled on the principles of Multidimensional Treatment Foster Care. With funding from

the National Institutes of Mental Health, the partnership has recently completed a two-phase study of the model's effectiveness with promising results for children in foster care.

The National Child Traumatic Stress Network, supported by the Substance Abuse and Mental Health Services Administration, is currently disseminating TF-CBT to several sites around the country. The network provides training, subsequent consultation/supervision, and manual development. As the intervention developers train local clinicians who will then become trainers, a cascading effect should be seen through greater availability of expert treatment. Use of the internet for training in areas of the country where face-to-face training is not available (or in concert with in-person training where trainers are available) will further increase access to TF-CBT.

Finally, resources are available to provide conceptual and empirical guidance about factors that require attention prior to and during dissemination initiatives. An example of one guide is *Implementation research: A synthesis of the literature*.<sup>7</sup>

## Conclusions

This article has described exemplary trauma-focused treatments, focusing on how these treatments are useful for treating the mental health difficulties typically experienced by children who are involved in child welfare systems. Research on these interventions has revealed some common characteristics of effective treatments for children who have experienced trauma. Specifically, treatment is more effective when it is brief and when parents are involved. Overall, the findings presented here are promising and give hope that children who receive evidence-based treatment for trauma can have significantly improved lives.

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# Early Intervention as Prevention: Addressing Trauma in Young Children

**T**wo and one-half-year-old David was in his mother's arms as his father stabbed her. David was not injured physically, but he saw the entire event. After David's mother was stabbed, she ran into the street and hailed a passerby, who called the police. As his mother collapsed, the passerby picked up David and held him. When the police arrived, his mother was taken to the hospital. David was taken to a neighbor's home where he stayed for three hours until his grandmother could pick him up. He did not see his mother for 5 days, until she returned home from the hospital.

According to his mother, David seemed subdued when she returned home. He refused to go to his daycare program. He had trouble sleeping at night. He asked repeatedly about his mother's "boo-boos." His mother worried about the changes in his behavior, and wondered if what he saw could have a lasting effect on David. She decided to call her pediatrician, who suggested that she might talk to a therapist about her concerns. She was referred to a program that offered specialized services to preschoolers.

The story of David raises important questions about the impact of trauma on very young children. How does David understand what happened? How do we make sense of David's response to this event? How might this event affect his behavior and his relationship with his mother? How do we effectively help this mother and child? For the past five years, the Early Trauma Treatment Network, a consortium of four specialized early



childhood mental health programs around the country, has provided counseling and support to parents and children affected by domestic violence who are similar to David and his mother. This article will present an overview of the research on early childhood trauma, and what we have learned about effective intervention.

## Babies, Toddlers, and Trauma

Young children bear a disproportionate share of violence and abuse in the home. Infants and toddlers experience the highest rates of child maltreatment of any age group. Of the 1400 children who died from child abuse in 2004, 76% were under the age of four.<sup>9</sup> Domestic violence (defined here as abuse or threats of

abuse between adult partners in the home) also affects many young children. A survey of American households revealed that nearly 30% of children in this country live in homes where there is some form of intimate partner violence.<sup>7</sup> A study on police responses to domestic violence calls in five large metropolitan areas found that children under the age of six were disproportionately represented in the homes that police responded to.<sup>2</sup> Some were directly injured; others, like David, were the helpless bystanders to the violence.

## Young Age and Vulnerability

In the past 15 years, tremendous strides have been made in recognizing the vulnerability of our youngest children to trauma in the environment. Previously, it was commonly thought that young age somehow protected children: they were too young to understand, and therefore, they could not be seriously affected. However, research has shown that babies take in much more of their world than we previously thought, and the developing brain is highly responsive to the caregiving environment. This knowledge of the sensitivity of very young children to their environment and the malleability of the developing brain in the neonatal and early childhood developmental periods has increased the importance of early identification of significant childhood stressors.

The meaning of a traumatic event in the life of a child is based on the child's stage of cognitive and emo-

tional development. Two-year-old David may witness his mother being battered, and construct a meaning of the event that will be quite different from the explanation that a five- or eleven-year-old would develop. In one study of young victims of child abuse, researchers found that the most powerful predictor of the development of traumatic symptoms was not the direct abuse, but the child's perceptions of the physical safety of a caregiver.<sup>10</sup> Given this finding, David's reactions to his mother's abuse become more comprehensible. In general, young children lack the cognitive capacities to understand cause and effect; they are less able to anticipate danger or to know how to keep themselves safe, thus being particularly vulnerable to the effects of violence exposure. A study by Davidson and Smith<sup>1</sup> reported results consistent with this view, finding that traumatic events experienced prior to age twelve are three times more likely to result in Post Traumatic Stress Disorder than such events experienced after age twelve.

### Young Children and Exposure to Violence

Child stressors fall on a continuum, ranging from short-term, tolerable or even beneficial stress, to prolonged, uncontrollable stress that is traumatic or toxic to child development. Chronic exposure to traumatic stress can produce dramatic changes in the stress response system and in extreme cases may result in the development of a smaller brain.<sup>8</sup>

In our work with young children and families, we have learned that when children are exposed to family violence, their expectations for a safe and predictable world are shattered.<sup>3</sup> Young children depend on the attachment relationship with the primary caregiver to organize what is safe and

dangerous in the environment, and when this fails, children lose their basic trust that a parent can emotionally and physically protect them. This disruption of the attachment relationship is at the core of risk for children. The strains on the attachment relationship are further exacerbated if the



parent is also traumatized. Consider David and his mother: she is a victim of abuse. Her ability to be physically and emotionally available to David may be compromised. For example, she was physically separated from him immediately after the traumatic experience, at the time when he most needed the comfort and security of his mother.

Children respond to trauma-related feelings of fear and vulnerability in a variety of ways. Often, the child is aggressive. In fact, the most frequent referral complaint voiced by parents is concern about their child's aggression, short temper, or impulsive behavior. Other children respond with increased anxiety about any separation from a parent, and with irregular sleeping and eating patterns. Children also learn early and powerful lessons about the use of violence in interpersonal relationships. Violence is an acceptable way to relieve stress and exert one's will. It can also be confused with expressions of love and intimacy.

### Interventions with Children and Parents

The Early Trauma Treatment Network uses a model of intervention, Child-Parent Psychotherapy.<sup>5</sup> Child-Parent Psychotherapy (CPP) is based on the premise that trauma-related problems in young children should be addressed within the context of the child's primary attachment relationships. For many children, this relationship is with their mothers or mothers and fathers. However, for children in foster or kinship care, there are other possibilities for an attachment relationship. The essential premise of this treatment is that the caregiver-child relationship is targeted and strengthened, thus enhancing supportive, protective and responsive parenting, and restoring the child's sense

of safety and trust in adult caretakers. CPP interventions revolve around free play with the parent and child and the therapeutic use of developmental guidance and information. The intervention also guides the caretaker and child to create a joint narrative of the traumatic experience, so that each person has a greater understanding of the experience of the other, and what was unspeakable becomes tolerable to talk about. An evaluation of this intervention has substantiated CPP's effectiveness in decreasing children's behavior problems and trauma-related symptoms. The intervention also decreased mothers' trauma-related symptoms.<sup>6</sup>

### Intervention with David and his Mother

David and his mother were seen together by a mental health clinician for 6 months. In the beginning, his mother had difficulty talking about what had happened. David also avoided all talk or reminders about what he had seen. The issue came up when David saw his mother's scars, and asked

about the “boo-boos.” The therapist had several sessions with David’s mother, alone, to talk about what she observed with her son, to discuss her own trauma, and to inquire about the possibility of talking about what had happened with David. His mother felt uncomfortable with this idea. As the therapist explored her resistance, David’s mother spoke of her remorse about what her son had witnessed. Once she explored these feelings with the therapist, she felt more able to talk about the incident with her son. The therapist facilitated this discussion with the use of puppets and dolls to act out what David had seen. As David played out his memories of the incident, it became clear that the most upsetting aspect of this event for him was the disappearance of his mother when she was taken to the hospital. David’s mother learned important information about how he had perceived the event and she was able to speak directly to him about his fear and anger at her for leaving him. At the conclusion of this intervention, David’s symptoms had decreased. Both mother and son had a deeper understanding of how this trauma affected them, and the mother was able to support David in sorting out his confused and frightened feelings.

This case provides an example of the impact of traumatic events for very young children and of the power of developmentally informed interventions that support both children and parents. With support, David’s mother was able to respond to David’s worries and fears, thereby helping him to feel protected. Both mother and child benefited from this treatment.

### Identifying Young Children Affected by Trauma

Perhaps the greatest challenge that lies ahead is to develop systems that can provide early identification of children such as David and link them with appropriate intervention. The research on the adverse effects of early child exposure to violence creates a compelling case for developing more effective identification strategies. There are a variety of screening tools, both formal and informal, to assess for child abuse. However, tools for assessing exposure to domestic violence have not been as well developed, and

screening for this type of exposure is not universally done.

Healthcare, early care/education settings, and Head Start are examples of agencies that see large numbers of young children and parents, and they offer important opportunities to screen for early trauma as well as other early childhood mental health risks. Some of these institutions have created tools for screening. For example, as part of the intake assessment at Head Start, families are asked about domestic violence and safety in the home. In pediatric and family healthcare settings, there is also a growing awareness of the importance of early identification of mental health issues in pre-schoolers. Recommendations for inquiring about family violence in pediatric and family health settings have been developed and are widely distributed.<sup>4</sup>

A greater capacity to identify young children who are affected by trauma must be met with greater resources for intervention. The first step toward increasing programmatic resources is to raise public awareness of the risks of trauma exposure for young children and the importance of investing in their early lives. We owe our youngest children this effort.

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## Adapting Evidence-Based Treatments for Use with American Indian and Native Alaskan Children and Youth

It is impossible to capture or explain the nature and extent of assaults experienced by American Indians and Alaskan Native (AI/AN) families. AI/AN communities experience a disproportionate number of events that put them at risk for trauma reactions. Often, these contemporary disruptions have roots in the historical past.

According to the National Childhood Traumatic Stress Network (NCTSN), trauma is a unique individual experience associated with a traumatic event or enduring conditions.<sup>7</sup> This definition is of limited usefulness within the AI/AN communities, however, since it does not take into account the cultural trauma, historical trauma, and intergenerational trauma that has accumulated in AI/AN communities through centuries of exposure to racism, warfare, violence, and catastrophic disease. Cultural trauma is an attack on the fabric of a society, affecting the essence of the community and its members. Attacks on AI/AN communities have included prohibiting the use of traditional languages, banning spiritual/healing practices, removing or relocating individuals or whole communities, and restricting access to public or sacred spaces. Historical

trauma is the cumulative exposure of traumatic events that affects an individual and continues to affect subsequent generations. Intergenerational trauma occurs when the trauma of an event is not resolved and is subsequently internalized and passed from one generation to the next through impaired parenting and lack of support in the community. These types of traumas increase individuals' risks of experiencing traumatic stressors while also decreasing their opportunities to draw on the strengths of their culture, family, or community for social and emotional support.

### Service Needs

Currently, the majority of Native people live in urban areas. Although many move from isolated and economically deprived settings to seek better living conditions, they often-times have difficulty securing stable employment. Many Native people are employed in low-wage, unskilled positions and they may require assistance such as food stamps, reduced-price school lunches, and/or subsidized housing. Heads of households for the majority of Native families are women, who are not only poorly paid, but also often engaged in a

constant struggle to provide support to immediate and extended family members. The bitter reality is that a large proportion of the Native population experiences severe financial hardship, which increases stress and compounds the risk of exposure to crime and violence.

AI/AN families are also at risk for violence due to political, economic, and social inequalities. According to the Department of Justice,<sup>9</sup> the average annual violent crime rate among AI/AN people over 12 years of age is approximately 2.5 times the national rate. There is approximately one substantiated report of violent crime per year for every 30 Native children.<sup>10</sup>

Average life expectancy among AI/AN people is lower than in the non-Indian population. Given the shorter life expectancy and population growth of AI/AN persons, nearly half the AI/AN population is comprised of minors who need care, guidance, and support. The community's ability to provide these resources is compromised as the challenges of maintaining a livelihood, combating cultural genocide, coping with violence, and rebounding against emotional and spiritual bankruptcy tear at the integrity of home and culture.

Given the multiple risks present in

AI/AN communities, it is not surprising that the prevalence of post-traumatic stress disorder (PTSD) is substantially higher among AI/AN persons than in the general community (22% vs. 8%).<sup>5</sup> It is likely that higher rates of exposure to traumatic events coupled with the overarching cultural, historical, and intergenerational traumas make this population

remarkable resilience. Communities have retained cultural strength in kinship networks, language, stories, songs, ceremonies, and spiritual beliefs. However, to survive, many individuals have developed coping strategies that leave them ill-equipped to deal with the ongoing trauma, stress, and hardship they endure. Because of past experiences with misguided

professionals may be few.

The process of adaptation began with identifying the core concepts within existing EBTs. At the same time, the ICCTC worked to identify Native traditional teachings and concepts that would be relevant for trauma therapy in Indian Country. Particular focus was placed on traditions related to parenting, nurturing, and therapeutic practice. Attention was also paid to traditional ways of teaching and learning, and to cultural worldviews that are used to explain individual behavior. Using a pro-

*Because of past experiences with misguided programs offered by the government and social service organizations, many AI/AN people are distrustful and reluctant to consider professional mental health services.*

more vulnerable to PTSD. In addition, people who have traumatic experiences and develop PTSD are also at risk for several other negative mental health outcomes. Rates of substance abuse disorders and other mental health disorders, particularly depression, are also elevated among AI/AN peoples.<sup>1</sup> In short, the AI/AN population is especially susceptible to mental health difficulties.

### Honoring Children: EBT for Indian Country

Despite the hardships outlined above, Native people have shown



programs offered by the government and social service organizations, many AI/AN people are distrustful and reluctant to consider professional mental health services. What is more, therapeutic services offered to Native people in the past have often proven ineffective and inappropriate for AI/AN populations. Recognizing these barriers to treatment, the Indian Country Child Trauma Center (ICCTC) at the University of Oklahoma Health Sciences Center is working with the NCTSN and the Substance Abuse and Mental Health Services Administration (SAMHSA) to develop, refine, disseminate, and evaluate culturally relevant trauma intervention models for use with children in Indian Country. The interventions are adapted from existing evidence-based treatments (EBTs). The premise of the cultural adaptation is that AI/AN cultures have traditional healing practices, activities, and ceremonies that are used therapeutically to provide instruction about relationships and parenting. The resulting four Honoring Children interventions developed by the ICCTC build on common and tribal-specific cultural elements to provide culturally relevant therapeutic approaches that also respect the substantial individual variability in cultural identity among AI/AN people. The adaptations are also based on the recognition that these interventions must be appropriate for dissemination in rural and/or isolated tribal communities where li-

cess of ongoing and open dialogue, the ICCTC worked with EBT developers and a diverse group of Native cultural consultants to create intervention and training materials as well as implementation support strategies and protocols.

### Honoring Children, Making Relatives

An existing EBT called Parent-Child Interaction Therapy (PCIT)<sup>4</sup> was adapted into Honoring Children, Making Relatives. This intervention maintains the guiding principles and theory of PCIT while incorporating AI/AN practices, rituals, traditions, and other cultural elements.

One Native method of teaching typically moves from observation to teaching others: "Watch. Listen, as I tell you what to do. Do it this way. Now go teach your little sister." This same series of steps is a central feature in Honoring Children, Making Relatives: instruct the parents, model the behavior, let the parent practice, have the parent work directly with the child, and be sure the parent praises the child. For example, when a child demonstrates disruptive behaviors or is difficult to control, some parents may punish the child. The traditional Native concept of respect and honor, however, would dictate that the adult be patient, be instructive, not embarrass, and use the opportunity to teach. During PCIT, the parent engages the child in positive interactions, attends

to the child, lets the child know what the child is doing right, and eventually instructs the child in good behavior. Honoring Children, Making Relatives is the clinical application of parenting techniques in a traditional framework that supports the emphasis that AI/



AN culture places on honor, respect, extended family, instruction, modeling, and teachings.

### *Honoring Children, Respectful Ways*

Native youth confront many challenges that negatively impact their sense of self, their interactions with others, and their connection to their culture. Traumas of sexual abuse, physical abuse, and violence, overlaid with historical and cultural trauma, can lead young people to disregard or devalue modesty and to develop inappropriate sexual behavior. Inappropriate sexual behaviors can have wide-ranging impact on the children themselves, and can also significantly affect the family, the extended family, and the community. Ultimately, inappropriate behavior can result in serious negative social or legal consequences. Honoring Children, Respectful Ways<sup>8</sup> is designed to honor AI/AN children and promote their self-respect while also promoting respect for others, elders, and all living things.

The Honoring Children, Respectful Ways curriculum teaches young

people culturally congruent ways to honor themselves. The use of traditional healing and cultural practices encourages young people to identify with their AI/AN heritage. This treatment approach is congruent with an evidenced-based group treatment program for children with sexual behavior problems.<sup>3</sup> In addition, Honoring Children, Respectful Ways is an approach that can be implemented as a prevention or intervention treatment program that helps AI/AN children and their families to connect with their traditional values, ways, and practices, and to develop positive beliefs about themselves and healthy values and behaviors in their relationships with others.

### *Honoring Children, Honoring the Future*

The impact of youth suicide in Indian country cannot be underestimated. The resultant loss of family members reverberates throughout the community, putting other family members at risk for depression, grief reactions, poor work performance, drug and alcohol use, and domestic violence, as well as for contemplations of suicide. The American Indian Life Skills Development Curriculum (AILSDC),<sup>6</sup> the only evidence-based suicide prevention program in Indian country recognized by SAMHSA and the National Registry of Effective Programs, is the clinical component of Honoring Children, Honoring the Future. The larger intervention includes supports for case consultation, program development, and training in risk.

The AILSDC uses risk and protective factors specific to AI/AN youth as the basis for its prevention strategies. The curriculum, designed for middle- and high-school students, teaches such life skills as communication, problem solving, depression and stress management, anger regulation, and goal setting. Problem solving and suicide intervention skills are taught through activities that encourage students to seek out cultural knowledge in their communities. AILSDC curriculum is specifically tailored to be compatible with the norms, values, beliefs, and attitudes of Native communities. Special attention is paid to worldviews, communication styles,

and forms of recognition.

### *Honoring Children, Mending the Circle*

Trauma-Focused Cognitive-Behavioral Therapy (TF-CBT) is an evidence-based application of cognitive behavioral techniques to support the healing process of trauma in children. Honoring Children, Mending the Circle<sup>2</sup> is grounded in a traditional framework that supports the AI/AN traditional belief in spiritual renewal leading to healing and recovery.

The TF-CBT adaptation is based on traditional AI/AN beliefs and practices about behavior, health, healing, humor, and children. The premise is the belief that AI/AN cultures have current healing practices, activities, and ceremonies that, like cognitive-behavioral therapy, instruct individuals about how to manage thoughts, emotions, and physical reactions. For example, with trauma-exposed children, a common symptom is intrusive thoughts that create anxiety and inability to concentrate. During many traditional ceremonies and activities traditional healers instruct participants to “leave bad thoughts at the door” or “come in with good thoughts.” A similar technique used in TF-CBT is the “stop sign.” A child is instructed to use a stop sign image when intrusive thoughts begin.

Common reactions to trauma include physical sensations of rapid heartbeat and breathing that result in distress or discomfort. Relevant tradi-

**T**here are currently over 550 federally recognized tribes in the United States. There are 33 states with reservations nationwide. Twenty-one of the 24 states located west of the Mississippi River have at least one Indian reservation within their borders. Tribes range from two to three members in several California tribes to the Western Band of the Cherokee Nation, headquartered in Oklahoma, with over 300,000 members. Navajo Nation, located at the Four Corners region connecting Utah, Arizona, Colorado and New Mexico, has over 200,000 members.

tional instructions during ceremonial or related activities might be to “Bring yourself to this place, think about this place, close your eyes, breathe in, think about where your body is, your spirit, your connection with Mother

these sacred teachings. With Honoring Children, this prophecy has been partially fulfilled. Respect for American Indian and Alaskan Native ways of healing is being upheld.



Earth, you being okay with who you are.” This kind of instruction is similar to the relaxation techniques of TF-CBT.

### Summary

The Indian Country Child Trauma Center is providing important resources to American Indian and Alaskan Native communities. Beyond the culturally-based therapeutic approaches, the Center offers training and implementation support that is also culturally based. The guiding vision is that Native children who are experiencing trauma will be able to access treatment that is structured and systematic, but also culturally responsive, promoting connection with their community, their culture, and their heritage.

There is a prophecy held sacred by Native people which foretold the coming of a different people who would bring disease and sickness to the Great Turtle Island (America). The story tells that it would be the ancient traditions and teachings of past generations that would help Native people climb up and regain their heritage as proud and rightful Nations. The Native people hold to the promise of

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*The authors are dedicated to providing more trauma informed services for American Indian and Alaskan Native children. For more information, please go to [www.icctc.org](http://www.icctc.org).*

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# Creating a Trauma-Informed Child Welfare System

This issue of *Focal Point* presents the story of Aaron (page 9), whose life was deeply influenced by childhood experiences of severe physical abuse, sexual abuse, and systems-induced trauma. Unfortunately, Aaron's story is typical of many abused and neglected children and adolescents who become involved with the child welfare system. Each year, there are more than 500,000 children living in out-of-home child welfare placements.<sup>6</sup> It is well established that abused and neglected children suffer from short- and long-term psychological and behavioral difficulties. Among youth in the foster care system, it is estimated that more than half experience at least one significant psychological disorder, including depression, posttraumatic stress disorder (PTSD), social phobia, panic syndrome, or drug dependence.<sup>2</sup>

The most common sources of traumatic experiences for children who become involved in the child welfare system are abuse, neglect, and domestic violence. Like Aaron, many children in the child welfare system are exposed to multiple or complex traumas. What is more, children are often further traumatized by their involvement with the child welfare



system itself. Common causes of such system-induced trauma include repeated, insensitive, or humiliating interviews; unnecessary ruptures of family, extended family, and community relationships; repeated changes of placement; confrontations with abusers; and court testimony. There is growing attention to the need to create trauma-informed child welfare systems that are more aware of and responsive to the needs of vulnerable and traumatized children.<sup>8</sup> Most recently, the National Child Traumatic Stress Network (NCTSN) has described services that are designed to

reduce the impact of trauma on the child and family as trauma-informed services.<sup>4</sup>

Many child welfare systems around the country lack the ability to respond sensitively to the specific needs of children with complex trauma issues. This article explores challenges to creating trauma-informed child welfare systems and provides recommendations for future directions in the field.

## Eight Essential Elements

As a first step in helping to create child welfare systems that are more trauma informed, the NCTSN has identified eight essential elements of trauma-informed child welfare practice.<sup>5</sup> The eight essential elements are as follows:

1. Maximize the child's sense of safety.
2. Connect children with professionals who can assist them in reducing overwhelming emotions.
3. Connect children with professionals who can help them develop a coherent understanding of their traumatic experiences.
4. Connect children with profession-

als who can help them integrate traumatic experiences and gain mastery over their experiences.

5. Address ripple effects in the child's behavior, development, relationships, and survival strategies following a trauma.
6. Provide support and guidance to the child's family.
7. Coordinate services with other agencies.
8. Ensure that caseworkers manage their own professional and personal stress.

Achieving these eight essential elements requires work at the level of individual children, the children's immediate families (including both foster parents and biological parents), and the child welfare system.

At the individual level, children's safety must be ensured, and children must be connected with services that will help them process and integrate traumatic experiences. At the family level, both foster parents and biological parents need to learn about trauma and its effects, as well as how to provide a safe and supportive environment for a traumatized child. Often, biological and foster parents also need information about what resources the system can offer to support them, including resources for increasing parenting competency.



Providing training for the biological parents is particularly important, given the focus on reunification in the child welfare system.

On a systemic level, the creation of a more trauma-informed system requires educating all child welfare staff (direct service providers, management, and foster parents) about the impact of childhood traumatic experiences and about how systems can traumatically impact a child. Training on these topics should include basic definitions of trauma, information about how children vary in their experiences of and reactions to trauma, and a discussion of cultural interpretations of traumatic events. Training should emphasize that different forms of maltreatment impact children differently and cause different symptoms. The short- and long-term impact of trauma, and the development of maladaptive coping strategies as a response to trauma, should also be discussed. Training should also emphasize the importance of performing a thorough assessment, including taking a detailed trauma history, identifying salient symptoms, and discovering trauma triggers. Child welfare workers and administrators should receive training in effectively communicating a child or family's trauma history to other professionals, foster parents, or biological parents; and in developing an intervention plan that is consistent across child-serving systems. Only after child welfare staff, foster parents, and biological parents have been trained in this manner can appropriate placements and intervention decisions be made.

Building awareness about trauma is necessary, but not sufficient, in the creation and implementation of a trauma-informed system. Caseworkers must also change their practice. They should be supported in seeking out trauma-informed mental health providers. These providers are trained to deliver established trauma treatments that are consistent with the eight essential elements in that they focus on maximizing interpersonal safety, reducing negative emotions, and helping a child integrate traumatic experiences and achieve mastery over the traumatic experience. These interventions teach children practical ways to identify and control the

## CHILD WELFARE SYSTEM TRAINING TOPICS

- *How children experience trauma*
  - *Maltreatment issues*
  - *System-induced trauma*
- *Immediate and long term impact of trauma*
- *Understanding and adequately assessing the unique trauma experience of the child*
  - *Using assessment tools*
  - *Using the trauma history*
- *Identifying trauma triggers*
- *Communicating trauma history to other professionals, including foster parents and law enforcement*
- *Continuity of Care: Developing an intervention plan that is consistent across systems*
- *Foster parent competencies*
- *Skills training for biological parents*

emotions associated with traumatic memories, typically using relaxation techniques (e.g., focused breathing or progressive muscle relaxation), techniques for controlling intrusive thoughts (e.g., "thought stopping"), and positive self-soothing activities (e.g., visualization).

Treatment strategies that address the individual child's trauma experience and incorporate evidence-based, practical interventions show promise for the future of treatment for traumatized children. For example, the Assessment-Based Treatment for Traumatized Children: A Trauma Assessment Pathway<sup>7</sup> model uses an individualized assessment process as a basis for selecting an appropriate evidence-based intervention for a child with trauma symptoms. In some cases of complex trauma, an evidence-based treatment may not be the best choice. In these cases, an individualized treatment approach should be

employed to address the most prevalent symptoms, while work continues within the larger system to meet the child's particular needs.

More generally, trauma-informed child welfare systems work to ensure that trauma-affected children and families are appropriately linked to services and resources in the community. One challenge is ensuring that trauma-affected children are appropriately identified. Child-serving agencies (including the courts, child welfare, and juvenile justice) should be made aware of their options for making referrals and be informed about how to assess whether or not a child needs a referral for trauma-specific or general mental health services. Use of a trauma assessment tool (e.g., the Child Welfare Trauma Referral Tool)<sup>3</sup> provides a structured way for caseworkers to assess a child's trauma history, the severity of the child's reactions to the trauma, and any developmental concerns. A further challenge is identifying providers who are qualified to deliver the best evidence-based services available. A coordinated response between referring agencies and treatment providers helps ensure that children and families receive the best promising and/or evidence-based treatments available. Although challenging, it is essential that child-serving agencies are informed about best practices and know who in their community provides such services. Child welfare staff can obtain a list of qualified providers by directly contacting the developers of an evidence-based practice.

### A Community Protocol

Involvement in the child welfare system can further traumatize an already vulnerable child. In this issue, Aaron's story illustrates how something as simple as asking a child to visit with his abusive mother can result in a lifetime of traumatic memories. Achieving a coordinated child welfare system response that serves to heal, rather than re-traumatize a child, requires creating a community

protocol that focuses on addressing the complex and varying needs of the individual children served. Open communication among agencies is essential. Agencies can share information and coordinate their responses for individual children via an interdisciplinary child protection team that includes representatives from a variety of child-serving agencies and meets regularly to focus on a specific child's case. Child protection teams often include social workers, law enforcement agents, district attorneys, medical doctors, and mental health counselors. The child's attorney or advocate can join these meetings to



provide a voice for the child. Working together, team members can share their various perspectives to create a plan for the child that considers his unique trauma experiences and needs.

Former foster youth, foster parents, and biological parents also have valuable perspectives to contribute to community efforts to create a child welfare system that heals rather than re-traumatizes. These consumers of child welfare services have important

information about ways to improve child welfare treatment, case management, and services. Creating opportunities and incentives to air and act upon these perspectives is a key element in creating a child welfare system that avoids further traumatization, and promotes healing for the children and families served.

Another way systems can avoid further traumatizing children is through the use of forensic interviewing, in which a child can tell her story to a trained interviewer who is experienced in sensitively obtaining the details of the abuse in a manner that is defensible in court. Other agencies can then use the forensic interview and transcripts to review the abuse details, eliminating the need for the child or parents to retell the story.

Finally, it is important to recognize the impact on a child and family if the child has to testify in court. Coordination between the agencies involved serves to minimize the stress children experience when they are called into court and helps prevent re-traumatization. The Kids and Teens in Court program in San Diego, California, brings the components of trauma-focused cognitive-behavioral therapy into a real courtroom.<sup>1</sup> Prior to appearing in court, children visit the courtroom and learn what to expect when they testify. They are also coached in anxiety reduction, cognitive coping, and relaxation techniques. The use of this practice in court preparation provides children with skills that will enhance their ability to understand the interplay of their feelings, thoughts, and behaviors; help them regulate their emotions; and increase their ability to keep themselves safe both in the courtroom and in other areas of their lives.

### Policies and Procedures

The core of trauma-informed child welfare practices is knowledge. In this type of child welfare system, staff are encouraged to stay up-to-date on current knowledge in the field of child trauma. Effective trauma-informed

policies guide the care of vulnerable and traumatized children. These policies should clearly state how the eight essential elements of a trauma-informed child welfare system are to be implemented.

Policies can be structured to ensure that traumatized children in the child welfare system are served by staff who understand their special needs. Policies should be individualized depending upon the specific clientele of the agency and available community resources. Examples of trauma-informed child welfare policies include the following:

- Immediately after entering the system, children will be assessed for the existence of trauma-related symptoms and specific interventions that would be most beneficial.
- To the extent that it is developmentally appropriate, children and adolescents will be involved in developing their case plans.
- All child welfare system staff, as well as foster and biological parents, will be trained to recognize behavioral indicators of trauma.
- Foster and biological parents will be provided with ongoing support by child welfare staff to manage children's trauma-related behaviors, thus reducing the risk of systemic trauma through disrupted placements.

### Conclusion

While it has long been clear that virtually all of the children involved in the child welfare system have suffered from one or multiple traumatic experiences, systems continue to struggle to offer an appropriate healing response. The eight essential elements provide a framework for creating a responsive, healing system. Within this framework, the perspectives of children, adolescents, and biological and foster parents can be integrated with provider and

system perspectives to identify and address the individual and systemic needs of traumatized children. The use of assessment-focused products, such as the Trauma Assessment Pathway and the Child Welfare Trauma Referral Tool, hold promise for helping to ensure that trauma-affected children are identified, and that they receive appropriate and effective trauma-informed interventions. Finally, strategies are being developed to ensure that system involvement serves to heal, rather than re-traumatize children and families. Further exploration and discussion in each of these areas is a necessary step in continuing efforts to create child welfare systems that are truly trauma-informed.

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## Child Trauma: The Role of Public Policy

Public policy decisions play a pivotal role in prevention, service, and treatment efforts for children who have been affected by traumatic events. An understanding of this role is a critical part of well-informed discussion of the impact of traumatic events on the health and well-being of children and families. Well-informed policy decisions can lead to better prevention efforts, more appropriate services, more effective treatments, and sufficient funding for these activities, but poor decisions can fail to help or make a bad situation worse. Ideally, policymakers are informed by a comprehensive understanding of how traumatic events impact children and families. In reality, policymakers may not have the information they need.

Child traumatic stress occurs when children are exposed to traumatic events, and when this exposure overwhelms their ability to cope with what they have experienced. Policies cannot prevent all bad things from happening to children, but they can help prevent some traumatizing events from occurring and help ensure that the necessary infrastructure is in place when events do occur and support is needed.

Good public policies must address the complexities of child trauma directly. Child trauma comes in many forms, including abuse, disaster, bereavement, violence, or war, and affects all ages, genders, cultures, and communities. Child trauma occurs, is diagnosed, and is treated in a variety of settings, including hospitals, schools, surrogate care, or family homes. Funding for services comes from multiple sources, including federal health care, private health insurance, state block grants, federal discretionary programs, and personal income. Creating effective policy in such complex contexts requires strong collaborative relationships among policy leaders, affected families, and all those who work with traumatized children.

### Policy Interventions at Multiple Levels

Repeated exposure to traumatic events can affect a child's development and greatly increase the risk of future serious health problems, even death.<sup>4</sup> Left untreated, problems can worsen, negatively affecting a child's educational, social, and mental health outcomes. Fortunately, knowledge about

how best to identify and treat traumatized children is increasing. Policy interventions can help ensure that this knowledge continues to expand, and that what is learned is mobilized effectively to improve the lives of traumatized children. Such interventions are needed at the federal, state, local community, and program/treatment level.

### *Federal*

Federal policies do address some forms of child trauma, but these efforts are piecemeal and uncoordinated. In contrast, a coordinated public health approach would work to reduce the impact of trauma across the population as a whole.<sup>6</sup> This kind of approach targets different segments of the population with different kinds of efforts focusing on prevention programs for the general public, early detection and intervention for populations at risk (including children), and treatment for those who need it. Public health programs can provide psychoeducational information to the public about what child trauma is, what signs of trouble to watch for, and where help can be sought. Such campaigns have been launched

around acute events, such as the September 11, 2001 terrorist attacks and the 2005 Gulf Coast hurricanes. Incorporating trauma information into standard public health and mental health campaigns could provide a psychoeducational “vaccine,” helping families and others to understand,

### *Local Community*

Policy efforts at the local level can support collaborative partnerships among agencies whose missions overlap in the service of children’s needs. This kind of collaboration generally requires policy changes at the institu-

of mental health services into schools was shown to be effective in addressing the chronic exposure to violence experienced by many children in the Los Angeles Unified School District.<sup>10</sup>

Ideally, all child-serving systems will someday have an understanding about the impact of trauma and how to collaborate to provide support for children and families. Such community partnerships are not yet the standard of care, as noted in a recent survey by the National Child Traumatic Stress Network (NCTSN).<sup>11</sup> The survey revealed major shortcomings in the ways in which trauma issues were addressed. Regardless of the type of service system, agencies rarely received in-depth information about a child’s trauma history when a child was first referred to them. Collecting and sharing such information is critical to the development of an effective case management and treatment plan.

*Incorporating trauma information into standard public health and mental health campaigns could provide a psychoeducational “vaccine.”*

prepare for, and support children when they are exposed to traumatic events of all kinds.

Federal policies should also support evaluation of prevention and intervention efforts, as well as coordinated studies of prevalence and incidence across all trauma types. Large gaps exist in available information, and the information that currently exists in federal studies and reports has not been synthesized or comprehensively analyzed.<sup>3</sup> A thorough synthesis could provide important guidance about how to create and implement effective prevention and intervention programs.

### *State*

State policies can directly affect the ways in which child trauma services are integrated into child-serving state systems, including child welfare, mental health and addiction services, juvenile justice, and schools. Several states (Ohio, Oklahoma, and New Mexico) are currently addressing the impact of trauma through state infrastructure grants, funded by the Substance Abuse and Mental Health Services Administration to help states transform their mental health systems. In the state of Massachusetts, policymakers are fully involved in a coalition of concerned advocates that is addressing trauma in the public school system. This partnership led to specific legislative changes and funding for schools to remove trauma as a barrier to learning.<sup>1</sup>

tional or agency level. Creating effective collaboration also requires building trust among diverse professional groups, and between families and the organizations who are offering services to them.

Several programs have been successful in building such partnerships.<sup>8</sup> In one case, a prevention effort, a partnership between a local substance abuse program and a pediatric primary care clinic helped mothers obtain the addiction treatment they needed and get pediatric care for their children at the same location. Because this program succeeded, literacy programs and early childhood education services were added. In a second case, a community child development clinic joined with a police department to create a child development/community policing program to help children and families who were affected by domestic and community violence. This program expanded to offer “24/7” on-call services for child clinicians to work with first responders in cases of domestic violence, and to offer training in this model to police and other clinicians. In a third case, the integration

### *Program/Treatment*

Policy changes within programs and agencies can directly affect indi-



vidual treatment and services. In this issue, the report by Ingelman and colleagues (pages 23-26) describes an approach that can help guide caseworkers to make more trauma-informed decisions. This approach is founded on eight essential elements; for example, "Maximize the child's sense of safety," and "Address ripple effects in the child's behavior, development, relationships, and survival strategies following a trauma." Policies that promote the inclusion of families as treatment partners are also critical for providing high quality care.

### A Broad View of Child Trauma

The complexity of the child trauma issue underscores the responsibility of the public health system to move beyond a narrow focus on medical issues.<sup>7</sup> Understanding public health as closely aligned with social justice leads to greater clarity about how policy directives affect children exposed to trauma. Taking this broader view highlights key policy imperatives such as improving the public health system, reducing socioeconomic disparities, addressing health determinants (such as poverty, pollution, unemployment, or hunger), and planning for health emergencies with a focus on the needs of the most vulnerable, including children. The chronic underfunding of the public health system, with mental health and trauma needs often particularly neglected, results in an unfortunate over-emphasis on intervention only after problems have become severe (and possibly less amenable to treatment), and a corresponding under-emphasis on prevention and early intervention. Emergency response plans often fail to consider the vulnerabilities of those without resources, or the impact that chronic exposure to trauma and the lack of access to health care may have on chances for future recovery. A broad public health perspective would take into account the multiple ways that social justice issues, such as poverty, racism, and violence, affect the health and safety of children.

Policymakers generally rely heavily on science-based evidence when making decisions.<sup>5</sup> This can work well when the science base is adequate.

When it is not, then society has a responsibility to fund research that moves beyond biological- or individual-level causes and cures to a larger psychosocial, public health perspective. To enhance the research base, research funding priorities should expand to include qualitative information, economic evaluations of the total impact of interventions and policy changes, systematic research of actual demonstrations of techniques, and the full participation of survivors in the identification of research needs.<sup>2</sup>

### Current Policy Issues

In 2006-2007, many federal and state policy-related challenges illustrate the tensions imposed by the chronic underfunding of public health and social services related to child trauma. Examples of successful recent efforts, initiatives that are in progress, and some notable setbacks include:

- Head Start Federal legislation for programs to serve children at risk of abuse addressed support for home-based services, training of parents in child development, promotion of collaborations between Head Start and child welfare agencies, and training of Head Start staff regarding children exposed to trauma.
- Federal legislation enacted in the Violence Against Women Act extended services to children exposed to domestic violence.
- The State Child Welfare Legislation Report<sup>9</sup> highlighted key state-level child welfare issues, including some which involve children exposed to trauma:
  - Adoption, including adoption of children with abuse histories;
  - Parent and child involvement in case planning to ensure a comprehensive understanding of the child's history;
  - Social worker loan forgiveness programs to attract and keep a workforce in place and reduce turnover; and
  - Strengthening of behavioral health care for children in the child welfare system, so that training in trauma-informed care



can be integrated into child services through these service structures.

- The Deficit Reduction Act made several highly significant changes to Medicaid that have the potential for reducing services for traumatized children. Such changes include reductions in reimbursement for Medicaid rehabilitation and school-based services, and the addition of restrictions to the scope of Medicaid rehabilitation services.
- Following a Government Accounting Office report which documented at least 12,700 children placed in child welfare and juvenile justice systems solely to access mental health services, new policies have been recommended. Efforts around custody (e.g., Keeping Families Together Act, HR 5803) establish state family support grants to help ensure that families do not have to give up custody of their children solely to obtain mental health services. The traumatic impact of losing one's child, or one's family, in order to obtain health care is an example of the secondary traumatization that can be caused by the very system that is supposed to help. This Act is intended to prevent these losses from occurring.

The integration of high quality, trauma-informed services into all child-serving systems is a more efficient way to allocate scarce resources to ensure that traumatized children and families obtain appropriate care regardless of the service system that helps them. The National Child Traumatic Stress Network and its national and local partners are working in multiple ways to raise the standard of care for traumatized children in all service systems, including developing and supporting policies that help this integration of services and system transformation to occur.

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# **Interventions**

# Dialectical Behavior Therapy in a Nutshell

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## INTRODUCTION

Dialectical behavior therapy (DBT) is a comprehensive cognitive-behavioral treatment for complex, difficult-to-treat mental disorders (Linehan, 1993a,b). Originally developed for chronically suicidal individuals, DBT has evolved into a treatment for multi-disordered individuals with borderline personality disorder (BPD). DBT has since been adapted for other seemingly intractable behavioral disorders involving emotion dysregulation, including substance dependence in individuals with BPD (Linehan, Schmidt, Dimeff, Craft, Kanter, & Comtois, 1999; Dimeff, Rizvi, Brown, & Linehan, 2000), binge eating (Telch, Agras, & Linehan, in press), depressed, suicidal adolescents (Miller, 1999; Rathus & Miller, 2000), depressed elderly (Lynch, 2000), and to a variety of settings, including inpatient and partial hospitalization, forensic settings (Swenson, Sanderson, Dulit, & Linehan, in press; McCann & Ball, 1996; McCann, Ball, & Ivanoff, under review).

DBT is based on a combined capability deficit and motivational model of BPD which states that (1) people with BPD lack important interpersonal, self-regulation (including emotional regulation) and distress tolerance skills, and (2) personal and environmental factors often both block and/or inhibit the use of behavioral skills that clients do have, and reinforce dysfunctional behaviors. DBT combines the basic strategies of behavior therapy with eastern mindfulness practices, residing within an overarching dialectical worldview that emphasizes the synthesis of opposites. The term dialectical is also meant to convey both the multiple tensions that co-occur in therapy with suicidal clients with BPD as well as the emphasis in DBT of enhancing dialectical thinking patterns to replace rigid, dichotomous thinking. The fundamental dialectic in DBT is between validation and acceptance of the client as they are within the context of simultaneously helping them change. Acceptance procedures in DBT include mindfulness (e.g., attention to the present moment, assuming a non-judgmental stance, focusing on effectiveness) and a variety of validation and acceptance-based stylistic strategies. Change strategies in DBT include behavioral analysis of maladaptive behaviors and problem-solving techniques, including skills training, contingency management (i.e., reinforcers, punishment), cognitive modification, and exposure-based strategies.

As a comprehensive treatment, DBT serves the following five functions: 1) enhances behavioral capabilities, 2) improves motivation to change (by modifying inhibitions and reinforcement contingencies), 3) assures that new capabilities generalize to the natural environment, 4) structures the treatment environment in the ways

essential to support client and therapist capabilities, and 5) enhances therapist capabilities and motivation to treat clients effectively. In standard DBT, these functions are divided among modes of service delivery, including individual psychotherapy, group skills training, phone consultation, and therapist consultation team.

## ORIGINS OF DBT

DBT grew out of a series of failed attempts to apply the standard cognitive and behavior therapy protocols of the late 1970's to chronically suicidal clients. These difficulties included:

1. focusing on change procedures was frequently experienced as invalidating by the client and often precipitated withdrawal from therapy, attacks on the therapist, or vacillations between these two poles;
2. teaching and strengthening new skills was extraordinarily difficult to do within the context of an individual therapy session while concurrently targeting and treating the client's motivation to die and suicidal behaviors that had occurred during the previous week;
3. individuals with BPD often unwittingly reinforced the therapist for iatrogenic treatment (e.g., a client stops attacking the therapist when the therapist changes the topic from one the client is afraid to discuss to a pleasant or neutral topic) and punished them for effective treatment strategies (e.g., a client attempts suicide when the therapist refuses to recommend hospitalization stays that reinforce suicide threats).

To overcome these difficulties, several modifications were made that formed the basis of DBT. First, strategies that reflect radical acceptance and validation of clients' current capabilities and behavioral functioning were added to the treatment. The synthesis of acceptance and change within the treatment as a whole and within each treatment interaction led to adding the term "dialectical" to the name of the treatment. This dialectical emphasis brings together in DBT the "technologies of change" based on both principles of learning and crises theory and the "technologies of acceptance" (so to speak) drawn from principles of eastern Zen and western contemplative practices. Second, the therapy as a whole was split into several different components, each focusing on a specific aspect of treatment. The components in standard outpatient DBT are highly structured individual or group skills training (to enhance capability), individual psychotherapy (addressing motivation and skills strengthening), and telephone

Dimeff, L., & Linehan, M.M. (2001). Dialectical behavior therapy in a nutshell. *The California Psychologist*, 34, 10-13.

contact with the individual therapist (addressing application of coping skills). Third, a consultation/team meeting focused specifically on keeping therapists motivated and providing effective treatment was also added.

#### **BEHAVIORAL TARGETS AND STAGES OF TREATMENT IN DBT**

DBT is designed to treat clients at all levels of severity and complexity of disorders and is conceptualized as occurring in stages. In Stage 1, the primary focus is on stabilizing the client and achieving behavioral control. Behavioral targets in this initial stage of treatment include: decreasing life-threatening, suicidal behaviors (e.g., parasuicide acts, including suicide attempts, high risk suicidal ideation, plans and threats), decreasing therapy-interfering behaviors (e.g., missing or coming late to session, phoning at unreasonable hours, not returning phone calls), decreasing quality-of-life interfering behaviors (e.g., reducing behavioral patterns serious enough to substantially interfere with any chance of a reasonable quality of life (e.g., depression, substance dependence, homelessness, chronically unemployed), and increasing behavioral skills (e.g., skills in emotion regulation, interpersonal effectiveness, distress tolerance, mindfulness, and self-management). In the subsequent stages, the treatment goals are to replace “quiet desperation” with non-traumatic emotional experiencing [Stage 2], to achieve “ordinary” happiness and unhappiness and reduce ongoing disorders and problems in living [Stage 3], and to resolve a sense of incompleteness and achieve joy [Stage 4]. In sum, the orientation of the treatment is to first get action under control, then to help the client to feel better, to resolve problems in living and residual disorders, and to find joy and, for some, a sense of transcendence. The overwhelming majority of data to date on DBT has focused on the severely and multi-disordered client who enters treatment at Stage 1.

#### **MOVEMENT, SPEED, AND FLOW**

DBT requires that the therapist balance use of acceptance and change strategies within each treatment interaction, from the rapid juxtaposition of change and acceptance techniques to the therapist's use of both irreverent and warmly responsive communication styles. This dance between change and acceptance are required to maintain forward movement in the face of a client who at various moments oscillates between suicidal crises, withdrawal and dissociative responses, rigid refusal to collaborate, attack, rapid emotional escalation and a full collaborative effort. In order to movement, speed, and flow, the DBT therapist must be able to inhibit judgmental attitudes and practice radical acceptance of the client in each moment while keeping an eye on the ultimate goal of the treatment: to move the client from a life in hell to a life worth living as quickly and efficiently as possible. The therapist must also strike a balance between unwavering

centeredness (i.e., believing in oneself, the client, and the treatment) and with compassionate flexibility (i.e., the ability to take in relevant information about the client and modify one's position accordingly, including the ability to admit to and repair one's inevitable mistakes), and a nurturing style (i.e., teaching, coaching, and assisting the client) with a benevolently demanding approach (i.e., dragging out new behaviors from the client, recognizing the client's existing capabilities and capacity to change, having clients “do for themselves” rather than “doing for them.”

#### **RESEARCH IN DBT**

The first DBT randomized clinical trial compared DBT to a treatment-as-usual (TAU) control condition (Linehan, Armstrong, Suarez, Allmon, & Heard, 1991; Linehan, Heard, & Armstrong, 1993; Linehan, Tutek, Heard, & Armstrong, 1994). DBT subjects were significantly less likely to parasuicide during the treatment year, reported fewer parasuicide episodes at each assessment point, and had less medically severe parasuicides over the year. DBT was more effective than TAU at limiting treatment drop-out, the most serious therapy-interfering behavior. DBT subjects tended to enter psychiatric units less often, had fewer inpatient psychiatric days per client, and improved more on scores of global as well as social adjustment. DBT subjects showed significantly more improvement in reducing anger than did TAU subjects. DBT superiority was largely maintained during the one-year post-treatment follow-up period. Since then, two RCTs have been conducted evaluating DBT as compared to TAU and one study has been conducted comparing DBT to an ongoing parallel treatment with matched controls. In general, results have largely replicated the initial RCT. Koons and her associates found that BPD women in the VA system assigned to DBT had greater reductions in parasuicide acts and in depression scores than those assigned to TAU and those assigned to DBT (but not to TAU) also had significant improvements in suicide ideation, hopelessness, anger, hostility, and dissociation (Koons, Robins, Tweed, Lynch, Gonzalez, Morse, Bishop, Butterfield, & Bastian, in press). In our recent application of DBT to substance dependent individuals with BPD, DBT subjects had greater reductions in illicit substance use (measured by both structured interview and urinalyses) both during treatment and at follow-up and greater improvements in global functioning and social adjustment at follow-up (Linehan, et al., 1999).

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# First Aid for Traumatized Children

## General Guidelines

1. Trauma activates the more primitive parts of the brain. Verbal processing and the higher order thinking/decision-making of the brain's frontal cortex are constricted.

Non-verbal communications are more readily processed than any verbal communications; actions will speak much louder than words. Effective self-soothing rituals built on smell and touch are particularly powerful.

Nonverbal helping skills involve the informed use of voice quality, gestures, eye contact, posture, paraverbals, facial expressions and use of the environment.

2. Physical touch can be triggers for children who have been physically or sexually abused and children need physical comfort from nurturing adults.

Attend closely to the child's verbal and nonverbal response when physically comforting a child to find what "safe touch" is for the child. Avoid any command to kiss or hug anyone.

3. Structure and discipline are especially important to traumatized children and these apply to areas of discipline. Children need to understand family rules and expectations and the consequences of positive and negative behaviors.

4. Children need age appropriate factual information to make sense of their world. For children who've been abused and/or neglected, age appropriate information includes understanding what must happen for them to return home, including tasks and activities identified in the service plan. It also includes "safety messages" and specific actions to keep themselves safe.

5. All traumatized children evidence some signs of re-enactment, avoidance or hyper-arousal, sometimes years after the trauma. When this occurs, it is likely that a reminder of the trauma has been experienced, either in thoughts or activity. Provide comfort to the child and record the patterns and emotions to help establish a possible pattern in the behaviors.

6. Avoid activities that are re-traumatizing the child. Limit or prohibit exposure to activities like movies, CDs, videogames that simulate violence.

7. Find ways to give the child age appropriate control in everyday events and interactions.

8. Watch for signs of re-enactment, avoidance, and hyper-arousal.

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## **When a child first enters placement:**

### **Contact and Engagement**

Initiate contact in non-intrusive, compassionate, and helpful manner. Introduce yourself.

### **Safety and Comfort**

Enhance immediate and ongoing safety; initiate and provide physical and emotional comfort:

- “Here is the bathroom.”
- “Here is food.”
- “Here is the safety escape plan for our house.”

### **Stabilization**

Calm and orient emotionally overwhelmed, distraught survivors:

- “Do you want to see where you will be sleeping?”
- “This is our place and you will be staying here tonight.”

### **Information gathering and current needs assessment**

Identify immediate needs: “What do you need right now?”

### **Offer practical assistance to survivor in terms of immediate needs and concerns:**

- “The caseworker will be trying to locate your mom.”
- “The neighbor you stayed with knows how to get in touch with the caseworker and can tell your mom how to do this.”
- “The caseworker left a note for your mom to see when she comes back so she will know that you are safe.”

### **Connection to social supports:**

- “Your brothers and sisters are safe with \_\_\_\_\_ (if siblings cannot be placed together) and tomorrow ...”
- “The caseworker will contact your \_\_\_\_\_ (grandmother, uncle, aunt, older brother) to let them know what happened.”

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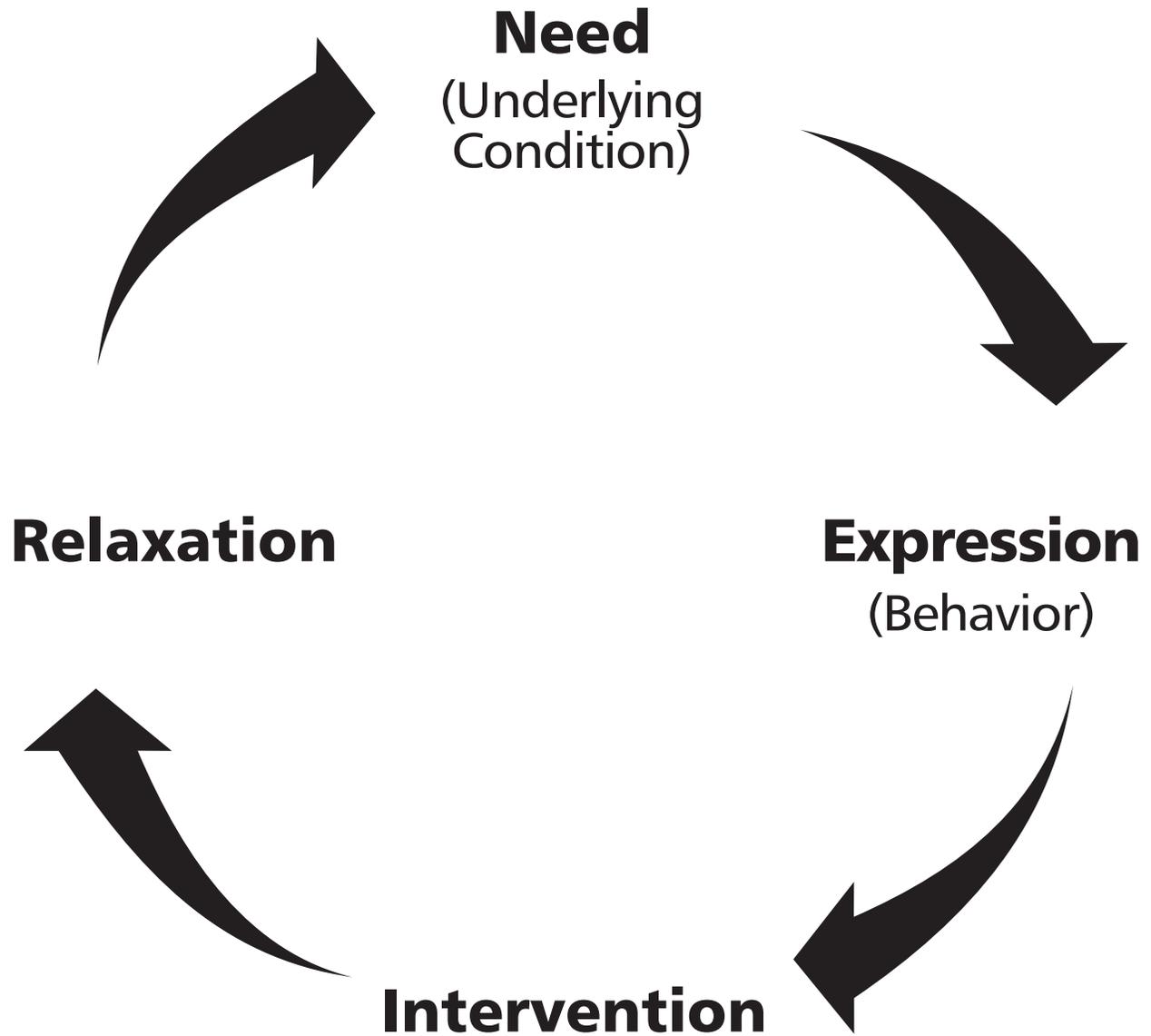
### **Information and coping:**

Provide information about stress reaction and coping to reduce distress and promote adaptive functioning:

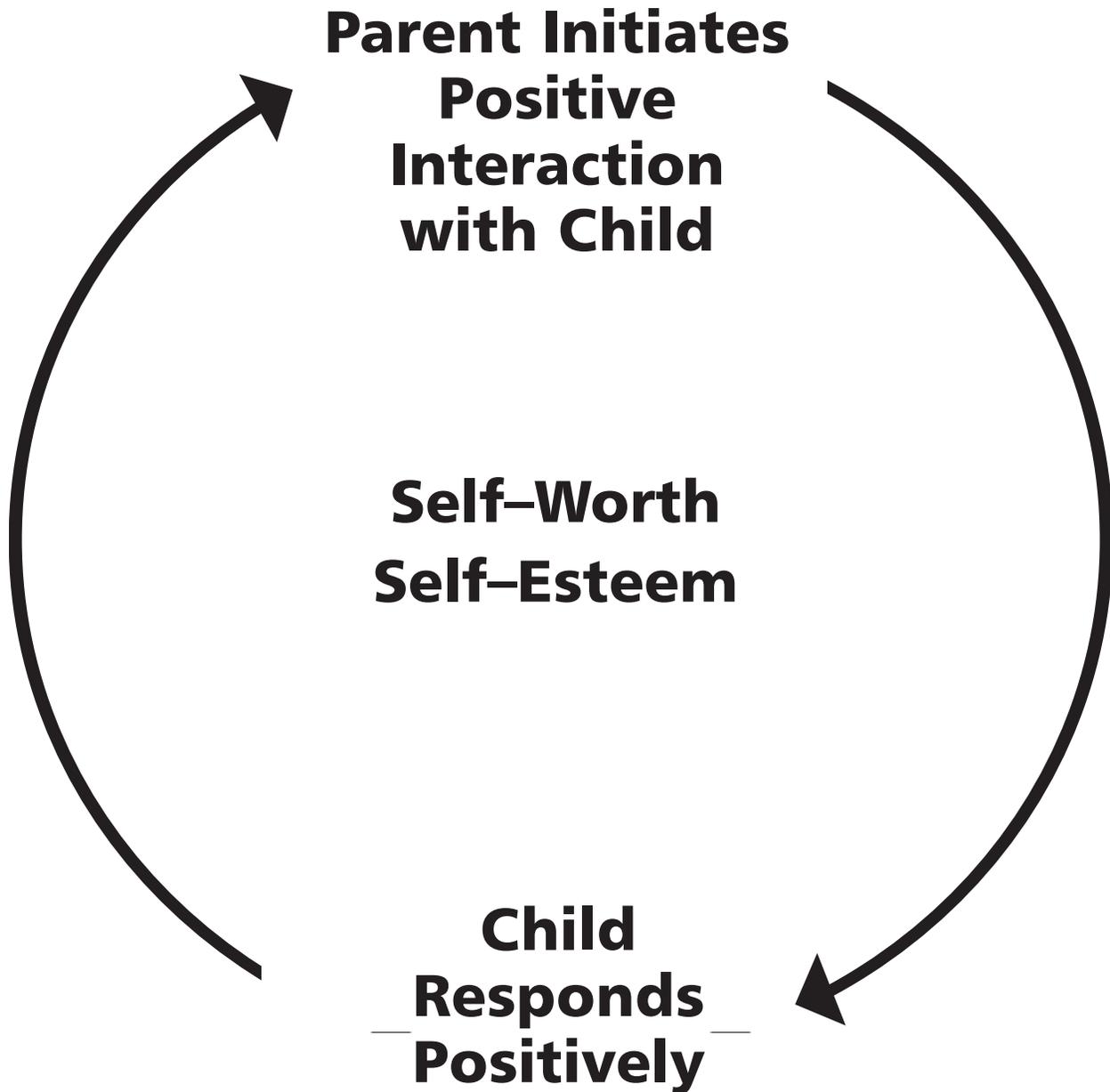
- “Kids tell me how scary the first night was when they first came to my house. Some kids felt like their heart was beating so loud everyone could hear it.”
- Help reestablish the person's sense of control; e.g., “Is it OK if I sit with you?”
- Stabilization; i.e., take it out of the heart and put it into the head.
  - “Can I ask, what's your teddy bear's name?”
  - “Do you like video games? We have about ten that we all play with.”

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# The Cycle of Need: Attachment



## **The Positive Interaction Cycle\***



\* Reproduced from "Attachment and Separation: A Workbook" by Vera Fahlberg, M.D. in PROJECT CRAFT, Training in the Adoption of Children with Special Needs. Ann Arbor, MI: University of Michigan School of Social Work, 1980, pp. V-23. V-25.

# Parenting to Support Emotional Security and Attachment

Although many of the parenting behaviors on this list may already be familiar to you from having used them with other children, you may be surprised by a particular child's negative response to them. When building security and attachment, it is important to know the child, to respond to the child's "cues and clues," and to work in partnership to select parenting behaviors that will meet the child's underlying needs. Allowing enough time and repeating these suggested parenting behaviors again and again can make a positive difference in a child's life.

## 1. Create a positive family life for children.

Feed them when they are hungry.

Take them to the doctor when they are sick.

Help them with their homework.

## 2. Nurture and show empathy through tone of voice.

Because children often "do not hear the words" that are said to them and only respond to the sound of a message, use a soothing, calming, and neutral tone of voice to connect with them.

## 3. Use the nonverbal helping skills to communicate interest.

Smile, wink, and nod to show warmth and interest.

Listen to children's words.

## 4. Provide nurturance through physical touch.

Cuddle children during feedings or while reading a story together.

Rock them in a rocker at bedtime or when they seem upset.

Play "tag" and other physical games.

Comb or arrange their hair.

Give a quick hug when they come home or just before they go to sleep.

*(Caution: A number of children in care have been sexually abused, some without the knowledge of the caseworker or caretakers. Know the history of the child.*

*Touch can be safe and brief, such as patting a child's hand. Pay attention to the child's nonverbal and verbal responses to touch, and act accordingly.)*

**5. Turn off the TV and play games with them.**

**6. Include children in family routines at their own pace.**

Encourage participation in family chores by saying things like: “In this family we take turns drying the dishes. Tonight it's your turn.”

**7. Begin or continue traditions that support belonging and family membership.**

Say things like: “In this family, the birthday person gets to choose the dinner menu.”

**8. Regularly set aside “special time” for sharing good times between child and parent.**

Bake cookies together.

Take walks together.

Laugh, sing, and read together.

**9. Use routines and rules in the home environment to give messages of control and safety.**

Set regular times for meals, play, homework, and bed.

**10. Be concrete when communicating with children.**

Say things like: “Please pick up your clothes off the floor, put them in the laundry basket, and make your bed,” rather than “Clean up your room.”

**11. Identify strengths and provide encouragement.**

Say things like: “You did a good job of setting the table and helping me get ready for dinner.”

**12. Model “naming feelings” so that children can learn that it's “okay” to talk about feelings.**

Say things like: “I feel sad you didn't make the team,” and talk about feelings to tell the child that having feelings and talking about them is “okay.”

**13. Use reflecting responses to help children identify their own feelings.**

Say things like: “You seem kind of sad right now” or “You feel happy.”

**14. Help children to connect their body language with their inner feelings.**

Use reflecting responses, and say things like: “Your face is red and your fist is clenched—you look angry.”

**15. Use reflecting responses to show empathy.**

Say things like: “It seems really hard for you to...” to show that you are aware of the child's feelings.

**16. Provide consequences with genuine empathy.**

Let children find out that behaviors have consequences, but do so by showing genuine empathy.

Say things such as: “You hit Juan on the school bus and now you can't ride the bus for two weeks. You will have to miss soccer. I know how much you like it. You cannot hit people because you are angry. Let's talk about what you can do differently the next time.”

**17. Use the “time in” technique to stop unacceptable behavior.**

“Time in” is “time out”—only within the sight and hearing of the caretaker.

**18. Provide supervision and structure that will fit children's needs as shown by their behaviors.**

**19. Provide choices to cut down on control battles between parent and child.**

Say things like: “You can either play in the pool without diving in or else come in and sit on the towel. The choice is yours.”

**20. Identify the needs behind difficult and/or unacceptable behaviors and then find creative ways to meet those needs.**

If a child hoards food, put some healthy snacks into a backpack and give it to him as a way of reassuring him that food will always be available.

**21. Help children to connect with their parents in a positive way.**

Say things like: “It seems like you really enjoyed going shopping with your mom” or “Your dad really did a good job of showing you how to tie your shoelaces.”



**22. Help the child to make a Life Book, which is a scrapbook containing important pictures of things, people, and events in a child's life and which provides important connections to others.**

**23. Invite the child's parents to visit in your home.**

Use birthdays, holidays, and other types of events and celebrations as natural times for such visits between parents and children.



**24. Provide activities or suggestions for positive visits with parents.**

Say things like: "Be sure to show your mom the picture you drew of the firehouse," or "Maybe the two of you could organize your baseball card collection together."

**25. Provide children with positive information about their parent(s).**

Say things like: "Guess what? Your mom found an apartment last week."

# Guidelines for Talking About Loss\*

The suggestions below can be very helpful when dealing with children who may be grieving recent or past losses. It is advisable to consider the “clues” provided by children's words and/or behaviors when selecting one or more of the suggestions offered.

## 1. Assure the child that she is not alone and will be cared for.

*“I am here and I will be here when you get up tomorrow morning.”*

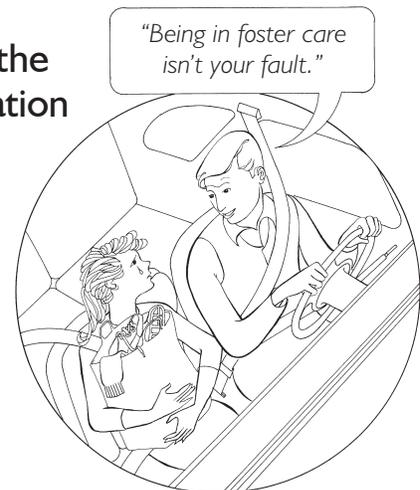
## 2. Talk to the child about things that she knows or has already experienced, and try to connect that information to one of the child's physical senses.

Children, particularly young children, take in information mainly through their physical senses. Connecting the experience to what a child may have seen, heard, felt, touched, or smelled can make the experience real and helps the child move through shock/denial.

*“You know that Mommy had trouble figuring out how to earn money and plan how to use it. Sometimes you heard her crying when she wanted to buy something and didn't have enough money.”*

## 3. Without blaming the parent, explain the adult reality or the facts of the separation and loss.

*“Your Mommy took some money from the store where she was working. Taking money that doesn't belong to you is breaking the law. She had to go to jail until the judge says she can come home.”*



\* Adapted with permission from: Jarrett, Claudia Jewett. 1994. *Helping Children Cope with Separation and Loss*. Boston: Harvard Common Press.

**4. Encourage questions and provide honest answers to them.**

*“I know that this is a lot for you to remember. I am glad that you are asking questions. You will probably think of more later on. I hope you will ask those too.”*

**5. Clearly and firmly respond to any feelings of self-blame on the part of the child.**

*“There is nothing that you did to make this happen.” If appropriate, add some words like: “There is nothing that you can do to make this change.”*

**6. Respect and support all the child's feelings.**

*“You feel angry that your mommy isn't here right now.”*

Using these guidelines can also be helpful with children who have been in care for some time and who were given misinformation or who may be blaming themselves for the loss. Assessing children for self-blame might be a variation of Step 3 (“So what might make a mom take something that didn't belong to her?”).

# Ways to Encourage Attachment

In general, children in care have not experienced healthy attachments. The list below describes actions that are likely to build attachment between the child and the caretaker.

1. Respond to the child when he/she is physically ill.
2. Accompany the child or youth to doctor and dentist.
3. Help the child or youth express and cope with feelings of anger and frustration.
4. Share the child's excitement over his/her achievements.
5. Help the child cope with feelings about moving.
6. Help the child learn more about his/her past by developing a Life Book.
7. Respond to a child who is hurt or injured.
8. Educate the young person about sexual issues.
9. Make affectionate overtures: hugs, kisses, physical closeness. (The child's age will determine what is appropriate; generally, teens resist shows of affection until they are very comfortable with an adult.)
10. Read to the child.
11. Play games.
12. Go shopping together for clothes/toys for the child.
13. Go on special outings: circus, plays, church socials, family events listed in the paper, or the like.
14. Support the youth's outside activities by providing transportation or being a group leader.
15. Help the child with homework when he or she needs it.
16. Teach the child to cook or bake.
17. Teach the child about extended family members through pictures and talk.
18. Help the child understand family "jokes" or sayings.
19. Teach the child to participate in family activities, such as bowling, camping, or skating.
20. Help the child meet the expectations of the other parent.
21. Hang pictures of the child on the wall.
22. Include the child in family rituals.
23. Make statements such as, "In our family we do it this way," in a supportive, not scolding, manner.
24. Say, "I love you."

# **Guidelines for Meeting the Needs of Children Who Have Been Sexually Abused**

1. Offer support to the child in a clear but unobtrusive way.
2. Develop a daily routine and stick to it as much as possible.
3. Provide the child with as much privacy as possible.
4. Offer choices to the child whenever possible.
5. Help the child label his or her emotions.
6. Help the child express his or her feelings directly and in positive, healthy ways.
7. Help the child state his or her needs clearly and directly.
8. Catch the child being good.
9. Provide physical outlets for the child.
10. Encourage creative expression.
11. Help the child to be a child and to experience fun.
12. Provide the child with information so the child knows what is happening and when.
13. Be aware of the increased risk to the child of further abuse and take the necessary steps to prevent it.
14. Do not permit yourself to be talked into taking another child into your home if you are having difficulty managing the children for whom you are currently providing care.

## **Five Elements of a Cover Story**

1. The cover story is what the child and family tell most people about the reason for placement.
2. The cover story is not a lie.
3. The cover story is a generalization, and leaves out details.
4. The cover story is a minimization, and leaves out trauma.
5. The cover story is a universalization, and sounds like a situation many children could be in without feeling ashamed.

## Sample Cover Story: Lillie

Lillie, age 7, comes from a stable, two-parent family, where spanking is used only as a last resort. Her father is a hard worker and dedicated family man, who drinks too much when under stress. He was recently laid off. He later lost his temper and pushed Lillie, who fell into the radiator and got a concussion. She was treated at the hospital and sent home.

Later that same night, Lillie's father got a DUI, was jailed briefly, then went to live with his sister who had bailed him out.

Under all this stress, Lillie began to have tantrums. Two days later, her mother slapped Lillie and gave her a bloody nose. Lillie's mother, concerned about the possibility of further injury after the concussion, took Lillie back to the hospital.

Lillie has been placed in care. On the seventh day, she begins sexual play with dolls. When you give her permission to talk about this, she reveals her uncle Billy had placed his finger in her vagina.

Lillie will be in therapy with a licensed clinical social worker, and she will be a witness in court. The permanency plan is to use the birth family's strengths for reunification.

To explain why she is in care and going to these appointments, Lillie, with the help of her birth parents, caretakers, and caseworker developed a cover story. Because Lillie lives in a small community where people could easily see her going into court or to the mental health center, she also decided to plan for questions about these in her cover story. Following is Lillie's cover story:

My parents are looking full-time for jobs, so I am living with the Smith family for a while. Our helper, the caseworker, knew the Smiths well enough to say I would be well taken care of.

Our helper, the caseworker, also knew a way to help my uncle. We are all going to the court for family meetings with a judge to help Uncle Billy.

Because all this is new for me, I have a special counselor, not the regular school counselor, to help me understand and feel better. This is why I will have to miss some school, or go in the car with my caseworker sometimes.

# Inviting Disclosure of a Painful Secret

1. Use a private setting.
2. Sit at or below the child's level.
3. Use informal body posture.
4. Use very casual eye contact. (Too much direct eye contact may make the child's shame feel even stronger. Going for a walk or a drive while you talk is often relaxing for the child.)
5. Control your emotions.
6. Look for the child's emotions; watch facial expression, gestures, and posture.
7. Give the child permission to feel emotions.
8. Use the child's words, especially sexual terms.
9. Use words to reassure the child, for example:
  - ◆ "It is good that you tell me. Nothing you tell me would make me not care about you."
10. Give the child permission to tell, for example:
  - ◆ "I won't think you are bad, and I won't punish you."
  - ◆ "I know you try to kiss like that because you want to feel close. Tell me how you learned that kind of kiss."
  - ◆ "I can tell you were hurt. It wasn't your fault, and you are safe now. I'd like to know about that part of your life so I can help you feel better."
11. Let the child know this has happened to other children.
12. Ask open-ended questions that get more information, for example:
  - ◆ "What happened then? How did that feel? What else did he do? How did his clothes get off?"
13. Believe the child.
14. Reassure the child you are not angry with him or her and that you care about him or her.

\* Wayne Deuhn, et al. *Beyond Sexual Abuse: The Healing Power of Adoptive Families* (Pittsburgh, PA: Three Rivers Council, 1990).

# Suggestions for Helping Children Through the Trauma of Placement\*

## Early Phase

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### Issues:

Vulnerability, depression, humiliation, perceived rejection, shock, denial, bargaining, self-blame, and expectation of death.

### Reaction of Child:

Shock or numbness, alarm, disorientation, denial (claims the abuse did not occur), disbelief, hiding feelings and compliance (being submissive).

### Needs of Child:

Safety, intensive support, warmth, information about what arrangements are being made for him or her, information about his or her birth family, and help to anticipate feelings.

### Suggestions:

Make sure the child is warm and comfortable and has his or her comfort items, such as favorite toys and foods. Tell the child what is going to happen next for him or her as well as for his or her birth family. Provide a routine. Make sure the child has contact at least by telephone with a supportive family member or friend, if the worker approves this contact.

## Acute Phase

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### Issues:

Hidden anger arises and the child acts on it; fear, anxiety, helplessness; children may display patterns of risky behaviors that help them pretend their fears are under control (counterphobic defense).

### Reaction of Child:

Strong emotions (sadness, guilt, anger, shame); angry acting out; despair, disorganization, confusion, yearning and pining; fear of parents' deaths; searching, stress symptoms (rocking, head-banging, bed-wetting, headaches, stomachaches); mistrust; intense emotional neediness; possible sexual acting out; regressive behavior; asthma, sleeping and eating problems; colds, flu, and intense anxiety.

\* Some of this material was adapted from Jewett, C. *Helping Children Cope with Separation and Loss* (Harvard Common Press, 1982).

**Needs of Child:**

Intensive support; careful, safe touch and eye contact; positive ways to express emotions, especially grief and rage; lots of attention, releases, and fun.

**Suggestions:**

Provide physical outlets for the child to release energy and decrease anxiety. Keep separations to a minimum. Use music to soothe children, even older children. Encourage the child to write about how he or she feels, especially poems, letters and stories. Take the child out with other family members and have fun together. Provide drawing or painting materials to encourage self-expression.

## **Integration Phase**

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**Issues:**

Powerful emotions become more manageable. Thoughts of death or running away are balanced with increased trust in the team. More emotions are expressed in words, and fewer emotions are expressed indirectly through behavior. The child has direct experience of sadness, understanding, and acceptance.

**Reaction of Child:**

Child is able to mourn; child accepts the process of loss; child is willing to risk closeness; child “lets go” of grief, yet realizes some sadness will always remain; and child lets go of shame and self-blame.

**Needs of Child:**

Often a year or more of consistent nurture will be required to begin to resolve sexual abuse and placement issues. Placement stability, reunification, or adoption must be achieved to avoid repeating the loss or betrayal process; the child needs a sense of permanence and belonging.

**Suggestions:**

Continue to encourage self-expression through art, music, writing, and photography. Encourage rediscovery of self. Encourage participation in peer group activities to help the child feel that he or she fits in. Encourage the open discussion of grief, sadness, and anger. Determine a permanent outcome for the child, and involve the child in the goals and steps with birth family or child welfare team.

# Team Tips for Managing Separation Trauma

Whenever individuals share the same space and common experiences over time, a relationship usually develops during which they become significant to one another. The loss of a relationship, or even a change threatening it, stimulates feelings and behavior.

The practice of placing children in care generally creates separation trauma for everyone at some point and to varying degrees. It cannot be avoided. Below is information to help the treatment team manage this human process.

## As Relationships Begin

When children enter care, a whole new set of relationships is started, while at the same time the child and her/his family are experiencing separation trauma. Our concern and commitment to children must be twofold: to help the child and the child's family manage their loss; and to help the child, and hopefully the child's family, form new relationships with other members of the treatment team.

### Team Tips

1. Accept that it is important for all members of the permanency team to develop and maintain meaningful relationships with one another. This helps reduce separation trauma for children and families and lays the foundation for good working relationships throughout the life of the case.
2. Be aware of your feelings and needs in relation to other team members, especially the child and the child's family.
3. Assess the stages and tasks of separation for children in care and other members of their family; respond accordingly.
4. Develop and share your family's Life Book with the child.
5. Start a Life Book for the child.
6. Initiate active visitation as soon as possible.
7. Embrace the spirit of families helping families.

## As Relationships Grow

The major tendency at this stage is the formation of connections between the child and members of the treatment team, especially the caretakers. Because people want to maintain their essential connections, the child's family and its continuing involvement with the child can be seen as a threat to the new and important relationships developing within the foster family.

### **Team Tips**

1. Assess and acknowledge to yourself and other team members the attachment that is forming between team members, especially between caretakers and the child, as well as feelings toward the child's family when the permanency goal is for the child to return home.
2. Maintain and enhance the child's essential connections, both old and new.
3. Be especially mindful of helping the child experience a sense of belonging in the new setting.
4. Maintain sensitivity to the child's family during this time, since family members may feel left out.
5. Share information for maintaining and building essential connections with all team members, paying particular attention to the child's family.
6. Model parenting skills and support parents in applying them within their families.
7. Continue developing the child's Life Book.

### **As Relationships Change**

When children return to their families or move to another home, caretakers in particular are likely to experience separation trauma, just as the children and their parents did when placement first occurred. Children in care also are compelled to start relationships with new caretakers and friends, abandoning those made with you, thus once again enduring separation trauma. Adjustments must be made sensitively.

### **Team Tips**

1. Clarify, accept, and share feelings when the child changes homes.
2. Increase team efforts at reconnecting the child in the family or the new home through active visitation.
3. Prepare the child and his or her family for the change, including consideration of losses and gains.
4. Establish a plan for future contacts with the child and/or the family, especially for the first several months following the change. Be prepared to allow the relationships to fade, as happens in most relationships that are broken by physical separation.
5. Prepare the child's Life Book for the addition of new chapters.
6. Make sure the child has something to take with him or her that was acquired in the current placement.
7. Help the child pack.
8. Have a "going home" party.
9. Take pleasure in having accomplished the goal of permanence.

# Needs, Expressing Needs, and Meeting Needs

## I. Expression of Need: Sexually Acting Out

The child may engage in overly mature behavior\* or sexual interaction with other children or with you as the caretaker.

### Need

Need to feel close and seek affection and attention in safe ways.

### Ways to Meet Need

Set limits gently but clearly. For example, "It's not OK for you to touch the private parts of my body, and I won't touch yours." "I can see you want to get my attention; there are other ways to do that." "I like showing you that I like you by kissing you on the cheek, but it's not OK for you to try and put your tongue in my mouth."

Provide clear support. Acknowledge the child's emotions, even if you must help the child change behaviors.

Let the caseworker know; be specific in reporting the child's behavior.

Provide sex education. The caseworker can provide guidance in arranging to enroll the child in sex education programs in the school or community.

Encourage the child to talk to you if he or she needs to act out sexually.

Encourage the child to engage in activities or games that expend energy.

Use activities that redirect the child's mind from the sexual focus. The activity can be solitary, or you may want to participate with the child.

Do not overreact. Do not be harsh or punish the child.

Do not ignore or minimize the child's behavior. Talk explicitly about how the behavior can be unsafe and what behavior would more likely meet the emotional need.

\* Some people may call these behaviors "seductive," "coy," or "flirtatious." Avoiding the term "seductive" when describing a child helps us to remember these children are not responsible for this overly mature, sexualized behavior.

## **2. Expression of Need: Compulsive Masturbation**

The child may masturbate numerous times a day and may insert objects in himself or herself. The child may make groaning sounds, thrusting motions, or seem lost in a trance.

### **Needs**

Need to experience their bodies as capable of giving them pleasure without fear, violence, embarrassment, or dirtiness.

Need to learn how to get affection in safe ways.

Need to believe that he or she is lovable, capable, and worthwhile.

### **Ways to Meet Needs**

Provide clear support, such as talking about how natural it is to want to feel good.

Note how often the sexual behavior occurs.

Remove sexual stimuli (sexy magazines and television shows, dirty jokes) that may increase sexual feelings or confusion.

Teach the child that masturbation is done in private, such as in the bedroom behind a closed door.

Provide the child with privacy.

## **3. Expression of Need: Self-Mutilation**

The child may show signs of self-destructive behavior, such as causing injury to self.

### **Needs**

Need to believe that he or she is lovable, capable, and worthwhile.

Need to work through anger and self-hatred about being sexually abused.

Need to connect with birth family, roots, and culture.

### **Ways to Meet Needs**

Instruct the child to tell you when he or she feels like hurting himself or herself.

Watch the child's body language, listen to tone of voice, and then identify the child's likely emotions in words the child can understand.

Provide sex education.

Give lots of support, love, and attention.

Encourage child to become involved in activities where he or she can develop friendships.

Provide individual and group therapy for the child. The caseworker can provide guidance in arranging therapy sessions for the child.

Lock up knives, scissors, and other harmful items in the home.

#### **4. Expression of Need: Aggressive Behavior**

The child may behave aggressively toward others by, for example, picking fistfights with other children.

##### **Needs**

Need to express anger in positive ways.

Need to reduce self-hatred and anger about being sexually abused.

Need to express low self-esteem in a constructive way.

Need to connect with birth family, either through direct contact or through indirect contact, such as hearing about his or her birth family or receiving letters and pictures from them.

##### **Ways to Meet Needs**

Provide clear support for the child's emotions.

Reassure child that he or she is safe in the home.

Discuss birth parents' strengths and needs (instead of their weaknesses) and allow the child to feel anger at birth parents.

Help the child name emotions.

Show empathy. For example, "I know you are in pain; let's find a better way to deal with the pain. Maybe you can hit a pillow, throw a tennis ball against the wall, or draw a picture of how you feel."

Model ways to express anger when you are angry. In other words, when you are angry in the presence of the child, demonstrate how to express anger in a non-harmful or non-threatening way, such as by explaining in a measured tone why you feel angry and what could reasonably be done to make you feel less angry.

Provide individual and group therapy for the child.

Teach the child how to express anger directly in words.

Provide rewards for the child's positive behaviors.

Be clear about what is acceptable and unacceptable behavior.

Discipline the child. For example, you might place the child on restriction or, if the child is young, you might give the child "time out." "Time out" is when you instruct a child who is acting out to be still and quiet for a brief time, providing the child with a few moments to collect himself or herself.

Offer choices to the child as much as possible. For example, "You can pick your way of being angry. Hit this pillow, yell in the back hall, or get your bat and ball and hit homers."

## 5. Expression of Need: Alcohol and Other Drug Abuse

The child may show signs of alcohol or other drug abuse.

### Needs

Need to assess the impact of substance abuse on personal health and on the family.

Need for physical health and to feel emotions honestly and directly.

### Ways to Meet Needs

Provide clear support and praise for positives. For example, "It's good you can talk with me about your abuse of alcohol and other drugs."

Provide substance abuse assessment, psychotherapy, and individual and family therapy. The caseworker can provide guidance in arranging therapy sessions.

Bring the child to Alcoholics Anonymous or Narcotics Anonymous. The caseworker can provide guidance for contacting a chapter of AA or NA in your community.

Help the child state his or her needs directly.

Respectfully discuss the strengths and needs of the child's relatives who have addiction.

Some children may need residential treatment and aftercare.

Provide a safe and supportive environment with a daily routine.

Provide information about addiction and recovery, which you can get from an Alcoholics Anonymous or Narcotics Anonymous central office or from a treatment program.

## 6. Expression of Need: Running Away

The child may repeatedly stay away for hours beyond the time expected home or even stay away for days.

### Needs

Need to feel safe.

Need to work through fear and loss of control related to the sexual abuse.

### Ways to Meet Needs

Provide clear support for the child's emotions.

If running away is a pattern for the child, be aware of the stresses that have led to the child's running away.

Provide pictures of birth parents and other kin.

Establish an agreement with the child on the consequences of running away; ask the child what the consequences should be.

Provide a nurturing, safe, and secure environment.

- Discuss the birth parents' strengths and needs (instead of their weaknesses).
- Provide individual and group therapy.
- Visit the child's original neighborhood and friends.
- Develop a daily routine and stick to it.
- Develop a Life Book with the child.

## **7. Expression of Need: School Problems**

The child may earn poor grades, fear school, or be truant.

### **Needs**

- Need to feel capable and worthwhile.
- Need to experience success in school.
- Need to feel in control of his or her life.
- Need to work through feelings of helplessness regarding sexual abuse.

### **Ways to Meet Needs**

- Provide clear support for the child's emotions, such as fear of failure, feelings of inferiority, or hopelessness about doing well.
- Go to school with the child until child feels safe without you.
- Intervene with the school on behalf of the child. For example, you might make a request to the teacher or principal that the child receive tutoring.
- Provide encouragement for improved performance in school. For example, "What can you do to pull that D to a C? And how can I help?"
- Reward good behavior in school.
- Provide individual and group therapy.

## **8. Expression of Need: Suicide**

The child may threaten to kill himself or herself, may carry out gestures such as collecting pills, or may attempt to kill himself or herself.

### **Needs**

- Need to feel capable and worthwhile.
- Need to work through feelings of self-hatred regarding sexual abuse.
- Need to connect with birth family and with his or her culture.

### **Ways to Meet Needs**

Provide clear support for emotions. For example, “After what you've been through, I can see how hopeless you might feel.”

Pay attention to signs of depression.

Be alert to signs and symptoms of suicidal thoughts, such as giving away items of importance.

Provide physical outlets, especially running or other exercise.

Ask the child if he or she is thinking of killing himself or herself.

Provide love, support, and reassurance.

Discuss birth parents' strengths and needs (instead of their weaknesses).

Help the child experience fun.

Tell the child you understand how hard it is to feel lovable.

Develop a Life Book with the child.

Provide individual therapy and hospitalization if necessary.

“Catch” the child being good. In other words, say something to the child to let him or her know you have noticed and appreciate something good he or she has done or that he or she is simply behaving well in general.

When the child is not upset, discuss openly any of the child's relatives or friends who may have been suicidal.

## **9. Expression of Need: Fears**

The child may have nightmares and night terrors and a fear of men, women, or places, or may cling to another person.

### **Needs**

Need to feel safe and secure.

Need to believe that the sexual abuse will not happen again.

### **Ways to Meet Needs**

Provide clear support for emotions. For example, “You deserve to feel safe and protected.”

Teach child how to say no and protect himself or herself when feeling at risk.

Encourage creative expression, such as the child's drawing pictures of his or her fears.

Reassure the child that people such as yourself will help him or her to be safe.

Provide comfort and security at bedtime by reading to the child, leaving a light on, or giving him or her a soft toy or blanket.

Help the child develop trust in you by responding to his or her emotions. For example, “When you act angry, perhaps you also feel a little scared.”

Allow child to have privacy rules for his or her room, such as a lightweight latch on his or her door which can be controlled from the inside.

# What Happened to This Child: Understanding Trauma



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# **Introduction**

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Missy Bradley, 2003 (Cross Country training, 3/10/04, Rochester, NY;  
Susan OH, facilitator)

School and Community Based Post-Traumatic Stress Management:  
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Childhood Loss and Behavioral Problems: Loosening the Links, Pg. 13;  
Vera Institute of Justice, 233 Broadway, 12th floor, New York, NY 10279.

The following is adapted from Daniel J. Siegel, MD's Foreword to *Handbook of EMDR and Family Therapy Processes* (edited by Francine Shapiro, Florence W. Kaslow, Louise Maxfield John Wiley & Sons, 2007). Permission pending.

Our brains are the social organs of our bodies. In the early years of our lives, interactions with others shape the important connections in our brains that in turn influence our internal sense of self and our capacity for healthy relationships with others. The internal and the interpersonal are woven together during these early years, and these domains of our experience continue to weave a tapestry of our ways of living throughout our lives. In clinical terms, "self-regulation" is the way we manage and balance such things as our emotions, our bodily functions, our thinking, and even our communication patterns with others. The term *self* can be misleading: An individual is continually shaped by relationships with others throughout the life span. This view is reinforced by new findings that the brain continually restructures itself in response to life experiences.

The synaptic connections among neurons create the fundamental structure of the brain. Genes are important for determining the overall architecture of the brain, but the conditions in the womb can also influence these connections, contributing to the temperament with which one is born. Temperament is the constitutional makeup of the nervous system, one's sensitivities, proclivities to react intensely or subtly, overall mood, regularity, and capacity to engage with novel situations. When a baby is born, his or her communication patterns with others, especially caregivers, play a fundamental role in molding the continuing development of the brain. Research in attachment has revealed that it is these patterns of communication between caregiver and child that influence the development of the child's capacity for self-regulation: balancing emotions, interpersonal intimacy, and even how he or she develops self-reflection (Sroufe, Egeland, Carlson, & Collins, 2005).

## Attachment

When a child is fortunate enough to have interactions that are caring, attuned, and mutually regulating with the caregiver, he or she usually develops a *secure* attachment relationship. This attachment experience results in healthy development across a wide array of domains, including social, emotional, and cognitive (Cassidy & Shaver, 1999). Children less fortunate, who have suboptimal experiences with their caregivers, often develop insecure attachment types. If parents are emotionally distant, the child's attachment can become *avoidant*, and the child may become prematurely independent (Sroufe et al., 2005). These children ultimately may experience a distancing of their own awareness from their internal state as well as the internal worlds of others (Siegel, 1999). When caregivers are inconsistent and intrusive, the child's attachment relationship tends to be *ambivalent*, and the child may grow up with a great deal of uncertainty and anxiety about having his or her needs met or relying on others. In both of these situations, children adapt the best they can, finding a solution to their situation and coping in a way that enables them to survive and move on in life.

When the parent is terrifying to the child, a *disorganized* form of attachment can develop. In this situation, unlike the secure and first two insecure forms, the child has “fear without solution” and lives with the biological paradox of two simultaneously activated brain circuits: When children are placed in a state of terror, their brain activates the reflex “Go to my parent for soothing and safety”; simultaneously, the brain also has the activated circuit “Go away from the source of terror.” There is no organized adaptation to these conflicting experiences. Some theorists (Hesse, Main, Yost-Abrams, & Rifkin, 2003) have hypothesized that the result of fragmentation in the child’s state, one that ultimately leads to clinical forms of dissociation. This situation is not the same as the “double bind,” which has been alluded to in the family literature (Watzlawick, 1963), but is a form of biological paradox in which two circuits are simultaneously activated in the child’s brain, leading to the fragmentation of a coherent response.

Attachment researchers (Hesse et al, 2003) found that the best predictor of each of these four categories of children’s attachment—secure, insecure-avoidant, insecure-ambivalent, and disorganized—was the nature of the parents’ adult attachment category:

<b>Child’s Attachment Category</b>	<b>Parent’s Attachment State of Mind</b>
Secure	Secure-autonomous
Insecure-avoidant	Dismissing
Insecure-ambivalent	Preoccupied
Disorganized	Unresolved-disorganized

The parents’ adult attachment state of mind was measured by assessing their *narrative coherence*. A coherent narrative indicates that a parent has made sense of his or her early life and understands and is open to the impact of past relationships on present experiences. Even if parents had a frightening upbringing, the research suggests that if they have come to terms with their early life experience, their children will develop a secure attachment relationship. It is never too late to develop a coherent life story. Processes that aid the integration of the brain and facilitate the development of coherent narratives of one’s life, such as EMDR, can be very effective in assisting parents to explore the nature of their own attachment, so that they can “earn” security in their own lives (Siegel & Hartzell, 2003). Family systems therapy can help them change their parenting behaviors so that their children can thrive.

If parents’ communication with their child is distant, they may have developed a “dismissing” style of attachment. Their narrative will reveal a kind of incoherence—if they have not yet created a coherent life story—that is characterized by a dismissing of the importance of relationships in the past and in the present. There is often an insistence on not recalling prior family experiences. It is likely that this lack of recall is not due to “repression” of trauma per se, but rather to a lack of encoding of emotionally barren interactions. Sometimes self-reflection, new forms of relationships, and therapeutic interactions can help individuals get in touch with the nonverbal, visceral, and emotional senses of their inner life; this enables them to progress toward an adult form of secure attachment and a coherent narrative of their life.

When parents' behaviors are inconsistent and intrusive, their narrative often contains "leftover" issues, in which themes from the past intrude into current life reflections. This adult form of "preoccupied" attachment often reveals painful needs that were not met in a confusing childhood family situation. With the adult's mind still mired in emotionally unsettled past experiences, it is probable that these may intrude into interactions with the child. Relationships, including those of psychotherapy, that help parents examine these concerns and find an inner sense of understanding and peace can help them progress to a freer form of coherent, secure attachment narrative.

For parents who experience states in which they unintentionally terrify their child, the narrative often has elements of unresolved trauma or grief. As they tell their early life story, moments of disorganization and disorientation are apparent in both verbal and nonverbal communication. These unresolved states of mind seem to increase the risk that they will enter into states of irrational behavior, filled with fear, anger, or sadness. These overwhelm the parents' capacity to parent in that moment and create a state of terror in the child. Individual therapy, such as Eye Movement Desensitization and Reprocessing (EMDR), can help parents identify and address these painful past losses and traumas and profoundly change their attachment state of mind. With the assistance of family systems therapy, they can alter the quality and nature of their relationships, thus shifting the child's developmental pathway from disorganized to secure.

## **Brain Development**

Our state of knowledge about the independent fields of brain science and attachment research point to the likelihood that each of these four patterns of communication shape the ongoing development of circuits in the brain (Cozolino, 2006; Schore, 2003a, 2003b; Siegel 1999, 2001). A multidisciplinary view of the brain, family relationships, and cognitive development leads to the idea that experiences within families directly influence the development of the self-regulatory circuits of the brain. From this perspective, healthy secure attachment likely promotes the development of integrative regions of the brain, especially in the prefrontal regions responsible for self-regulation.

The brain develops from a predominant genetic influence in the womb, beginning with the lower brain stem and moving upward to the limbic areas regulating emotion and attachment, and then to the top of the brain at the level of the cortex. Much of the cortex's interconnections develop after birth, influenced both by genetics and then by experiences as the child interacts with his or her environment. It appears likely that attachment experiences early in life directly shape the cortical processes involved in bodily regulation, capacity for communication with others, emotional balance, flexibility, empathy, self-understanding, and the capacity to self-soothe states of fear. Brain research (Siegel, 2007b) has revealed that this diverse set of regulatory processes is carried out by the functions of the middle aspect of the front-most part of the cortex, called the middle prefrontal cortex.

Recent explorations of the impact of psychotherapy on the resolution of trauma suggest that this area of the brain plays an important role in the process of healing, becoming more engaged after effective psychotherapy than in the unresolved state (van der Kolk, 2006). Mindfulness meditation may also promote the development of this region and prevent its natural thinning as one ages (Lazar et al., 2005). What these separate studies suggest is that secure attachment, effective psychotherapy, and mindful practices may each involve the development and activity of the middle prefrontal cortex (Siegel, 2007b).

## Interpersonal Neurobiology

To understand the inner workings of mind, brain, and human relationships at the heart of psychotherapy, a wide array of scientific disciplines have been brought together in an integrated perspective called “interpersonal neurobiology” (Cozolino, 2001, 2006; Schore 2003a, 2003b; Siegel, 1999, 2001). By examining the parallel findings from independent efforts to understand reality, from anthropology to genetics, and psychology to complexity theory, this interdisciplinary view weaves a picture of the larger whole of human development.

From an interpersonal neurobiology perspective, the mind is defined as a process that regulates the flow of energy and information. The mind can be seen as *emerging* moment to moment, as energy and information flow between neurons and among people; this can be understood as a transaction between the domains of the neurobiological and the interpersonal. The mind’s *development* is determined both by its genetic program and ongoing experience. It is thought that, during psychotherapy, when clients focus attention on the elements of their mental experience, novel states of neural firing are initiated, which directly shape the growth of new synaptic connections within the brain. These connections are the product of neural plasticity, and they can alter the future functioning of the individual’s mind and his or her interpersonal communication patterns.

Interpersonal neurobiology posits that the field of mental health can offer a working *definition of mental well-being*. In my own experience of lecturing to more than 60,000 mental health practitioners in the first 6 years of this millennium, I have found that an average of only 5% had received formal education defining the mind or mental health. Naturally, the vast majority had studied disorder, disease, and symptom-focused interventions. However, it is striking that each of the fields in the larger domain of mental health has lacked a definition of what we are practicing.

Interpersonal neurobiology offers a working definition of mental health that emerges from various scientific disciplines. It states that a system that moves toward well-being is one that flows toward a flexible, adaptive, coherent, energized, and stable (FACES) state (Siegel, 2007b). This FACES state travels a river of well-being that is flanked on one side by rigidity and on the other by chaos. An examination of the *Diagnostic and Statistical Manual of Mental Disorders* (American Psychiatric Association, 2000) reveals that most of the symptoms listed in that text are examples of either rigidity or chaos. This working definition of mental health offers each of our disciplines a neutral lens through which we can define our personal and professional goal of mental well-being.

The FACES state of well-being has at its core the quality of COHERENCE (the word itself is the acronym): connected, open, harmonious, engaged, receptive, emergent (a feeling of newness moment to moment), noetic (knowing with a sense of clarity), compassionate, and empathic. These characteristics of a coherent mind are an articulation of the qualities of a FACES state of well-being from the interpersonal neurobiology viewpoint.

How does one achieve a coherent mind and a FACES state of well-being? Having examined a range of disciplines, we propose that well-being emerges when a system is *integrated*. When differentiated components of a system become connected, that system moves toward an integrated state. Integration is defined as the linkage of separate elements into a functional whole. Integration itself is a process, an ever-moving state of being, and thus well-being is a dynamic process in a continual state of emergence.

Well-being can be seen to involve at least three elements, visualized as the three sides of a triangle composed of mind, brain, and relationships. In this perspective, a coherent mind, an integrated brain, and attuned, empathic relationships mutually reinforce and create each other.

EMDR's powerful efficacy can be understood from an interpersonal neurobiology perspective. During EMDR, both the protocol and the bilateral stimulation contribute to the simultaneous activation of previously disconnected elements of neural, mental, and interpersonal processes. This simultaneous activation then primes the system to achieve new levels of integration.

In the example of Posttraumatic Stress Disorder, various impairments to the integration of memory and affective regulation can be seen as the fundamental blockage to well-being (Siegel, 2003). In parents who have not “made sense” of past trauma or loss, there is a direct negative impact on the outcome of attachment for their children (Hesse et al., 2003). These findings suggest that when parents make sense of their early life experiences through the creation of a coherent narrative, there may be a corresponding change in their interpersonal style and an increase in their children's security (Siegel & Hartzell, 2003). The combination of EMDR and family therapy offers a powerful strategy through which to alter familial patterns of suboptimal interactions; it also helps parents make sense of the confusion in their past and present lives emanating from unresolved trauma, loss, and other issues. Such a movement from an incoherent (nonsense-making) to a coherent (making-sense) narrative has been shown to help families transform from insecure attachment styles in both parent and child to a more resilient form of secure attachment and improved patterns of communication in the parent-child relationship (see Sroufe et al., 2005).

Parents and children are hardwired to connect to each other from birth (Cozolino, 2006; Schore, 2003a, 2003b; Siegel, 1999). The neural circuitry that regulates affective states, bodily balance of the autonomic nervous system, self-knowing awareness, and empathy is directly impacted by relational experiences early in life (Schore, 2003a, 2003b; Siegel, 2001). These socially shaped regulatory processes appear to be open to continued development throughout the life span. Consequently, it appears that deficits from early childhood can be remedied with adequate experiences later in life. It may be possible to stimulate the growth of new and compensatory—if not reparative—neural connectivity that could bring an individual to a more neurally integrated state of well-being. EMDR with family therapy may catalyze these changes in the brains of treated individuals. It is anticipated that one outcome will be a more robust activation of areas in the brain, such as the middle aspect of the prefrontal cortex, which contributes to both self-regulation and various forms of neural integration. Within the social settings of family and couple life, individual neural integration may be greatly amplified by the collective experiences that are inspired in these therapeutic endeavors and then reinforced at home. Partners and family members who share their lives with each other can reinforce integrative interactions beyond the therapeutic session.

There are a number of relational features that seem to enhance this amplification of therapeutic efficacy and that contribute to the “integrative” quality of interpersonal communication (Siegel & Hartzell, 2003). These include attunement, collaboration and compassion, and connection and cooperation. *Attunement* is at the heart of secure attachment and can be described as the resonance of two individuals to create a mutually regulating set of reverberant states. With interpersonal attunement, an integrated state is created within the mind/brain/body of both the interactive members.

Clinicians can promote interpersonal and intrapersonal attunement. Intrapersonal attunement is the capacity to become intimate with the inner workings of one’s own mind and is central to our innate potential for *mindsight*. This is the ability to see our own minds compassionately with insight and to envision the minds of others with caring and empathy, and it yields the inner resources for well-being (Siegel, 2007a). EMDR may enhance *mindsight* by facilitating the integration of the brain that provides these mind-maps with clarity and fluidity in their construction. Promoting *mindsight* in family and couples therapy enables clinicians to harness the power of integration so that it is naturally reinforced in caring relationships.

As the drive toward integration moves couples and families into more coherent states of functioning, the natural drive toward well-being is liberated. This innate drive toward health (Shapiro, 2001) is the therapist’s ally. Our task is not so much to do something *to* those with whom we work, but to work *with* them so that their own innate drive toward well-being will be released. Finding creative ways to liberate this human drive toward health and well-being is both the joy and the challenge of our profession.

DANIEL J. SIEGEL, MD

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# Components of Well-Being of Children and Youth in Foster Care

Here are several questions to help caretakers assess the components of well-being of children in foster care:

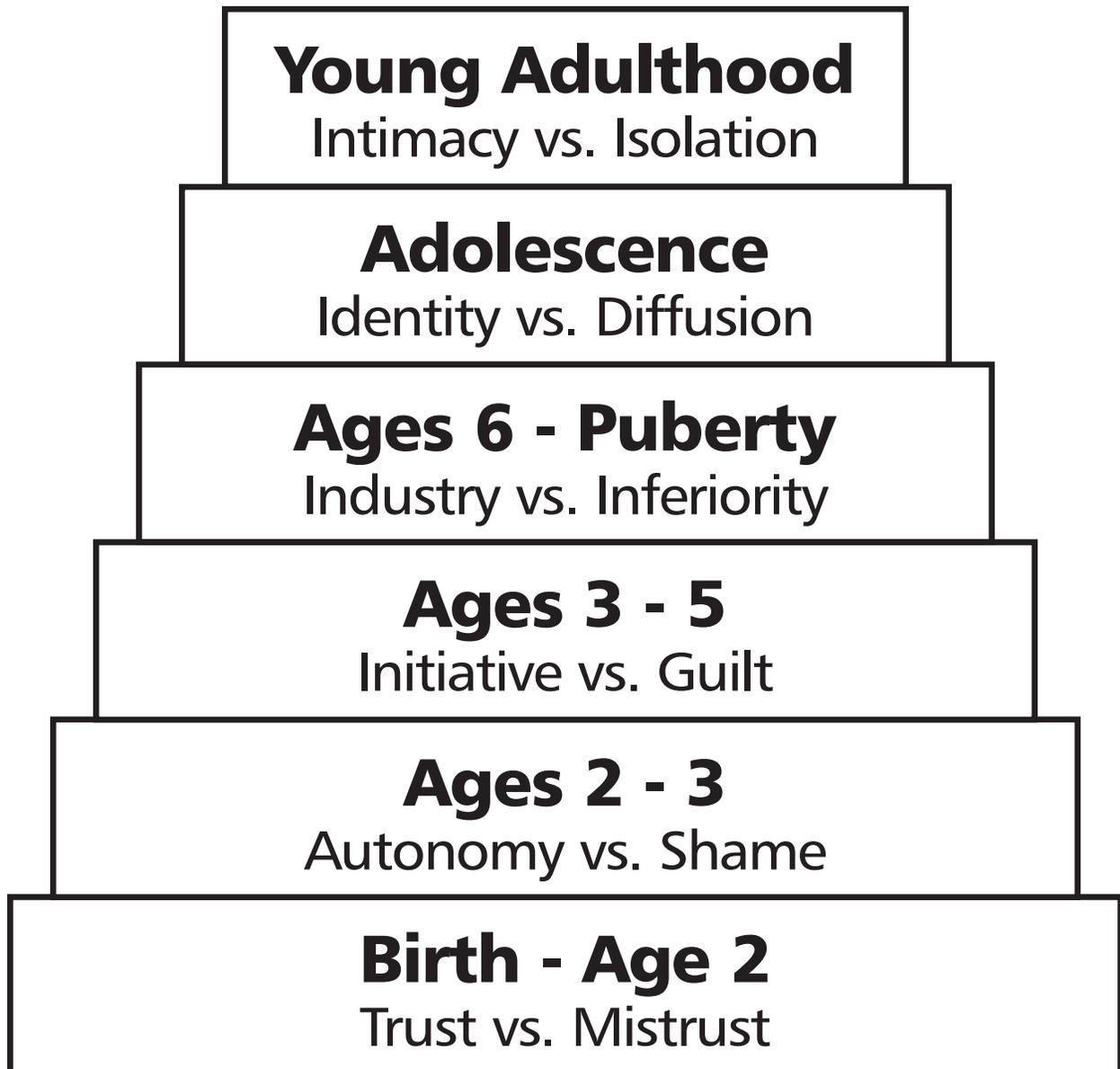
- ◆ Is this child or youth **physically healthy**? If not, does this child have the medical attention required to restore or optimize health, given the condition?
- ◆ Is this child or youth **emotionally healthy**? Does this child experience being lovable, capable, and worthwhile?
- ◆ Is this child or youth **socially healthy**? Does this child interact in work and play activities at a level appropriate for age and abilities?
- ◆ Is this child or youth **intellectually** on target? If not, does this child have the educational resources required to optimize intellectual growth?
- ◆ Is this child or youth **spiritually/morally healthy**? Does this child have a sense of right and wrong and an ability to understand the feelings of others? Does this child have hope for the future? Does this child have a belief in a positive power greater than himself or herself?
- ◆ Does this child or youth have **healthy attachments**, including **cultural and family connections**?
- ◆ Is this child or youth **grieving loss** in a healthy way through expressions of anger, sadness, fear, and sorrow?
- ◆ Is this child or youth able to **manage his or her own behavior** in an age-appropriate way?

## **Basic Human Needs\***



\* Adapted from concepts of Abraham Maslow.

# Erikson's Stages of Development\*



\* Erickson, E.H. Childhood and Society, 2d ed. NY: WW Norton, 1963.

## **Definition of Attachment**

**Attachment is the affectionate and emotional tie between people that continues indefinitely over time and lasts even when people are geographically apart.\***

\* Fahlberg, Vera. "Attachment and Separation" PROJECT CRAFT, Training in the Adoption of Children with Special Needs. Ann Arbor, MI: University of Michigan School of Social Work, 1980, pp. V-1 - V-93.

# Bonding and Attachment\*

Children cannot grow up normally unless they have a continuing stable relationship, an attachment to at least one nurturing adult. According to Dr. Vera Fahlberg, in normal development most infants bond with the mother or caretaker through the feeding experience. It is beginning to be recognized that bonding and attachment occur through a stress/stress-reduction type of cycle.

In feeding, the baby gets stressed because he is hungry. After being fed he feels the reduction of that stress, the feeling of relaxation. The feeling of being safe and cared for comes from being with this one particular person who looks, smells, and sounds the same every time he is fed. He begins to feel that the world is safe. He feels, "If I'm in any kind of trouble this particular person will help me out!" We sometimes see babies who become shy around strangers and cling to their mothers (or fathers if they are bonded with their fathers). If there is a loud noise in a room of toddlers they all end up around their appropriate mother's knees. This is the attachment cycle that is absolutely necessary for children to learn and to be emotionally and behaviorally intact.

Removing children and putting them in foster care is extremely damaging to children because it disrupts the basic developmental process of attachment to a particular adult. Sometimes removal is necessary. But we have to be very clear about what is being done when children are removed and put somewhere else. One thing that happens is interruption of the basic developmental process, and it is life threatening at times.

Many children put in institutions in the past and cared for by different people around the clock died by the time they were one year old. The foster care movement came out of that experience. If babies were cared for by foster families, they didn't seem to die as readily. It became obvious that having one consistent person care for an infant was important. Over the past 50 years, and particularly within the last ten, we have become aware that this bonding and attachment of a child to a caring adult is an important one. What happens when we break this attachment? What happens when we remove a child either through death or through foster care from the parent or the adult they are bonded to? We tend to get some very specific effects.

The very young child whose parent dies goes into a grief process. People who do bereavement counseling are beginning to recognize children's grief as lasting from six to eight years. The younger the child, the more intense and long-lasting is the grief.

Adults typically take one to two years to go through the grief cycle, but young children can take half their childhood. Removing a child from a parent or caretaker to whom he is attached has an effect similar to a loss by death; it initiates a grief process.

\* Reproduced from Adoptalk. "Bonding and Attachment," by Ann Coyne, Ph.D., Associate Professor, School of Social Work, University of Nebraska at Omaha. July/August 1983.

What happens, then, to children coming into foster care or into adoption? First of all, there are apt to be short-term memory deficits. These children typically are not processing information well. You tell them something; they don't remember a thing. You think, "Why is he doing this to me?" Why is this child seemingly so compliant and yet not doing anything he's asked? You say to him, "You told me 15 minutes ago you were going to do this and you haven't done it!" He says, "You never told me!" He really doesn't remember. He literally forgets, because his short-term memory isn't processing well. When short-term memory isn't processing well, long-term memory is also affected, which means he doesn't learn to read well. Many children who are in foster and adoptive homes are learning disabled. It is probably not because they were born learning disabled or that they have received brain damage. It is more likely that the process of grief is disrupting short-term memory. Developmental delay is common in children who are in foster care. The grief process has disrupted their ability to develop and learn.

A second issue is children's sense of who they are. We all need to know where we started and how we developed in order to have a story about ourselves. We know we were born in a certain place; we grew up in a certain place; these were our parents; these were our brothers and sisters; that was the school we went to; these were the teams we played on; these were our friends. Children in foster care tend to not remember clearly. Children in foster care don't know which of these four or five families they lived with was their birth family. A lot remember the family they were living with at about age four. That could have been their third foster family, but they sometimes think it is their birth family. Maybe they only stayed there a month, but they suddenly get it into their head, "that person is my mother." Yet they have other memories that don't quite fit. They remember three or four different dogs and all those siblings; they're not sure which are theirs and which are someone else's. And the big question: why were they there?

Suddenly, instead of a consistent story about who they are, they have a history with confusion in it. They don't know where they came from. It is not unusual for children in foster care to think they came full grown, that they did not grow inside a mother, and that they were not born. Some children in foster care under eight or nine will tell you they were never born, that they just came, that they somehow appeared in a foster home at about age three.

These children have an exceedingly difficult time reattaching to a family when they are adopted, because they cannot attach and go through a process of separation from what has happened to them in the past. They can't do it because they don't understand what's happened. It's very important to reduce the number of different families these children experience. It is also important that we communicate to them very clearly about everything that has happened to them.

Workers are beginning to do this by using Life Books with pictures and drawings. In what order did his families happen? His life should be documented so that the child, even if it's not a story he likes, at least has a story about who he is. He can then begin to detach from all that hurt and all that grief, and begin to make a more positive attachment to his adoptive family. Otherwise he may never be able to reattach.

The third issue I want to look at is behavior. The behavior of children in foster and adoptive homes many times indicates a grief process. Some of the first behaviors you see are denial and bargaining. Often there is a honeymoon period where children coming into care will be very good for a few weeks. That's a combination of denial and bargaining. "If I'm really good they will let me go home," "If I'm really good my mother will love me." Most times the children feel they did something wrong: "If I had not thought those bad things about my parents, then the sheriff wouldn't have picked me up."

There are a lot of common behaviors in denial. One is very rhythmic behavior. Children may skip rope continuously, or bounce a basketball, or kick the wall, or sit with toys making noise. This kind of rhythmic behavior is not usually recognized by adults as a grief response. If the child keeps running, if he keeps banging the wall, he won't have to deal with the hurt.

The anger of these children is often very serious and there is a great deal of acting out of their behavior problems. What wouldn't normally bother a child will bother these children. They are angry about disconnections, angry about the detachments. They go through the stages of grief. In the depression stage you have children who are not sad or crying, but with very little energy. These kinds of behaviors are really indications to us that they are grieving. We need to treat them as people in grief, to do grief work with them.

The whole philosophy of permanency planning is to have a system in which we try to protect children's primary attachments. We need to protect children's attachments to their birth parents. We need to move services into the home to protect children at risk of being abused by those they live with. In those situations where it's not possible, we need to have a system that creates new attachments for children to have adopted parents. Every child must have an attachment to one or several adults that is consistent, that is expected to be permanent, that is to someone he can count on.

Adults don't have to be attached to children. Adults don't have to be attached to one another. We like to be attached to our husbands and wives, but we are not going to die without it. We may go through grief but we aren't going to go through all kinds of developmental problems. Children must be attached. They simply must. They cannot develop normally without being attached to one adult over a period of time because their whole sense of safety, their whole sense of the world, their whole sense of learning, depends on it.

## **Why Attachment Is Important to Children**

### **Attachment helps children:**

- ◆ Develop a conscience  
**(moral/spiritual development)**
- ◆ Become independent  
**(social development)**
- ◆ Deal with stress, frustration, fear, and worry  
**(emotional development)**
- ◆ Think logically  
**(mental development)**
- ◆ Develop future relationships  
**(social development)**
- ◆ Grow physically and develop health  
**(physical development)**

# Behaviors That Express Secure Attachment

Look for the following in children's everyday behaviors. Remember, the age of children is important. How children think, express feelings, get along with others, and manage their behaviors to get their needs met and to meet the needs of others develops and changes with age. Discuss your observations with the caseworker.

Accepts responsibility for personal actions

Expresses guilt, sorrow, or regret when his actions hurt others

Thinks logically

Understands that actions have consequences

Gives and receives positive expressions of caring

Expresses pride, happiness, and enthusiasm in day-to-day accomplishments

Generally sees herself as a "good person"

Generally sees others as "good people"

Respects the rights of others

Expects good things from adults

Has friends and shares good times with them

Asks for help when needed

Accepts help when needed

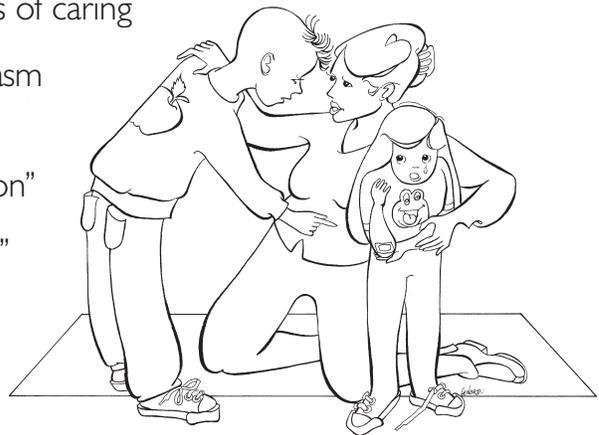
Recognizes the feelings and needs of others

Recognizes own feelings

Expresses feelings in a way that does not harm himself or others

Is able to "give and take" with others

Manages own behaviors in a positive way



# Resources

# **Titles and Roles of Mental Health Providers Who Work With Families**

## **Evaluation**

Clinical social workers, psychologists, and psychiatrists provide specialized evaluations, such as family assessments, and interviews to confirm sexual abuse. Sometimes they use puppets or anatomical dolls to help the child explain the sexual abuse.

Evaluations attempt to give a picture to the child welfare agency, the court, or the family of the various social, emotional, or medical needs, problems, and strengths of an individual or family. The evaluating professional is most likely a clinical social worker, a psychologist, or a psychiatrist (who is a medical doctor). Depending on the outcome of the evaluation, a referral may be made for ongoing psychotherapy. Sometimes evaluations are court-ordered.

Psychologists, who have doctorates in psychology but are not medical doctors, use scientifically reliable and validated tests to assist in their evaluation of behavior, learning, development, and symptoms.

## **Psychotherapy**

The term *psychotherapy* covers many different, specialized forms of emotional healing, behavior change, and growth.

Family therapy, group therapy, individual therapy, and couples therapy are common forms of psychotherapy. Other forms of psychotherapy that are more unusual are play therapy, music therapy, art therapy, and dance therapy. Psychotherapy can involve either short-term (about six sessions over about six weeks) or long-term treatment.

Psychotherapy may be provided by one of the following:

- ◆ Clinical social worker (master's or doctoral degree, often with academy certification or an advanced license, depending upon the state). Clinical social workers often specialize in child and family issues.
- ◆ Psychologist (doctoral degree and license). Psychologists often specialize in working with individuals on behavioral problems.
- ◆ Psychiatrist (medical degree, plus advanced board certification and license). Psychiatrists specialize in the biological aspects of emotions and behavior and are qualified to prescribe medication and diet, to hospitalize, and to provide other medically related treatments.
- ◆ Expressive arts therapist (master's degree or certification). Expressive arts therapists are skilled in movement therapy using music and movement, art therapy, sand tray, and other forms of expressive therapy.

- ◆ Nurse clinician (master's degree and advanced license). Nurse clinicians often practice in psychiatric hospitals or community clinics or provide psychotherapy in private practice.
- ◆ Counselor (credentials not necessarily required). Counselors usually specialize in vocational rehabilitation, education, career development, or religion. Increasingly, counselors are working in mental health and psychotherapy.

## **Other Role Functions of Mental Health Providers**

- ◆ Mental health providers develop treatment plans, which are goal-oriented plans that map out how specific needs or problem areas are to be resolved in treatment. The most effective treatment plans specify who will do what and when, and are shared with all people involved in the care of the child.
- ◆ Mental health providers schedule regular sessions with the child or family and maintain regular contact.
- ◆ Mental health providers keep the birth family and the caretakers informed of the progress in treatment, make the family members partners in treatment whenever possible, maintain confidentiality regarding the client and treatment sessions, and provide coverage in emergencies.
- ◆ Mental health providers identify ways the birth family can understand the behavior of the child and ways they can contribute to the treatment plan.
- ◆ Mental health providers evaluate the child's ability to visit, return home, or testify in a court of law. They also appear in court when necessary, sometimes as an “expert witness,” to testify as to the child's or family's progress in treatment or emotional status.
- ◆ Mental health providers evaluate the likelihood of recurrence of sexual abuse.
- ◆ Mental health providers evaluate the readiness of the birth parents to reunite with their child.
- ◆ Mental health providers work toward reunification of the family whenever possible and toward acceptance of termination of parental rights when necessary.

# **Court-Appointed Special Advocates\***

## **What is a CASA volunteer?**

A court-appointed special advocate (CASA) volunteer is a trained citizen who is appointed by a judge to advocate for the best interests of a child in juvenile court. Most of the children helped by CASAs are victims of abuse and neglect.

## **What is the role of the CASA volunteer?**

A CASA volunteer provides the judge with a carefully researched background of the child to help the court make a sound decision about that child's future. Each case is as unique as the child involved, and the CASA provides an independent perspective on the child's situation. The CASA advocates for what would be best for the child and helps to protect the child from any harmful effects of the adversarial court process. For example, the CASA may request "child friendly" courtroom procedures. The CASA volunteer makes a recommendation to the judge on permanence for the child and services needed to obtain it. The CASA follows through on the case until it is permanently resolved.

## **How does a CASA volunteer investigate a case?**

To prepare a recommendation, the CASA volunteer talks with the child, parents, family members, social workers, school officials, health providers, and others who are knowledgeable about the child's history. The CASA volunteer also reviews all records pertaining to the child.

## **How does the role of a CASA volunteer differ from the role of a caseworker?**

Caseworkers are employed by state or county governments. They sometimes work on as many as 60 to 90 cases at a time and are frequently unable to conduct a comprehensive investigation of each. The CASA is a volunteer with more time and a smaller caseload (an average of three cases). The CASA volunteer does not replace a caseworker on a case; he or she is an independent appointee of the court. The CASA volunteer can thoroughly examine a child's case, has knowledge of community resources, and can make a recommendation to the court independent of state agency restrictions.

## **How does the role of a CASA volunteer differ from the role of an attorney?**

The CASA volunteer does not provide legal representation in the courtroom. That is the role of an attorney, usually a *guardian ad litem*. The CASA volunteer does provide crucial background information and recommendations in court. It is important to remember that CASA volunteers do not represent a child's wishes in court. Rather, they speak to the child's best interests.

\* Adapted from *Georgia CASA Information Sheet* (Atlanta, Georgia: Georgia CASA, 1990).

# Resources

## Therapeutic Materials

Abilitations/Kinetic Kids	Toll Free (800) 850-8602	<a href="http://www.abilitations.com">www.abilitations.com</a>
Achievement Products	Toll Free (800) 373-4699 Fax (800) 766-4303	Achievepro@aol.com <a href="http://www.specialkidszone.com">www.specialkidszone.com</a>
Equipment Shops	Toll Free (800) 525-7681 Tel (781) 275-7681 Fax (781) 275-4094	info@equipmentshop.com <a href="http://www.equipmentshop.com">www.equipmentshop.com</a>
Integrations	Toll Free (800) 850-8602 Tel (770) 449-5700 Fax (800) 845-1535	<a href="http://www.integrationscatalog.com">www.integrationscatalog.com</a>
Jump-In	Toll Free (810) 231-9042 Fax (810) 231-9063	info@jump-in-products.com <a href="http://www.jump-in-products.com">www.jump-in-products.com</a>
Mealtimes	Toll Free (800) 606-7112 Tel (434) 361-2285	<a href="http://www.new-vis.com">www.new-vis.com</a>
Pocket Full of Therapy	Tel (732) 441-0404 Fax (732) 441-1422	<a href="http://www.pfot.com">www.pfot.com</a>
Professional Development Products	Tel (651) 439-8865 Fax (651) 439-0421	<a href="http://www.pdppro.com">www.pdppro.com</a>
Sammons Preston	Toll Free (800) 323-5547 Fax (800) 547-4333	<a href="http://www.sammonspreston.com">www.sammonspreston.com</a>
Sensory Comfort	Toll Free (888) 436-2622 Fax (603) 436-8422	comfort@sensorycomfort.com <a href="http://www.sensorycomfort.com">www.sensorycomfort.com</a>
Sensory Resources	Toll Free (888) 357-5867 Tel (702) 433-0404 Fax (702) 891-8899	<a href="http://www.sensoryresources.com">www.sensoryresources.com</a>
Southpaw Enterprises, Inc.	Toll Free (800) 228-1698 Fax (937) 252-8502	therapy@southpawenterprises.com <a href="http://www.southpawenterprises.com">www.southpawenterprises.com</a>

Spio Works	Toll Free (877) 977-7746 Tel (360) 897-0001 Fax (360) 897-0311	<a href="mailto:spioworks@earthlink.net">spioworks@earthlink.net</a> <a href="http://www.spioworks.com">www.spioworks.com</a>
Sprint Aquatic Rehabilitation	Toll Free (800) 235-2156 Fax (805) 541-5339	<a href="mailto:info@sprintaquatics.com">info@sprintaquatics.com</a> <a href="http://www.sprintaquatics.com">www.sprintaquatics.com</a>
TalkTools	Toll Free (888) 529-2879 Tel (520) 795-8544 Fax (520) 795-8559	<a href="mailto:info@talktools.net">info@talktools.net</a> <a href="http://www.talktools.net">www.talktools.net</a>
Therapro	Toll Free (800) 257-5376 Tel (508) 872-9494 Fax (800) 265-6624	<a href="mailto:info@theraproducts.com">info@theraproducts.com</a> <a href="http://www.theraproducts.com">www.theraproducts.com</a>
Weighted Wearables	Tel (715) 505-3651 Fax (715) 309-2268	<a href="http://www.weightedwearables.com">www.weightedwearables.com</a>

## Toys

Back to Basics	Toll Free (800) 356-5360	<a href="http://www.basictoys.com">www.basictoys.com</a>
Discovery Toys <i>(only available through a Discovery Toys representative)</i>	Toll Free (800) 341-8697	<a href="http://www.discoverytoysinc.com">www.discoverytoysinc.com</a>
Highlights	Toll Free (888) 876-3810	<a href="http://www.highlightscatalog.com">www.highlightscatalog.com</a>
Leaps & Bounds	Toll Free (800) 477-2189 Fax (847) 615-2478	<a href="http://www.leapsandboundscatalog.com">www.leapsandboundscatalog.com</a>
Oriental Trading Company, Inc.	Toll Free (800) 875-8480	<a href="http://www.oriental.com">www.oriental.com</a>

## Information and Referral to Community Services

### **United Way of America**

Local chapters typically provide information and referrals for bereavement services and support groups. <http://national.unitedway.org>

### **National Mental Health Association**

Local chapters typically provide information and referrals for bereavement services and support groups. <http://www.nmh.org>

### **The Dougy Center for Grieving Children and Families**

Dougy's National Center for Grieving Children and Families provides local, national, and international support to individuals and organizations seeking to assist the children who are grieving. <http://www.dougy.org>

### **National Child Traumatic Stress Network**

Provides information and resources for personnel in schools and other child-serving settings. <http://www.nctsnet.org>

### **UCLA School Mental Health Project Center for Mental Health in Schools**

Has materials on childhood grief and bereavement. <http://smhp.psych.ucla.edu>

## Web Sites for Adults

### **Helping Students Cope with Trauma and Loss**

Online training for school personnel with Helene Jackson, Ph.D., Columbia University School of Social Work. <http://ci.columbia.edu/w0521>

### **Hospice Foundation of America**

(See section on grief and loss). <http://www.hospicefoundation.org>

### **New York University (NYU) Child Study Center**

Offers several resources for helping children and adolescents cope with trauma and death. <http://www.aboutourkids.org>

### **The Children's Bereavement Center of South Texas**

The resources section offers a bibliography for children, adolescents, and adults. <http://www.cbcst.org>

## Web Sites for Youth

### **FosterClub: The National Network for Youth in Foster Care**

Website offers information, support, and networking for youth in foster care.

<http://www.fosterclub.org>

### **KIDSAID**

Owned and run by GriefNet, created and designed by Elyzabeth Lynn, Ph.D., KIDSAID is “a safe place for kids to share and to help each other deal with grief about any of their losses.” <http://www.kidsaid.com>

### **GirlThrive**

This web-site is designed by Dr. Patti Feuereisen, a psychologist from New York City that brings real stories from real girls, real information from real experts, web-links, and all kinds of helpful insights into sexual abuse and young women. [www.girlthrive.org](http://www.girlthrive.org)

# Glossary

**Adrenaline** the “fight or flight” hormone produced by the adrenal glands; increases during stress, widens airways of the lungs, constricts small blood vessels, releases sugar stored in the liver, makes muscles work harder.

**Amygdala** the part of the brain related to the emotions and emotional learning, and a key area for “instinctive” responses (including the body’s “fight or flight” response to stress).

**Attachment** the affectionate and emotional tie between people that continues indefinitely over time and lasts even when people are geographically apart.

**Autonomic Nervous System (ANS)** spontaneous control of involuntary bodily functions such as, smooth muscle action of the heart, blood vessels, glands, lungs, stomach, colon, bladder, and other visceral organs not subject to willful control; it’s also associated with the fight-flight response.

**Behavior** a person’s actions, which are the ways that specific needs, underlying conditions, and feelings are expressed.

**Child sexual abuse** sexual acts imposed on a child who lacks emotional, maturational and cognitive development to truly consent (can be a legal or a clinical definition).

**Chronological age** biological age as measured by time (in years and months for young children; in years for adults).

**Cortisol (hydrocortisone)** the primary or chief steroid hormone secreted by the adrenal cortex.

**Culture** the way of life of a people.

**Cycle of attachment** the term describing the process or sequence of events (feeling a need, expressing the need through a behavior, satisfaction of the need, and experiencing relaxation as a result) which, when successfully repeated in early life, allows infants to learn trust and form attachments.

**Depersonalization** the experience of being estranged from oneself, one’s body, and the environment. The person observes occurrences involving the self from the perspective of a detached outsider.

**Developmental age** age as measured by achievement of certain skills and abilities and/or characteristic interests and concerns.

**Developmental domains** the five areas (physical, emotional, social, mental, and moral) encompassing the range and spectrum of human development (also sometimes referred to as the “five domains”).

**Developmental delay** the term used to identify instances when a child’s skills, abilities, and/or growth fall below what would be considered “normal” development for the child’s chronological age (also sometimes referred to as developmental “lag”).

**Developmental stage** the age period (identifiable throughout life for all people) during which certain needs, behaviors, capabilities, and experiences are commonly shared with others of the same age group and easily distinguishable from those of other age groups.

**Developmental task** the accomplishment or “job” that must typically be achieved at a certain age or stage of life before an individual can successfully progress to the next stage.

**DID** common acronym for Dissociative Identity Disorder (formerly Multiple Personality Disorder); a dramatic and extreme instance of a dissociative state that usually occurs in persons who have experienced multiple traumas in childhood.

**Dissociation** the splitting off from one another of ordinarily closely connected behavior, thoughts, and feelings.

**Early intervention program** a statewide program that provides many different types of early intervention services to infants and toddlers with disabilities and their families.

**EMDR** Eye Movement Desensitization and Reprocessing, a powerful method of doing psychotherapy, developed by Francine Shapiro, Ph.D. in 1987. EMDR incorporates many treatment modalities into one primary protocol. Extensive research by Bessel van der Kolk, M.D., one of the world’s leading authorities on trauma research, indicates EMDR is five times more effective in the treatment of trauma than any other modality. EMDR is used for a wide variety of psychological conditions, as well as Performance Enhancement.

**Emotional incest** sometimes called “covert incest” is when a child inappropriately becomes the object of a parent’s affection, love, passion, and preoccupation. The child is often used as an emotional surrogate spouse to the parent and the child’s emotional developmental needs are not met.

**Hippocampus** the part of the brain that is important in memory formation, storage, retrieval, and processing.

**Human development** the lifelong, dynamic relationship between a person and the world, which occurs in orderly, predictable steps.

**Hyperarousal** the state of being overly active and overly responsive to life events.

**Imprinting** a specialized form of learning occurring early in life and often influencing behavior later in life. The learning is particularly resistant to change. Konrad Lorenz (early 1900s) was best known for his work with imprinting.

**Incest** any form of sexual activity between a child and a parent, stepparent, or extended family member, or surrogate family member (of any age). The act of incest involves sexual behavior (fondling, intercourse or oral/anal contact) between close blood relatives, reformed families, and step-relations.

Incest taboos of some sort have existed in every culture known to humans. They are sanctioned by law, tradition, and religion. The particular taboo or definition of incest has varied in different eras and societies.

**Interventions** purposeful, planned actions or strategies used by caregivers to meet children's needs or to teach children appropriate ways to meet their own needs.

**Limbic system** the network of interconnected structures that regulates emotions and "gut reactions," and which plays a critical role in motivation, learning, and memory. Thought to be the part of the central nervous system that maintains and guides the emotions and behavior necessary for self-preservation and survival of the species.

**Naming feelings** the use of reflection of feelings ("You seem sad..." "You look angry...") as a way of helping children recognize and identify their own feelings and/or using identification of personal feelings ("I feel proud that..." "I am worried that...") as a way to help children learn how to recognize feelings in others.

**Negative working model** the child's internal view or "picture" of himself as unlovable and of others as unwilling or able to meet his needs.

**Neural pathways** the "wiring" and "circuitry" that the brain develops for receiving, interpreting, categorizing, storing, and using information about the self and the world.

**NOPS** acronym for the term non-offending parents; stereotypically and statistically seen as the mother "who failed to protect the child from the molesting father."

**Parasympathetic Nervous System (PNS)** some of the effects of the PNS are constriction of pupils, slowing of heart rate, contraction of smooth muscles, increased glandular secretion, and constriction of bronchioles.

**Positive interaction cycle** the process in which the parent or caregiver initiates a positive experience with the child and the child, in turn, responds in a way that supports and reinforces future, similar parent initiated interactions.

**Positive working model** the child's internal view or "picture" of himself as lovable and of others as wanting and able to respond to his or her needs.

**Prefrontal cortex** the area of the brain that regulates "executive" functions, including judgment, reasoning, motivation, and impulse control.

**Splitting** the term used for the process that occurs when a child's behaviors create or lead to misunderstandings and miscommunication between caregivers.

**Sympathetic Nervous System (SNS)** is the part of the autonomic nervous system that stimulates the heart beat, dilates the pupils, contracts the blood vessels, and functions in opposition of the parasympathetic nervous system.

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