

Trauma Informed Caregiving



Addressing the Needs of Young Children in Foster Care



2015 Child Health, Education, and Care Summit

Introduction to Our Presenters

Cherie Schroeder

Foster & Kinship Care Education
Woodland Community College
cherie@yolofostercare.com (530) 574-1964

Cherie is Program Director, Instructional Specialist, and foster parent with 20 years of experience in Early Childhood and Foster and Kinship Care Education. The impact of early trauma and loss on a child's development are of particular interest. To enhance her graduate work obtained at UC Davis, she recently completed a 2-year Advanced Transdisciplinary Mental Health Practitioner endorsement in the fields of Infant/Family and Early Childhood through WestEd and sponsored by First 5 Yolo. She and her husband Ken are foster parents.



Juline Aguilar

Foster & Kinship Care Education
Folsom Lake Community College
aguilai@flc.losrios.edu (530) 642.5626

For the last ten years, Juline Aguilar has coordinated the Foster and Kinship Care Education (FKCE) program at The El Dorado Center of Folsom Lake College, serving both Amador and El Dorado Counties. As an Instructional Specialist she has developed curriculum, with a particular focus on trauma and serving the young child in foster care. She holds a Master Degree in Educational Psychology from U.C. Berkeley, and is a former elementary school teacher.



Regan Overholt

First 5 Yolo County
Foster/Adoptive Parent
roverholt@first5yolo.org (530) 867-1425

Regan Overholt is the First 5 Yolo School Readiness Coordinator and Program Liaison to the Yolo County Foster Care Integrated Support Initiative Recruitment and Retention Grant, which was honored as the 2013 "High 5 Recipient." She is committed to building collaborative and innovative programs that support children and families and has worked in the non-profit sector most of her professional life. Trauma and its impact was directly brought into her home when she and her husband accepted placement of two young children, both with very rough early beginnings. As a foster-to-adopt family they have experienced firsthand the long-term ramifications of relational and toxic trauma.



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What Is Trauma Informed Care?

A trauma informed approach to child welfare involves a system in which all parties involved recognize and respond to the varying impact of traumatic stress on children, caregivers and those who have contact with “the system”. Programs within the child welfare system infuse this knowledge, awareness and skills into their organizational culture, policies, and practices. They act in collaboration, using the best available science, to facilitate and support resiliency and recovery. Trauma informed systems promote and recognition that effectively serving children and families means recognizing that their exposure to traumatic events and subsequent reactions affect the worker’s ability to achieve the goals of safety, permanency, and well-being.

Systems which utilize trauma research information and adapt their programs, policies and behaviors are frequently referred to as “Trauma Informed Practices” (TIPS).

Failure to identify traumatized children or teens leaves them without the services and treatment they need for healing and successful life adjustment.

The National Child Traumatic Stress Network (NCTSN) lists the following range of traumatic experiences:

Community and School Violence
Domestic Violence
Early Childhood Trauma (0-6 years old)
Medical Trauma
Natural Disasters
Neglect
Physical Abuse
Refuge and War Zone Trauma
Sexual Abuse
Terrorism
Traumatic Grief
Complex Trauma

Exposure to multiple or prolonged traumatic events; often our children coming under the umbrella of Child Welfare Services

In addition to children and teens entering the Child Welfare System for abuse and neglect, between 75 and 93 percent of youth entering the juvenile justice system annually have experienced some degree of trauma.

Children are twice as likely as adults to be victims of serious violent crime and 3 times more likely to experience assault. Thirty-five to 46 percent of adolescents report witnessing violence. Youth of color are more likely to experience violence than their white counterparts.

What is Trauma?

Every year millions of children undergo physical or emotional trauma.

We hope from this workshop you will leave with a greater understanding for our work with hurt and traumatized children. Physical abuse, rapes, hurricanes, fires, car accidents, witnessing violence, multiple painful medical procedures, life-threatening medical conditions, sudden death of a parent, and threat of violence at school or home can all be characterized as traumatizing events.



In the **United States** alone, approximately **five million children experience some form of traumatic event each year.** More than two million of these children are victims of physical and/or sexual abuse. Millions more live in the terrorizing atmosphere of domestic violence.

By the time a child reaches the age of 18, the probability that he or she will have been touched directly by interpersonal or community violence is approximately one in four. Across the world, these numbers are even more astounding. In some war-torn countries, more than 60 percent of the children are displaced and chronically traumatized. These numbers are more than mere statistics. No one remains unscathed by traumatic events. First, trauma can have a devastating impact on the individual child, profoundly altering physical, emotional, cognitive, and social development. Second, the child's experience directly impacts his or her family and community.

We now know that a child's potential to be creative, productive, healthy, and caring depends upon his or her experiences in childhood, and if these experiences are threatening, chaotic, and traumatic, the child's potential is diminished. Ultimately, we all pay the price exacted by childhood trauma, whether we are dealing with individual children or large numbers of scarred adults assuming their places in society.

<http://www.childtraumaacademy.com/>

Childhood Trauma Increases Risks in Adulthood

People who have experienced traumatic events in childhood are at increased risk for a host of other problems, impacting all domains of functioning. Impaired emotional, social, cognitive, and physiological functioning can result from adverse childhood events.

Social problems of traumatized children can manifest in teenage pregnancy, adolescent drug abuse, school failure, victimization, and anti-social behavior. Victims of childhood trauma can suffer from neuropsychiatric conditions, such as **post-traumatic stress disorder**, dissociative disorders, and conduct disorders.

Medical problems such as heart disease and asthma can also be directly attributed to childhood trauma in some cases. Childhood trauma has even been linked to increased risk for cigarette smoking:

Researchers from Kaiser Permanente in California studied data on 9,215 patients in health maintenance organizations. They questioned patients about their smoking habits and exposure to the following events: being emotionally, sexually, and/or physically abused; having a battered mother; divorce or separation of parents; growing up around substance abuse; or growing up with a mentally ill or incarcerated household member.

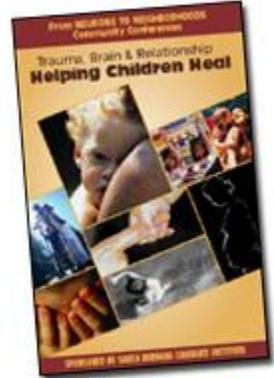
Kids exposed to five or more of the eight types of negative childhood experiences were 5.4 times more likely to begin smoking by age 14 or 15 than kids who did not have such negative experiences. And children with negative experiences were twice as likely to be a current smoker and nearly three times more likely to be a heavy smoker than children who were not exposed to negative events. American Medical Association, November, 1999

The escalating cycles of abuse and neglect of our children seen in some of our urban and rural communities can, in turn, become a major contributor to many other social problems. Some would consider the deterioration of public education, the proliferation of urban violence, and an alarming rate of social disintegration all as direct results of childhood trauma.



Trauma, Brain and Relationship: Helping Children Heal

This 30-minute documentary video about psychological or emotional trauma in children is taken from interviews conducted at the From Neurons to Neighborhoods community conferences. The documentary is an overview to help those who care about children recognize, prevent and heal psychological trauma. Internationally and nationally recognized authorities who work with children and teenagers in the field of emotional trauma, including Drs. Bruce Perry and Daniel Siegel, offer new insight and information about the origins of relationship/developmental problems, as well as problems associated with PTSD later in life.



New research on the brain is highlighted, as is information about how seemingly benign incidents bring about traumatic responses in young children. A central message of the documentary is that even though psychological trauma often goes unrecognized in children, emotional trauma is very responsive to relational repair.

An outline of the documentary accompanies the video and clarifies such points as the difference between emotional trauma and emotional stress. Also available on this site are [transcripts of full interviews](#) that went into the development of the documentary.

Outline

Relational trauma can profoundly affect the way children think, feel and act. Trauma is more widespread than we formerly thought with a far broader imprint than that defined by PTSD. Trauma's aftermath affects children's abilities to focus mentally, calm themselves emotionally and be aware of others. It is the source of chronic learning and attention problems, emotional and social problems and physical problems. Fortunately, all forms of trauma-including relational trauma and single incident trauma-can be readily repaired in young children.

Traumatic distress can be distinguished from routine stress by assessing the following:

- how quickly upset is triggered
- how frequently upset is triggered
- how intensely threatening the source of upset is
- how long upset lasts
- how long it takes to calm down

This documentary introduces revolutionary new discoveries from leading universities and research centers throughout US and in Canada including UCLA, UCSD, UC Berkeley that help identify, prevent and heal trauma in children.

Specifically, the documentary focuses on three areas:

- **Introduces new awareness about the many causes of trauma in children based on groundbreaking advances in brain research.** Brain scans permit us to view images of the functional disruptions caused by trauma. As a result of what we can actually see, traumatic experience takes on a vast new meaning. For the first time, we know that trauma in infants and children can be caused by any of the following disruptive neurological events that:

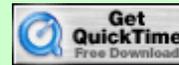
- Happen in the womb;
 - Result from frightening and overwhelming experiences;
 - Result from conscious abuse or neglect;
 - Happen unintentionally in relationships with primary caregivers who themselves are traumatized, depressed or were poorly connected to their primary caregivers.
- **Highlights relationship as the most powerful way of healing trauma in young children.** Neural repair results from having primary relationships that calm, soothe and help a child organize their experiences. This fact is also based on brain imaging research that reveals the tremendous plasticity of the brain -particularly in the first five years of life. Unfortunately, the pressure of urban life greatly reduces opportunities for the kind of relationships that prevent and heal trauma in children.
- **Emphasizes the exceptional opportunity to heal young children.** During the first five years of life, a child's brain remains extraordinarily plastic and amenable to recovery from trauma. Unfortunately, ninety-five percent of public funds are spent on children after the age of five when it is more difficult and expensive to affect change.

Section Overview

Below each section description there is a link to view the video section in Quick Time format.

If you don't have Quick Time you can download it for free - click on the button to the right. Download the free version, it is not necessary to purchase the Pro version to view our video clips.

We recommend a broad band connection for viewing the video clips.



Introduction (1:40 min)

Click [here](#) to view in QuickTime format.

Section One: The Very First Relationship (3:38 min)

All relationships, and especially primary relationships, profoundly impact the developing brain, for better or worse. When children feel "seen," safe and supported, their nervous systems develop in a very coherent manner; but if they don't feel safe and connected in their primary relationships, their brains develop in a disrupted way. Click [here](#) to view in QuickTime format.

Section Two: Brain Development at Risk (1:10 min)

A child's relationships that do not provide consistent, sensitive care, dysregulate the brain, creating experiences that are overwhelming, frightening and enraging. Many of these experiences go undetected.

Click [here](#) to view in QuickTime format.

Section Three: The Many Faces of Trauma (3:51 min)

Several stress responses signal trauma in young children including hypersensitive hyper-reactive behavior, hyper-vigilant behavior and shut down, tuned out behavior. The undistruptive responses of anxious and self-absorbed children are often missed or ignored. These often "quiet" or "good" children manifest problems that can be even more serious than those of disruptive children. Click [here](#) to view in QuickTime format.

Section Four: Relationship Induced Trauma (2:52 min)

When the attachment figure is frightening or confusing, the child is traumatized. Most parents of traumatized children are themselves traumatized and are relationally insecure. When these parents learn to see their behavior from the perspective of the child, they can repair the relationship and heal their child. *Click [here](#) to view in QuickTime format.*

Section Five: Healing Trauma (5:02 min)

Healing trauma in children means creating safety for the child. It also requires caregivers to become sensitive to the child's sensory reactions. When we know or suspect that a child has been traumatized, we can help children communicate their distress both with and without words. The quality of eye contact, facial expression, posture, gesture, timing and intensity of response can soothe even a child too young for words. *Click [here](#) to view in QuickTime format.*

Section Six: You Make the Difference (5:32 min)

Early childhood trauma changes the biology of the brain, but early childhood support also changes the biology of the brain. Even when a child has a poor relationship with a primary caretaker, if that child has as few as one secure relationship with another adult, childcare or daycare provider, there is hope for healing the brain. What makes children recover from emotional trauma are other human beings who are kind, patient, sensitive and supportive. *Click [here](#) to view in QuickTime format.*

Featured in the video are:



Bruce D. Perry, M.D., Ph.D., is an internationally-recognized authority on children in crisis. Dr. Perry is the Provincial Medical Director in Children's Mental Health for the Alberta Mental Health Board. He is also the Senior Fellow of the ChildTrauma Academy, a Houston-based organization dedicated to research and education on child maltreatment. Dr. Perry's work has been instrumental in describing how traumatic events in childhood change the biology of the brain. The author of more than 200 journal articles, book chapters, and scientific proceedings and is the recipient of a variety of professional awards. See www.childtrauma.org

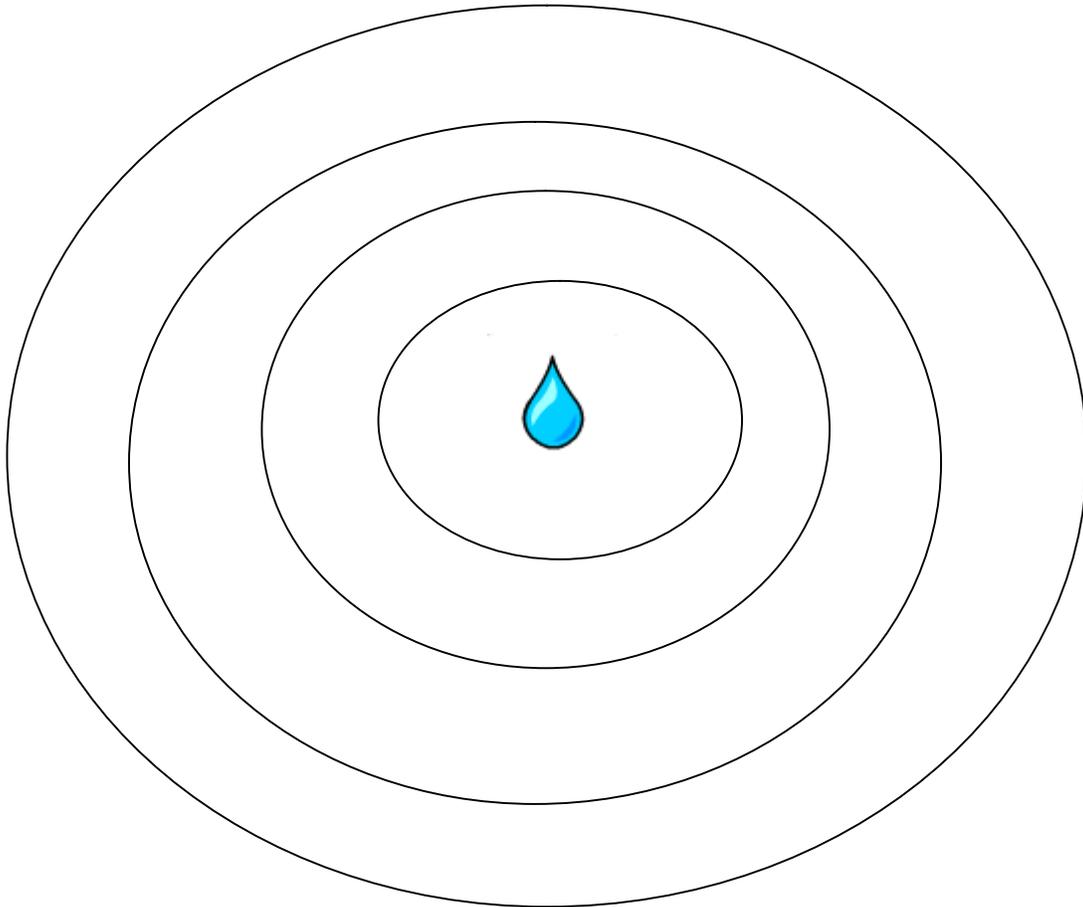


Daniel J. Siegel, M.D., is a practicing psychotherapist who received his medical degree from Harvard University and is presently on the faculty at UCLA where he is an associate clinical professor of psychiatry. Dr. Siegel has published several books, including *The Developing Mind: How relationships and the brain interact to shape who we are*; *Parenting from the Inside Out: How a deeper self-understanding can help you raise children who thrive* (co-authored with Mary Hartzell); and *Healing Trauma: Attachment, mind, body, and brain* (Co-edited with Marion Solomon). He is also the editor-in-chief of the Norton Series on Interpersonal Neurobiology.



Constance M. Lillas, Ph.D., MFT, RN is a 2003 Zero To Three Fellow and Director, Interdisciplinary Training Institute. She is the Director of Infant Mental Health Training for The Early Childhood Center Foundation, a Training and Supervising Analyst at the Institute of Contemporary Psychoanalysis and the Newport Psychoanalytic Institute, a private practice practitioner for families with birth to five year olds and adults, and a private consultant. Dr. Lillas brings a synthesis of three distinct backgrounds and disciplines to her psychoneurobiological model: maternal-child nursing, systems theory; and her emphasis in development and infant research.

The Ripple Effect of Trauma



1. **What is the drop** - the primary trauma?
2. What are the ripples **in the home**?
3. What are the ripples **in the child's body**?
4. What are the ripples **in the community**?
5. What are the ripples **in the school**?
6. What are the ripples from outside, including interventions?



Early Childhood Trauma

(Print version of

http://nctsn.org/nccts/nav.do?pid=typ_early1)

August 2010

Zero to Six Collaborative Group

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Overview

Early childhood trauma generally refers to the traumatic experiences that occur to children aged 0–6. Because infants' and young children's reactions may be different from older children's, and because they may not be able to verbalize their reactions to threatening or dangerous events, many people assume that young age protects children from the impact of traumatic experiences. When young children experience or witness a traumatic event, sometimes adults say, "They're too young to understand, so it's probably better if we don't talk to them about it." However, young children are affected by traumatic events, even though they may not understand what happened.

A growing body of research has established that young children—even infants—may be affected by events that threaten their safety or the safety of their parents/caregivers, and their symptoms have been well documented. These traumas can be the result of intentional violence—such as child physical or sexual abuse, or domestic violence—or the result of natural disaster, accidents, or war. Young children also may experience traumatic stress in response to painful medical procedures or the sudden loss of a parent/caregiver.

Sometimes adults say, "They're too young to understand." However, young children are affected by traumatic events, even though they may not understand what happened.

How Is Early Childhood Trauma Unique?

Traumatic events have a profound sensory impact on young children. Their sense of safety may be shattered by frightening visual stimuli, loud noises, violent movements, and other sensations associated with an unpredictable frightening event. The frightening images tend to recur in the form of nightmares, new fears, and actions or play that reenact the event. Lacking an accurate understanding of the relationship between cause and effect, young children believe that their thoughts, wishes, and fears have the power to become real and can make things happen. Young children are less able to anticipate danger or to know how to keep themselves safe, and so are

Children may blame themselves or their parents for not preventing a frightening event or for not being able to change its outcome.

particularly vulnerable to the effects of exposure to trauma. A 2-year-old who witnesses a traumatic event like his mother being battered may interpret it quite differently from the way a 5-year-old or an 11-year-old would. Children may blame themselves or their parents for not preventing a frightening event or for not being able to change its outcome. These misconceptions of reality compound the negative impact of

traumatic effects on children's development.

As with older children, young children experience both behavioral and physiological symptoms associated with trauma. Unlike older children, young children cannot express in words whether they feel afraid, overwhelmed, or helpless. However, their behaviors provide us with important clues about how they are affected.

Young children who experience trauma are at particular risk because their rapidly developing brains are very vulnerable. Early childhood trauma has been associated with reduced size of the brain cortex. This area is responsible for many complex functions including memory, attention, perceptual awareness, thinking, language, and consciousness. These changes may affect IQ and the ability to regulate emotions, and the child may become more fearful and may not feel as safe or as protected.

Young children depend exclusively on parents/caregivers for survival and protection—both physical and emotional. When trauma also impacts the parent/caregiver, the relationship between that person and the child may be strongly affected. Without the support of a trusted parent/caregiver to help them regulate their strong emotions, children may experience overwhelming stress, with little ability to effectively communicate what they feel or need. They often develop symptoms that parents/caregivers don't understand and may display uncharacteristic behaviors that adults may not know how to appropriately respond to.

Read More About It

For more on the impact of trauma on brain development, see *Excessive Stress Disrupts the Architecture of the Developing Brain*, a working paper from the National Scientific Council on the Developing Child, available at http://developingchild.harvard.edu/library/reports_and_working_papers/wp3/

Scope of the Problem

Young children are exposed to traumatic stressors at rates similar to those of older children. In one study of children aged 2–5, more than half (52.5%) had experienced a severe stressor in their lifetime.¹

The most common traumatic stressors for young children include: accidents, physical trauma, abuse, neglect, and exposure to domestic and community violence.

Child Accidents and Physical Trauma

- Children aged five and under are hospitalized or die from drowning, burns, falls, choking, and poisoning more frequently than do children in any other age group.²
- One in three children under the age of six has injuries severe enough to warrant medical attention.³

Child Abuse and Neglect

- Young children have the highest rate of abuse and neglect, and are more likely to die because of their injuries.
- Children younger than three years of age constituted 31.9 percent of all maltreatment victims reported to authorities in 2007.⁴
- Infants are the fastest growing category of children entering foster care in the United States.⁵
- Infants removed from their homes and placed in foster care are more likely than are older children to experience further maltreatment and to be in out-of-home care longer.⁶

Child Exposure to Domestic or Community Violence

- In a survey of parents in three SAMHSA-funded community mental health partnerships, 23 percent of parents reported that their children had seen or heard a family member bring threatened with physical harm.⁷
- Nearly two-thirds of young children attending a Head Start program had either witnessed or been victimized by community violence, according to parent reports.⁸
- In a survey of parents of children aged six and under in an outpatient pediatric setting, it was found that one in ten children had witnessed a knifing or shooting; half the reported violence occurred in the home.⁹

Data from National Child Traumatic Stress Network (NCTSN) Sites

In 2002 the NCTSN Complex Trauma Task Force conducted a clinician survey on trauma exposure for children who were receiving assessment and/or intervention services. Among the findings—published in a white paper, *Complex Trauma in Children and Adolescents*—was that 78 percent of children had experienced more than one trauma type and that the initial exposure on average occurred at age five.¹⁰ Additional data from more than 10,000 cases of children receiving trauma-focused services from sites in the NCTSN reveal that in this cohort, one-fifth of children are aged zero to six. The traumas these children most often received services for were exposure to domestic violence, sexual abuse, neglect, and traumatic loss/bereavement.¹¹

Symptoms and Behaviors Associated with Exposure to Trauma

Children suffering from traumatic stress symptoms generally have difficulty regulating their behaviors and emotions. They may be clingy and fearful of new situations, easily frightened, difficult to console, and/or aggressive and impulsive. They may also have difficulty sleeping, lose recently acquired developmental skills, and show regression in functioning and behavior.

Possible Reactions of Children Aged Zero to Six Exposed to Traumatic Stress		
Behavior Type	Children aged 0-2	Children aged 3-6
Cognitive		
Demonstrate poor verbal skills	✓	
Exhibit memory problems	✓	
Have difficulties focusing or learning in school		✓
Develop learning disabilities		✓
Show poor skill development		✓
Behavioral		
Display excessive temper	✓	✓
Demand attention through both positive and negative behaviors	✓	✓
Exhibit regressive behaviors	✓	✓
Exhibit aggressive behaviors	✓	✓
Act out in social situations		✓
Imitate the abusive/traumatic event		✓
Are verbally abusive		✓
Scream or cry excessively	✓	
Startle easily	✓	✓
Are unable to trust others or make friends		✓
Believe they are to blame for the traumatic experience		✓
Fear adults who remind them of the traumatic event	✓	✓
Fear being separated from parent/caregiver	✓	✓
Are anxious and fearful and avoidant		✓

Possible Reactions of Children Aged Zero to Six Exposed to Traumatic Stress		
Behavior Type	Children aged 0-2	Children aged 3-6
Show irritability, sadness, and anxiety	✓	✓
Act withdrawn	✓	✓
Lack self-confidence		✓
Physiological		
Have a poor appetite, low weight, and/or digestive problems	✓	
Experience stomachaches and headaches		✓
Have poor sleep habits	✓	✓
Experience nightmares or sleep difficulties	✓	✓
Wet the bed or self after being toilet trained or exhibit other regressive behaviors		✓
Physiological		
Have a poor appetite, low weight, and/or digestive problems	✓	
Experience stomachaches and headaches		✓
Have poor sleep habits	✓	✓
Experience nightmares or sleep difficulties	✓	✓

Identifying and Providing Services to Young Children Who Have Been Exposed to Trauma: For Professionals

Due to the particular developmental risks associated with young children's traumatic experiences, it is essential that vulnerable children be identified as early as possible after the trauma. Many community resources—including health systems, Early Intervention programs, child welfare agencies, Head Start, child care programs, and early education systems—play an important role in identifying children, and in linking them and their families with services.

Some of these systems now try to address possible traumatic experiences by including questions about specific traumas into their intake and/or assessment protocols. For example, both Head Start and Early Intervention intake protocols include questions about domestic violence in families. Other protocols may include targeted questions about accidents, loss of family members, and/or significant medical history.

For Mental Health Professionals

Behavioral Health Assessment

Assessment of trauma in young children must focus on the presenting problem in the context of the child's overall development. This information can be gathered through interviews with the parents/significant caregivers in the child's life, observation of the parent/caregiver-child interaction, and standardized assessment tools. Clinical assessment should include review of the specifics of the traumatic experience(s) including:

- Reactions of the child and parents/caregivers
- Changes in the child's behavior
- Resources in the environment to stabilize the child and family
- Quality of the child's primary attachment relationships
- Ability of parents/caregivers to facilitate the child's healthy socioemotional, psychological, and cognitive development

Instruments for Assessing Traumatic Stress in Young Children

Below is a list of some of the standardized instruments used within the NCTSN to assess traumatic stress in young children.

- Child Behavior Checklist (CBCL)¹⁴—aged 1½–5
- Posttraumatic Stress Disorder Semi-Structured Interview and Observation Record¹⁵—aged 0–4 years of age
- Posttraumatic Symptom Inventory for Children (PT-SIC)¹⁶—aged 4–8 years
- Preschool Age Psychiatric Assessment (PAPA)¹⁷—aged 2–5
- PTSD Symptoms in Preschool Aged Children (PTSD-PAC)¹⁸—aged 3–5¹⁸
- Traumatic Events Screening Inventory-Parent Report Revised (TESI-PRR)¹⁹—aged 0–6
- Trauma Symptom Checklist for Young Children (TSCYC)²⁰—aged 3–12
- Violence Exposure Scale for Children-Preschool Version (VEX-PV)⁸—aged 4–10

- Violence Exposure Scale for Children-Revised Parent Report (VEX-RPR)⁸—for parents of preschool-aged children aged 4–10⁸

Instruments for Assessing Parenting Stress and Strengths

- Life Stressor Checklist—Revised (LSC-R)²¹
- Parenting Stress Index (PSI)²²
- Davidson Trauma Scale (DTS)²³

When conducting an assessment of a young child, it is also important to assess developmental delays (e.g., gross/fine motor, speech/language, sensory processing), which may indicate that the child could benefit from evaluation and/or services from another professional (e.g., occupational therapist, speech/language therapist, physical therapist). And it is often helpful to consult and/or to work collaboratively with these professionals to conduct a multidisciplinary evaluation.

For Medical Professionals

Screening/Assessment in Health Settings

Most young children are seen at regular intervals by providers in the pediatric health care system, enabling repeated opportunities for identifying early childhood trauma.

Medical providers can also play an important role in diminishing risks and in maximizing protective factors associated with young children's exposure to trauma. They can supply information to prevent accidents and can incorporate questions about stressful and traumatic experiences into their interviews with families.

Resources for Identifying Traumatic Stressors in Young Children

Online resources

The Child Trauma Academy (<http://www.childtrauma.org>)

Articles for professionals (<http://www.childtrauma.org/index.php/articles/articles-for-professionals>)

The Health Care Toolbox (<http://www.healthcaredtoolbox.org/index.php>)

Center for Pediatric Traumatic Stress at The Children's Hospital of Philadelphia

Centers for Disease Control and Prevention (<http://www.cdc.gov>)

Injury—A Risk at Any Stage of Life

(http://www.cdc.gov/ncipc/fact_book/Injury%E2%80%94A%20Risk%20at%20Any%20Stage%20of%20Life-2006.pdf)

Journal Articles

Cohen, J. A., Kelleher, K. J., & Mannarino, A. P. (2008). Identifying, treating, and referring traumatized children: The role of pediatric providers. *Archives of Pediatrics and Adolescent Medicine*, 162(5), 447–452.

Dehon, C., & Scheeringa, M. S. (2006). Screening for preschool posttraumatic stress disorder with the Child Behavior Checklist. *Journal of Pediatric Psychology*, 31(4), 431–435.

Groves, B. M., & Augustyn, M. (2009). Pediatric care. Moving From Evidence to Action: *The Safe Start Series on Children Exposed to Violence, Issue Brief #2*. North Bethesda, MD: Safe Start Center, Office of Juvenile Justice and Delinquency Prevention, Office of Justice Program, U.S. Department of Justice. Retrieved August 5, 2010 from http://www.safestartcenter.org/pdf/IssueBrief2_PEDIATRIC.pdf

For Early Educators and Childcare Providers

Educators and childcare providers may inquire about children's safety; offer resources to reestablish safety for families; and, most importantly, support young children's learning through nurturing relationships, and through predictable expectations and routines in the classroom.

Resources for Early Educators and Childcare Providers	
Online resources	
Center on the Social and Emotional Foundations for Early Learning (http://csefel.vanderbilt.edu/about.html)	<i>Practical Strategies for Teachers/Caregivers</i> (http://csefel.vanderbilt.edu/resources/strategies.html)
Head Start (http://www.headstart.org/)	<i>Head Start Bulletin #73: Child Mental Health</i> (http://eclkc.ohs.acf.hhs.gov/hslc/resources/ECLKC_Bookstore/PDFs/A6E18B91317C94E72DD233C75C4DBD7D.pdf) <i>Head Start Bulletin #80: Mental Health</i> (http://www.headstartresourcecenter.org/assets/file/Publications/Bulletin-Mental%20Health%202009v3.pdf)
National Child Traumatic Stress Network (http://www.nctsn.org)	<i>Child Trauma Toolkit for Educators</i> (http://www.nctsn.org/nctsn_assets/pdfs/Child_Trauma_Toolkit_Final.pdf) <i>Caja de Herramientas Para Educadores Para el Manejo de Trauma Infantil</i> (http://www.nctsn.org/nctsn_assets/pdfs/SP_Child_Trauma_Toolkit_111009_FINAL.pdf)
Scholastic for Teachers (http://www2.scholastic.com/)	Library of articles by trauma expert Bruce D. Perry, MD, PhD (http://teacher.scholastic.com/professional/bruceperry/index.htm) Greenspan, S. I. (2002). Meeting learning challenges: Working with the child who has PTSD. <i>Scholastic Early Childhood Today</i> . Perry, B. D. (2006). Death and loss: Helping children manage their grief. <i>Scholastic Early Childhood Today</i> .
Print Resource	
Rice, K. F., & Groves, B. M. (2005). <i>Hope and healing: A caregiver's guide to helping young children affected by trauma</i> . Washington, D.C.: Zero to Three Press.	

For Family Court Judges and Staff

The more that family court judges know about child development and the effects of child trauma, the better equipped they are to make decisions regarding permanency planning for abused and neglected children, to improve the lives of children who have witnessed domestic violence, and to adjudicate custody and visitation cases.

Resources for Family Court Judges and Staff	
Online resources	
National Child Traumatic Stress Network http://www.nctsn.org	<i>Helping Traumatized Children: Tips for Judges</i> http://www.nctsn.org/nctsn_assets/pdfs/JudgesFactSheet.pdf <i>NCTSN Service Systems Brief: Judges and Child Trauma: Findings from the National Child Traumatic Stress Network/National Council of Juvenile and Family Court Judges Focus Groups</i> http://www.nctsn.org/nctsn_assets/pdfs/judicialbrief.pdf
Safe Start Center http://www.safestartcenter.org/	<i>A Judicial Checklist For Children And Youth Exposed To Violence</i> http://www.safestartcenter.org/pdf/childandyouth_checklist.pdf .
Zero to Three http://www.zerotothree.org/	<i>Helping Babies from the Bench: Using the Science of Early Childhood Development in Court</i> (DVD) Order form available at http://www.zerotothree.org/about-us/funded-projects/court-teams/dvd_order_form_2009.pdf

For Faith-Based, Community, and Mentoring Organizations

Community and faith-based organizations have in-depth knowledge of the resources and challenges in their communities. They play a vital role in linking families to resources that help stabilize and support them in the aftermath of trauma events. Advocating for families and increasing access to care can help families begin their recovery process. NCTSN offers the following excellent resources for such organizations.

- *Psychological First Aid: Field Operations Guide, 2nd Edition and Psychological First Aid Field Operations Guide for Community/Religious Professionals*. Available from NCTSN at http://www.nctsn.org/nccts/nav.do?pid=typ terr resources_pfa

Helping Young Children Exposed to Trauma: For Families and Caregivers

When young children experience a traumatic stressor, their first response is usually to look for reassurance from the adults who care for them. The most important adults in a young child's life are his/her caregivers and relatives. These adults can help reestablish security and stability for children who have experienced trauma by:

- Answering children's questions in language they can understand, so that they can develop an understanding of the events and changes in their life
- Developing family safety plans
- Engaging in age-appropriate activities that stimulate the mind and body
- Finding ways to have fun and relax together
- Helping children expand their "feelings" vocabulary
- Honoring family traditions that bring them close to the people they love, e.g., storytelling, holiday celebrations, reunions, trips
- Looking for changes in behaviors
- Helping children to get back on track
- Setting and adhering to routines and schedules
- Setting boundaries and limits with consistency and patience
- Showing love and affection

Caregivers and relatives are the most important adults in children's lives. They can help reestablish security and stability for children who have experienced trauma.

Resources for Family and Caregivers	
Online resources	
After the Injury (http://aftertheinjury.org/)	Find Ways to Help Your Child Recover (http://aftertheinjury.org/findWhat.html)
Center on the Social and Emotional Foundations for Early Learning (http://csefel.vanderbilt.edu/about.html)	Family Tools (http://csefel.vanderbilt.edu/resources/family.html)
National Child Traumatic Stress Network (http://www.nctsn.org)	After the Hurricane: Helping Young Children Heal (http://www.nctsn.org/nctsn_assets/pdfs/edu_materials/Helping_Young_Children_Heal.pdf) Helping Young Children and Families Cope with Trauma (http://www.nctsn.org/nctsn_assets/pdfs/Helping_Young_Children_and_Families_Cope_with_Trauma.pdf)
Scholastic.com (http://www2.scholastic.com/browse/home.jsp)	Brodin A. M. (2005). Talking with children about natural disasters. <i>Scholastic Early Childhood Today</i>

Treatments for Children and Families

As recognition has grown about the prevalence and impact of trauma on young children, more age-appropriate treatment approaches have been developed and tested for this population. These interventions share many of the same core components. For example, they are generally relationship-based, and focus on healing and supporting the child-parent relationship.

NCTSN has developed a series of fact sheets on the clinical treatment and trauma-informed service approaches being implemented by Network centers. The complete fact sheets are available on the NCTSN Web site at http://www.nctsnet.org/ncts/nav.do?pid=ctr_top_tmnt_prom#q3.

The treatment approaches discussed below have all been developed and evaluated for the treatment of young children and have significant empirical support for efficacy.

Alternatives for Families: A Cognitive Behavioral Therapy (AF-CBT) for Preschoolers

(http://nctsn.org/nctsn_assets/pdfs/promising_practices/afcbt_general.pdf)

AF-CBT treatment is designed to help physically abused children and their offending parents by addressing underlying contributors to maltreatment including changing parental hostility, anger, maladaptive coercive family interactions, negative perceptions of children, and harsh parenting.

Abused children are helped to view abuse as wrong and illegal; and are taught emotional comprehension, expression, and regulation as well as social skills. Parents learn proper emotion regulation skills, how to avoid potentially abusive situations, and healthy child management and disciplinary techniques. Dyadic work gives families an opportunity to measure progress, to help identify and clarify family miscommunication, and to establish a family no-violence agreement.^{24,25}

Attachment, Self-Regulation and Competency (ARC)

(http://nctsn.org/nctsn_assets/pdfs/promising_practices/arc_general.pdf)

ARC is a framework for intervention with youth and families who have experienced multiple and/or prolonged traumatic stress. ARC identifies three core domains that impact traumatized youth and that are relevant to future resiliency. ARC provides a theoretical framework, core principles of intervention, and a guiding structure for providers working with these children and their parents/caregivers, while recognizing that a one-size model does not fit all.

Within the three core domains, ten building blocks of trauma-informed treatment and service are identified. For each principle, the ARC manual provides key concepts and guiding theoretical structure, educational information for providers and parents/caregivers, tools for clinicians, and developmental issues to consider. ARC is designed for youth from early childhood to adolescence and their parents/caregivers or caregiving systems.

Read More About It

The Trauma Center at Justice Resource Institute provides an excellent overview of ARC on their Web site, at <http://www.traumacenter.org/research/arcot.php>.

Child-Parent Psychotherapy (CPP)

(http://www.nctsnet.org/nctsn_assets/pdfs/promising_practices/cpp_general.pdf)

CPP integrates psychodynamic, attachment, trauma, cognitive-behavioral, and social-learning theories into a dyadic treatment approach designed to restore both the child-parent relationship and the child's mental health and developmental progression that have been damaged by the experience of family violence. Child-parent interactions are the focus of the intervention.

The goals of CPP are to address issues of safety, improve affect regulation, improve the child-parent relationship, normalize trauma-related response, allow the parent and child to jointly construct a trauma narrative, and return the child to a normal developmental trajectory. The intervention runs for fifty weeks and can be conducted in the office or in the home.

Parent-Child Interaction Therapy (PCIT)

(http://www.nctsn.org/nctsn_assets/pdfs/promising_practices/pcit_general.pdf)

PCIT is a parent training intervention that teaches parents/caregivers targeted behavior management techniques as they play with their child. PCIT focuses on improving the parent/caregiver-child relationship and on increasing children's positive behaviors. It has been adapted for children who have experienced trauma.

Parents/caregivers are coached live by the therapist while engaging in specific play therapy and discipline skills with their child. PCIT is a short-term, mastery-based treatment that typically runs for sixteen to twenty weeks, based on the needs of the family.

Preschool PTSD Intervention

The Preschool PTSD Intervention is a protocol-specific cognitive-behavioral treatment that is combined with parent/caregiver involvement in every session. Treatment is for twelve weeks, and it can be focused on PTSD symptoms from any type of trauma. The cognitive-behavioral components include relaxation training, graded systematic exposure, and homework. The protocol also encourages coverage of parental and parent-child relational issues.

The manual for this intervention, the *Preschool PTSD Treatment Manual*, was developed by Michael Scheeringa, MD, Judith Cohen, MD, and Lisa Amaya-Jackson, MD, and is available free by contacting Dr. Scheeringa at mscheer@tulane.edu.

Trauma Focused Cognitive Behavioral Therapy (TF-CBT)

(http://www.nctsn.org/nctsn_assets/pdfs/promising_practices/TF-CBT_fact_sheet_3-20-07.pdf)

Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) uses cognitive-behavioral theory and principles, and was developed by Judith Cohen, MD, Anthony Mannarino, PhD, and Esther Deblinger, PhD. TF-CBT was originally designed for children with posttraumatic symptoms as a result of sexual abuse.

Treatment generally consists of twelve treatment sessions. Maltreated children and their nonabusing family members learn stress-management skills and practice these techniques during graduated exposure to abuse-constructed trauma. Parents/caregivers learn how to address their own emotional reactions. Several joint parent/caregiver-child sessions are included to enhance family communication about sexual abuse and other issues. Children who participate in TF-CBT show significant improvement in their fear reactions, depressive symptoms, inappropriate sexualized behaviors, and self-worth.

Read More About It

NCTSN offers guidelines on the use of TF-CBT in the manual *How to Implement Trauma-Focused Cognitive Behavioral Therapy*, available at

http://www.nctsn.org/nctsn_assets/pdfs/TF-CBT_Implementation_Manual.pdf

Web-based training in TF-CBT is available from the National Crime Victims Research and Treatment Center at the Department of Psychiatry and Behavioral Sciences, Medical University of South Carolina, at <http://tfcbt.musc.edu/>.

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TRAUMA- INFORMED CHILD WELFARE PRACTICE

All children in the child welfare system have been neglected, abused, or abandoned. By definition these children have suffered trauma. They have been traumatized in their homes of origin and they suffer further trauma if they are moved about in foster care, neglected, abused or poorly placed. This experience of trauma increases vulnerability to stress, affects the capacity to problem solve, and results in a resistance to change. If these children are misunderstood as behavior disordered or mentally ill then their care and treatment will be ineffective in meeting their needs and possibly destructive to their development beyond the damage done by the trauma they experience.

“Unless caregivers [and professionals] understand the nature of trauma reenactments, they are likely to label the child as ‘oppositional’, ‘rebellious’, ‘unmotivated’, or ‘anti-social’.”

Bessel A. van der Kolk, M.D. Developmental Trauma Disorder.

TRAUMA INFORMED PRACTICE INVOLVES A PARADIGM SHIFT

In order to ensure that children in the child welfare system receive effective care that meets their needs, a trauma informed practice involves a paradigm shift in how these children are treated.

- ***The focus should be*** “What Happened to You?” not “What is Wrong with You?”
- The child should be viewed as injured, not as behaviorally bad or emotionally ill or genetically flawed.
- The child’s responses or behavior were adaptive in a neglectful/abusive environment. However, in a normal environment these responses may be seriously maladaptive.
- The move to a safe environment, alone, may not change the child’s behavior.
- Structural changes may have occurred in the child’s brain itself.
- If the child is failing, the care and treatment is not providing what the child needs.
- It is not the child failing the treatment program; it is the program failing the child.
- Trauma-informed assessment, treatment, and environment are essential.

OPERATIONALIZING A TRAUMA-INFORMED PRACTICE

The National Child Traumatic Stress Network, recognizing the importance of institutionalizing child trauma research, developed a trauma-informed child welfare model of practice, which includes:

1. Support positive and stable relationships in the life of the child.
2. Maximizing the child's sense of safety.
3. Services to the child should be guided by a thorough assessment of the child's experiences and their impact on the child's development.
4. Assist children in reducing overwhelming emotion.
5. Help children make new meaning of their trauma history and current experiences.
6. Address the impact of trauma and subsequent changes in the child's behavior, development and relationships.
7. Provide support and guidance to the child's family and caregivers.
8. Coordinate services with other agencies.
9. Manage professional and personal stress.

Connie Black-Pond, James Henry *A Trauma-Informed Child Welfare Systems Practice: The Essential Elements*. Michigan Child Welfare Law Journal. p 11- 23 Winter 2008. See also www.nctsn.org/resources for resources on how to parent, train and/or educate children that have experienced trauma

ASSESSMENT GUIDELINES FOR INFANTS AND YOUNG CHILDREN

1. "Always use multiple sources of information: 'Assessment must be based on an integrated developmental model; involves multiple sources of information and multiple components', 'formal tests or tools should not be the cornerstone of the assessment of an infant or young child'.
2. The child's primary relationship is the cornerstone of an assessment: 'The child's relationships and interactions with his most trusted caregiver should form the cornerstone of an assessment'.
3. Do not separate child from parents: 'Young children should never be challenged during assessment by separation from their parents or familiar caregivers'.
4. The examiner should know the child: 'Young children should never be assessed by a strange examiner'."

S.I Greenspan and S.J. Meisels, (1996) *Toward a New Vision for the Developmental Assessment of Infants and Young Children*. pp. 17, 19, 23, 24 as cited in Connie Lillas and Janiece Turnbull *Infant/Child Mental Health, Early Intervention, and Relationship-Based Therapies*. (2009) W.W. Norton Co., Inc. New York, pp. 161-162

Trauma in Early Infancy or Childhood

“The causes and symptoms of infant trauma differ from that of older children and adults because very young children are upset or frightened by different things than adults and preverbal children cannot manage intense emotions independently... While chronic stress and trauma can change the adult brain they can seriously alter the *organization* of the infant brain.

[W]hen infants do not get a predictable response to their distress cues, as in situations of neglect, their stress response systems are activated with no resolution. Long term exposure to ongoing elevated stress results in large amounts of cortisol in the brain, which can be toxic to the developing brain and may cause permanent changes in brain structure.

When parents are frightening to infants, such as being physically or emotionally abusive to the infant, violent to one another or consistently unresponsive to their baby’s cues and signals of stress, as in situations of chronic or severe neglect, babies experience intense stress as described above. This type of trauma is referred to as ‘cumulative’ or ‘relational’ trauma and has been linked to significant lifelong psychological harm and in extreme cases, to substantial neurological harm.

Babies and young children who are afraid of their caregiver, or who haven’t developed the expectation of a comforting response to distress cues, often have problems with self-regulation. These difficulties can initially appear as problems with feeding...,erratic sleep, inconsolable crying..., extreme passivity or listlessness, primitive and persistent self-soothing behaviors..., and/or dissociation (distinct period of disorientation or freezing.)

The most effective intervention for infant emotional trauma is exposure to high quality, stable, predictable caregiving relationships.”

Evelyn Witherspoon, Erinn Hawkins, Pamela Gough, *Emotional Trauma in Infancy*. (2009) Centre of Excellence for Child Welfare Information Paper #75E, Canada.

“Brain development is actually the process of creating, strengthening, and discarding connections, called synapses, among the neurons. Synapses organize the brain by forming pathways that connect the parts of the brain governing everything we do — from breathing and sleeping to thinking and feeling... By the age of 3, a baby’s brain has reached almost 90 percent of its adult size. The growth in each region of the brain largely depends on receiving stimulation, which spurs activity in that region... If the appropriate exposure does not happen, the pathways developed in anticipation may be discarded...If a child’s caretakers are indifferent or hostile, the child’s brain development may be impaired.

Babies are born with the capacity for *implicit memory*, which means they can perceive their environment and recall it in certain *unconscious* ways...In contrast, *explicit memory*, which develops around age 2, and is tied to language development...allows conscious recollections... children who have been abused or suffered other trauma may not retain or be able to access explicit memories...However, they may retain implicit memories..., and these may produce flashbacks, nightmares, or other uncontrollable reactions.

An enormous body of research now exists that provides evidence for the long-term damage of physical, sexual, and emotional abuse on babies and children...This chronic stimulation of the brain’s fear response means those regions of the brain are frequently activated. Other regions of the brain, such as those involved in complex thought and abstract cognition, are less frequently activated, and the child becomes less competent at processing this type of information...[E]motional abuse or severe deprivation...may permanently alter the brain’s ability to use serotonin, which helps produce feelings of well-being and emotional stability.

Neglect alone can be devastating...For children to master developmental tasks,...they need opportunities, encouragement, and acknowledgement from their caregivers. If this stimulation is lacking during children's early years, the weak neuronal pathways that had been developed in expectation of these experiences may wither and die and the children may not achieve the usual developmental milestones...delays may extend to...cognitive-behavioral, socio-emotional, and physical development...severe global neglect can have devastating consequences... such as significantly smaller brains.

Intensive, early interventions are key to minimizing the long-term effects of early trauma on children's brain development...In order to heal a damaged or altered brain, interventions must target those portions that have been altered. Because brain functioning is altered by repeated experiences that strengthen and sensitize neuronal pathways, interventions cannot be limited to weekly therapy appointments. Interventions must address the totality of the child's life, providing frequent, consistent replacement experiences so that the child's brain can begin to incorporate a new environment – one that is safe, predictable and nurturing.

Issue Brief. November 2009. Child Welfare Information Gateway.

The Bottom Line - Relationships Matter!

The research on the most effective treatment to help child trauma victims might be accurately summed up this way: what works best is anything that increases the quality and number of relationships in the child's life.

HEALTHY RELATIONSHIPS!

The currency for systemic change is trust, and trust comes through forming healthy relationships.

Bruce D. Perry and Maia Szalavitz: *The Boy Who Was Raised As A Dog: What Traumatized Children Can Teach Us About Loss, Love, and Healing.* (2006) Basic Books, p. 80

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A Note to Caregivers

“One of the critical ingredients that make stressful events tolerable rather than toxic is the presence of supportive adults who create safe environments that help children learn to cope and recover” ~ National Scientific Council on the Developing Child

A CHALLENGE

Children that experience trauma, stress, or abuse or neglect often learn that it is not safe to trust others. They learn that adults are unable or unwilling to keep them safe. They may be fearful of adults, even those who have not harmed them. Children with such feelings and behaviors can be extremely hard to understand. If the child placed in your care has been abused or neglected that child may:

- Have no experience with a caring adult who helped them learn how to calm down.
- Have learned that bad behavior gets attention and good behavior is ignored.
- Have hidden negative beliefs about adults: You are unresponsive. You are unreliable. You are or will be dangerous.
- Have unspoken negative beliefs about themselves: I am worthless. I am always in danger. I am powerless.

These feelings and behaviors can cause a serious threat to your resolve to help this child. They can result in another placement. They can result in another trauma. An important part of effectively dealing with a child's troubling feelings and behaviors is to understand their origins.

A CAREGIVER'S IMPACT ON GROWTH AND LEARNING

Like the other parts of our bodies, our brains develop as we age. Children, in particular, are built to learn. They learn in stages. These stages build upon one another. More importantly, relationships provide the foundation for each stage. So a child's relationship with past caregivers was critical to the child's learning. In short, relationships are and were critical to their brain development.

For example:

- **Infants get upset and cry.**
- If a loving caregiver consistently responds to the child and helps restore them to calm. The child learns, eventually, to calm themselves.
- What did an infant learn from a caregiver who often responded with frustration or who did not respond at all?
- **Toddlers are beginning to learn emotions and language and they do this by mirroring the behavior of the caregivers in their lives.**

- An engaged and compassionate caregiver creates an engaged and compassionate toddler.
- How would this stage of development have been affected by mirroring an impatient or emotionally distant caregiver?
- **Adolescents are starting to actively think and ask questions about their surroundings.**
- Encouragement and understanding help this stage of development in adolescents.
- What impact would a caregiver have on independent thought and creativity, if the adolescent's thoughts and questions were always met with annoyance and irritation?
- **Teenagers are just beginning to control impulses and make calculated decisions.**
- Engaged caregivers who demonstrate an even-temper and who encourage a teen to work through decisions, help this stage of development.
- How would a teen have been affected by a caregiver who criticized, discouraged, and who responded with anger or even violence?

The Effects of Chronic Stress or Trauma

When people feel threatened or unsafe, the body goes into survival mode (fight, flight, or freeze). The body acts to protect itself and chemical and physical changes occur. The “thinking” and “rational” parts of the brain begin to shut down. Heart-rate increases and senses are heightened. If this survival system is activated regularly during childhood, survival mode can become normal mode. This learned condition may be mistaken for a behavioral or mental health disorder.

Imagine being in a jungle surrounded by the sights, smells and sounds of a place full of danger. A snake drops from a tree and coils ready to strike. Would you be calm? *Could* you be? Would you be able to learn math? Could you, in that moment, talk to the snake about why it upsets you? Children that have been repeatedly hurt “learn” that other people pose a threat to them much like we learn that snakes, or other animals, may pose a threat to us.

Like chronic stress, trauma can interrupt brain development. Research suggests that if there is injury at one stage of development, the following stages may not begin on a firm foundation. Gaps develop in the child's ability to learn and control emotions.

Sometimes children who seemingly cannot pay attention to anything, are really just constantly assessing threats. The problem is not inattention; these children are really hyper-attentive, paying attention to *everything*. Often they are this way only because they have learned that they have to be this way to survive. Relearning how to behave can take time.

SOME SOLUTIONS

#1. Don't give up!

You have already taken an important step toward helping this child. Children are resilient. When they are safe and supported, they can heal and thrive!

- By being patient, reliable, consistent and responsive, you can teach a child that adults can care for them and keep them safe
- You can help them learn to cope and recover.
- Recovery takes time. It may take all of the patience you have.
- Educating yourself about the impact abuse and neglect has on children can help you cope with these challenges.
- Telling a child, repeatedly if necessary, they are safe and wanted in your home can be an important part of the healing process.

You may want to get a “tangle toy”, or a pinwheel. These are more than just toys. They are tools. They are examples of the many tools that are at your disposal to help the children in your care that have survived trauma. When a child is anxious, upset or having difficulty communicating we have learned that directing their attention toward playing with objects such as this toy, (or with silly putty or playing in a sand box) can be calming and relaxing.

Other simple activities that often *really* work (almost magically) in helping some children to calm down include:

- **Rhythm and repetition:** tossing a ball, rocking, swinging, snapping alternating fingers, music, reading nursery rhymes or Dr. Seuss books, drumming, dancing, or swimming.
- **Breath regulation:** in and out through the nose with an emphasis on the exhale, or blowing bubbles.
- **Calming:** yoga, music, or walking

There is help for the child in your care and there is help for you. Don't give up!

The Iowa Alliance for Drug Endangered Children

The following have resources with information that can help you troubleshoot difficult behavior and support you as you support this child.

The Trauma Informed Care Project www.traumainformedcareproject.org

National Child Traumatic Stress Network www.nctsn.org

Iowa Foster and Adoptive Parents Association www.ifapa.org

Iowa Department of Human Services www.dhs.state.ia.us/Consumers/Find_Help/MapLocations

Visiting Nurse Services www.vnsdm.org/resources/CommunityResourceDirectory

United Way 2-1-1 211unitedway.org

Polk County Crisis & Advocacy Services www.polkcountyiowa.gov Blank Children's Hospital Regional Child Protection Center www.blankchildrens.org/child-protection

Resources for Further Reading:

- “Britannica information about **mental illness**”. Britannica Concise Encyclopedia. 1 March. 2007
- “Helping Children and Adolescents Cope with Violence and Disasters”. National Institute of Health 17Feb.2006.1. March.2007
- Kaminier, Debra, Seedat, Soraya, Stein, Dan.J. "Post-traumatic stress disorder in children".World Psychiatry. 2005 June; 4(2): 121–125. 27 Feb.2007
- Iribarren. Javier, Prolo. Paolo, Neagos. Negoita and Chiappelli, Francesco. “Post-Traumatic StressDisorder: Evidence-Based Research for the Third Millennium”. Evid Based ComplementAlternat Med. 2005 December; 2(4): 503–512. 27 Feb. 2007
- Perry, Bruce. D., Pollard, Ronnie. A., Blakley, Toi L., Baker, William.L., Vigilante, Domenico (1995).“Childhood Trauma, the Neurobiology of Adaptation & Use-dependent Development of the Brain: How States become Traits”. Infant Mental Health Journal , 16(4), 271-291. 27 March.
- Perry, Bruce D. “Violence and Childhood: How Persisting Fear Can Alter the Developing Child’sBrain”. (2001) 27 Feb. 2007
- Seng, Julia S., Graham-Bermann. Sandra A., Clark. M. Kathleen, McCarthy. Ann Marie, and L. Ronis, David. “Posttraumatic Stress Disorder and Physical Comorbidity Among Female Children and Adolescents: Results From Service-Use Data”. Pediatrics Vol. 116 No. 6 December 2005, pp. e767-e776. 26 Feb.2007
- Walsh, Nancy. "Childhood Violence Tied to Later Mental Illness". Nov. 2006. 28 Feb 2007.
- <http://depressiongrief.suite101.com>
- Suite101.com
- <http://noogenesis.com/malama/discouragement/helplessness.html>
- <http://www.dukemednews.org/>
- www.ChildTraumaAcademy.org.
- <http://www.filmideas.com/understandingchildhoodtrauma.html>
- FILM. Shadows to Light, A Guide to Child Abuse Reporting, 1995, 29 minutes. Write to: California Attorney General’s Office, P.O. Box 944255, Sacramento, CA 94244-2550 or visit: www.safestate.org
- FILM: Is Anyone in There? Adopting a Wounded Child, 2004, 11 minutes. Write to: Michael Trout, The Infant-Parent Institute, 328 North Neil Street, Champaign Illinois. Phone: (217) 352-4060 or visit: www.infant-parent.com or mtrout@infant-parent.com
- FILM: Survivor’s Pride, Building Resilience in Youth at Risk, Attainment Company, Inc., 1994. Write to: P.O. Box 930106, Verona, Wisconsin 53593-1060
- FILMS: Understanding Childhood Trauma Series. Series on Trauma during childhood---how to identify it, how to understand it, and how to respond to it in supportive ways. Featuring Dr. Bruce D. Perry, Chief of Psychiatry at TX Children’s Hospital and founder of the Child Trauma Academy, this comprehensive 8-part video series presents the latest information on childhood trauma and its causes and effects. Trauma in childhood can cause a variety of physical and emotional problems for both children and adults, creating a need for intervention and support. This series provides caregivers, teachers, health care providers, and others with observational criteria for identifying traumatic behavior in children and with techniques for intervention. Write to: filmid@ais.net 308 North Wolf Road, Wheeling, Il 60090 or call: (800) 475-3456 or (847) 419-0255.
- VIDEO: 11th Commandment, by Collin Raye. starshine1.com/11th/11thCommandment.html

Building Resilience in Children

The world can be a frightening place. As a parent, I am constantly aware of choices that I make to minimize my perception of fear and uncertainty. Death, illness, divorce, crime, war, child abductions, tsunamis, and terrorism — both here and abroad — have defined an evolving landscape for raising our families. How do we manage to parent from a place of love and understanding, not fear and paranoia?

It's not possible to protect our children from the ups and downs of life. Raising resilient children, however, is possible and can provide them with the tools they need to respond to the challenges of adolescence and young adulthood and to navigate successfully in adulthood. Despite our best efforts, we cannot prevent adversity and daily stress; but we can learn to be more resilient by changing how we think about challenges and adversities.

Today's families, especially our children, are under tremendous stress with the potential to damage both physical health and psychological well-being.

The stress comes from families who are always on the go, who are overscheduled with extracurricular activities, and ever-present peer pressure. In the teen years, the anxiety and pressure are related to getting into "the" college.

In today's environment, children and teens need to develop strengths, acquire skills to cope, recover from hardships, and be prepared for future challenges. They need to be resilient in order to succeed in life.

That is why Kenneth Ginsburg, M.D., MS Ed, FAAP, a pediatrician specializing in adolescent medicine at The Children's Hospital of Philadelphia (CHOP), has joined forces with the American Academy of Pediatrics (AAP) to author *A Parent's Guide to Building Resilience in Children and Teens: Giving Your Child Roots and Wings*. The new book provides a dynamic resource to help parents and caregivers build resilience in children, teens, and young adults.

Dr. Ginsburg has identified seven "C"s of resilience, recognizing that "resilience isn't a simple, one-part entity." Parents can use these guidelines to help their children recognize their abilities and inner resources.

Competence

Competence describes the feeling of knowing that you can handle a situation effectively. We can help the development of competence by:

- Helping children focus on individual strengths
- Focusing any identified mistakes on specific incidents
- Empowering children to make decisions
- Being careful that your desire to protect your child doesn't mistakenly send a message that you don't think he or she is competent to handle things
- Recognizing the competencies of siblings individually and avoiding comparisons

Confidence

A child's belief in his own abilities is derived from competence. Build confidence by:

- Focusing on the best in each child so that he or she can see that, as well
- Clearly expressing the best qualities, such as fairness, integrity, persistence, and kindness
- Recognizing when he or she has done well
- Praising honestly about specific achievements; not diffusing praise that may lack authenticity
- Not pushing the child to take on more than he or she can realistically handle

Connection

Developing close ties to family and community creates a solid sense of security that helps lead to strong values and prevents alternative destructive paths to love and attention. You can help your child connect with others by:

- Building a sense of physical safety and emotional security within your home
- Allowing the expression of all emotions, so that kids will feel comfortable reaching out during difficult times
- Addressing conflict openly in the family to resolve problems
- Creating a common area where the family can share time (not necessarily TV time)
- Fostering healthy relationships that will reinforce positive messages

Character

Children need to develop a solid set of morals and values to determine right from wrong and to demonstrate a caring attitude toward others. To strengthen your child's character, start by:

- Demonstrating how behaviors affect others
- Helping your child recognize himself or herself as a caring person
- Demonstrating the importance of community
- Encouraging the development of spirituality
- Avoiding racist or hateful statements or stereotypes

Contribution

Children need to realize that the world is a better place because they are in it. Understanding the importance of personal contribution can serve as a source of purpose and motivation. Teach your children how to contribute by:

- Communicating to children that many people in the world do not have what they need
- Stressing the importance of serving others by modeling generosity
- Creating opportunities for each child to contribute in some specific way

Coping

Learning to cope effectively with stress will help your child be better prepared to overcome life's challenges. Positive coping lessons include:

- Modeling positive coping strategies on a consistent basis
- Guiding your child to develop positive and effective coping strategies
- Realizing that telling him or her to stop the negative behavior will not be effective
- Understanding that many risky behaviors are attempts to alleviate the stress and pain in kids' daily lives
- Not condemning your child for negative behaviors and, potentially, increasing his or her sense of shame

Control

Children who realize that they can control the outcomes of their decisions are more likely to realize that they have the ability to bounce back. Your child's understanding that he or she can make a difference further promotes competence and confidence. You can try to empower your child by:

- Helping your child to understand that life's events are not purely random and that most things that happen are the result of another individual's choices and actions
- Learning that discipline is about teaching, not punishing or controlling; using discipline to help your child to understand that his actions produce certain consequences

Dr. Ginsburg summarizes what we know for sure about the development of resilience in kids by the following:

- Children need to know that there is an adult in their life who believes in them and loves them unconditionally.
- Kids will live "up" or "down" to our expectations.

There is no simple answer to guarantee resilience in every situation. But we can challenge ourselves to help our children develop the ability to negotiate their own challenges and to be more resilient, more capable, and happier.

Overview of Stress

- There will always be stress in our lives.
- Stress is an important tool that can aid in our survival.
- Our body's reaction to stress is mediated through a complex interplay of sensory input—sights and sounds—as well as the brain and nervous system, hormones, and the body's cells and organs.
- Emotions play an important role in how we experience stress because the brain is the conductor of this system. The way we think about stress and what we choose to do about it can affect the impact of a stressful event.

Incredible Kids - A Resource List



www.developingchild.net Center on the developing child / Harvard

www.nctsn.org National child trauma network

www.zerotothree.org Cool baby brain map!

www.cdc.gov/actearly developmental milestones and when to be concerned

www.csefl.vanderbilt.edu Center on the social emotional foundation for learning

www.healthychildren.org Information on ages and stages.

www.naeyc.org – self regulation article

Born for love. Bruce D. Perry

Brain-based parenting: the neuroscience of caregiving for healthy attachment. Daniel Hughes, and Jonathen Baylin.

From neurons to neighborhoods: the science of early childhood development. Jack Shonkoff and Deborah Phillips, Editors.

How to Talk So Kids Will Listen, and Listen So Kids Will Talk. Elaine Faber, Adele Mazlish.

J. Nelson and J. Nelson, (2005) Kids Need to be Safe: A Book for Children in Foster Care

Magic trees of the mind: how to nurture your child's intelligence, creativity and healthy emotions from birth through adolescence. Marian Diamon and Janet Hopson.

Maybe Days by J. Wilgocki and M.K. Wright a book for children in foster care. Ages 4-8

Parenting from the Inside Out. Daniel Siegal & Mary Hartzell.

The Incredible Years. Carolyn-Webster Stratton

The whole-brain child: 12 revolutionary strategies to nurture your child's developing mind. Daniel Siegel, MD and Tina Payne Bryson, PhD

Without freedom
from the past,
there is no freedom
at all,
because the mind
is never new,
fresh,
or innocent.

~ Krishnamurti