Child Trauma:
A Workshop for Foster Caregivers

RESOURCE GUIDE

Illinois Department of Children and Family Services

Child Trauma Resource Guide
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Child Trauma
A Workshop for Foster Caregivers

Training Objectives

After participating in this workshop participants will be able to:

1. Define Child Trauma and Adverse Childhood Experiences (ACES) as used by the Department in policy and Procedure.
2. Use a trauma-sensitive lens to understand the impact of trauma on a child's development and behavior.
3. Use case examples to apply trauma to the context of child safety and well-being.
4. Describe the impact of trauma on brain development, learning, perception and regulation of emotion.
5. Identify risks for re-traumatizing the child.
6. Identify care giving strategies to avoid re-traumatizing the child.
7. List strategies for helping children heal from the experience of trauma.
8. Explain how cultural identity can be a source of strength and can moderate the adverse experience of trauma.
9. Identify how personal traumatic experiences impact the ability of child welfare staff and Caregivers to meet the needs of children.
10. Respond to children using a trauma sensitive lens so children can achieve safety and well-being throughout their lives.

CHILD TRAUMA
DEFINITIONS, TYPES OF TRAUMA & ACES

What is Trauma?

Trauma is a psychologically distressing event that is outside the range of usual human experience, often involving a sense of intense fear, terror and helplessness. (Perry)

Trauma is an experience that is emotionally painful, distressful, or shocking, which often results in lasting mental and physical effects. (NIMH)

Prevalence of Childhood Trauma

- Nationally, 4 out of 10 children report witnessing violence.
- One in four children will experience a traumatic event before they reach their 16th birthday.
- High number of teens have witnessed violence or experienced physical or sexual abuse.

Types of Child Trauma (General)

<u>Sexual Abuse</u>- Child sexual abuse includes a wide range of sexual behaviors that take place between a child and an older person. Behaviors that are sexually abusive often involve bodily contact, such as in the case of sexual kissing, touching, fondling of genitals, and intercourse. However, behaviors may be sexually abusive even if they do not involve contact, such as in the case of genital exposure ("flashing"), verbal pressure for sex, and sexual exploitation for purposes of prostitution or pornography.

<u>Physical Abuse</u>- Sometimes also termed physical maltreatment, physical abuse refers to actual or attempted infliction of bodily pain and/or injury, including the use of severe corporal punishment. Physical abuse is characterized by physical injury (for example, bruises and fractures) resulting from punching, beating, kicking, burning, or otherwise harming a child. In some cases, the injury may result from over discipline or physical punishment that is inappropriate to the child's age or condition. Physical abuse can occur in single or repeated episodes and can, in the extreme, result in death.

<u>Psychological Maltreatment</u>- Sometimes called emotional abuse, psychological maltreatment includes acts or omissions by parents or caregivers that have caused, or could cause, serious behavioral, cognitive, emotional, or mental disorders. Examples include verbal abuse (e.g. insults, belittling, threats of violence), bullying and the use of coercive control, emotional neglect (e.g. shunning, withdrawal of love), and intentional social deprivation (e.g. isolation, confinement). Some forms of psychological

maltreatment can be difficult to identify, and demonstrable harm to the child is often required for public agencies to intervene.

Neglect- Child neglect involves the failure to provide needed, age-appropriate care although financially able to do so, or offered financial or other means to do so. This includes physical neglect (e.g. deprivation of food, clothing, shelter), medical neglect (e.g. failure to provide child with access to needed medical or mental health treatments or to consistently administer prescribed medications), and educational neglect (e.g. withholding child from school, failure to attend to special education needs). Also included under the definition of neglect are providing inadequate nutrition, clothing, or hygiene; exposure to unsafe environments; inadequate supervision, including the use of inadequate caretakers; and abandonment or expulsion from the home.

Community Violence- Community violence refers to both predatory violence (e.g. robbery) and violence arising from non-family interpersonal conflicts and may include brutal acts such as shootings, rapes, stabbings, and beatings. Children's exposure to community violence can be as direct victims or as witnesses (e.g. seeing someone killed, hearing gunfire).

School Violence- Indicators of school violence include fatal and nonfatal student victimization, nonfatal teacher victimization, students being threatened or injured with a weapon at school, fights at school, and students carrying weapons to school. Formal definitions of school violence range from very narrow to very broad, such as the Center for the Prevention of School Violence definition of school violence as "any behavior that violates a school's educational mission or climate of respect or jeopardizes the intent of the school to be free of aggression against persons or property, drugs, weapons, disruptions, and disorder."

Domestic Violence- Domestic violence—also referred to as intimate partner violence, domestic abuse, or battering—involves a pattern of assault or coercive behaviors, including actual or threatened physical or sexual violence or psychological and emotional abuse as well as economic coercion that adults use against their intimate partners to gain power and control in the relationship. Children's exposure to domestic violence can be as witnesses and may sometimes involve direct harm. Domestic violence can be directed toward a current or former spouse or relationship partner, including heterosexual or same-sex partners.

Traumatic Grief- Childhood traumatic grief occurs following the death of a loved one when the child objectively or subjectively perceives the experience as traumatic. The death can be due to what is usually described as traumatic, such as an act of violence, accident, disaster, or war; or it can be due to natural causes. The hallmark of childhood traumatic grief is that trauma symptoms interfere with the child's ability to navigate the typical bereavement process and at times, daily activities.

Natural or Man-made Disaster- A disaster is defined as any natural catastrophe (e.g. tornado, hurricane, earthquake), or regardless of cause, any fire, flood, or explosion that

causes damage of sufficient severity and magnitude to warrant the intervention of local, state, or federal agencies and disaster relief organizations. Disasters can be the unintentional result of a manmade event (e.g. nuclear reactor explosion) but do not include damage that is intentionally caused, which would be classified as terrorism.

Terrorism- Terrorism is defined in a variety of formal, legal ways but the essential element is the intent to inflict psychological damage on an adversary. The U.S. Department of Defense defines terrorism as "the calculated use of violence or the threat of violence to inculcate fear, intended to coerce or to intimidate governments or societies in the pursuit of goals that are generally political, religious, or ideological." Terrorism includes attacks by individuals acting in isolation (e.g. sniper attacks).

Medical Trauma- Medical trauma includes trauma associated with an injury or accident, chronic or life-threatening illness, or painful or invasive medical procedures. Examples include the event of being told that one has a serious illness (e.g. cancer or AIDS) and the experience of difficult medical procedures such as changing burn dressings or undergoing chemotherapy.

Refugee Trauma- Refugee trauma includes exposure to war, political violence or torture. Refugee trauma can be the result of living in a region affected by bombing, shooting, or looting, as well as forced displacement to a new home due to political reasons. Some young refugees have served as soldiers, guerrillas or other combatants in their home countries, and their traumatic experiences may closely resemble those of combat veterans.

Adverse Childhood Experiences[1] (often seen in child welfare)

Growing up (prior to 18) in a household with:

1. Recurrent physical abuse
2. Recurrent emotional abuse
3. Sexual abuse
4. Emotional or physical neglect
5. An alcohol or drug abuser
6. An incarcerated household member
7. Someone who is chronically depressed, suicidal, institutionalized or mentally ill
8. Mother being treated violently
9. One or no biological parents
10. Removal from biological parents
11. Unplanned placement moves
12. Three or more placements in an eighteen month period

[1] The Development of the IDCFS Behavioral Health System. 2005. A Paradigm Shift to Focus on Trauma. IDCFS Presentation. (Contact: TGawron@idcfs.state.il.us)

The Lifelong Effects of Trauma[2]

1. Trauma and Mental Health
    a. Trauma increases the odds for major depression nearly two-fold
    b. Trauma increases the odds for suicide
    c. Trauma is associated with poor response to antidepressant medication and poor overall treatment outcomes.

2. Trauma and Substance Abuse
    a. Trauma significantly increases the risk for alcohol and drug abuse in adolescents.
    b. Trauma is the best predictor of drug and alcohol abuse in women.
    c. Trauma is associated with poor treatment outcomes and increased treatment drop out.

3. Trauma and HIV/STD Risk
    a. Childhood trauma dramatically increases risks for HIV-risk behavior:
        i. IV Drug Use
        ii. Promiscuity

4. Trauma and Physical Health
    a. Adverse Childhood Experiences Study:
        i. Increased ACES correlate with smoking
        ii. Increased ACES correlate with adult alcoholism
        iii. Increased ACES underlie chronic depression (see above)
            1. According to World Health Organization (WHO), depression is becoming the 2nd most costly illness.
        iv. ACES correlate with increased sexual partners
        v. ACES correlate with history of STD
        vi. ACES correlate with sexual abuse of male children and their subsequent likelihood of impregnating a teenage girl
        vii. ACES correlate with unintended pregnancy or elective abortion
        viii. ACES correlate with rape

5. Trauma and Academics
    a. Trauma negatively impacts school readiness
    b. Trauma negatively impacts school performance
    c. Trauma impacts cognitive functioning which may result in behavioral difficulties.
    d. Trauma increases the likelihood of dropping out of high school

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[2] IDCFS: SI/Behavioral Health Team, Tim Gawron Statewide Administrator, Behavioral Health Services

Responses to Trauma throughout Development

Infants (Birth- $2^1/_2$ yrs.)

- Eating disturbance
- Irritable, difficult to soothe
- Developmental regression
- Language delay
- Attachment disorder
- Failure to thrive
- Sleep disturbance

ATTACHMENT
Cannot trust or expect basic needs will be met, listless, unresponsive, irritable, labile, inability to calm, agitation, inconsolable, spacing out, looking away

REGULATION OF EMOTIONS
Listless, unresponsive, irritable, difficult to console

COGNITION AND DISSOCIATION
Delays in speech and motor development, does not respond to interaction with adults

SELF CONCEPT
Lack of positive emotion

PHYSICAL & HEALTH
Failure to thrive, developmental delays, hypersensitivity to physical contact, suppressed immune system

Young Children ($2^{1}/_{2}$- 6 yrs.)

- Helplessness and Passivity
- Generalized Fear
- Confusion, difficulty planning
- Difficulty identifying what is bothering them
- Attributing magical qualities to traumatic reminders
- Fighting or threatening behavior
- Attention Problems
- Sadness/Depression
- Separation Anxiety
- Specific Fears

ATTACHMENT

Can not trust or expect basic needs will be met, avoidant, anxious, disorganized, vacillation from clinginess to aggression, inconsolable, spacing out, looking away, poor peer relationships

REGULATION OF EMOTIONS

Low frustration tolerance, restless, hyperactive, impulsive, moody

REGULATION OF BEHAVIOR

Aggressive, defiant, lying, inattention, hoarding things, significant problems with toilet training

COGNITION AND DISSOCIATION

Inattention, difficulty problem solving, learning disabilities, school problems, continuous daydreaming, inability to feel pain, inappropriate emotional responses

SELF CONCEPT

Social problems (controlling or overly permissive with peers)

PHYSICAL & HEALTH

Suppressed immune system, headaches, stomach aches, dizziness, gastrointestinal problems, palpitations, intolerance of food, hypersensitivity to physical contact, difficulties with coordination and balance

School-age Children (6-11 yrs.)

- Physical complaints
- Bedwetting
- School failure/absenteeism
- Behavioral problems
- Attention problems
- Fighting or threatening Behavior
- Guilt feelings
- Acting like a parent to siblings
- Depression

ATTACHMENT
Oppositional, defiant, lying, stealing, hoarding food, poor peer relationships

REGULATION OF BEHAVIOR
Aggressive/withdrawn, defiant, lying, stealing

COGNITION AND DISSOCIATION
Inattention, difficulty problem solving, learning disabilities, school problems, continuous daydreaming, inability to feel pain, inappropriate emotional responses

SELF CONCEPT
Self-blame, sees self as “bad”, self-harm, aggressive or difficult maintaining relationships with peers, sees the world as unfair, self-harm

PHYSICAL & HEALTH
Suppressed immune system, headaches, stomach aches, dizziness, gastrointestinal problems, palpitations, intolerance of food, hypersensitivity to physical contact, difficulties with coordination and balance

Adolescents (12-18 yrs.)

- Antisocial behavior
- Runaway
- Depression/Suicidal
- Sleep Disorders
- Absenteeism
- Acting like a parent to siblings
- Eating Disorders
- Dating violence
- Substance abuse
- School failure
- Relationship problems

ATTACHMENT

Extreme difficulty establishing and maintaining relationships, social withdrawal, dangerous activities to gain attention

REGULATION OF BEHAVIOR

Drug use, delinquent behavior, sexual acting out, school failure

COGNITION AND DISSOCIATION

Loses time, spaces out a great deal, skips school, inattention, poor problem solving, learning disabilities, school problems, continuous daydreaming, inability to feel pain, inappropriate emotional responses

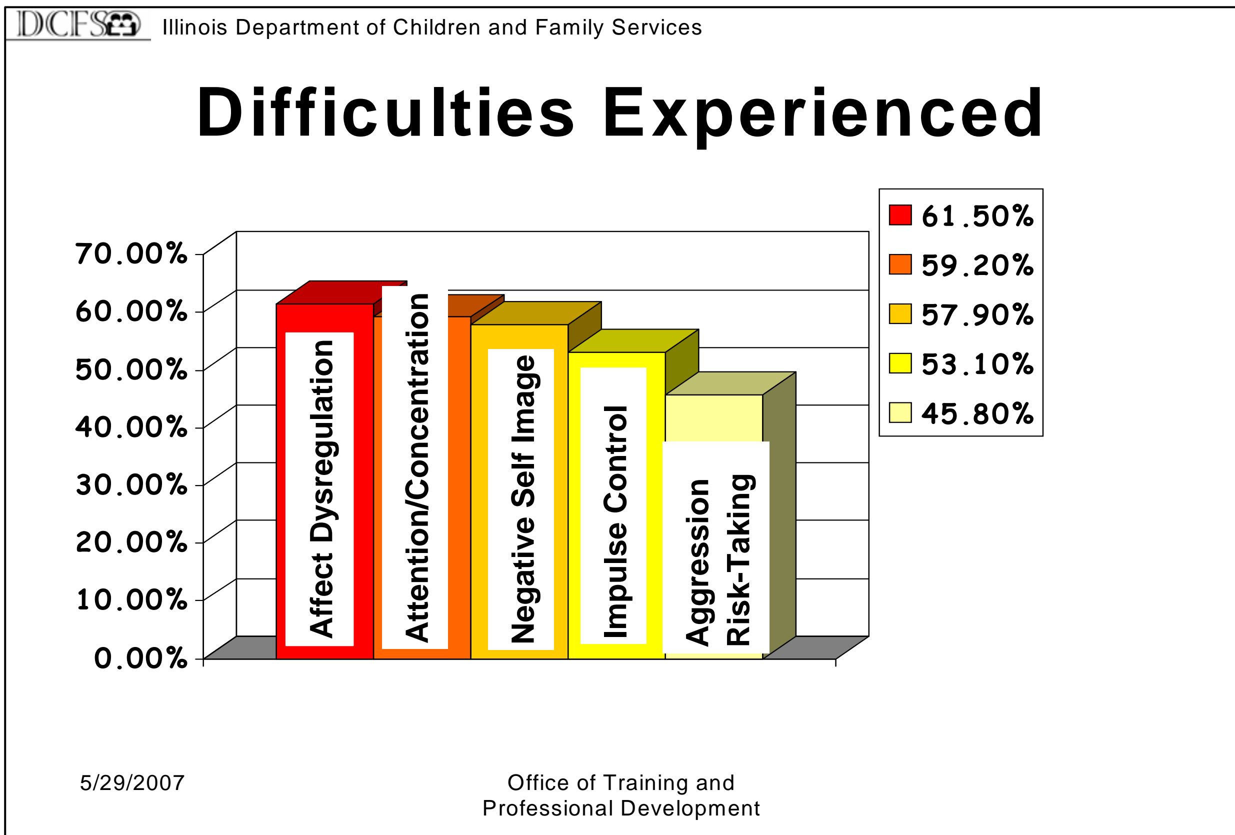
SELF CONCEPT

Difficulty seeing any future for self, sees the world as unpredictable and unfair, no sense of purpose, feels life has no meaning, rejects religion/spirituality, feels betrayed, relationship failures, lack of friends, self-harm, suicide

PHYSICAL & HEALTH

Includes school-age difficulties noted above in addition to skin problems, fainting and losing consciousness, pseudo-seizures, painful or uncomfortable sensations associated with menstruation and health risk behaviors (e.g., HIV, pregnancy, smoking)

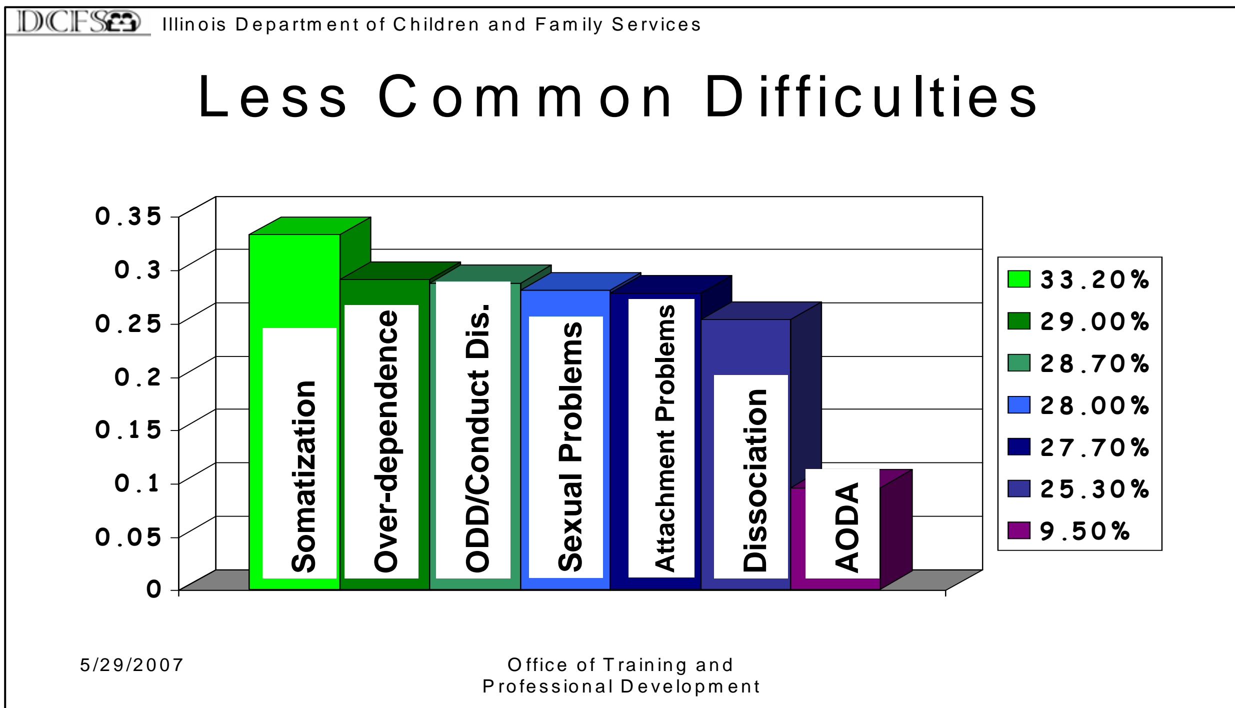
Common Difficulties Experienced by Children Exposed to Trauma



Definitions:

1. **Affect Dysregulation**- Affect Regulation refers to the development of regulation and expression of emotions and feelings. "Dysregulation" infers the opposite of regulation. The child with affect regulation often has problems identifying, describing and working with his/her emotions as well as difficulty understanding the feelings of others. He or she may also have difficulty differentiating between his/her emotions and bodily sensations of arousal (e.g. differentiating between anger and the physical sensation of their heart racing)
2. **Attention/Concentration**- The ability to mentally focus on a topic through close and careful listening and/or observation
3. **Negative Self Image**- Seeing oneself in a negative manner or way.
4. **Impulse Control**- Being able to control one's behaviors
5. **Aggression/Risk-Taking**- Hostile or destructive acts/engaging in behavior that has a high potential for harm.

Less Common Difficulties Experienced By Children Exposed to Trauma



Definitions:

1. **Somatization**- Multiple physical complaints involving any system of the body. Children with somatization should not be viewed as "faking" nor should they be expected to control their symptoms.
2. **Over-dependence**- characterized by feelings of not being capable to do things on their own that another child of the same chronological age and intellectual level would be able to do.
3. **Oppositional Defiant Disorder (ODD)/Conduct Disorder**- These are disorders of behavior. Conduct disorder is more severe but both disorders involve breaking rules.
4. **Sexual Problems**- This covers a wide array of problems including acting out sexually and sexually aggressive behaviors.
5. **Attachment Problems**- Difficulty establishing a trusting relationship with another person, usually a caregiver.
6. **Dissociation**- a mental state in which certain thoughts, emotions, sensations or memories are compartmentalized because they are too distressing for the conscious mind to integrate.
7. **AODA**- Alcohol and Other Drug Abuse/Dependence- this number may seem low. Remember, we are looking at all children exposed to trauma. The rate of AODA among adolescent trauma victims would be much higher.

Note: While these difficulties are identified as "less common," they still occur in approximately 10-30% of children exposed to trauma.

Stress and the Body's Alarm System

NORMAL STRESS & DANGER ⇩ DEALING WITH PROBLEMS	VS	OVERWHELMING STRESS & TRAUMA ⇩ FEELING OVERWHELMED
BODY SIGNALS Heart pounding Rapid breathing Muscles tense up Fight or flight		**BODY SIGNALS** Heart feels like bursting Gasping, feeling smothered Muscles feel like exploding Overreacting or freezing
FEELINGS Excited or worried Frustrated, determined Angry or scared Some loss of control Worried about yourself		**FEELINGS** Terrified or panicked Enraged or aggressive Hopeless or doomed Helpless or out of control Worthless, like a failure
THINKING Some clear thinking Some clear memories		**THINKING** Confused, mentally shut down Memory like a broken puzzle
ACTIONS Acting rapidly Facing problems Taking on challenges Searching for Solutions		**ACTIONS** Automatic reflexes or freezing Avoiding problems Taking foolish risks Making a mess of your life (at work, with family, and friends)

SPARCS, 2004 adapted from Ford et al. (2004)

Basic Principles of Brain Development

1. The human brain begins its development about two weeks after conception, forming the neurons that are the basic material of the brain. By the time the fetus is 20 weeks, most neurons are already in place. At birth, all brain structures are present, but brain development is far from complete. During the first 2 years of life, the brain expands two-and-a-half times, and continues to develop through adolescence.

2. During the prenatal period, maternal alcohol, drug, and tobacco use, and other adverse experiences can have a negative effect on the developing brain. Maternal stress can also affect brain development.

3. The different parts of the brain have different functions. The brainstem and midbrain are responsible for the body's basic functions such as breathing, heart beat, blood pressure, and the stress response. The limbic and cortex are responsible for more complex functions such as feeling and thinking.

4. The brain develops sequentially from less complex or basic functions to more complex functions. The brain stem, which as we mentioned before, supports basic functions, is fully formed at birth. The rest of the brain, which is responsible for more complex functions, remains more sensitive to development through learning and experience.

5. The autonomic nervous system is controlled by the brain stem. When someone experiences stress, a frightening event, or other adverse experiences, stress hormones or chemical messages are sent via the autonomic nervous system to the rest of the brain in order to "survive" whatever the perceived threat may be.

6. The problem occurs when an individual remains in a state of chronic or extreme stress for long periods of time because the chemical "baths" that occur during this state disrupt normal brain development.

7. This is particularly critical for infants and very young children as most post-natal brain development occurs in the first few years of life.

Adapted from:

1. National Research Council, Institute of Medicine, (2000), From Neurons to Neighborhoods. J. Shonkoff and D. Phillips, Eds. National Academy of Sciences.
2. Perry, BD, Plooard, RA, Blakeley TL, Baker WL, Vigilante D. (1995). Childhood Trauma, The Neurobiological Adaptation and Use-dependent Development of the Brain: How States Become Traits. Infant Mental Health Journal, 16, 271-291
3. Stein, P, and Kendall, J. (2004) Psychological Trauma and the Developing Brain, The Haworth Press, Inc.

Table 2: Stages of socio-emotional development and markers of socio-emotional competence in pre-school*

Age Range for Development	Socio-Emotional Skill	Description	Associated Socio-Emotional Competence in Pre-school
0-3 months	1. Regulation and Interest in the World	*Regulation of states of arousal and biorhythms	*Ability to sit still and remain focused for short periods of time
3-5 months	2. Forming Relationships and Attachments	*Interaction synchrony, engagement and relating	*Ability to initiate and terminate peer interaction
5-9 months	3. Intentional Two-Way Communication	*Reciprocal communication, social referencing	*Ability to maintain peer interaction through turn-taking and seeking adult help
9-18 months	4. Complex sense of Self	*Behavioral initiation and organization or elaboration and emotion to convey specific intent	*Ability to engage in shared goals, regulate impulses for sharing, read others' emotional cues, express personal desires, show pride
18-24 months	5. Emotional Ideas	*Representational capacity	*Ability to lead and follow peers in pretend play
24-36 months	6. Emotional Thinking	*Problem solving through representational elaboration	*Ability to use social play to build friendships, practice social roles, negotiate power dynamics, and resolve personal dilemmas

First three columns excerpted from Greenspan & Wieder (1999

Notes: For (*) asterisked items, the social and emotional skills description and associated socio emotional competence in Pre-School have been clarified below:

Socio-Emotional Skill Definitions/Description and Examples:

1. **Regulation and Interest in the World-** This refers to the infant's ability to regulate or manage his/her attention and behavior while being interested in a full range of sensations (sounds, sights, smells, movement.) The infant learns how to manage or regulate his/her behavior when s/he is stimulated or aroused. When the stimulation becomes overwhelming to the infant, s/he will focus on behaviors that will help restore a sense of composure and well-being. (Example: Baby gets fussy and upset and learns to initiate behaviors that help alleviate his/her discomfort by thumb-sucking, sucking on a pacifier, fingers etc.)

   As the infant learns how to manage his/her reaction to people, situations and surroundings, s/he will be able to engage with the world for increasing periods of time. This allows the infant to develop an interest in his/her world and surroundings. Through repetition, the infant learns to control how much stimulation they can handle. S/he also learns additional ways to comfort hi/herself when s/he is stimulated or aroused. Learning how to do this lays the foundation for having the ability to sit still and remain focused for short periods of time in pre-school.

2. **Forming Relationships and Attachments-** Connecting with others and developing relationships and emotional attachments (ex. love, empathy, caring, fondness) is the focus of this stage. As the caregiver attends and responds to the baby's needs the baby associates the caregiver with physical and emotional nurturing. (Example: The baby is hungry and cries. The caregiver feeds the baby in her arms and caresses and comforts the baby while feeding.) With each repetition of this routine, emotional attachment continues to grow and develop with the caregiver. This behavior will be repeated continually throughout this stage. With each interaction the child is learning how to communicate, engage others and develop emotional bonds. The baby "mirrors" the communication and behaviors s/he is learning from the caregiver. By pre-school, the child who has mastered these skills is able to both initiate and end interactions with his/her pre-school peers.

3. **Intentional Two-Way Communication**- At 5-9 months, the baby purposely initiates communication with others. As the caregiver responds, the baby learns how to engage and relate to others. The baby recognizes the caregiver and no longer smiles indiscriminately, preferring the caregiver(s) over strangers. The baby is able to recognize and respond to the emotional cues of others and often "mirrors" the communication and behavior of the caregiver. S/he learns to use sounds and gestures to get attention and enjoys being cuddled. Throughout this stage, this behavior is continually repeated. With each interaction the child is learning how to communicate, engage others, respond to others and, as a result, develop emotional bonds. Through the process of continual Two-Way Communication with the caregivers, the baby learns social cues. This learning lays the foundation for such skills as the ability to maintain peer interaction through turn-taking and seeking adult help that will help them in pre-school.

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4. **Complex Sense of Self**- Between 9-18 months, the child begins to develop a sense of self. S/he initiates behavior and learns how to get his/her needs met. S/he shows affection and his/her behavior conveys specific intent. (For example, when sad or scared, the child may be clingy; when confident or determined, the child may declare "no" or push the adult away as s/he demonstrates his/her ability to do something independently.) The child is becoming increasingly aware of themselves as separate from others. As the child develops a sense of self, independence, and the ability to get his/her needs met, s/he will learn the skills which set the foundation for self-expression in pre-school. These skills will enable him/her to engage in shared goals, regulate impulses for sharing, read others' emotional cues, express personal desires, and show pride.

5. **Emotional Ideas-** The 18-24-month-old child will play alongside other children but will not actually play *with* them. At this stage, the child begins to copy or mimic more advanced behaviors (e.g. copying the caregiver when the caregiver is doing household chores.) The child enjoys role-playing or what the child refers to as 'Let's Play Pretend." S/he does not yet know how to share toys and attention. The child is increasingly aware of him/herself as separate from others. S/he wants everything "now" and is reluctant to compromise. S/he may have more temper tantrums but adults can divert the child's attention. The child will learn how to play "pretend" with peers and lead and follow in play, but before they can do this they have to "mimic" behavior they see in others and learn how to role play and play "pretend." This behavior serves as the building block for learning how to play, and as the child grows s/he will learn how to lead and follow peers in pretend play.

6. **Emotional Thinking-** Through "Let's Pretend Play," the 2-3-year-old child begins to elaborate and expand his/her abilities and preferences. For example, by playing with his/her siblings, the child learns playtime is fun and s/he can enjoy the company of others. The caregiver is still primary, however, and separation anxiety is quite common. Through repetition of the "Play Routine" the child learns how to share, take turns and help. These skills translate into the preschool-aged child's ability to use social play to build friendships, practice social roles, negotiate power dynamics, and resolve personal dilemmas.

Considerations for the Developmental Impact of Trauma and Neglect on Children

When assessing the behavior of children impacted by trauma or neglect, it is important to use an attachment and developmental framework. This framework will allow you to understand the influences of present stresses; the developmental capacity of the child to manage stress; and how well the child's early attachment system was able to support the child, including the family's culture and the caregiver's own experience of being cared for.

Some Key Questions

What are the characteristics of the stress, fear, threat, or trauma to the child?

- Did it involve someone close to the child?
- Was the child a direct witness, or is the child hearing about the incident or seeing the results of it after the fact?
- Were their particularly terrifying sights and sounds that may be imprinted in the child's memory and act as traumatic reminders, keeping the child aroused if the child is later exposed to similar stimuli?

What is the child's genetic and developmental capacity to manage stress?

- Is the child healthy and physically robust?
- Does the child have an easy or a difficult temperament?
- Is the child intelligent?

How well is the attachment system able to support the child?

- Is the parent available to the child?
- Is the parent able to notice and respond to the child's cues and to provide continuing comfort and reassurance after the stressor ends?
- Is the parent able to be protective against future stresses?
- Is the caregivers' own experience of trauma reenacted in their care of their children?
- Does the parent have supports for him/herself?
- What are the parenting practices and the cultural aspects of caregiving in this family?

Guiding Principles for Children Who Have Experienced Trauma

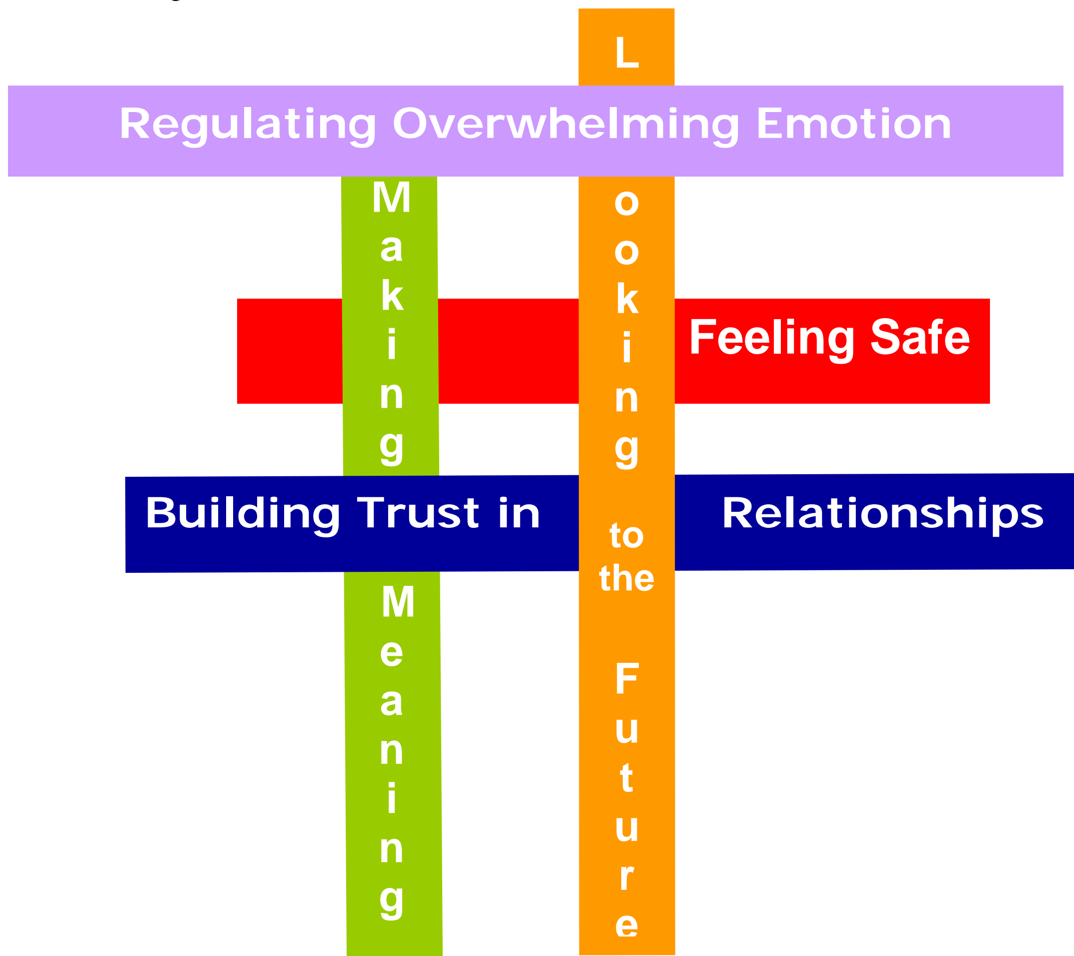
Feeling Safe
Demonstrating to a child, over time, that caring adults will validate that what happened was frightening; showing a child that adults will protect both the child and people the child loves from additional trauma.

Regulating Overwhelming Emotion
Keeping stress down and personal control up. Trauma stress responses involve intense emotional reactions. In the context of safe and caring relationships, the child can learn strategies to cope with stress and regulate, or control, these emotional responses.

Building Trust in Relationships
Learning that relationships can be consistently caring, safe, and genuine throughout day-to-day routines, personal interactions, and responsive care-giving and parenting. This is slow, steady, and infinitely important work

Making Meaning
Learning to understand how what has happened to them in the past affects the ways they think, feel, and behave in the present.

Looking to the Future
Building a child's resilience – skills, abilities, talents, and connections—to support optimal overall functioning.



Trauma Informed Treatment: A "Phase-Based" Approach

Most experts agree that treating trauma requires what is called a "***Phase-Based***" **approach**. The phases or steps in the treatment plan include the following components that build upon each other, but are interwoven and may not follow a linear process.

Safety	The beginning of treatment focuses on establishing physical and emotional ***safety***. This is critical and the foundation for any intervention. This phase involves the cooperation and collaboration of child welfare workers and school personnel in conjunction with foster and biological families working together as a team.
Regulating Emotions	The next phase includes enhancing the child's ability to ***regulate emotions*** & behavior and cope more effectively with trauma triggers. This phase is inextricably tied to the child's ***attachment and attunement*** with the primary caregivers, and includes teaching children and their caregivers about trauma and its impact
Interpersonal Skills and Attachment	Phase-based approaches specifically address ***interpersonal skills and attachments***, building trust and meaningful relationships with friends and family members.
Understanding and Making Meaning of the Trauma	Next, treatment addresses the child's current ***understanding and interpretation of the trauma***—what it means to him or her living and having lived in extremely stressful situations; addressing common issues like: trust, self-blame, shame, reenactment, feeling isolated, set apart and different from other people, for example

Enhancing Strengths	During the last phase of treatment the child and his/her caregiver focus more directly on ***enhancing strengths;*** helping the child build more positive experiences and making plans for the future within his/her culture and community.
	Important features of the work include:
	• Fostering an understanding of a youth's cultural heritage
	• A positive identity based on competence and values that tie the youth in a constructive way to their community
	    ▪ Facilitating participation in school/youth clubs or creative projects
	    ▪ Identifying ways children can make a contribution toward ***helping others***
	    ▪ ***Encouraging achievement*** and the development of unique talents.

Children Need To Feel Safe

Feeling safe is not a passive goal but an active process. Helping a child feel safe means soothing, protecting, monitoring, and intervening in a predictable manner. For children who have experienced trauma, "feeling safe" can be difficult to attain. Caring adults can help a child feel safe by understanding the child's experience and taking concrete actions that match the child's development.
The checklist that follows is tailored to address **a child's perspective** of common concerns of children who have experienced trauma.

Complete **INFORMATION GATHERING AND ASSESSMENT** to help you understand the child's experience and needs.

Have you…

- Gathered information about what has happened to the child to bring the child into care (both presently and in the past)?
- ☑ Identified the child's concerns, worries, and fears?
- ☑ Identified what is important to the child, what the child strives to protect, and the child's strengths?
- ☑ Identified feelings and behaviors that indicate the child is feeling unsafe?
- ☑ Identified triggers that may remind the child of their experience of trauma or stimulate overwhelming feelings and a trauma response?
- ☑ Identified important relationships to the child and to whom the child wants to remain close?
- ☑ Identified parents, relatives, friends, community members, and authorities that are involved and available to the child?

Develop a **PLAN FOR FEELING SAFE** to prove to the child that they will be kept safe.

Have you…

- ☑ Stated and demonstrated that you are going to care for them, protect them from harm, and help them feel safe?
- ☑ Clarified expectations and predictable routines of their current living/school situation, especially basic needs for care and comfort?
- ☑ Engaged the child in thinking about how they can recognize the signs of feeling unsafe and identifying what will help them to feel safe?

Identify ways to help the child **LEARN AND PRACTICE NEW SKILLS** that will build their own capacity to feel safe.

Have you …

- ☑ Identified what skill building and experiences might help the child practice self-soothing strategies?

- ☑ Identified ways to help the child: identify feelings, connect feelings to behavior, practice problem solving and identify alternative actions for improved emotional and behavioral regulation?
- ☑ Identified ways to: help the child feel more connected to caring adults; encourage the child to try new ways of interacting with others; and support building trust in relationships?
- ☑ Identified way to help the child: ask questions; feel listened to when they choose to share their story; and express their feelings to make meaning of what is happening to them?

Essential Elements of Treatment and Typical Course of Therapy

Build a strong therapeutic relationship
Like most forms of therapy, trauma treatment requires the skillful development of a clinical relationship with the child AND parents/caregivers.

Psycho-education about normal responses to trauma
Most trauma informed therapy includes a component that helps the child and parent/caregivers understand normal human reactions to trauma.

Parent support/Conjoint therapy-Parent training
Parents/Caregivers are typically powerful mediators of the child's treatment and recovery. Involving the parent, foster parent, or other caregiver is a vital element of trauma treatment. Some trauma-informed interventions include a parenting component to give the parent greater mastery of child management skills.

Affect expression and regulations skills
Helping the child identify and express powerful emotions related to the trauma and how to regulate or control their emotions and related behavior is an important element of trauma informed therapy.

Anxiety management/Relaxation skills
To accomplish the emotional regulation it is typically necessary to teach the child (and parent/caregiver) practical skills and tools to gain mastery over the overwhelming emotions often associated with trauma and its reminders.

Cognitive processing/reframing
Many children form unhealthy misunderstandings in the aftermath of the trauma, often assuming a great deal of self blame for the events or blaming someone for not knowing or not protecting them (when it may have been beyond their capacity to do so). Therapy often helps correct these misattributions.

Construction of a coherent trauma narrative
Successful trauma treatment includes building the child's capacity to talk about what happened in ways that do not produce overwhelming emotions. Many non-trauma informed therapists are uncomfortable with this aspect of treatment. This may involve gradual exposure to traumatic reminders using the anxiety management skills.

Strategies that allow exposure to traumatic memories and feelings in tolerable doses so that they can be mastered and integrated into the child's experience
Treatment often encourages the gradual exposure to innocuous (harmless) trauma reminders in a child's environment (e.g. basement, darkness, school, etc.) so the child learns they can control their emotional reactions to things that remind them of the trauma.

Personal safety training/empowerment activities
Trauma may have left the child feeling vulnerable and at risk. Trauma treatment often includes strategies that build upon the child's strengths and teaches them strategies that give them a sense of control over events and risks.

Resiliency and closure
The treatment often ends on a positive empowering note giving the child a sense of satisfaction and closure.

Essential Messages: Tips for Talking With Infants, Toddlers, and Preschoolers

What you can say:

Children need to know that there will always be someone there to take care of them.
What you can say:
"Scary things have happened to you, but you are safe now. You are with me and I will take care of you."

Children miss their parents, even if their parents have been abusive or neglectful.
What you can say:
"I know you miss your mom and dad. They broke some rules when they [hit you, or left you alone/some simple phrase that describes the child's experience]. There are grown-ups who are helping them learn to follow the rules so you can be safe with them. Right now, you are with me, and I will take care of you."

Children need to know that it is not their fault they were taken away.
What you can say:
"You didn't do anything wrong. Your mom was wrong to [hit you…]. You didn't deserve to be hit. She is trying her best to learn how to [not hit/take care of children] so you can be safe with her. Right now, you are with me, and I will take care of you."

Children need to know that their parents love them and want to take care of them.
What you can say:
"Your mom and dad love you very much, but they have problems and sometimes they don't know what a little boy or girl needs to be safe and healthy. They are trying very hard to learn how to take care of you and grown-ups are helping them get better. Right now, you are with me, and I will take care of you."

Other things you can do:

1. Remember that even babies who cannot speak understand much more than they can say. They are listening to you. Talk to them in simple words. Explain, as best you can, what is happening.
2. It is comforting for children to have structure. Set limits, explain them, and enforce them.
3. It is comforting for children to be close to adults. Little children who seem clingy are communicating a need for closeness. Let them stay near you as much as possible. Once they feel more secure, they will be able to explore more on their own.
4. It is comforting for children to have rituals. Have special songs, prayers, or stories that you share.
5. Always tell children the truth. If you don't know what is going to happen, be honest about that, but reassure them that there will always be someone to take care of them.
6. Help children develop a sense of self by helping them build the stories of their lives. There are several ways to do this with little children:
    a. Build picture books that show pictures of the houses they've lived and the people who cared for them. It would be good if the book could include a

description of a small ritual or other comforting custom that occurred in each home so that the child can have a sense of really having been cared about and cared for in that home.

b. If you can't build a book, tell children the story of the places they've lived and the people who have cared for them and loved them.
c. Make sure that children have comforting objects (including special toys or blankets and their life story books) that can go with them from home to home.

Books you can use…

1. Laura McAndrew, ***Little Flower***. (Suitable for any child old enough to sit still and listen to a story).
2. Jennifer Wilgocki and Marcia Kahn Wright , ***Maybe Days: A Book for Children in Foster Care***. Magination Press. (Children 4 – 10)
3. Geraldine and Paul Blomquist, ***Zachary's New Home: A Story for Foster and Adopted Children.*** Magination Press (Children 3 – 8)
4. Janice Levy, ***Finding the Right Spot: When Kids Can't Live With Their Parents***. Magination Press (children 6 – 10).
5. Jill Krementz, ***How it Feels to be Adopted***. (Children ages 10 – 15).
6. Katherine Paterson, ***The Great Gilly Hopkins***. (Children ages 9 – 15)

Tips for Talking To School Age Children and Adolescents

The same rules apply to older children and adolescents as apply to young children (See **Handout 5-8**), but the language, style of conversation, and the approaches shift according to the child's developmental (not necessarily chronological) age.

Essential messages:

What Happened
Children need to hear a clear message about the neglect, abuse, and violence that led to placement in words that are honest but not too frightening. The words need to be adapted to the developmental age of the child.

Placement is Never a Child's Fault
It is very common for children to blame themselves for what happened to them and what happened to their family. Validate the child's response to trauma as a normal reaction to what happened. It sometimes helps to have children think about how old, or how big, they were when the trauma took place that led to placement and that they were too young or too small to really make a difference. If the trauma occurred just recently, ask the child what they could have done instead. Begin to gently help the child understand that while they may want to believe that they could have prevented the trauma or saved their mother, father, siblings, etc., even the grown-ups in their family weren't able to do this.

Help for Parents
Children need to hear how their parents are being helped to do whatever is necessary to reunite and provide the safety, nurture, and guidance all children need. If parents are missing, children need to hear how service providers are working to search for them and help them once they are found.

Involvement in Service Planning
Older children can participate in information gathering and the service planning process. They need clear messages about progress, how parents/guardians are being helped, what parents/guardians are doing, the back-up/concurrent plan if parents/guardians can't or won't do what's necessary, time frames, and what children need to be doing day by day and in the next few weeks.

Time Frames
Older children need to hear a clear message of the time frame for working to make their families better including the timelines dictated by child welfare policy related to the search for permanency.

Capacity for Change
Older children are busy trying to figure out who they are and how they fit in the world. They need to understand that their experience with trauma, especially chronic, early trauma that takes place within the context of their family, does not mean that they will grow up to be "just like" those who have hurt them or their family. For example: Just because a child was hit doesn't mean that he/she will hit their own children.

Messages and Strategies for Dealing with Challenging Behavior

Frightening or Threatening Behavior
When children hurt themselves or someone else, they must be stopped. But it is not enough to tell them that the behavior is "not acceptable" or "not appropriate." Again, children need words to help them understand their experience. Children who are threatening need to be told the following messages in simple words:

1. It is not safe for you to hit. It hurts people. It is my job to keep you safe, and I'm not going to let you hurt me or yourself or anyone else.
2. Someone hit you (or you have seen people get hit), but that was wrong. Hitting isn't the way to solve problems. It hurts and makes people angry and afraid.
3. You didn't deserve to be hit. No one deserves to be hit, no matter what they do.
4. It is okay for you to be upset or angry. You can come to me. I will help you. But you need to find some way to tell me that you are upset and angry that doesn't hurt. You need to use your words or draw a picture or show me how you are feeling with dolls or puppets.

Hitting and Biting in Young Children
Avoid encouraging children to hit an object as a substitute for hitting a person. The very act of hitting the object can make them more angry, more aroused, and more difficult to calm down.

1. With very young children who bite, substituting a teething ring or other object can be useful. Say to the child, "You can't bite (yourself, or me, or your brother). Biting hurts. If you need to bite, bite this.
2. Use a game with puppets to help children problem-solve about hitting or biting. Have the puppet come to the child and say that it has a problem – it hits, or it bites, and it is getting into trouble all the time.
3. The puppet can ask the child for ideas about how to stop. This strategy distances the problem from the child a little bit, and lets the child think through ways to stop hitting.

Older Children and Adolescents
Older children need to hear the same messages about threatening behavior as just described. Caretakers must:

1. Take a gentle but firm stance emphasizing that the foster home does not allow violence by anyone, towards anyone, verbal or physical.
2. Let children and adolescents know that while you understand that unfortunately they were in situations where people's arguments became physical, you will be taking steps to make sure that everyone is safe.
3. Label and validate children's and adolescent's emotions after their behavior has been out of control.
4. Use a direct, honest, and calm approach, using humor when appropriate, and language that's "real" and not condescending or "too young." At the same time remember that a teen in foster care may emotionally be much younger than their years.
5. When things are calmer (helping them to do their own version of SOS), be sure to point out any positive behaviors, anything that went well and/or validate their

emotions or needs, positive behavior might include NOT doing something like not hitting after they cursed someone out.

Sexualized behavior
Firm limits, set in a way that gives the child words to help manage his/her experience. Key messages and ideas for dealing with sexualized behavior in children and adolescents need to be:

1. There are some parts of our bodies that no one else should touch. (If the child is masturbating, tell the child that masturbating is normal but it is a very private and personal act that should only be done when the child is alone in a private place.)
2. You have been touched in ways that frightened you or hurt you. That was wrong. The person who touched you should not have done it. It broke all the rules about how children should be treated. You didn't deserve to be hurt or frightened in that way.
3. When your feelings get to be too strong, you really want to touch someone else's private parts, but it isn't safe for me to let you do this. It's my job to keep you safe. You can tell me when your feelings get too hard and we can figure out something else for you to do that will help you feel better.

Older Children and Adolescents
Some practical strategies include:

1. Focus on safety issues regarding their peers and supporting appropriate boundaries at home.
2. Make rules simple, straight-forward and geared to the child's developmental age, e.g. "we don't allow anyone to touch another person's private parts here. In our house, bathrooms are private places. No one barges in. We wear clothes in shared spaces."
3. Maintain a firm and calm voice to deliver the message about sex, sexual behavior, and rules related to sexual behavior.
4. Be proactive and read books about appropriate touching to children in care who have been sexually abused, emphasizing how the child and caring adults will keep themselves safe.
5. Help adolescents understand that they have a choice about having sex. Focus on safety issues.
6. Offer information and support by asking open ended questions without judgment.
7. Have discussions about sex and sexual behavior in a way that is warm and matter-of-fact. Prepare yourself ahead of time with what you would like to do or say. Focus on what you want to communicate and what you want them to know. Just letting adolescents know you are comfortable and willing to discuss these matters is valuable.

Messages And Strategies For Helping Children Feel More In Control

Feeling More In Control
Children's behavior will improve when they feel more in control. The best ways for foster parents to help children feel more in control are:

1. Have predictable routines and rituals that the child can depend on.
2. Work with teachers or others in the child's life to establish similar kinds of expectations and consequences across environments.
3. Explain things to the child. Let him know what will be happening throughout the day. This will make the world feel more predictable to him and, therefore, more controllable.
4. Let the child make developmentally appropriate choices. For very young children, such choices may be limited to what shirt to wear or which breakfast cereal to eat. Older children can be allowed to choose when during the day they will do certain chores, or even what chores they will be expected to do. Adolescents who have been responsible may be given choices in what time their curfew will be.
5. Make the rules of your house very clear, and enforce them calmly and consistently.
6. Praise children for things that they do well. Make sure that in your praise, you include a description of exactly what the child did that you liked. Praising good behavior is the best way to achieve behavioral change. It is much more effective than punishing bad behavior.
7. Don't make promises you can't keep.
8. Prepare children for important occasions: visits with a parent, major changes in routine. Let them know what will be happening. Talk together about what the child is looking forward to, and what s/he may be worried about.
9. If parents don't follow through with visits, comfort the child. Empathize with the child's feelings. Don't condemn the parent. Just understand the child's frustration and pain, and reassure the child that it is not his fault that the parent didn't visit.
10. Help children anticipate that there will be problems between you, and that you understand that problems are a normal part of life and that they can be solved.
11. Be steadfast. Understand that you will have to do all of these things over and over again.
12. Use self monitoring techniques. Teach children to rate their Personal Stress and Self Control on Self Monitoring Thermometers or other scales.
13. Have some fun. Use games to make skill development enjoyable –day to day self-control, like taking turns, tolerating frustration, or losing the game with grace offer opportunities for learning and practice.
14. Remember that practice is crucial for learning new behaviors, especially practice geared to reminders that trigger traumatic responses.

Reparative Parenting

Reparative parenting centers on rebuilding a child's trust that caring adults can provide the protection, nurturing, consistency, and guidance that children need. Reparative parenting is tailored to the individual child, their developmental stage, as well as their strengths, interests, and talents.

Key Features of Reparative Parenting include:

1. Passing the child's tests – remaining firm and caring in the face of challenging behavior
2. Showing the child that caring adults can listen to them – validate their experience and understand the child's feelings
3. Taking the time for activities with the child that build skills and confidence – fostering relationships, growth and development
4. Showing the child that a caring adult dares to deal with a frightened child – using strength and perseverance
5. Reuniting with the child after discipline – including teaching a lesson with natural or logical consequences

Some Strategies for Reparative Parenting can be to:

1. Learn how behaviors fit with the child's experiences, beliefs expectations, and own family culture.
2. Catch the positive side of each child-build on strengths, interests, and talents
3. Help replace destructive messages-like "I am no good"-with constructive messages, a healing memory
4. Foster security and developing trust
   - Reaffirm family rules, impose logical consequences with consistency
   - Provide structure, predictable routines and rituals –daytime and bedtime
   - Re-attune, or attend to and reconnect with the child and repair the relationship after a reprimand
   - Model and teach skills: how to relate to others, express feelings, self control, being consistent, etc.
   - Display pictures of the child as part of the family having fun together
5. Share feelings safely
   - Draw or take pictures of feeling faces, a learning tool to help the child identify and express feelings
   - Practice making feeling faces together in a mirror
   - Get in touch with body messages; as a learning tool, help the child "show" feelings with their body; learn your child's body language and help to identify their feelings
   - Make up stories, television shows, radio interviews about feelings

Life in Family Environments (LIFE) Approach

The goals of Life in Family Environments (LIFE) are to:
1. Assess and establish (or increase) a family's use of structured and adaptive family routines
2. Increase positive interactions among children and parents in the course of these daily routines
3. Decrease punitive , coercive, and/or potentially harmful activities or interactions
4. Enable parents to implement child management techniques appropriately in the context of maintaining a safe environment adaptive to children's needs

Assessment begins with an examination of:
1. The location, time, and nature of the incident of child abuse or neglect that has occurred – current and past episodes
2. Age and development of child victims
3. Special needs of the parent
4. Observation of parent-child interaction during unstructured time
5. Observation of parent-child interaction during a play or meal routine
6. Discussion with custodial parent about how their household ran from wake-up through bedtime routines, including times, activities, children's behaviors, and the stress they felt while parenting during each part of their day while the child(ren) were with them. Much is gleaned from this, even if the parent really hadn't established household routines.

After the assessment is complete, each parent child visit has an agenda and purpose. If possible, training/coaching should start either with the time of day in which the abuse/ neglect occurred, or with the time of day the parent indicated was the most stressful for them. If neither of these apply, or if the caseworker is stuck with an office environment, you start with play or meal routines. ***Visiting in a homelike environment should be striven for if solid reunification recommendations are going to be made.*** Examples of routines include:
Wake-up Routine, Breakfast Routine, Nap Routine, Lunch Routine, Play Routine, Snack Routine, Bath Routine, After School Routine, Dinner Routine and Bedtime Routine. If a family has another safe routine that they do in their house, you can support and train on that as well!

The coach and the parent work together to develop the steps of the routine so that it reflects both the way the parent wants things to run as well the areas the coach wants to work on. The coach **always** wants to work on:
1. Positive parent-child interaction
2. Use of appropriate child management techniques
3. Demonstration of proper infant care if applicable
4. Provision of a safe environment when the visits leave an office setting

EXAMPLE:
The steps in a lunch routine may look like this:

1. Parent gives children an activity/ age appropriate toys/materials
2. Parent gives 5 minute warning to lunch
3. Parent has children wash their hands
4. Parent sits at the table with the children
5. Parent serves appropriate serving sizes from at least 3 food groups
6. Parent asks each verbal child 2 questions of their interests/about their day
7. Parent assists/teaches toddler to use utensils as needed
8. Parent has older children assist in part of clean up
9. Parent uses appropriate child management techniques (*planned ignoring for whiny and obnoxious behaviors, manual guidance for noncompliance behaviors, and time out for aggressive or dangerous behaviors*.)

Both the parent and the coach go over the routine before it starts. If there are specific child behaviors or parent behaviors that are a problem you write a step(s) to deal with it. If lunch routine is a new concept for a child coming out of a household of chaos, the routine should be gone over with the children as well.

The role of the coach is to prompt and support the parent through the routine. The goal of the parent is to be able to complete the routine without any prompting. You move to a new routine when the parent has mastered the steps. Training on nutrition, child management, and infant care can be done prior to the visit or at another time. Parents really can get into this because this is the way they want the routine to run and they are proud of themselves when they get the steps independently. Most children adapt to the steps quickly as they find out they are not going to change. The routines move much faster if the parent can generalize the skills (e.g. child management techniques, infant care) they have attained.

Christy Levine, UIUC, CFRC Foster Care Utilization Review Program notes the following:

- The coaches do not have to be parents themselves. The idea is that many parenting activities can be broken down into bite-sized pieces.

- The parents help write the routines and this alone excites and motivates the parent. When they feel competent in parenting they have more patience. It makes visits relevant.

- With regard to cultural sensitivity, everyone has to feed, play/interact, bathe, and bed their children safely. Variation is okay as long as the routine is safe.

- Unsupervised visits between parents and children start as they master routines. So, for example, you might allow an unsupervised visit to occur over a mealtime once the parent has mastered the mealtime routine. It's good for us to feel that the children are safe, and it's good for kids to walk into predictable situations. Unannounced visits are used to monitor progress.

- Recommendations for reunification are made after you have teased out what the parent can and cannot do in the context of day-to-day parenting. Trips to the store, school and doctor can also be made routines if the parent has trouble with the child in public. If the child has special physical or mental health issues, steps are incorporated into the routines to ensure the parent can handle the demands of the child. Steps can be written for parents, children, and paramours as well.

- Varying degrees of parenting ability are addressed by starting where your client is. For some parents, just getting the children and the food on the table at the same time is a challenge, for others that stuff is a breeze, but ignoring a whining child or dealing with child aggression without hitting is the challenge. Some don't know age-appropriate expectations. Flexibility and parent inclusiveness is key.

- For the purposes of service planning, goals can be written that are behaviorally specific and measurable. For example, "the parent will independently demonstrate the lunch routine 3 times in a row without prompting or coaching," or "the parent will demonstrate planned ignoring of Sally's whining behaviors," (where whining brought on the physical abuse), or in families where mom is stressed because she's doing everything, "dad will watch the children for 30 minutes after dinner so mom can go for a walk." It may sound simplistic but it works.

For a further review of the tools that were used, and for questions call Christy Levine 312-328-2092

Risk and Protective Factors[3]

Child Risk Factors	Child Protective Factors
1. Premature birth, birth anomalies, low birth weight, exposure to toxins *in utero* 2. Temperament: difficult or slow to warm up 3. Physical/cognitive/emotional disability, chronic or serious illness 4. Childhood trauma 5. Anti-social peer group 6. Age 7. Child aggression, behavior problems, attention deficits	1. Good health, history of adequate development 2. Above-average intelligence* 3. Hobbies and interests 4. Good peer relationships 5. Personality factors a. Easy temperament b. Positive disposition c. Active coping style d. Positive self-esteem e. Good social skills f. Internal locus of control g. Balance between help seeking and autonomy Internal Protective factors include[4]: 1. The ability to be proactive—to take control and make decisions 2. Having a positive outlook 3. Having a healthy set of coping and stress reduction strategies External Protective factors include: 1. Caring relationships- especially attachment with a caring adult 2. Positive and high expectations (of the child by an adult) 3. Opportunities for meaningful participation

Please NOTE: This is not an all-inclusive or exhaustive list. The factors listed do not imply causality and should not be interpreted as such.

[3] www.nccnch

[4] Promoting Resilience in Children: What Parents Can Do. Center for Effective Collaboration and Practice (www.cecp.air.org)

Parent Risk Factors	Parent Protective Factors
1. Personality Factors a. External locus of control b. Poor impulse control c. Depression/anxiety d. Low tolerance for frustration e. Feelings of insecurity f. Lack of trust 2. Insecure attachment with own parents 3. Childhood history of abuse 4. High parental conflict, domestic violence 5. Family structure - single parent with lack of support, high number of children in household 6. Social isolation, lack of support 7. Parental psychopathology 8. Substance abuse 9. Separation/divorce, especially high conflict divorce 10. Age 11. High general stress level 12. Poor parent-child interaction, negative attitudes and attributions about child's behavior 13. Inaccurate knowledge and expectations about child development	1. Secure attachment; positive and warm parent-child relationship 2. Supportive family environment 3. Household rules/structure; parental monitoring of child 4. Extended family support and involvement, including caregiving help 5. Stable relationship with own parents 6. Parents have a model of competence and good coping skills 7. Family expectations of pro-social behavior 8. High parental education 9. Parental resilience* 10. Social Connections* 11. Knowledge of parenting and child* development 12. Concrete support in times of need* * Identified as protective factors by the Strengthening Families Program

Social/Environmental Risk Factors	Social/Environmental Protective Factors
1. Low socioeconomic status 2. Stressful life events 3. Lack of access to medical care, health insurance, adequate child care, and social services 4. Parental unemployment; homelessness 5. Social isolation/lack of social support 6. Exposure to racism/discrimination 7. Poor schools 8. Exposure to environmental toxins 9. Dangerous/violent neighborhood 10. Community violence	1. Mid to high socioeconomic status 2. Access to health care and social services 3. Consistent parental employment 4. Adequate housing 5. Family religious faith participation 6. Good schools 7. Supportive adults outside of family who serve as role models/mentors to child

The Risk of Compassion Fatigue and Burnout

Working as child welfare workers and being foster parents includes highly stressful experiences and responsibilities. Compassion fatigue and burnout are very real risks among all partners in foster care and all levels of responsibility. Anyone experiencing symptoms of compassion fatigue and/or burnout can benefit from additional support.

Compassion Fatigue

1. **Compassion Fatigue** is a condition resulting from the secondary exposure to a traumatic event. It is the emotional residue of exposure to working with the suffering, particularly those suffering from the consequences of traumatic events.
   - It requires a relationship between 2 people: one who has been traumatized and one who wants to help.
   - It is a syndrome of symptoms that is nearly identical to those of post traumatic stress disorder (PTSD).
   - It is NOT burnout.
1. Compassion fatigue is often referred to as "secondary traumatic stress disorder (STSD)." The difference between PTSD and STSD is that in PTSD, the individual experiences the trauma personally while in STSD, or Compassion Fatigue, the individual experiences the trauma vicariously (or through another person).

Burnout

Burnout is a state of physical, emotional and mental exhaustion caused by a depletion of ability to cope with the ongoing demands of our daily lives. Symptoms of burnout may emerge gradually, and it may take a long time to recover from them.

In our definition of Compassion Fatigue, we said that it is not synonymous with burnout. It can, however, increase the likelihood that a foster caregiver may experience symptoms of burnout. Similarly, a foster caregiver who is already feeling "burned out," may be more likely to experience symptoms of Compassion Fatigue.

Common symptoms of BOTH Compassion Fatigue and Burnout

- Physical symptoms: fatigue, exhaustion, sleep difficulties and somatic problems like headaches, stomach aches, colds, flu
- Emotional symptoms: irritability, anxiety, depression, guilt, sense of helplessness
- Behavioral symptoms: aggression, pessimism, defensiveness, cynicism, substance abuse
- Work-related symptoms: poor performance, leaving the job, absenteeism, tardiness
- Interpersonal problems: perfunctory communication with others, trouble concentrating on others, withdrawal, intellectualization of others.

(Adapted from Figley, 1999; Kahill, 1988; and Pines and Arnson, 1989).

Dealing With Trauma

Focusing:SOS

Step 1: **SLOW DOWN**

- Pause, slow down your mind & body, take time out
- Take a deep breath---notice the air, listen to your heart
- One thought at a time

Step 2: **ORIENT YOURSELF**

- Bring your mind & body back to the present time/place
- Look around-notice where you are, who you're with, what you're doing
- Feel yourself in the chair, feel your feed touching the floor

Step 3: **SELF CHECK**

Personal Distress	Right now I feel….	
Completely Calm	1 2 3 4 5 6 7 8 9 10	Most Distressed Ever
Personal Control	Right now I am ….	
Completely In Control	1 2 3 4 5 6 7 8 9 10	Totally Out of Control

SPARCS, 2004 Adapted from Ford, et al (2004)