Words can build or destroy relationships, self-esteem and opportunity. Those of us connected to adoption have a special responsibility to use positive adoption language, to correct media's negative adoption images and terminology, and to sensitize educators and other professionals. Using positive adoption language ia a choice...we hope you will join us in promoting the positive language outlined in this brochure.

Donna Barnes *Teri McCoy*

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Positive Adoption Language

Which one is your **REAL** child?

***ALL** of them!*

Adoption World Specialties™, Ltd.

Negative or Offensive Language	Positive or Preferred Language	Explanations
"Real" or "Natural" (parent or child) Who is the real parent? Which one is your natural child?	Birth parent; biological parent; genetic parent; family of origin.	The use of **"real"** implies that the adoption is not a reality or that it is unnatural. The term **"birth parent/s"** describes the life-giving roles these person/s play in the child's life.
"My adopted child/my own" Sue is my adopted child and Kevin is my own. Which is your own child?	My/our child; my our son/daughter; my/our child whom I/we adopted.	Adoption is a process, not an adjective. When the process is completed, the adopted youngster becomes a **"child"** in the family just as any other and should be referred to as such. Saying **"my adopted child"** implies a second-class or qualified relationship. Distinguishing between you **"own"** child and an adopted child reflects a sense of **"ownership"** of one and not the other. Both children belong equally to the family.
"Adoptive" Parent	Mother/father.	It isn't wrong to say that you're an **"adoptive"** parent, but extended use by you or others (especially in front of our children), continues to qualify your parental status.
"Give Up", "Surrender", "Relinquish", "Adopt Out", "Put up for Adoption"	Make an adoption plan; transfer parental rights; choose a family to parent the child.	Terms such as **"give up"** or **"surrender"** are emotionally charged terms that imply coercion rather than a thought-out decision made by birth parents. In many cases, the birth parents actively participate in selecting adoptive parents for their child.
"Chosen" Child We chose you because you are special.	No substitute.	The term implies that the adoptive parent did all the choosing when, in fact, birth parents frequently choose a family for the child. This may set the stage for conflict between adopted children and birth children who weren't **"chosen."** A child may rationalize that if he/she was special enough to be **"chosen,"** he/she must continue to be special to receive ongoing love and acceptance from the adoptive parent.
Adoption ***"Triangle/Triad"***	Adoption circle; parties to the adoption.	Triad or triangle can imply ill will between parties. It also identifies only three main characters in an adoption, thus leaving out important persons in the **"adoption circle"** such as the social worker, attorney, judge, grandparents, and/or other relatives.
"Illegitmate"..."Unwanted"	No substitute.	Factors of birth should no longer stigmatize a child. Bury the word **"illegitimate"** with the past and let the child enjoy respect and full, unqualified rights as a family member. Birth parents choose adoption for many reasons– rarely because the child was unwanted.
"Unmarried/Unwed Mother or Father"	Birth mother; birth father; biological parent.	These labels stigmatize and place moral judgements on the birth parents. They imply that only marriage legitimizes birth–a cultural concept that ultimately hurts the child.
"Reunite/Reunion"	Searching; locating; meeting; making contact with biological relatives.	**"Reunion/reunited"** implies renewal of a previous relationship with a birth family and the dissolving of the adoptive family relationship. **"Meeting"** or **"locating"** biological relatives more accurately describes this contact.
"Hard to Place"	Child with special needs (NOT "special needs child"); waiting child.	**"Hard-to-place"** implies that the child is less than desirable, less than normal.
"Adopt-A-..." (whale, kitten, highway, etc.).	Sponsor a (whale, kitten, highway, etc.).	Campaigns that use the slogan **"Adopt- a....."** demean the dignity and self-worth children who are adopted and those who are waiting to be adopted.
Adopted ***"Child"*** (in reference to an adult)	Son/daughter who was adopted as a child; adult adoptee.	The word **"adopted"** is so frequently connected to **"child"** that it becomes habitual in thought and speech. An adult adoptee deserves not to be called a child.

Talking To Your Child About Adoption

Many parents struggle with how and when to talk to their children about being adopted. My experience with adoptive parents is that the topic often brings up feelings of anxiety. Parents wonder, "What will I say? What *should* I say? And what if my child asks questions that I can't answer?" They worry that the adoption story, and all of the circumstances around it, will be too much for their child to handle emotionally. Many adoptive parents struggle with what information is appropriate share, and at what age.

Because talking to your child about her/his adoption is an important part of their development, I'm suggesting some basic guidelines:

Start talking about adoption as early as possible. It is helpful for parents to begin talking about adoption right away, even while the child is still young and before expressive language is developed (this can even happen in infancy). These early one-sided discussions give parents the opportunity to practice having these words in their mouths before they are telling the story "for real" in conversation with their child(ren) (i.e. as you're holding your son or daughter, whispering, "I know you must be so confused, little one, because joining our family isn't something you can make sense of right now. You must have been so afraid the day that your birth mom left you, and I wonder if you worry the same thing may happen with me. But I won't leave you! We adopted you, and that means you'll be in our family forever!") Your little one will get a lot out of what you say about their adoption, even before they're able to understand the language you use (remember, the majority of communication is non-verbal). A bonus to early practice with the story is that parents are better equipped for 2-way conversations with their child about their early history and adoption. As opportunities to talk about adoption arise, even with a baby, take advantage of these times to "practice" sharing what you know about your child's story with him/her.

Be open and always tell the truth. While many children are too young at the time of adoption to consciously remember their histories in China, we need to understand that he/she still lived all of their experiences (and they are stored at a deeper level of memory). Your children know, embedded deep in their systems, the truth about their lives. So whatever you know, share it with sensitivity, choosing your words to match your child's developmental age. Don't try to shelter or hide your child from the truth of his/her experience; parents who take this approach often find that, down the road, their child feels "lied to." The rifts that may result carry far greater risk for psychological injury than the truth of his/ her history. The key to talking about a difficult past is being prepared to support your child through any tough feelings that may show up.

> Dr. Dan Hughes describes it this way: "We do not facilitate safety when we support a child's avoidance of the pain, but rather when we remain emotionally present when he is addressing and experiencing the pain." Being open and truthful about your child's history is one of the best ways to help them heal, even if the information has the potential to be distressing.

Also, be aware that if you withhold information about your child's story, he/she may get the non-verbal message that there is something about which he/she should be ashamed. Many adopted children wrestle with intrinsic feelings of shame anyway, so it is important to be very aware of and intentional about acceptance. At the core of their being, particularly when they are very young and just beginning to make sense of their adoption, many children believe that their separation from their birth parents was their "fault." They are too ego-centric to consider all of the other factors that may have gone into this early loss. It's essential, therefore, when discussing the adoption story, to be sure that we demonstrate acceptance and openness to combat potential feelings of shame.

Be aware of the trickle-down effect. Many parents are intimidated by conversations about their child's early history because the topic is also emotionally loaded for them. Moms and Dads have shared their underlying feelings of sadness and helplessness about what their child may have experienced before "coming home." So, if you experience stress as you imagine talking with your daughter or son about their adoption, know that those feelings will come through in your communication. If you are aware of how you feel and work through it, you are less likely to impose *your* feelings on your child.

Adopted children have a range of reactions to their adoption story; it's important that children have authentic reactionary experiences about their adoption story so that we are able to take cues about where they may need additional emotional support. The range of reactions can be from a matter-of-fact perspective, to a mild curiosity about their life in China, to desperate feelings to know his or her birth parents combined with feelings of confusion, sadness, and shame. Those children whose story has been a part of their life all along (i.e parents talk about adoption from the very beginning) tend to fare better than those whose parents sit them down for "the talk." It is important that you are emotionally available to your child when discussing the story. If you are consumed with your own feelings of anxiety, you may miss some of the cues your child sends about what your child needs from you as he/she integrates and heals from these experiences.

Don't make them choose. It can be scary for many adoptive parents to feel like their child has an interest in his/her birth parents. Some children have no conscious memory of their birth parents but express feelings of missing them, or loving them. This can be threatening to many forever parents (after all, sometimes part of the draw to international adoption is to avoid the legal risk associated with birth parents, right?). It's important, however, to allow your child to express and explore any feelings that they may have about their birth parents. If your child experiences an openness and acceptance from you on the topic, he/she will be better able to process all of this information and it will build your relationship. Just as there is enough love in you for all of your children and those that may still join your family, there is enough love in the heart of your child to have love for the parents who gave life and the parents who give him/her a forever family.

Find a "Sounding Board." If you are nervous about how to approach these sensitive issues with your child, if you need to brainstorm, or if you need some support as you work through your own feelings associated with your child's history, call Inward Bound for a consultation. Tap into other resources as well – talk to other adoptive parents, take advantage of mentoring programs, and speak candidly with your social worker. You don't have to be alone in this challenging season of parenthood. Give yourself the gift of consulting with someone who understands the heart of adoption issues. As your fears are eased, you're in a better position to provide your daughters and sons with the support they need.

Jennifer Winkelmann, MA, LPC, NCC is the Founder and Clinical Director of Inward Bound, LLC. As a psychotherapist for individuals, couples, and families, Jen's primary clinical focus is adoption and foster care issues, including the impact of early trauma and the spectrum of relationship difficulties that result from disrupted attachments. In addition, Jen works with couples addressing marital issues and with adult individuals to resolve depression, anxiety, relationship difficulties, stress, and struggles related to grief and loss. For more information about Jen or her services, please visit www.InwardBoundCo.com.

Lessons in Gratitude

Jennifer Winkelmann, MA, LPC

Children adopted at older ages frequently have more difficulty with building and maintaining relationships, even with people who should feel "safe" to them, like their adoptive parents. For those who have children that were adopted at older ages (caveat here: while there isn't agreement in the adoption community about the age at which a child is identified as "older", for the purposes of this article, "older" refers to any child out of infancy and beginning to acquire verbal skills), many would agree that there can be unique and unexpected challenges with parenting. During consultation with these families, I have often heard parents lament:

"This isn't what we signed up for, so what are we going to do? We can't live like this!"
"After everything we went through to make this adoption happen, how can it turn out like this? Our family is falling apart!"
"Our child came from abuse/poverty/neglect… Our home is a better and safer place for her to grow up. Why can't she just appreciate it?"
"I have given so much love to our son, and things are so much better for him with us. How could he not be grateful? He has everything… a new room, clothes, food to eat, a good school…"

While I can understand these questions from the parents' perspective, what it leaves to be desired is an understanding of the *child's* lens for relationships, love, and family.

The way we (including our children) view life is through the "lenses" provided to us in our first relationships; the experiences that shade or tint the lenses of our children often lead them to "see" differently than we do. Their sense of trust has often been fractured so early and profoundly that they can be haunted with fear of loss and abandonment in every subsequent relationship. Love and family are things to be feared, because prior experience has taught these children that they will be hurt, abandoned, or rejected in these contexts. Breaches of trust like these, during critical windows of development, cause high levels of stress in the child on an on-going basis. This heightened stress can result in challenging behavior that parents and caregivers may experience as disturbing, including: withdrawal, poor self-esteem, cutting/head-banging/rocking, aggression toward others (family members, teachers, peers, siblings, etc), disrespect, defiance…the list goes on and on.

When these behaviors are present, in the height of their frustration, parents ask: "Why, after everything, can't he/she just be *grateful*?"

Three-year-old Katie lived in an institution overseas for the first two years of her life. The ratio of nannies to children was less than ideal (though typical), so it'd be wise for her parents to assume no matter how much growth and improvement that they see, that Katie has at least two years ahead of her where she'll need to learn about this *new* kind of

relationship. She'll need time to learn that "family" means "forever" and parents are consistent, stable, and nurturing. Because the neural pathways in every human brain that make healthy connections about relationships are "use dependent" (meaning that they have to be used over and over to make strong connections), Katie will need lots of time and repetition for her brain to pave new pathways for relationship. Not only will her parents have to provide enough repetition in relationship to begin to combat the old pathways, but they'll have to provide enough to begin to pave new ones as well! A good rule of thumb for parents is to expect that for every year a child spends under stress, enduring abuse, neglect, or change, he/she will need a corresponding year of nurturing and consistency to heal. (Many children respond to the environments provided by their parents much more quickly than this little formula, but it helps us to prepare for the work involved and adjust our expectations appropriately.)

Ten-year-old Ty, who has lived in a chaotic home with his birth family, all gang members and substance abusers or dealers, will struggle to accept a new construct for "Mom" and "Dad" when he is finally placed in an adoptive home. See, after years of violence, neglect, and intimidation, Ty's family was investigated by DHS for the first time after his younger sister made a passing comment about her father and a firearm to her teacher. When Ty was removed following the investigation, the caseworker couldn't find a family willing to take a sibling group of five, so all the children were split. And after all, since older children can be "more challenging to place" (as "the System" so gently puts it), Ty will have had a handful of foster care placements before he's done being bounced around. And even then – he will likely struggle to believe that there is any security with this new "family"… he will have no construct of experience to identify "family" as "forever". On top of that, he will be grieving not just the loss of his parents and extended family, but separation from his birth siblings as well, even if efforts are made to maintain their relationship by their respective adoptive parents.

Katie won't feel grateful for finally getting the things *every child is supposed to get from the beginning*. Her little system is at a disadvantage for responding to new relationships in the ways that adults would deem normal or appropriate, because are too many gaps to fill in before she's able to function in ways that are easier for her parents to understand.

Ty has ten years with his birth family, and no matter how much he may be relieved by the safety and predictability of his new home, he will struggle to understand the way that this family works. He's used to his parents having strangers coming and going at all hours of the night, chaos, violence, and general unpredictability. The new "family" is not one he can understand – yet. And his confusion will be easy to see if we try to look at the world through Ty's lenses, instead of our own.

If you have an older adopted child, you must understand: Especially for older children, the actual process of adoption can be experienced by the child as something else in their lives beyond their control… and in some ways, it can be similar to the abuse, neglect, and trauma they have experienced – which was also beyond their control. Somehow, they are expected to adjust, assimilate, and accept, without anyone seeking to understand them

first. The day that you gain a new member of your family is also a day of tremendous loss and change for them.

As adults, we may know that children thrive in environments where they are nutritionally nourished, psychologically stimulated, and relationally valued. But just because this is best for children doesn't make the transition into this kind of life easy for them. In fact, the expectation that the child should transition seamlessly and "appreciate" what they are being given in and adoptive family makes the sting of those parental expectations even bigger. Why should a child have to be grateful for something that every human being should be afforded? How can we be angry when kids display behaviors consistent with their upbringing until the time that they come into our homes? They are only responding to the world in the ways that their brains have been shaped to respond. A process of re-wiring so that the child is *able* to respond differently must be intentional, compassionate, and patient. The years, months, days, hours, minutes, or seconds of abuse and neglect is a lifetime for a child. And this trauma is not always easily undone after a few months - or even years - in a nurturing environment. Just because our children may not have received attuned, loving, safe parents from the beginning does not translate to their need to be grateful when they finally do receive it through you.

And so, we circle back again – why don't they feel grateful? Because they shouldn't have to appreciate the respect, love, compassion, and security afforded that should be afforded to every youngster. If anyone should experience gratitude, it is us… If these children open up to us even a little, after the terrors they have survived, it's they who are taking another chance on adults. We may invest more than we ever expected in trying to build that relationship, but they bear the brunt of the risk associated with accepting it because of the days before us. When a child is able, after such difficulties and profound pain, to take another chance on humanity, *we* should feel grateful - because we receive something from them that the other "big people" in their lives haven't earned.

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Attachment Disorder

The diagnosis *Reactive Attachment Disorder* has received a lot of attention in the public media in the last few years. This is mainly a result of some couples who have adopted internationally and in spite of all they had to offer their child, the journey took a very difficult and sad path. As is always true, the public attention has had both a positive and negative impact: With media attention there is an increase in research (and the funding needed for the research), education for both professionals and the general public and hopefully positive changes in treatment outcomes and public policy. The down side can be that children can be inappropriately diagnosed and therefore not receive the most appropriate mental health treatment. This clearly was the case with the diagnosis of *Attention Deficit Disorder* and many professionals have concerns about the possibility of over diagnosis of *Mood Disorders* in children. Yes, these disorders clearly exist, as does *Reactive Attachment Disorder*, but in my experience they rarely stand alone and diagnosis is a complicated and often thorny path.

An attachment disorder can result when a young child's most basic physical and emotional needs are not met in a consistent and nurturing manner. When there is a pattern of inadequate care, this affects the child's development in all areas, i.e. physically, emotionally, and neurologically. Children who have been abandoned, neglected and/or abused are traumatized and their introduction into a safe and nurturing home does not automatically erase the deeply ingrained emotional pain and mental confusion they have experienced. In the case of internationally adopted children the research is showing that their inadequate care has a definite impact on their ability to regulate their emotions. In addition, it appears that they can easily misperceive situations, especially scenarios they experience as stressful, and therefore respond with behaviors that are viewed as inappropriate and in some cases, alarming.

There is little question that children who have been neglected or traumatized struggle with trusting their new caregivers. Their experience with "caregivers" has taught them to be vigilant and to not let their guard down. To turn themselves over to an adult to be nurtured and guided through the usual childhood challenges of growing up is to chance a repeat of their past neglect or abuse. To accept the nurturing care being extended and to reciprocate with affection is a frightening adventure. Few parents are truly prepared to have their loving and nurturing offerings rejected by hurtful and seemingly purposeful behaviors coming from the child. The result can be a loss of confidence on the parents' part and a lack of clarity about how to "be a family" when the child seems so resistant to accepting the expected parent-child roles.

Parents with a child who appears to be unattached may, in fact, have a child with *Reactive Attachment Disorder*. But, this also may **not** be the case. Attachment should not be viewed as an all or nothing phenomenon. I work with many children that are in the process of attaching (trusting) but who are still reticent about lap sitting, hugging, sharing their feelings, and yes, complying with parental requests. That does not mean they would be comfortable going off with a stranger. It is easier to learn many things when they are presented at developmentally correct times, i.e. swimming, riding a bike,

speaking a foreign language. The older we get, the more challenged we are to learn some things that would have been easy if learned earlier. Likewise, to learn to "attach" (trust) for the first time beyond one year of age, is going to require a leap of faith on the child's part and skills, patience, and confidence on the parent's part.

Adequate diagnosis is essential in formatting a healing treatment plan. Some children who exhibit symptoms commonly associated with an attachment disorder are in fact experiencing stress disorders associated with their past trauma. Many of the children I work with do not initially understand their own past and have many misperceptions and distortions about their past stories. It is hard to start a new story when there is no real closure on the old story. Older children often have clear memories of abuse and deprivation that need to validated and the treatment should focus on the trauma they experienced. Other children's apparent aloofness from parental nurturing may be due to an undiagnosed developmental disorder or issues associated with fetal alcohol spectrum disorders. Some children struggle cognitively which only adds to their struggles to understand their own feelings and the expectations of others.

Regardless of the diagnosis, parents need help with managing their child's acting out behaviors. The longer these behaviors are practiced the more difficult it becomes for both the parent and child to be in a loving relationship. Parents need to work with a therapist that clearly understands attachment issues and has the skills to help them manage their child's array of self-destructive behaviors, i.e. lying, noncompliance, emotional meltdowns, stealing, etc. Parents often need to adjust their expectations and timelines for their child to "change" and deserve factual information and support. Parents want to "be loved" by their child just as they want to love their child and when they feel this is not forthcoming in spite of their best sustained efforts, it is hurtful and frustrating. Sometimes parents need to hear that they are loved by their child, certainly to the best ability of that child given their background, and more is to come if they are able to offer the structure, perseverance, and steady loving presence so absent in the child's early beginnings.

(Ray Kinney M.S. is Director of Cornerstone Counseling Services in Waukesha, WI. He and his wife have four children, two which were adopted from Russia. Ray focuses his practice on working with adoptive families. He is called upon frequently to lecture on the topic of Attachment Disorder and holds workshops quarterly for parents struggling with attachment challenges. Most recently, he was interviewed by PBS Nova for a film that includes a segment on the relationship challenges of post-institutionalized children.Ray can be contacted at raywk2003@yahoo.com)

The "Other" Attachment Disorders

By Jan Tomski, MA, LMFT

Much has been written about Reactive Attachment Disorder (RAD). Dr John Alston has described RAD as "Post-Traumatic Stress Disorder of infancy and toddlerhood" which I think is an apt description of the cause and symptoms of this serious and difficult to treat psychological illness. However, many children who have experienced early childhood trauma do not have full blown RAD, but do have attachment "issues", some mild and some serious. This article will talk about how these issues come about, what they may look like and how parents can work with their children to make improvements.

Attachment issues can be involved in many psychological diagnosis' including ADHD/ADD, Oppositional Defiance Disorder, Post Traumatic Stress Disorder, feeding and eating disorders, mood disorders including bi-polar disorder and depression, relationship disorders, learning disorders, dissociation disorders, anxiety disorders, substance abuse, sexual perpetration, sleep disorders and personality disorders among others. Often addressing attachment issues with these problems is a critical part of the healing process.

The attachment cycle sets a template for our view of the world which is with us throughout our lives. The attachment cycle goes something like this; picture the outline of a circle evenly divided into four parts. Number one at the top represents a person feeling OK- no particular needs, pretty content and satisfied. Number two represents feeling a need i.e. hunger thirst, attention, pain, or tiredness. Number three represents expressing that need i.e. crying, looking for what will meet the need. Number four represents the need being met which leads back up to number one-being OK again. This cycle happens thousands of times during infancy and toddlerhood. This time of life is the most critical in large part because that is the time when we are least likely to be able to meet our own needs, are most dependent on others, and the foundations of our psychological makeup are being established. Those of us fortunate enough to have good early childhood caretakers will tend to feel safer and be much more optimistic about ourselves and the world meeting our needs than those who have not. People who feel safe think and behave well.

Conversely, with children who have neglectful and abusive caregivers, learn that when they have a need (#2) all h*## breaks loose. Once when I drew a circle describing this cycle for one child, he said "oh yeah, well this is what happened for me'' and then drew a chaotic mass of lines between points two and four. This is an accurate non-verbal expression of what these children (and adults) carry inside them.

Children with medical needs in early childhood also experience disruptions in the attachment cycle. Even with excellent caretaking, the child is unable to have their needs met. Sometimes painful medical procedures are necessary to save the child's life. Sometimes the child is withdrawing from drugs, has digestive issues or neurological problems that make it impossible to comfort the child. The infant's experience is still one of experiencing pain instead of needs being met. Since consciousness begins before birth, children whose mothers are involved in drugs or violence also experience a womb environment where their mother is unable to bond to them, or to take care of herself. Children who have prenatal and post natal experiences are doubly at risk for attachment difficulties.

For children who have experienced chaos and pain when they have needs, they have a learned pattern of reacting strongly when they have a need. When children experience a need, it represents a repetition of the often horrifying and life threatening experiences at the beginning of their being. It is felt emotionally, physically and intellectually. It is acted out behaviorally. Hearing "no" to a request can mean that the cycle will happen again, which generally leads to oppositional behaviors. Having the perception that he or she is not powerful or in charge in any way can lead to the expectation that the cycle will be repeated.

Somehow, sometimes miraculously, there are children who have severe disruptions in their needs being met still have the capacity for empathy. Empathy can be described as the ability to discern what another person is feeling AND to care and have compassion for these feelings. In children this can apply as much to animals as to people. A person can have a very accurate read on how others are feeling, but use this knowledge to harm or coerce rather than to help. This tendency towards harm and domination is one of the hallmarks of RAD. Sometimes children use this knowledge as a way to protect themselves from perceived harm from others, and sometimes in an aggressive manner. Whatever empathy the child has will prevent them from harming others to a significant degree. This is what often determines whether a child will have RAD or another diagnosis.

So, what can be done about this? First, it would be advisable to get competent professional advice for a good diagnosis of RAD or attachment "issues". If your child truly has RAD, outside extensive professional help will be needed for both the child and the family. If your child has attachments "issues", long term therapeutic help is also needed. Generally, the sooner the child is in treatment, the more results will come from the effort. Second it is important to have the child evaluated and treated for physically based influences that often co-exist with attachment difficulties. Once some of the physical and neurologically based difficulties are identified and treated, the child and family have more time and energy to deal with the attachment difficulties.

Treatment of attachment disruptions generally involves some re-learning of the attachment cycle so that the person is able to feel safer, more secure and is able to have more positive expectations about life. Even though your child may have experienced your love and care for many years, it does not mean that the worldview that was set in their foundational years will change on its own. It is common for children to have good parental care for many years, and still expect their current parents to change and become abusive toward them. They are waiting for "parents" to behave the way that their experience has taught them that "parents" do behave. Because of their worldview, many things that parents and others do are misinterpreted in a negative light, which reinforces that people and the world are scary and dangerous.

If disruptions in the attachment cycle are contributing to your child's mental illness, there are many ways to re-teach the attachment cycle. One way that is fairly straightforward and easy to use at home or in therapy is social scripts or social stories. It is best to write them out and let the child keep a copy. Some children use binders and collect them. The issue needs to be about something the child is genuinely worried about. It needs to be a situation where the possibility of success is high. The scripts follow the pattern of the attachment cycle and allow for a helpful out come. It goes something like this;

1. There is a problem coming up that causes anxiety (i.e. first day back to school). This is the "need" part of the cycle.
2. Catastrophize about what could happen (this is the "expressing the need" part of the cycle). It could be something like, I won't have any friends, people will be mean to me, I will be hungry and thirsty, the cat will miss me, I will miss out on the fun at home, I don't know how to do my work, etc. At this time it's important not to disagree with anything the child finds worry some. Adults and children have different worries. Kids often think adults worry about silly things (like running out of money when we can just go the ATM machine!)
3. Then make a statement like" But it's OK because" i.e. Amy or Sammy is my friend, I can use my skills or tell the teacher or aide on the playground if kids are mean to me, the cat will be OK because she has her toys, I will have fun when I get home, my special ed. teacher will help me with my work, etc .These solutions are just examples, solutions need to be real and accessible for the child. This represents the "need being met" part of the cycle.
4. End with something like "and then I will be happy to be at school" (the OK part of the cycle).

We all do this cycle when we are preparing for the future. For those of us who have had successful experiences with getting our needs met, and we problem solve with the expectation of successfully resolving things. How many of us when packing for a trip think of potential "disasters" and pack a little something in case it happens, even if we never use it; even if we haven't used it for the past couple of trips?

An example of a helpful social script is a session I had with a young girl who was adopted from China. She was very anxious at the end of the school year because she would be going to day camp part time, even though she had been there the summer before. As we were going through writing out a script for her, her older sister, who had been playing in the next room, came in and joined us. The older sister is a bright, secure, non-traumatized child. The older sister did not comment on the worries but made some great suggestions for solutions. This is when I realized that the older sister had mentally gone through this process herself, and because she was securely attached she assumed that the world and other adults would meet her needs, and did not have to be anxious. At the end of our list she also smiled at her sister and said "And I will be there too, so you can always come to me" and gave her little sister a hug. Our children can be so wise and compassionate at times. The younger girl then asked the page to be read to her, twice, and carried the page between both of her hands as she walked out of the office. Although there were still problems, the anxiety level of this child was significantly reduced.

For those of you raising children who have so profoundly lost their trust, I would like to express my respect and admiration. Your patience, endurance and efforts (even though at times imperfect) are helping to heal children who otherwise would have little hope. It is my hope that as you address the attachments needs that your child has, you will continue to see improvements in their healing.

Jan Tomski has a private practice in Lakewood Colorado and is the Clinical Director of Adoptive Family Resources. She has experience as a birth, foster and adoptive parent. She plans to write a book on raising children who have survived trauma. She can be contacted at jantomski@msn.com.

Bonding and Attachment in Maltreated Children: How You Can Help*

Handout #6

Dr. Bruce Perry

By Bruce D. Perry, M.D., Ph.D.

The most important property of humankind is the capacity to form and maintain relationships. These relationships are absolutely necessary for any of us to survive, learn, work, love, and procreate. Human relationships take many forms but the most intense, most pleasurable and most painful are those relationships with family, friends and loved ones. Within this inner circle of intimate relationships, we are bonded to each other with "emotional glue" — bonded with love.

Each individual's ability to form and maintain relationships using this "emotional glue" is different. Some people seem "naturally" capable of loving. They form numerous intimate and caring relationships and, in doing so, get pleasure. Others are not so lucky. They feel no "pull" to form intimate relationships, find little pleasure in being with or close to others. They have few, if any, friends, and more distant, less emotional glue with family. In extreme cases an individual may have no intact emotional bond to any other person. They are self-absorbed, aloof, or may even present with classic neuropsychiatric signs of being schizoid or autistic.

The capacity and desire to form emotional relationships is related to the organization and functioning of specific parts of the human brain. Just as the brain allows us to see, smell, taste, think, talk, and move, it is the organ that allows us to love — or not. The systems in the human brain that allow us to form and maintain emotional relationships develop during infancy and the first years of life. Experiences during this early vulnerable period of life are critical to shaping the capacity to form intimate and emotionally healthy relationships. Empathy, caring, sharing, inhibition of aggression, capacity to love, and a host of other characteristics of a healthy, happy, and productive person are related to the core *attachment* capabilities which are formed in infancy and early childhood.

What Can I Do To Help Maltreated Children?

Responsive adults, such as parents, teachers, and other caregivers make all the difference in the lives of maltreated children. This section suggests a few different ways to help.

Nurture these children. They need to be held, rocked, and cuddled. Be physical, caring, and loving to children with attachment problems. Be aware that for many of these children, touch in the past has been associated with pain, torture, or sexual abuse. In these cases, make sure you carefully monitor how they respond — be "attuned" to their responses to your nurturing and act accordingly. In many ways, you are providing replacement experiences that should have taken place during their infancy — but you are doing this when their brains are harder to modify and change. Therefore, they will need even more bonding experiences to help them to develop attachments.

Try to understand the behaviors before punishment or consequences. The more you can learn about attachment problems, bonding, normal development, and abnormal development, the more you will be able to develop useful behavioral and social interventions. Information about these problems can prevent you from misunderstanding the child's behaviors. When these children hoard food, for example, it should not be viewed as "stealing" but as a common and predictable result of being deprived of food during early childhood. A punitive approach to this problem (and many others) will not help the child mature. Instead, punishment may actually increase the child's sense of insecurity, distress, and need to hoard food. So many of these children's behaviors are confusing and disturbing to adults. You can get help from professionals if you find yourself struggling to create or implement a practical and useful approach to these problems.

Interact with these children based on emotional age. Abused and neglected children will often be

emotionally and socially delayed. And whenever they are frustrated or fearful, they will regress. This means that, at any given moment, a ten-year old child may emotionally be a two-year old. Despite our wishes that they would "act their age" and our insistence to do so, they are not capable of that. These are the times that we must interact with them at their emotional level. If they are tearful, frustrated, or overwhelmed (emotionally age two), treat them as if they were that age. Use soothing non-verbal interactions. Hold them. Rock them. Sing quietly. This is not the time to use complex verbal arguments about the consequences of inappropriate behavior.

Be consistent, predictable and repetitive. Maltreated children with attachment problems are very sensitive to changes in schedule, transitions, surprises, chaotic social situations, and, in general, any new situation. Busy and unique social situations will overwhelm them, even if they are pleasant! Birthday parties, sleepovers, holidays, family trips, the start of the school year, and the end of the school year — all can be disorganizing for these children. Because of this, any efforts that can be made to be consistent, predictable, and repetitive will be very important in making maltreated children feel safe and secure. When they feel safe, they can benefit from the nurturing and enriching emotional and social experiences you provide them. If they are anxious and fearful, they cannot benefit from your nurturing in the same ways.

Model and teach appropriate social behaviors. Many abused and neglected children do not know how to interact with other people. One of the best ways to teach them is to model this in your own behaviors, and then narrate for the child what you are doing and why. Become a play-by-play announcer: "I am going to the sink to wash my hands before dinner because…" or "I take the soap and put it on my hands like this…." Children see, hear, and imitate.

In addition to modeling, you can "coach" maltreated children as they play with other children. Use a similar play-by-play approach: "Well, when you take that from someone, they probably feel pretty upset; so if you want them to have fun when you play this game, then you should try…" By more effectively playing with other children, they will develop some improved self-esteem and confidence. Over time, success with other children will make the child less socially awkward and aggressive. Maltreated children are often "a mess" because of their delayed socialization. If the child is teased because of their clothes or grooming, it would be helpful to have "cool" clothes and improved hygiene.

Maltreated children have problems with modulating appropriate physical contact. They don't know when to hug, how close to stand, when to establish or break eye contact, what are appropriate contexts to wipe their nose, touch their genitals, or do other grooming behaviors.

Ironically, children with attachment problems will often initiate physical contact (hugs, holding hands, crawling into laps) with strangers. Adults misinterpret this as affectionate behavior. It is not. It is best understood as "supplication" behavior, and it is socially inappropriate. How adults handle this inappropriate physical contact is very important. We should not refuse to hug the child and lecture them about "appropriate behavior." We can gently guide the child on how to interact differently with grownups and other children ("Why don't you sit over here?"). It is important to make these lessons clear using as few words as possible. They do not have to be directive — rely on nonverbal cues. It is equally important to explain in a way that does not make the child feel bad or guilty.

Listen to and talk with these children. One of the most helpful things to do is just stop, sit, listen, and play with these children. When you are quiet and interactive with them, you will often find that they will begin to show you and tell you about what is really inside them. Yet as simple as this sounds, one of the most difficult things for adults to do is to stop, quit worrying about the time or your next task, and really relax into the moment with a child. Practice this. You will be amazed at the results. These children will sense that you are there just for them, and they will feel how you care for them.

It is during these moments that you can best reach and teach these children. This is a great time to begin teaching children about their different "feelings." Regardless of the activity, the following principles are important to include: (1) All feelings are okay to feel — sad, glad, or mad (more emotions for older

children); (2) Teach the child healthy ways to act when sad, glad, or mad; (3) Begin to explore how other people may feel and how they show their feelings — "How do you think Bobby feels when you push him?" (4) When you sense that the child is clearly happy, sad, or mad, ask them how they are feeling. Help them begin to put words and labels to these feelings.

Have realistic expectations of these children. Abused and neglected children have so much to overcome. And, for some, they will not overcome all of their problems. For a Romanian orphan adopted at age five after spending her early years without any emotional nurturing, the expectations should be limited. She was robbed of some, but not all, of her potential. We do not know how to predict potential in a vacuum, but we do know how to measure the emotional, behavioral, social, and physical strengths and weaknesses of a child. A comprehensive evaluation by skilled clinicians can be very helpful in beginning to define the skill areas of a child, as well as the areas where progress will be slower.

Be patient with the child's progress and with yourself. Progress will be slow. The slow progress can be frustrating, and many adults, espsecially adoptive parents, will feel inadequate because all of the love, time, and effort they spend with their child may not seem to be having any effect. But it does. Don't be hard on yourself. Many loving, skilled, and competent parents and teachers have been swamped by the needs of a neglected and abused child.

Take care of yourself. For parents and other adults, caring for maltreated children can be exhausting and demoralizing. Adults cannot provide the consistent, predictable, enriching, and nurturing care these children need if they are depleted; it is important to get rest and support. Respite care can be crucial for parents, who should also rely on friends, family, and community resources.

Take advantage of other resources. Many communities have support groups for adoptive or foster families; as an education professional, you might help by suggesting some, or asking a school psychologist or other counselor to do so. Professionals with experience in attachment problems or maltreated children can also be very helpful. You too will need help; don't be afraid to ask for it. Remember, the earlier and more aggressive the interventions, the better. Children are most malleable early in life, and as they get older, change is more difficult. Take advantage of this time to make a difference in a child's life.

*Adapted in part from: *"Maltreated Children: Experience, Brain Development and the Next Generation"* (W.W. Norton & Company, New York, in preparation)

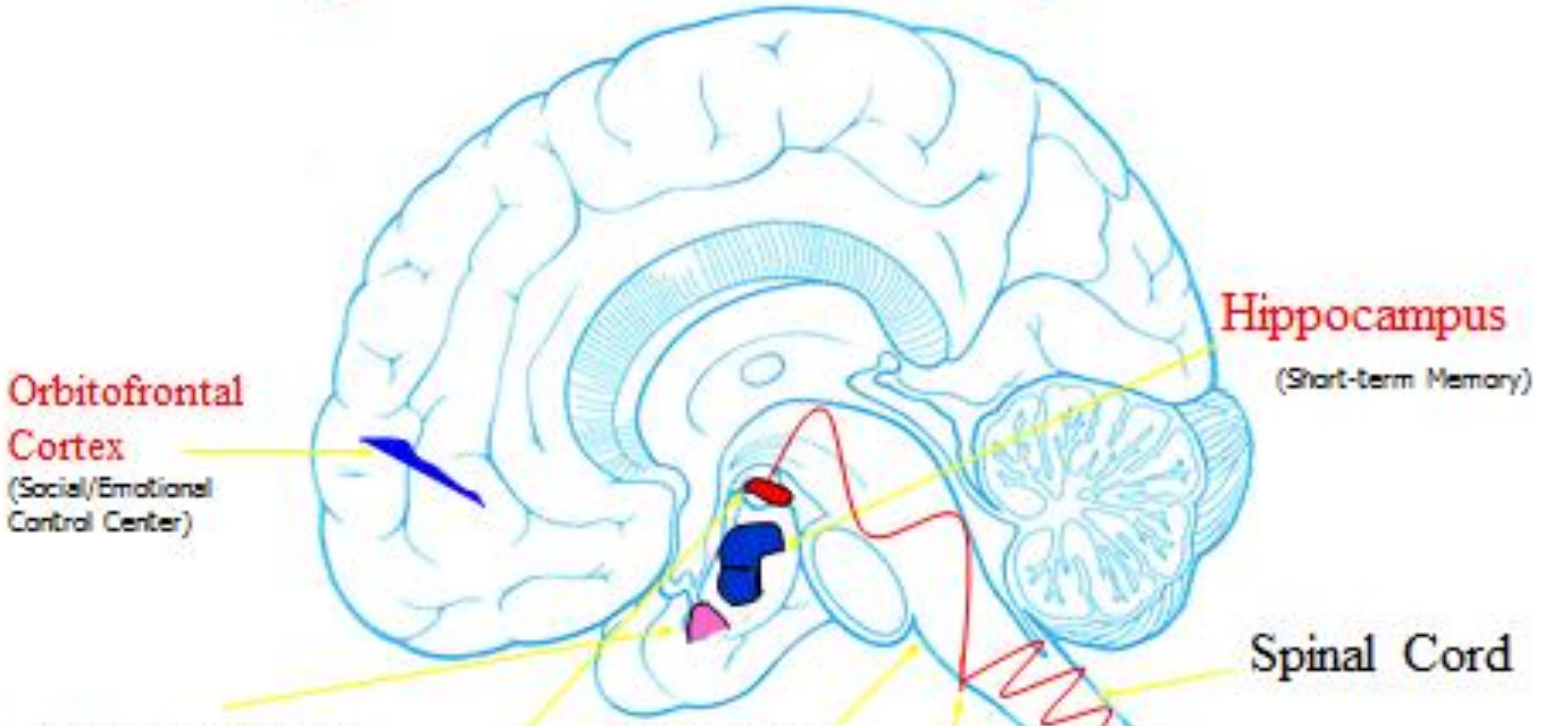
Back to top

SIDEBAR:

Dr. Bruce D. Perry, M.D., Ph.D., is an internationally recognized authority on brain development and children in crisis. Dr. Perry leads the ChildTrauma Academy, a pioneering center providing service, research and training in the area of child maltreatment (www.ChildTrauma.org). In addition he is the Medical Director for Provincial Programs in Children's Mental Health for Alberta, Canada. Dr. Perry served as consultant on many high-profile incidents involving traumatized children, including the Columbine High School shootings in Littleton, Colorado; the Oklahoma City Bombing; and the Branch Davidian siege. His clinical research and practice focuses on traumatized children-examining the long-term effects of trauma in children, adolescents and adults. 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.

Handout #8

Important Brain Systems



www.alvaradoconsultinggroup.com

The Power of One

Become the change you want to see in the world, starting at home…..

Note to the reader: If you are an adoptive or foster parent, about to read this article, please understand that the majority of children placed into foster care settings, or who have been adopted out of foster care, have suffered trauma. Trauma can and often does lead to emotional regulatory dysfunction which can lead to attachment challenges. In order to effectively parent children in this group it takes a deep understanding of Trauma, Regulation and Attachment. Unfortunately, most of us trained to foster or adopt children are not provided this information.

For more information, please visit www.coaching-forlife.com.

Attachment Disorder: what is it anyway?

Simply put: Children who grow up in the first 3 years of their life(or any portion of, beginning in utero) without parents who can lovingly meet their physical, social, emotional and psychological needs, often form what we call attachment challenge, or attachment disorder; simply put: if they learn early that adults can not always be trusted to care for them, they will grow up continuing to believe that adults can not take care of them and meet their needs and will even begin to believe that they are not worthy of being taken care of. They learn that it is not safe to attach to anyone, because 'anyone' continues to let you down!! Then…. that belief formed out of one or two early relationships gets transferred in their brains to *every other* relationship that presents itself. Children who learn that they can not trust others with their needs become older children who continue to believe that others are not to be trusted. And older children who grow up this way become adults who continue to believe that the world is bad, nobody is to be trusted, love is just a façade and that they must be meant to spend this life merely existing from one short lived relationship to another just getting out of each one whatever they can. Out of this faulty belief system children often begin to act in ways to prove to the world that they can not be taken care of by you or anyone and often begin to attempt to prove to us that they are right---we love and love and love them the only way we know how, and it appears that they want nothing to do with our love. Their emotional regulatory system which should allow for the emotional ups and downs in life always bringing us back to a calm state, does not develop and these children stay wired for emotional states that are dysregulated: either way up or way down, but struggle to remain emotionally stable in relationship.

A young woman approached me in a lecture just last week, telling me that she resonated with what I was saying. She went on to say that she had been raised in foster care and not once, in the multiple homes in which she lived, did she arrive thinking, "this is home and my family" or "finally a place to call home"…in her words quoted. She continued with…' foster homes were a place to get what I needed for a short time, until they moved me to the next home. I didn't really care about relationship because I didn't know what that was……'

Know anyone like that, child or adult?

The professional, clinical view: Reactive attachment disorder (RAD) is a mental health diagnosis listed in the Diagnostic and Statistical Manual of Mental Disorders (DSM-IVTR) under disorders usually first diagnosed in infancy, childhood, or adolescence.
Initially introduced to the mental health community over 20 years ago, this diagnosis has leant itself to a sad, hopeless and even dangerous picture of children who have attachment challenges.
Children with RAD have even been labeled antisocial. Many of the therapies available to treat this group of children are aggressive, confrontational, fear based approaches with the objective of controlling children and forcing attached relationships through the breaking of will, I call it the breaking of the soul, and hoping that through this process of breaking the child will allow him or her to rebuild relationship with a new caretaker. Most therapies are child centered instead of family centered which often just leads to increased frustration on the part of the parents who also need much support to parent these children.

The parent view: My RAD child is depressed, doesn't relate, doesn't seem to care about anyone but herself, or my RAD child is out of control, defiant, mean, and hostile; gets kicked out of school, can't make friends, is really hard to live with and is making my life miserable. HELP!!!!!!!!!!!!!!!!!

Sound familiar? This was my life. This was how I lived. This is what I thought foster care was like; just being and feeling miserable, existing day to day, determined not to give up, but hating how trapped that made me feel. Where was the loving parent I knew I could be?

Attachment Disorder is caused due to unhealthy relationship for children early in life. We used to believe that once children had been severely neglected or abused early in life and developed attachment challenges(and scary behaviors!) they would remain that way for life. That those patterns were set and could not be changed.

Children with attachment disorder can act in ways so scary that some of these children end up being placed in an institutional setting for years, even life: For 20 years I have worked with children placed in residential/institutional settings, group home settings, psychiatric hospital settings, foster and adoptive care. I have worked with some children who lived in an institution for more than 10 years!!!! And one little girl who was placed in an institution at the age of 3!!! Imagine…placing your 3 year old in an institution because you could not manage her??? Ok, ok, I hear some of you from wherever you are all the way to Colorado where I am!! You are saying, "of course I can imagine that. You ought to see my kids!"

And to that I say, I do hear you, I used to be you-and now know that there is a better way!

A way that I want to teach you about:

The Better Way:
In the last 15 years the amount of research on attachment, trauma and regulation have given us a deeper understanding of these children, of how they develop, of what attachment really is and How To Heal from attachment disorder…yes, HEAL from Attachment disorder that is caused out of unhealthy relationship.

Trauma that occurs in the context of relationship CAN be healed, but only in the context of relationship!

The Better Way: THE POWER OF ONE!

Children are born dependent on another for all of their needs. As those needs are met, children learn to trust others and at the same time, learn(brain development)to remain calm awaiting their needs to be met. And they continue to learn to wait longer and longer for their needs to be met(ie, feeding times spread further and further out; learning to sleep on their own), eventually learning to meet their own needs while in relationship with someone they trust to catch them anytime they fall(this is even the pattern that continues to exist between older adolescent and young adult children and their parents when there is evidence of healthy attachment. I moved out of my parent's home for the first time at 18 years of age, and back in at 19 and then out again at 26 for the final time!)

When this is the case, children attach to their parent or caretaker and then learn from that first critical relationship how to relate to, trust in and attach to others, such as a life long partner.

However, when the opportunity to attach to first, critical relationships with parents or caretakers is not there due to children living in traumatic environments where parents are incapable of meeting the needs of their child(neglect, abuse, addictions, domestic violence etc), the development of the regulatory system in our brain takes a hard hit and those children learn that others are not to be trusted. A healthy emotional regulatory system in our brain leads to healthy attachment to others. John Bowlby, the father and first teacher of attachment, was known to say that the first relationships for humans become the blueprint for all future relationships, and he was right! When children are suffering stress at an early age and that stress is chronic and consistent, that stress experience is 'traumatic'. And when children live in a consistently traumatic environment that trauma affects the ability of those children to develop optimally. If we learn healthy attachment with our parents or first caretakers, we learn to have healthy relationship with others in the future!! But if not, than we become attachment challenged(I prefer not to use the word Attachment Disorder; disorder indicates to me that something is broken. I do not see children as broken, but as challenged instead). In fact, Hans Seyle, a psychiatrist who first taught us about stress decades ago, said that when we are stressed, we all become challenged in our ability to remain attached to

anyone. Think about the last time you were really stressed out…did you want others attaching to you, talking to you, touching or holding you and telling you what to do how to do it and when and where to do it?

Many of our children in foster care and then adopted have lived in stress and trauma and have not developed optimally-therefore do not learn to attach, to relate and to trust others as other children may.

We may have to go back and provide for these children what they did not receive during those early critical years. We may have to provide for older children what younger children needed. We may have to treat our children like they are the age they act when they get stressed….if you have a child with baby talk, or whining or very young behaviors they are only saying to you the only way they know how, that that is the age at which they are emotionally functioning. They are saying they have needs that were not met at a younger age and until those needs get met they can not develop into more mature stages…….you learn to sit, crawl, stand and walk in sequential order……your emotional development is the same. You can not become emotionally mature if your emotional needs at younger ages have never been met. You will continue to regress to younger emotional states when stressed.(many therapies punish or condemn regressed behaviors. This can be traumatic for children. Please visit me at www.coaching-forlife.com for further information)

Regressed behaviors are only a symptom of stress

As parents, is it not incumbent on us to reduce stress for these kids whom we have committed ourselves to? Is it not an inherent responsibility to provide a stress free environment for children who come to us out of pure stress? Did we not commit to loving these children back to healing?

When we see only the behavior and not the stress underneath, we ***react*** to the behavior. However, when we understand that behavior is but a symptom of how we feel inside, and that all negative behavior comes from feeling bad inside, then we can move to a more compassionate understanding of the child's emotional state. And when we can see what looks like an angry, defiant, aggressive, hostile child on the outside, but feeling miserable on the inside, we can choose to ***respond*** to the inside emotional state which if calmed, will immediately cause a decrease in the negative behavior on the outside.(how nicely do you act when you are stressed out???)

Respond vs. React: Are you a loving responsive parent or an angry reactive parent?

When children are stressed and act out, and then we get stressed and react, the entire relationship is stressed. And then the entire family is stressed and then the entire classroom is stressed and then the entire school is stressed and then the entire community can get stressed….Follow me?

The Power of ONE
Regulation is Relationship Dependent
You can be the one to make the difference in the life of a child, FOREVER

If, as the responsible, responsive adult in the relationship
**we take the stand,
**remain calm,
**understand that any negative behavior is but a symptom to bad feelings inside,
**and work to decrease the internal stress of our child,
**figure out what is stressing him out,
**talk about it,
THEN…. we can move to teaching a better way.

YOU **CAN** PUNISH A STRESSED, acting out, CHILD

YOU **CAN** HUMILIATE AND YELL AT A STRESSED, acting out, CHILD

BUT……

YOU CAN NOT TEACH A STRESSED OUT CHILD

Stressed out brains can not take in new information, process information or learn. The adult's level of regulation or calm state, will directly impact the child's. The child can only be as emotionally regulated as the adults. Calm yourself, calm the child, teach the child, have a more loving and peaceful home!!!

Sounds so complex yet is so simple. Sounds so simple yet can be so complex!!!!

Work to reduce all stress in your home, work to keep yourself stress free first. Work to provide emotional needs for children at whatever age they act when stressed. Spend one on one, fun time with your children every day.

YOU be the ONE to become the loving, peaceful, regulated, attentive, content, happy, joy filled person that you so want for your children, and watch what happens.

Then watch the negative behaviors begin to decrease. Don't do anything else, just this and watch the negative behaviors decrease.

Watch for my next article with specifics for increasing peace, and regulation in relationship at home and in the office!

Until then,
Breathe, appreciate something everyday, love what you have and vision what you want!

Please copy, distribute and share this article with as many others as you can! We would just appreciate a reference to Coaching For Life and Juli Alvarado, with our contact information included. Please contact us at www.coaching-forlife.com or info@coaching-forlife.com for further information.

Getting and Staying Regulated!

Many of you have written to me over the years with suggestions for getting and staying regulated, so I thought I would share your ideas and add a few of my own.

If you are still in need of further understanding of Emotional Regulation, please visit me at www.coaching-forlife.com and visit our Resources and Links page for articles, research and further information on utilizing emotional regulation to create more joy, peace and contentment for you and your loved ones!

AWARENESS: unless you are aware of that which dysregulates you, you can not create an environment opposite to that for your healing. We must first take a look inside, figure out what stresses us, what frustrates us, where are we discontent and where are truly content. We must energize a **support system** around us so that when we simply need to be heard, we can be heard!

INTENTIONAL: we must become diligent and intentional in our work to become more emotionally regulated every day. You can accomplish this through prayer, meditation, taking in nature and exercise. If your nervous system does not have a break to calm down consistently, it can not calm down. Give your nervous system a break, everyday, by **creating calm, quiet, peaceful experiences** for yourself first so that you can provide that for your family as well.

LIFE BALANCE: this one is very hard, but oh so necessary. If you are working to leave a legacy to your children and family of **love, peace and fun**, how can you do that if you don't have those things in your own life? You must create a balance, every day, between family, work, and taking care of yourself. Give yourself permission, even if others don't like it, to be good to you, so you can be good to others.

FORGIVENESS: holding onto resentment, fear, anger and sadness just fill you up with more anger, resentment, fear and sadness. How can you be full of joy for your family like that? Learn to just let it go-take responsibility first for the forgiveness that we are all in need of at some time. Do you want others to see you as loving and forgiving, or angry and resentful? If you need to forgive yourself for the parent you were in the past, do it. We all do the best we can in any given moment from what we have learned from where we came. If you are choosing to be a different and better parent now, just do it. The past is gone, You only have now….

REGULATION IS RELATIONSHIP DEPENDENT: your children can only be as regulated as you are in relationship. Do you need to pay attention to your marriage or your other adult relationships that are providing the model for your children to grow into? If your children are dysregulated do you get dysregulated? Maybe we need to look at us as parents taking full responsibility for regulation first. The Coaching For Life audio program, Regulation is Relationship Dependent is a great tool for increasing awareness, education, understanding and the means for getting regulated so that our children may do the same!

SENSORY STIMULATION: remember your regulatory system is affected by the sensory input, what you hear, taste, touch, smell and see. Are your surroundings calm, soothing, tranquil and content? If not, what can you do to change that, now?

FUN and JOY: I don't believe that any of us have enough fun! God intended for you to be happy, to be filled with his joy and his love. If you are dysregulated you can not enjoy the benefits that he wants so badly to provide you with. Do something that makes you **smile and laugh**, every day.

BREATHTING: the quickest way to calm down in any situation, anywhere with anyone, is to simply breathe. Breathe deeply and watch your body/mind relax. When we are stressed and anxious we often stop breathing, literally! This will kill you-Breathing can save you. The next time

you find yourself becoming dysregulated, simply begin to breathe deeply and slowly, nothing else. You will find that the clear thinking you need will more quickly return as you breathe.

TIME OUT: never for your kids, but for you if needed! If you are at the point of blowing, you have permission to give yourself a time out. Let your children or loved ones know that you will be back, that you just need to walk away for a few minutes. That is must less damaging than what may slip out if you stay!

TRIPLE A's: affection, attention and attunement. Your kids need this everyday, but so do you. Create relationships that are full of affection, that provide you with the attention you need, and that are attuned to your needs and wants. The more of these you get, the more you can share!

Regardless of the situation you are in, the relationships you are in or the challenge your children may presently pose, there is no family, and no relationship beyond the hope of healing. You can do this, you can find, create and live in more peace, joy and abundance. It is yours for the taking. There is nothing that you can not do, or be or become. I, and so many of my clients over the past 20 years are testimony to this truth.

Please reach out, if you need support, ask someone. And if you need some professional guidance, contact us. We would be honored to support you on your journey in Life.

Decreasing Disrupted Placements and Failed Adoptions
through
Emotional Regulatory Healing,

Juli Alvarado, MA, LPC, NCC
www.coaching-forlife.com
866-570-0604

The majority of disrupted foster care placements and failed adoptions happen due to behavioral presentations that foster and adoptive parents determine are not acceptable in their families and homes. These behavioral presentations are often not well understood and lead to increased stress in our families, stress in our marriages, frustration, hopelessness, and even feelings of inadequacy on the part of the parent; and worse of all, children being moved *yet again*…..The plight of the foster and adoptive parent is often the focus of training, but rarely the focus of treatment-instead focusing on the identified child in treatment, leaving the family isolated, misunderstood, feeling judged and in the dark, again. Emotional Regulatory Healing is a family based method of treating trauma, attachment challenges in the entire family system and dysregulation that often leads to burnout for foster parents and even the dissolution of adoptions.

There is hope in Healing~
As a therapist, a child welfare administrator, nation wide consultant, mother of 4 and Treatment Foster Parent of 15 years, I have finally found what works, even for the most challenging of children, in my home and in my office.

Emotional Regulatory Healing, through Emotional Regulatory Parenting (ERP) and Emotional Regulatory Therapy (ERT), and its success, is based on solid neurological, psychological, biological, physiological and human development research, shared herein. Regulatory healing practice is a gentle, but structured and focused, love based practice geared toward reduction of even the most severe behaviors. The past two decades and the new field of neuroscience have taught us that children whom have suffered even the most severe trauma and children, who present with even the most challenging behaviors, are not beyond the hope of healing. But children who has suffered at the hands of angry, controlling, manipulative and uncaring adults will more effectively heal in treatment and with providers who are the opposite: unconditional loving and caring, non confrontational, not controlling or manipulative and gentle, not angry.

We find many children in the child welfare system, either in foster care, in adopted families, in residential treatment centers, day treatment programs and inpatient hospital settings, whom have suffered a life that few of us can actually comprehend at any real level. And that trauma has life long implications for those children; one of which is often a negative behavioral manifestation lending itself to even more challenging implications such as diagnosis of mental illness, institutionalization, and few if any long term opportunities for healthy attachment. And this, then, lends itself to children who become adults in our society, with the same lack of internal ability to *regulate* emotions, behaviors, social situations and life. And we know what happens to those adults.

The amount of money that our child welfare system spends on treatments for this population is astonishing and the level of success in these programs is not nearly high enough to warrant continuing to treat difficult children with the therapy models most often taught. Outcomes based

research projects are necessary and warranted, however, just as I learned in my graduate psychometric studies, you will find too, that outcomes can be manipulated and molded and reported in biased ways. If you want the truth of what is working in our child welfare system, just ask any therapist or social worker or foster or adoptive parent of very difficult children-they will surely inform you that not much works long term with our very difficult children. (go ahead, ask at least 5 parents or professionals and then communicate with me(info@coaching-forlife.com) to let me know how effective they feel current treatment modalities are in treating very difficult behaviors) And ask the children too; they too will inform you, as they have me over many years, that most of us just don't get it! *Therapy focused on the child is minimally effective in supporting the maintenance of difficult children in out of home care or challenging children in adoptive homes.*

Regulatory healing and practice is intended to treat even the most severely traumatized clients through a deep understanding of Trauma, Attachment and Regulation. Well noted authors such as Bruce Perry, Alan Shore, Daniel Siegel, Candace Pert, Bruce Lipton, and many others have been writing for a decade about the mind/body connection and how that mind/body system is impacted by developmental trauma. The experience of trauma propels our stress response, or our *regulatory system* into becoming activated causing a cascade of internal mind/body communication. When there are repeated traumatic, scary experiences our mind/body stress response system, *our regulatory system,* becomes hard wired to remain on alert at all times, in search of any impending threat. This can and does actually lead to underdevelopment of some parts of the brain necessary for attachment, relationship and cause and effect thinking. .Once the brain is wired to function in that way, it, the brain, utilizes all resources, cognitive and emotional, to survive possible attack. Therefore those resources, cognitive and emotional, are too busy to function as they should, ie: learning, social relationships and attachment. In addition, when our mind/body is on high alert for possible threat, our physiological system falls under attack as well, and manifests high blood pressure, increased heart rate and hyper vigilance. These physiological manifestations can cause what looks like angry, hostile, aggressive and defensive behaviors in children, although the reason for those behaviors is at times unconscious and unknown by the child and more importantly, the caretakers. *Foster and adoptive parents often assume the child is angry and mean, when in reality the child is scared to death and fighting for survival at every neurophysiological level.*

After two decades of working with child welfare and mental health I know that the goal of most child welfare programs is to protect children and families. However, many of their operations such as investigations, mandatory court appearances, removal from homes/families, foster placements, mandatory therapy etc, may actually reinforce the child's view of the world as hostile, threatening, scary, unknown and uncontrollable. These experiences actually contribute to a traumatized child's 'catalog' of threatening situations. In addition to this unintended outcome of our child welfare system, many county and states as well as private agencies have not yet created effective training programs for social workers and clinicians including development of brain, trauma manifestations, and parenting paradigms known to counter the child's earlier trauma experiences. *The intention of this author, teacher, foster parent and therapist is to support foster and adoptive parents in supporting all children, by filling the gap of understanding of Emotional Regulatory Healing.*

To the extent possible the child welfare macro-system must, now, not later, address deficits and reform practice and policy to provide consistent, repetitious, nurturing, and predictable environments for every child for whom we take responsibility. It is incumbent upon each one of us, with this new research in hand, to diminish the fearful nature of child welfare as we know it

today, for children. And accomplishing this huge, but necessary task, requires that stakeholders at all levels in child welfare receive specialized training establishing outcomes that focus on long term healing from trauma, not just behavior modification. Judges, GALs, highest level administrators, managers, supervisors, all front line staff and most importantly the foster and adoptive parents, must be included in systemic training.

Although I have the years of graduate and post graduate clinical study that afford me lots of letters after my name, it is not in the title, the letters, the degrees or diplomas that I hold that prompts me to engage in a life of research on human healing. It is instead out of my own struggles, and my own pain; and it is out of the struggles and pain and abuse that the more than 30 foster children for whom I have cared for in my home and the multitudes of foster children in residential treatment centers, inpatient psychiatric hospital settings, day treatment programs and special needs preschool programs with whom I have worked over the past 15 years that compels me to continue my own healing journey, and to travel that with the many children whom I have been so blessed to care for, to learn from and to suffer with. For I know, it is out of great suffering that the greatest healing can occur.

In order for healing to occur for the foster or adopted child, healing must occur in the family system. The model I teach, and have found more effective than any behavioral modification program, or any cognitive/behavioral method, and far more effective than levels, charts, points and bribes, is:

Emotional Regulatory Therapy and Emotional Regulatory Parenting

Tenants of my model are:

1)All therapy should be directed at the family unit, not individuals.

2)All therapy should be directed at support for the foundation of the family, the parents.

3)There must be a solid psychoeducational component in regulatory development and healing integrated into the therapy process with the parents.

4)The therapist must be skilled and experienced in their own regulatory work so that they can become the foundation for the parents as the work begins.

Emotional regulatory therapy is focused on the parental dyad or single parent who is taking responsibility for the level of regulation in the family system. Regulation, the ability to remain in a state of calm arousal, or the ability to return to this state after an experience of fear, is a necessary ingredient in any family environment, and mostly in the foster or adoptive family environment who is now caring for a dysregulated child. *Regulation is relationship dependent. The child will be only as regulated as the parent.*

This model of therapy supports the parents in a deep exploration of their own regulatory development through a review of history into their original families, their childhood and their relationship with parents. Making the connection between the parent's personal history and their current parenting paradigms allows for great understanding of the dynamics at work in present functioning. In addition, a review of mutigenerational transmission of values, morals, feelings, thoughts and family story allow for even deeper understanding of the roots of the parents, who can then apply that deeper understanding and knowledge to the same journey for their children.

All interventions are geared toward increased regulation on the part of the parents. If the parents are suffering challenges in marriage, work, or financially, they will remain in a state of dysregulation, unconsciously and unintentionally at times, leading to higher levels of dysregulation for the children in the home. It is important to focus on and work through the needs of the parents first, before addressing the family system.

Psycoeducation in developmental trauma, trauma that occurs during critical stages of brain development, and of regulatory development and healing is necessary for the parents in order to gain a deeper understanding of themselves as well as their child. This understanding of the neurophysiological impact of trauma and the social/emotional/behavioral manifestations of such, will become imperative in creating a parenting paradigm that assumes responsibility for the provision of needs of children that should have been met way back, but must be met now in order for healing to occur. As children have needs and those needs are met consistently, their brain develops in an organized manner allowing for healthy relationship to grow in trust and mutual respect. However, when those needs are not consistently met the brain develops in a disorganized manner not allowing for healthy relationship.

When our foster and adopted children whom have experienced trauma move into states of dysregulation, only a highly regulated parent is capable of providing soothing. Parents must come to understand the functioning of the brain/body system in response to trauma and how that manifests into behaviors over the years before they can effectively provide a healing environment for that child. The therapist will learn and then teach the parents that many of our children are suffering from underdeveloped emotional brains. In learning about and understanding the psychophysiological dynamics at work within the child, the therapist and then parent are taught to create a regulated, healing environment for the child. With repeated dysregulated behaviors from the child being met with repeated understanding and regulation by the parent, the once damaged self regulatory process in the child can begin to heal. However, parents who react from a dysregulated state will only serve to increase the dysregulation for the child leading to even more negative behavior. Learning the difference between dysregulation and defiance allows parents to make healing decisions for their children, before moving to discipline or punishment.

Many parents have experienced trauma or loss themselves and have not worked through those experiences toward healing. Those residual experiences can shape the parenting paradigms they utilize not allowing for healing for the child either. It does occur that

engrained dysfunctional patterns of relating from past harmful relationships continue to play out unconsciously in present day relationships. Because most of this is unconscious to us, the regulatory therapist must be well aware of their own history, their own strengths and weaknesses and must be open to support in supervision so that they can remain the regulatory foundation for the parents during difficult times.

Emotional regulatory parenting assumes that the parents will take responsibility for healing and change within the family system and that healing and change must start with the parents first. The parent's level of regulation will become the vehicle for the reparative state for the child. Dysregulated parents typically move into anger and blaming the child for the behavior, or for disrupting the family or for causing everyone more stress. The trained regulatory parent will see that the child's behavior is but an indication of an unmet need, past or present, and that in repeated meeting of that need the behavior will subside. It is the responsibility of the parent to begin to meet that need before the child acts out to get the need met.

In an emotionally regulated environment, the damage done due to developmental trauma can be repaired. We know that the longer a child has been exposed to trauma the longer it may take for healing to occur. However, we also now know that the part of the brain where emotional regulation develops, the frontal cortex, is open to change throughout the lifespan supporting my belief that there is no child or adult beyond hope of healing. When regulated environments are created for these children we are not only providing good care, we are providing learning and the opportunity for needed brain development.

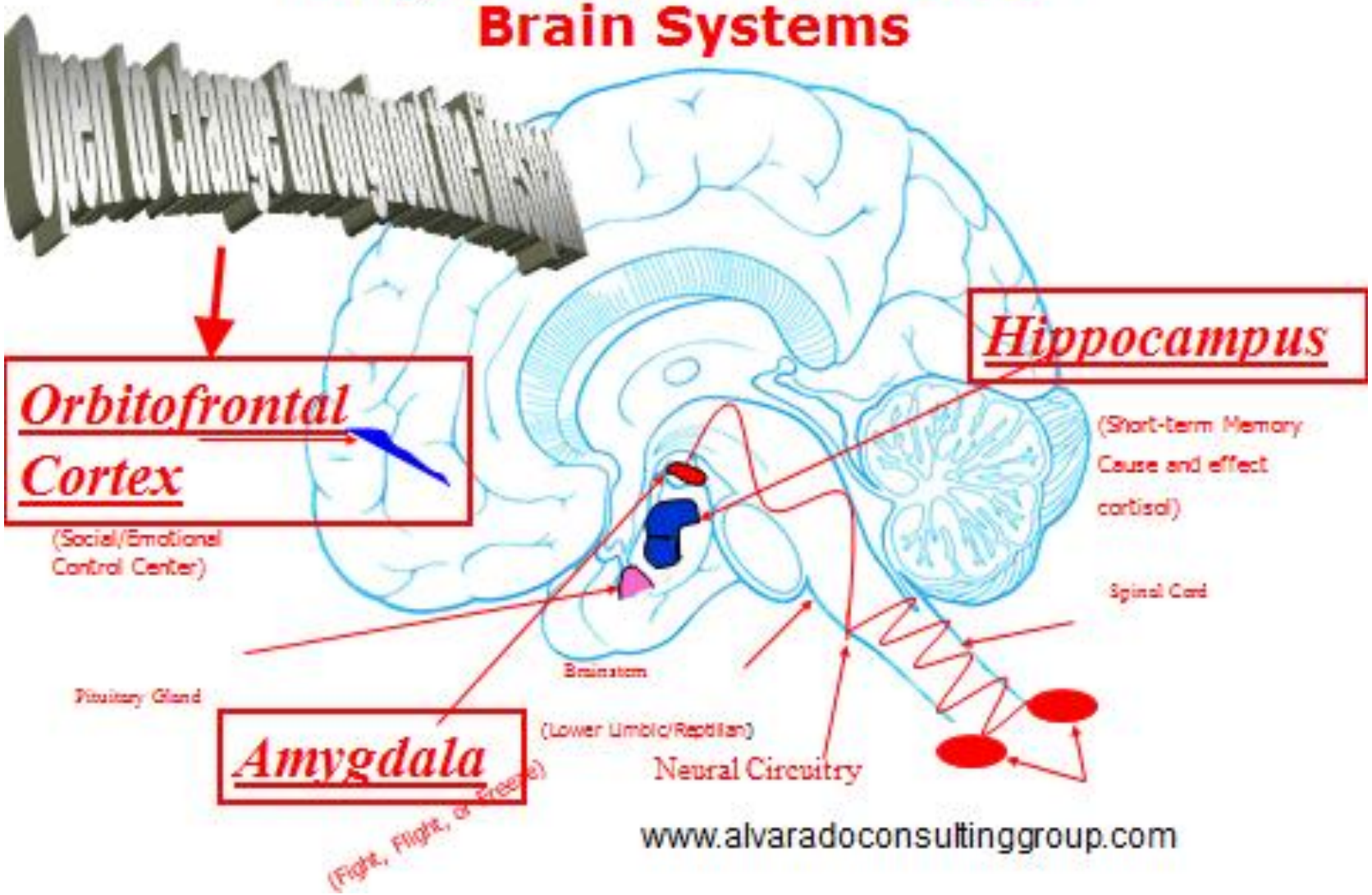
Parenting children of trauma is not easy, it is not always fun and it is not well understood by those who have not attempted it. The toll it can take on family systems, marriages, agencies and even county and state departments is large. . With new research on developmental trauma, brain development and regulatory functioning, it is time to understand why behavior modification and consequences don't work well in parenting some of our children. And truth be told, these children have paid consequences in this lifetime already that most of us can not imagine. Until we are willing to break old molds, teach new paradigms, provide a strong foundation for our foster and adoptive families, we will continue to see the macrosystem of child welfare in the state it is in, which for the most part, is not good.

It is not the fault of the system, it is not the fault of the governor, it is not the fault of your caseworker or your partner. It is nobody's fault. It just is.

However, as part of the system that is hurting, I challenge you each to work to improve your part of it. Just your part. To make one decision today that will lead to healing change for one child, one family, one day at a time.

Handout #9

Regulatory Components: Brain Systems



www.alvaradoconsultinggroup.com

Special discipline for special children:

Juli Alvarado, MA, LPC, NCC

Coaching for LIFE® 2009

Many Parents contact us at coaching for LIFE regarding effective and appropriate discipline for children who struggle in their attachment systems. We have found that traditional discipline does not typically work for our children, yet know that there must be a way to teach that is aligned with healing for children of trauma. You have tried taking away their 'stuff', you have tried time out, you have tried yelling and screaming and jumping jacks and grounding and everything in between. Nothing works. Here is why, and more importantly, here is some hope for hurting parents and children.

The danger of traditional discipline with most of our children is that it assumes that our children can take in, process and learn from (after all discipline is about teaching isn't it?) complex information in complex relationships (foster and adoptive families) and to then make logical and rational decisions about what to do with the information that they have just taken in. Most children who have been raised by their biological parents in a stable, loving and healthy family can absolutely do that! For example: Johnny who is 14 doesn't show up after school. Mom becomes very worried and begins calling his cell phone and his friends to no avail. She decides to drive to the school to check it out for herself, and lo and behold, who does she see but Johnny playing football with his buddies! Johnny knows the instant that he sees mom that he is in trouble. *Yet in that very same instant Johnny knows that he is also safe.* His brain can manage that conflicting information as he tosses the ball to his buddy, hangs his head and walks over to mom who simply says, 'get in, we need to talk.'

However, we know that children who have suffered trauma (foster care and adoption included: see www.coaching-forlife.com for more information), may very well be delayed in certain areas of brain development that would allow for structuring and organizing information that comes in and then making rational and logical decisions about what to do with that information in the moment. So if in the example above, Johnny is a child who has suffered some trauma, has lost his original family, is living in a different family system, his brain may register *being in trouble as being in danger.* And when we are in danger, we immediately move into fight, flight or freeze mode; we fight back, we run, or we simply freeze and can not even respond! (How many times have you tried to talk to your child and he/she just stares at you, almost like they can not even hear you, like that 'deer in the headlights look?...this is freeze mode)

The brain is an amazing, historical organ. It manages to store memories from prior to birth. Our earliest memories remain stored in what is known as state level memory which is unconscious, yet which directs every future level of memory development. This is why children, who are adopted even at birth, may struggle in attached relationship to their families; the unconscious memories of separation by the biological mother are forever stored and get triggered during times of stress, such as being in trouble. When the brain

becomes stressed, it experiences a state of threat; and when any of us experience threat we immediately move into fight, flight or freeze.

Think for a moment about the reaction of your child to discipline that you have been using that has not been effective. All of their reactions will fall into either fighting you (anger, defiance, refusal, combative, hostile, threatening) or running from you (running away, depression, isolation, refuse to talk) or freeze (stare at you, answer your questions with 'I don't know' consistently).

The only time the human condition is pushed into fight/flight/freeze is during threat and fear. But what on earth could my child be sensing as threat and fear? She/he has been with us for 16 years and we adopted at birth? I can hear you loud and clear and after more than 20 years in the field and 15 as a foster parent, I know.

For the purpose of this article, suffice it to say that there are memories and patterns laid down in the brain, that are highly sensitive to any threat, and having been adopted or being in foster care, means having been separated from the biological family which is threatening. That identity of separation for children is recorded even at birth through sensory memories; what biological mother smelled like, sounded like and even the rate and sound of her heartbeat. Babies in utero have auditory and psychological processing by the 4th month of pregnancy and absolutely experience fear and stress even prior to birth. This experience leads to heightened sensory experiences as they grow and develop and often emotional regulation and attachment challenges. With decreased emotional regulation and attachment challenges come negative behaviors which require discipline, yet everything we have been taught to do, that we watched our parents do and that we have effectively done with other children doesn't work. What now?

Traditional discipline instills fear in our children when it is fear that we are working so diligently to distill. Fear is riddled with shame and humiliation and many of our children come to us full of shame and humiliation already. Increased fear in children tends to push them away from us, instead of bring them closer which is our goal in attachment parenting. And fear and isolation from parents and family leads to increased risk of antisocial behavior including crime and substance abuse.

Instilling fear in children by yelling, screaming, harsh words, harsh tone of voice serves no purpose and actually increases the fear, shame and humiliation our children may already experience.

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Studies show that spanking and other physical punishment create more behavioral and emotional challenges, not less.

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Harsh, physical discipline promotes violence as acceptable means for solving problems.

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Controlling and manipulative discipline wreaks havoc on the attachment bond destroying trust and reliance for safety.

Let's look at a more gentle, and healing method of discipline~

First, I offer to you *that you can not give away that which is not yours to begin with*. You can not provide sanctuary at home, peace in your family and tranquility in relationship if you do not first experience them yourself. It is a sign of strength, healing and growth for any parent to examine their own childhood and current relationship experiences for indications of how they may be negatively impacting their parenting paradigms today. Seeking support or help when we know that we are more angry, frustrated and unhappy with our children than not, is a first step.

Second: an ounce of prevention is worth a ton of intervention!

Special discipline begins at birth when the bonds of attachment and trust are first being formed. As parents respond consistently and compassionately to all of their infants needs the foundation of discipline is set. (responsive relationship and responsibility)

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Positive discipline involves using prevention, distraction and substitution to gently guide children away from the situation. However, many of our children can not respond to distraction and may need to be gently moved from the situation and possible harm.

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After the child has been removed and after safety has been assessed for, we will need to move into highly attuned relationship with our child, seeing the situation through his/her lens. Much more on this in the workshop~

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Listening to behavior instead of reacting to a child's behavior allows us to understand their needs. They may have no other way of communicating to us, in the moment, what they are experiencing internally and exposing externally.

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Working to resolve any problem together instead of using time out, or 'let me know when you figure this out' leaves everyone's dignity in tact. Dignity is vital for our children.

****

When we are stressed, we emotionally regress. It is important to see the behavior at the developmental level of your child, perhaps not the chronological age.

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Children will learn more through what we do than what we say. Modeling gentle, empathic, understanding, quiet and calm responses to them at all times provides more opportunity for them to develop these same traits. Remember, these are the children who may some day, care for us.

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And remember, we are not perfect; when we have reacted in ways of anger, frustration, intolerance or tension, we absolutely can repair that later with a simple, 'I am sorry, this is not the parent/person that I want to be. Can we start over?"

Parenting paradigms of the past may not work for our children, yet integrating a new parenting paradigm takes time, conscious effort and intentional energy.

Be gentle with yourself, get support, talk to others. Consider this list below and how you can integrate this information into who you are today~

Special Tools for Special Parents of Special Children

- Maintain a positive relationship
- Use empathy and respect
- Research positive discipline
- Understand the unmet need
- Work out a solution together
- Be proactive
- Understand the child's developmental abilities
- Create a "yes" environment
- Discipline through play
- Change things up
- State facts rather than making demands
- Avoid labeling
- Make requests in the affirmative
- Allow natural consequences
- Use care when offering praise
- Use time-in rather than time-out
- Use time-in as a parent, too
- Talk to a child before intervening
- Don't force apologies
- Comfort the hurt child first
- Offer choices
- Be sensitive to and allow strong emotions
- Consider carefully before imposing the parent's will
- Use logical consequences sparingly and with compassion
- Use incentives creatively with older children

Complex Trauma in Children and Adolescents

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

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

The diagnosis of posttraumatic stress disorder (PTSD) does not capture the full range of developmental difficulties that traumatized children experience. Children exposed to maltreatment, family violence, or loss of their caregivers often meet diagnostic criteria for depression, attention-deficit/hyperactivity disorder (ADHD), oppositional defiant disorder (ODD), conduct disorder, anxiety disorders, eating disorders, sleep disorders, communication disorders, separation anxiety disorder, and/or reactive attachment disorder. Yet each of these diagnoses captures only a limited aspect of the traumatized child's complex self-regulatory and relational difficulties. A more comprehensive view of the impact of complex trauma can be gained by examining trauma's impact on a child's growth and development.

Impact on Development

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

Attachment

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

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

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

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

Biology

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

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

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

Affect Regulation

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

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

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

Dissociation

Dissociation is one of the key features of complex trauma in children. In essence, dissociation is the failure to take in or integrate information and experiences. Thus, thoughts and emotions are disconnected, physical sensations are outside conscious awareness, and repetitive behavior takes place without conscious choice, planning, or self-awareness. Although dissociation begins as a protective mechanism in the face of overwhelming trauma, it can develop into a problematic disorder. Chronic trauma exposure may lead to an over-reliance on dissociation as a coping mechanism that, in turn, can exacerbate difficulties with behavioral management, affect regulation, and self-concept.

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

Behavioral Regulation

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

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

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

Cognition

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

By early elementary school, maltreated children are more frequently referred for special education services. A history of maltreatment is associated with lower grades and poorer scores on standardized tests and other indices of academic achievement. Maltreated children have three times the dropout rate of the general population. These findings have been demonstrated across a variety of trauma exposures (e.g., physical abuse, sexual abuse, neglect, and exposure to domestic violence) and cannot be accounted for by the effects of other psychosocial stressors such as poverty.

Self-Concept

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

By 18 months, maltreated toddlers already are more likely to respond to self-recognition with neutral or negative affect than nontraumatized children. In preschool, traumatized children are more resistant to talking about internal states, particularly those they perceive as negative. Traumatized children have problems estimating their own competence. Early exaggerations of competence in preschool shift to significantly lowered estimates of self-competence by late elementary school. By adulthood, they tend to suffer from a high degree of self-blame.

Family Context

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

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

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

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

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

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

Ethnocultural Issues

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

Resilience Factors

While exposure to complex trauma has a potentially devastating impact on the developing child, there is also the possibility that a victimized child may function well in certain domains while exhibiting distress in others. Areas of competence also can shift as children are faced with new stressors and developmental challenges. Several factors have been shown to be linked to children's resilience in the face of stress: positive attachment and connections to emotionally supportive and competent adults within the family or community, development of cognitive and self-regulation abilities, and positive beliefs about oneself and motivation to act effectively in one's environment. Additional individual factors associated with resilience include an easygoing disposition, positive temperament, and sociable demeanor; internal locus of control and external attributions for blame; effective coping strategies; a high degree of mastery and autonomy; special talents; creativity; and spirituality.

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

Assessment and Treatment

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

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

1. *Safety:* Creating a home, school, and community environment in which the child feels safe and cared for.
2. *Self-regulation:* Enhancing a child's capacity to modulate arousal and restore equilibrium following disregulation of affect, behavior, physiology, cognition, interpersonal relatedness and self-attribution.
3. *Self-reflective information processing:* Helping the child construct self-narratives, reflect on past and present experience, and develop skills in planning and decision making.
4. *Traumatic experiences integration:* Enabling the child to transform or resolve traumatic reminders and memories using such therapeutic strategies as meaning-making, traumatic memory containment or processing, remembrance and mourning of the traumatic loss, symptom management and development of coping skills, and cultivation of present-oriented thinking and behavior.
5. *Relational engagement:* Teaching the child to form appropriate attachments and to apply this knowledge to current interpersonal relationships, including the therapeutic alliance, with emphasis on development of such critical interpersonal skills as assertiveness, cooperation, perspective-taking, boundaries and limit-setting, reciprocity, social em-

pathy, and the capacity for physical and emotional intimacy.

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

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

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

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

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This article has been adapted from the following sources:
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Cook, A., Blaustein, M., Spinazzola, J, & van der Kolk, B. (Eds.). *Complex trauma in children and adolescents*. National Child Traumatic Stress Network. www.nctsnet.org/nccts/nav.do?pid=typ_ct

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FOCAL POiNT Research, Policy, and Practice in Children's Mental Health

Domains of Impairment in Children Exposed to Complex Trauma

Complex Trauma in Children and Adolescents
National Child Traumatic Stress Network
www.NCTSNet.org
http://www.nctsnet.org/nctsn_assets/pdfs/edu_materials/ComplexTrauma_All.pdf

I. Attachment

Uncertainty about the reliability and predictability of the world
Problems with boundaries
Distrust and suspiciousness
Social isolation
Interpersonal difficulties
Difficulty attuning to other people's emotional states
Difficulty with perspective taking
Difficulty enlisting other people as allies

II. Biology

Sensorimotor developmental problems
Hypersensitivity to physical contact
Analgesia
Problems with coordination, balance, body tone
Difficulties localizing skin contact
Somatization
Increased medical problems across a wide span, e.g., pelvic pain, asthma, skin problems, autoimmune disorders, pseudoseizures

III. Affect Regulation

Difficulty with emotional self-regulation
Difficulty describing feelings and internal experience
Problems knowing and describing internal states
Difficulty communicating wishes and desires

IV. Dissociation

Distinct alterations in states of consciousness
Amnesia
Depersonalization and derealization
Two or more distinct states of consciousness, with impaired memory for state-based events

V. Behavioral Control

Poor modulation of impulses
Self-destructive behavior
Aggression against others
Pathological self-soothing behaviors
Sleep disturbances
Eating disorders
Substance abuse
Excessive compliance
Oppositional behavior
Difficulty understanding and complying with rules
Communication of traumatic past by reenactment in day-to-day behavior or play (sexual, aggressive, etc.)

VI. Cognition

Difficulties in attention regulation and executive functioning
Lack of sustained curiosity
Problems with processing novel information
Problems focusing on and completing tasks
Problems with object constancy
Difficulty planning and anticipating
Problems understanding own contribution to what happens to them
Learning difficulties
Problems with language development
Problems with orientation in time and space
Acoustic and visual perceptual problems
Impaired comprehension of complex visual-spatial
Patterns

VII. Self-Concept

Lack of a continuous, predictable sense of self
Poor sense of separateness
Disturbances of body image
Low self-esteem
Shame and guilt

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From *The Connection* (Winter 2004, Vo. 20, No. 4)
Quarterly Magazine of the National Court Appointed Special Advocate (CASA) Association

Mental Health Needs of Youth in Foster Care: Challenges and Strategies

By Lisette Austin

When life becomes chaotic and feels like it is falling apart, it is easy to feel alone and depressed. And when you are an abused or neglected child who has been separated from family and shuttled from home to home, the feelings can become incredibly overwhelming and isolating—perhaps even spinning out of control. For many in foster care, the result of this kind of emotional trauma is the development of a mental health disorder. They find themselves in a system that is ill-equipped to provide the mental health services they need and that can further impede their progress towards emotional well-being.

According to the World Health Organization, nearly 20% of children and adolescents worldwide suffer from some type of emotional or behavioral problem. The U.S. Surgeon General reports that roughly 1 in 10 American children experience a mental illness severe enough to cause significant impairment. The prevalence of mental health problems of youth in foster care is even more staggering. "Anywhere from 40 to 85% of kids in foster care have mental health disorders, depending on which report you read," says Stephen Hornberger, director of behavioral health for the Child Welfare League of America.

The reasons for these high numbers are understandable. Children in foster care are struggling to cope with the traumatic events that brought them into care, including parental abuse or neglect, homelessness and exposure to domestic violence and substance abuse. While they struggle to deal with the tremendous loss of their family, they also frequently blame themselves for being removed. Many children long to return to their families, regardless of the history of mistreatment. At a time when they desperately need a sense of consistency and stability, they are living in the uncertain world that is foster care: multiple placements, unpredictable contact with family and the inability to control their own lives. These conditions can be a hotbed for serious emotional disturbances.

Although it is clear that a large number of children and youth in foster care are in need of mental health care, studies show that less than one-third receive mental health services. One of the reasons is the lack of experienced mental health professionals available to this population. "There is a shortage of well trained providers who can deal specifically with loss issues," says Dr. Toni Heineman, clinical psychologist and executive director of A Home Within, a nonprofit organization dedicated to helping meet the mental health needs of children in foster care. Heineman adds that a recent, informal survey revealed that only 3% of mental health providers work with children in foster care. Those that do are often inexperienced trainees unfamiliar with navigating the child welfare system and only available for one year. "Being abused, neglected and removed from their family are extraordinarily painful experiences for these kids," she says. "Put them with people who aren't well trained and it can be an overwhelming experience for both parties."

I went to my first therapist at age 12. At the time, my life was filled with chaos, and I didn't know who to talk to or how to handle it. My dad was in jail, my mother and I weren't talking, and in a little more than a year, several family members had died. All the feelings I had began to build up inside, and I felt like I was drowning in my emotions. Sometimes I would cry like a baby. Other times I'd feel angry and confused.

I didn't trust anyone, especially my family, and I thought people were saying negative things about me. I started to disrespect my elders, steal, stay out late, and fail in school. Things got so bad that I was sent to two different group homes. At the homes I pretended to feel better about myself, but being there made me feel like more of a failure and like I didn't deserve to live.*

**This excerpt was written by Norm Brandt and reprinted from* I'm Not Crazy: A Teen Guide to Getting Mental Health Help. *For more information on this and other Youth Communication publications, visit youthcomm.org or see the sidebar on page 7.*

Another major challenge is the lack of mental health training for both child welfare staff and foster families. Minimal legislative and media attention to issues of child safety mean that less attention is placed by the system on the emotional needs of children in foster care. Although there is some variance from state to state, the general trend is that caseworkers have limited training in mental health issues. Lack of resources, high turnover rates and overburdened staff also contribute to unmet mental health needs.

Lack of training for foster parents adds to the problem. Former foster parent Shawn Hosford experienced this firsthand when she wasn't told that her 7-year-old foster-to-adopt son had Reactive Attachment Disorder, a fairly common diagnosis among foster children (see sidebar, pg. 13). Unaware and unprepared, her family struggled through an increasingly difficult period that ultimately ended with his removal. This devastating experience led her to quit her job and start a nonprofit organization dedicated to providing support and education for foster parents and anyone involved in the child welfare system. "Anyone who works with these children should be informed about the different mental health disorders these kids are dealing with," she says. "Education is critical."

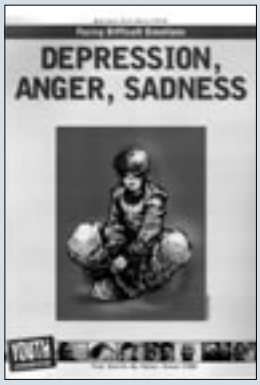
Without training, those involved with foster children frequently have difficulty recognizing serious disorders. Many mental health problems go undiagnosed because symptoms are overshadowed by other disruptive behaviors such as substance abuse, anger and opposition. "Anxiety and depression are very common, and both are often masked by drug use," says Anita Marshall, senior child welfare advisor for the American Institutes for Research in Washington, DC.

Mental Health Resources by Youth

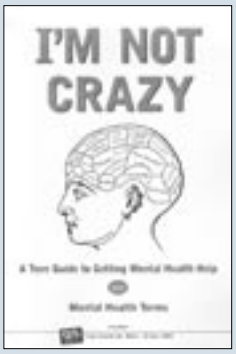
Youth Communication helps teenagers develop their skills in reading, writing, thinking and reflection so they can acquire the information they need to make thoughtful choices about their lives. Youth Communication trains teens in journalism and related skills; publishes magazines, books and other materials written and illustrated by young people; and encourages teens and the adults who work with them to use their publications to stimulate reading, writing, discussion and reflection. Below are three resources developed by Youth Communication that address the topic of mental health issues faced by teens.

Fighting the Monster contains 39 true, credible and realistic stories by teens about getting help for depression, cutting, sexual abuse, domestic violence, substance abuse, eating disorders, bereavement, promiscuity, uncontrolled anger and many other topics. Teens describe what worked for them, including self-help, therapy and medication. This easy-to-read resource also contains "Think About It" questions with each story.

The teens in *Depression, Anger, and Sadness* candidly describe facing difficult emotional problems and what they did to try and help themselves. Because these writers not only describe their problems and fears but also the various ways they have tried to help themselves, their stories will help teens to face and better understand their own emotions.



An informative, reassuring and affirming guide for teens about how to get help from the mental health system, *I'm Not Crazy* is designed to tell teens the "real deal" about getting help, in language they can understand. This resource explains mental health services in a way that helps the teen reader get the services they need to get the most out of their lives.



All proceeds from sales go to furthering Youth Communication's nonprofit training and publishing programs for teens. Visit youthcomm.org to order these publications.

Web Resources

- National Institute of Mental Health
  nimh.nih.gov/healthinformation/childmenu.cfm
- Child Welfare League of America
  cwla.org

  (In May 2005, CWLA hosts the "Addressing the Mental Health Needs of Children, Youth and Families" conference in New Orleans, LA.)
- A Home Within
  ahomewithin.org
- American Academy of Child and Adolescent Psychiatry (AACAP)
  aacap.org
- American Academy of Pediatrics
  aap.org
- Comprehensive Mental Health Services Program for Children and their Families
  mentalhealth.samhsa.gov/cmhs/childrenscampaign/ccmhs.asp
- National Child Welfare Resource Center for Family Centered Practice
  cwresource.org
- The Carter Center Mental Health Program
  cartercenter.org/healthprograms/program6.htm
- Screening for Mental Health, Inc.
  mentalhealthscreening.org

"They are often self-medicating."

Hornberger of CWLA agrees, adding that some disorders are overlooked because of the belief that parental neglect is less detrimental than abuse. "Research shows that neglect can actually have more long-term effects compared to the abuse cases," he says. "Just because kids are quiet doesn't mean that they are well."

Additional system challenges include lack of collaboration between providers and parents (both foster and biological), lack of continuity of care due to multiple placements, budget cuts that further limit access to trained providers, lack of routine mental health assessments and unmet mental health needs in family members. "I would say that the system has certainly had difficulty addressing the complexity and severity of mental health needs of these kids," says Hornberger. "We are failing them in all jurisdictions."

Pockets of Hope

With these circumstances, it is understandable that many who are involved in child welfare can end up feeling frustrated and helpless. But there are pockets of hope—people and organizations that are brainstorming and implementing solutions that could ultimately serve as guideposts for communities across the country.

One organization that is trying to make a difference is A Home Within. Their mission is to support and enhance the emotional well-being of children in foster care by addressing the low numbers of available mental health providers. Their innovative Children's Psychotherapy Project (CPP) offers long-term individual psychotherapy with experienced clinicians to foster children and adolescents. With 10 chapters nationwide and one in Australia, directors are actively recruiting experienced therapists who are willing to volunteer their time. Therapists are asked to take one foster child into weekly psychotherapy for as long as that child needs treatment.

Another newer approach is therapeutic foster care, also called treatment foster care. An evidenced-based practice that was originally started to help children and youth in the juvenile justice system, it has now grown to include those in foster care and is being introduced in a number of communities nationwide. This model actively includes foster parents in mental health treatment by having them provide the primary intervention in their homes. In order to do so, they receive mental health training, consultation and regular clinical support. Therapeutic foster care usually lasts six to twelve months and is often used as an alternative to residential treatment. "Many kids need to be in foster care that is actively supported by mental health providers," says Marshall from the American Institutes for Research. "We need a lot more of this model out there."

Solutions are also being developed and examined at a national level. In 1992, Congress passed legislation creating the Comprehensive Mental Health Services Program for Children and Their Families. This program in turn funded 85 state and local communities to build a "system of care" approach. This philosophy aims to help children and adolescents access individually-tailored mental health services near their homes through the close collaboration of local organizations and providers. Preliminary studies show this approach is more effective than traditional, uncoordinated mental health services.

Because children in foster care find themselves involved with several systems at once (families, foster care, mental health, school), this collaborative approach is ideal. In 1999, the *Surgeon General's Report on Mental Health* outlined three evidence-based interventions that reflect effective system of care principles for foster youth: therapeutic foster care, intensive case management and wrap-around services, and Multisystemic Therapy (MST), a home and community-based intervention that addresses conduct-related mental health needs by intervening in all systems that impact youth. Studies

(continued on page 12)

Systems Challenges

Children and youth can find themselves involved with several social systems: foster care, mental health and their own families. All three systems share the same ultimate goals: to enable children to live safely with their families, attend and make progress in local schools, participate in the social and cultural life of their communities and develop the skills to live independently as young adults and contribute to society.

Foster care sees these goals through the mandates of child safety, permanence and well-being. Mental health's vision is characterized by the fulfillment of age-appropriate developmental-intellectual, emotional and social milestones in the child's family, schools and community. Families want their children to be successful and to belong. Families want to be asked what they know, what they think will or will not work and what support or resources they may need for their child and family to reach goals. Yet in spite of the connections among these goals, foster care, mental health and families face numerous systemic challenges that require an uncommon level of collaboration to resolve.

Challenges in the Foster Care System

- Staff turnover hinders the ability to meet the special needs of children and youth who have serious emotional disturbances. New staff often receive inappropriate training or insufficient supervision to support the child, the foster parent and the biological parent. When a child is oppositional or aggressive, both the foster parent and child need adequate support; otherwise, a disrupted placement and another rejection for the child result.
- The growing needs of seriously emotionally disturbed children and youth and the inconsistent availability of foster parent training and support result in high foster parent turnover. The result: placement disruption, inconsistent treatment and increased trauma for the child.
- Foster parents need to be considered partners in the treatment of children in their care.
- The legislatively mandated focus and media attention on the safety needs of children increase child welfare professionals' anxiety and take time away from attending to the emotional and trauma needs of the children for whom they are responsible.
- Increased mental health challenges of children require training to ensure earlier recognition and intervention. Younger children who display aggressive or sexually inappropriate behaviors are an increasing challenge for staff and foster parents who have limited training and support.
- Access to mental health services for referred children and youth is limited.

Challenges in the Mental Health System

- Fewer child and adolescent mental health professionals, especially psychiatrists, are available to work with children in foster care. This shortage is complicated by systemic budget cuts and low insurance rates of reimbursement.
- Mental health professionals working with foster care staff may not understand the child welfare system's mandates; the roles of individual workers; judicial time frames; the variance of roles across differing services components (such as guardianship, family reunification and permanency planning) and the rights retained by parents with children in foster care.
- Opportunities to identify children who are showing early signs of serious emotional disturbances are limited. Children entering foster care are not routinely screened for mental health needs but are referred only after they display problematic behavior.
- Coordinating and integrating care with multiple systems is difficult due in part to different mandates and values.
- Mental health providers often receive referrals with insufficient information to appropriately assess for treatment.
- Multiple and disrupted placements, missed appointments, lack of communication with mental health providers and discontinuation of treatment after the child is reunified with the family contribute to the lack of continuity of mental health care.
- Many mental health providers need more training to work with an increasing population of preschool sexually abused and/or sexually aggressive youngsters.
- Many mental health professionals need more training in effective and evidence-based interventions.

Challenges in Families

- Although 70% of children in foster care return to their families, these families are seldom seen as team members in their children's treatment while in care.
- Families are not routinely included in information gathering, such as their child's previous behaviors and demonstrated needs; previous treatments, both effective and ineffective; family history; and treatment preferences, including issues about medication.
- Within both the foster care and mental health cultures, families are not usually seen as partners and therapeutic allies.
- Youth in care are seldom involved in decisions about their care, such as treatment options, medications and education about psychotropic drugs and alternatives prior to discharge from foster care.
- Often family members have unmet mental health needs.

Source: Best Practice Next Practice Family-Centered Child Welfare, *a publication of the National Child Welfare Resource Center for Family-Centered Practice, a service of the Children's Bureau.*

The national evaluator of the Comprehensive Mental Health Services Program for Children and Their Families, ORC Macro, identified the five most prevalent diagnoses of children referred by foster care:

- Mood Disorders and Depression
- Oppositional Defiance Disorder
- Post-Traumatic Stress Disorder
- Adjustment Disorder
- Conduct Disorders

Source: Diagnostic and Statistical Manual of Mental Disorders—Fourth Edition (DSM-IV)

While diagnosing children's mental health problems is the job of professionals and not CASA volunteers, the following information may be helpful background in advocating for assessments and treatments.

Disorders Usually First Diagnosed in Infancy, Childhood or Adolescence

Depressive Disorders

Depressive disorders, which include major depressive disorder, dysthymic disorder and bipolar disorder, adversely affect mood, energy, interest, sleep, appetite and overall functioning. In contrast to the normal emotional experiences of sadness, feelings of loss or passing mood states, symptoms of depressive disorders are extreme and persistent and can interfere significantly with a young person's ability to function at home, at school and with peers.

Major depressive disorder (major depression) is characterized by five or more of the following symptoms: persistent sad or irritable mood, loss of interest in activities once enjoyed, significant change in appetite or body weight, difficulty sleeping or oversleeping, psychomotor agitation or slowing, loss of energy, feelings of worthlessness or inappropriate guilt, difficulty concentrating and recurrent thoughts of death or suicide.

Dysthymic disorder, a typically less severe but more chronic form of depression, is diagnosed when depressed mood persists for at least one year in children and is accompanied by at least two other symptoms of depression (without meeting the criteria for major depression). Youth with dysthymic disorder are at risk for developing major depression.

Although ***bipolar disorder*** (manic-depressive illness) typically emerges in late adolescence or early adulthood, there is increasing evidence that this illness also can begin in childhood. Bipolar disorder beginning in childhood or early adolescence may be a different, possibly more severe form of the illness than older adolescent and adult-onset bipolar disorder. Research has revealed that when the illness begins before or soon after puberty, it is often characterized by a continuous, rapid-cycling, irritable and mixed manic and depressive symptom state that may co-occur with disruptive behavior disorders (particularly attention-deficit hyperactivity disorder or conduct disorder) or may have features of these disorders as initial symptoms. Diagnosis and treatment of depressive disorders in children and adolescents are critical for enabling young people with these illnesses to live up to their full potential.

Anxiety Disorders

Anxiety disorders, as a group, are the most common mental illnesses that occur in children and adolescents regardless of foster care status. Researchers estimate that the prevalence of any anxiety disorder among children and adolescents in the US is 13% in a six-month period.

Generalized anxiety disorder is characterized by persistent, exaggerated worry and tension over everyday events.

Obsessive-compulsive disorder (OCD) is characterized by intrusive, unwanted, repetitive thoughts and behaviors performed out of a feeling of urgent need.

Panic disorder is characterized by feelings of extreme fear and dread that strike unexpectedly and repeatedly for no apparent reason, often accompanied by intense physical symptoms, such as chest pain, pounding heart, shortness of breath, dizziness or abdominal distress.

Post-traumatic stress disorder (PTSD) is a condition that can occur after exposure to a terrifying event, most often characterized by the repeated re-experience of the ordeal in the form of frightening, intrusive memories; brings on hyper-vigilance and deadening of normal emotions.

Phobias: social phobia is the extreme fear of embarrassment or being scrutinized by others; specific phobia is the excessive

fear of an object or situation, such as dogs, heights, loud sounds, flying, costumed characters and enclosed spaces.

Other disorders: separation anxiety is excessive anxiety concerning separation from the home or from those to whom the person is most attached; selective mutism is the persistent failure to speak in specific social situations.

ADHD

Attention deficit hyperactivity disorder (ADHD) affects an estimated 4% of children and adolescents in the US in a six-month period. Its core symptoms include developmentally inappropriate levels of attention, concentration, activity, distractibility and impulsivity. Children with ADHD usually have impaired functioning in peer relationships and multiple settings including home and school. Untreated ADHD also has been found to have long-term adverse effects on academic performance, vocational success and social-emotional development.

Eating Disorders

Eating disorders involve serious disturbances in eating behavior, such as extreme and unhealthy reduction of food intake or severe overeating, as well as feelings of distress or extreme concern about body shape or weight. In the US, eating disorders are most common among adolescent girls and young adult women; only an estimated 5-15% of people with ***anorexia nervosa*** or ***bulimia nervosa*** and an estimated 35% of those with binge eating disorder are male. Eating disorders often co-occur with other illnesses such as depression, substance abuse and anxiety disorders. In addition, eating disorders are associated with a wide range of other health complications, including serious heart conditions and kidney failure, which may lead to death.

Eating disorders are not due to a failure of will or behavior; rather, they are real, treatable medical illnesses in which certain maladaptive patterns of eating take on a life of their own.

Autism and Other Pervasive Developmental Disorders

Autism and other pervasive developmental disorders (PDDs), including ***Asperger's disorder***, ***Rett's disorder***, ***childhood disintegrative disorder*** and ***pervasive developmental disorder—Not otherwise specified (PDD-NOS)***, are brain disorders that occur in an estimated 2 to 6 per 1,000 American children. They typically affect the ability to communicate, to form relationships with others and to respond appropriately to the outside world. The signs of PDDs usually develop by 3 years of age. The symptoms and deficits associated with each PDD may vary among children. For example, while some individuals with autism function at a relatively high level, with speech and intelligence intact, others are developmentally delayed, do not speak or have serious language difficulty. Research has made it possible to identify earlier those children who show signs of developing a PDD and thus to initiate early intervention. While there is no single best treatment program for all children with PDDs, both psychosocial and pharmacological interventions can help improve their behavioral and cognitive functioning.

Schizophrenia

Schizophrenia is a chronic, severe and disabling brain disorder that affects about 1% of the population during their lifetime. Symptoms include hallucinations, false beliefs, disordered thinking and social withdrawal. Schizophrenia appears to be extremely rare in children; more typically, the illness emerges in late adolescence or early adulthood. However, research studies are revealing that various cognitive and social impairments may be evident early in children who later develop schizophrenia. These and other findings may lead to the development of preventive interventions for children. Only in this decade have researchers begun to make significant headway in understanding the origins of schizophrenia. In the emerging picture, genetic factors which confer susceptibility to schizophrenia appear to combine with other factors early in life to interfere with normal brain development. These developmental disturbances eventually appear as symptoms of schizophrenia many years later, typically during adolescence or young adulthood.

Adapted from the National Institute of Mental Health Brief Notes on the Mental Health of Children and Adolescents, *available at nimh.nih.gov.*

Additional Advocate Strategies & Tips

- Work as a team with family, foster parents, teachers, mental health providers and caseworkers to find ways to support and improve the child's self-esteem.
- Get foster parents access to resources if possible; encourage them to find ways to get support.
- Get support for yourself; find a therapist or mental health attorney willing to provide occasional consultations.
- Find out if mental health trainings are available in your area.
- Seek out community and online mental health resources.
- Advocate for mental health assessments whenever possible.
- Research the child's medication history—get second opinions if necessary.
- Watch for signs of major depression or other mental health issues (see sidebar at right).

(continued from page 8)

of these interventions show improved outcomes among foster youth including fewer placement changes, decreased aggression, reduction in arrests and hospitalizations and improved general functioning.

These outcomes illustrate the importance of an integrated community approach in addressing foster child and adolescent mental health needs. In response, the Child Welfare League of America and the American Academy of Child and Adolescent Psychiatry, together with more than 50 other consumer, professional and family-run organizations, have launched a national initiative to improve the design, delivery and outcomes of mental health services provided to children in the foster care system. This strategic plan incorporates the values of the system of care philosophy and includes service coordination, early identification and family participation in all aspects of service planning and evaluation. Most of all, it stresses system collaboration. "No one system has the mandates, the resources or the reach to help each person," says Hornberger. "It needs to be a community effort."

The Role of a CASA Volunteer

As part of that community, what can CASA volunteers do to help the situation? How can they contribute to the improvement of the emotional well-being of the children they work with? Although the issues are complicated and solutions require many systems working together, there are steps CASA volunteers can take to help strengthen their role as mental health advocates—small steps that could potentially make a big difference.

The first is to pay attention. "CASA volunteers can be good eyes and ears," says Hornberger. "Stay close to the child and the family situation where they are residing. If things don't seem right, raise concerns immediately," he says. Harriet Zaretsky, a CASA volunteer for seven years, agrees. "Really pay attention to what is happening," she says. "A lot of times people make things look like everything is going well. You can write anything in a report, but it doesn't mean it's true."

Part of being able to recognize a red flag is getting more education about mental health issues. Although CASA training does include some components on mental health, there is always room for more learning. "CASA volunteers should become educated about the different mental health disorders that kids are dealing with," says former foster parent Hosford. "These are complex issues," she says, "and it can be easy to look at them through our own filters, opinions and biases. Education can help you move beyond your own viewpoint." CASA volunteer Zaretsky also feels that being informed is key. "It is important to have a sensitivity to what the issues are—even if we aren't the professionals."

Signs of Depression in Children & Adolescents

- Persistent sad or irritable mood
- Loss of interest in favorite activities
- Poor performance in school; frequent absences
- Unprovoked anger or aggression
- Frequent, unexplained physical complaints such as head or stomach aches
- Tearfulness
- Loss of energy
- Difficulties with relationships
- Alcohol or substance abuse
- Reckless behavior
- Social isolation, poor communication
- Difficulty concentrating
- Extreme sensitivity to rejection or failure
- Recurring thoughts about death, self-injury or suicide

Note: None of the above symptoms alone is enough to indicate major depressive disorder. The National Institutes of Mental Health says that five or more symptoms must persist for at least two weeks before a diagnosis of major depression is indicated.

Reactive Attachment Disorder (RAD)

Reactive attachment disorder is a disturbance of social interaction caused by neglect of a child's basic physical and emotional needs, particularly during infancy. Babies placed in orphanages at birth and raised by multiple caretakers without primary parent-figures can also develop this disorder, even if physical care was adequate. A complete history, physical examination and psychiatric evaluation can help diagnose this disorder.

Reactive attachment disorder is caused by neglect of an infant's needs for physical safety, food, touching and emotional bonds with a primary or secondary caretaker. The risk of neglect to the infant or child is increased with parental isolation, lack of parenting skills, teen parents or a caregiver who is developmentally delayed. A frequent change in caregivers (for example, those occuring in orphanages or foster care) is another cause of reactive attachment disorder.

To Learn More:
nlm.nih.gov
National Institutes of Health information on RAD, its symptoms, causes and risk factors.

radkids.org
RAD information, pointers on getting help and a list of related resources.

Although mental health trainings may not be readily available, there are online resources that can help point volunteers in the right direction (see sidebar pg.8). A mental health attorney can also be a good resource, suggests Zaretsky. It also can be helpful to try to locate support and education opportunities for foster parents, who in their genuine desire to help may not realize that they might have unrealistic emotional expectations of their foster child. The more they can understand about the tremendous impact of loss and emotional upheaval the child is experiencing, the better.

Obtaining mental health assessments is also important. "When any child is taken away from their family and put in a situation that is strange to them, there may be a need for some kind of mental health assessment," says Marshall. Hornberger adds that it is important that the assessment is tailored to the child and isn't one-size-fits-all (for example, finding culturally sensitive assessments). "The battle isn't just to get more treatment services," he says, "but also to find services that work and make sense."

Trying to advocate for a foster child in the area of mental health can often become overwhelming and confusing. CASA volunteers need to recognize this and look for ways to get support. Being able to talk to a therapist or mental health attorney can help bring new insights and strategies. Heineman feels that it could be helpful for volunteers to touch base with a therapist on a regular basis—and not just for the volunteers. "We need cross-fertilization here," she says. "We need to learn what CASA volunteers can do to be helpful to kids, and we need to let them know how we can be helpful." A Home Within is an organization that is available as a supportive resource.

Lastly, it is important to continue to mobilize the community so a child can receive the most comprehensive intervention possible. In this way, advocates can implement their own small system of care for the child. "Circles of communication are so important," says Hosford. Heineman agrees. "We see over and over again the fragmentation in the foster care system," she says. "It's so easy to point fingers, but what is most important here is working together. CASA volunteers can really help by getting everyone on the same page."

Clearly, even with these various strategies, navigating the mental health needs of children in foster care will not be simple. The barriers inherent in the foster care system will inevitably continue to challenge and frustrate those who want to help. Perhaps the most important message is to keep trying. "It's a very difficult area, working with mental health issues, but you can't give up," says Zaretsky. "These kids are going to have to work through what happened to them somehow—and if they have someone in their corner, that might make a difference. They really do need an advocate in the end."

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THE EFFECTIVE CORRECTIVE, ATTACHMENT THERAPIST

By: Juli Alvarado, MA, LPC, NCC

In order for any of us as therapists in the field of attachment, we must have a deep understanding of the behavioral manifestations of disrupted attachments and trauma suffered by our child clients in their formative years. If not, we continue to see these behaviors as abnormal, severe, scary and 'bad'. In this last "decade of the brain" we have been blessed with a much deeper understanding of the developing brain and the outcome of healthy or unhealthy environments on that development. There are many, many models and theories of effective work with these clients and families, however, we find time after time that long term healing and change in severe behavior is hard to come by with merely a cognitive and behavioral understanding of therapy and relationships.

Trauma and attachment disruptions are suffered within the complexities of relationship. True healing will come only in the context of relationship, and the primary relationship is that between parent and child.

The therapist's only responsibility in this situation is to strengthen and solidify the marital relationship first and then that of the parent child relationship.

Just as we support parents in providing the following for their children, we, as therapists, first, must demonstrate the following in all client relationships:

- Tolerance, empathy, patience, and compassion
- Emotionally nonreactive, ability to remain regulated in session
- Accepting, nonjudgmental and supportive
- Comfortable with anger and other strong emotions
- Free of current, personal abuse issues
- Confident and able to instill confidence
- Genuine sense of humor, devoid of sarcasm and ridicule
- Able to give and receive love
- Resolved grief, loss and wounded child issues, and continues to work on them
- Continue to grow and evolve as therapist and person
- Sensitive to cultural backgrounds and differences
- Adept at dealing with resistance in creative and flexible manner
- Able to work effectively with a treatment team
- Realistic and able to maintain hope and optimism facing intense despair of clients
- Emotionally able and professionally willing to utilize nontraditional interventions; mindbody work, somatic processing

For those therapists who continue to struggle with any of the above, a deep exploration of our own histories, our own triggers, and our own current level of functioning within our personal relationships will compel us to continue to move along the continuum of regulation. Only when we can remain regulated in the face of dysregulation can we expect our parent clients to be able to do the same with their children.

Emotional Regulatory Therapy is an effective and empowering means for achieving this. For more information on the above please visit www.Coaching-forlife.com.

As we engage in the process of paradigm change, we all need support. Every therapist, just as every parent, deserves someone with whom they can be 'real' and with whom they can share their deepest fears and concerns.

Consider for yourself the level of work that you provide, the amount of secondary trauma that you experience day in and day out, and the need for you, too, to have someone with whom you can consult at anytime, regarding a client situation, or yours, as the supporting regulatory foundation.

Handout # 18

Secondary Trauma Checklist for Professionals

www.childtraumaacademy.com

Curious about how your work is impacting you? Answer the following questions:

1. Do you think about work (whether you want to or not) when you at home or away from work?	Yes	No
2. Do pictures of things you've seen or heard others talk about in your work flash in your mind?	Yes	No
3. Do you feel like you are "on call" (e.g., checking your pager/cell phone) during your free time?	Yes	No
4. Do you ever dream about your work (related to a specific situation or in general)?	Yes	No
5. Do you have trouble falling asleep because you can't stop thinking about your work?	Yes	No
6. Are there times when you feel you sleep too much (or feel like you need more sleep than normal)?	Yes	No
7. Have you experienced a decrease in your appetite?	Yes	No
8. Have you found yourself eating more, whether or not you are hungry?	Yes	No
9. When you arrive at work (or even in the parking lot), do you ever experience: a racing heart, a tight stomach, nausea, headaches, increased perspiration, muscle tension, or other physical changes?	Yes	No
10. Do you avoid people, activities, TV programs, or places that frequently or strongly remind you of your work?	Yes	No
11. At work, do you find yourself spending significant time on menial, less significant and/or easily completed tasks, at the expense of key/necessary tasks essential to your work?	Yes	No
12. Do you ever feel as though you are "going-through-the-motions" at work?	Yes	No
13. Do you ever have a sense that your work, while producing immediate changes, has no lasting impact?	Yes	No
14. Do you feel a decreased ability to "relate," empathize, or understand the perspective of your clients/consumers?	Yes	No
15. In your current job, have you experienced a steady and continuous decrease in your ability to concentrate?	Yes	No
16. Do you feel that you have become increasingly irritable and/or "moody" since starting your current position?	Yes	No
17. Do you feel increasingly "jumpy" or "on edge" since taking your current position?	Yes	No
18. Do you find yourself spending significant time checking and re-checking your work?	Yes	No

19. Do you experience uneasy, anxious feelings or a sense of dread in response to previously common events (e.g., when the phone rings)?	Yes	No

If you answered "yes" to five or fewer questions, it is likely that you have developed healthy skills to cope with the daily stressors inherent in your work. If you answered "yes" to 6 - 10 questions, don't be alarmed. Approximately. 80% of all frontline workers with have difficulty with these symptoms at one time or another. If you answered "Yes" to more than 11 of these questions and feel that your symptoms are persistent and interfering with your ability to do your work or enjoy your life, you should consider talking with someone about whether or not you need professional help to cope with the stressors you face at work.

EXERCISE: *What Stresses Are In Foster Care?*

For the following list, mark an "X" beside the item if you have experienced any of the following situations.

___ Getting a new foster child.
___ Injury of foster child.
___ Change of social worker.
___ Meeting birth parent for first time.
___ Court hearing.
___ Foster child is in trouble at school.
___ Foster child using alcohol/drugs.
___ Birth parent doesn't show for visit.
___ Foster child runs away.
___ Birth child fighting with foster child.
___ Foster child acting out sexually.
___ Foster child gets pregnant.
___ Illness in the household.
___ Conference with foster child's teacher.
___ Foster child stealing from family members.
___ Social worker not returning phone call.
___ Medical emergency or illness in foster child.
___ Disciplining foster child.
___ Requesting a foster child be removed.
___ Foster child causes injury to a family pet.
___ Acting-out behaviors after visits.
___ Complaint filed against foster parents.
___ Stress in foster parent's marriage.
___ Need for respite care, but none available.
___ Shopping with foster child for new clothes.
___ Parenting a special needs foster child.
___ Involvement with foster child's counselor.

EXERCISE: *What are the Internal Factors that Cause Me Stress?*

For the following list, mark an "X" beside the item if you have experienced any of the following situations.

___ Worried about a sick relative

___ Grieving or missing someone

___ Worried someone might not like you

___ Dreading a visit with a social worker, or other professional

___ Dreading a visit with a birth parent

___ Not knowing what to do with a child

___ Feeling fear

___ Feeling persecuted

___ Feeling unsupported by your spouse

___ Not sleeping well

___ Not able to eat or eating too much

___ Drinking more than you should or using too many sedatives

___ Disagreeing strongly with the case plan/permanency plan for a child

___ Waiting for the results of an investigation

___ Fearing the pain of a dental operation

___ Feeling sick or tired

___ Having internal pain

___ Thinking about what you wished you had said to someone

EXERCISE: *What are the signs that I am Stressed?*

Read through the following signs. Check which ones apply to you when you are experiencing a great amount of stress.

___ Pounding of the heart

___ Urge to cry, run, or hide

___ Insomnia

___ Being emotionally exhausted

___ Feeling sick to your stomach

___ Pain in the neck or lower back

___ Increased smoking

___ Accident proneness

___ Feeling keyed up

___ Feeling afraid, but not knowing what we're afraid of

___ Feeling hopeless

___ Being tired

___ Feeling depressed

___ High pitched, nervous laughter

___ Sweating

___ Feeling worthless

___ Headaches

___ Loss of or excessive appetite

___ Increased alcohol or drug use

___ Inability to concentrate

___ Nightmares

Comparing Burnout, Vicarious Trauma and Secondary Trauma

BURNOUT	VICARIOUS TRAUMA COMMPASSION FATIGUE	SECONDARY TRAUMA INDIRECT TRAUMA
Cumulative, usually over long period of time	Cumulative with symptoms that are unique to each service provider	Immediate and mirrors client/patient trauma
Predictable	Less predictable	Less predictable
Work dissatisfaction	Life dissatisfaction	Life dissatisfaction
Evident in work environment	Permeates work and home	Permeates work and home
Related to work environment conditions	Related to empathic relationship with multiple client's/patient's trauma experiences	Related to empathic relationship with one client's/patient's trauma experience
Can lead to health problems	Can lead to health problems	Can lead to health problems
Feel under pressure	Feel out of control	Feel out of control
Lack of motivation and/or energy	Symptoms of post-traumatic stress disorder	Symptoms of post-traumatic stress disorder similar to client/patient
No evidence of triggers	May have triggers that are unique to the practitioner	Often have triggers that are similar to the client's/patient's triggers
Remedy is time away from work (vacation, stress leave) to recharge or positive change in work environment (this might mean a new job)	Remedy is treatment of self, similar to trauma treatment	Remedy is treatment of self, similar to trauma treatment