Caregiver Core Training – Participant Manual

Session 5: Growing up with Trauma, Grief, and Loss

In this session, we will focus on the child’s experience as they are placed outside of a parent’s care and as they grow and develop in a caregiver’s home. We’ll look at attachment and at how dealing with trauma, grief and loss impact children from newborns to youth on the verge of adulthood. This session will also cover brain development, exposure to drugs and alcohol in utero, and how child development may unfold differently when children have experienced abuse, neglect, and/or unpredictable living environments. We’ll end with an exploration of grief and loss and the essential connections.
Session 5: Growing Up with Trauma, Grief and Loss

Topics covered in Session 5

- Child Development
- Attachment
- Trauma, Grief, and Loss

Competencies covered in Session 5

CFAM131-01  Awareness of child and human development across all developmental domains.
CFAM131-02  Awareness that early childhood is a critical window for brain development.
CFAM131-03  Awareness of the effects of poverty, trauma, and maltreatment on development and how children in care, due to genetic factors, may also be at elevated risks of developing health, mental health and/or developmental concerns.
CFAM132-01  Awareness of the child’s need to heal from physical and emotional trauma.
CFAM133-02  Awareness that children in out-of-home care may be affected by attachment issues and disorders.
CFAM133-03  Awareness that separation and placement affects early brain development, relationships and attachments.
CFAM133-04  Awareness that relationships with trustworthy, consistent caregivers will have a positive effect of the development of the child’s brain.
CFAM133-05  Awareness that separation, grief, and loss is experienced by children, families, caregivers, and social workers.
CFAM139-01  Awareness that a child entering care may have special needs: illness or medical condition; developmental delays; emotional and/or behavioral issues; may be medically fragile.
CFAM139-04  Awareness of the possible effects of prenatal drug exposure.
CFAM139-05  Awareness that Fetal Alcohol Spectrum Disorder may impact development.
CFAM139-10  Awareness that post-traumatic stress disorder (PTSD) may occur in children of trauma.
CFAM139-11  Awareness of healthy sexual development in children and youth including knowledge of puberty.
CFAM139-12  Awareness that sexual abuse may impact a child’s behavior, thoughts and development.
CFAM139-13  Awareness that some children may have been exposed to domestic violence.
CFAM139-15  Awareness that children placed in care may not possess age appropriate life skills.

Begin Session 5
For detailed information on child development see the Center for Disease Control:
Child development: https://www.cdc.gov/ncbddd/childdevelopment/facts.html
Milestones birth to 5:
Free materials on child development:
https://www.cdc.gov/ncbddd/actearly/resources.html

1 Information presented here is from HealthyChildren.org’s ages and stages web pages and the CDC’s multiple web pages on child development. HealthyChildren.org is the American Academy of Pediatrics website for parents, caregivers, and others who work with children.
Infancy (Birth – 1 year)

Physical Development (fine and gross motor)
2 months – can hold head up and look around during tummy time
4 months – pushes up to elbows during tummy time. Holds head steady with support. Holds head when an adult pulls him slowly from laying on his back to sitting upright. Holds, shakes, reaches for toys. When held upright to “stand” she pushes/bounces with her feet.
6 months- can roll from tummy to back and back to tummy. Brings toys to mouth. Sits independently.
12 months – “cruises” by holding onto furniture and walking. Takes objects out of a container. Uses pincer grasp.

Cognitive Development
4-5 months – begins to understand cause and effect (notices that when she bangs a block on the table it makes a sound, drops objects and looks to see that the caregiver notices and picks them up) Looks for a partially hidden object.
9-12 months – explores the environment to understand how things work

Social/Emotional Development
3 months - Begins to develop social smile, Enjoys playing with people, imitates some movements & expressions
4-7 months – smiles, laughs, babbles. Clearly looks for caregiver and enjoys interactions. Interested in mirrors. Notices and responds to others emotions. Shows joy and surprise. Begins to strongly show her temperament (her beginning personality and preference for interacting in the world)
9-12 months – may be shy or anxious with strangers, Cries when caregiver leaves, enjoys imitating people in play, shows specific preferences for certain people and toys, tests parental responses to his behavior

Self-Help/Adaptive
9-12 months- Finger-feeds himself, extends arm or leg to help when being dressed

Language & Communication
4-7 months – smiles, laughs, babbles. Clearly looks for caregiver and enjoys interactions. Responds to own name. Usually recognizes the word no. May show he recognizes other words.
9-12 months – uses gestures like shaking head yes/no. May say words like mama or dada. May say Oh oh! Shows she understands many words by looking at the right picture in a book or getting the right object (Bring me a book).

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2 Also see HealthyChildren.Org’s child development page on the first year: https://healthychildren.org/english/ages-stages/baby/pages/default.aspx
And the CDC’s positive parenting tips for the first year: https://www.cdc.gov/ncbddd/childdevelopment/positiveparenting/infants.html
Toddlerhood (1 – 3 Years)

Physical Development (fine and gross motor)

15 months – walks or takes several steps regularly
18 months – Walks independently. Can go from sitting to standing without using his hands/arms or holding furniture.
2 years - Pulls toys behind her while walking, carries large toy or several toys while walking, begins to run, Stands on tiptoes, Kicks a ball, Climbs onto and down from furniture unassisted, Walks up and down stairs holding on to support, scribbles, builds a block tower of 4 blocks, 3 years – increasing coordination. Begins to be physically capable in most tasks without help.

Cognitive Development

2 years - Begins to sort by shapes and colors, Begins make-believe play
3 years – stronger ability to pretend and understand when others are pretending.

Social/Emotional Development

18 months - Increasing episodes of separation anxiety reach their peak around this time then begin to fade
2 years - Imitates behavior of others, especially adults and older children, Increasingly aware of herself as separate from others, Increasingly enthusiastic about company of other children, begins to show defiant behavior

Self-Help/Adaptive

2 years - Demonstrates increasing independence and often wants to do things himself
3 years – understands taking turns and can do so with help, and with frequent episodes of refusal. May be able to put on or take off some articles of clothing. Potty training occurs between 2 and 4 years, and daytime success happens between 2 ½ and 3 for many children.4

Language & Communication

15-18 months - says several single words, repeats words overheard in conversation
2 years - Points to object or picture, recognizes names of familiar people, objects, and body parts, Uses simple phrases and two- to four-word sentences, and follows simple instructions

3 Also see HealthyChildren.Org’s child development page on the toddler years: https://healthychildren.org/english/ages-stages/toddler/pages/default.aspx
And the CDC’s positive parenting tips for 1 year olds: https://www.cdc.gov/ncbddd/childdevelopment/positiveparenting/toddlers.html
and 2 year olds: https://www.cdc.gov/ncbddd/childdevelopment/positiveparenting/toddlers.html
4 https://www.webmd.com/parenting/features/potty-training-seven-surprising-facts#2
Preschool (3-5 Years)

Physical Development (fine and gross motor)
4 years - Hops and stands on one foot up to five seconds, Goes up and down stairs without support, Throws ball overhand, Catches bounced ball most of the time, Draws a person with two to four body parts, Uses scissors, Draws circles and squares, Begins to copy some capital letters
5 years - Stands on one foot for ten seconds or longer, Hops, somersaults, Swings, climbs, May be able to skip, Copies triangle and other geometric patterns, Draws person with body, Prints some letters

Cognitive Development
4 years - Understands the concepts of “same” and “different”, Has mastered some basic rules of grammar, Correctly names some colors, Understands the concept of counting and may know a few numbers, basic problem solving, knows the concept of gender and identifies as a boy or a girl
5 years – Can count ten or more objects, Correctly names at least four colors, Better understands the concept of time, Knows about things used every day in the home (money, food, appliances)

Social/Emotional Development
4 years – Interested in new experiences, Cooperates with other children, Plays “Mom” or “Dad” Increasingly inventive in fantasy play, Negotiates solutions to conflicts, More independent, Imagines “monsters”, Often cannot distinguish between fantasy and reality, shows affection for trusted others in culturally appropriate ways
5 years - Wants to please and be like friends, Likes to sing, dance, and act, Shows more independence and may visit a next-door neighbor by herself, less ‘defiance’ but isn’t consistent in following rules

Self-Help/Adaptive
4 years – drinks from cup and can use silverware (as is culturally appropriate), is interested in and can perform simple ‘chores’ (put your plate in the sink, take off your shoes, hang up your coat)
5 years - Dresses and undresses without assistance, Uses fork, spoon, and (sometimes) a table knife, Usually cares for own toilet needs, can buckle and un buckle car seat/buckle seat belt around booster, may know address or telephone, may be able to speak to strangers in public (librarian, store clerk)

Language & Communication
4 years - Speaks clearly enough for strangers to understand, Speaks in sentences of five to six words, Tells stories, knows simple songs
5 years - Recalls parts of a story, Speaks sentences of more than five words, Uses future tense, Tells longer stories

5 Also see HealthyChildren.Org’s child development page on the preschool years: https://healthychildren.org/english/ages-stages/preschool/pages/default.aspx
And the CDC’s positive parenting tips for the preschool years: https://www.cdc.gov/ncbddd/childdevelopment/positiveparenting/preschoolers.html
6 Children who will later go on to identify as transgender may or may not do so at this stage. Children may be quite flexible in how they understand or express being a girl or being a boy, or they may be very rigid, insisting that certain toys, clothes or colors are only for boys or only for girls.
School Age (6-12 Years)\textsuperscript{7}

Physical Development (fine and gross motor)
8 years – continued large motor development, may learn skills like riding a bike, swimming, roller skating. Writes more legibly. Draws more organized and recognizable pictures.
10-12 – beginning puberty, especially for girls.

Cognitive Development
8 years – begins to read independently (may need ongoing help/support), thoughts become more complex and questions about how the world works are common, begins to consider how others think and feel, though still primarily focused on self.
10-12 – have an increased attention span and focus intently on activities of interest, read and write independently (though often still need help organizing school work and staying on task), are better able to see the point of view of others and to consider multiple views on a topic or problem. Still can’t regularly consider the long term consequences for their actions.

Social/Emotional Development
8 years - can think about the future and plan small goals (will need help to achieve them), understands that others have an opinion of them, wants to be accepted by family and liked by friends. Wants to be competent. Develops and pursues unique interests and has preferences for activities she enjoys and others she dislikes.
11 -12 years - form stronger, more complex friendships and peer relationships. Understand how peers evaluate them, become more aware of his or her body as puberty approaches. Body image and eating problems may start between 9 and 12. Still very much need and want attention and guidance from trusted adults, but also want to be independent.

Self-Help/Adaptive
8 years – can tie shoes, are typically night time potty trained, can learn to use emotional regulation methods (belly breathing, counting, check ins with a safe adult) if instructed and supported to do so, can perform regular simple chores such as putting laundry in basket, putting clothes in the drawer, or taking out the trash.
10-12 – increasing desire and skill at meeting own hygiene needs. Begin to want privacy.

Language & Communication
8 years – increase in vocabulary, usually know and can use many words to describe how they are feeling and what they want. Usually use grammar correctly when speaking.
11-12 – Need guidance to communicate online or via cell phone app safely.

\textsuperscript{7} Also see HealthyChildren.Org’s child development page on the grade school years: https://healthychildren.org/english/ages-stages/gradeschool/pages/default.aspx

And the CDC’s positive parenting tips for middle childhood 6-8 years: https://www.cdc.gov/ncbdd/childdevelopment/positiveparenting/middle.html

CDC’s positive parenting tips for Middle Childhood 9-11 years: https://www.cdc.gov/ncbdd/childdevelopment/positiveparenting/middle2.html
Adolescence (12-17 Years)

Physical Development (fine and gross motor)
14 years – most girls have developed breasts, pubic hair, and have started to have periods. Most boys have developed pubic and facial hair, and their voices have deepened.
13-16 years - Girls stop growing though boys may continue to grow into adulthood.

Cognitive Development
14 years – continue developing the ability for more complex thoughts and consideration of problems from different points of view. May develop independent opinions on things like religion, politics, cultural norms, etc.
15-17 years – have an increased capacity to think about and plan for the future (though still need support). Increased (but still limited) ability to consider the consequences of their actions.

Social/Emotional Development
14 years - Show great concern about body image, looks, and clothes, Focus on themselves; going back and forth between high expectations and lack of confidence, Experience more moodiness, Show more interest in and influence by peer group, Express less affection toward parents; sometimes might seem rude or short-tempered, symptoms of mental health disorders like depression, anxiety, and eating disorders are much more prevalent at this age than in previous stages. Want and need their opinions and ideas to be respected.
15-17 years - Have more interest in romantic relationships and sexuality, and may have ongoing relationships with a boyfriend or girlfriend, less conflict with and less time with parents. Continue to want and need safe, close, supportive relationships with adults, though these relationships must increasingly be on the youth’s terms.

Self-Help/Adaptive
Gain and refine organization, self-management, and attention skills which help them meet expectations at school and enjoy sports, hobbies, or other activities.
Make choices that increase or decrease their safety in the community (behavior, friends, using substances, sex) Need clear, nonjudgmental guidance to support them in making safe choices.
Skills like driving (or managing a transportation system) and working drive further independence.
Learn beginning money management if an adult supports them to do so.

Language & Communication
Use language fluently, as capably as adults. Often use slang or other ‘in-group’ language.

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8 Also see HealthyChildren.Org’s child development page on teens: [https://healthychildren.org/english/ages-stages/teen/pages/default.aspx](https://healthychildren.org/english/ages-stages/teen/pages/default.aspx)
And the CDC’s positive parenting tips for young teens: [https://www.cdc.gov/ncbddd/childdevelopment/positiveparenting/adolescence.html](https://www.cdc.gov/ncbddd/childdevelopment/positiveparenting/adolescence.html)
CDC’s positive parenting tips for teenagers: [https://www.cdc.gov/ncbddd/childdevelopment/positiveparenting/adolescence2.html](https://www.cdc.gov/ncbddd/childdevelopment/positiveparenting/adolescence2.html)
Infant SAFE SLEEP Guidelines

- Always place your baby on his or her back to sleep, for naps and at night.
- Use a firm sleep surface, such as a mattress in a safety-approved crib, covered by a fitted sheet.
- Avoid wedges, positioners or other products unless prescribed by your baby’s doctor.
- Keep pillows, bottles, toys, crib bumpers, and loose bedding out of your baby’s sleep area.
- Don’t sleep with your baby in a bed, on a chair or couch – put your baby in his or her own bed.
- Keeping your baby’s sleep area in the same room where you sleep reduces the risk of SIDS and other sleep-related causes of infant death.
- Offer your baby a pacifier that is not attached to a string for naps and at night. If your baby is breast-fed, wait until your baby is one month old before offering a pacifier.
- Keep your baby warm, but not hot. Dress your baby in one layer of clothing extra than what you would wear to be comfortable and leave the blanket out of the crib.
- Follow your health care provider’s guidance on your baby’s vaccines and regular health checkups. Talk with your doctor if you have any questions about how your baby sleeps.
- Give your baby plenty of time on his or her tummy when awake and when someone is watching.
- Do not smoke or allow smoking around your baby.
- Place your baby’s crib away from curtains or blinds to avoid strangulation by cords.
- Make sure anyone caring for your baby knows about safe sleep practices.

*The actions listed here are based on recommendations from the American Academy of Pediatrics Task Force on SIDS.
Period of Purple Crying

**THE LETTERS IN PURPLE STAND FOR**

<table>
<thead>
<tr>
<th>Letter</th>
<th>Description</th>
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<tr>
<td>P</td>
<td>Peak of Crying</td>
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<td>U</td>
<td>Unexpected</td>
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<td>R</td>
<td>Resists Soothing</td>
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<td>P</td>
<td>Pain-like Face</td>
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<td>L</td>
<td>Long Lasting</td>
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<td>E</td>
<td>Evening</td>
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**THE WORD PERIOD MEANS THAT THE CRYING HAS A BEGINNING AND AN END**
Fetal Alcohol Spectrum Disorder: A Few Facts

Fetal alcohol spectrum disorders (FASDs) are a group of conditions that can occur in a person whose mother drank alcohol during pregnancy. These conditions can affect each person in different ways, and can range from mild to severe. They can include physical problems and problems with behavior and learning.9

**Physical differences can include:** abnormal facial features, such as a smooth ridge between the nose and upper lip (this ridge is called the philtrum), small head size, shorter than average height, low body weight, poor coordination, vision or hearing problems, sleep and sucking problems as a baby, problems with the heart, kidneys or bones.

**Behavior and developmental signs can include:** hyperactive behavior, difficulty paying attention, poor memory, difficulty in school (especially with math), speech and language delays, learning disabilities, intellectual disabilities or low IQ, poor reasoning and judgement skills.

- FASDs are the leading known cause of intellectual disabilities.10
- FASDs effect an estimated 40,000 newborns each year in the United States.11
- FASDs are more common than autism.12
- FASD is not just a health care issue. Its primary impact is on schools, foster/adoptive care, the justice system, and mental health services. Less than 10% of adults with FASD live independently or remain employed.
- The effects of FASDs last a lifetime but people with an FASD can grow, improve, and function well in life with proper support.

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9 Centers for Disease Control, Diseases and Conditions
10 May & Gossage, 2001; The Arc, 2005.
12 The Autism Society of America (2009) estimates that there are 24,000 new cases of autism each year in the U.S. Meanwhile, an estimated 870 children are born with FASD in WA each year (1% of all births). An estimated 70,000 individuals with FASD of all ages currently live in WA State.
Strategies for Parenting a Child with FASD

- Concentrate on your child’s strengths and talents.
- Accept your child’s limitations.
- Be consistent with everything (discipline, school, behaviors).
- Use concrete language and examples.
- Use stable routines that do not change daily.
- Keep it simple.
- Be specific; say exactly what you mean.
- Structure your child’s world to provide a foundation for daily living.
- Use visual aids, music, and hands-on activities to help your child learn.
- Use positive reinforcement often (praise, incentives).
- Supervise: friends, visits, routines.
- Repeat, repeat, repeat.

Impact of Exposure to Substances In Utero: Our Current Understanding

We know much less about the impact of exposure to substances like opiates, cocaine, and methamphetamine than we do on how Alcohol impacts a developing fetus. Below is a table from the 2013 article “Prenatal Substance Abuse: Short- and Long-term Effects on the Exposed Fetus” published by the American Academy of Pediatrics13, which summarizes the current thinking supported by research about exposure to these other substances.

Remember that each child is a unique individual, with their own genetic vulnerabilities and protective factors, and with their own set of experiences prior to arriving in your home. Some children who were exposed to substances will do very well and be indistinguishable from their peers. Others will struggle in many areas. What all these children need is to experience consistent, safe, nurturing caregiving so that they can reach their full potential.

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<tr>
<th>Summary of Effects of Prenatal Drug Exposure</th>
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<tr>
<td>Short Term Effects/ Birth Outcomes</td>
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<td>Fetal Growth</td>
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<td>Neurobehavior</td>
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<td>Achievement</td>
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*Limited or no data available

13 Link to the article at: [http://pediatrics.aappublications.org/content/pediatrics/131/3/e1009.full.pdf](http://pediatrics.aappublications.org/content/pediatrics/131/3/e1009.full.pdf)
14 Methamphetamine
Post Traumatic Stress Disorder

What Are the Signs & Symptoms of PTSD?

People with PTSD have symptoms of stress, anxiety, and depression that include many of the following:

- **Intrusive thoughts or memories of the event** that keep coming back
- upsetting dreams or nightmares
- acting or feeling as though the event is happening again (flashbacks)
- heartache and fear when reminded of the event
- feeling jumpy, startled, or nervous when something triggers memories of the event
- children may reenact what happened in their play or drawings
- **Avoidance of any reminders of the event**
  - avoiding thinking about or talking about the trauma
  - avoiding activities, places, or people that are reminders of the event
  - being unable to remember important parts of what happened
- **Negative thinking or mood since the event happened**

Signs of PTSD in teens are similar to those in adults. But PTSD in children can look a little different. Younger kids can show more fearful and regressive behaviors. They may reenact the trauma through play.

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Also see:

- Child Welfare Information Gateway’s Fact Sheet for Families “Parenting a Child who has Experienced Trauma” [https://www.childwelfare.gov/pubPDFs/child-trauma.pdf](https://www.childwelfare.gov/pubPDFs/child-trauma.pdf)
- [https://www.nami.org/Learn-More/Mental-Health-Conditions/Posttraumatic-Stress-Disorder](https://www.nami.org/Learn-More/Mental-Health-Conditions/Posttraumatic-Stress-Disorder)
Who Gets PTSD?
Not everyone who goes through a traumatic event gets PTSD. The chances of developing it and how severe it is vary based on things like personality, history of mental health issues, social support, family history, childhood experiences, current stress levels, and the nature of the traumatic event. Children and teens who go through the most severe trauma tend to have the highest levels of PTSD symptoms. The more frequent the trauma, the higher the rate of PTSD. Studies show that people with PTSD often have atypical levels of key hormones involved in the stress response. For instance, research has shown that they have lower-than-normal cortisol levels and higher-than-normal epinephrine and norepinephrine levels — all of which play a big role in the body's "fight-or-flight" reaction to sudden stress. (It's known as "fight or flight" because that's exactly what the body is preparing itself to do — to either fight off the danger or run from it.)

How Is PTSD Treated?
Therapy can help address symptoms of avoidance, intrusive and negative thoughts, and a depressed or negative mood. A therapist will work with your family to help you and your child or teen adjust to what happened and get back to living life.

Cognitive-behavioral therapy is very effective for people who develop PTSD. This type of therapy teaches ways to replace negative, unhelpful thoughts and feelings with more positive thinking. Behavioral strategies can be used at a child's own pace to help desensitize the child to the traumatic parts of what happened so he or she doesn't feel so afraid of them.

Eye movement desensitization and reprocessing therapy (EMDR) combines cognitive therapy with directed eye movements. This has been shown to be effective in treating people of all ages with PTSD.

Play therapy is used to treat young children with PTSD who can't directly deal with the trauma. In some cases, medicine can help treat serious symptoms of depression and anxiety. This can help those with PTSD cope with school and other daily activities while being treated. Medicine often is used only until someone feels better, then therapy can help get the person back on track.

Finally, group therapy or support groups are helpful because they let kids and teens know that they're not alone. Groups also provide a safe place to share feelings. Ask your child's therapist for referrals or suggestions.
How Can I Help My Child?

Above all, your child needs your support and understanding. Sometimes other family members like parents and siblings will need support too. While family and friends can play a key role in helping someone recover, help usually is needed from a trained therapist.

Here are some other things parents can do to support kids with PTSD:

- Most kids will need a period of adjustment after a stressful event. During this time, it's important for parents to offer support, love, and understanding.
- Try to keep kids' schedules and lives as similar as possible to before the event. This means not allowing your child to take off too much time from school or activities, even if it's hard at the beginning.
- Let them talk about the traumatic event when and if they feel ready. Praise them for being strong when they do talk about it, but don't force the issue if they don't feel like sharing their thoughts. Some kids may prefer to draw or write about their experiences. Either way, encouragement and praise can help them get feelings out.
- Reassure them that their feelings are typical and that they're not "going crazy." Support and understanding from parents can help with handling difficult feelings.
- Some kids and teens find it helpful to get involved in a support group for trauma survivors. Look online or check with your pediatrician or the school counselor to find groups nearby.
- Get professional help immediately if you have any concern that a child has thoughts of self-harm. Thoughts of suicide are serious at any age and should be treated right away.
- Help build self-confidence by encouraging kids to make everyday decisions where appropriate. PTSD can make kids feel powerless, so parents can help by showing their kids that they have control over some parts of their lives. Depending on a child's age, parents might consider letting him or her choose a weekend activity or decide things like what's for dinner or what to wear.
- Tell them that the traumatic event is not their fault. Encourage kids to talk about any feelings of guilt, but don't let them blame themselves for what happened.
- Stay in touch with caregivers. It's important to talk to teachers, babysitters, and other people who are involved in your child's life.
- Do not criticize regressive behavior (returning to a previous level of development). If children want to sleep with the lights on or take a favorite stuffed animal to bed, it might help them get through this difficult time. Speak to your child's doctor or therapist if you're not sure about what is helpful for your son or daughter.

Looking Ahead

Be sure to also take care of yourself. Helping your child or teen cope with PTSD can be very challenging and may require a lot of patience and support. Time does heal, and getting good support for your family can help everyone move forward.
Challenges Related to Attachment in Children who have Experienced Child Abuse or Neglect & Strategies to Help

The behaviors or challenges you might see in children who have a history of maltreatment and attachment difficulties will vary depending upon the nature, intensity, duration and timing of the neglect and abuse. Some children will have profound and obvious problems and some will have very subtle problems that you may not realize are related to early life neglect.

**Developmental delays:** Children experiencing emotional neglect in early childhood often have developmental delay in other domains. The bond between the young child and caregivers provides the major vehicle for developing physically, emotionally and cognitively. It is in this primary context that children learn language, social behaviors, and a host of other key behaviors required for healthy development. Lack of consistent and enriched experiences in early childhood can result in delays in motor, language, social and cognitive development.

**Eating:** Odd eating behaviors are common, especially in children with severe neglect and attachment problems. They will hoard food, hide food in their rooms, eat as if there will be no more meals even if they have had years of consistent available foods. They may have failure to thrive, rumination (throwing up food), swallowing problems and, later in life, odd eating behaviors that are often misdiagnosed as anorexia nervosa.

**Soothing behavior:** These children will use very primitive, immature and bizarre soothing behaviors. They may bite themselves, head bang, rock, chant, scratch or cut themselves. These symptoms will increase during times of distress or threat.

**Emotional functioning:** A range of emotional problems is common in these children including depressive and anxiety symptoms. One common behavior is “indiscriminant” attachment. All children seek safety. Keeping in mind that attachment is important for survival; children may seek attachments -- any attachments -- for their safety. Non-clinicians may notice abused and neglected children are “loving” and hug virtual strangers. Children do not develop a deep emotional bond with relatively unknown people; rather, these "affectionate" behaviors are actually safety seeking behaviors. Clinicians are concerned because these behaviors contribute to the abused child’s confusion about intimacy and are not consistent with normal social interactions.

**Inappropriate modeling:** Children model adult behavior - even if it is abusive. They learn abusive behavior is the “right” way to interact with others. As you can see, this potentially causes problems in their social interactions with adults and other children. For children that have been sexually abused, they may become more at-risk for future victimization. Males that have been sexually abused may become sexual offenders.

**Aggression:** One of the major problems with these children is aggression and cruelty. This is related to two primary problems in neglected children: (1) lack of empathy and (2) poor impulse control. The ability to emotionally "understand" the impact of your behavior on others is impaired in these children. They really do not understand or feel what it is like for others when they do or don’t do something.

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say something hurtful. Indeed, these children often feel compelled to lash out and hurt others - most typically something less powerful than they are. They will hurt animals, smaller children, peers and siblings. One of the most disturbing elements of this aggression is that it is often accompanied by a detached, cold lack of empathy. They may show regret (an intellectual response) but not remorse (an emotional response) when confronted about their aggressive or cruel behaviors.

What Caregivers Can Do

Nurture these children: These children need to be held and 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 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 food deprived during early childhood. A punitive approach to this problem (and many others) will not help the child mature. Indeed, punishment may actually increase the child's sense of insecurity, distress and need to hoard food. Many of these children's behaviors are confusing and disturbing to caregivers. You can get help from professionals if you find yourself struggling to create or implement a practical and useful approach to these problems.

Parent 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, overwhelmed (emotionally age two) parent 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 these children feel "safe" and secure. When they feel safe and secure 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...” Children see, hear and imitate.

"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...” 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 were teased because of their clothes or grooming, it would be helpful to have “cool” clothes and improved hygiene.

Help children understand 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 pick 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 the 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 grown-ups 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 pleasurable things to do is just stop, sit, listen and play with these children. When you are quiet and interactive with them you find that they will begin to show you and tell you about what is really inside them. Yet as simple as this sounds it is one of the most difficult things for adults to do - to stop, quit worrying about the time or your next task and really relax into the moment with a child. 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 and 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 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 have been swamped by the needs of a neglected and abused child that they have taken in.

**Take care of yourself:** Caring for maltreated children can be exhausting and demoralizing. You cannot provide the consistent, predictable, enriching and nurturing care these children need if you are depleted. Make sure you get rest and support. Respite care can be crucial. Use friends, family and community resources. You will not be able to help your child if you are exhausted, depressed, angry, overwhelmed and resentful.

**Take advantage of other resources:** For more information on this and other like topics, visit www.ChildTraumaAcademy.org. Many communities have support groups for adoptive or foster families. Professionals with experience in attachment problems or maltreated children can be very helpful. You will need help. 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.
Myths and Facts: Sexually Abused Children

**Myth:** Children in foster care have usually been sexually abused.

**Fact:** Not all children who are in care have been sexually abused. However, childhood sexual abuse is very common in the general population, and among children who have been removed from their parents care. Sadly, you likely know several adults and children who have had this experience – whether they have chosen to share this with you or not.

Many children who have experienced sexual abuse have not yet disclosed this abuse. It’s not uncommon for people who have survived sexual abuse to wait years, sometimes decades, to tell about what happened to them.

**Myth:** Children who experienced sexual abuse will probably go on to be adults who sexually abuse children.

**Fact:** The vast majority of people who were sexually abused as children do not go on to abuse children. The vast majority of people who sexually abuse children were NOT themselves sexually abused as children. Research finds nearly no link between experiencing sexual abuse as a child and later perpetration of sexual abuse for girls/women. Recent research has identified that being a boy who survived sexual abuse as a child may increase the risk of becoming an adult who sexually abuses children, but there are several other risk factors which appear to play a role as well. This research continues to confirm that the majority of boys and the overwhelming majority of girls who experience sexual abuse as children will not go on to sexually abuse children as adults.

**Myth:** A child I’m caring for has occasional sexual behaviors, so they were probably sexually abused.

**Fact:** Sexual behaviors are common in childhood, but sexual behavior problems are more common in children who experienced sexual abuse. Sexual development, including some sexual behaviors, begin when most children are very young. Behaviors which are common, and typically not cause for concern, are listed below.

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## Common Sexual Behaviors in Childhood

| Children Under 4 Years | • Exploring and touching private parts, in public and in private  
|                        | • Rubbing private parts (with hand or against objects)  
|                        | • Showing private parts to others  
|                        | • Trying to touch mother’s or other women’s breasts  
|                        | • Removing clothes and wanting to be naked  
|                        | • Attempting to see other people when they are naked or undressing (such as in the bathroom)  
|                        | • Asking questions about their own—and others’—bodies and bodily functions  
|                        | • Talking to children their own age about bodily functions such as “poop” and “pee”  
| 4-6 year olds          | • Purposefully touching private parts (masturbation), occasionally in the presence of others  
|                        | • Attempting to see other people when they are naked or undressing  
|                        | • Mimicking dating behavior (such as kissing, or holding hands)  
|                        | • Talking about private parts and using “naughty” words, even when they don’t understand the meaning  
|                        | • Exploring private parts with children their own age (such as “playing doctor”, “I’ll show you mine if you show me yours,” etc.)  
| 7-12 year olds         | • Purposefully touching private parts (masturbation), usually in private  
|                        | • Playing games with children their own age that involve sexual behavior (such as “truth or dare”, “playing family,” or “boyfriend/girlfriend”)  
|                        | • Attempting to see other people naked or undressing  
|                        | • Looking at pictures of naked or partially naked people  
|                        | • Viewing/listening to sexual content in media (television, movies, games, the Internet, music, etc.)  
|                        | • Wanting more privacy (for example, not wanting to undress in front of other people) and being reluctant to talk to adults about sexual issues  
|                        | • Beginnings of sexual attraction to/interest in peers  

### Typical sexual play and exploration:
- Occurs between children who play together regularly and know each other well
- Occurs between children of the same general age and physical size
- Is spontaneous and unplanned
- Is infrequent
- Is voluntary (the children agreed to the behavior, none of the involved children seem uncomfortable or upset)
- Is easily diverted when parents tell children to stop and explain privacy rules

### Sexual behaviors that are cause for concern:
- Are clearly beyond the child’s developmental stage (e.g., a three-year-old attempting to kiss an adult's genitals)
- Involve threats, force, or aggression
- Involve children of widely different ages or abilities (such as a 12-year-old “playing doctor” with a four-year-old)
- Provoke strong emotional reactions in the child—such as anger or anxiety

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20 From “Caring for Kids who have been Sexually Abused: What parents need to know” accessed at https://www.nctsn.org/sites/default/files/resources/fact-sheet/caring_for_kids_what_parents_need_know_about_sexual_abuse.pdf
Responding to sexual behavior: While it’s not helpful to panic or overreact, it IS important to attend to sexualized behavior, especially if it appears problematic. Children who have been sexually abused have over three times as many sexual behavior problems as children who have not been sexually abused\(^\text{21}\).

Myth: if a child has been assessed to have a sexual behavior problem or be “Sexually Aggressive” there is no helpful treatment and little hope for a safe and typical future.

Fact: Sexual behavior problems typically respond well to treatment, especially when the child has supportive caregivers and a structured environment. You can access reliable information about supporting children with Sexual Behavior problems at: https://www.nctsn.org/resources/understanding-and-coping-sexual-behavior-problems-children-information-parents-and

Possible Impacts of Abuse and Neglect on Child Development

Developmental Delays
- Children/youth impacted by abuse or neglect often have significant developmental delays in one or more areas of development.
  - Some delays are caused by genetics.
  - Some are the result of prenatal exposure to drugs or alcohol.
  - Some are the result of poor prenatal care or from situations in which children lived after birth.
  - Some delays are the direct result of trauma, abuse, and neglect.

Consequences of Abuse and Neglect on Physical Development
- Chronic malnutrition of infants and toddlers may result in limited overall growth, including impacts to the brain and intellectual disability.
- Direct blows to the head can result in blindness, deafness, intellectual disability, epilepsy, cerebral palsy, skull fracture, paralysis and coma. Less severe injuries can occur which might go undetected without a CT scan but might impact the child’s development.
- Injury to the hypothalamus and pituitary glands in the brain can impact physical growth.
- Blows or slaps to the side of the head over the ear can injure the inner ear mechanism and cause partial or complete hearing loss.
- Medical neglect, as in withholding treatment for treatable conditions, can lead to permanent physical disability, such as hearing loss from untreated serious ear infections, or respiratory damage from pneumonia or chronic bronchitis.
- Neglected infants and toddlers may have poor muscle tone, poor motor control, exhibit delays in gross and fine motor development and coordination, and fail to develop and perfect basic motor skills without professional intervention supported by a safe and consistent caregiver. Since most of an infant’s cognitive development is facilitated by motor involvement with the environment, physical delays contribute to cognitive delays as well.

Consequences of Abuse and Neglect on Cognitive Development
Absence of stimulation interferes with the growth and development of the brain.
- Brain damage from injury or malnutrition can lead to intellectual disabilities, though

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22 Adapted from RAFT: Relative, Adoptive, Foster Parent Training, New Mexico CYFD, Resource Family Pre-Service Training, Version 3.0
early intervention and ongoing services help children achieve higher levels of functioning.

- Because their environments are chaotic, harsh and/or don’t reward the child for interacting with people or things, maltreated infants may seem apathetic, listless, placid or immobile. They often do not manipulate objects or do so in repetitive, unsophisticated ways. They may have learned that it’s safest to be still and not explore, so may not seem to be curious or explore their environments the way children from safe environments do.

- Abused and neglected toddlers typically exhibit language and speech delays. This impacts cognitive development and can also affect social/emotional development.

Consequences of Abuse and Neglect on Social/Emotional Development

Because caregiving adults failed to interact with them in predictable, safe and nurturing ways, maltreated infants may develop insecure attachments. This can set the foundation for difficulty with managing emotions and engaging in close and safe relationships across childhood and beyond.

- Maltreated infants may not develop separation or stranger anxiety. They may willingly go to anyone and show equal pleasure in the presence of strangers and close family. This is unsurprising if you consider their experience that any adult, regardless of how well the baby knows them, may be either kind or harmful - and this happens in ways that are totally unpredictable to the infant.

- Maltreated infants may not maintain eye contact with others, may not become excited when talked to or approached, and may not engage in early serve and return (cooing, babbling, imitating the face) interactions with caregivers. If they are not provided persistently nurturing care by a reliable adult, these children may not develop adequate social and emotional skills.

- Abused infants often exhibit a state of frozen watchfulness, remaining passive and immobile but intently observant of the environment. This is a protective strategy in response to a fear of attack. It is as if the infant is on guard.

- Abused or neglected toddlers may not develop play skills and may not be interested in or have the skills for successful reciprocal, interactive play. This can affect their relationships with other children/youth.

- Abused toddlers may feel that they are bad children. This has a pervasive effect on the development of self-esteem.

- Abused and neglected toddlers may be fearful and anxious or depressed and withdrawn.
Experiencing child abuse or neglect has an impact. But **that impact will vary with each child**. Some children will be profoundly impacted and they will struggle throughout their lives. Others will be impacted much less and will reach adulthood with the skills they need for safe, productive lives.

One thing we KNOW is that we can create the kinds of experiences and environments that will help children reach their potential, whatever it may be. You can help promote children’s resilience, growth, and recovery in specific ways. For more on what you can do to help children heal from trauma see the following website: [https://changingmindsnow.org/healing](https://changingmindsnow.org/healing)
Impact of Trauma on the Brain

Each year in the United States alone, there are over three million children that are abused or neglected. These destructive experiences impact the developing child; increasing risk for emotional, behavioral, academic, social and physical problems throughout life. The purpose of this article is to outline how these experiences may result in increased risk by influencing the development and functioning of the child’s brain.

The Brain

The human brain is an amazing and complex organ. It allows us to think, act, feel, laugh, speak, create and love. The brain mediates all of the qualities of humanity, good and bad, yet the core mission of the brain is to sense, perceive, process, store, and act on information from the external and internal environment to promote survival. In order to do this, the human brain has evolved an efficient and logical organization structure.

The brain has a bottom-up organization. The bottom regions (i.e., brainstem and midbrain) control the most simple functions such as respiration, heart rate and blood pressure regulation while the top areas (i.e., limbic and cortex) control more complex functions such as thinking and regulating emotions.

Brain Development

At birth, the human brain is undeveloped. Not all of the brain’s areas are organized and fully functional. It is during childhood that the brain matures and the whole set of brain-related capabilities develop in a sequential fashion. We crawl before we walk, we babble before we talk.

The development of the brain during infancy and childhood follows the bottom-up structure. The most regulatory, bottom regions of the brain develop first, followed in sequence by adjacent but higher, more complex regions.

The process of sequential development of the brain and, of course, the sequential development of function, is guided by experience. The brain develops and modifies itself in response to experience. Neurons and neuronal connections (synapses) change in an activity-dependent fashion. This “use-dependent” development is the key to understanding the

23 Adapted from Bruce D. Perry, M.D., Ph.D. and John Marcellus, M.D. The ChildTrauma Academy
http://www.childtrauma.org/
impact of neglect and trauma on children. These areas organize during development and change in the mature brain in a "use-dependent" fashion.

The more a certain neural system is activated, the more it will "build-in" this neural state -- what occurs in this process is the creation of an "internal representation" of the experience corresponding to the neural activation. This "use-dependent" capacity to make an "internal representation" of the external or internal world is the basis for learning and memory. The simple and unavoidable result of this sequential neurodevelopment is that the organizing, "sensitive" brain of an infant or young child is more malleable to experience than a mature brain. While experience may alter and change the functioning of an adult, experience literally provides the organizing framework for an infant and child.

The brain is most plastic (receptive to environmental input) in early childhood. The consequence of sequential development is that as different regions are organizing, they require specific kinds of experience targeting the region’s specific function (e.g., visual input while the visual system is organizing) in order to develop normally. These times during development are called critical or sensitive periods.

**Traumatic Experiences and Development**

With optimal experiences, the brain develops healthy, flexible and diverse capabilities. When there is disruption of the timing, intensity, quality or quantity of normal developmental experiences, however, there may be devastating impact on neurodevelopment and, thereby, function. For millions of abused and neglected children, the nature of their experiences adversely influences the development of their brains. During the traumatic experience, these children’s brains are in a state of fear-related activation.

This activation of key neural systems in the brain leads to adaptive changes in emotional, behavioral and cognitive functioning to promote survival. Yet, persisting or chronic activation of this adaptive fear response can result in the maladaptive persistence of a fear state. This activation causes hyper-vigilance, increased muscle tone, a focus on threat-related cues (typically non-verbal), anxiety, behavioral impulsivity -- all of which are adaptive during a threatening event yet become maladaptive when the immediate threat has passed.

This is the dilemma that traumatic abuse brings to the child’s developing brain. The very process of using the proper adaptive neural response during a threat will also be the process that underlies the neural pathology, which causes so much distress and pain through the child’s life. The chronically traumatized child will develop a host of physical signs (e.g., altered cardiovascular regulation) and symptoms (e.g., attention, sleep and mood problems) which make their lives difficult.
There is hope, however. The brain is very plastic meaning it is capable of changing in response to experiences, especially repetitive and patterned experiences. Furthermore, the brain is most plastic during early childhood. Aggressive early identification and intervention with abused and neglected children has the capacity to modify and influence development in many positive ways.

The elements of successful intervention must be guided by the core principles of brain development. The brain changes in a use-dependent fashion. Therapeutic interventions that restore a sense of safety and control are very important for the acutely traumatized child. In cases of chronic abuse and neglect, however, the very act of intervening can contribute to the child’s catalogue of fearful situation.

Investigation, court, removal, placement, re-location, and re-unification all contribute to the unknown, uncontrollable and, often, frightening experiences of the abused child. Our systems, placements and therapeutic activities can diminish the fearful nature of these children’s lives by providing consistency, repetition (familiarity), nurturance, predictability and control (returned to the child). Yet the poorly coordinated, over-burdened and reactive systems mandated to help these children rarely can provide those key elements.

Alarm Systems in the Brain
The alarm systems of those who have experienced multiple traumatic events or severe neglect in infancy are triggered with regularity. The reaction is often a behavior related to fear or rage. The behavior can be primitive in nature (aggression, yelling, etc.) as the primitive part of the brain is activated, not the frontal cortex (which is associated with problem solving, verbalizing emotions, etc.).

People who have experienced trauma can be triggered easily by people, smells, and scenarios that look and feel similar to the traumatic event or persons involved in the incident. For example, a low flying plane in New York may provoke biological reactions (heart palpitations, hyper-vigilance, and/ or shallow breathing) in those persons who witnessed, heard, or saw the 9/11 tragedy. A child or youth who has been traumatized may react with aggression to a request or person that he/she may misperceive as threatening. His/her body may respond in a variety of ways: increasing agitation or increased numbing out (remember fight, flight, and freeze).

The brain has billions and billions of neural pathways. We learn by watching and experiencing. What we learn, in repeating actions over and over, whether it is considered to
be a good behavior or bad behavior, is a connection made in the brain. Children develop behaviors in chaotic, harmful and unpredictable environments which help them stay safe or get their needs met. These behaviors and strategies were adaptive in that environment, but may not be helpful (and may be seen as very problematic) in a safe environment. For instance, indiscriminate friendliness with adults, aggression in response to a wide array of situations, or extreme people pleasing are often strategies adopted by children to keep themselves safe in an unsafe environment. It’s not that they didn’t have adults reminding them not to hit (though they may not have) – it’s that hitting and yelling and making an enormous scene (or withdrawing, or pleasing, or sexualized behaviors, or…) seemed the best way to get potentially harmful adults not to harm them, or if they could not avoid the abuse to at least cope while it was happening. These behaviors were repeated over and over because they helped, but now that they are in a safe environment the behaviors aren’t easy to modify because they are wired into the brain.

For more information and ideas on how you can help children heal and thrive, see “Supporting Brain Development in Traumatized Children and Youth” at: https://www.childwelfare.gov/pubPDFs/braindevtrauma.pdf
Comfort

Safety and stability — the same basic needs that comfort us as adults — greatly help all kids, particularly those experiencing traumatic stress.

Studies show that adults who provide consistent emotional and physical support can buffer the “fight or flight” stress response in children. So offer a compassionate, reassuring presence and demonstrate your commitment through repetition. Create a safe environment to help children re-establish a sense of security and stability. Teach them how to manage their emotions and calm themselves down.

Sometimes it can be difficult to remain calm and supportive when children are exhibiting signs of toxic stress. Try to remember to take a deep breath. And use the information below to comfort the children in your life, as well as yourself.

General Tips

- Be kind and passionate. Sometimes, children who need the most help tend to push people away. Reassure them and let them know you’re here to help.
- Practice active listening and speak softly, regulate your own breathing, and offer validation and affection when appropriate.
- Provide support during both small stressors and big issues.
- Help them label and manage their emotions by connecting words to feelings.
- Practice relaxation and emotional regulation skills to help them manage their stress.
- Help children know what to expect by establishing structured and predictable routines and environments.
Age-Related Tips

**Infants & Toddlers:**
- Foster a deep, nurturing connection with children. Babies learn to soothe themselves in times of distress by being soothed by their caregivers.
- Offer physical and emotional affection to create a feeling of safety. For infants, swaddling, shushing, and rocking can help them calm down.
- Be patient during the tough times. By supporting babies even at their most difficult moments, you are letting them know they can trust and rely on you.
- Provide children with acceptable, non-violent ways to share strong feelings. For example, toddlers can rip paper, stomp their feet, or throw a foam ball when they're very mad.
- Respond to children's needs for increased attention, comfort, and reassurance. Increase your response to match what they need.
- Pay close attention to children's feelings, and validate them.
- Help children identify their feelings by naming them. For example, you might say, “I can see that you feel really angry at him for knocking over your blocks.”
- Very young children work through frightening events by reenacting them through play. So try not to discourage the way they play, even if you find it disturbing. Comfort children who seem distressed by their play, and gently redirect them to other activities.
- Be patient and calm when children are clingy, whiny, or aggressive. They need you to help them regain control and feel safe.
- Help children feel safe enough to feel emotions, even while limiting their actions. For example, “You can be as mad as you want, but I won't let you hit.”
- Provide young children with a comfort object, like a special stuffed animal or a soft blanket. For very young children, using a pacifier or allowing them to suck their thumb can help them self-soothe.
- Stay calm in stressful situations. Infants take their emotional cues from their caregivers.

**Elementary/Middle School:**
- Practice relaxation techniques when children are not under stress — like counting to ten, deep breathing, meditation, or positive self-talk. Repetition will make them more likely to utilize these techniques when they're upset.
- Help a child empathize and take others' perspectives by labeling other children's emotions. This can also help them understand appropriate behavioral norms.
- Help children feel like they can trust you by only making promises you can keep.
- Offer them safe ways to express feelings, such as drawing, pretend play, or telling stories.
- Teach children positive self-talk to help them deal with everyday frustrations.
- Recognize that when children are disruptive, they are generally feeling out of control and may not have the ability to express themselves in other ways. Use a calm approach to help children regain a sense of safety and control.
**Teens:**
- Be present and pay attention. Look for changes in behaviors and check in with them about what you’re noticing.
- Offer validating and reflecting statements to help them label their own emotions when in distress.
- Practice relaxation techniques when they are not under stress — like counting to ten, deep breathing, meditation, or positive self-talk. Repetition will make them more likely to utilize these techniques when they’re upset.
- Help teens identify their strategies to manage stress and control their impulses.
- Help them identify friends that make them feel happy and confident.

**Environment-Related Tips**

**At School:**
- Respond in a kind, compassionate way when a child is going into survival mode. For example, when children turn red and clench their fists, start rapidly breathing, or if they freeze and have a “deer-in-the-headlights” look, approach them and offer comfort, rather than discipline or more stimuli.
- When you notice that a child might be having a difficult time, ask yourself, “What’s happening here?” rather than “What’s wrong with this child?” This simple mental switch can help you realize that the student has been triggered into a fear response, which can take many forms.
- When you recognize children who have been triggered, compassionately reflect back to them: “You seem like you’re having trouble or getting irritated,” and then offer a couple choices of things they can do. This will help them gain a sense of control and agency, and it will help them to feel safe again.
- Engage students in activities and assignments such as yoga, meditation, breathing games, and affirmations to help them learn emotional regulation, social awareness, self-awareness, relationship skills, and anger management.
- Create predictable routines and transitions for children so they know what to expect. Some teachers will play music or ring a meditation bell to signal that it’s time to transition.
- Create a safe and cozy space in your classroom where kids who are upset can go to calm themselves down.
- During your daily routines, you may notice children’s triggers. When you see patterns, proactively develop strategies to minimize the issues.

**In the Community:**
- Take children’s concerns seriously, and offer validating statements. Refer to further assessments or services as needed.
- Set clear, consistent boundaries and limits with children.
- Don’t make promises you can’t keep.
- Help children identify early warning signs of anger, sadness, and fear, and develop strategies that they can use to calm down in the moment.
- Praise children’s efforts to regulate their emotions, and offer healthy, non-violent ways to express negative feelings.
- Help children identify and expand their network of consistently caring adults.
In Healthcare Settings:

- Take children’s concerns seriously and offer validating statements. Refer to further assessments or services as needed.
- Explain what you are going to do, in detail, to help children know what to expect.
- When appropriate, allow parents or caregivers to offer emotional and physical support during visits. Prompt parents or caregivers to prepare children ahead of time.
- Respect children’s privacy and, when appropriate, talk to them without their caregivers present.
- Answer children’s questions honestly, but age appropriately.
- Allow a child to participate in some choices, as appropriate.
- If a procedure will be painful or scary, offer coping or relaxation strategies such as deep breathing, blowing bubbles, or singing together.
- Talk to children about strategies to calm themselves down when they’re feeling upset, angry, or afraid. Discuss what they notice about their bodies when they have these feelings (heart beating faster, stomach feeling funny). Guide adolescents to appropriate brief meditation or deep-breathing videos or apps.

At Home:

- Bond physically with children. Simple things like eye contact, kisses, and hugging will help them feel safe and secure.
- Take care of children’s everyday needs. Make sure they are getting their sleep, meals, snacks, baths, and playtime.
- Provide as much consistency and stability as possible. Help children know what to expect by developing routines and creating a safe, welcoming home environment.
- Be patient. Accept and validate children’s feelings, and remember that negative behavior is often a result of feeling out of control, not a deliberate attempt to upset you.
- Talk about your own feelings and use language to describe your emotions. For example, “I feel sad that my favorite necklace broke and that I can’t wear it anymore.”
- Encourage children to talk about their feelings. Help them expand the words they use to describe emotions.
- Help children identify early warning signs of anger, sadness, and fear, and develop strategies that they can use to calm down in the moment.
- Praise children’s efforts to regulate their emotions, and offer healthy, non-violent ways to express negative feelings.
- Play games, read stories, and engage in activities that help children develop the ability to identify and regulate their emotions. Encourage them to label emotions while reading or watching television.
Why it Works

Providing comfort to children can make the difference between fear and security, and can provide a foundation for resilience. Children’s responses to witnessing violence and experiencing traumatic stress most often include intense fear, helplessness, or horror (American Psychiatric Association, 2000; The National Child Traumatic Stress Network, 2007). This can impair their neuropsychological development as well as their ability to regulate emotions and control impulsive behaviors (Cole et al., 2005).

Exposure to violence changes their diurnal cortisol reactivity and leads to over-activation of the hypothalamic, pituitary, adrenal (HPA) axis system (or the central stress response system) and can lead to toxic stress. Additionally, children who have experienced chronic trauma often approach everyday situations as if every moment is dangerous; they can remain hypervigilant or react to situations in a “fight, flight, or freeze” manner. This heightened state of alertness can affect a child’s attention span and ability to engage with material at school, home, and in other settings (Cole et al., 2005).

Caring adults can provide a buffer to traumatic stress. Through comfort and support, they can help reverse the effects of toxic stress in children and assist them in making sense of their experiences and regaining a feeling of safety (Center on the Developing Child, Harvard University). Over time, your everyday support and conversations with children can build up their emotional health by helping them to differentiate among their thoughts, emotions, and feelings (Pool, 1997). When children are able to regulate their emotions, such as anger and sadness, they are better able to sustain relationships, focus on tasks, and succeed socially and educationally. Such skills, including self-soothing or calming, are increasingly recognized as important to overall well-being and resilience. As a caring adult, you can be a model of healthy emotional expression and behaviors, and you can help provide the supportive guidance children need.

References

4 Center on the Developing Child, Harvard University. http://developingchild.harvard.edu/
A fundamental goal of parenting is to help children grow and thrive to the best of their potential. Parents anticipate protecting their children from danger whenever possible, but sometimes serious danger threatens, whether it is manmade, such as a school shooting or domestic violence, or natural, such as a flood or earthquake. And when a danger is life-threatening or poses a threat of serious injury, it becomes a potentially traumatic event for children.

By understanding how children experience traumatic events and how these children express their lingering distress over the experience, parents, physicians, communities, and schools can respond to their children and help them through this challenging time. The goal is to restore balance to these children’s lives and the lives of their families.

HOW CHILDREN MAY REACT

How children experience traumatic events and how they express their lingering distress depends, in large part, on the children’s age and level of development.

**Preschool and young school-age children** exposed to a traumatic event may experience a feeling of helplessness, uncertainty about whether there is continued danger, a general fear that extends beyond the traumatic event and into other aspects of their lives, and difficulty describing in words what is bothering them or what they are experiencing emotionally.

This feeling of helplessness and anxiety is often expressed as a loss of previously acquired developmental skills. Children who experience traumatic events might not be able to fall asleep on their own or might not be able to separate from parents at school. Children who might have ventured out to play in the yard prior to a traumatic event now might not be willing to play in the absence of a family member. Often, children lose some speech and toileting skills, or their sleep is disturbed by nightmares, night terrors, or fear of going to sleep. In many cases, children may engage in traumatic play—a repetitive and less imaginative form of play that may represent children’s continued focus on the traumatic event or an attempt to change a negative outcome of a traumatic event.

**For school-age children,** a traumatic experience may elicit feelings of persistent concern over their own safety and the safety of others in their school or family. These children may be preoccupied with their own actions during the event. Often they experience guilt or shame over what they did or did not do during a traumatic event. School-age children might engage in constant retelling of the traumatic event, or they may describe being overwhelmed by their feelings of fear or sadness.
A traumatic experience may compromise the developmental tasks of school-age children as well. Children of this age may display sleep disturbances, which might include difficulty falling asleep, fear of sleeping alone, or frequent nightmares. Teachers often comment that these children are having greater difficulties concentrating and learning at school. Children of this age, following a traumatic event, may complain of headaches and stomach aches without obvious cause, and some children engage in unusually reckless or aggressive behavior.

Adolescents exposed to a traumatic event feel self-conscious about their emotional responses to the event. Feelings of fear, vulnerability, and concern over being labeled “abnormal” or different from their peers may cause adolescents to withdraw from family and friends. Adolescents often experience feelings of shame and guilt about the traumatic event and may express fantasies about revenge and retribution. A traumatic event for adolescents may foster a radical shift in the way these children think about the world. Some adolescents engage in self-destructive or accident-prone behaviors.

Some adolescents engage in self-destructive or accident-prone behaviors.

HOW TO HELP

The involvement of family, physicians, school, and community is critical in supporting children through the emotional and physical challenges they face after exposure to a traumatic event.

For young children, parents can offer invaluable support, by providing comfort, rest, and an opportunity to play or draw. Parents can be available to provide reassurance that the traumatic event is over and that the children are safe. It is helpful for parents, family, and teachers to help children verbalize their feelings so that they don’t feel alone with their emotions. Providing consistent caretaking by ensuring that children are picked up from school at the anticipated time and by informing children of parents’ whereabouts can provide a sense of security for children who have recently experienced a traumatic event. Parents, family, caregivers, and teachers may need to tolerate regression in developmental tasks for a period of time following a traumatic event.

Older children will also need encouragement to express fears, sadness, and anger in the supportive environment of the family. These school-age children may need to be encouraged to discuss their worries with family members. It is important to acknowledge the normality of their feelings and to correct any distortions of the traumatic events that they express. Parents can be invaluable in supporting their children in reporting to teachers when their thoughts and feelings are getting in the way of their concentrating and learning.

For adolescents who have experienced a traumatic event, the family can encourage discussion of the event and feelings about it and expectations of what could have been done to prevent the event. Parents can discuss the expectable strain on relationships with family and peers, and offer support in these challenges. It may be important to help adolescents understand “acting out” behavior as an effort to voice anger about traumatic events. It may also be important to discuss thoughts of revenge following an act of violence, address realistic consequences of actions, and help formulate constructive alternatives that lessen the sense of helplessness the adolescents may be experiencing.

When children experience a traumatic event, the entire family is affected. Often, family members have different experiences around the event and different emotional responses to the traumatic event. Recognizing each others’ experience of the event, and helping each other cope with possible feelings of fear, helplessness, anger, or even guilt in not being able to protect children from a traumatic experience, is an important component of a family’s emotional recovery.
# Understanding How a Child Responds to Loss

<table>
<thead>
<tr>
<th>Age</th>
<th>Possible Short Term Impacts</th>
<th>Possible Long Term Impacts</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infancy</td>
<td>• Sense of security and trust in adults could be undermined</td>
<td>• Trouble trusting others</td>
</tr>
<tr>
<td></td>
<td>• Developmental regression or freeze in development as infant adjusts to completely new routine and surroundings</td>
<td>• Learning problems</td>
</tr>
</tbody>
</table>

**What You Can Do:**
- Keep up the same routines the child has had: e.g. feeding, bathing.
- Change as little as possible
- Incorporate familiar smells, objects, places, and people
- Primary caregiver should be available “on demand” for the infant
- Be guided by the question, “What will help this infant learn to trust that adults will be available?”
- Follow a consistent routine
- Record information so that it will be available to the child when he/she gets older.

<table>
<thead>
<tr>
<th>Toddlerhood</th>
<th>• Developmental Regression</th>
<th>• Develops a need to always be in control</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Language regression or language delays</td>
<td>• Has trouble learning to recognize own needs</td>
</tr>
<tr>
<td></td>
<td>• May become too dependent or very self-reliant</td>
<td>• Has problems developing appropriate relationships</td>
</tr>
</tbody>
</table>

**What You Can Do:**
- Prepare the child for moves and allow lots of transition time.
- Keep routines the same:
  - e.g. meals, bath, bed every day at the same time.
- Say things like, “it’s OK to miss your Mommy and Daddy. I know it must hurt.”
- Don’t pressure the child to acquire typical development. Allow for a period of adjustment and developmental lag first (e.g. allowing the bottle, eating with hands, potty-training.)

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<table>
<thead>
<tr>
<th>Age</th>
<th>Possible Short Term Impacts</th>
<th>Possible Long Term Impacts</th>
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</thead>
</table>
| PreSchool Years (3-6) | • May feel that he/she caused the loss by thinking “bad things” or “wishing things would change” – magical thinking  
 • Not differentiating between safe/known and unknown adults  
 • Conflicting feelings about him/herself | • Blames himself/herself for the loss  
 • Has problems developing a positive self-image |
| What You Can Do:  | • Make sure the child understands that they did not cause this and aren’t to blame.  
 Respond to even small statements or gestures that show the child believes they are bad.  
 • Offer age-appropriate explanations for the separation and loss.  
 • Encourage the child to express his/her feelings through play.  
 • Provide ways for the child to remember the people and places he/she is separated from.  
 • Reassure the child that you will take care of him/her.  
 • Be extremely consistent in meeting needs. |}
| Grade School      | • Lack of energy to do things because of the time spent grieving/wondering/trying to end the separation  
 • Noticing how peers may not have experienced loss. This can impact peer relationships.  
 • Grief may look like sadness or despair, anger, and anxiety in this age group. | • Ongoing problems in school, including difficulty making friends, paying attention, and meeting expectations  
 • Resentment and anger may impact inclination and ability to behave in safe, kind (e.g. moral) ways |
| What You Can Do:  | • Encourage the child to talk about his/her feelings and don’t be judgmental.  
 • Give the child clear, developmentally appropriate information about the loss to reduce his/her feelings of responsibility and/or guilt.  
 • Provide the child with opportunities to focus on grieving so that at other times he can focus on the tasks at hand, whether they are academic or peer related.  
 • When the child seems ready, it can help for the parent or others to give permission to let go of old attachments and form new ones. This might mean saying that it’s ok if the child enjoys the foster father’s cooking, the camping trip they just took, or holidays with the foster family’s extended family. That doesn’t mean they don’t still love their parent. It’s ok to enjoy both.  
 • Help the child have an explanation that they feel comfortable with for when peers (or adults) ask why they don’t live with their parent. |
### Possible Short Term Impacts

- May feel hopeless, out of control, different from others
- May have school problems, including choosing peers who are not positive
- May show fear, unhappiness, anxiety, denial
- May have trouble getting close to or trusting others
- May want and expect high levels of consistency from others
- May run away, try to reunite with the parent, or imagine doing so in adulthood

### Possible Long Term Impacts

- Mental health issues, particularly depression
- Suicidal behavior
- Antisocial behavior

### What You Can Do:

- Involve the youth, whenever possible, in making decisions.
- Be open and honest when the youth asks questions about why they are in care and what is happening now. Refer to the Social Worker if you can’t answer a question or propose talking to the social worker together.
- Encourage him/her to talk about his/her feelings.
- Be available, but allow the youth time alone and with peers as well.
- Help the youth determine how much to share, with whom, and when, about their story.
## Helping Children Progress Developmentally

<table>
<thead>
<tr>
<th>Physical</th>
<th>Create opportunities for them to use their bodies:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Play at the park</td>
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<tr>
<td></td>
<td>• Take swimming lessons</td>
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<td></td>
<td>• Do gymnastics</td>
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<td>• Kick a ball or practice pitching/hitting</td>
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<td></td>
<td>• Go to a climbing wall</td>
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<td></td>
<td>• Make an obstacle course</td>
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<td></td>
<td>• Roller skate or skate board</td>
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<tr>
<td></td>
<td>• Dance!</td>
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<tr>
<td></td>
<td>Find ways to practice fine motor skills:</td>
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<tr>
<td></td>
<td>• Sew or knit</td>
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<tr>
<td></td>
<td>• Paint or draw</td>
</tr>
<tr>
<td></td>
<td>• Young children can play with blocks, legos, even hold and turn pages in books</td>
</tr>
<tr>
<td></td>
<td>• Bead</td>
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<tr>
<td></td>
<td>Eat nutritiously but avoid fights about food (gradually introduce more healthy options)</td>
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</tbody>
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<table>
<thead>
<tr>
<th>Cognitive</th>
<th>Meet the child’s sleep needs¹</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Help child soothe self at bedtime</td>
</tr>
<tr>
<td></td>
<td>• Create a consistent, pleasurable routine</td>
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<tr>
<td></td>
<td>• Avoid sleep overs or trips until sleeping routine is well established</td>
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<tr>
<td></td>
<td>Be involved at school or daycare. Ask for periodic reports about progress and issues of concern.</td>
</tr>
<tr>
<td></td>
<td>Advocate for assessments and services after a period of observation and settling in</td>
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<td></td>
<td>Play games and do puzzles</td>
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<tr>
<td></td>
<td>Read to the child every day</td>
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<tr>
<td></td>
<td>Cook (follow recipes)</td>
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<tr>
<td></td>
<td>Explore in nature</td>
</tr>
<tr>
<td></td>
<td>Draw pictures and label them</td>
</tr>
<tr>
<td></td>
<td>Talk about stories</td>
</tr>
<tr>
<td></td>
<td>Ask ‘why’ and ‘how’ questions. Find answers together.</td>
</tr>
</tbody>
</table>

¹ [https://sleepfoundation.org/excessivesleepiness/content/how-much-sleep-do-we-really-need-0](https://sleepfoundation.org/excessivesleepiness/content/how-much-sleep-do-we-really-need-0)
<p>| Social/Emotional | Build attachment (see previous handouts) |
| | Keep routines and expectations consistent |
| | Label emotions |
| | Notice how others are feeling in books or movies, how they express the feeling, and that hard feelings pass |
| | Model healthy expression and management of your feelings |
| | Books and apps exist that help older children and teens learn social emotional skills and manage symptoms related to trauma or loss |
| | Create a ‘calm down’ or ‘safe space’ area for younger children with soft toys, things that encourage deep breathing, and help manage sensory input (ear phones, sunglasses, soft stuffies, pinwheels, balloons to blow up, etc) |
| | Create clear rules about privacy (1 person in bathrooms and bedrooms at once, etc) |
| | Role play or ‘practice’ ahead of a challenging situation. |
| | Play “guess what I’m feeling” and show an emotion on your face. Let the child have a turn |
| | Monitor interactions with friends. Coach the child through difficult situations without fixing. |
| | Step in when social situations are more than a child has skills to manage (bullying or peer pressure) |
| Self-Help/Adaptive | Don’t make a big deal out of the skills they don’t have |
| | Practice skills one at a time |
| | Celebrate achievements and new competence |
| | Break down a skill into its parts and tackle piece by piece (start with putting on shoes, then pulling laces and crossing, then tying them) |
| | Use charts or visual reminders to help with routines and staying organized/finishing tasks |</p>
<table>
<thead>
<tr>
<th>Language &amp; Communication</th>
<th>Read to the child daily</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Make up stories. Write and illustrate them.</td>
</tr>
<tr>
<td></td>
<td>play ‘what if’ games</td>
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<tr>
<td></td>
<td>Have a ‘word of the day’</td>
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<tr>
<td></td>
<td>Sing</td>
</tr>
<tr>
<td></td>
<td>Tell jokes, read joke books, do tongue twisters and riddles</td>
</tr>
<tr>
<td></td>
<td>Play, create, and listen to music</td>
</tr>
<tr>
<td></td>
<td>Describe what you are doing and what you see to infants and toddlers</td>
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<tr>
<td></td>
<td>Ask “can you think of a word that rhymes with?”</td>
</tr>
</tbody>
</table>
Resource Links Provided in Session 5

Learn more about the importance of following safe sleep guidelines from the Center for Disease Control
Link: [https://www.cdc.gov/sids/AboutSUIDandSIDS.htm](https://www.cdc.gov/sids/AboutSUIDandSIDS.htm)

Here is a news report regarding fetal alcohol syndrome and its frequency.

Learn more about University of Washington's FASD Diagnostic and Prevention Network
Link: [https://depts.washington.edu/fasdpn/](https://depts.washington.edu/fasdpn/)

Learn more about Fetal Alcohol Spectrum Disorder from the Center for Disease Control
Link: [https://www.cdc.gov/ncbddd/fasd/index.html](https://www.cdc.gov/ncbddd/fasd/index.html)

The Alliance offers trainings for Caregivers parenting children with specific diagnoses and mental health needs.
Link: [http://alliancecatalog.org/](http://alliancecatalog.org/)

Check out this brief story from the PBS News Hour about a program to help children heal from childhood trauma.
Link: [https://www.youtube.com/watch?v=bFJHbCMV7kc](https://www.youtube.com/watch?v=bFJHbCMV7kc)

This video is a five-minute primer to help you understand Adverse Childhood Experiences (ACES).
Link: [https://acestoohigh.com/2016/04/05/five-minute-video-primer-about-adverse-childhood-experiences-study/](https://acestoohigh.com/2016/04/05/five-minute-video-primer-about-adverse-childhood-experiences-study/)

Learn more about ACES from the Robert Wood Johnson Foundation.

Learn more about ACES in this renowned Ted Talk from Dr. Nadine Burke Harris.
Link: [https://www.ted.com/talks/nadine_burke_harris_how_childhood_trauma_affects_health_across_a_lifetime](https://www.ted.com/talks/nadine_burke_harris_how_childhood_trauma_affects_health_across_a_lifetime)

Here's a video from a Seattle foster and adoptive parent about creating memory boxes for the children in your care as a way to keep them connected to their pasts.
Link: [https://www.youtube.com/watch?v=CLpV8VJzs3Q](https://www.youtube.com/watch?v=CLpV8VJzs3Q)