Session Three

Meeting Developmental Needs: Attachment

Session Three

Competencies and Objectives

Competencies

Prospective foster parents and adoptive parents:

- Understand the factors which contribute to neglect, emotional maltreatment, physical abuse, and sexual abuse.
- Know the physical, medical, emotional, and behavioral indicators of neglect.
- Know the physical, medical, emotional, and behavioral indicators of physical abuse.
- Know the physical, medical, emotional, and behavioral indicators of sexual abuse.
- Know the indicators of emotional maltreatment.
- Know the stages of normal human growth and development.
- Know how physcial abuse, sexual abuse, neglect, and emotional maltreatment affect attachment.
- Know the impact of multiple placements on a child's development.
- Know how physical abuse, sexual abuse, neglect, and emotional maltreatment affect child behavior.
- Know how physical abuse, sexual abuse, neglect, and emotional maltreatment affect child growth and development.
- Know the conditions and experiences that may cause developmental delays and affect attachment.
- Can apply an understanding of attachment to the adoption process.
- Can recognize developmental delays and respond appropriately.

In-Session Learning Objectives

As a result of their participation in this training program, prospective foster parents and adoptive parents will be able to:

1. List and define the three areas of development.
2. Explain that children's development is influenced by ethnic and cultural identity, education, appearance, and life experiences.
3. Explain the role of attachment in the child's overall growth and development.
4. Explain that development occurs in stages, and that each stage is important for the next.
5. Describe the use of "developmental milestones" within a wide range of what is considered normal growth and development.
6. Describe the three major developmental tasks of adolescents and why these tasks present significant challenges for youth in family foster care.
7. Describe how attachment develops as a result of having needs met.
8. Explain how child maltreatment impacts attachment.
9. Explain how attachment is affected when needs are not met.
10. Identify the conditions that contribute to delayed development.
11. Describe how a child's difficulty with attachments may be compounded by the placement process.
12. Identify ways to strengthen attachment between children and their foster families or adoptive families.
13. Explain how different types of child maltreatment may impact the child's behavior.
14. Identify strategies to deal with challenging behaviors that a child who is maltreated is likely to present.
15. Describe how chronological age and appearance affect expectations of child behavior.
16. Explain why it is important to be culturally competent when assessing a child's development.

17. Describe the impact of child maltreatment on the child's development.

18. Describe how foster families and adoptive families can continue the challenging process of building attachments with children.

19. Describe the importance of teamwork in meeting the developmental needs of children, and addressing their developmental delays.

At-Home Learning Objectives

Through reviewing, at home, the information in their PRIDEbook, prospective foster parents and adoptive parents will be able to:

1. Describe the child growth and development chart and how it can be used.

2. Describe the conditions that negatively affect child growth and development, and how these conditions affect attachment.

3. Identify the indicators of:

   - Infants exposed to alcohol/drugs during pregnancy
   - Developmental disabilities
   - Emotional maltreatment
   - Neglect
   - Physical abuse
   - Sexual abuse
   - HIV/AIDS

4. Describe ways to lessen the effects of sexual abuse on child victims.

5. Identify issues affecting their ability and willingness to work effectively with birth parents, based on the information obtained from this session's A Birth Parent's Perspective.

Session Three

Agenda

Part I: Welcome and Connecting with PRIDE

A. Welcome and Review of Competencies, Objectives, and Agenda

B. Making Connections from Session Two

C. Making Connections with Assessment, Licensing, and Certification

Part II: Overview of Human Development

A. The Influence of Family, Environment, and Attachment

B. Overview of Attachment

C. Developmental Challenges

Part III: The Impact of Maltreatment and Trauma on the Child

A. The Child's Experience of Abuse and Neglect

B. The Impact of Maltreatment and Trauma on Attachment

C. The Impact of Maltreatment and Trauma on Behavior

D. The Impact of Maltreatment and Trauma on Development

Part IV: Closing Remarks

A. PRIDEbook Resources

B. A Birth Parent's Perspective

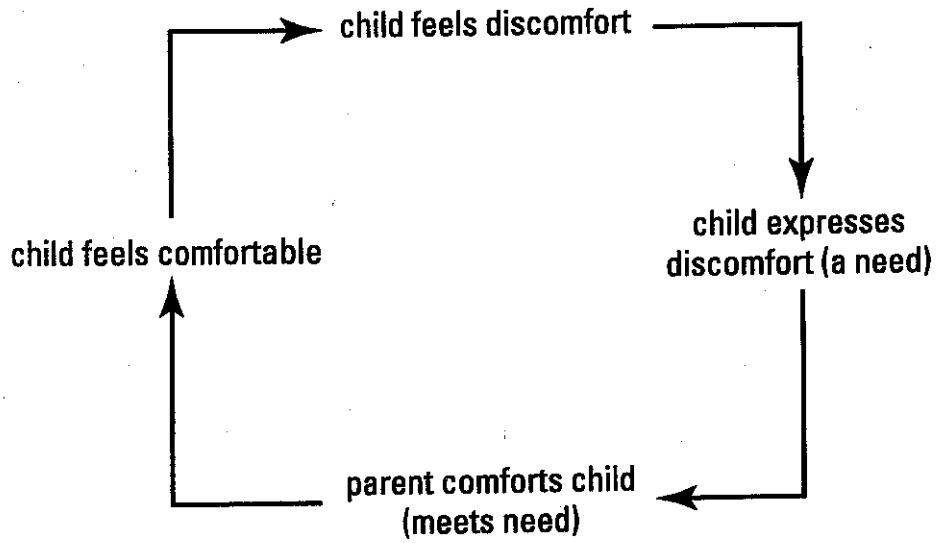
C. PRIDE Connection

D. Preview of Session Four

E. Making a Difference!

F. End Session

How Attachment Develops



Definitions of Child Abuse and Neglect

Physical abuse—physical acts that caused or could have caused bodily injury to a child (Example: Hitting that results in bodily harm such as broken bones or bruises.)

Sexual abuse—the offender's involvement of the child in sexual activity to provide sexual gratification or financial benefit to the offender, including contact with the child for sexual purposes, prostitution, exposure, or other sexually exploitative activities. Sexual abuse does not always involve direct contact. Exhibitionism, viewing pornography together, or taking sexualized pictures of a child are examples of sexual abuse that does not involve contact. Examples of direct contact include fondling, inappropriate sexual touch, or sexual intercourse.

Neglect—depriving the child of necessities; failing to provide the child with needed, age-appropriate care, even though the caregiver is financially able to do so, or offered financial or other means to do so. (Example: The home is so dirty that a toddler is exposed to broken glass and dog feces on the floor).

Medical neglect—the failure of a caregiver to provide appropriate health care for the child, resulting in harm to the child's health, even though the caregiver is financially able to do so, or is offered financial or other means to do so. This may include prenatal exposure to drugs. (Example: A caregiver does not provide a diabetic child with needed insulin on a consistent basis.)

Emotional/psychological maltreatment—the offender's acts or omissions, other than physical or sexual abuse, that caused or could have caused cognitive, affective, conduct, or mental disorders in the child. (Example: A child is repeatedly told that he or she is worthless and stupid. The child, who is of average intelligence, begins to have significant problems in school, is afraid to take tests, and refuses to try to learn.)

Child Maltreatment and Trauma Case Vignettes

Case One: Alicia

Alicia came into care at age four due to severe neglect. She had not been properly supervised and had sustained several injuries. She was malnourished and dehydrated. She was unable to ask for anything. Instead she would immediately begin to scream and throw temper tantrums. Alicia would not smile. She would accept a hug from the foster parents, but would not hug back.

The more the foster parents tried to meet her needs, the more attention she demanded. The foster parents responded by seeking to fulfill and even anticipate Alicia's needs. Over several months, Alicia's temper tantrums decreased. She began to smile and make eye contact.

After a year, Alicia was placed with her preadoptive family. Her behavior baffled the family. She began to have temper tantrums again. She was very distant and would not let the family come near her. She would not ask for what she needed but would constantly seek to draw attention to herself through negative behaviors.

1. What behaviors does Alicia exhibit that may be difficult for the preadoptive family to handle?

2. What are some strategies to deal with these behaviors?

Case Two: Kevin

Kevin came into care at age eight due to physical abuse by his mother. Kevin was an only child, very bright, who achieved well in school. His mother had been abused as a child and had grown up in foster care. Kevin's mother abused him when she became frustrated or overwhelmed. Sporadic drug use, intended to calm her, had increased her frustration. Kevin was whipped with a belt and a baseball bat.

At the time he came into care, he was covered with bruises and lacerations of varying ages. Kevin's foster parents were somewhat surprised that he showed no anger toward his mother. In fact, he expressed a lot of worry and concern for her and blamed himself for what had happened.

After a few weeks he began to express his anger—but toward the foster parents. He complained constantly, refused to help around the house, and called household members "stupid." When confronted he would say, "You're not may mother! I don't have to listen to you!" No matter what the family did they could not please Kevin.

1. What behaviors that Kevin exhibits may be difficult for the foster family to handle?

2. What are some strategies to deal with these behaviors?

Case Three: Annie

Annie came into care at age eight due to sexual abuse by her father. The sexual abuse consisted of fondling and digital penetration that had been occurring over a period of two to three months. Annie was also physically and emotionally abused. When Annie came into care she was very quiet and withdrawn. She would not make eye contact with the foster father and tried to stay away from him. She would talk to the foster mother, but often seemed removed and sad. The foster mother wondered if she was getting through to Annie.

1. What behaviors does Annie exhibit that may be difficult for the foster family to handle?

2. What are some strategies to deal with these behaviors?

Attachment in Children: Tips for Caregivers

At one time or another it is likely that you will have a child in your care who exhibits a range of behaviors that do not make sense to you and/or for whom your usual methods of discipline seem ineffective. If this is the case, it is likely that the child may have attachment issues. Many children in family foster care do have attachment issues. This is because attachment issues often occur when a child experiences traumatic separations and losses. The very fact that the child has been placed in your care means that the child has experienced a separation from his or her family. The child's behaviors may seem overwhelming at times. However, there are some things you can keep in mind that may be of help to you in caring for the child.

Building Positive Attachment: When the child's behaviors are overwhelming to you, it may be difficult for you to consider ways to build positive attachment with the child. However, that is actually the best way to address the behavior issues in the long run. The child may continue to exhibit poor behavior as a way to ensure that you do not have positive interactions with him or her. Therefore you may have to work very hard to build positive moments into your relationship:

- Search for the rare moment when the child is able to interact positively with you and seek to build on this moment by giving the child attention. You want the child to see that positive interactions are rewarding.
- Try to find out what the child likes to do and make a special effort to spend time with the child doing these activities. It could be something simple like baking cookies or playing a game.
- Help the child develop a Lifebook. During Session 5 of Preservice you will learn more about Lifebooks and will see a sample of one. There is even more discussion of Lifebooks in Module 7 of Foster PRIDE Core (Inservice). The child may not be able to resist the fun of looking at pictures and having the opportunity to talk about him or herself.
- Encourage the child to attach to a special blanket or stuffed animal or toy, regardless of the child's age. The child needs a comfort object.
- Build nurturing and supportive routines into the child's day to day life. The child who will not accept a hug or any type of affection, may allow you to fix his or her hair, read a book, or watch a favorite show together.
- Create supportive family rituals. In the video "Making a Difference" the candle lighting ritual helped Vernon acknowledge the importance of his birth family and his foster family, and supported his transition to his adoptive family. Rituals help the child develop a cohesive sense of self through merging the past with the present.

- Find creative ways to communicate. Send the child a note, draw a picture, take a picture, or start a diary where you write back and forth to one another.
- Encourage the child to be a part of your family. Explain your family traditions and rules. Encourage participation in family projects. Let the child know what life is like in your family on a day to day basis. This is referred to as "claiming" the child.

Handling the Bad Moments: The behaviors that children with attachment issues present can be overwhelming and frustrating. But there are things you can do to help both yourself and the child get through these moments.

- Realize that the behavior has very little to do with you or your parenting. The behavior is likely the result of many things that have occurred in the child's life that you cannot control or change and the child cannot control or change.
- Handle poor behavior with as little emotion as possible. Seek to keep your voice low and even. Matter-of-factly state the rule or the behavior you are addressing as well as the consequence.
- Prioritize the behaviors you will address. Behavior that compromises the child's or someone else's safety is always a priority and most children, regardless of their attachment issues, will have some understanding of this.
- There may be some bad moments that you need to ignore.
- Protect the child from hurting self or others when the child tantrums. This is best done by giving the child pillows to hit, escorting the child to a safe space (where hard objects are removed and the space is filled with pillows and blankets), and reassuring the child of safety. You can say, "I am here to make sure you are safe." Never yell or demand that the child stop the behavior. You can encourage the child by saying, "I know you are afraid. But I believe that you are going to be able to handle your feelings very soon. I am here until you can."
- Avoid long lectures. The child is usually in an emotional state and is not able to attend to what you are saying. You will likely get more frustrated.

What to Do in the Long Run: Foster parents who deal with children who have attachment issues will tell you that it can be a long process before you see progress. But they would recommend you do the following:

- Involve the child's team in order to ensure that the child receives all needed services. This is a child who is also likely to have issues in school. Therapy is usually necessary, as the child may have experienced multiple losses and trauma. The team needs to work together on the child's behalf.
- Develop clear rules and expectations that are simple to remember. Session Six of Preservice Training is devoted entirely to discipline of children who have experienced abuse and neglect. Also, Modules One and Two of the Foster PRIDE Core (In-Service) Training Program offers 21 hours of instruction to help foster parents deal with behaviors.

- Expect the child to exhibit behaviors that are younger than his or her chronological age. Instead of getting angry or trying to get the child to change the behaviors, help the child to move through them. For example, if the child insists on sleeping with the light on, then let it be. Then try a dimmer light, then move to a night light, all the while encouraging and helping the child to feel safe.
- Patience, patience, patience.

Suggested Resources*

Some Children's Books

Allen, M. *The Rainy Day Band*

Berenstain, S. & J. *The Berenstain Bears and the Messy Room*

Bloomquist, G. & P Zachary's *New Home: A Story For Foster and Adopted Children*

Callen, L. *The Just-Right Family*

Gikow, L. *Muppet Kids in "I'm Mad at You!"*

Gliori, D. *No Matter What*

Karst, P. *The Invisible String*

Kraus, R. *Leo the Late Bloomer*

Leonard, M. *How I Feel Happy*

Lopshire, R. *I Want to Be Somebody New!*

Mayer, M. *I Just Forgot*

McCourt, L. *I Love You Stinky Face*

Modesitt, J. *Mama, If You Had A Wish*

Moser, A. *Don't Feed the Monster on Tuesdays!*

Moser, A. *Don't Pop Your Cork on Mondays!*

Munsch, R. *Love You Forever*

Piper, W. *The Little Engine that Could*

Polocco, P. Chicken Sunday

Viorst, J. *Alexander and the Terrible, Horrible, No Good, Very Bad Day*

Wilt, J. *Handling Your Ups and Downs*

Winter, S. *A Baby Just Like Me*

*Compiled by Nory Behana, Grossmont College Foster, Adoptive and Kinship Care Education Program

Some Books for Adults

Cline, F. & Fay, J. (2006) *Parenting Teens With Love And Logic: Preparing Teens for Responsible Adulthood,* Updated and Expanded Edition. Colorado Springs, CO: Pinon Press.

Delise, D. & J. (1996) *Growing Good Kids: 28 Activities to Enhance Self-Awareness, Compassion, and Leadership.* Minneapolis, MN: Free Spirit Publishing.

Goleman, D. (1994) *Emotional Intelligence,* New York: Bantam Books.

Fahlberg, V. (1994) *A Child's Journey Through Placement.* Indianapolis, IN: Perspectives Press, Inc.

Forbes, H. & Post, B. (2006) *Beyond Consequences, Logic, And Control: A Love Based Approach to Helping Attachment-Challenged Children with Severe Behaviors.* Orlando, FL: Beyond Consequences Institute.

Hughes, D. (1999) *Building The Bonds Of Attachment: Awakening Love In Deeply Troubled Children.* Northvale, NJ: Jason Aronson Printers.

Hughes, D. (2000) *Facilitating Developmental Attachment: The Road to Emotional Recovery and Behavior Change in Foster and Adopted Children.* Northvale, NJ: Jason Aronson Printers.

Hughes, D. (2008) *Principles Of Attachment-Focused Parenitng: Effective Strategies to Care for Children.* Northvale, NJ: Jason Aronson Printers.

Jernberg, A & Booth, P. (1999) *Theraplay: Helping Parents and Children Build Better Relationships through Attachment-Based Play.* New York: Jossey-Bass, Inc.

Jewett-Jarrett, C. (1994) *Helping Children Cope with Separation and Loss,* Revised Edition. Boston: The Harvard Common Press.

Keck, G. & Kupecky, R. (1995) *Adopting the Hurt Child.* Colorado Springs, CO: Pinon Press.

Levy, T. & Orlans, M. (1998) *Atachment, Trauma and Healing: Understanding and Treating Attachment Disorder in Children and Families.* Washington D.C.: Child Welfare League of America.

Morin, V. (1999) *Fun to Grow On: Engaging Play Activities for Kids with Teachers, Parents and Grandparents.* Chicago: Magnolia Street Publishing.

Nelson, J. et. al. (1992) *Positive Discipline: The First Three Years.* Rocklin, CA: Prima Press.

Shapiro, L. (1998) *How To Raise A Child With High EQ: A Parent's Guide to Emotional Quotient.* New York: Harper Collins Publ.

Siegel, D. (2003) *Parenting From the Inside Out: How a Deeper Self-Understanding Can Help You Raise Children Who Thrive.* NY: J.P. Tarchey

Summary of Stages of Child Growth and Development

Age	Physical Milestones	Emotional/Social Milestones	Intellectual Milestones
0–3 months	• Sucking, grasping reflexes • Lifts head when held at shoulder • Moves arms and legs actively • Is able to follow objects and to focus	• Wants to have needs met • Smiles spontaneously and responsively • Likes movement, to be held and rocked	• Vocalizes sounds (coos) • Smiles and expresses pleasure when sees faces
3–6 months	• Rolls over • Holds head up when held in sitting position • Lifts up knees, crawling motions • Reaches for objects	• Smiles responsively • Laughs aloud • Socializes with anyone, but knows mother • Responds to tickling	• Recognizes primary caregiver • Uses both hands to grasp objects • Has extensive visual interests
6–9 months	• Sits unaided, spends more time in upright position • Learns to crawl • Climbs stairs • Develops eye-hand coordination	• Prefers primary caregiver • May cry when strangers approach • Commonly exhibits separation anxiety	• Puts everything in mouth • Solves simple problems, e.g., will move obstacles aside to reach objects • Transfers objects from hand to hand • Responds to changes in environment and can repeat action that caused it, (e.g., sound of rattle) • Drops objects repeatedly • Is fascinated with small objects • Begins to respond selectively to words
9–14 months	• Achieves mobility, strong urge to climb, crawl • Stands and walks • Learns to walk on his or her own • Learns to grasp with thumb and finger • Feeds self	• Extends attachments for primary caregivers to the world; in love with world and wants to explore everything • Demonstrates object permanence: knows parents exist and will return (helps child deal with separation anxiety) • Is typically friendly and affectionate with caregivers, less so with new acquaintances	• Demonstrates intentional behavior, initiates actions • Is eager for sensory experience, explores everything, has to touch and mouth every object • Curious about everything • Realizes objects exist when out of sight and will look for them (object permanence) • Stares for long periods to gain information • Is interested and understands words • Says words like "mama," "dada"

Age	Physical Milestones	Emotional/Social Milestones	Intellectual Milestones
14–24 months	• Walks and runs • Drinks from a cup alone • Turns pages of books • Scribbles spontaneously • Walks backwards • Loves to practice new skills • Uses fingers with increasing skill • Likes gymnastics and climbing and descending slides • Stacks two–three blocks	• Tends to exhibit negativism; "no" stage • Becomes aware of self as an independent entity and starts to assert independence • Tests limits • Develops concept of self, fearful of injury; band-aid stage; wants everything, possessive • Tends to stay near mother and makes regular overtures to her, seeks approval, asks for help	• Uses language to serve immediate needs: "mine," "cookie" • Imitates words readily and understands a lot more than can say • Is able to do actions in head, can retain images, memory improves, experiments to see what will happen • Learns to use new means to achieve ends, e.g., can tilt objects to get them through bars in crib • Spends long periods of time exploring a single subject • Loves to play with others
2–3 years	• Has sufficient muscle control for toilet training • Is highly mobile, skills are refined • Uses spoon to feed self • Throws and kicks a ball • Disassembles simple objects and puts them back together • Has increased eye-hand coordination, can do simple puzzles, string beads, stack blocks	• Has great difficulty sharing • Has strong urges and desires but is developing ability to exert self-control. Wants to please parents, but sometimes has difficulty containing impulses • Displays affection, especially for caregiver • Initiates own play activity and occupies self • Is able to communicate and converse • Is developing interest in peers	• Is capable of thinking before acting • Is becoming very verbal • Enjoys talking to self and others • Enjoys creative activities, e.g., block play, art • Loves to pretend and to imitate others • Thinks through and solves problems in head before acting (has moved beyond action-bound stage)
3–4 years	• Jumps in place • Walks down stairs • Balances on one foot • Uses toilet consistently • Begins to dress self • Builds with blocks and constructs toys • Has developed fine muscle control • Has boundless energy	• Knows name, sex, age, and sees self as part of a family unit • Has difficulty sharing • Plays alongside other children and begins to interact with them • Helps with small household tasks • Likes to be "big" and to achieve new skills	• Believes there is a purpose for everything and asks "why" • Uses symbolic play; has strong fantasy life • Loves to imitate and role play • Understands some number concepts, comparisons, colors • Converses and reasons • Is interested in letters • Is able to scribble, and to draw recognizable objects and circles

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Summary of Stages of Child Growth and Development *(continued)*

Age	Physical Milestones	Emotional/Social Milestones	Intellectual Milestones
4–6 years	• Has refined coordination and is learning many new skills • Has improved finger dexterity, able to hold and use pencil, cut with scissors, catch a ball, use a fork and spoon, brush teeth • Climbs, hops, skips, and likes to do stunts	• Plays cooperatively with peers • Develops capacity to share and take turns • Is developing ethnic and sexual identification • Displays independence • Protects self and stands up for rights • Identifies with parents and likes to imitate them • Often has "best friends" • Likes to show off skills to adults • Continually forms images of self, based on interactions with others	• Shows increased attention span • Understands cause and effect relationships • Expands dramatic play with attention to detail and reality • Has increasingly more complex and versatile language skills • Expresses ideas, asks questions, engages in discussions • Speaks clearly • Knows and can name members of family and friends
6–12 years	• Enjoys using new skills, both gross and fine motor • Likes to achieve in sports • Is energetic and tends to have large appetite • Is increasing in height and weight at a steady rate • Has increased coordination and strength • Is developing body proportions similar to adult	• Is developing a more refined personality • Acts very independent and self-assured, but at times can be childish and silly • Enjoys working/playing with others and alone • Defines self-concept in part by success at school • Has a strong group identity; increasingly defines self through peers • Plays almost exclusively with same sex • Begins to experience conflicts between parents' values and those of peers • Has a strong sense of fairness and fair play • Believes that rules are important and must be followed • Likes affection from adults; wants them to be there to help • Is able to assume responsibility for self, and may care for younger siblings	• Enjoys projects that are task-oriented like sewing, cooking, woodwork • Is highly verbal; enjoys jokes and puns, uses language creatively • Asks questions that are fact-oriented; wants to know how, why, and when • Likes to make up stories, plays, and puppet shows • Is able to deal with abstract ideas • Judges success on ability to learn to read, write, and do arithmetic

Age	Physical Milestones	Emotional/Social Milestones	Intellectual Milestones
12–18 years	• Is experiencing a dramatic growth spurt. For boys, growth in height and weight takes place between 12 and 14; for girls, growth spurt tends to take place between 10 and 12 • May be anxious about physical changes and worry about deviation from "ideals" • Achieves sexual maturity and increased sexual drives	• Needs help in dealing with most changes taking place in order to retain a strong sense of identity and values • Is likely to show extreme swings; often doesn't know how to express anger • Enjoys social activities at school • Relies heavily on peers; struggles to be independent of parents • Tries to conform to group norms • Has close friendships and emotional involvements • Is concerned with meaningful interpersonal relationships and is developing personal morality code • Seeks emotional alliances outside family; is less dependent on family for affection and emotional support • Experiences conflicts with parents on expectations, e.g., for achievements • Strives to define self as separate individual and may adopt extreme hairstyles, clothes, destructive behavior • Often feels misunderstood by parents	• Shows increased or decreased interest in school, or loss of interest in academic studies • Achieves impressive changes in cognitive development • Is able to reason, to generate hypotheses, and to test them out against evidence • Begins to consider and sometimes make vocational choices • Is interested in making money; takes part-time jobs

Drew, K., Salus, M., and Dodge, D. (1981). Child Protective Services Inservice Training for Supervisors and Social Workers, Washington, DC: U.S. Department of Health and Human Services.

Effects of Trauma on Child Development

Infants and Toddlers

Domain	Normal Development	How Trauma Impacts	Specific Issues with Physical Abuse	Specific Issues with Sexual Abuse	Specific Issues with Neglect
Physical	Child develops ability to control own muscles; balance, coordination, and stability. Child progresses from lifting head, to rolling over, to crawling, to pulling up, to walking. Child learns to use hands and grasp toys.	Child has limited motivation to learn or practice physical actions leading to delays in both fine and gross motor skills. Trauma interrupts child's ability to establish physical routines such as eating, sleeping, and self-soothing.	Physical abuse may cause pain that limits physical movement and results in delays; muscles may be poorly developed; fear of abuse prevents child from exploring and taking risks needed to tackle physical tasks such as walking.	Sleep problems and anxiety related to bedtime; problems with toilet training; intense sexualized behaviors that lead to excessive masturbation.	Lack of basic food and care limits child's physical growth; Infant left in one position has limited opportunity to practice physical tasks; lack of stimulation leads to lethargy; lack of nurturing relationship limits child's motivation to tackle new tasks.
Cognitive	Child develops ability to recognize people; develops object permanence around 9 months to 1 year; begins to understand use of language; and begins to say words and express self in simple sentences.	Trauma interferes with child's ability to focus and concentrate, resulting in overall delayed cognitive development. The child may have difficulty making language associations, understanding the meaning of words, and have overall delays in speech.	Child may experience physical pain that prevents other cognitive tasks from occurring; physical disabilities may arise from abuse such as hearing or sight problems that further limit child's cognitive abilities.	Child may experience physical pain that prevents other cognitive tasks from occurring; sexual abuse may pre-empt age appropriate care that supports cognitive development (no games, books, bedtime stories etc).	Child does not receive nurturing and encouragement that promotes cognitive learning; child is not exposed to toys or books that promote learning; child is deprived of interaction that promotes language development.
Social/ Emotional	Primary task of infant is to develop attachment to caregiver. Toddler learns to develop trusting relationships with others; play simple games; and interact with others. The toddler may begin to develop an understanding of right and wrong or good and bad.	Trauma interferes with positive attachment and limits the child's ability to form positive, trusting relationships with others.	Child will have difficulty forming positive relation-ships, knowing who he/she can trust, and have general anxiety and fear of others. This greatly interferes with child's social interactions and ability to form a positive sense of self. Abuse also confuses child's sense of right and wrong.	Child has distorted sense of relationships; may touch others inappropriately, exhibit sexualized behavior, and not know how to relate to other children. Child may also feel anxious and fearful.	Child may develop only weak attachments; may not learn positive ways of interacting with caregivers or other children (which in turn may lead to further neglect of child); may have limited opportunities for interaction.

Pre-School (Age 3–5)					
Domain	**Normal Development**	**How Trauma Impacts**	**Specific Issues with Physical Abuse**	**Specific Issues with Sexual Abuse**	**Specific Issues with Neglect**
Physical	Motor skills are constantly practiced. Child enjoys physical challenges.	Dealing with trauma limits the energy the child has to practice physical activities leading to over-all delay in motor skills, poor muscle tone and coordination. Child may have difficulty regulating physical functions such as eating, sleeping, and digesting.	Physical abuse may cause pain and limit movement; child may withdraw and not participate in physical activities; and physical disabilities may result from abuse. All of these lead to delays in physical development.	Sleep problems, nightmares, and anxiety related to bedtime; psychosomatic complaints; fearfulness and generalized anxiety.	Child may be malnourished, underweight, lethargic, and listless; child may sit for hours before television or have limited exposure to physical activity; child may not have established patterns for eating and sleeping; child may be frequently ill, have skin problems (such as scabies or fungal infections); and have vitamin deficiencies.
Cognitive	Child develops ability to communicate in words and vocabulary increases greatly. Child has concrete ideas and thinking is very focused on self. Child may have fantasies and may begin to understand simple examples of cause and effect.	Trauma interferes with child's ability to focus and concentrate, resulting in overall delayed cognitive development. Language is delayed or hard to understand; thinking is disorganized; child has very short attention span.	Physical abuse distorts child's understanding of cause and effect; child has limited ability to understand the abuse and may be overly compliant trying to avoid abuse or may act out the experiences of abuse. Child may play and replay abuse experiences in his/her mind. Child does not have language to express self , leading to non-verbal expressions of anxiety, modeling the abuse in play, and fantasy thinking.	Same as physical abuse. But children who are sexually abused may also have a vague sense that the behavior is wrong or "bad" and may begin to form a negative sense of self or have tremendous confusion around what has happened.	Limited interactions lead to language delays; child has limited opportunity to ask questions or learn about cause and effect.
Social/ Emotional	Child learns to understand his place in the family and extended family; enjoys interactions with family members; explores social roles; plays (sometimes cooperatively) with other children; has sense of right and wrong.	Trauma interferes with development of positive relationships. The ability to develop a sense of right and wrong is impaired as this understanding generally emanates through positive relationships with others.	Child has difficulty trusting others and the world around him. This results in social/emotional responses that are extreme—aggression and anger; withdrawal and depression; or extreme clinginess. Child may model aggressive behavior with other children.	The child does not understand his/her role in the family and may be very confused, upset, and anxious. Child may exhibit or try to act out sexual behaviors, leading to issues with other children.	Child may have little knowledge of social interaction, how to play with other children, or even how to communicate. Child may appear withdrawn and emotionless; and have no interest in social activities. Child may be very needy and clingy—even with people whom they have no relationship.

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Effects of Trauma on Child Development *(continued)*

School Age (6–12)

Domain	Normal Development	How Trauma Impacts	Specific Issues with Physical Abuse	Specific Issues with Sexual Abuse	Specific Issues with Neglect
Physical	Child refines and masters motor skills; child is energetic and active; child enters puberty with accompanying sexual development and hormonal changes.	Trauma interferes with child's motivation and level of activity. Child may be lethargic or withdrawn, and continue to have difficulty with regulation of basic physical functions such as sleeping, eating, digestive, and toileting processes. Accidents may occur as child is unable to focus on tasks.	Physical abuse may cause pain that limits physical movement and results in delays; physical injuries from abuse may cause additional delays.	Sexual abuse distorts the normal developmental tasks related to sexual development that occur at this age. Physical issues from sexual trauma, such as bruises or tears, or STDs present additional challenges.	Child's over-all physical development may be delayed; child may be underweight or obese making physical tasks even more difficult for the child. If medical needs have been neglected child may have issues such as bad teeth, difficulty hearing (from multiple ear infections), vitamin deficiency, head lice, or fungal infections.
Cognitive	Child develops rational and logical thinking; thinking moves from "self" to "others"; can see other points view; can develop problem solving strategies and act on them; and develops special interests.	Trauma interferes with ability to focus and concentrate, resulting in frustration, lack of patience, and an inability to stick with tasks and carry them out. This makes school an incredible challenge for the child who has experienced trauma.	Child uses strategies to try to deal with abuse—magical thinking, denial it is happening, "black-outs", or distortions of reality. Memories of the abuse may replay in the child's mind causing high anxiety and fear. Little energy for school, problem solving, or special interests.	Same as with physical abuse.	Neglected children have little motivation for learning. Child may be listless in school, and have no interest in books or toys. Because child's basic needs have often not been met, the child's thinking has not moved outward to develop empathy for others or to develop problem solving strategies.
Social/ Emotional	Family continues to important to child, but important relationships begin to develop outside the family. Peer groups develop. Child likes to participate in group activities—sports, clubs, dance, etc. Child imitates, learns and adopts the behaviors of those around him/her.	Trauma history interferes with ability to have positive relationships so at this age discipline issues may emerge both at home and at school. Experiencing trauma at this age makes child feel disconnected from others.	Child will have difficulty forming positive relationships or knowing who he/she can trust, and have general anxiety and fear of others. This greatly interferes with child's social interactions and ability to form a positive sense of self. Abuse also confuses child's sense of right and wrong.	Child has distorted sense of relationships; may touch others inappropriately, exhibit sexualized behavior, and not know how to relate to other children. Child may also feel anxious and fearful.	Child may develop only weak attachments; may not learn positive ways of interacting with caregivers or other children (which in turn may lead to further neglect of child); may have limited opportunities for interaction.

Teens (Age 13–19)					
Domain	**Normal Development**	**How Trauma Impacts**	**Specific Issues with Physical Abuse**	**Specific Issues with Sexual Abuse**	**Specific Issues with Neglect**
Physical	Teen experiences tremendous growth and development; hormonal changes related to sexual development; and physical maturity. Teens have sexual feelings and begin to develop their sexuality.	Trauma interferes with focus, thus resulting in accidents and injuries. Trauma also interferes with established physiological processes such as sleeping patterns, eating patterns, and digestion. Trauma induces high levels of anxiety that keeps teen in a hyper-vigilant and on-edge state.	Physical abuse may cause pain that limits physical movement and results in delays; physical injuries from abuse may cause additional delays.	Sexual abuse of teen will directly impact child's ability to manage sexual developmental tasks—teen may become over sexualized or may withdraw from sexual expression; or may explore lesbian or gay sexuality. Sleep problems and eating issues (bulimia, anorexia, or obesity) may develop. STDs may develop.	History of chronic neglect becomes more apparent in teen who may suffer from long term vitamin deficiency, and poor immune system. Lack of activity and poor diet may put teens at risk for diabetes and heart disease.
Cognitive	Teen thinking becomes more complex and adult-like; develops insight and under-standing; and can problem solve complex issues.	Trauma interferes with ability to achieve and meet the demands of high school; memories and images of trauma may be acute, re-playing in the teen's mind, causing high anxiety on an ongoing basis. Teen may try to relieve anxiety through substance abuse or alcohol. Teen struggles to think through cause and effect of trauma.	Thinking is distorted as teen struggles to make sense of abuse; magical thinking may continue, as well as denial and use of substances to enable denial. Moral development is corrupted by teen's inability to understand cause and effect of abuse; teen may become abusive or set self up to be abused again.	Teen wills struggle to understand sexual abuse; may feel tremendous guilt related to abuse and have continuous thoughts of suicide or violence; or may seek to explore sexuality with others as a means to erase the event. Over-all cognitive development suffers as so much energy is directed toward handling abuse.	The neglected teen may have little stimulation other than video games and television; lack of relationship role models results in little ability to problem solve, learn basic life skills, or develop special interests that lead to a vocation or career. Neglected teens typically do poor in school.
Social/ Emotional	Family continues to important to child, but important relationships begin to develop outside the family. Peer groups develop. Child likes to participate in group activities—sports, clubs, dance, etc. Child imitates, learns and adopts the behaviors of those around him/her.	Trauma history interferes with ability to have positive relationships so in the teen years control issues may become paramount both at home and at school. Experiencing trauma at this age makes child feel disconnected from others. Teen can only focus on self and own needs; has little empathy for others.	Teen will have difficulty forming positive relationships or knowing who he/she can trust, and have general anxiety and fear of others. This greatly interferes with child's social interactions and ability to form a positive sense of self. Abuse also confuses child's sense of right and wrong.	Sexual abuse of teen leads to issues with self-esteem, depression, guilt, and feelings of self-worth. Teen may sexually act out with others, be heavily dependent on others to meet needs, and have a distorted view of right and wrong. Depression and emotional issues may make social situations challenging.	The neglected teen has weak attachments, fights with others, and is generally ineffective in relationships. There is heightened difficulty with authority or criticism; little energy to form positive emotional relationships; lack of motivation for employment or vocational participation.

Effects of Sexual Abuse on Child Development

Infants and Toddlers (birth to 3 years)

Domain	Normal Development	Result of Abuse
Physical	Birth–One: Develops ability to control own muscles One–Two: Develops balance, coordination and stability. Two–Three: Develops increased strength and coordination. Can meet challenges in the environment (bikes, stairs, playground equipment, crayons, etc.). Ready to be toilet trained.	Delays in both gross and fine motor skills; muscles can be poorly developed if neglect or physical abuse is also present. Sleep problems; apparent fear around sleep time. Problems with toilet training. Internal damage, such as pain, inflammation, bruising, bleeding, scarring, sexually transmitted diseases. Inappropriate immobility. Intense sexualized feelings, leading to excessive masturbation.
Cognitive	Birth–One: Beginning to be alert and aware, can recognize significant people. Interested in looking, listening, touching. Can remember objects even if they are hidden (object permanence). One–Two: Understands that objects have names, that the names mean something (symbolic thought), and learns to use the names. Two–Three: Able to speak more clearly, use words to communicate with others.	Apathy, listlessness. Delay of speech, including loss of already developed speech in extreme cases. Does not explore environment or manipulate objects; lacks curiosity. Does not master basic ideas, such as object permanence or basic skills in problem-solving, may appear to be developmentally delayed if severely neglected as well as sexually abused.
Social/ Emotional	Birth–One: Attaches to caregiver, then learns to trust the caregiver. One–Two: Affectionate and trusting relationships develop with people other than the primary caregiver. Can play simple games. Two–Three: Enjoys playing "beside" other children. Likes to do things by herself. Understands the idea of "good" and "bad."	Failure to form attachments and trust relationships; lack of ability to pick out significant people.Does not appear to notice or respond to separation from parent; may not show stranger anxiety. Inability to relate with other children; may touch others inappropriately. Shows adult knowledge of sexual behavior. Cautious, watchful, on guard, "frozen." Perception of self as "bad" child. Fearful, anxious. Avoids or is alarmed by visual or tactile reminders of the abuse (triggers).

Preschool (3 to 5 years)		
Domain	**Normal Development**	**Result of Abuse**
Physical	Most gross motor skills have been developed, now being practiced. Enjoys new physical challenges.	Motor skills may be delayed or absent. Poor muscle tone, poor motor coordination; lack of strength if neglect, confinement, or under-stimulation were part of the abuse. Sleep problems, fearfulness, nightmares and night terrors, fear of being alone and of going to sleep. Psychosomatic complaints (aches and pains that have no physical basis).
Cognitive	Language develops well, words are used in correct order, and vocabulary increases rapidly, can communicate in words. Ideas are concrete and centre around self. Cannot yet follow step-by-step approach to solving problems but can draw conclusions based on little information. At this age children have many fantasies and their facts and fantasies are often mixed together. Poor understanding of cause and effect. Reasoning may not make sense to us but makes perfect sense to the child. When adult points out flaws, child stubbornly clings to her version.	Speech may be absent, delayed, or hard to understand. Receptive language (ability to understand what is being said) may be far better than expressive language (the ability to express self in words). Can eventually lead to a learning disability. May have an unusually short attention span, not be interested in things in the surroundings, and have trouble concentrating. Thinking skills may present as those of a younger child. Tries to make sense of the traumatic experience. When the child cannot understand an event, may make up a magical explanation for it. Sees images of unpleasant memories of the traumatic events. These images pop into the child's mind against his or her will, and s/he is unable to talk about them.
Social/ Emotional	Has relationships with adults outside of the family. Can interact and play cooperatively with peers. Understands, explores, and pretends about "social roles" (e.g., This is what mommy does, or I'm a fireman). Learns the concept of right and wrong, can judge her own behavior in relation to others, which affects her sense of self. Experiences guilt when s/he has behaved badly. Able to try new things, likes to take charge, and can take initiative in activities. No longer dependent.	Play shows confusion about events that have injured or shocked the child. Other children might also be enlisted to "play out" the trauma. May include aggression, sexualized touching of others. Excessively fearful, anxious, easily upset or apathetic; shows a loss of interest in activities.

(continued next page)

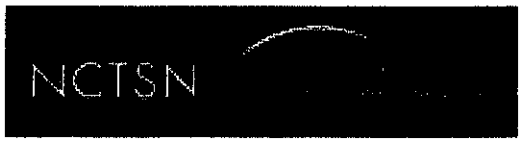
Effects of Sexual Abuse on Child Development
(continued)

School Age (6 to 12 years)

Domain	Normal Development	Result of Abuse
Physical	Practices, refines and masters complex gross and fine motor skills. The child is energetic, active, "always on the go". Boys tend to be more "rough and tumble", girls more adept at fine motor skills, probably because of what they are encouraged to do by adult caregivers (socialization). Experiences some discomfort or embarrassment about sexual topics, urges, and own development.	Can experience toileting accidents (wetting pants, soiling). Also see previous stages.
Cognitive	Instead of being magical and self-centred, the child is now capable of thinking that is more logical and rational. The child is now capable of observing and correctly understanding how relationships, actions, objects, etc., work. She/he can develop ideas about how to interact with things to make them work out well (concrete operational thought). The child is less self-centred, more able to see other people's points of view and to act on those perceptions.	"Intrusions" of unwanted thoughts and images and memories of the trauma. These images disrupt concentration and create anxiety. Performance at school can be affected because of inability to concentrate. Ordinary life events (seasons, special occasions, etc.) have become strongly associated with and can bring on memories of the abuse. Perceptions of these events or seasons may have been distorted by the abuse. The child's memories of the traumatic events may have been affected and changed by the child's fears or wishes about the event. The length of the event can seem either longer or shorter than it actually was, which can upset the child's sense of time.
Social/ Emotional	Relationships outside the immediate family take on importance to the child. S/he enjoys participating in peer groups. The child imitates, learns, and adopts the behaviors of those around him/her. Being like others and fitting in takes on importance for the first time. The child understands rules, why they exist, and what happens if they are not adhered to. She/he is interested in and concerned with following the rules. She/he is becoming more aware of herself as an individual, and the child's self esteem is affected by how s/he sees her/himself (self-perception).	Anxiety, fearfulness, fear of traumatic event recurring. Fears and mistrusts all adults. Intensity of own feelings is frightening. Secretive re-enactment or playing out of the traumatic event. May be able to talk about the sexual abuse. Sometimes repeatedly talks about the traumatic event, seemingly without getting any relief in the telling. Either withdrawn and quiet or excessively aggressive and testing rules and limitations. Engages in behaviors that cannot be mistaken as anything else but sexual aggression or intrusiveness (simulated or actual intercourse, fondling, etc.). Relates to adults in a sexual way.

Adolescents (13+ Years)		
Domain	**Normal Development**	**Result of Abuse**
Physical	As the body matures into adulthood, hormones cause changes. Includes fast physical growth and a new physical maturity. This also includes development of the sexual organs. The changes in the body need getting used to. Some of the changes mean the child will need to behave differently (e.g., physically maturing girl will feel less comfortable with touch football). The body becomes ready for sexual interaction and is able to reproduce.	Accident prone. Problems with sleeping. Eating disorders, such as bulimia or anorexia. See also previous stages.
Cognitive	Thinking has become almost adult in its complexity. Adolescents can develop an idea, look at its various points of view and logically analyze the idea (thinking hypothetically). The adolescent can, for the first time, think about the process of thinking in an abstract way, especially in mid and late adolescence. Insight is developed. Can solve problems by thinking about them in detail, working out complex solutions, and evaluate those solutions.	The memories and images of the trauma become acute and pierce into the child's day-to-day living. The child is extremely aware of these images and distressed by them. "Flashback" episodes (sudden memories of the traumatizing event) become more frequent and have more negative impact.
Social/ Emotional	Peers are more important than family relationships. The values and ideas of the peer group will be more important to the teen than the parents' ideas in terms of guiding their behavior. Peer acceptance is important to self esteem. Feeling "different" is unacceptable. First interest in sexual partners, leading to interest in sex itself. Some teens will experiment with sex. Mood swings; teens can be quite reactive to emotional stress.	Teen feels shame, guilt humiliation. The inner turmoil (tension) is managed through unhelpful tension reducers (running, withdrawal, sexual acting out, etc.). Wish for revenge or action to "put things right". Vulnerable to depression, pessimism, fear of growing up. Clings to remaining in the protection of a family, even if the family is negative. Teen wants to escape the horror of the trauma and mistakenly believes that adult behavior (e.g., early marriage, childbirth, dropping out of school, and change from peer to adult relationships) will somehow take him/her away from having to work out the impact of the abuse.

SOURCE: Osmond, Margaret, Durham, Duane, Leggett, Andrew, Keating, John. *Treating the Aftermath of Sexual Abuse - A Handbook for Working with Children in Care*. CWLA Press, Washington DC. Appendix B, p. 149–152.



Understanding Child Traumatic Stress: Information for Resource Parents

Resource 3-J

What is traumatic stress?

By the time most children enter the foster care system they have already been exposed to a wide range of painful and distressing experiences. Although all of these experiences are stressful, experiences are considered **traumatic** when they **threaten the life or physical wholeness of the child or someone critically important to the child (such as a parent or sibling).** Traumatic stress characteristically produces intense physical and emotional reactions, including:

- A primal fight, flight, or freeze response
- An overwhelming sense of terror, helplessness, and horror
- Physical sensations such as rapid heart rate, trembling, dizziness, or loss of bladder or bowel control

Not every distressing event automatically results in traumatic stress. Something that is traumatic for one child may not be traumatic for another. The actual impact of a potentially traumatic event depends on several factors, notably:

- The child's age and developmental stage
- The child's perception of the danger faced
- Whether the child was the victim or a witness
- The child's relationship to the victim or perpetrator
- The child's past experience with trauma
- The adversities the child faces in the aftermath of the trauma
- The presence/availability of adults who can offer help and protection

In general, children who have been exposed to repeated stressful events within an environment of abuse and neglect are more vulnerable to experiencing traumatic stress.

Types of Traumatic Stress: Acute Trauma

A single traumatic event that is limited in time is called an **acute trauma.** A natural disaster, dog bite, or motor vehicle accident are all examples of acute traumas. Over the course of even a brief event, a child may go through a variety of complicated sensations, thoughts, feelings, and physical responses that change from moment-to-moment as the child appraises and re-appraises the danger faced and the prospects of safety. As the traumatic event unfolds, the child's pounding heart, out-of-control emotions, loss of bladder control, and

other physical reactions are frightening in themselves and contribute to his/her sense of being overwhelmed. After going through an acute trauma, a child may experience:

- Nervousness, jumpiness, and a sense of being on edge
- Difficulty sleeping, nightmares, or night terrors
- Intrusive repeated thoughts, images, and sensations of what happened
- Secret fantasies and wishes about how it could have been different
- Anger or aggression
- Difficulty concentrating or paying attention in school
- Play that recreates the whole event or some moments in it
- A feeling of being numb
- Withdrawal from ordinary activities and relationships
- Feelings of isolation and of having been made different from others by the experience
- Strong reactions to any person, place, thing, situation, or feeling that remind the child of the traumatic event

Types of Traumatic Stress: Chronic Trauma

When a child has experienced multiple traumatic events, the term **chronic trauma** is used. Chronic trauma may refer to multiple and varied events—such as a child who is exposed to domestic violence, is involved in a serious car accident, and then becomes a victim of community violence—or long-standing trauma such as physical abuse or war.

Chronic trauma may result in any or all of the symptoms of acute trauma, but these problems may be more severe and more long lasting. The effects of trauma are often cumulative, as each event serves to remind the child of prior trauma and reinforce its negative impact. A child exposed to a series of traumas may become more overwhelmed by each subsequent event and more convinced that the world is not a safe place. Over time, a child who has felt overwhelmed over and over again may become more sensitive and less able to tolerate ordinary everyday stress.

Types of Traumatic Stress: Complex Trauma

"Complex trauma" is a term used by some experts to describe both exposure to chronic trauma—usually caused by adults entrusted with the child's care, such as parents or caregivers—and the long-term impact of such exposure on the child. Children who experienced complex trauma have endured multiple interpersonal traumatic events (such as physical or sexual abuse, profound neglect, or community violence) from a very young age (typically younger than age 5).

When trauma is associated with the failure of those who should be protecting and nurturing the child, it has profound and far-reaching effects on nearly every aspect of a child's development and functioning. Children who have

experienced complex trauma have had to cope with chronically overwhelming and unmanageable stresses almost entirely on their own. As a result, these children often:

- Have extreme difficulty regulating their feelings and emotions
- Believe they are unlovable and that others will not respond to their needs
- Have difficulty forming trusting relationships
- Have difficulty describing their feelings because no adult has ever helped them understand and find words for their experiences
- Have problems forming coherent memories and may experience a sense of dissociation— as if they are in a dream or outside their own bodies— when under stress
- Have no fixed sense of who they are or where they fit in the world

Neglect and Trauma

Neglect is defined as **the failure to provide for a child's basic physical, medical, educational, and emotional needs.** Whereas physical and sexual abuses involve clear "acts of commission," neglect results from "omissions" in care, making it more difficult to measure. It is important to understand that an infant or very young child, left alone in a crib, without predictable loving attention, in a wet diaper, and suffering from the pain of hunger, cannot recognize the difference between acts of "omission" vs. "commission." Abandonment feels like an acute threat to survival.

Neglect can have broad and significantly negative effects on all aspects of a child's development. Its effects may resemble those of complex trauma, and it may be difficult to differentiate the effects of neglect from those of abuse, since neglect often occurs in the context of other maltreatment.

Transcending Trauma: The Role of Resource Parents

No matter what the age of a child or what types of trauma a child has experienced, healing is possible. With nurture and support, children who have been through trauma can regain trust, confidence, and hope.

Resource parents are critical in helping children in their care overcome the emotional and behavioral effects of child traumatic stress. By creating a structured, predictable environment, being willing to listen to the child's story at the child's pace, and working with professionals trained in trauma and its treatment, resource parents can make all the difference.

For more information on the impact of trauma on children, visit the National Child Traumatic Stress Network (NCTSN) at www.nctsn.org.

Coping with Trauma Reminders: Facts for Resource Parents

What are trauma reminders?

Many children in the foster care system have been through multiple traumatic events, often at the hands of those they trusted to take care of them. When faced with people, situations, places, or things that remind them of these events, children may re-experience the intense and disturbing feelings tied to the original trauma. These "trauma reminders" can lead to behaviors that seem out of place in the current situation, but were appropriate—and perhaps even helpful—at the time of the original traumatic event. For example:
A seven-year-old boy whose father and older brother fought physically in front of him becomes frantic and tries to separate classmates playfully wrestling on the schoolyard.

- A three-year-old girl who witnessed her father beating her mother clings to her resource mother, crying hysterically when her resource parents have a mild dispute in front of her.
- A nine-year-old girl who was repeatedly abused in the basement of a family friend's house refuses to enter the resource family's basement playroom.
- A toddler who saw her cousin lying in a pool of blood after a drive by shooting has a tantrum after a bottle of catsup spills on the kitchen floor.
- A teenager who was abused by her stepfather refuses to go to gym class after meeting the new gym teacher who wears the same aftershave as her stepfather.
- A twelve-year-old boy who'd been molested by a man in a Santa Clause suit runs screaming out of a YMCA Christmas party.

What happens when a child responds to a trauma reminder?

When faced with a "trauma reminder," children may feel frightened, jumpy, angry, or shut down. Their hearts may pound or they may freeze in their tracks, just as one might do when confronting an immediate danger. Or they may experience physical symptoms such as nausea or dizziness. They may feel inexplicably guilty or ashamed or experience a sense of dissociation, as if they are in a dream or outside their own bodies.

Children's reactions may vary somewhat by age. Preschool children may:

- Feel vulnerable and helpless
- React very literally and dramatically (e.g., flinching, crying, trying to hide) to concrete reminders such as a raised hand or a facial expression
- Exhibit sudden strong emotional outbursts or tantrums
- Have little memory of the traumatic events that they can put into words
- Act out the traumatic events in play

School-aged children may:

- Exhibit physical symptoms, such as stomachaches or headaches
- Vacillate between being withdrawn and quiet or aggressive and noisy

Teenagers may:

- Respond recklessly, taking more risks or abusing substances
- Limit themselves or withdraw from activities to avoid reminders
- Fear that their strong reactions mean they are "going crazy"
- Feel stigmatized by having gone through traumatic events and may not feel that they can talk about them

Sometimes children are aware of their reaction and its connection to the original event. More often, however, they are unaware of the root cause of their feelings and may even feel frightened by the intensity of their reaction.

How can I help?

Children who have experienced trauma may face so many trauma reminders in the course of an ordinary day that the whole world seems dangerous, and no adult seems deserving of trust. Resource parents are in a unique position to help these children recognize safety and begin to trust adults who do indeed deserve their trust.

It's very difficult for children in the midst of a reaction to a trauma reminder to calm themselves, especially if they do not understand why they are experiencing such intense feelings. Despite reassurance, these children may be convinced that danger is imminent or that the "bad thing" is about to happen again. It is therefore critical to create as safe an environment as possible. Children who have experienced trauma need repeated reassurances of their safety. When a child is experiencing a trauma reminder, it is important to state very clearly and specifically the reasons why the child is now safe. Each time a child copes with a trauma reminder and learns once more that he/she is finally safe, the world becomes a little less dangerous, and other people a little more reliable.

Tips for Helping Your Child Identify and Cope With Trauma Reminders

- **Learn as many specifics as you can of what your child experienced** so that you can identify when your child is reacting to a reminder. Look for patterns (time of day, month, season, activity, location, sounds, sights, smells) that will help you understand when your child is reacting. Help your child to recognize these trauma reminders. Sometimes just realizing where a feeling came from can help to minimize its intensity.
- **Do not force your child into situations that seem to cause unbearable distress.** Allow your child to avoid the most intense reminders, at least initially, until he or she feels safe and trusts you.
- When your child is reacting to a reminder, **help him or her to discriminate between past experiences and the present one.** Calmly point out all the ways in which the current situation is different from the past. Part of the way children learn to overcome their powerful responses is by distinguishing between the past and the present. They learn, on both an emotional (feeling) and cognitive (thinking and understanding) level, that the new experience is different from the old one.
- **Provide tools to manage emotional and physical reactions.** Deep breathing, meditation, or other techniques may help a child to manage emotional and physical reactions to reminders. If you are unfamiliar with such techniques, ask a counselor to help.
- **Recognize the seriousness of what the child went through, and empathize with his or her feelings.** Don't be surprised or impatient if your child continues to react to reminders weeks, months, or even years after the events. Help your child to recognize that reactions to trauma reminders are normal and not a sign of being out of control, crazy, or weak. Shame about reactions can make the experience worse.
- **Anticipate that anniversaries of events, holidays, and birthdays may serve as reminders.**
- **With your child, identify ways that you can best reassure and comfort during a trauma reminder.** These might be a look of support, a reassurance of safety, words of comfort, a physical gesture, or help in distinguishing between the present and the past.
- **Seek professional help if your child's distress is extreme,** or if avoidance of trauma reminders is seriously limiting your child's life or movement forward.
- **Be self-aware.** A child's reaction to a trauma reminder may serve to remind you of something bad that happened in your own past. Work to separate your own reactions from those of your child.

For more information on the impact of trauma on children, visit the National Child Traumatic Stress Network (NCTSN) at www.nctsn.org.

Key Points
Meeting Developmental Needs: Attachment

The Role of Attachment in Human Development

Understanding human development is a necessary first step toward understanding the children placed with you for foster care or adoption. Given the right conditions, a baby will be born and progress through normal stages of development. Unfortunately, certain factors impede or delay growth and development. These factors shape the adults these children become.

Attachment is the basis for all human development. Human babies are helpless. Their physical survival and social development depend on attachments they form to parents or adult caregivers. Children need a great deal of care for many years. But food, clothing, and shelter are not enough to promote normal development. Children require loving care and attention in order to become adults who can form relationships with others.

Research in orphanages and institutions shows that infants get sick and even die from a lack of significant contact with other human beings, even when all their physical needs are met. Children who do not get sufficient attention run a serious risk of mental, social, emotional, and physical delays. Recent research on trauma and brain imaging technology are providing us with new information about how process and structures in the brain are actually shaped by early experiences.[1]

How Attachment Develops

Human babies are adaptable and sociable. They have the capacity to draw adults to them and to develop strong emotional ties to the adults they come to rely on. We call this "attachment." From the time they are born, infants express their needs. Hungry babies feel tense and uncomfortable, and begin to cry. Likewise, they cry when they are wet, cold, too hot, tired, or overstimulated.

Responsive, nurturing parents quickly learn to understand the needs their babies communicate. They meet needs by feeding, changing diapers, regulating temperature, or calming them in various ways.

When the need is met, the infant feels relaxed and comfortable again until the next need is felt, for example, when he or she needs a diaper changed again. As each need is expressed and met, infants develop a sense of trust that their needs will be met, and a sense of attachment to the persons meeting their needs.

[1] Shonkoff, J.P. & Phillips, D.A. (Eds.). (2000). From Neurons to Neighborhoods. Washington, DC: National Academy Press.

This cycle is known as the arousal/relaxation cycle. It continues throughout our life. Every time we have a need, express it, and someone meets that need, we feel attached to that individual. Eventually, we trust that they will continue to meet our needs and take care of us. There is no limit to the number of attachments people can develop in a lifetime.

Developmental Challenges

Unfortunately, there are factors that impede or delay attachment and child growth and development. They are:

- Genetic or congenital conditions
- Prenatal factors
- Physical neglect
- Physical abuse
- Emotional abuse and neglect
- Sexual abuse
- Accidents and trauma
- Inappropriate behavioral patterns

These same conditions are the reasons why children come into foster care. That is why it is so important for foster parents and adoptive parents to understand how to address developmental delays.

Adolescence can also present as a developmental challenge because of the rapid rate of change. The major developmental tasks include: 1) separation from family, 2) developing a sense of one's sexuality, and 3) developing a career path. Youth dealing with the impact of maltreatment may have great difficulty attending to these developmental tasks.

The Impact of Maltreatment and Trauma on the Child

There may be no topic that is as disturbing and as confusing to us as child abuse and neglect. More than 900,000 children were confirmed victims of child abuse or neglect in 1996.[2] The same year, there were 930 reported child abuse fatalities.[3] With the growth of public awareness, as well as the prevalence of risk factors such as substance abuse and poverty, the number of children reported for child abuse and neglect has risen dramatically since 1980.[4] This has placed tremendous responsibility on state and county child protection systems and has increased the need for family foster care and adoption services.

[2] US Department of Health and Human Services, Children's Bureau. (1998). Child Maltreatment 1996: Reports from the States to the National Child Abuse and Neglect Data System. Washington, DC: NCANDS.

[3] Petit, M.R., Curtis, P.A., Woodruff, K., Arnold, L., Feagan, L., & Ang, J. (1999). Child Abuse and Neglect: A Look at the States. 1999 CWLA Stat Book. Washington, DC. CWLA Press.

[4] Ibid.

While the numbers are quite significant, they do not tell the entire story. Trauma impacts neurological and psychological development with long-term adverse effects on attachments and relationships, behavior, and overall development. The impact of abuse and neglect is far reaching and long term. It is the responsibility of the child protection system not only to protect and ensure the child's safety, but to safeguard and support the child's well-being over time.

In thinking about a child's attachment history, it is helpful to look at a continuum that goes from "insecurity" to "security" in relationships. A caring adult who is consistently present and available, responsive to the child's individual needs and supportive of the child's growth and development offers a secure base for the child. Such a base of security allows children to devote most of their energy and attention to learning and growing, knowing that the person or persons they rely on will be there to take care of them, guide them, and keep them safe. An unpredictable, insecure base requires children to give most of their attention and energy to survival and safety. Operating from such a place of insecurity takes a lot of energy away from the normal and important activities of exploring and playing. This is perhaps one reason why insecurely attached children suffer from gaps and delays in development. There is a wide range of behaviors that we recognize as evidence of secure or insecure attachment. No two children or adults will behave in exactly the

same way. But we know that the sooner children have a permanent, safe home with loving caregivers, the sooner they can begin the difficult process of learning that they deserve and can rely on others to really love and care for them.

All children can be helped to make small, gradual steps toward feeling more secure in relationships and in learning to let go of learned patterns of attempting to control others, avoiding closeness and protecting themselves from hurt. This gradual process requires stable, safe relationships that, over time, offer children opportunities to learn that they can be safe in relationships, that people they love won't disappear, and that they are in fact lovable even when their behavior is out-of-control.

Attachment Disorders

In some situations, children become "attachment-disordered." This means that the child's normal process of attachment has been disrupted, usually because of severe maltreatment and multiple rejections. While we think of families as being safe, some children have learned that families are not safe. Instead, they are places where children get hurt, and even where big people have sex with little people.

In the most extreme cases, children with attachment disorders may be severely withdrawn and depressed, very destructive and aggressive, or both. These children need families who can offer them a permanent, safe, and secure environment, and they need therapeutic intervention by skilled social workers, therapists, and possibly residential treatment along the way. On the continuum, these are the children who fall toward the left end and are insecurely attached.

Categories of Behavior Associated with Insecure Attachment

An **unattached child** is rare because most children will have formed an attachment to someone along the way even if the attachment is fragile. But this can occur in situations where children are extremely neglected; have received routine, mechanized, institutional care, or have experienced sensory deprivation.

Moving to the right on the continuum, there are attachment problems more commonly found in children in need of family foster care or adoption services. **Insecure** attachment in some children leads to disordered behaviors. These are children who don't appear to know how to get their needs met. They appear to be out of control, have difficulty regulating their emotions and behaviors, and struggle to express what they need. Moving further toward the right, another group of insecurely attached children are those whose behaviors are **avoidant.** These children learned at a young age that the best strategy for being in a relationship is to hide your needs and feelings behind a mask of detachment. It is likely that they were punished for expressing their needs and for developing.

Despite the sense of self-sufficiency they may exhibit, these children do need to be protected, nurtured, and valued. In contrast, the insecurely attached child whose behaviors are **anxious** exhibits clingy and needy behavior. These are children who have experienced some attachment but are preoccupied with not being left alone and with ensuring that their needs are met. These children were likely to have been left alone a lot, and to have experienced multiple separations or periods of time when needs were not met.

Fortunately, most children are able to develop some attachment to their parents, even when they have been abused, neglected, and otherwise maltreated. But in some ways, this is confusing. We naturally wonder, "Why wouldn't children be happy or at least relieved to get away from where they were being hurt?" In the video shown in Session One, instead of being happy and relieved, Vernon was very angry when he moved to the Hansons, even though it was a safe and nurturing home. This could be due to one of the following reasons:

- The child was raised in this environment, and it's all he knows or understands. The relationship is painful, but it is also familiar.
- Instead of thinking the parent is at fault, the child blames himself. It is typical for children to think that their parents are okay, and they are bad.
- Abusive attention (physical, sexual, or verbal) may be the only attention the child receives. Negative attention is better than no attention at all.

Even though parents may be abusive and neglectful, they are probably not consistent in those behaviors. More likely, there are times when they behave in a nurturing or loving way with the child. It is during these times that positive feelings and attachments are reinforced.

The Impact of Maltreatment on Attachment

The impact of maltreatment on attachment may differ depending on the type of maltreatment the child experiences. Let's look at some of the different types of maltreatment and how they may impact attachment and behavior.

Neglect: When children are neglected, they are left on their own a lot with uncomfortable or distressing feelings and unmet needs. Sometimes, they don't learn how to reach out and receive nurturing from others. They may turn inward and rely only on themselves. They generally do not get their needs met consistently enough to get on a regular schedule that allows them to learn how to regulate their emotions and responses. Serious developmental delays are often an outcome of neglect.

Physical abuse: Children who are physically abused often learn to be hypervigilant, scanning their environment constantly for clues about possible threats of harm. They may be hyperactive, angry, and aggressive. Some children may be overcompliant, always trying to please and appease

adults as a way of keeping themselves safe. Physically abused children develop a fear-based attachment that leaves little opportunity for them to play freely or relax. They may exhibit violent and abusive behaviors that model what they experienced and offer them a way to express some of the rage they feel about being abused themselves.

Sexual abuse: Depending on the circumstances, there are many different ways that attachment could be affected by sexual abuse. A child may have great difficulty trusting adults to meet needs for safety. While physical closeness normally helps builds security, physical closeness comes to mean sexual intimacy for the child who has been sexually abused. These children may fear any type of intimacy or closeness with an adult for fear that it will result in sexual contact. Sexual abuse could result in children feeling so much shame that they feel they are unworthy of any type of secure relationship. Feelings of closeness, comfort and being cared for may be linked with feeling overpowered, coerced, and out-of-control. Sexually abused children may express their confused feelings of sexual arousal, anger, fear and shame through bedwetting, encopresis, enuresis, fear of going to bed, masturbation or sexually provocative behaviors with other children or adults.

Emotional maltreatment: These children may come to believe that they are "stupid" or "ugly" or "bad." They may not feel worthy of positive attention or genuine unconditional affection. In some types of emotional maltreatment the perpetrator may use the child to meet his or her own emotional needs, discouraging relationships with others. The child then has difficulty developing peer relationships or relationships with other adults such as teachers. Behavior is often withdrawn or sad. The child may lack self-confidence, motivation, problem solving skills, and hope. They have a tendency to misread other people's intentions and feelings, often believing that others are hostile toward them when they are not.

The Impact of Trauma and Maltreatment on Development

Fortunately, there are some general predictions we can make about how children need to be growing and developing. Children develop in stages with different developmental tasks at each stage of development. The tasks are focused on the three broad areas—physical development, emotional and social development, and intellectual development. This information has been gathered and condensed into developmental charts.

The developmental chart will be a useful tool for you. You can think of the "milestones" as general guidelines about what a child at a given age should be able to do. Being a little behind is probably not of concern. Likewise, being

behind in one area may simply reflect that development can be irregular. However, delays across all areas, or significant delays in one area, may indicate a problem. The chart is a helpful tool to identify when more assessment is needed. Pediatricians, psychologists, and social workers may all be helpful in continuing to assess with you if there is a developmental problem. It is not your job to diagnose a developmental delay or disability. It is up to you to express your concerns to the child welfare team, because child maltreatment and trauma may directly impact the child's development even beyond what was discussed regarding attachment.

It is important to keep in mind that the developmental chart is only a tool and is intended to give you an overall sense of how the child is developing. The chart reflects where most children are at a given point in the developmental process—it is reflective of how the majority of children develop. The chart is therefore not culturally sensitive or aware. That is your responsibility. When assessing a child's overall development, it is important to understand the child's culture. For example, the dominant culture in the United States places a high value on independence. In other cultures this value may not be as prevalent. In some cultures, the caregiver may hold and keep the child close, and discourage independence, for a longer period of time. This child could appear delayed, based only on the developmental charts.

Neglect might affect a child's development in the following ways:

- Children who are neglected in regard to supervision may harm themselves and as a result may learn not to take risks. This can delay development.
- Children need caregivers to guide and direct their developmental learning. A child left alone cannot model or mimic skills and may not receive needed help.
- Children in a deprived environment may not receive needed stimulation. Children need objects to play with and things to watch and observe.
- Basic needs must be met before children can concern themselves with other developmental tasks. If children are hungry, sick, or craving emotional attention, they cannot attend to other skills or learning.

Physical abuse might affect a child's development in the following ways:

- A child who is physically abused may be afraid to take risks for fear of doing something wrong, and development may be delayed.
- Some children sustain serious injuries that affect their development on an ongoing basis such as hearing loss, blindness, or brain injuries.

Sexual abuse might affect development in the following ways:

- Sexual abuse may introduce sexual activity before a child is physically mature. This may cause physical injury that impedes the child's normal sexual development.
- Sexually transmitted diseases and infections may impede the child's normal sexual development.
- The emotional trauma of sexual abuse may impede normal sexual development—contributing to promiscuous sexual behavior or a fear of sexuality.
- The emotional trauma of sexual abuse may take tremendous energy and focus that would otherwise be devoted to age appropriate developmental tasks. For example, how does an 11-year-old who has been sexually abused by her two uncles sit around and giggle with her girlfriends about "cute boys" in her class?

Emotional maltreatment might impact development in the following ways:

- Emotional maltreatment may cause self-esteem to erode to the point where the child feels incompetent to tackle even the most basic of skills.
- Emotional maltreatment that keeps a child from developing outside relationships can result in poor social development, lack of social skills, difficulty with peers, etc.

Understanding the Child's Developmental Jigsaw Puzzle

We all make assumptions about people's behavior and developmental levels based on their age. This works because for most people, development takes a normal course. Most aspects of their development match their age. This means that an eight year old is physically, emotionally, intellectually, academically, and socially at an eight-year-old level. In a jigsaw puzzle representing the child's development, all the pieces would read "eight years old."

But for children whose experiences may lead to developmental delays, it is unrealistic to expect development to be consistent with age. Because of their experiences, children may be normal in some areas of development, but exhibit delays in other areas. For example, a child may have normal intelligence and physical appearance for his age, but emotionally, socially, and academically may function at a much younger level.

In family foster care and adoption, child development can be compared to a jigsaw puzzle where every piece must be labeled with a different age or developmental level. It is important for foster parents and adoptive parents to identify the puzzle pieces, and understand the child's level of functioning in each aspect of development.

There are no shortcuts when it comes to raising healthy children. Separating children from those who have abused and/or neglected them only stops the abuse and neglect. It does not automatically guarantee a child's normal development.

An important concept of human development is that human beings progress through certain stages, and no stage can be skipped. This means that the foster family, or adoptive family, must begin to care for each child at the child's actual stage of development, not his or her chronological age, and help the child move forward from there.

Human beings are extremely vulnerable. However, it is important to remember that human beings are also quite resilient. We are vulnerable to many genetic, prenatal, and environmental influences, yet most of us develop into reasonably healthy humans. With your care and commitment, and with the support of everyone on the team, children who have been abused and neglected can too!

Promoting Mutual Attachment and Supporting Commitment

Foster parents and adoptive parents can help children develop attachments by:

- Consistently understanding and meeting children's needs.
- Helping children express their feelings and demonstrating that they understand.
- Helping children relax and have fun.
- Using non-abusive discipline.
- Helping children feel good about themselves.
- Making sure that children do not feel rejected even when their behavior is unacceptable.

Foster parents or adoptive parents can help develop attachments to children by:

- Spending the time necessary to understand children and their needs.
- Taking time to enjoy children, and finding things to do together that they both enjoy.
- Helping children learn appropriate behavior so that they are easier to live with.

- Helping children learn skills in which both the children and the parents can take pride.

Foster parents and adoptive parents can remain committed by:

- Seeking the help of other team members to understand the children's needs.
- Using the agency and other resources such as foster parent and adoptive parent support groups.
- Having time alone and as a couple to prevent "burn out."
- Maintaining a sense of humor and perspective.
- Having realistic expectations.
- Understanding that most behaviors and relationships will improve over time.
- Taking pride in small accomplishments and steps forward.

You Need to Know!
Children's Growth and Development*

Child behavior that is typical at one age or stage may not be at another. For example, temper tantrums in which a child falls on the floor screaming and kicking are not unusual at two years of age. The same behavior at 10 years of age is a cause for concern.

Likewise, interest in sexual intercourse is expected among teens, but similar interest in a four year old is a problem and should be discussed with the foster care team.

Most children in family foster care, and most children available for adoption through child welfare agencies, have experienced one or more conditions that interfere with normal growth and development.

Always remember to react to the context of a child's behavior, not to the behavior itself. It is important to keep in mind that when children express strong feelings and inappropriate behaviors, it may be because they:

- Have learned these patterns in the past.
- Are developmentally delayed and react like a much younger child.
- Have a developmental disability that limits their understanding or behavior.
- Are grieving.
- Have real fears.

As foster parents and adoptive parents, you can help children deal with these experiences and learn more appropriate ways of coping and behaving. To do this, you may need help.

This does not mean that you are inadequate, or that the child is mentally ill. If a child has a broken leg, you seek medical help. When a fever persists, you take the child to a physician. In the same way, when a child demonstrates serious problems, you must seek professional help. Discuss this with your social worker, and she or he can help you find the most appropriate resource.

* Adapted from California Early Intervention Technical Assistance Network Work Group, December, 1989, Pasadena, CA.

Conditions and Experiences That May Cause Developmental Delays and Affect Attachment

Genetic or Congenital Conditions

Some children are born with conditions that affect their development. Examples include Down's Syndrome, and congenital blindness. These conditions may affect their social interactions with others and complicate attachment formation.

Prenatal Factors

Sometimes the conditions of fetal development or problems during birth limit developmental potential. Examples include exposure to measles, alcohol and other drugs, HIV/AIDS, poor nutrition, and lack of prenatal care. As a result, children may demonstrate behaviors that may make it difficult for others to like them; this can affect children's ability to attach.

Neglect

Some children do not receive the physical care they need for health and optimal growth. Typically, they are deprived of necessities such as food, hygiene, clothing, and shelter. They also may lack supervision, health care, and education. Often, parents are more unable than unwilling to provide what their children need. Parents may not know or understand how to care for their children, or may be too ill or poor to provide basic care.

Physical Abuse

Some children suffer attacks on their bodies. Examples include beating, kicking, whipping, burning with cigarettes and hot water, pinching, hair pulling, being tied up, and a range of other physical tortures. Sometimes, parents use extreme forms of punishment as discipline, or sometimes parents and other caregivers, such as babysitters, just lose control. Parents may be under extreme stress, or they punish their children the way they were punished. Sometimes, abuse results when parents or other caregivers expect too much from children. In other cases, parents may get personal gratification from hurting their children, or fail to recognize that their children feel pain. These circumstances may cause developmental delays, and may also affect children's abilities to trust and attach, not only to the parent, but to any adult.

Emotional Maltreatment

Some children receive just enough physical care to survive, but do not get the emotional care and security they need to feel good about themselves (self-esteem) and others. This may be due to caregivers who are unable or unwilling to provide this basic care. Examples of maltreatment are: putting children down with words, e.g., calling them stupid, or ugly; bullying and

threatening; shaming; consistent inattention and ignoring; preventing children from having normal relationships, so they have no friends and are made to feel alone; and encouraging children to behave in self-destructive ways.

Whenever parents significantly and consistently betray children's trust and fail to meet their needs, children are at risk for problems with attachment.

Sexual Abuse

Some parents use their children for their own sexual pleasure or for the pleasure of others. Children of all ages may be sexually abused, including infants, toddlers, preschool children, grade school children, and teenagers. This abuse may include: sexual touching and fondling; oral sex; anal and vaginal penetration with fingers, a penis, or other objects; age inappropriate sexual discussions; and using children for pornography or prostitution. These traumatic experiences often place children at risk for both developmental delays and serious attachment problems.

Accidents and Trauma

Some children are permanently injured, either accidentally or through deliberate acts of their caregivers. Examples include automobile accidents and falls. The nature of the accident or trauma, and the overall psychological health of the child determine the effects.

Inappropriate Behavioral Patterns

Some children are reared by adults who directly or indirectly teach them inappropriate behaviors. They may just copy the inappropriate behaviors of these adults, or they may be deliberately taught to behave in unacceptable ways. Examples include patterns of family violence, substance abuse, and criminality, which children copy or which the parents actually teach them. These situations may affect the children's development, and ability to have positive attachments with others.

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Some Indicators of Infants Exposed to Alcohol or Other Drugs During Pregnancy

Infants exposed to alcohol or other addictive substances during pregnancy may go through **withdrawal** after birth when the substance is no longer being carried in their bloodstream. They may exhibit the following symptoms:

- High irritability
- Problems with sleep and eating
- Low birth weight
- Stiffening of the body
- Failure to bond

Infants with fetal alcohol syndrome may remain mentally impaired.

When crack cocaine enters the mother's body, both the mother's and the fetus's blood vessels constrict, and the flow of blood to the fetus is sharply reduced. This reduced blood flow deprives the fetus of oxygen, resulting in:

- Delayed growth
- Birth defects affecting the heart, lungs, intestines
- Premature birth

The fetus's brain cells, deprived of oxygen, can atrophy and die, resulting in developmental problems and delays in motor functioning, speech, hearing, vision, smell, touch, and the planning and organization of thoughts and actions.

Crack cocaine affects the central nervous system by overstimulating the baby's nerves and damaging nerve endings. A damaged central nervous system cannot carry messages about body functions, feelings, and thoughts. Children with this kind of damage may have:

- Attention deficit disorders
- Periods of uncontrollable rage or restlessness
- Inability to be comforted
- Inability to respond to typical caregiving functions

Foster parents and adoptive parents can provide these children with the protective, predictable, and nurturing environments that they need. The benefits of one consistent and nurturing caregiver are overwhelmingly positive.

General Information about Attachment*

What is it?

Attachment is an enduring affectionate bond between two individuals that joins them emotionally.

Why is it important?

Attachment between caregiver and infant lays the foundation for healthy psychological, physical, and cognitive development in a child. You see the process of attachment when you observe a caregiver touching, holding, caressing, and having eye contact with his or her infant.

What does this mean for me?

Many children in family foster care or placed with adoptive families have never formed a secure attachment to a caregiver. These children may behave in ways that compensate for this lack of attachment.

What should I look for?

Lack of secure attachment may cause the following behaviors:

- Manipulation
- Chronic anxiety
- Problems getting along with people in authority
- Aggressiveness
- Hostility
- Poor relationships with others
- Poor self-esteem
- Self-isolation

* Shatz, M.S. & Faust, T.P. (1992). Parenting the Poorly Attached Teenager. Fort Collins, CO: Colorado Department of Social Services.

What can I do?

Foster parents and adoptive parents can promote attachment and reduce behavior problems of children who are poorly attached through:

- Positive interactions with the child.
- Strong nurturing.
- Allowing the child to grieve and mourn.
- Providing structure in the home.

What if the behavior continues or gets worse?

Foster parents and adoptive parents may not be able to "reach" a child who is poorly attached. Contact your social worker, because the child may need an assessment and treatment.

Some Indicators of Developmental Disabilities

Developmental disabilities/delays can result when a child lacks the conditions necessary for physical, emotional, social, cultural, and intellectual growth. Some causes of developmental disabilities/delays are:

- Lack of prenatal care
- Genetic inheritance
- Prenatal trauma
- Prenatal exposure to drugs/alcohol
- Accident or birth injury
- Poor nutrition
- Certain diseases
- Physical abuse
- Emotional abuse

These children usually have severe problems in one or more of the following areas:

- Self-care
- Walking
- Appropriate behavior
- Speech
- Manners
- Age appropriate use of home and neighborhood
- Getting along with others
- Self-direction

Some children with developmental disabilities/delays will be able to develop a degree of self-sufficiency as adults. Others will always be dependent.

> NOTE: As foster parents and adoptive parents, you are not alone in providing care for children who have developmental disabilities. Special education services are available through the public school system. Your social worker may also direct you to other agencies in your community.

Educators and other professionals working with the child who is developmentally disabled form the team that prepares the child's individualized education plan (IEP). Adoptive parents are always invited to the IEP meeting. Foster parents are usually encouraged to attend, but this varies according to school district. Contact the school. Your input is valuable.

You Need to Know!
Indicators of Child Maltreatment*

Some Indicators of Emotional Maltreatment

Child's Appearance

- Speech disorders
- Lags in physical development

Child's Behavior

- Habit disorders:
  - — sucking, biting, rocking
  - — bedwetting, soiling
  - — feeding problems
- Conduct problems, such as
  - — destructiveness
  - — cruelty
  - — stealing
- Neurotic traits:
  - — sleep disorders
  - — inhibitions in play
  - — hysteria
- Obsessiveness, compulsiveness, phobias

* Adapted from Pasztor, E.M. and Murphy, M. (1984). The Army Family Advocacy Program: Child Abuse and Neglect Training for Child Development Services and Youth Activities Personnel (A Training Manual). Washington, DC: Nova University Institute for Social Services to Families.

- Extreme behaviors:
  - — overly compliant
  - — extremely passive or aggressive
  - — very demanding or not demanding at all
- Overly adaptive behaviors:
  - — inappropriately adult (parenting other children)
  - — inappropriately infantile (rocking, head banging)
- Developmental lags:
  - — in emotional development
  - — in intellectual development
  - — suicide attempts

NOTE: These characteristics may also describe a child with emotional disturbance. Discuss any concerns with other members of the professional team.

Some Indicators of Neglect

Child's Appearance

- Inappropriate or poor hygiene:
  - — chronically unwashed
  - — chronic diaper rash
- Inappropriate clothing for weather conditions, age, size
- Shaved head or matted hair

Child's Health

- Underweight
- Prone to illness
- Pale
- Listless
- Delayed growth
- Delayed speech

Eating habits:

- Begs, steals, hoards food
- Constantly hungry
- Chronic school absenteeism

Some Indicators of Severe Neglect

- Failure to thrive due to underfeeding:
  - — extreme underweight condition
  - — failure to gain weight at home
  - — rapid weight gain out of the home
  - — ravenous appetite
- Medical neglect:
  - — lack of life-sustaining medical attention
  - — extreme obesity due to overeating
  - — untreated eating disorder
  - — untreated severe and chronic medical/dental condition

Some Indicators of Physical Abuse

Child's Appearance

- Bruises and welts:
  - — unexplained, unusual, suspicious, non-accidental
  - — located on face, lips, mouth, torso, buttocks, thighs
  - — in various stages of healing (of different colors)
  - — clustered, forming regular patterns
  - — reflecting shape of article used (e.g., electric cord, buckle)
  - — choke marks
  - — human hand marks
  - — regularly appear after absence (weekend, vacation)
  - — any bruise on an infant

- Burns:
  - — shaped like a cigar or cigarette, especially on soles, palms, back, or buttocks
  - — immersion burns (socklike, glovelike, doughnut-shaped on buttocks or genitals)
  - — patterned like an electric burner or iron
  - — rope burns on arms, legs, neck, or torso
- Fractures:
  - — of various ages
  - — inconsistent with explanation
  - — spiral fracture in infant
  - — repeated fractures to same site
- Unexplained lacerations or abrasions:
  - — on mouth, lips, gums, eyes, genitals
- Unexplained or unusual abdominal injuries:
  - — swelling of abdomen
  - — constant vomiting
- Head injuries, subdural hematomas
- Internal injuries

Child's Behavior

- Wary of physical contact with adults:
  - — refuses, draws away from contact
  - — draws back, shrinks away at the touch or approach of an adult
- Anxious, apprehensive:
  - — when other children cry
  - — about any normal activity, for example, taking a nap, eating
  - — experiences nightmares
  - — experiences flashbacks
- Fearful
  - — shrinks from contact with parents or caregiver
  - — reports injury by a parent or caregiver
  - — accepts blame for everything that goes wrong
  - — protects from pain by repressing or blocking memory

- Demonstrates extreme behaviors:
  - — extreme aggressiveness
  - — extreme withdrawal
  - — overly compliant
  - — obnoxious, hurtful, or destructive behavior
  - — any behavior outside the range of average, expected for the child's age and stage of development

Some Indicators of Sexual Abuse

Child's Appearance

- Difficulty in walking or sitting
- Torn, stained, or bloodied underclothing
- Bruises or bleeding in genital, vaginal, or anal area
- Blood or semen on clothing
- Foreign bodies in genital, anal, or urethral openings
- Sperm in vagina
- Trauma to breasts, buttocks, lower abdomen, or thighs
- Pregnancy
- Venereal disease

Child's Behaviors

- Displays bizarre, unusual, sophisticated knowledge or behavior regarding sex (the younger the child, the stronger the indicator)
- Does an unusual amount of sex play with self or toys
- Initiates sex play with other children

Relationships with Others

- Generally poor relationships with other children
- Unwillingness to participate in physical activities
- Overly compliant
- Emotional state:
  - — appears withdrawn, engages in fantasy or unusually infantile behavior
- Excessive acting out of any kind
- Sudden drop in school performance or interest in activities
- Difficulty in sleeping
- Regressive behavior
- Continuously depressed
- Acts overly grown-up
- Complains of pain or itching in genital area
- Runs away from home
- Talks about suicide
- States that she or he has been forced to have sex

NOTE: A child can be molested even though there is no medical evidence, for example, through fondling, oral copulation, masturbation, pornographic photography.

What Foster Parents and Adoptive Parents Can Do to Decrease the Effects of Sexual Abuse on Child Victims

Some child victims:	Foster parents and adoptive parents should:
Consider themselves "damaged goods." This puts them at risk for further sexual abuse. Moreover, some men and boys view the child victim as fair game: "One more time won't hurt."	Remember to treat the victim as a child, not as an adult or piece of "damaged goods." Provide closer supervision of the victim when he or she is around adolescents or adults who are aware of his or her victimization.
Feel guilt for being a victim; they believe they somehow "asked for it" or could have stopped it. They are labeled "seductive."	Remind the child that the perpetrator is the only one responsible for the sexual abuse. Children do not give consent for sexual activity; they "cooperate" because the perpetrator is a parent, a member of the family, or a trusted adult.
Feel guilt over the consequences of reporting the sexual abuse; the disruption to the family. Family members may blame the child for their pain: "Look what you have done to your family/father."	Reassure the child that he or she did the right thing in reporting the sexual abuse. You should also emphasize that a child can never be held responsible for initiating or participating in sexual activity with an adult, or for the disruption that follows.
Have a fear of being abused again. This could result in sleep disturbances or nightmares. Most victims also have feelings of depression.	Encourage the child to talk about any fears. You must create an environment in which the child can express all feelings, positive and negative, and feel believed and supported.

The Need for Therapy

Child victims of sexual abuse must resolve feelings of:

- Guilt
- Low self-esteem
- Anger (sometimes not expressed)
- Inability to develop trusting relationships

These are best resolved in a therapeutic setting with:

- Individual therapy
- Group therapy
- Therapy with parent and/or perpetrator
- Any combination of the above

Foster Parents and Adoptive Parents Play a Vital Role

As foster parents and adoptive parents, you provide a truly invaluable service when you stick with a child victim, even as she acts out her pain. You show her that it is possible for someone to love her without exploiting her. You also provide a model of positive parenting. But remember you don't have to do this alone; you are a member of a team within a social work agency which will support and advise you.

> NOTE: Although the female "she" was used above, many victims of child sexual abuse are boys and young men.

Some Information About HIV/AIDS

Foster parents and adoptive parents caring for children with the Human Immunodeficiency Virus (HIV) infection face a particular challenge. However, with the support of health and social work professionals you can provide a loving, stable and nurturing environment. By doing so, you can enhance the quality, meaning, and even the length of a child's life.

HIV is transmitted through:

- Direct contact with infected blood, semen, or vaginal fluids
- Prenatal or perinatal exposure from mother to infant
- In rare cases, breast milk

Children who test positive for HIV may exhibit "nonspecific" symptoms such as:

- Enlarged lymph nodes
- Enlarged liver and spleen
- Oral thrush
- Diarrhea
- Weight loss
- Fever
- A disease known as lymphocytic interstitial pneumonia (LIP)

The progression of the virus from HIV infection to full blown AIDS differs from one infected child to the next. However: **HIV Can Be Spread Only by Direct Contact with Infected Body Fluids. There Is No Evidence That HIV Can Be Transmitted by Casual Contact with an Infected Child.**

Children who are HIV-infected need:

- Consistent loving attention and nurturing stimulation.
- Individual therapy to help the child resolve any shame or anger, and to bolster self-esteem.
- Family therapy to assist in developing open communication in the home.
- Consistent preventive care with appropriate antibiotics as the child's immune system becomes increasingly compromised.
- Close monitoring of growth and development for any changes, such as failure to gain weight, which signal a serious progression of the HIV infection.
- Nutrition management to help enhance the child's immune system and development.
- Consistent immunizations in accordance with Centers for Disease Control (CDC) recommendations.
- Frequent monitoring by health care professionals who are aware of the child's health history, knowledgeable of pediatric HIV infection, and are in contact with experts in the field.

A Birth Parent's Perspective
"Letting Go Was Best for Both of Us"

To Bennie's Adoptive Parents:
Hi—I'm Janine—I'm Bennie's mother.

When Bennie was just born, I was 15 years old and living at home. My momma said she'd get up at night to feed him and soothe him back to sleep and she did. I was in school. He was little, cuddly and cute, and I would take him to teen parenting classes every day. At night momma took over and fed him, bathed him and got up in the middle of the night as well. Then Bennie started to walk and talk and say, "No." He wanted to do everything his own way and be a "big boy." It got harder and harder to make it to school day care. I still had one semester left before graduation.

Momma needed to return to work and her time with Bennie changed. It was all on me now. I was so tired that I couldn't get up in the morning. I started missing school and sleeping a lot. Bennie just wanted me all the time. He got me really mad lots of times. That's when the spankings started.

He stopped coming to me for things he needed. It got pretty bad between us. I knew this wasn't the right thing. The more frustrated I got, the more screaming and demanding Bennie was. That's when I started drinking and it got more difficult for him and for me after that. I love Bennie. I loved the idea of having my own baby and being on my own. But doing it all was almost impossible. Dressing him every day, money, food, school, homework... and every single day!

It became impossible. My momma wasn't able to help out much more. Someone at school day care noticed bruises on Bennie. The agency came in then and things got more complicated. I want you to know that I loved Bennie and tried as long as I could. It was just too hard for me. I'm still sad and I'm angry too at myself, at the school people, and at Bennie for not being a better boy. It got worse the older he became.

I hope you can give him the time and help I couldn't. He's almost four now, he has some problems in pre-school with other kids and I still have my GED to finish. Maybe someday you can help him understand how this got harder and harder for me.

Letting go was best for both of us. It still hurts though.... Maybe it always will. But I hope Bennie's future is better for knowing I tried for as long as I could.

PRIDE Connection

Name:_____

Date: _____

Family Development Specialist: _____

Meeting Developmental Needs—Past and Present

One of the competency categories for foster parents and adoptive parents is to meet children's developmental needs and address their developmental delays. Reflecting on how your own developmental needs were met as you grew up will help you think about values and skills you bring to meeting the developmental needs of children.

Think about the way people met your developmental needs, and how that has affected the way you meet these same developmental needs for children in your family now. Use the chart on the next page to fill in short answers or quick notes to remind you of your thoughts. A discussion on this topic will be part of the mutual family assessment.

Needs of All Children	Who Met This Need for You and How Did They Do It?	How Would You Meet This Need for Children?
For Self-Esteem		
For Cultural and Spiritual Identity		
For Positive Guidance		
For Appropriate Discipline		
To be Interested in Learning		
To Learn to Get Along Well With Others		

Name: _____
Date: _____
Family Development Specialist: _____

Factors that Impact Growth and Development

Some factors that might have an impact on normal growth and development in children are:

- Genetic and prenatal conditions
- Handicapping conditions
- Physical neglect
- Physical abuse
- Sexual abuse
- Emotional abuse and neglect
- Accidents and trauma
- Being exposed to inappropriate behavioral patterns of adults such as substance abuse or domestic violence

1. Describe any experiences you or someone you know has had with these situations.

2. How will you use these experiences to help you be an effective foster parent or adoptive parent?

Making a Difference!

My husband and I became the adoptive parents for a 10-year-old boy who was energetic, a non-stop talker, funny and friendly. He had a lot of wonderful traits, in spite of the fact that he also had endured a lot of physical and emotional tragedies in his short decade of life. As a result, his jigsaw puzzle looked like this: age, 10 years; appearance, nine years; intellectual ability, eight years; school grade, reading and writing at first grade level= six years; social age, three years; emotional age, infant to one year; cultural match with adoptive parents, same ethnicity, religion, few shared values; life experience, adult.

One day, when our son was 19, I was talking with a friend who also happened to be a social worker. I was discouraged about the lack of progress for our son. I told my friend, "He's 19 years old and he's only completed one college course, it took him seven times to pass his driver's test, he can only manage a part-time job, he has only one friend, he's only had one date, and he likes hanging out with us. I don't think we're making much progress toward independence!"

My friend said, "Remember his jigsaw puzzle when he was 10 years old: reading at first grade level, not having any friends, not trusting any adults?" "I remember," I said.

My friend said, "Well, in just nine years he's been able to get to college when it takes most kids 12 years. And in just nine years this untrusting, unsociable kid, with no self-confidence, has been able to take a test until he passed, hold down a job for more than a year, and become attached to his parents. Given where he started from nine years ago, he's not delayed... this kid is an overachiever!"

So, when our son got home, I said to him, "You know, I'm really proud of you. I love you." And our son said, "I know, Mom, thanks."

Adoptive Parent

California