UNDERSTANDING & MEETING THE PSYCHOLOGICAL NEEDS OF TRAUMATIZED CHILDREN IN THE FOSTER CARE/ADOPTION SYSTEM

Therapeutic Assessment, Services, and the Importance of the Collaborative Approach across Support Systems.

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Introduction
SAMPLE OF FACTS REGARDING TRAUMA EXPERIENCES AND CHILDREN IN FOSTER CARE: THE HARVARD CRIMSON RESEARCH REVIEW BY CANDICE M. PLOTKIN (2005)

Candice M. Plotkin’s article in the Harvard Crimson Research Review provided a summary of results released by a collaborative effort between Harvard Medical School, The University of Michigan and Case Family Programs, and The Northwest Foster Care Alumni Study, in 2005.
Children in foster care are almost twice as likely to suffer from Post-Traumatic Stress Disorder as U.S. war veterans...,” per the Harvard/University of Michigan, and Case Family Programs study (Plotkin, 2005).
The Northwest Foster Care Alumni Study Summary

- Followed 659 foster care alumni from the Oregon and Washington State welfare agencies:

  - Results indicated that former foster children have low completion rates for post-secondary education and lower employment rates compared to the general population.
  - One in four (25%) of alumni had experienced PTSD in the previous 12 months and more than half had experienced at least one mental health problem such as depression, social phobia, or panic syndrome.

  - These elevated rates of mental health problems may also affect rates of educational and occupational success:
    - Greater than 4/5 foster care alumni completed high school.
    - Yet only 1.8% of foster care alumni graduated from college vs. 24% of graduating college students within the general population.
    - The employment rates for young adults ages 20-34: 80.1% of Foster Care Alumni vs. 95% of General Population
    - Yet, 1/3 of Foster Care Alumni had household incomes at or below the poverty level.
Additional Cited Implications from the 2005 Harvard Crimson Article

- Per Plotkin’s article, Peter J. Pecora, Senior Director of Research Services at Casey Family Program, which promotes advances in child-welfare practice and policies, reported:

  “Frequent placement changes and lack of permanent support guarantees often faced by foster children contribute to feelings of anxiety and social instability.”

  “The first placement should be the last placement,” said Pecora. “The average age a person leaves home is 25. People are taking longer to reach adulthood, finish school, and have children. Given that backdrop, why would we expect that someone who has faced the challenges of the welfare system to be fully self-sufficient by age eighteen?”

- 65% of children in foster care experience 7+ school changes from elementary to high school. Following the age of 18, the foster care system no longer has an obligation to provide foster children with family placements.

- Per Plotkin, “Professor of Health Care Policy Ronald Kessler, a co-author of the project, says foster children’s greater likelihood of mental health risks is primarily based upon the experiences, such as neglect and abuse, that children face before entering the foster system.”
Additional Cited Implications from the 2005 Harvard Crimson Article (Plotkin, 2005)

**Recommendations based on results:**

- **There is a need for more mental health treatment within the current foster care system.**
- Treatment exists “for kids who have acting-out problems, like violence or substance disorders or [Attention Deficit and Hyperactivity Disorder], but not nearly as much for kids with more silent mental health problems like depression or PTSD,” Kessler wrote.
- States should not only help kids within the foster care network, but also provide assistance to its alumni. Beyond lengthening placements and providing more social service workers to foster children, the provision of social and financial support for alumni may counteract future mental health risks.
KEY CHARACTERISTICS OF TRAUMA AND STRESSOR-RELATED DISORDERS IN CHILDREN

Key Characteristics of Trauma and Stressor-Related Disorders In Children:

1. **TRAUMA EXPOSURE**

- Exposure to ACTUAL OR THREATENED death, serious injury (i.e., Domestic Violence), or sexual violence:
  - **Direct Exposure**
  - **Witnessing** the traumatic event in Person
    
    **NOTE:** Per the DSM-V, witnessing DOES NOT include events seen in electronic media, television, movies, or pictures.
  - **Learning** that the traumatic event occurred to someone significant in his/her life:
    - Children 6 and older and (Adults): May include a close family member or friend.
    - Children under 6: The person is defined as parent or other care-giver.
  - **Experiencing repeated or extreme exposure** to details of the traumatic event.
Key Characteristics of Trauma and Stressor-Related Disorders In Children Continued:

2. *Intrusion Symptoms Following the Traumatic Event:*

- Recurring, involuntary, and distressing memories/thoughts related to trauma
- Nightmares/Distressing Dreams related to the event either with direct content of the trauma or with indirect themes related to the trauma
- “Flashbacks” of the trauma: Person feels or acts as if the trauma is still happening
- Avoidance of Trauma-Related Triggers/Events
Key Characteristics of Trauma and Stressor-Related Disorders In Children Continued: Significant Psychological Distress

Anxiety, Worry, or Fear-Based

Examples:

* Persistent avoidance of upsetting memories, thoughts, feelings about, or closely related to, the trauma
  (With children 6 and under, “Spontaneous and intrusive memories may no necessarily appear distressing and may be expressed as play reenactment.” (American Psychiatric Association. 2013, p. 273)
* Avoidance of environmental/external reminders of the trauma (e.g., children may resist transitioning from location to location; avoid situations or places that remind them of the trauma).
* Intrusive Symptoms (e.g., Repetitive reenactment of the trauma and/or themes related to the trauma, recurrent, distressing, unwanted memories of trauma)
Key Characteristics of Trauma and Stressor-Related Disorders In Children Continued:

*Intrusion continued: Dissociative Symptoms*

The child feels or acts as if the trauma is still occurring; may manifest in trauma-reenactment in play.

* So-Called “Out of Body” Experiences
Depressive Symptoms

- Persistent sadness,
- Irritability,
- Lack of pleasure in interests previously enjoyed
- Flat, or restricted affect (i.e., not visibly showing a lot of emotion and/or facial expression)
- Increased occurrence and/or intensity of negative emotional expressions (e.g., fear, guilt, shame, Confusion)
- Social Withdrawal (e.g., not wanting to participate in play, restricted play, avoidance of others who might remind them of the trauma)
Key Characteristics of Trauma and Stressor-Related Disorders In Children Continued:

• **The Fight/Flight/Freeze Response in Traumatized Children:** Bio-physiologically-Based Stress Response

  • **Fight** for survival (e.g., verbal and/or physical behavior, destruction of property)
  • **Take Flight** for survival (e.g., running away, hiding)
  • **Freeze** (as in “shutting down, withdrawing, not participating with others, unable to start/complete work, etc.).
  • Other non-essential functions of the brain/body are compromised (e.g., executive functioning skills, language processing skills, sensory-motor functioning, etc.)
Behavioral Symptoms of Fight/Flight/Freeze

• Active or passive avoidance of trauma-related Reminders
• Hypervigilance (Consistently “on edge, as if waiting for something awful to happen.
• Exaggerated “Startle Response” (e.g., if they are touched, especially unexpectedly, they might jump, look shocked
• Irritability, anger outbursts (e.g., verbal and/or physical aggression towards people or objects)
  • There can be little or no apparent reason/known trigger.
  • There likely IS an internal or external trauma-memory-related trigger.
  • The child may or may not know the connection between his/her behavior/anxiety/stress-response
Key Characteristics of Trauma and Stressor-Related Disorders In Children Continued:

Additional Behaviors Associated with Fight/Flight/Freeze Trauma Response:

- Irritability, anger outbursts (e.g., verbal and/or physical aggression towards people or objects, tantrums)
  - There can be little or no apparent reason/known trigger. There likely IS an internal or external trauma-memory-related trigger.
  - The child may or may not know the connection between his/her behavior/anxiety/stress-response

- Oppositional-defiant LOOKING behaviors: (But think in terms of trauma-related anxiety):
  - Refusal to follow directions, arguing.
  - Avoidance of (i.e., resistance to) activities, places, or physical reminders of trauma event (these triggers may or may not be immediately apparent).
Key Characteristics of Trauma and Stressor-Related Disorders In Children Continued:

- Social Withdrawal/Unusual Social Play (Flight)
  - Diminished interest in playing with others.
  - Diminished interest in participating in significant activities.
  - Guarded (restriction) in play and/or verbal interactions
  - Repeated “reenactment” of play related to trauma experience or trauma-related themes.
Key Characteristics of Trauma and Stressor-Related Disorders In Children Continued:

- **Associated Medical/Physical Concerns**
  - * Appetite Changes
  - * Bedwetting/encopresis
  - * Sleep disturbances (including nightmares,, difficulties falling or staying asleep, difficulties waking in the morning).
  - * Difficulties focusing/maintaining attention
  - * Other Physical Symptoms (e.g., headaches, stomach-aches, dizziness, muscle tension, restlessness, increased heart rate, sweating, rapid and shallow breathing).

*** These are real symptoms and “not all in one’s head.”

- **Other Factors Impacted by trauma:**
  - * Neurodevelopmental delays (e.g., cognitive delays, speech and language impairments or delays, sensory-motor developmental delays/impairments (especially with prolonged, intense, and/or recurrent exposure to traumatic events.}
Important Points To Remember

• We are not meant to remain at high levels of stress.

• Yet, on-going, recurrent and/or intensive trauma exposure, as is often the case with children who have been placed in multiple foster care placements and/or adopted……..

➤ Leads to chronic states of stress/anxiety, which in turn, can lead to intensive and on-going emotional, social, behavioral, cognitive, and developmental delays and challenges.
ATTACHMENT AND THE IMPACT OF TRAUMA
A Brief Summary About Attachment Development

• Biologically/neurologically based as a means by there is a “goal-corrected” partnership between the infant and caregiver (Zeanah, 2000, pg. 68-69) so that the infant can maintain proximity to the caregiver, so as to reduce stress (get basic needs for food, warmth, comfort met), regulate emotions, and promote safe exploration.

• The degree to, and speed by which the caregiver is sensitively responsive to the infant’s needs impacts the quality of the attachment.

• According to John Bowlby, who developed the attachment perspective, “infants whose mothers respond quickly and appropriately to their cues (e.g., by attempting to soothe a crying baby) learn that they can count on their mothers to respond when they need assistance (i.e., feel secure) and begin to form an understanding or internal representation of themselves and others based on these early experiences.” (Zeanah, 2000, pg. 69).
Trauma’s Impact on Children’s Social Bonding and Development of Healthy Attachment:

- OFTEN SEEN WITH CHILDREN WHO HAVE EXPERIENCES REPEATED CHANGES IN FOSTER CARE/MULTIPLE CARE-GIVING PLACEMENTS

- The child has known, identified, experiences of extremes in or inadequate care (basic needs for emotional comfort were not met, lack of, extremely limited, or extremely inconsistent opportunities for social and cognitive stimulation by caregiving adults

- There are repeated changes in caregiving adults which limit opportunities to establish and maintain stable and healthy attachments.

- With abuse and neglect, healthy attachment development is significantly impaired, particularly with chronic and profound abuse and neglect. Separation of the infant from the primary caregiver has been identified as a primary factor contributing to the development of an insecure attachment relationship (Zeanah, 2000, pg. 71).

- Current caregiving and previous attachment-based experiences, including neglect and abuse by caregivers, painful medical treatments (e.g., NICU), and separation from previous caregivers, prior to foster care and/or adoption placement (Zeanah, 2000, pg. 71).

- The older the infant is at placement, the more likely he/she is to have had these experiences, which lead to the development of capacities which contribute to forming insecure attachments in new attachment relationships (Zeanah, 2000, pg. 71).
• OFTEN SEEN WITH CHILDREN WHO HAVE EXPERIENCES REPEATED CHANGES IN FOSTER CARE/MULTIPLE CARE-GIVING PLACEMENTS

• The child has known, identified, experiences of extremes in or inadequate care (basic needs for emotional comfort were not met, lack of, extremely limited, or extremely inconsistent opportunities for social and cognitive stimulation by caregiving adults)

• There are repeated changes in caregiving adults which limit opportunities to establish and maintain stable and healthy attachments
Environmental Factors Considered Regarding Attachment-Related Disorders:

- Rearing in unusual and depriving settings that severely limit the child’s opportunity to form specific and positive attachments
- Deprivation of care is presumed responsible for behavioral concerns
- Disturbance is evident before age 5
- The child’s developmental age is at least 9 months.
- NOTE: It has been determined, via clinical assessment, that child DOES NOT have Autism
Impact on the Child-Caregiver Attachment Relationship:

- Inability or difficulties establishing and maintaining social bonds/attachments

- Consistent patterns of being inhibited (shy) or emotionally withdrawn behavior toward parent or care-giver

- Child rarely or minimally seeks comfort when upset

- Child rarely or minimally responds to comfort offered when upset

- Persistent emotional and social disturbances, especially towards caregivers (e.g., minimal responsiveness to others, limited positive affect/mood, episodes of unexplained irritability, sadness, fear, even during seemingly non-threatening interactions with care-givers

Common Attachment-Related Challenges Associated with Trauma (Continued)
Attachment Disorders’ Behavioral Impact on the Child:

Difficulties/Inability Establishing and Maintaining Social Bonds/Attachments

* Consistent Patterns of being inhibited (shy) or emotionally withdrawn behavior toward parent or care-giver
* Child rarely or minimally seeks comfort when upset
* Child rarely or minimally responds to comfort offered when upset
* Persistent Emotional and Social Disturbances Especially Towards Caregivers (e.g., minimal responsiveness to others, limited positive affect/mood, episodes of unexplained irritability, sadness, fear, even during seemingly non-threatening interactions with CARE-GIVERS)
* The child actively approaches and interacts with unfamiliar adults (Indiscriminate willingness to approach or accompany an unknown adult).
* The child minimally or does not “check back” (touch base) with the adult care-giver after venturing away from unfamiliar settings.
* Such Behavior Patterns are not limited to impulsivity alone (as in ADHD).
Collaborative and Comprehensive Assessment Strategies:

Applying an Ecological Systems Model: Beyond viewing the child as “the problem.”

Consider:
One Childhood Representation of Uri Bronfenbrenner’s Ecological Systems Model

For Children and Youth In the Foster Care/Adoption System, With Added Considerations:
Foster Care/Adoption Agency Placement Systems
Therapy Systems
Other Systems…?
ReMoved/ReMoved Pt. 2

ReMoved

https://www.youtube.com/watch?v=IOeQUwdAjE0

ReMoved Part 2.

https://www.youtube.com/watch?v=ECLBaoFLT3s
• Elements of A Therapeutic Comprehensive Assessment and Treatment

* Structured Interview Developmental/Psychosocial History and Current Social, Emotional, Behavioral, Academic, and Developmental functioning at home, community, school (across settings).
* Structured Child Interview
* Child Behavioral and Social Interactional Observations
* Administration of Comprehensive Behavior Rating Scales providing information re: diagnoses, treatment planning, progress in treatment
* Input From School Personnel (e.g., teachers, school social workers/counselors, ancillary support staff if relevant, IEP/MET information
* Health/Medical Information (Can involve collaboration with physicians, OT’s, SLPs, PTs, etc.)
* Input from Foster Care/Adoption Workers
* Input from any other significant care-givers/support systems
Within the Clinical Therapy Office: Implications for Treatment and Care

• Individual Child Therapy
  * Trauma Reprocessing and Understanding via various techniques/treatment modalities (play therapy, art therapy, music therapy, use of visual cues and visual tools to support (e.g., Life Books) especially with younger children
  * Social Skill Development
  * Emotional and Behavioral Regulation Understanding and skills/strategies to improve positive mood, manage anxiety, improve behavioral self-regulation, etc., using a variety of therapy techniques, depending upon the specific needs of the child

• Attachment-based Family Therapy to build and maintain healthy, safe, functioning, nurturing and loving family relationships and family dynamics/structure.

• Positive Behavioral Support (PBS) Strategies
  • Specific behavior goals/action steps identified, posted, with rewards attached to pro-social and healthy behaviors and self-regulation
  • PBS strategies involve consultation between therapist and care-givers for consistent and effective carry-over at home
Each Care-giver/Service Provider provides valuable and expert information:

“It Takes a Village To Raise a Child”

RATHER:

“It takes an educated, informed, collaborative and compassionate team to heal, nurture, and above all, care for, a traumatized child.”
Considerations for Treatment and Care Beyond the Clinical Setting

COLLABORATION! COLLABORATION! COLLABORATION!

- The most effective care for children in the child welfare system is collaborative care from the time of assessment throughout the therapy, and I’d argue, placement process, and post-placement process.

- This is NOT Brief Therapy with children who have experienced trauma. This is long-term. The children need safety, consistency, security, love, and validation over time, above all else.

- Expect periodic regression in behaviors/emotional/social/developmental functioning, especially when there are changes in environment, routine, expectations, etc., during anniversaries and/or reminders/triggers of specific losses and/or traumas. Regression DOES NOT mean all is lost. This can be worked through and the team can support the child, family, and other care-givers through this.

- It requires collaboration and legal sharing of information (I.E. Permission to Release Information discussed and signed) across settings and with multiple disciplines and experts, which includes the care-givers, foster care and adoption workers, CASA’s.

- We all bring valuable information to the table on behalf of the child. We are all at once experts, and collaborators, as well as learners. Not one team member has all of the answers but together, we are powerful on behalf of the best interest of the child.
Reflection Activity:

• In thinking about the nature and complexity of trauma experienced by children in the foster care system, what is one way you can support and advocate for the needs and experiences, keeping in mind the lens’ of trauma and attachment-based relationships of the children and youth for whom you are responsible?

• How do you see your role and/or responsibilities within the context of the collaborative team approach on behalf of the needs of the children for whom you are responsible?

• What strengths do you possess, which you could apply and share on behalf of the children for whom you are advocating? In what ways will you apply these strengths to support the well-being and positive placement of a child into permanent care?
References and Select Suggested Readings


For additional resources, please contact Darcie Ries, SSW, LCSW at darcieres@collaborativecounselingllc.net