Child Development

Effects of Maltreatment and Trauma

Jaime Trujillo & Chris Henderson

Reasons Children Come Into Care

- Neglect – physical, educational
- Abuse – physical, sexual, emotional
- Abandonment
- Physical or mental illness – of child or parent
- Death of a parent
- Poverty

- Theses issues continue to have an impact on a child during placement and when the child is adopted.

Who are the Children in Care ?

- All ages
- Special Needs
    - Age (over 6)
    - Sibling Group
    - Psychological Problems
    - Medical Problems
        - Extra risk factor: Minority heritage (due to system overrepresentation)

Who are their Parents ?

- People with issues of :
- Substance abuse
- Psychological problems
- Victimization
- Criminal history
- Domestic Violence
- Generational family dysfunction
  - Extra risk factor : poverty

“Removed”

- https://vimeo.com/73172036

Determine the safety of the child, family, and their environment

In all circumstances, one of the first tasks is to determine the safety of the child, the family, and their environment.

- The immediate situation and circumstances
- Safety and security issues that must be addressed
- Any need for medical care or other protection from harm
- Any need for police, protective services (child welfare), shelter, or other emergency supports
- The availability of a safe place to live or stay temporarily
- Reliable and supportive family member(s) or friend(s)
- Other services or community agencies to provide resources and supports
- Concrete steps to take to remain safe and supported
- Follow-up and/or ongoing contact and services

Working In Collaboration with Providers and Caregivers

Provide Tools

- Through child/classroom observation and regular interaction with staff, help to differentiate normative behaviors with those that suggest signs and symptoms of exposure to trauma

- With appropriate permission, provide additional information about a specific child and family

- Guide strategies for providing support for children and families impacted by trauma

Working with Providers Cont….

- Help teachers/staff create a safe and supportive environment, with predictable routines and encourage these practices at home
- Outline ways to establish an intervention or "response plan" that matches the child's and family's needs and circumstances and encourage these practices at home.
- Help teachers/staff and families to identify reminders or triggers and find ways to anticipate and/or cope with them
- Identify specific supports or strategies for helping a child express and manage his/her feelings
- Encourage realistic positive problem solving and offer step-by-step support
- Identify community resources for effective therapeutic intervention and facilitate a referral in collaboration with Head Start/Early Head Start staff (Teacher, Home Visitor, Family Advocate, etc.) and the family

Provide support

- Acknowledge family's feelings, including frustration, helplessness, etc. and normalize these feelings. Family can be biological or foster family.

- Talk openly about the challenges of caring for a child who has experienced trauma and the family's own response.

- Recommend or offer opportunities for peer support, supervision, or ongoing consultation for family as well as self-care strategies, including family members to help avoid burn-out or "secondary traumatization."

- Respond to the special support needs of family members who may have their own experience with trauma and encourage outside personal supports when needed.

(Adapted from Blumenfeld, et al, 2010, used with permission)

Two Types of Trauma

- It is important to note that <u>not all</u> experiences of trauma lead to a trauma response or trauma-related disorder or diagnosis. There is a normal period of time, following a traumatic event or experience that we might expect to see trauma related responses or signs that do not necessarily develop into a post-traumatic stress disorder. However, when signs and symptoms of traumatic stress endure over time (one month or longer), disrupt a child's or adult's daily life, impact their social and emotional health, and meet specific diagnostic criteria, there are two types of trauma diagnoses.

Post Traumatic Stress Disorder

- Post traumatic stress disorder (PTSD) describes symptoms associated with a traumatic event — such as a car accident, witnessing violence, natural disaster, etc (see list of types of traumatic experiences below). The symptoms may include recurrent bad dreams, physical reactions, flashbacks, startle reaction, loss of interest in usual activities, avoiding reminders of the event, etc.

Complex Trauma

The term complex trauma — also known as Complex PTSD — has been proposed as a potential new diagnostic category, Developmental Trauma Disorder, in the Diagnostic and Statistical Manual of Mental Disorders (DSM), 5th edition (van der Kolk, 2005; van der Kolk et al, 2009). Complex Trauma or Developmental Trauma Disorder — describes how children's exposure to multiple or prolonged traumatic events impacts their ongoing development. Typically, complex trauma exposure involves the simultaneous or sequential occurrence of child maltreatment and may include psychological maltreatment, neglect, physical and sexual abuse, and witnessing domestic violence.

Complex Trauma Continued…

Complex trauma is:

- Chronic
- Begins in early childhood, and
- Occurs within the child's primary caregiving system and/or social environment

Exposure to these initial traumatic experiences, the resulting emotional dysregulation, and the loss of safety, direction, and the ability to detect or respond to danger cues may impact a child's development over time and can lead to subsequent or repeated trauma exposure in adolescence and adulthood without supports that might buffer the negative effects.

(Adapted from Blumenfeld, et al, 2010, used with permission)

Trauma in the Context of Relationships

Infants and young children experience their world as an environment of relationships and these relationships affect virtually all aspects of their development — intellectual, social, emotional, physical, behavioral, and moral. The quality and stability of these relationships in the early years lay the foundation for a wide range of later developmental outcomes (National Scientific Council on the Developing Child, 2004).

The importance of caregiver emotional availability and empathic responsiveness in helping the infant and young child to regulate affect and organize internal experience has been described extensively. This bond begins with the mother-child or primary caregiver-child bond, representing a time when unconditional care helps the child feel perfectly understood, accepted, and protected. (Lieberman, et al, 2005)

Trauma in the Context of Relationships continued…

The relationships children have with their caregivers play a critical role in regulating stress and a child's response to stress during the early years of a child's life. The experience of an infant who is hungry or wet, cries in discomfort, and has a caring adult come and care for him/her in a timely manner, is less stressful than that of an infant who is left to cry, alone or handled harshly by his/her caregiver. The repeated experiences of either type of response can influence the child's ongoing stress response.

Trauma in the Context of Relationships continued…

- Those children who have secure relationships have a more controlled stress hormone reaction when they are upset or frightened. They are able to explore the world, meet challenges and be frightened at times and calmed without sustained reactivity to stress and threat. In contrast, children whose caregiving relationships are insecure, disorganized, or unpredictable demonstrate higher stress hormone levels when they are even mildly frightened and their expectations for a safe and predictable world are shattered (Groves, B., 2002; National Scientific Council on the Developing Child, 2005).

Influence of Relationships

- The influence of relationships on development continue throughout the lifespan — and includes those caring relationships from multiple-caregivers (grandparents, aunts and uncles, etc.) and those outside of the child's family like Early Head Start and Head Start early care and educators and staff.

- When young children experience a trauma — are injured in an accident, witness violence, or other types of trauma — their recovery from that single experience is enhanced if they can rely on secure relationships with caring adults. This does not mean that they don't experience stress or completely avoid potential signs of post-traumatic stress disorder. However, they can be comforted, guided, and supported by attuned and trusted caregivers, including those who understand the impact of trauma, and move toward a positive outcome.

Influence of Relationships Continued…

- Young children under chronic stress, especially maltreated children and those exposed to trauma within the context of their caregiving relationships or in the context of unavailable caregiving relationships, have often failed to develop a secure attachment to their caregivers and do not have a sense of basic security or trust in the world (Cohen & Walthall, 2003; Osofsky, 1995). In complex or chronic trauma, the caregivers may be unable to protect or may actively harm the child so that his or her interpersonal world is in a constant state of crisis. The "holding environment" so critical to a young child's health and development is affected, and ongoing stress and trauma in a family disrupts the scaffolding for the growth of many developmental competencies. (Rice & Groves, 2005; Cook et al, 2003). Without intervention, these circumstances make recovery and return to typical development difficult.

- Individual protective factors, coping strategies, and resilience can support recovery from trauma and traumatic stress. Characteristics of the child, the family, and the community can be part of the dynamic process of development, recovery, and positive outcomes for children and families impacted by trauma. Again, nurturing relationships — or a community of caring adults — are a critical factor in promoting resilience and recovery from trauma (Masten, A.S.,2001; Rice & Groves, 2005).

Types of Traumatic Experiences

The National Traumatic Stress Network has strived to provide definitions of types of traumatic events; differentiating them from one another based on the event, who is involved, and the interpretation of law. Below are brief definitions to capture the core of each type of trauma.

- **Sexual Abuse or Assault:** Actual or attempted sexual contact, exposure to age-inappropriate sexual material or environments, sexual exploitation, unwanted or coercive sexual contact.

- **Physical Abuse or Assault:** Actual or attempted infliction of physical pain with or without use of an object or weapon and including use of severe corporeal punishment.

- **Emotional Abuse/Psychological Maltreatment:** Acts of commission against a minor child, other than physical or sexual abuse, that caused or could have caused conduct, cognitive, affective or other mental disturbance, such as verbal abuse, emotional abuse, excessive demands on a child's performance that may lead to negative self-image and disturbed behavior. Acts of omission against a minor child that caused or could have caused conduct, cognitive, affective or other mental disturbance, such as emotional neglect or intentional social deprivation.

Types of Traumatic Experiences cont.

- **Neglect:** Failure by the child victim's caretaker(s) to provide needed, age-appropriate care although financially able to do so, or offered financial or other means to do so, including physical neglect, medical neglect, or educational neglect.

- **Serious Accident or Illness/Medical Procedure:** Unintentional injury or accident, having a physical illness or experiencing medical procedures that are extremely painful and/or life threatening.

- **Witness to Domestic Violence:** Exposure to emotional abuse, actual/attempted physical or sexual assault, or aggressive control perpetrated between a parent/caretaker and another adult in the child victim's home environment or perpetrated by an adolescent against one or more adults in the child victim's home environment.

- **Victim/Witness to Community Violence:** Extreme violence in the community, including exposure to gang-related violence.

- **School Violence:** Violence that occurs in a school setting, including, but not limited to school shootings, bullying, interpersonal violence among classmates, and classmate suicide.

Types of Traumatic Experiences cont.

- **Natural or Manmade Disasters:** Major accident or disaster that is an unintentional result of a manmade or natural event.

- **Forced Displacement:** Forced relocation to a new home due to political reasons, generally including political asylees or immigrants fleeing political persecution.

- **War/Terrorism/Political Violence:** Exposure to acts of war/terrorism/political violence including incidents such bombing, shooting, looting, or accidents that are a result of terrorist activity as well as actions of individuals acting in isolation if they are considered political in nature.

- **Victim/Witness to Extreme Personal/Interpersonal Violence:** Includes extreme violence by or between individuals including exposure to homicide, suicide and other similar extreme events.

- **Traumatic Grief/Separation:** Death of a parent, primary caretaker or sibling, abrupt and/or unexpected, accidental or premature death or homicide of a close friend, family member, or other close relative; abrupt, unexplained and/or indefinite separation from a parent, primary caretaker or sibling due to circumstances beyond the child victim's.

- **System-Induced Trauma:** Traumatic removal from the home, traumatic foster placement, sibling separation, or multiple placements in a short amount of time.

Impacts of Abuse and Neglect on a Child's Development

- Child May have missed key developmental tasks. Often have cognitive, emotional and social delays.
- Strategies and habits learned by children to survive in a chaotic home environment are maladaptive in other settings.
- Three out of four school aged children who have been in foster care have been sexually abused – the ultimate betrayal.

There are ongoing effects from abuse/neglect and drug exposure that require special kinds of parenting and continuing, long term parental patience.

Identifying trauma and symptoms

- Identify trauma signs and symptoms in infants, toddlers, and young children

Trauma Signs and Symptoms

Trauma signs and symptoms in young children can take many forms. Understanding these signs and symptoms as trauma related depends upon sensitive information gathering from the child, family, and Early Head Start and Head Start staff. That said, the signs and symptoms listed below must always be considered in the context of a young child's history, caregiving system, supports, etc. and with recognition that these symptoms could also be symptoms unrelated to trauma.

Infants
(birth to 3 years)

- Eating disturbance
- Sleep disturbances
- Somatic complaints
- Clingy/separation anxiety
- Feeling helpless/passive
- Irritable/difficult to soothe
- Constricted play, exploration, mood
- Repetitive/post-traumatic play
- Developmental regression
- General fearfulness/new fears
- Easily startled
- Language delay
- Aggressive behavior
- Sexualized behavior
- Talking about the traumatic event and reacting to reminders/trauma triggers

Trauma Signs and Symptoms Continued….

Young children
(3 to 6)

- Avoidant, anxious, clingy
- General fearfulness/new fears
- Helplessness, passive, low frustration
- Restless, impulsive, hyperactive
- Physical symptoms (headache, etc.)
- Difficulty identifying what is bothering them
- Inattention, difficulty problem solving
- Daydreaming or dissociation
- Irritability
- Aggressive behavior
- Sexualized behavior
- Loss of recent developmental achievements
- Repetitive/ post-traumatic play
- Talking about the traumatic event and reacting to reminders/trauma triggers
- Sadness/depression
- Poor peer relationships and social problems (controlling/over permissive)

Signs of Disruption or Impairment

Complex trauma, in particular, may affect all domains of a child's development and functioning. Based on National Child Traumatic Stress Network's (NCTSN) White Paper (2003), Complex Trauma in Children and Adolescents, the table below identifies each domain of development and possible signs of disruption or impairment. Again, it is essential to consider the young child's developmental age and stage, specific developmental tasks, and caregiving context.

Attachment

- Difficulty trusting others
- Uncertain about the reliability/predictability of others
- Interpersonal difficulty
- Social isolation
- Difficulty seeking help
- Clingy, difficulty with separations

Physical

- Sensorimotor development problems
- Hypersensitivity to physical contact
- Somatization
- Increased medical problems
- Problems with coordination and balance

Signs of Disruption or Impairment Continued…

Affect Regulation

- Problems with emotional regulation
- Easily upset and/or difficulty calming
- Difficulty describing emotions and internal experiences
- Difficulty knowing and describing internal states
- Problems with communicating needs

Behavioral Control

- Poor impulse control
- Self-destructive behavior
- Aggressive behavior
- Oppositional behavior
- Excessive compliance
- Sleep disturbance
- Eating disorders
- Reenactment of traumatic event/past
- Pathological self-soothing practices

Signs of Disruption or Impairment Continued…

Cognition

- Difficulty paying attention
- Lack of sustained curiosity
- Problems processing information
- Problems focusing on/completing tasks
- Difficulty planning and anticipating consequences
- Learning difficulties, developmental delays
- Problems with language development

Signs of Disruption or Impairment Continued…

Self-Concept

- Lack of continuous/predictable sense of self
- Poor sense of separateness
- Disturbance of body image
- Low self-esteem
- Shame and guilt

Early recognition of these signs and symptoms along with mental health consultation that guides planned and effective strategies to support the child and family in the Early Head Start and Head Start program can help reduce and remediate these symptoms. Some children may need more intensive, therapeutic intervention through trauma-focused therapy designed for clinical work with young children and their families.

The Role of the Consultant and Consultation

Learning Objectives

- It is important to recognize and understand the role of the consultant in addressing trauma in the early care and education setting. Trained early childhood mental health consultants have a wealth of knowledge about child development, family relationships, and mental health.

- In addition, a consultant's perspective on child development, the impact of trauma on children and their families, trauma, intervention strategies, and community resources provides an essential support for Early Head Start and Head Start teachers, staff, and families.

Finding Qualified Therapists and Effective Therapy

- Together, the early childhood mental health consultant, Early Head Start and Head Start staff, and the child's family may decide that a child needs mental health intervention services. When making a referral for a specific child and family, the consultant, staff, and family should look for the following features of qualified providers and effective treatment.

ASK Questions ????

Questions to Ask Early Childhood Mental Health Providers

- Does the agency/therapist provide trauma specific or informed therapy, especially focused on young children and families?
- Does the individual/agency that provides therapy conduct an age appropriate comprehensive trauma assessment?
  - What specific standardized measures appropriate for young children are given?
  - What does your assessment show about the young child and the family?
  - What are some of the major strengths and/or areas of concern for the child and family?

ASK Questions ???? Cont….

- Is the clinician/agency familiar with evidenced-based treatment models for young children?
- Have clinicians had specific training in an evidenced-based model (when, where, by whom, how much)?
- Does the individual/agency provide ongoing clinical supervision and consultation to its staff, including how model fidelity is monitored?

ASK Questions ???? Cont….

- Which approach(es) does the clinician/agency use with young children and families?
- How are parent support, conjoint therapy, parent training, and/or psychoeducation offered?
- Which techniques are used for assisting with the following:
  - Building a strong collaborative and therapeutic relationship with parents or caregivers and the young child
  - Identifying feelings and supporting emotional expression and regulation
  - Identifying strategies to help calm the child when feeling overwhelmed
  - Establishing routines and helping the child feel secure (including at home/and Head Start)
  - Cognitive processing/reframing in language appropriate to the child's development; linking feelings, thoughts, and memories
  - Construction of a trauma narrative through age appropriate conversation and observing the child's play and interaction
  - Developmentally appropriate strategies that allow exposure to trauma reminders/memories and feelings in tolerable doses so that they can be mastered and integrated into the child's experience
  - Assuring safety, encouraging self- control, and allowing age-appropriate choices
  - Supporting developmental progress, building resiliency, and closure

ASK Questions ???? Cont….

- How are cultural competency and special needs issues addressed?
- Is the clinician or agency willing to participate in the Early Head Start/Head Start multidisciplinary team meetings for individualized service planning (e.g. Individualized Family Service Plan (IFSP), Individualized Education Plan (IEP)?

(Adapted from The National Child Traumatic Stress Network, 2008)

Recommending Evidence-based Interventions for Young Children and their Families

- When considering therapeutic intervention for young children and their families affected by trauma, there are interventions that have an established evidence-base. These interventions have been listed by The National Child Traumatic Stress Network (NCTSN), indicating the treatment developer, the intended age group, the level of evidence, and a brief description of the focus and design of the intervention. Below is an alphabetical list of those evidence-based interventions that are designated as appropriate for young children — birth through 5 — and their families or caregivers. Detailed fact sheets are available for each intervention at http://www.nctsnet.org/resources/topics/treatments-that-work/promising-practices, except for Preschool PTSD Treatment which is an emerging promising practice that post-dates the NCTSN document. Many communities are building their capacity to provide services to young children and their families through these interventions.

Empirically Supported Treatments and Promising Practices Relevant to Young Children and Their Families

Treatment & Developer Site	Ages	Level of Evidence	Description
Attachment, Self-Regulation, and Competence (ARC): A Common-Sense Framework for Intervention with Complexly Traumatized Youth The Trauma Center Allston, MA	All ages	Promising and Acceptable	Trauma symptoms attachment(s), regulatory capacity, competency, and systems of care implemented in school, community, or clinic settings
Child-Parent Psychotherapy (CPP) Early Trauma Treatment Network San Francisco, CA	0-6 and caregivers	Well Supported and Efficacious	parent child relationship IQ, child behavior problems child PTSD symptoms, symptoms of anxious attachment, maternal PTSD Clinic or home setting
Combined Parent Child Cognitive-Behavioral Approach for Children and Families At-Risk for Child Physical Abuse NJCARES Institute UMDNJ-SOM Stratford, NJ	4-17 and caregivers	Supported and Acceptable	PTSD, depression, abuse-related attributions, & externalizing behavior problems in children. Parental anger, behavior management skills, parent to child violence, & parent-child relationship.

COPE-Community Outreach Program National Crime Victims Research and Treatment Center Charleston, SC	**4-18 and caregivers**	**Supported and Acceptable**	**Trauma symptoms TF-CBT, PCIT framework + Case management Applied in home, school based settings**
Forensically Sensitive Therapy National Children's Advocacy Center Huntsville, AL	4-17	Promising and Acceptable	Trauma symptoms sexual abused individual treatment
Parent-Child Interaction Therapy Sheila Eyberg, PhD, University of Florida Gainesville, FL	4-12	Supported and Probably Efficacious	parenting skills parent child relationship child externalizing behaviors parent to child physical abuse
Preschool PTSD Treatment (PPT) Michael Scheeringa, MD Tulane University New Orleans, LA	3-6	In Development, Promising (Preliminary findings)	child trauma symptoms: depression, separation anxiety, oppositional defiant behavior parent depression

Empirically Supported Treatments and Promising Practices, Retrieved August 9, 2010 from www.NCTSNet.org and personal communication with Scheeringa, M, 2010

Sensitive Inquiry and Observation

- Most often, a mental health consultant is alerted to a concern about a child or family by Early Head Start and Head Start staff. Sometimes, during a regular classroom observation, the consultant will note a child whose behavior is concerning. In either circumstance, consultation — child and family centered consultation — always includes sensitive inquiry and observation. There can be particularly sensitive issues to explore in the case of children impacted by trauma, especially when a family member or other caregiver may be involved in the traumatizing event or circumstances. Consultants should consider the following when gathering trauma specific information:
- Observable signs, symptoms, behavioral concerns
- Child and family circumstances
- Family and staff perceptions/explanations of the child's behavior
- Any recent change or event that may have contributed to the child's behavior
- Any upsetting or traumatic event or history, if so describe who, what, when, where and what happened immediately after and since the traumatic event

Sensitive Inquiry and Observation Continued…

- The child's "story" about any recent change, traumatic event, or history
- How the client and family perceive the trauma and its effects from a cultural perspective
- Level of concern about the child's response to trauma
- Level of disruption in the child's functioning (social, emotional, behavior, etc.)
- How the child is coping and the child's strengths
- Safety of the child, family, and their environment (see below)
- Openness to consultation or additional therapy services that might be helpful

Trauma Screen

- Trauma focused screening instruments for use with young children are less well developed than those for older children. A place to start may be using the Early Head Start/Head Start intake assessment that for example, includes inquiry about domestic violence and safety in the home (Groves, 2007). Some standardized screening instruments may be useful in an initial phase of information gathering (such as the Child Behavior Check List (CBCL)), others are more likely to be part of a clinical intake assessment after referring the child and family for intervention services from a trauma-informed provider

Three Types of Trauma Screens

Trauma Symptom Checklist for Young Children (TSCYC): A 90-item caretaker report instrument developed for the assessment of trauma related symptoms in children ages 3-12.

•Traumatic Events Screening Inventory — Parent Report Revised (TESI-PRR): This parent report inventory is available for children under 7 and inquires about a variety of traumatic events, including current and previous injuries, hospitalizations, domestic violence, community violence, disasters, accidents, physical, and sexual abuse. Each form takes 20 - 30 minutes to complete.

•Parenting Stress Index: Available in two forms, this screening instrument measures stress in the parent-child relationship, identifies dysfunctional parenting and predicts the potential for parental behavior problems and child adjustment difficulties within the family system. While its primary focus is on the preschool child, the PSI can be used with parents whose children are 12 years of age or younger. The 101-item format takes 20-25 minutes for the parent to complete. The 36 item Short Form (PSI/SF) takes 10 minutes.

(Chadwick Center for Children and Families, 2009)

Psychological Issues/Diagnosis

Attachment Issues/Disorder (RAD or lesser compromise of attachment)

Attention Deficit/Hyperactivity Disorder (ADHD)

Oppositional Defiant Disorder(ODD)

Affective Disorder (Bi-Polar disorder, depression, etc.)

Post Traumatic Stress Disorder (PTSD)

Fetal Alcohol Spectrum Disorder (FAS/FAE)

Drug Effects

Sexual Abuse

Psychotropic and Over the counter Medication

- ***Psychiatric medication should not be used alone.*** **The use of medication should be based on a comprehensive psychiatric evaluation and be one part of a comprehensive treatment plan.**

- Before recommending any medication, the child and adolescent psychiatrist interviews the youngster and makes a thorough diagnostic evaluation. In some cases, the evaluation may include a physical exam, psychological testing, laboratory tests, other medical tests such as an electrocardiogram (EKG) or electroencephalogram (EEG), and consultation with other medical specialists.

- Medications which have beneficial effects may also have side effects, ranging from just annoying to very serious. As each youngster is different and may have individual reactions to medication, close contact with the treating physician is recommended. Do not stop or change a medication without speaking to the doctor. Psychiatric medication should be used as part of a comprehensive plan of treatment, with ongoing medical assessment and, in most cases, individual and/or family psychotherapy. When prescribed appropriately by a psychiatrist (preferably a child and adolescent psychiatrist), and taken as prescribed, medication may reduce or eliminate troubling symptoms and improve the daily functioning of children and adolescents with psychiatric disorders.

Medication may be prescribed for psychiatric symptoms and disorders, including, but not limited to:

- **Bedwetting**-if it persists regularly after age 5 and causes serious problems in low self-esteem and social interaction.
- **Anxiety** (school refusal, phobias, separation or social fears, generalized anxiety, or posttraumatic stress disorders)-if it keeps the youngster from normal daily activities.
- **Attention deficit hyperactivity disorder (ADHD)**-marked by a short attention span, trouble concentrating and restlessness. The child is easily upset and frustrated, often has problems getting along with family and friends, and usually has trouble in school.
- **Obsessive-compulsive disorder (OCD)**-recurring obsessions (troublesome and intrusive thoughts) and/or compulsions (repetitive behaviors or rituals such as handwashing, counting, or checking to see if doors are locked) which are often seen as senseless but that interfere with a youngster's daily functioning.
- **Depression**-lasting feelings of sadness, helplessness, hopelessness, unworthiness, guilt, inability to feel pleasure, a decline in school work and changes in sleeping and eating habits.
- **Eating disorder**-either self-starvation (anorexia nervosa) or binge eating and vomiting (bulimia), or a combination of the two.

Medication may be prescribed for psychiatric symptoms and disorders, including, but not limited to: Continued…

- **Bipolar (manic-depressive) disorder**-periods of depression alternating with manic periods, which may include irritability, "high" or happy mood, excessive energy, behavior problems, staying up late at night, and grand plans.
- **Psychosis**-symptoms include irrational beliefs, paranoia, hallucinations (seeing things or hearing sounds that don't exist) social withdrawal, clinging, strange behavior, extreme stubbornness, persistent rituals, and deterioration of personal habits. Psychosis may be seen in developmental disorders, severe depression, schizoaffective disorder, schizophrenia, and some forms of substance abuse.
- **Autism**-(or other pervasive developmental disorder such as Asperger's Syndrome)-characterized by severe deficits in social interactions, language, and/or thinking or ability to learn, and usually diagnosed in early childhood.
- **Severe aggression**-which may include assaultiveness, excessive property damage, or prolonged self-abuse, such as head-banging or cutting.
- **Sleep problems**-symptoms can include insomnia, night terrors, sleep walking, fear of separation, or anxiety.

Stages of Child Development and Trauma Needs

Infant, Toddlers and Pre-school (0-3 years old)

- Attachment is critical at this age. The child tend to have a primary bond, but can bond to several people. It is critical that each child is properly access as due to the nature of abuse and or neglect the child may miss this mile stone out lack of exposure and or opportunity. A Child Find shall be recommended in efforts to access and identify any development barriers a child may have due to the trauma they have experience. If through the assessment areas of support are identified a treatment plan will be put in efforts to encompass the areas of concern, prior to school age. In addition a trauma screen shall be requested by your county DHS case worker to identify appropriate trauma services for your child.

Stages of Child Development and Trauma Needs Continued…

- It is important that children of this age group have a consistent schedule and lots of nurturing. In efforts to maintain attachment and foster the bonding process.
- Children of this age group have difficulty separating for long periods of time from primary caregiver, which is why establishing parenting time as soon as possible is critical if appropriate.
- Parenting time is crucial at this age and shall include more frequent shorter periods of time with parent/parents.

School Aged (4-11 years)

- Children of this age need an emotional foundation that provides confidence and self-worth. As they are emotional beings at this time and learning how to deal with different situations.
- By this age they have developed the ability to attach and are able to form bonds. At this age an (IEP) Individual Education Plan shall be requested by the child educational decision maker, should you access any academic, social/emotional or mental health concerns as a result of the child's trauma. This evaluation is conducted by the child home school district and request for evaluation shall be made to the child's school.

School Aged (4-11 years)

- In addition a trauma screen shall be requested by your county DHS case worker to identify appropriate trauma services for your child.
- Parenting time needs a scheduled that allows the child to focus on school, and shall be after school hours in efforts to keep the child's mind distracted from the familia issues and focused on school. The same is to be said for therapy and or other services.

Pre-Adolescent (12-14 years)

- Children at this age need help with school, peer problems and disruption of family. Therapeutic services are critical in helping the child develop coping skills and giving them a safe environment to discuss their worries. In addition identify if your child has an IEP and review the current services and or request a review due to the change in circumstances in efforts to identify if the current service plan is still appropriate in supporting the child's needs.
- In addition a trauma screen shall be requested by your county DHS case worker to identify appropriate trauma services for your child.
- Children at this age need time to have organized activities and time with friends in efforts to maintain a sense of normalcy. Extracurricular activities are extremely important in giving the child a normal outlet due to the trauma they may have experience outside of therapeutic services.
- Parenting time should incorporate the flexibility to work around the

Adolescents (15-18 years)

- Children at this age can be difficult and want their plans to be important too. It is critical at this age you include the child in decisions that are being made for them. In addition, have discussions with the child as to what an emancipation plan looks like for them if an identified permanent home is not available for them. It is critical by the age of 16 that an independent living plan is identified and the child is being referred for IL services and Chafee.
- Children this age should be attending court hearings.
- At this age, children are very private and do not want others to know their business. They may prefer to have home base services. It is important we meet the child where they are at and we use our relationship with the child to encourage them to participate in appropriate services.
- Adolescent children need consistent rules by all care givers. They can be very manipulative and challenge the caregiver if consistency is not maintained.
- Parenting time, the adolescent may want to spend time with peers vs parents and as a team need to discuss what this looks like for each child.

Young Adults 18-21 years old

The effects of childhood abuse on an adult are very serious and unless dealt with, can manifest in various ways.

- Women who were emotionally abused as children often develop eating disorders, experience substance abuse problems, partake in “self harm” such as cutting or burning themselves, have virtually no self-esteem and experience depression, among other things.

- Childhood abuse affects men in similar ways. According to studies, men also suffer from depression, substance abuse and self harm, in addition to profound sadness, aggression and an inability to trust others.

  If the effects of childhood abuse are not addressed early on, men who have suffered this type of abuse also tend to emotionally abuse women in their lives, particularly those they have romantic relationships with, such as their girlfriends or wives.

Young Adults 18-21 years old Continued…

- “Research is now showing that effects of neglect last well into adulthood and not just emotionally, but physically as well,” Barriere said. Child neglect is associated with the poorest academic achievement and not doing well in school or dropping out altogether can obviously cause large obstacles in the life of that child as they become an adult.

  Adults who were neglected as children also suffer from self esteem issues, depression, difficulty trusting others and substance abuse. Effects of childhood trauma are deep and long-lasting.

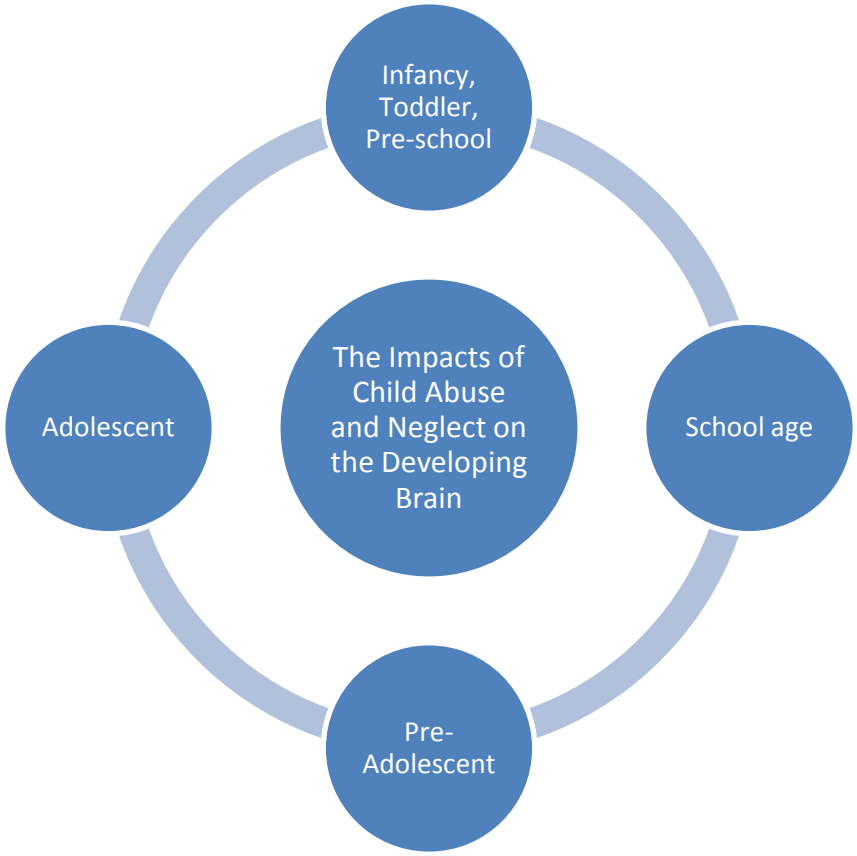
Attachment

- Attachment is a reciprocal process by which an emotional connection develops between an infant and his/her primary caregiver. It influences the child's physical, neurological, cognitive and psychological development. It becomes the basis for development of basic trust or mistrust, and shapes how the child will relate to the world, learn and form relationships throughout life.

Roadblocks to healthy parent child relationships

- Abrupt loss of a parent through death or illness
- Multiple Caregivers
- Invasive or painful procedures
- Hospitalization
- Abuse and or/Neglect
- Mother’s poor prenatal care or prenatal alcohol or drug exposure.
- Neurological problems

VERBAL/LINGUISTIC
Playing with WORD
INTERPERSONAL
LOVE Blossoms
LOGICAL / MATHEMATICAL
REASON Out
NATURALISTIC
Earth CARE
BODILY/ KINESTHETIC
HEALTHY Body
INTRAPERSONAL
High THINKING
MUSICAL / RHYTHMIC
Rhythmic INFERENCES
VISUAL / SPATIAL
IMAGINATION Has no rules!!
BODILY/ PHYSICAL
INTRA-PERSONAL
INTERPERSONAL
MUSICAL
VISUAL/ SPATIAL
LINGUISTIC
MATHEMATICAL / LOGICAL
Self
Smart


Infancy, Toddler, Pre-school
School age
Pre-Adolescent
Adolescent
The Impacts of Child Abuse and Neglect on the Developing Brain

Traumatic Experiences and Development

- For millions of abused and neglected children. The nature of their experiences adversely influences the development of their brain.
- During these traumatic experiences the children's brains are in a state of fear related activation.
- Activation of key neural systems in the brain leads to adaptive changes in emotional, behavioral and cognitive functioning to promote survival.

Trauma Experiences and Development Continued…

- Persistent or chronic exposure to abuse and/or trauma trigger a fear activation and can result maladaptive persistence of a fear state.
- This activation causes hypervigilance, a focus on threat related cues (typically non-verbal) , anxiety, behavioral impulsivity all which are adaptive during a threatening event yet become maladaptive when the immediate threat has passed.

Trauma Experiences and Development Continued…

- Traumatic abuse brings dilemmas to the child's developing brain.
- The neurological process causes so much pain and distress through the child's life.
- The chronically traumatized child will develop physical signs such as altered cardiovascular regulation and symptoms that include attentional, sleep, mood problems which make their lives difficult.

Trauma Experiences and Development Continued…

- There is hope, the brain is able to change its response to experience, especially repetitive and patterned experiences.
- The brain is most moldable during early childhood.

Moving Past The Trauma

- Aggressive early identification and intervention with abused and neglected children has the capacity to modify and influence development in many positive ways.
- The elements of successful intervention must be guided by the core principals of brain development.
- Therapeutic interventions that restore a sense of safety and control are very important for the acutely traumatized.

Moving Past The Trauma Continued…

- In cases of chronic abuse and neglect, the very act of intervening can add to the child’s catalogue of fearful situations.
- Investigation, court, removal, placement, re-location, and –reunification all contribute to the unknown, uncontrollable and often, frightening experiences of the abused child.
- Our systems , placement and therapeutic activities can diminish the fearful nature of these children's lives by providing consistency, reputation (familiarity), nurturance, predictability and control(returned to the child).

Prevention and Policy

- What we are as adults is the product of the world we experienced as children. The way society functions is a reflection of the childrearing practices of that society. We do not educate our children about development, parenting or about the impact of neglect and trauma on children.
- The problems related to maltreatment of children are complex and they have a complex impact on our society. As professionals we are tasked with ongoing education and early intervention as to the neurodevelopmental impacts of neglect and trauma on children we serve to effectively advocate for children and their needs.

Take Home Messages

Trauma is the unique individual experience of an event or enduring conditions in which the individual's ability to integrate his/her emotional experience is overwhelmed, and the individual experiences (either objectively or subjectively) a threat to her/her life, bodily integrity, or that of a caregiver or family. (Saakvitne, K, et al, 2000)

- There are two types of trauma diagnoses:
  - Post traumatic stress disorder (PTSD) — associated with a traumatic event
  - Complex trauma or complex PTSD — associated with exposure to multiple or prolonged events, such as child maltreatment, neglect, abuse, etc.

- Types of traumatic experiences are varied yet distinct, including sexual abuse or assault, physical abuse or assault, emotional/psychological maltreatment, neglect, serious accident or medical illness, witness to domestic violence, victim/witness to community violence, school violence, natural or manmade disasters, forced displacement, war/terrorism, victim/witness to extreme personal/interpersonal violence, traumatic grief/separation, and system-induced trauma.

- Many Early Head Start and Head Start children have experienced at least one trauma.

Take Home Messages Continued…

- The stress response refers to how stress influences the body and the brain, the impact of stress hormones (adrenalin, cortisol, etc.) and from basic body signals of "fight or flight" to feelings, thinking, and actions.

- Overwhelming or traumatic stress involves such a strong response that the individual is "frozen", unable to manage their feelings and physical response.

- Chronic or uncontrollable stress "down regulates" the neurobiological chemicals associated with the stress response, making the stress response to even the slightest stress more likely an lead to significant long term effects or difficulties.

- For young children, early exposure to trauma and overwhelming stress can impact the developing brain, particularly in the areas of emotions and learning.

- The impact of trauma for young children requires a developmental perspective: the characteristics of the trauma, the child's genetic and developmental capacity to manage stress, the quality of the child's early attachment and caregiving system, and the aspects of child's current functioning and development that have been affected.

Take Home Messages Continued…

- The relationships that infants and young children have with caregiving adults are crucial to learning to managing stress, regulating emotions, and positive developmental outcomes.

- Trauma signs and symptoms in infants and young children include emotional, functional, and developmental forms.

- Early childhood mental health consultants can recognize the signs and symptoms of trauma and collaborate with Early Head Start and Head Start staff to help address the impact of trauma on young children by:
    - Providing information and hope to Early Head Start and Head Start staff and families,
    - Conducting sensitive inquiry and observation that is trauma focused
    - Determining the safety of the child, family, and their environment
    - Reporting suspected child abuse and neglect, yet maintaining a relationships with the child and family
    - Providing tools and support in collaboration with providers, caregivers, and families
    - Linking families to resources
    - Finding qualified therapists and accessible, effective therapy
    - Advocating for and building trauma informed services
    - Pursuing further learning and continuing education related to trauma, its impact, and intervention.

ASSESSMENT OF COMPETENCE

FAMILY SCENARIO

- Case 1. Two minor children ages 1.5 and 3years old,
- reason for petition severe abuse.
- RF in custody, history of drug use, extensive criminal history,
- RM drug history, criminal history includes petty offenses

SERVICE NEEDS

- Access the minor children, identify whereabouts/placement?
- Access extent of minor children's injuries.
- Schedule TDM/Family Engagement meeting, in efforts to identify the team players and direction of the case.
- At this time service referrals will be identified and made.
- Example; request of medical records to be ordered, Trauma Screen to be complete by DHS for the minor children, referral for Signal Evaluation for both parents to access substance abuse.
- Access parents' criminal history

ASSESSMENT OF COMPETENCE

FAMILY SCENARIO

- Case 2. 3 minor children ages, 1, 3, and 6years old.
- Reason for petition, educational and medical neglect.
- Both RF and RM has history of substance abuse no criminal history.
- Children remain in the home.

SERVICE NEEDS

- See the minor children, in the home to assess for safety/risk
- Access extent of the allegations.
- A TDM/family engagement meeting was held prior to the filing.
- Begin independent investigation Request of medical and education records to be ordered,
- Contact the school the 6 year old is enrolled in.
- Contact the medical office where the minor children seek care.

Activity: What Should Happen Next?

Scene 1:
Justin Santos was an energetic and verbal child who enjoyed being in his Early Head Start classroom. After having turned three over the summer, Justin moved into Mrs. Huggins Head Start classroom.

Unlike last year, Justin seemed less settled and focused. His behavior was sometimes aggressive. He had difficulty sustaining play and a hard time finishing any activity. With other children, he was bossy and irritable, sometimes acting abruptly and pushing whoever was in his way. When approached by his teacher to interrupt this type of behavior, he would shrug and duck his head, appearing startled or afraid.

Possible Answers »

- **Mrs. Huggins should discuss her concerns with the mental health consultant.**
- **The consultant should make a classroom/child observation focused on the environment, behavior, and interaction.**
- **Together, Mrs. Huggins and the consultant should arrange an appointment with Justin's mother to inquire about Justin's behavior, home life, any changes, etc.**

Activity: What Should Happen Next?

Scene 2:
Mrs. Huggins and the mental health consultant met with Justin's mother, Maria Santos, and shared their concerns with her. Ms. Santos said she hadn't noticed any change in Justin's behavior at home. The consultant invited Ms. Santos to share information about herself and their family life.

Ms. Santos described herself as a single mother who worked two part-time jobs to make ends meet. She also admitted a history of alcohol use, but had quit drinking after going through rehabilitation and attending AA meetings. Ms. Santos claimed to be proud of her accomplishments and her continuing sobriety, but admitted having few supports in the community, often feeling alone with her struggle to raise Justin on her own.

They agreed to continue to observe Justin's behavior in the classroom, implement some strategies to reduce his aggressive behavior, and stay in touch about how Justin was doing. A week later, Justin came to school with a dark bruise on his wrist. When Mrs. Huggins asked Justin about the bruise, he hid his hand behind his back and said he was" just wrestling with Roger". Mrs. Huggins learned from the Family Advocate that Ms. Santos had recently started seeing a new boyfriend that she had met at an AA meeting.

Possible Answers »

- **Mrs. Huggins should document the bruise on Justin's arm, with support from her supervisor and the consultant and should inform Ms. Santos about her observation of the bruise on Justin's arm and concerns for his safety.**
- **The consultant, Mrs. Huggins and other involved staff should try to determine the safety of Justin in his family situation, consider if a suspected child abuse report should be filed, and review the Head Start program's Suspected Child Abuse reporting procedure. Together, they should decide about reporting suspected child abuse and neglect and discuss how to inform and maintain a relationship with Ms. Santos after any filing.**
- **Mrs. Huggins and/or the consultant should contact Ms. Santos and gather more information about changes at home and Roger's role and relationship.**

Activity: What Should Happen Next?

Scene 3:
In her next communication with Ms. Santos, Mrs. Huggins described the bruise on Justin's arm and asked Ms. Santos what happened. She responded by saying that Justin had been wrestling with a family friend and that it was an accident.

Mrs. Huggins asked if anything had changed at home. At first Ms. Santos said no, but then when Mrs. Huggins asked about Roger, she admitted that she has been seeing him and he sometimes spends the night. Ms. Santos described Roger as caring about her and Justin, and acknowledged that they sometimes disagree on how to discipline Justin. Roger had a tough childhood and was stricter than Ms. Santos, but she said Roger would never hurt Justin.

Mrs. Huggins was concerned about Justin's family situation and now his safety. She was also becoming increasingly frustrated with his behavior. She wondered if some of his fearful behavior when an adult would approach to stop and redirect his behavior was linked to possible strict discipline from Roger. However, she could not understand his continuing aggressive behavior and his insistence on pretending to be a powerful, villain superhero. She began to wonder what else might be going on and if Justin was becoming a bully.

Possible Answers »

- **Mrs. Huggins should be clear with Ms. Santos of her responsibility to assure Justin's safety and role as a mandated reporter as well as her wish to be a support to Justin and Ms. Santos.**
- **The consultant should discuss Mrs. Huggins' understanding of Justin's behavior and share basic information about trauma, child abuse, and the impact of trauma on young children and their behavior; specifically exploring the mix of his fearful and "victim" like behavior, his possible "identification with the aggressor" in his aggressive behavior, and possible wish to be more "powerful" and control what's happening at home.**
- **The consultant can help Mrs. Huggins to focus on Justin's strengths and understand that his current behavior is not his "destiny" to become a bully.**
- **The consultant can encourage Mrs. Huggins and the Family Advocate to work together to have Ms. Santos, and possibly Roger, meet with them to continue to support intervention around Justin's behavior at school and the issue of discipline at home.**

Activity: What Should Happen Next?

Scene 4:
Mrs. Huggins remained vigilant for any signs of physical punishment or harsh treatment from Roger. Justin had no further bruises or marks that she could see. Ms. Santos continued to deny any difficulties at home.

One day, Justin says, "I'm not supposed to tell, but my mommy keeps a special secret bottle in the closet by her bed. She says it's medicine and not for kids. Sometimes she shares it with Roger, but not me." Mrs. Huggins supports Justin having shared this information and asks if he is worried about his mom. Justin nods silently.

From this revelation, Mrs. Huggins, the Family Advocate, and the consultant suspect that Ms. Santos is drinking again. When they invite her to meet to discuss Justin's progress in the classroom, she says she is too busy or too tired from her jobs to come in. The consultant and the staff work together to explore other strategies to reach out to Ms. Santos, help her connect back to her AA supports, and seek additional assistance for herself and Justin.

Possible Answers »

- **The consultant can help Mrs. Huggins and the Family Advocate deal with the stress and frustration they feel in this situation.**
- **The consultant can emphasize their important role in continuing to support Justin in his Head Start program and reframe Ms. Santos's reluctance to set up times to meet with them (denial, shame, fear, etc.).**
- **Together, they can consider strategies to continue to reach out to Ms. Santos and monitor Justin's safety as much as possible.**
- **Together, they can discuss what community resources might be of additional support to Ms. Santos (e.g. her AA sponsor, her church, etc.) that might be agreeable to her and for Justin (e.g. therapy or intervention resources) should his behavior warrant referral for more intensive services.**

Questions ????

References

Adoption.com

http://www.adoption.com

Information on all aspects of adoption, articles, online links & resources.

Child Trauma Academy

http://www.childtraumaacademy.org and http://www.childtraumaacademy.com

Dr. Bruce Perry's websites with articles and trainings on trauma.

Institute for Attachment & Child Development

http://www.institutiteforattachment.org

Treatment, training & child placement agency specializing win children with attachment disorder.

Resources

- American Trauma Society *(ATS)*
- The American Trauma Society (ATS), a membership organization for health care trauma personnel, works to save lives through improved trauma care and injury prevention. ATS provides critical information on trauma to its members, to policy makers, and to the public. It supports the needs of families. It is also a strong supporter of injury prevention, creating and producing programs and providing these programs to its members. ATS programs cover the life-time of a person beginning with safety for children (the "Traumaroo Program"), teen behavior (alcohol, driving, etc.), adult and senior years (falls and driving). The society provides brochures and other print materials, videos, and posters to assist members in their community injury prevention programs.

- Institute on Violence, Abuse and Trauma *(IVAT)*
- The Institute on Violence, Abuse and Trauma (IVAT) works to improve the quality of life and promote violence-free living for individuals on a local, national, and international level by conducting research, sharing and disseminating information, improving networking among professionals, and assisting with program evaluation, consultation, and training. Formed when the Family Violence and Sexual Assault Institute merged with the Alliant International University, the institute promotes collaboration across disciplines and incorporates many centers that focus on family violence, sexual assault, youth and school violence, workplace violence, violence prevention, and traumatic stress. IVAT publishes a bulletin, journals, and resource lists; and hosts an international conference.

Resources

- International Society for Traumatic Stress Studies *(ISTSS)*
- The International Society for Traumatic Stress Studies (ISTSS), is a membership based organization that is dedicated to the stimulation of policy, program, and service initiatives that seek to reduce traumatic stress and its immediate and long-term consequences. Members include professionals who work with victims of crime, abuse, neglect, family or community violence, exploitation, or oppression; Holocaust survivors; refugees; torture victims; war veterans; survivors of disasters; and persons in high-risk occupations. The society is dedicated to the discovery and dissemination of knowledge and provides a forum for the sharing of research, clinical strategies, public policy concerns, and theoretical formulations on trauma in the United States and around the world. Publications include the Journal of Traumatic Stress and Traumatic Stress Points.

- National Child Traumatic Stress Network *(NCTSN)*
- The National Child Traumatic Stress Network (NCTSN) is a coalition of 54 treatment centers working to improve the quality, effectiveness, and availability of therapeutic services delivered to all children and adolescents experiencing traumatic events. The Network -- a Congressional initiative funded by the Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, US Department of Health and Human Services -- will collect data for systematic study; help to educate professionals and the public about the effects of trauma on children; and develop and disseminate effective, evidence-based treatments. The National Resource Center for Child Traumatic Stress (NRC-CTS) supports the mission of NCTSN by providing relevant information and resources to professionals and the public, including survivors of childhood trauma, their families, and communities. The Resource Center provides referrals, inquiry responses, reference information, and publications for consumers. The NCTSN Web site provides access to full-text reports, related reading lists, an archive of NCTSN newsletters, and the PILOTS database of scientific literature on traumatic stress. Some client brochures about child traumatic stress are available in foreign languages.

Resources

- National Child Traumatic Stress Network *(NCTSN)*
- The National Child Traumatic Stress Network (NCTSN) is a coalition of 54 treatment centers working to improve the quality, effectiveness, and availability of therapeutic services delivered to all children and adolescents experiencing traumatic events. The Network -- a Congressional initiative funded by the Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, US Department of Health and Human Services -- will collect data for systematic study; help to educate professionals and the public about the effects of trauma on children; and develop and disseminate effective, evidence-based treatments. The National Resource Center for Child Traumatic Stress (NRC-CTS) supports the mission of NCTSN by providing relevant information and resources to professionals and the public, including survivors of childhood trauma, their families, and communities. The Resource Center provides referrals, inquiry responses, reference information, and publications for consumers. The NCTSN Web site provides access to full-text reports, related reading lists, an archive of NCTSN newsletters, and the PILOTS database of scientific literature on traumatic stress. Some client brochures about child traumatic stress are available in foreign languages.

- Trauma Foundation
- The Trauma Foundation is an independent nonprofit agency whose mission is to reduce the number of injuries and deaths due to injuries, including those related to burns, domestic violence, firearms, transportation, the workplace, youth violence, and all injuries involving excess alcohol use, through prevention, improved trauma care, and improved rehabilitation. Its activities include data collection and research to support injury prevention policies; policy development and education; and information dissemination.

References

- Adoption.com http://www.adoption.com
  Information on all aspects of adoption, articles, online links & resources.

- American Psychiatric Association (2010). DSM-5: The Future of Psychiatric Diagnosis. Proposed Draft Revisions to DSM Disorders and Criteria: Posttraumatic Stress Disorder in Preschool Children. Retrieved October 5, 2010 from http://www.dsm5.org/ProposedRevisions/Pages/proposedrevision.aspx?rid=396#

- Blumenfeld, S., Groves, B.M., Rice, K.F., & Weinreb, M. (2010). Children and trauma: A curriculum for mental health clinicians. Chicago: The Domestic Violence & Mental Health Policy Initiative.

- Chadwick Center for Children and Families (2009). Assessment-Based Treatment for Traumatized Children: A Trauma Assessment Pathway (TAP). San Diego, CA: Author. Retrieved August 17, 2010 from http://www.TAPtraining.net/
- Center on the Developing Child (ND) Toxic Stress Response: Questions & Answers. Boston: Harvard University. Available at http://developingchild.harvard.edu/topics/science_of_early_childhood/toxic_stress_response/

- Child Trauma Academy http://www.childtraumaacademy.org and http://www.childtraumaacademy.com
  Dr. Bruce Perry's websites with articles and trainings on trauma.

- Cohen, E. & Walthall, B. (2003) Silent Realities: Supporting Young Children and Their Families Who Experienced Violence. Washington DC: The National Child Welfare Resource Center for Family-Centered Practice.

- Cook, A., Blaustein, M., Spinazzola, J., & van der Kolk, B. Eds., (2003). Complex trauma in children and adolescents: White paper. National Child Traumatic Stress Network. Retrieved July 2005 from http://www.NCTSN.org/

Referenced Continued…

- Cooper, J.L., Masi, R., Dababnah, S., Aratani, Y., & Knitzer, J. (2007). Strengthening policies to support children, youth, and families who experience trauma: Unclaimed Children Revisited, Working Paper No.2. Retrieved August 5, 2010 from http://www.nccp.org/publications/pub_737.html

- Early Promotion and Prevention Research Consortium (2008). Research to Practice: Lessons learned from interventions to address Infant Mental Health in Early Head Start. Administration for Children & Families, Health and Human Services, Office of Planning, Research, and Evaluation. Retrieved August 14, 2010 http://www.acf.hhs.gov/programs/opre/ehs/epirc/

- Early Trauma Treatment Network, (ND) Trauma definition. University of San Francisco.

- Groves, B.M. (2002) Children Who See Too Much: Lessons from the Child Witness to Violence Project. Beacon Press.

- Groves, B.M. (2007). Early intervention as prevention: Addressing trauma in young children in Traumatic Stress/Child Welfare. Focal Point: Research, policy,& practice in children's mental health. Winter 2007, Research and Training Center, Portland OR: Portland State University, policy & Practice. Available at http://www.rtc.pdx.edu/PDF/fpW07.pdf

- Institute for Attachment & Child Development http://www.institutiteforattachment.org
  Treatment, training & child placement agency specializing win children with attachment disorder.

- Lieberman, A.F., Padron, E., Van Horn, P, & Harris, W.W. (2005). Angels in the Nursery: The intergenerational transmission of benevolent parental influences. Infant Mental Health Journal, 26, 504-520.

References Continued…

- National Center for Child Traumatic Stress (2010) Current and Affiliated NCTSN Organizational Members. Retrieved on August 10, 2010 from http://www.nctsnet.org/about-us/network-members

- National Center for Child Traumatic Stress, Zero To Six Collaborative Group (2010) Early Childhood Trauma. Retrieved on August 23 from http://www.nctsnet.org/sites/default/files/assets/pdfs/nctsn_earlychildhoodtrauma_08-2010final.pdf

- National Research Council and Institute of Medicine (2000). From Neurons to Neighborhoods: the Science of Early Childhood Development. Committee on Integrating the Science of Early Childhood Development. Jack P. Shonkoff and Deborah A. Phillips. Ed.s Board on Children, Youth, and Families, Commission on Behavioral and Social Sciences and Education. Washington, DC: National Academy Press.

- National Scientific Council on the Developing Child (2010). Persistent Fear and Anxiety Can Affect Young Children's Learning and Development: Working Paper #9. Boston: Center on the Developing Child at Harvard University. Available at http://www.developingchild.net/

- National Scientific Council on the Developing Child (2005). Excessive Stress Disrupts the Architecture of the Developing Brain: Working Paper #3. Boston: Center on the Developing Child at Harvard University. Available at http://www.developingchild.net/

- National Scientific Council on the Developing Child (ND). In Brief: The Impact of Early Adversity on Children's Development. Boston: Center on the Developing Child at Harvard University. Available at http://developingchild.harvard.edu/library/multimedia/inbrief_series/

References Continued…

- National Scientific Council on the Developing Child (ND). In Brief: The Science of Early Childhood Development. Boston: Center on the Developing Child at Harvard University. Available at http://developingchild.harvard.edu/library/multimedia/inbrief_series/

- National Scientific Council on the Developing Child (2007). The Timing and quality of Early Experiences combine to Shape Brain Architecture: Working paper #5. Boston: Center on the Developing Child at Harvard University. Available at http://www.developingchild.net/

- National Child Traumatic Stress Network (2008). Child Welfare Trauma Training Toolkit. Retrieved on August 20, 2010 from http://www.nctsnet.org/nccts/nav.do?pid=ctr_cwtool

- Osofsky, J.D. (1996). When the helper is hurting. In J. Osofsky and E. Fenichel (Eds.), Islands of Safety Washington, DC: Zero to Three.

- Office of Planning, Research, and Evaluation, Administration for Children and Families (2000, 2006) The Family and Child Experiences Survey (FACES). Washington DC: U.S. Department of Health and Human Services. Reports available at http://www.acf.hhs.gov/programs/opre/hs/faces/

- Rice, K. F. & Groves B.M. (2005). Hope & healing: A caregiver's guide to helping young children affected by trauma. Washington DC: ZERO TO THREE Press.

References Continued…

- Saakvitne, K., Gamble, S, Pearlman L, & Tabor Lev, B (2000). Risking Connection: A Training Curriculum for Working with Survivors of Childhood Abuse. Baltimore, MD: Sidran Press.

- Scheeringa, M. Personal communication on August 10, 2010 co-author of Preschool PTSD Treatment (PPT) Scheeringa, M.S. & Zeanah, C. H. (2001). A relational perspective on PTSD in early childhood. Journal of Traumatic Stress, 14(4), 799-815+

- van der Kolk, B., Pynoos, R., Cicchetti, D., Cloitre, M., D'Andrea, W., Ford, J., Liebermann, A., Putnam, F., Saxe, G., Spinazolla, J., Stolbach, B., & Teicher, M. (2009). Proposal to include a developmental trauma disorder diagnosis for children and adolescents in DSM-V. Retrieved September 24, 2010 from http://www.traumacenter.org/

- van der Kolk, B. (2005). Developmental trauma disorder: Towards a rational diagnosis for children with complex trauma histories. Psychiatric Annals, 35,401-408.

- Van Horn, P. (2008). Children Exposed to Domestic Violence: A Curriculum for DV Advocates. Chicago: Domestic Violence Mental Health Policy Initiative.

- ZERO TO THREE (2005). Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood, Revised (DC:0-3R) Washington DC: ZERO TO THREE Press

- ZERO TO THREE (ND). FAQ's On the Brain. Washington DC: Author Retrieved on August 13, 2010 from http://www.zerotothree.org/child-development/brain-development/faqs-on-the-brain.html

- Zindler, P. Hogan, A. & Graham, M. (2010). Addressing the unique trauma-related needs of young children. Tallahassee: Florida State University Center for Prevention & Early Intervention Policy. Retrieved August 25, 2010 from http://cpeip.fsu.edu/resourcefiles/TraumaRelated_needs_children.pdf?CFID=135049&CFTOKEN=44089600