
MODULE 5

What Is the Influence of Developmental Stage?

The Influence of Developmental Stage

- Child traumatic stress reactions vary by developmental stage.
- Children who have been exposed to trauma expend a great deal of energy responding to, coping with, and coming to terms with the event.
- This may reduce children's capacity to explore the environment and to master age-appropriate developmental tasks.
- The longer traumatic stress goes untreated, the farther children tend to stray from appropriate developmental pathways.

Trauma and Development in Young Children

Developmental delays are common (50%, according to the National Survey of Child and Adolescent Well-Being [NSCAW]) among children in the child welfare system. These delays can be in the areas of:

- Cognitive functioning
- Gross and fine motor skills
- Speech and language skills
- Sensory skills
- Emotional/behavioral regulation

Due to the prevalence of developmental delays and the impact of trauma on children's ability to master age-appropriate tasks, developmental screenings are recommended for all young children in the child welfare system. These screenings help to evaluate:

- Emotional well-being
- Gross and fine motor skills
- Coping skills
- Speech and language skills
- Self-help abilities
- Relationship with caregivers

(First & Palfrey, 1994; Reams, 1999; Rosenberg, Zhang, & Robinson, 2008; Stahmer et al., 2005)

The Influence of Developmental Stage: Young Children

Young children who have experienced trauma may:

- Express their distress through strong physiological and sensory reactions (e.g., changes in eating, sleeping, activity level, or responding to touch and transitions).
- Display changes in behavior by:
 - Becoming passive and quiet
 - Becoming negative and engaging in aggressive behaviors
- Engage in post-traumatic play by:
 - Repeatedly playing out the event with toys and with strong emotion, as if the event were occurring in the present
 - Repeatedly playing out the event with toys and with restricted/flat affect
 - Not changing the theme or outcome of the play theme
- Repeatedly discuss the event, if they have the language skills, at socially inappropriate times or with strangers.
- Become clingy and fearful, especially regarding separations and new situations.
- Become fearful of things or situations not related to the traumatic event.
- Experience strong startle reactions, sleep problems, and night terrors.
- Experience confusion in terms of assessing threat and finding protection, especially in cases where a parent or caretaker is the aggressor. These children may find threat in safe situations or assess dangerous situations as safe.
- Regress to age-inappropriate behaviors (e.g., baby talk, bed-wetting, crying).
- Blame themselves due to poor understanding of cause and effect and/or magical thinking.

Trauma and Attachment

- The sensitive period for attachment is the first two years of life.
- All development occurs in the context of attachment, which:
 - Supports affect regulation
 - Builds a foundation for trust and safety
 - Establishes self-worth and competence

- The four attachment classifications are:
 - Secure – The child uses the caregiver as a secure base for exploration, and the caregiver responds appropriately, promptly, and consistently to the child's needs.
 - Insecure/Avoidant – The child shows little emotion or affection toward the caregiver, and the caregiver does not respond to the child when he/she is upset.
 - Insecure/Resistant – The child is ambivalent toward the caregiver, seeking comfort but also pushing the caregiver away. The caregiver responds inconsistently to the child (sometimes attentive and sometimes neglectful).
 - Disorganized – The child shows contradictory or disoriented behavior, and the caregiver displays frightening, frightened, intrusive, and/or withdrawn behavior toward the child.
- Attachment classification is relationship-specific, meaning the child can experience different classifications for each parent/caregiver in his or her life.

Disorganized Attachment

- Disorganized attachments occur when children do not have a consistent pattern of interacting with a caregiver.
- Disorganized attachment is more common in maltreated and institutionalized children.
- Contributing factors to disorganized attachment can be:
 - Domestic violence
 - Maternal depressive disorder or schizophrenia
 - Parental substance abuse
 - Parental dissociation
 - Parental role confusion
- Common signs of disorganized attachment include unusual behaviors that represent confused and/or fearful responses.
- In interacting with a caregiver, children with disorganized attachment may display contradictory, fearful, or disoriented behaviors. They may appear dazed, or engage in repetitive behavior (e.g., rocking).

- Possible outcomes of disorganized attachment include:
 - Poor affect regulation and/or dissociation
 - Poor impulse control and attention
 - Cognitive impairments
 - High risk for psychopathology

(Smyke & Potter, 2011)

Attachment Figures as Mediators of Trauma Response

A child's relationship with an attachment figure (e.g., parent or caregiver) can mediate the child's response to a trauma. Young children with supportive, nurturing, and responsive caregivers are more likely to be resilient following a trauma.

Often times, the caregivers' response to the trauma influences how the child perceives the trauma. Children have more positive outcomes when caregivers have fewer symptoms and are able to be emotionally available.

When there is interpersonal trauma, children and caregivers may serve as traumatic reminders for one another. Thus, treatment may be required, since the person the child previously experienced as a secure base now serves as a trauma reminder.

Challenges to Attachment Formation in the Child Welfare System

- Trauma can inhibit secure attachment:
 - A young child can be separated from a parent. Separation may be experienced as traumatic when abrupt and associated with overwhelming change and loss.
 - A child may end up having multiple caregivers or disruptions in caregiving that can be numerous and sudden.
 - Interruptions in familiar schedules and routines can occur.
- A child may have difficulty forming healthy attachments to a resource parent (foster, kinship, or adoptive) due to:
 - The child's having divided loyalties
 - The child's behavior (e.g., rejecting, detached) possibly confusing the resource parent
 - The resource parent's possibly not encouraging attachment
 - Possible disruptions that may make it harder for the child to attach to a new caregiver

The Influence of Developmental Stage: School-Age Children

School-age children with a history of trauma may:

- Experience unwanted and intrusive thoughts and images
- Become preoccupied with frightening moments from the traumatic experience
- Replay the traumatic event in their minds in order to figure out what could have been prevented or how it could have been different
- Develop intense, specific new fears linking back to the original danger

School-age children may also:

- Alternate between shy/withdrawn behavior and unusually aggressive behavior
- Become so fearful of recurrence that they avoid previously enjoyable activities
- Have thoughts of revenge
- Experience sleep disturbances that may interfere with daytime concentration and attention

The Influence of Developmental Stage: Adolescents

In response to trauma, **adolescents** may feel:

- That they are weak, strange, childish, or “going crazy”
- Embarrassed by their bouts of fear or exaggerated physical responses
- That they are unique and alone in their pain and suffering
- Anxiety and depression
- Intense anger
- Low self-esteem and helplessness

These trauma reactions may in turn lead to:

- Aggressive or disruptive behavior
- Sleep disturbances masked by late-night studying, television watching, or partying
- Drug and alcohol use as a coping mechanism to deal with stress
- Self-harm (e.g., cutting)
- Over- or under-estimation of danger
- Expectations of maltreatment or abandonment

- Difficulties with trust
- Increased risk of revictimization, especially if the adolescent has lived with chronic or complex trauma

Adolescents, Trauma, and Substance Abuse

Adolescents who have experienced trauma may use alcohol or drugs in an attempt to avoid overwhelming emotional and physical responses. For these teens:

- Reminders of past trauma may elicit cravings for drugs or alcohol.
- Substance abuse further impairs their ability to cope with distressing and traumatic events.
- Substance abuse increases the risk of engaging in risky activities that could lead to additional trauma.

Child welfare workers must address the links between trauma and substance abuse and consider referrals for relevant treatment(s).

Specific Adolescent Groups

- **Homeless youth** are at greater risk for experiencing trauma than other adolescents:
 - Many have run away to escape recurrent physical, sexual, and/or emotional abuse.
 - Female homeless teens are particularly at risk for sexual trauma.

(Whitbeck, Hoyt, & Yoder, 1999)
- **Special needs adolescents** are two to 10 times more likely to be abused than their typically developing counterparts (Sullivan & Knutson, 2000).
- **Lesbian, gay, bisexual, transgender, or questioning (LGBTQ) adolescents** contend with violence directed at them in response to suspicion about or declaration of their sexual orientation and gender identity (Kosciw, Greytak, Bartkiewicz, Boesen, & Palmer, 2012).
- **HIV positive youth** experience high rates of traumatic stress. Research indicates that receiving a positive HIV diagnosis is additionally traumatic for most of them (Radcliffe et al., 2007). This may impact participation in medical care.

Multi-System or Crossover Youth

- These youth are involved in both the child welfare system and the juvenile justice system.

- Maltreatment is a risk factor for delinquent behavior.
 - The majority of multi-system youth start out in the child welfare system and then enter the juvenile justice system.
 - There are a disproportionate number of children of color in the crossover population compared to the general population, the child welfare population, and the juvenile justice population.
 - There are a higher number of females in the crossover population compared to the general delinquency population.
 - Crossover youth experience prevalent educational (including special education), mental health, and substance abuse problems.
 - Many are in foster care for long periods of time.
 - Lack of cross-system communication in case planning leads to many crossover youth falling through the cracks.
- (Herz et al., 2012)
- Outcomes for crossover youth can include recidivism, adult criminal justice involvement, mental health and substance abuse problems, and need for public assistance (Culhane et al., 2011).

Prevent Child Welfare Youth from Crossing Over by Reducing Risk Factors for Delinquency, Such as:

- Physical abuse (Maas, Herrenkohl, & Sousa, 2008)
- Neglect (Jonson-Reid and Barth, 2000; Smith, Ireland, & Thornberry, 2005)
- Maltreatment starting or lasting into adolescence (Smith, Ireland, & Thornberry, 2005)
- Group home placement (Ryan, Marshall, Herz, & Hernandez, 2008)
- Placement instability (Widom & Maxfield, 2001)

Awareness of the above risk factors can also help link high-risk youth to more intensive services to prevent delinquency.

Protective Factors That Can Prevent Child Welfare Youth from Crossing Over to Delinquency Include:

- Positive attachments to others
 - Safe school environments
- (Ryan, Testa, & Zhai, 2008; Crooks, Scott, Wolf, Chiodo, & Killip, 2007; Benda & Corwyn, 2002)

Transitional-Aged Youth

Transitional-aged youth are described as those aged 16-24 who are transitioning or aging out of foster care. These youth are often on their own; they have been in care for many years and lack stable, supportive families. As a result, many transitional-aged youth do not have the support and skills needed to succeed independently as adults. They experience high rates of mental health (including PTSD) and substance abuse problems, homelessness, unemployment, and crime (Courtney, Hook, & Lee, 2010).

Many foster care alumni (20%) still lack a high school diploma or GED by age 25. This is likely related to the fact that they have experienced multiple school changes while in care (Courtney et al., 2011).

One-third are living below the poverty level and lack health insurance (Pecora et al., 2005).

What can a child welfare worker do?

- Recognize the signs and symptoms of child traumatic stress and how they vary in different age groups.
- Recognize that child welfare system interventions have the potential to either exacerbate or lessen the impact of previous traumas.
- Decrease the risk of system-induced secondary trauma by serving as a protective and stress-reducing buffer for children:
 - Develop trust with children through listening, frequent contacts, and honesty in order to mitigate previous traumatic stress.
 - Avoid repeated interviews, especially about experiences of sexual abuse.
 - Avoid making professional promises that, if unfulfilled, are likely to increase traumatization.
- Understand the impact of trauma on different developmental domains and attachment formation.
- Understand the cumulative effect of trauma.
- Ensure developmental screening for young children to identify potential trauma-related developmental challenges and the need for further evaluation and/or services.

- Carefully consider the potential developmental risks to young children when making the decision to remove or change placement.
- Try to avoid placement changes for children between 0-24 months of age, when safely possible, since this is when attachment is being consolidated.
- Plan transitions well to allow young children to preserve memories and maintain routine.
- Gather and document psychosocial and medical information regarding all traumas in the child's life to make better-informed decisions.
- Educate resource parents about the impact of trauma on children of different ages and ask them about reactions and behaviors that could be trauma-related.
- Assess whether a resource parent is reluctant to attach to a child given that the child is likely to move. Explain that forming a secure attachment, even if short term, is beneficial to the child.
- Identify youth at risk for delinquency and link them to services to reduce key risk factors.
- Provide ongoing support, trauma-informed services, and outreach to crossover and transitional youth to help them become successful adults.
- Ensure that all youth are connected to stable, supportive adults when they exit the system.

Signature

Today's Date

Signature

Today's Date