

**LONG-TERM FOSTER CARE FOR ABUSED  
AND NEGLECTED CHILDREN:**

**HOW FOSTER PARENTS CAN HELP IN  
HEALING THE TRAUMA**



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## **THE USE OF THIS MANUAL**

This manual is designed to help foster parents, particularly those taking on the care of younger infants and children needing a long-term placement.

It is not a comprehensive text on "how to foster", but is more focused on the emotional needs and the healing process for abused and neglected children, especially those with attachment disturbances. It does not focus on the issues around contact with biological family.

This manual reflects the clinical views of its author, and does not represent the official policy of any fostering agency.

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Toni Single

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## **CHAPTER 1:**

### **THE AIMS OF LONG-TERM FOSTER CARE FOR ABUSED AND NEGLECTED CHILDREN**

A good foster home which provides care for previously abused and neglected children has three main aims:

- 1. A HOME IN WHICH CHILDREN ARE PROTECTED FROM FURTHER ABUSE AND NEGLECT.**
  
- 2. A HOME IN WHICH CHILDREN CAN LEARN ABOUT:**
  - Normal family life
  - Social expectations
  - How to “be a child”
  - How to deal with conflict
  - How to give and receive love
  - How to develop a positive self-image
  - How to learn life skills and appropriate self-reliance
  
- 3. A HOME IN WHICH CHILDREN CAN “HEAL” FROM THE EMOTIONAL DAMAGE CAUSED BY ABUSE AND NEGLECT.**

In many cases, these traumatic experiences have stunted or distorted the child’s personality and his/her ability to make appropriate attachments to others. Long-term foster placement can be a “healing” place to undo such damage, with the child learning to make new and loving relationships within a “family” context. This is why long-term foster care is often called:

#### **“A REPARATIVE ENVIRONMENT”**

Such an environment is the best therapy for healing of the psychological damage caused by abuse and neglect.

## CHAPTER 2:

### **FACTORS WHICH CONTRIBUTE TO SUCCESS IN LONG-TERM REPARATIVE FOSTER CARE**

There are three main groups of factors which will likely decide the eventual success of this healing environment, namely:

1. **FACTORS IN THE CHILD**
2. **FACTORS IN THE FOSTER PARENTS**
3. **FACTORS IN THE PLACEMENT**

#### 1. **FACTORS IN THE CHILD**

Some children are more able to respond or are able to respond more quickly to a "healing" foster environment than can others. Much depends on:

- *The age of the child when placed.*  
Generally, the younger the child, the better the outcome.
- *The severity of the child's personality difficulties and the severity of attachment damage.*  
Generally, the less damaged the child, the more successful will be the healing process, and the quicker it will proceed.
- *The extent to which contact with the biological parents assists rather than interferes with the child healing.*  
In most cases, the child's maintenance of a relationship with biological parents is essential for long-term emotional development. However in a minority of cases, contact with biological parents may be so frequent or so stressful that it interferes with the "healing" process.

## **2. FACTORS IN THE FOSTER PARENTS**

Long term fostering has a greater chance of success if:

- The foster parents are emotionally healthy and have the capacity to make strong and loving attachments to a child who is not biologically theirs.
- The foster parents themselves do not have mental health, substance abuse, anger management or marital problems.
- The foster parents do not have unresolved childhood abuses themselves, which are preoccupying for them.
- The foster parents are empathic to what the child has suffered, and realise that the damage from abuse can be long-standing and may take a long time to resolve.
- The foster parents have an understanding of what the child has experienced; have an understanding of how abuse / neglect can harm a child's development; and have realistic expectations about how the child will behave and may respond to being in foster care.
- The foster parents understand the importance of a child's biological family, whether the child has contact with them or not.
- The foster parents can work well with the fostering agency.

### **3. FACTORS IN THE PLACEMENT**

Long term fostering is more likely to succeed if the placement has SECURITY for all parties (foster parents, biological parents and child) i.e. all parties are accepting of the child needing a long-term, uninterrupted residency with the foster family. Acceptance of this is of course the most difficult for biological parents, whose "resolution" is often inhibited by intense grief about the loss of their child, sometimes manifesting itself in anger.

Such security has multiple benefits, in that:

- It provides an environment in which the child can feel that he really "belongs", and is not threatened by fears of future loss of (foster) "parents" to whom he has become attached.
- It provides an environment in which the foster parents feel "safe enough" to intensely attach to their foster child, and are protected from uncertainty about the placement. This is needed if the child, in turn, is to make appropriate attachments to them and is thus to recover from attachment damage.
- It provides the biological family with some closure so that at some level, they can grieve their loss appropriately, instead of existing in "false hope" which can engender numerous requests for restoration. Such requests and Court applications are often highly disruptive to the child's security and the stability of the foster placement.

## CHAPTER 3:

### AN INTRODUCTION TO THE LONG TERM EFFECTS OF ABUSE AND NEGLECT ON CHILDREN

**The effects of a maltreating environment on a young child can take many forms and can affect each child, even within the same family, very differently.**

**Most of us would understand that children who have been abused or neglected may exhibit fear, sadness, difficulties with schoolwork, bed-wetting, nightmares, self-harming behaviours and other expressions of distress and trauma. However some children express these effects differently. What is less well known is that children, especially those who have suffered early abuse and neglect, may show less apparent but ironically more damaging signs of trauma.**

These less apparent but more damaging effects of trauma can include:

- Difficulty in making deep attachments to others
- Difficulty in feeling guilt about wrong doing
- Difficulty in feeling empathy for others in distress
- Difficulty in expressing or experiencing feelings
- Anti-social behaviours and attitudes

These types of "traumas" effects are more difficult to understand because they are less obvious than the "post traumatic" symptoms of fear, anxiety and sadness that are easily seen. However, these types of trauma effects represent damage at deeper levels of the child's personality development, and as such may be harder to reverse than the more usual "post traumatic" symptoms.

Research is now showing that the type of parenting a child receives in his first few years of life, can have a profound and long lasting effect on brain development in childhood and adulthood. This is shown in the over-representation of abused/neglected children who, when grown-up:

- Have recurrent relationship problems
- Experience mental health problems
- Are involved in criminal activities
- Have major problems in parenting their own children

However not all abused children will grow up to have these problems. Those who do better in later life are those who have experienced some “good” attachment in their early years, or those who have been able to benefit from a reparative (healing) environment following the abuse and neglect.

## CHAPTER 4:

### **HOW TRAUMA (ABUSE AND NEGLECT) MAY AFFECT A CHILD'S BEHAVIOUR (Jernberg & Booth)<sup>1</sup>**

#### **1. TRAUMA MAY LEAD TO AN ONGOING LOW-LEVEL STATE OF FEAR**

The repeatedly traumatised child's brain organisation has developed around the over-use of the "stress – alarm – fear" response mechanism. This can lead to such behaviours as:

- Tantrums
- Aggressive behaviour
- Dissociation ("switching off" of feelings)
- Impulsivity and an over-reactive response.

#### **2. TRAUMA CAN CREATE A MEMORY DISORDER**

The child may experience intense recollections of the trauma, as though he is experiencing this at present. The feeling as well as the thoughts around the original trauma may thus be reactivated. This can present as:

- Lying
- Unexplained aggression
- Withdrawal
- Dissociated "blank" staring

#### **3. TRAUMA CAN CAUSE DISTURBANCES TO AFFECT (EXPRESSION OF FEELING)**

This can cause emotions to be poorly regulated, effectively leading to:

- Out of control expressions of feelings
- Abrupt, intense changes of mood

- Oppositional, defiant, un-cooperative behaviour
- Depression

#### **4. TRAUMA CAN LEAD TO AVOIDANCE OF CLOSENESS**

For traumatised children, being close to another can lead to feelings of loss of control and vulnerability. Therefore such children may avoid intimacy as indicated by:

- Inability to trust / guardedness
- Aversion to physical closeness
- A high need for control of the environment
- Pseudo-mature or adult-like behaviour

#### **5. TRAUMA CAN LEAD THE CHILD TO REJECT POSITIVE EXPERIENCES**

The traumatised child may have lowered self-worth and may feel she does not really deserve good things, even though she may demand them. This can lead to such behaviour as:

- Having an outburst of bad behaviour immediately following a happy experience.
- Destroying gifts/clothes given to her
- Angrily rejecting the foster parents
- Extreme passivity and incapacity to stand up for oneself

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<sup>1</sup> Jernberg A.M & Booth P.B Theraplay : Helping Parents and Children Build Better Relationships Through Attachment-Based Play. (Jossey-Bass, San Francisco, 1999) – available in Australia.

## **CHAPTER 5:**

### **AN OVERVIEW OF INFANT BRAIN DEVELOPMENT**

#### **WHY DO FOSTER PARENTS NEED TO KNOW ABOUT BRAIN DEVELOPMENT?**

No-one expects foster parents to become experts in neurology but an understanding of how abuse and neglect can affect an infant/child's developing brain will help in understanding some of the more deep-seated attachment and other problems in young abused/neglected children.

A basic knowledge of how the brain develops and how it responds to trauma and neglect may help foster parents:

- To understand the importance of EARLY experiences on a child's development
- To understand which parts of the brain are most affected by abuse and neglect
- To understand how to "target" those parts of brain development which optimise the "healing" environment being provided for maltreated children.

## **IMPORTANT CONCEPTS IN BRAIN DEVELOPMENT**

### **1. THE BRAIN MUST BE "USED" TO GROW AND DEVELOP**

This has huge implications for babies who have suffered early neglect and lack of stimulation. Such experiences can lead to under-development of some areas of the brain.

### **2. THERE ARE CRITICAL PERIODS FOR BRAIN DEVELOPMENT.**

i.e. different parts of the brain grow and develop at different stages of life.

### **3. THE GREATEST BRAIN DEVELOPMENT TAKES PLACE IN THE FIRST THREE YEARS OF LIFE.**

- By age 3, the brain is already 90% the size of an adult's brain (compared to a 3 year old's body which is only 18% of adult size).
- During the first year of life, 70% of calories which the baby consumes goes into brain growth. Most parents intuitively know this, and understand the importance of adequate feeding and ongoing monitoring of a baby's growth.

It follows that lack of calories (particularly in cases of starvation / failure to thrive) in the first year of life, may have long term effects on brain growth.

### **4. "OVERUSE" AND TRAUMATIC OVERSTIMULATION OF SOME AREAS OF THE BRAIN TOO EARLY IN LIFE CAN ALSO AFFECT DEVELOPMENT.**

Again, most parents are intuitively aware of this and provide a calm, gentle and soothing environment for their babies and protect them from harsh stimulation or fearful experiences.

However some young children live in violent and frightening environments. For these youngsters the “alarm” system (fear triggering) areas of their brains may become overly stimulated (over used) because of repeated exposure to fearful experiences.

5. **THE BRAIN NEEDS PATTERNED AND REPEATED EXPERIENCES TO DEVELOP APPROPRIATELY.**

This means that in early development the baby needs;

- Lots of repetition of experiences in order to learn.
- Predictable routines to enhance “patterning”.

Most parents provide these elements intuitively.

## **SEQUENCING OF BRAIN DEVELOPMENT**

- The brain organises and grows in SEQUENCE, starting from the lowest and most regulated areas of the brain (BRAINSTEM), and working up through the levels to the most complex area (CORTEX).



**CORTEX**

**LIMBIC SYSTEM**

**MID BRAIN**

**BRAIN STEM**

- Different areas of the brain develop and become fully efficient at different times during childhood.
  - eg: Heart rate, breathing (primarily controlled by BRAINSTEM) are well developed at birth.
  - eg: Sensory/motor control (eg grasping for objects) is primarily controlled by the MID-BRAIN which becomes relatively functional in the first year of life but becomes more “finely tuned” and complex in later years.
  - eg: “Feeling” of and expression of emotion begins to develop in the later part of the first year of life. This is at first primarily controlled by the LIMBIC SYSTEM, (a deeply embedded area of the brain). However later on this function becomes integrated with higher levels of the brain, so that more complex and socially acceptable expressions of emotion are enhanced.
  - eg: “Knowledge” and problem solving activities primarily take place in the CORTEX, which has a huge growth spurt in the second year of life

when major leaps in language development and a thirst for learning new material is seen.

eg: "Abstract (symbolic) thinking" or ideas and reasoning involving higher levels of the cortex become more developed in later childhood and adulthood.

**PRIMARY FUNCTIONS OF PARTS OF THE BRAIN<sup>2</sup>**

<b>Developmental Age</b>	<b>"Sensitive" Brain Areas *</b>	<b>Critical Functions</b>
0 – 1	BRAINSTEM	Regulates sleep, heart beat, arousal, "fear" states
1 – 2	MIDBRAIN	Motor control. Sensory (seeing, hearing, touch, smell etc) integration.
1 – 4	LIMBIC	Emotional states Attachment Empathy
2 – 6	CORTEX	Abstract reasoning Creativity Social / emotional integration.

\*However, most parts of the brain have connections to other areas of the brain, so that the brain areas listed are only the primary sites of functioning.

Most parents "intuitively" understand this sequencing in brain development and adapt their parenting behaviours to target that area of brain development which is most important at that stage of the child's life.

*For example – parents of newborn babies concentrate on BRAINSTEM functions, getting the baby into a sleep / wake routine, having him calmed by primitive bodily soothing, holding and rhythmic rocking. Most parents do not try to read encyclopaedias to a young baby to simulate the higher levels of his CORTEX! However as the baby grows older, parents intuitively know to "target" higher areas of brain functioning at appropriate stages.*

<sup>2</sup> CIVITAS Healing Arts Project 1998.

## **DISRUPTIONS TO BRAIN DEVELOPMENT**

Disruptions to healthy brain development can result from:

1. Lack of use (lack of experience) during critical periods of brain development  
i.e. NEGLECT (UNDER-USE OF THE BRAIN).

**OR**

2. Abnormal extremes of experiences i.e PHYSICAL ABUSE; REPEATED EXPERIENCES OF EXTREME FEAR; EXPOSURE TO DOMESTIC VIOLENCE (TRAUMATIC OVER-USE OF THE BRAIN).

However some children coming into care have suffered BOTH disruptions to normal brain development i.e. they have experienced both neglect and repeated exposure to fearful situations, especially if they have resided in chaotic households.

## **TIMING OF BRAIN DEVELOPMENT**

1. Timing of experiences is the crucial factor in brain development.
2. The first three years of life, but especially the first year, are the most significant.
3. During the first few years of development, the brain is more flexible (malleable) and therefore easier to modify because development in most brain areas is still ongoing.
4. Thus, placement of an abused child in a reparative environment should be done as early as possible, if major change is to be effected.
5. This does not mean that older children cannot heal. However the older the child, the more "fixed" is brain development especially in the lower areas of the brain. Therefore the older the child on coming into a healing environment, the more difficult it will be to turn around abnormal development.

The following proverb (courtesy of Professor Bruce Perry) is an apt one as it applies to abnormal brain development and its reparation.

**IT IS NOT EASY TO STRAIGHTEN  
IN THE OAK  
THE CROOK  
THAT GREW IN THE  
SAPLING**

Gaelic Proverb.

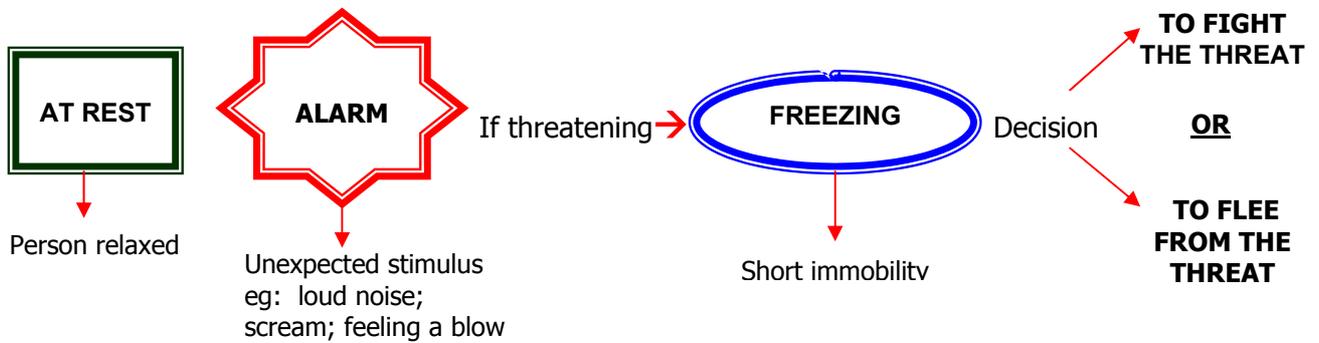
## **CONDITIONS UNDER WHICH TRAUMA MAY HAVE LONG TERM EFFECTS ON BRAIN DEVELOPMENT (Bruce Perry)**

1. When the trauma occurs at a young age and cannot be “consciously” remembered.
2. When the trauma is repetitive, rather than just a single incident.
3. When the trauma is severe and terrifying.
4. When the trauma is unpredictable i.e. comes with no warning and no understandable trigger.
5. When no support or comfort is offered to the child when he has been traumatised.

A baby / child who is chronically abused, (through repeated physical abuse; repeated screaming into the face of a young baby; or repeated exposure to parental domestic violence), is more likely to show ongoing traumatic symptoms than is a child who has been traumatised by a single incident (eg car accident; earthquake) and has been comforted at the time by loving and comforting caretakers.

In situations of abuse or exposure to domestic violence, the abusive parent cannot provide comfort/reassurance to a child at the time he most needs it, because that parent IS the source of the trauma and fear. Thus in such situations, the child is not only terrified, but there is no comforting (healing) experience for him.

## "THE ALARM SYSTEM" AND HOW IT RESPONDS TO A THREAT / FEAR / TRAUMA



The processing of the response to a threat is initially activated in the brain stem region, but then later involves higher brain systems.

## **NORMAL RESPONSES TO TRAUMA OR THREAT**

Our brain responds to a threat first by activation of the lower areas of the brain, and then sequentially involves the higher areas.

### **FIRST RESPONSE → BRAIN STEM**

- Without even thinking about it, our brain stem prepares our body for action if it perceives a threat
- Without us being aware of it, the brain increases our blood pressure, heart and respiration rates, increases blood sugar, increases muscle tone etc.
- This is the brain's way of preparing our body to either fight off or run away from a threat
- This is an AUTOMATIC and INITIAL response to threat.  
eg: we can feel our heart "racing" and our body become tense.

### **SECOND RESPONSE → LIMBIC SYSTEM**

- This involves our EMOTIONAL reaction to threat/trauma ie. We FEEL fear, anxiety, panic etc.

### **THIRD RESPONSE → CORTEX**

- Later and after the threat has been conquered, we "THINK ABOUT" it and begin to process the experience and make some "meaning" of it.

## **THE EFFECT OF REPEATED TRAUMA ON BRAIN DEVELOPMENT IN YOUNG CHILDREN**

1. The damage to brain development comes about when the threat/trauma is severe and repetitive.  
The alarm system in the brain gets triggered off again and again, with fear responses being continually evoked eg. The child who repeatedly witnesses domestic violence.
2. If this happens too often and too severely while the brain is in its most important stage of development (the first three years of life), these "alarm" areas may become over-used (over-activated).
3. Such over-use causes these brain areas to become OVER-SENSITISED in response to future threats.
4. Such oversensitivity means that in future the child's brain only needs a MINOR trigger to set off a full-blown alarm/stress response.
5. This response can be triggered off when a child is reminded (consciously or unconsciously) of a traumatic event they have experienced in the past, for example:
  - The sight or sound of the abuser, or even someone who looks like him/her.
  - Thinking about the abuse.
  - Dreaming about the abuse or similar situations.
  - General associations with the abuse (loud voices, beards, baths, glasses etc.)

6. Therefore, these full-blown stress responses in the child can continue to be activated again and again, even if the actual abuse is not occurring. Many behavioural problems in abused children are due to this repeated activation even when the child is in safe foster care.

## **THE "FREEZING" RESPONSE TO A THREAT**

1. All of us use "freezing" on occasions to respond to a threat.
2. "Freezing" implies very brief immobilisation of the body and mind as an initial reaction to threat.
3. Freezing allows us to:
  - "take stock" – we can see and hear more clearly if our mind and body are "still". This means we have a clearer observance of the environment to detect the threat.
  - To "camouflage" ourselves in order to survive. It makes it harder for our attacker to find us if we "lie doggo" (still and silent).
4. Our "mind" can sometimes "freeze" as well, so that we can more clearly cope with stress overload. We all know of times when we were so overloaded with tasks, that we temporarily could not proceed. This "psychological freezing" allows us to "take stock" and re-evaluate the situation.
5. While all human beings (and animals) use freezing as a limited response to threat, traumatised infants and children on the other hand use freezing:
  - More often, including in situations where it is not needed
  - For more prolonged periods than the average child/person  
*eg: A common abnormal freezing response in young abused babies is to lie completely motionless and silent for long periods in the presence of a threatening person.*
6. Previously traumatised children will often revert to freezing when they become anxious in other situations. They may not be conscious of doing this.

7. When abused children are reminded (consciously or unconsciously) of the abusive situation they may “automatically” freeze in response to this eg: a loud voice of an adult very close to them demanding they do something. However it might appear that the child is ignoring or passively refusing to obey, when in fact the child is experiencing reactivated fear which is making her behave in this way. Sometimes such “freezing” is therefore wrongly labelled “Oppositional Behaviour”, when it really represents an over-sensitivity (fear) to minor anxiety.
  
8. Unfortunately in such situations, adults may try to “up the ante” by speaking in an even louder voice to make their commands known. Of course this will just exacerbate the child’s fear response (freezing) and the adult may wrongly view this as the child becoming more and more deliberately oppositional, when in actuality the child is becoming more and more anxious.
  
9. An important issue for foster parents is differentiating between resistance in a child which represents fear, and resistance which represents deliberate oppositionality. Of course the management of each situation will be markedly different. Sometimes differentiating these differences may not be easy, and professional help may be needed.

## **FIGHT OR FLIGHT FROM THE THREAT: HOW DO WE CHOOSE?**

In order to overcome an immediate threat we either stay to fight it or run away from the threat. This "choice" is often not conscious and may involve very little reasoning or logic. We are more inclined to make such decisions based on our bodily or emotional reactions, than on our "thinking" capacity.

### **DISSOCIATION: THE CHILD'S "FLIGHT" REACTION**

1. A young frightened baby is not able to physically run away from a threat eg. a parent who is abusing him; witnessing domestic violence. Nor are babies able to "fight" such a threat.
2. Young infants in this situation may therefore use psychological "running away" (dissociation) to cope with their fear i.e. "blocking out" of feelings of fear and distress.
3. Dissociation has been described as:  
"The (child's) escape in situations where there is no escape" (Perry).
4. Dissociation means that the young infant/child disengages from the frightening situation in the external world and turns to her own "inner" (psychological) world. On the surface she may seem unresponsive, when it would be expected that she would react to such a situation with observable fear or anxiety eg. a child who seems unreactive to incidents of domestic violence; the child who does not seem to feel the physical pain of an injury.

5. Dissociation however can also be a normal response to threat/discomfort and all of us use it. Clearly however, some forms of dissociation are abnormal.
6. Normal uses of dissociation occur when we "daydream" during a boring lecture, or when on a long trip we have been so absorbed by our inner thoughts that we cannot remember travelling there.
7. Dissociation too may be very adaptive(normal) in extreme situations:
  - Injuries sustained during war or a car accident often cannot be immediately "felt" by the person. We may describe this as "being in shock", but it is the body's (dissociated) response to assist survival.
  - "Fainting" when we hear of the death of a close relative, may be the brain's way of "escaping" unbearable trauma.
8. Abnormal dissociation on the other hand can include amnesia and de-personalisation (feeling that one is outside one's own body).
9. Abused and traumatised children tend to use dissociation more often, for more prolonged periods and in more unusual forms.
  - eg. excessive day dreaming, including prolonged periods of blank, glazed staring.
  - eg. pain insensitivity when injured – the child does not appear to feel pain when he head-bangs, falls over very hard, has infections or stitches, or suffers other injury.
  - eg. failure to react to extreme situations such as witnessing violence.

## **THE "FIGHT" RESPONSE**

1. Very young children are not really developmentally able – physically or psychologically – to fight off a threat.
2. Most young babies and toddlers in such situations cry in response to a threat, thereby engaging responsive adults to fight the threat on their behalf.
3. However a young child who is being abused or who is witnessing domestic violence cannot engage his carer in this way, because the carer may be the threat (the aggressor). On the other hand the other "victim" parent in this situation may also be unprotective of or unresponsive to the child at this time because of her own preoccupations and trauma.
4. Some abused children still attempt to use "fight" responses when anxious/threatened, and this often displays itself in the form of severe temper tantrums.
5. Such tantrums as a response to threat are often misunderstood, and are sometimes mistaken for the wilful tantrums of the normal 2 year old. The two types of "tantrums" are however quite different.
6. Consider the analogy of an aggressive animal (eg. cat) in differentiating between these two "temper tantrum" types. The **wilful** aggression in the cat is displayed when he is stalking his prey in a deliberate and purposeful manner and then pounces in an outburst of "aggression". This is very different from the **fearful** "aggression" of a cat which has been caught and cornered.

7. The same principles can be used in differentiating the two types of temper tantrums in children, especially those who have suffered previous abuse/neglect.
  - The “wilful” (normal) temper tantrum of a 2-3 year old is conscious, planned and purposeful. eg. the child at the supermarket who kicks and screams when refused a chocolate, with the hope that such a display will reverse the parent’s refusal.
  - On the other hand, the “regressed” temper tantrum (like the cornered animal) occurs when the child shows extreme tantruming that is purposeless, unplanned and “out of control”. This represents the brain’s automatic “fight” response in situations in which the child is extremely fearful (even though the child may not be consciously aware of what is evoking his fear).
  
8. Of course the behaviour management of these two different types of “temper tantrums” will vary markedly.
  - The “wilful” temper tantrum needs firm limit setting on the child’s behaviour.
  - Management of the “regressed” temper tantrum however needs to target the underlying fear i.e. by reassurance, comforting, loving containment and a validation of the child’s feelings.

## **THE HYPER-AROUSABLE (FIGHT ORIENTATED) CHILD**

1. One principle of brain development is that the brain ADAPTS to an environment to maximise SURVIVAL.
2. This principle is particularly relevant to a child who has been raised in a chaotic, unpredictable and chronically violent environment. The child's brain structure will likely change to help him ADAPT to (survive) in this environment.
3. To survive better in a chaotic, violent environment, a child needs to:
  - Be hypervigilant of (on the alert to) cues in the environment which may signal a threat, especially the non-verbal cues in others
  - Be able to "screen out" other cues, and so concentrate on the potential threat.
  - Be hyper-aroused so he can respond immediately to a threat.
  - Be able to act quickly and impulsively.

The child living in a violent and unpredictable environment therefore needs to be in a continual state of HIGH AROUSAL if he is to survive well in this situation.
4. While these changes in his brain structure are adaptive to his violent home situation and enhances his survival, it is NOT adaptive in other situations eg. at school, in a non-violent home environment (foster care).
5. In such safe environments, even though there is no threat, the child may remain in a high state of arousal, i.e. overactive; distractible and impulsive; being unable to concentrate on schoolwork and having problems with learning.

6. Such children often receive labels such as
  - Attention Deficit Hyperactivity Disorder
  - Conduct Disorder
  - Oppositional Defiant Disorder.

## CHAPTER 6:

### "HEALING" OF ABNORMAL BRAIN DEVELOPMENT

#### INTRODUCTORY CONCEPTS

- The higher areas of the brain which develop later in life are more malleable and thus more easily changed.
- For instance, the CORTEX remains quite malleable over our lifespan, and even at an older age, we are able to take in and retain additional facts quite quickly (knowledge / information) or learn new ideas replacing previously held ones.
- However it is difficult to "change" lower areas of brain functioning which are relatively fixed.

*Example: When we learn to ride a pushbike (primarily a mid-brain function), we have "learnt it for life". We don't "un-learn" it just because we may not have ridden for a while or because we tell ourselves we cannot do it.*

The same also holds for some children whose traumatic, neglectful experiences have impacted on areas of lower brain functioning (especially the deeply embedded limbic system). Such experiences may be "burnt into" the deeper and more rigid brain areas, where they may be difficult to dislodge, even with much effort. This is especially the case in older children entering care.

- This means that very young children coming out of abusive and neglectful situations, often make significant gains quite quickly in higher areas of the brain (IQ scores, language) when placed in good foster care.

- However those developmental tasks which are mediated by lower and deeper brain areas (attachment; empathy; conscience, reaction to stress/fear) usually take much longer to repair. This is because the lower areas of the brain are less plastic and less malleable to change.

## **HOW THE BRAIN CAN HEAL FROM EXPERIENCES OF NEGLECT AND TRAUMA**

1. The earlier healing takes place, the better.
2. No part of the brain will develop unless it is "used" (activated, stimulated).
3. Remember that different areas of the brain are responsible for different areas of functioning (see Table on page 18).

The brain areas most adversely affected in abuse / neglect involve:

- The brainstem
- Midbrain
- Limbic areas

Thus "healing" experiences need to be primarily targeted at these areas.

4. Healing takes place when a child has actual and repeated experiences of new and reparative ways of relating and dealing with stress and by having actual and repeated experiences of loving and empathic interactions in a family environment.
5. Healing takes place through REPETITIVE, SPECIFIC, PREDICTABLE EXPERIENCES in a cognitively stimulating and attachment-rich environment i.e. in a seven day a week good, loving family environment.

6. These concepts are often misunderstood, and sometimes foster parents and workers try to effect “healing” by wrongly targeting the higher brain areas (the cortex). They try to do this by providing the child with “knowledge” of their experiences or through “counselling” about their past traumas. These may be helpful in sometimes relieving fears of which the child is already aware and in giving some cognitive “meaning” to her experiences. However counselling or psychotherapy will be unlikely to really impact on the child’s recovery from her (attachment) damage.
  - Reparation (treatment) needs to be aimed at that part of the brain which has been affected.

eg: if a child has been repeatedly traumatised by fear, those areas of the brain affected are likely to be the lower and deeper ones (brain/stem; mid-brain; limbic system).

Thus it is little use trying to heal the child’s attachment damage through “talking” therapies (eg: counselling) or explanations/rationalisations, since this is directed towards the higher areas of the brain (cortex).
  - Remember that some abused children’s brains have become ADAPTED to living in a frightening and unpredictable environment because it allows the child to “survive” better in that environment. The brain has become this way because of repeated (patterned) episodes of fear for the child.
  - Thus to provide healing, the brain will need even more and very different “patterning” (repetition) of good, safe and predictable experiences to modify the abnormal development.

Abused / neglected children in reality need repeated experiences (not words) of safety, comfort, predicability, affection, and empathy – just like toddlers/infants do when they are developing and learning about intimate relationships.

This means that some children who have missed out on the basic aspects of being parented (the foundations), may need to be “taught” again – just like we would do with an infant. We take for granted that most 3, 4, 6 or 8 year olds have “learned” and integrated such things as infants, but this may not be the case for children coming into foster care. Such “foundations” may need to be experienced again and again for such children.

Such “teaching” should be:

- Predictable
- Nurturing
- Repetitive
- Based on experience of the event rather than “words” (although appropriate words can be helpful).
- Supportive and comforting to the child, especially when he is upset/distressed/fearful.

The best “therapy” for abused and neglected children is a seven day a week placement in a loving, stable environment where they can make deep attachments to their long-term foster carers.

The “healing” which foster parents can offer comes about through ordinary devoted care of the child, using normal activities which all parents use with young children.

Activities and interactions which are focussed on the earliest phases of development (“relationship” establishment), just as parents would do with a young baby – the intimate, nurturing experiences of holding, caressing, rocking, soothing, eye contact, smiling and talking to the baby.

## CHAPTER 7:

### HEALING AND FOSTER CARE

#### THE THERAPEUTIC ROLE OF FOSTER CARE

The best “treatment” for attachment damage in abused children is the children’s later actual experience of being part of a loving family on a long-term basis. Healing of attachment damage takes place in the context of the child having an opportunity to attach deeply to loving and responsive “parents”, in the same way that a baby gradually develops an intimate relationship with those people who care for him on a day-to-day basis.

The process of re-attaching and healing is often a long one – sometimes taking years – and cannot be hurried. There are no gimmicks or therapeutic “tricks” involved. What is needed is stable, ordinary, good parenting.

True healing through new relationships with foster parents not only involves the child attaching to foster parents, but also involves the foster parents being able to attach deeply to the child. In long-term care, this involves the foster parents loving the child as “one of their own”, despite the child having another set of (biological) parents. A child needs such committed love and a sense of belonging from the foster parents if he is to heal fully. A child really cannot form a genuine and appropriate attachment to an adult who is just “going through the motions” of routine care. Children can sense this, and it can lead to insecurity and accompanying behavioural problems.

However unless foster parents can be made to feel ‘secure’ about the placement, their capacity to attach deeply to a child in long-term care may be diminished. This is why ‘Permanency Planning’ of placements for young children needing long-

term care is so important, particularly when it is known early on that restoration to biological parents is not a realistic option.

### **UNDERSTANDING WHAT THE CHILD HAS SUFFERED.**

Behavioural problems in children are usually the outward expressions of emotional conflict or attachment damage. Most foster parents find that time spontaneously resolves many behavioural problems. Most children coming into long term care show improvements across many areas – physical growth, learning, emotional stability and eventually attachment change. However some abused children may not fully recover from their early traumatic experiences, or may show deterioration in behaviour during times of even minor crises for them.

So often the emotional climate in the foster home, particularly empathy for the child, is a core component in effecting positive behavioural change in the child. If the foster parents can truly understand the cause of the child's emotional turmoil, it makes it easier to tolerate and appropriately respond to. This is relevant in any situation involving distressed children.

#### **Example:**

*If a child is rude, angry and has a massive tantrum at school one day, there may be a temptation for a teacher to immediately set strong limits, to admonish the child forcefully in front of her peers and to punish the child with "time out". However if beforehand, the teacher had been told that the child's mother has recently died or has just deserted the family, the teacher would obviously be more empathic and would likely use different methods to deal with the child's anger, through recognising the distress that lay beneath this behaviour. The child would then feel she had been understood, and this would likely modify the behaviour.*

The same applies in the fostering situation. This is why it is so important for foster parents who take on children in long term care, to have a detailed knowledge of what the child has experienced in their biological family, or in previous foster placements. Sometimes workers are fearful of giving such detailed information to foster parents because they are concerned about confidentiality issues for the biological parents. Workers may also be worried that it will cause the foster parents to have negative feelings about the biological parents. However, such withholding of information can put the foster parents in an "emotional straightjacket" in terms of both their management of the child's behaviour and their empathy for what the child has suffered.

*Example:*

*Ricky (3) was placed in foster care when he was 20 months old, following physical abuse and emotional neglect. He was terrified of having a bath or going for a swim, and would scream loudly and kick whenever he had to do so. No amount of tender encouragement by the foster parents helped. The foster mother consulted a Psychologist who put the child on a Behaviour Management Programme (Star Chart rewards) but this did not work. Eventually the foster mother was referred to another Clinician who had known the biological family history. Ricky, while in the biological family had suffered many abuses, including several episodes in which he had been violently held under water as punishment. The knowledge of this quickly changed the foster mother's perception of this "behavioural problem" and she worked on more unorthodox ways of overcoming this, completely abandoning for the time-being efforts to coax Ricky into the bath. For example she initially encouraged him to bath a baby doll while only having showers himself. She talked to him about the "baby's"*

*fears of falling under the water, and encouraged Ricky to talk to the baby doll, to reassure the doll and to hold it tightly. When Ricky was eventually placed in the bath, the foster mother at first treated him like he was a baby taking his first bath, and in fact used a baby's bath for this. Ricky's confidence gradually increased and he began to run the bath for himself eventually gaining some measure of control in overcoming his fear. However it would have been much better had the foster family been informed from the outset of the specific abuses which Ricky had suffered.*

Having knowledge about the way abused children behave can also be helpful for the foster parent's understanding of what the child has experienced. While it is usually easy to understand the emotional pain of a child who looks sad, frightened or teary and has nightmares, many abused children may express their suffering in quite different and unusual forms. Repeatedly abused children often have had to build up "emotional barriers" to block out their emotional pain. When distressed, they may therefore show different sorts of behaviours from normal children – behaviours that on the surface do not reveal their deep sadness, fear or anxiety. These unusual behaviours can include:

- Excessive eating; gorging and hoarding of food (even when there is ample food available)
- Insensitivity to pain
- Rocking and other self-stimulating behaviour
- Blank staring episodes
- Reckless, manic, accident-prone behaviour
- Hypervigilance and hypersensitivity
- Sleeping disturbances, such as wandering in the night or going on "food raids" at night
- Provoking of rejection by the foster parents
- Self-harming activities such as head-banging, picking of sores

These are often indicators of a child's distress, even though on the surface the child may generally appear animated and happy.

## **FOSTER PLACEMENT AS AN ALIEN "ENVIRONMENT"** **FOR THE CHILD**

Foster parents sometimes report that what works in managing behavioural problems with their own biological children, may not always work with foster children, whose behaviour can be bizarre and even at times, quite frightening. It is well to remember however that these children have not had the normal "formative" experiences of growing up in a stable, loving home. They may have been subjected to all types of violence, chaos, disharmony and unsavoury criminal behaviours that even we as adults, may not have experienced in our own lives. Such experiences may have become the "template" or "norm" for family life, and these may be difficult to reverse especially for relatively older children.

### **Example:**

*Children who have never cleaned their teeth; washed their hands after toileting; slept between sheets or had a bedtime story read to them, may have no knowledge of such experiences. They may need repeated exposure to these in foster care before they become a normal part of family life for them, just as we have to give repeated and simple "teaching" to infants about such matters before they become automatic.*

### **Example:**

*Jody (11) and her younger siblings had been living in a car with their mother who prostituted to support her heavy drug use. The children had not attended school for some time. They were often observed on the streets of Kings Cross, accosting people for food or money. They*

*"swore like troopers" and had a precocious knowledge of adult sexual activity; drug use and anti-social behaviour. These children subsequently had major difficulties in adapting to normal family life and normal family "rules" in foster placement. Jody could not settle in this environment, being repeatedly provocative to foster parents and leaving the home at all hours. She eventually had to be placed in a Refuge.*

Coming into foster care, especially for the first time, may be like an alien experience for some children, no matter how pleasant this experience. Putting aside the issue of "grief" for their biological parents, the abrupt changes in lifestyle between the two households may be quite profound. The novelty of it all and the freedom from abuse and neglect, may be a relief for these children at least initially. As well, because of their attachment damage, they may not feel or show the expected grief about losing their biological parents. If this is the case, the child may initially seem to settle well into foster care, with few behavioural problems and even joyousness (often called the "honeymoon" period). But as time goes on, the attachment disturbance in such children may become apparent and behavioural/emotional problems may emerge, with many behavioural regressions and a reversion to "known" and familiar ways of relating and behaviour.

*Example: Peter*

*Peter was 7 when he was removed from his violent and neglectful biological home. Prior to this removal, he was displaying significant behavioural problems. He had severe temper tantrums, was defiant at school, was stealing and was very active. He had a diagnosis of ADHD and was on Ritalin. He had seen many clinicians who were unable to find the cause of his behaviour. Peter was placed in foster care with Mr and Mrs J. For the first three weeks, his behaviour was exemplary, both at home and at school. He seemed like a "different" boy. His activity level normalised, he was obedient to instruction and was very helpful*

*around the foster home. It became apparent that his previous behavioural problems were likely reactive to the abuse and neglect in his former home. Mr and Mrs J. found it hard to believe reports about his previous behaviour, because initially there were no signs of this. However after some weeks, Peter began challenging the rules in the foster home. He stole money from Mrs J's purse. At times he was rude and aggressive. The foster parents were astounded by this regression in Peter's behaviour, and sought advice from his treating clinician. They were helped to understand the meaning of the "honeymoon" period, and how such dramatic improvements in behaviour were unlikely to be sustained. Peter stayed on his medication; and was enrolled in the Little Athletics, a sport he loved but was previously not formally involved with. He and the foster father also did a lot of "male" activities together – fishing; camping and bike-riding. Over the months, Peter's tantrums became fewer and less intense. By the end of the first year of placement, Peter's behaviour had improved remarkably both at home and school, although he was still vulnerable to behavioural set-backs if he became stressed.*

Sometimes "fostering" can also feel like an alien environment for the foster parents, who may have successfully raised their own biological children but who may feel at a loss about how to manage the severe behavioural problems of their foster child. This can often lead to a foster parent feeling a "failure", and becoming depressed with lowered self-esteem. This is not an uncommon feeling, particularly in relatively new foster parents, but will usually pass as the situation improves. However if it does not, it may be advisable for the foster parents to consult with the agency about this.

## CHAPTER 8:

### UNDERSTANDING ATTACHMENT DISORDER IN ABUSED AND NEGLECTED INFANTS AND CHILDREN

#### THE NORMAL DEVELOPMENT OF DISCRIMINATE ATTACHMENTS

- As human beings we are biologically programmed to attach deeply to a small number of specific people, in strict hierarchical ordering.
- The most powerful initial attachment is the baby to the “mother” who does his day-to-day care.
- Attachment occurs gradually, but begins to show itself around six months of age when the baby begins to only want “Mum” and becomes distressed when separated from her, or when confronted by strangers i.e. the baby is now starting to be **discriminate** in his attachments.
- The baby will also begin to attach to other people with whom he has regular contact, particularly those who regularly give him love, care and stimulation.
- These attachment experiences become part of ongoing BRAIN development, and the brain automatically then responds to attachment cues eg: recognising the loved parent; having an expectation of how a loved parent will react etc.

## **ATTACHMENT DISORDERS**

- An Attachment Disorder impairs a child's capacity to make deep, empathic and secure relationships to others.
- Attachment Disorders have their onset in the first few years of life, although they may persist into childhood and adulthood.
- Attachment Disorders involve BRAIN CHANGES and are not under the child's conscious control. In fact, most children (and adults) who have serious Attachment Disorders, do not even realise that there is anything wrong with their attachments.

## **TYPES OF ATTACHMENT DISORDERS**

The two main types of Attachment Disorders (there are several others) are:

### **A. ANXIOUS ATTACHMENT**

The child (and adult) is able to make strong relationships to specific people, but these attachments are dependent, clingy, possessive and immature, with an intolerance to any separation from the loved person.

### **B. INDISCRIMINATE ATTACHMENT**

The child (and adult) may have a good interactional style, but there is a superficiality in attachments i.e. an incapacity to make and sustain deep attachments, and a lack of discrimination about whom the child/adult "attaches" to.

The next section will focus on Indiscriminate Attachment, which is the more difficult Attachment Disorder to treat.

## **CAUSES OF INDISCRIMINATE ATTACHMENT DISORDER**

- Children with Indiscriminate Attachment Disorder, have experienced severe disruptions of the brain and normal attachment processes.
- They have likely experienced such disruptions in an abusive/neglectful home during their earliest formative years:
  - **neglect** of their attachment needs i.e. their attempts to interact with caregivers do not get responded to  
and / or
  - repeated **disruptions** to their attachments eg: many changes of caretakers  
and / or
  - severe **rejection** of their attachment needs due to hatred of the child; scapegoating of the child etc.
- These experiences severely disrupt a child's attachment development. The child's brain changes and adapts, to assist them in psychologically surviving such neglectful / traumatic attachment situations.
- The brain does this by learning to "block out" the normal attachment cues which people normally use in their interactions with others.
- This results in the Indiscriminately Attached Child:
  - losing his capacity to be discriminate in relationships
  - not developing a proper capacity for empathy
  - does "learning" about the cues for nurturing.
- The child has NO INSIGHT into these incapacities, and they become part of "who he is" in terms of his attachment development (i.e. part of personality).

## **SOME SIGNS OF INDISCRIMINATE ATTACHMENT DISORDER**

Not all children with this Disorder have ALL of the symptoms listed below. Some children are more severely affected than others.

### **1. Lack of Discrimination in Relationships**

These children relate to familiar and unfamiliar people in the same way. They may show over-familiar behaviour towards complete strangers.

*eg: approaching strangers in the street*

*eg: initiating affection towards a stranger*

*eg: calling every female "Mummy"*

*eg: calling the foster parents "Mum" and "Dad" immediately*

### **2. Abnormal Reaction to Loss**

- When normally attached children lose or are separated from loved parents, they show signs of grief, anxiety and depression.
- However, children with Indiscriminate Attachment Disorder do not exhibit appropriate grief / feelings of loss/separation anxiety in such situations.

*eg: these children may "go off" with anyone.*

*eg: they may settle immediately into foster care with no distress or depression, even though they have just "lost" their entire family and familiar environment.*

### **3. Superficial Early Intensity in Relationships, but with an Inability to Sustain this.**

These children may be "full on" instantly in their "attachments" to new foster parents, but this may quickly dissipate once the "excitement" of the new placement wears off i.e. it is not really **true** attachment, but rather represents the child's initial positivity about the placement.

This is in contrast to normally attached children who will be grieving the loss of biological parents and will only gradually attach to new “parents” over a long period of time.

#### **4. Preoccupation with Physical Need Fulfillment over Attachment**

##### **Satisfaction**

Normally attached children like to be with their parents primarily because of their love for them, rather than what the parents give them “materially”.

However for children with serious Attachment Disorder, the “attachment value” of adults has been lost to them, and they may be much more focused on what they can materially exploit from relationships.

*eg: they may be more concerned about whether their new foster home has a swimming pool, than they are about the loss of the biological parents.*

#### **5. Insensitivity to Others Feelings**

These children are often self-seeking and insensitive to the needs of others, being unable to really empathise with others, despite sometimes knowing the “right words” to say. These children have not experienced empathy themselves as infants from their carers, and so are unable to transmit this to others.

However despite this lack of real empathy (feelings) there may be a cognitive understanding of how another person feels, sometimes with a manipulation of others’ feelings for self-gain.

## **6. Difficulty with Control of Aggression**

This may involve one or more factors:

- Many of these children have been subjected to violence in their early lives, and this becomes their automatic (adaptive) response for dealing with conflict or anxiety/fear.
- Some of these children have grown up in households in which they have been hated and rejected. Rage in the child about this rejection may become part of his core attachment model, even if he is unaware of the cause of this.

Often for such children, this rage may be hidden during the “honeymoon period” of early fostering, where the child’s material and other needs are being met in a way they have not been before. However when day-to-day life becomes routine, the rage may begin to break through. This is more than “just testing” of the foster parents, and may be activated over and over again in situations of even mild conflict or anxiety.

## **7. Premature Independence and Self-Sufficiency**

These children have learned from an early age that adults cannot be relied upon or trusted to give comfort/support and nurturing. So the child in a sense takes matters into her own hands by becoming prematurely self-reliant. This is sometimes called “survival” behaviour or “streetwise” behaviour.

*eg: A baby when hurt, does not seek comfort from a caregiver, but rather comforts / soothes herself.*

*eg: A seven year old who dresses, acts like and has the preoccupations of an adolescent.*

*eg: Some young people who leave home at a very early age to live on the streets.*

## CHAPTER 9:

### THE PROCESS OF REPAIRING ATTACHMENT DAMAGE

The reparative process in healing attachment damage is akin to how early attachments between infants and their parents develop and how early brain development takes place, although some aspects may be symbolically rather than realistically replicated.

In the early years during normal and intimate human attachment development, there is a long period of repeated and intense contact between parent and child during which emotional bonds form. Around five to six months of age, the baby only wants “mother”<sup>3</sup> and begins to show fear of strangers. For some time, the baby needs the mother’s continual presence to feel safe. As the child becomes older, he<sup>4</sup> learns to feel safe even when away from his mother i.e. the attachment has become “internalised” and more mature. As adults we have so “internalised” our attachments that we are able to sustain prolonged separation from our adult attachment figures with little emotional harm. We are also able to relate comfortably to strangers with little anxiety.

However the attachment-damaged child on coming into foster care might already present as being precociously “secure” in attachments i.e. showing ease with complete strangers, displaying no grief about the loss of biological parents etc. But this is a **false** security because this is really a child who is detached (indiscriminate) and has not achieved true attachment security by gradually working through the attachment stages to maturity.

Healing of this type of attachment damage can be seen when a previously “detached” child after some time in foster care, regresses to the clinginess /

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<sup>3</sup> “Mother” is used in the generic sense to denote the child’s known attachment figures.

attachment anxiety stage of infancy, even if the child is considerably older. This is really the first stage of repairing of attachment damage – this “clingy” stage may last a lot longer than in a normal baby – but is vital as a “stepping stone” to later mature and discriminate attachments.

*Example: Tiffany*

*Tiffany was admitted to hospital at age 11 months, with Failure-to-Thrive. She was severely underweight; appeared to be developmentally delayed and apathetic. She lay completely still but awake for prolonged periods. She was compliant to being picked up on the hospital ward by anyone including complete strangers, but was not responsive to them. After 2 weeks in hospital, Tiffany had made good weight gains, began to show some interest in her environment and was starting to “babble”. She also began to display “clingy” behaviour but she would do this to anyone, including complete strangers.*

*Tiffany went into good long-term foster care, with minimal contact with her biological parents. She “clung” to the foster mother – but also to anyone else who was available for some weeks after her placement. This seemed to be “empty” clinging, rather than it representing discriminate anxious attachment. Tiffany showed “catch up” in general development to normal levels within a few months, although her language development took a further 12 months to normalise. Her empty clinging stopped after a few months, and she became interactive but on an indiscriminate basis, being over-familiar with strangers.*

*After about 12 months in foster care, Tiffany gradually began to show “clingy” behaviour again but this time it was specifically directed towards the foster parents. She would become anxious if strangers*

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<sup>4</sup> “He” is used to denote baby/child, rather than the more cumbersome “he/she”.

*approached her, and reacted to even minor separation from her foster mother with distress. The foster mother responded to this as would the mother of a young infant going through the same behaviour. This insecure attachment behaviour lasted about 2 years before Tiffany began to exhibit secure attachment behaviour. She now presents as a well adjusted 8 year old who is doing well at school, has many friends and is deeply attached to her foster family.*

*Example: Melinda (10) and Kylie (7)*

*Melinda and Kylie were raised by their single mother who had a very unstable lifestyle, used heroin and was prostituting. The girls were often left with a variety of caregivers, some they did not know. Melinda had been sexually abused by her mother's boyfriend. The children were removed from the mother's care when Melinda was 3 years and Kylie 11 months. Over the next 3 years, the girls experienced six different placements, some of which were initially felt to be "long term". They experienced abuse in two of these placements.*

*When they came into their final placement with Mr and Mrs P, the girls were aged 6 and 4 years respectively. They were very indiscriminate in their attachments and were extremely attention seeking. They would approach complete strangers for affection. They called the P's "Mum" and "Dad" immediately on coming into care. The girls were also displaying sexualised behaviours; were aggressive; gorged large amounts of food; and would steal food and money. Melinda was also extremely controlling in her behaviour.*

*The foster parents were an emotionally mature couple, with strong attachments themselves. They were confident in their handling of the*

*children; had a good sense of humour; and showed much insight into the needs of these unusual children. The foster parents set very firm limits on the girls' inappropriate behaviours. The first year of placement was difficult and exhausting but after this, things started to improve.*

*Now, 3½ year later, the girls are showing strong and preferential attachment to Mr and Mrs P; they are doing well at school and have no major behavioural problems. They see their biological mother (who is very positive about their placement) once a month. The girls look forward to these visits and show no behavioural after-effects.*

## **WHAT TO DO ABOUT INDISCRIMINATE ATTACHMENT DISORDER**

- You cannot “talk” to a child about his Attachment Disorder to make him modify his attachment behaviour, although he may be “taught” certain behaviours e.g. not to approach strangers.
- There are no counselling or therapy programmes which can change Indiscriminate Attachment Disorder.
- “Treatment” of this Disorder can only occur through “A HEALING PARENTAL RELATIONSHIP”.  
i.e. full time placement in a loving predictable and stimulating environment for a prolonged period.

- Reversal of this Disorder takes place through

**REPETITIVE, RE- PATTERNING OF THE BRAIN'S ATTACHMENT AREAS.**

That is, through uninterrupted, "normal" loving parenting over a prolonged period (many months for infants, perhaps years for older children).

- However the process of reversal of such an Attachment Disorder will depend upon a number of factors:
  - The severity of the Attachment Disorder when the child first comes into reparative care (children who have suffered early chronic neglect seem to be more severely affected).
  - The age which the child comes into reparative care (the younger the child, the better the prognosis).
  - The quality of the foster parents and their capacity to provide loving, intimate, and stable care.
- This does not mean that older children with an Indiscriminate Attachment Disorder cannot benefit from foster care. They can – particularly in their social and educational skills, their anger management and their emotional stability – even if there is not a full reversal of their Attachment Disorder.

*Example: Sarah (11)*

*Sarah came into care at age 11. She had suffered chronic abuse and neglect, and was already in trouble with the Police. She was smoking cigarettes and truanting from school, and was quite rebellious. She had a severe attachment disturbance, being overly-familiar with strangers, little preoccupied with her biological family and showing little empathy in her relationships. Her experienced foster parents were aware that Sarah would have difficulty being part of a "close" family network. They*

*were aware of her attachment damage and so they had limited expectations that Sarah would become deeply attached to them. They thus set about primarily providing a safe, predictable environment for Sarah, and looked at practical ways for her to learn social skills e.g. organised sport, local Youth Group. Sarah stayed for three years in this placement. The foster parents became very fond of Sarah but were realistic about her long-term prognosis. Sarah's life stabilised and she settled well at school. However her Attachment Damage remained. She left the placement suddenly at age 15 when she ran off with her boyfriend, and has not contacted the foster parents or biological family since.*

## CHAPTER 10:

### THE ROLE OF "COMFORT" IN THE HEALING PROCESS

- Most of us learn to recover from injuries, emotional pain or distress through our early experiences of being comforted and reassured by loved ones when we are in these states.
- When a young baby is hurt or frightened, we naturally pick her up immediately, soothe her, rock her, tend to any physical hurts and hold her close until her frightened feelings subside. We often name the hurt
  - eg: "Ooh, you've hurt your arm" (while rubbing it).
  - eg: "Don't feel frightened – mummy is here" (while holding her)We tend to go "overboard" with young babies in this way if they are hurt or frightened. We do not make them endure their pain nor encourage them to "act tough". This "overboard" reaction is how a young baby normally initially learns about feelings.
- Thus the normal baby learns ***through experience*** to discriminate what is painful and what is not; what is dangerous and what is safe; and builds up an expectation that he can rely on adults to assist him and soothe him at times of distress.
- Such comforting at the time validates the child's feelings, and this is the basis for him later being able to discriminate and express his own feelings, and to be attuned to those feelings in others (empathy).
- However when an infant / child repeatedly experiences terrifying situations during abuse or witnessing domestic violence, the scenario is very different.

- There is no comfort because the one supposed to be comforting (parent) is actually the source of the fear.  
i.e. the pain is being inflicted by the very person who should be comforting the child.
  
- Thus for infants/children in such situations, there is often no place to turn for comfort in time of stress or fear, and no validation of how he is feeling.
  
- Most young abused children deal with such repetitive non-comforting situations, through DISSOCIATION i.e. a kind of psychological "switching off".
  
- They may do this by:
  - "Day dreaming" → "switching off" their thoughts.
  - "Switching off" pain sensitivity (some abused children do not seem to feel physical pain when injured).
  - By becoming emotionally "hardened" to incidents of loss / grief / trauma in themselves and others.
  
- This can result in abused children
  - Having difficulty in recognising their feelings of distress.
  - Not seeking comfort when hurt.
  - Not recognising and responding to physically painful stimuli (pain insensitivity).
  - Failing to recognise distress in others i.e. lack of empathy.

- This also applies to many neglected children (even in the absence of abuse) who have been deprived of comforting during normal distress episodes.
- Thus such children can present on the surface as not seeking comfort when physically hurt / distressed.

### **HELPING ABUSED CHILDREN DURING TIMES OF HURT AND DISTRESS**

- One of the aims of the reparative environment is to re-create the “infant” experience of being comforted when hurt or upset, and of having the distressing experience labelled and validated for them.
- Thus foster parents may initially have to “go overboard” in labelling / comforting, just like we would do with an infant. This is because the abused child may be so “hardened” to distress/pain that she will not recognise when it is appropriate to do so.
- This involves instances of both physical and emotional distress.

#### *Example: (Physical Issues – Jade (3½))*

*Jade had been raised in a violent and chaotic household. When she came into care at age 3, she did not respond to physical pain. If she fell heavily, hit her head or jammed her finger, she did not cry or even seem upset. Her foster mother was aware of how abnormal this was and sought advice. She was advised to react to every hurt in the child – no matter how minor, and to label this and provide comfort. When Jade next grazed her knee, she just kept playing, as though nothing had happened. The foster mother however went to Jade with a concerned look on her face, saying, “Oh Jade, you’ve*

*hurt yourself" (labelling). She then proceeded to elaborately wash, rub ointment into and bandaid the wound. Then she held Jade and rocked her, commenting on her sore leg. Afterwards, she asked about Jade's leg often. This routine was repeated for many months, every time Jade was injured, even in the most minor way. Gradually Jade's pain reaction normalised. She began to feel pain and to spontaneously seek comfort when hurt. While the foster mother initially had to exaggerate and "fuss" a lot about the injury, (just as mothers of normal infants do in such minor situations), eventually she did not need to do so, since Jade herself began to "label" her hurt and seek comfort.*

*This is a good example of the re-creation and repetition of aspects of the normal infant – mother relationship (although the child was well out of infancy) as part of the healing process.*

*Example: Emotional Pain – Edward (6)*

*Edward, on coming into care seemed a self-reliant child who never cried. He denied ever feeling hurt or upset when things went wrong. He was attached to his biological mother, but when she would fail to turn up for contact visits, he claimed he did not care. However after such incidents, Edward tended to become more defiant towards the foster mother. She understood that his anger towards her was really a projection of his anger towards his biological mother. She understood that underlying this anger, were feelings of sadness, grief and worthlessness, which Edward was having difficulty in acknowledging. Recognition of this was helpful in stopping a personal "battle of wills" between the foster mother and Edward. Initially the foster mother felt she should just let it "blow over" and after a few days Edward would settle down. However she realised that in the long term this was not really resolving the*

*problem for Edward, so she decided to face his distress with him. She told him she realised he was angry, disappointed and upset about his mother not turning up, and that she could understand this. She told him she understood why he became angry with her (foster mother) because his mother was not there to be angry with. Later when Edward was less angry, the foster mother cuddled him and reflected on his sadness at not seeing his mother, and commented that she knew how much he loved his biological mother. He cried for the first time in the placement and revealed his feelings that his own bad behaviour had made him come into foster care. The foster mother reassured him on this point, while holding and soothing him, providing him with brief factual information, while being careful not to denigrate his biological parents.*

### **ISSUES FOR COMFORTING**

- Immediacy of reaction – offer comfort at the time of the distress.
- Validation of the child’s feelings.
- “Labelling” the child’s feelings (verbal validation).
- Physical comforting of child (holding, rocking, tending to injury).
- “Emotional” comforting through empathy.

## CHAPTER 11:

### WAYS TO HELP THE REGULATION OF FEELINGS

- Very young children gradually learn to control their emotions partly through being rocked, held and nurtured by their carers, particularly when they are distressed or fearful.
- Such touching and holding also triggers the release of growth hormone, which is essential for optimum growth.
- Many abused children however have experienced
  - Too little touching/holding (neglect)

**OR**

- Too much or too aversive handling eg abuse; chaotic handling; abrupt and unpredictable handling.

Thus such children may have difficulties in modulating their emotions, since they have in essence “missed out” on the early, containing, predictable and tender handling which most infants experience.

- While modulating emotion may be harder to achieve in an older child coming into care, there are some ordinary holding/touching “games” which may help in this (especially when these are repeated).
  - Being rocked and sung to
  - Being rocked in a blanket (for older children, two adults can hold each corner).
  - “Moving games” like “Row Row Your Boat”.
  - Massaging of the child (baby massage is good for all ages) in appropriate areas of the body, such as hands, feet, shoulders etc.

- Teaching the child about the feel of his body (games where the child acts "hard and floppy", wriggling just one part of the body eg toe; "This Little Piggy").
  - Having the child in a swing facing the adult, with playful physical contact with the adult repeated again and again.
  - Rhythmical jumping in time on a trampoline.
  - Lots of hugging, cuddling, stroking.
- It must be acknowledged that it is not always easy to soothe, comfort and handle a child who has had little experience of this.
  - Some abused children may find such touching "aversive", especially those who are "hardened" or those who have been sexually abused. It may be that these "games" need to be introduced more slowly, in a group setting or initially less directly.
  - If possible, such touching "games" should be included naturally in the normal routines (as one would do for an infant), rather than setting aside a time for "therapy" eg. the foster parent rubbing of a child's feet and hands with lotion as part of a daily "routine", can provide valuable touching and attachment experiences for the child.
  - Remember that:
    - HOLDING
    - GAZING
    - SMILING
    - KISSING
    - LAUGHINGare all activities that lead to normal brain organisation.

## **VALIDATING FEELINGS**

- Many abused children have problems with feelings:
  - They cannot control them (temper tantrums; running away).
  - They cannot express them (the child who never cries).
  - They cannot name them.
  
- There are some interactions foster parents can initiate which can enhance children's acknowledgement of feelings.
  - Acknowledge how the child feels; "you seem sad today"; "this makes you so happy".
  - Validating the child's feelings; "I'd be angry too if that happened to me"; "that must have made you feel so sad"; "you must have felt really scared when you heard that".
  
- There are some "games" to play which can develop children's acknowledgement of feelings.
  - Make faces/gestures and have the child "label" the feeling you are expressing.
  - There are many children's books dealing with facial expressions – go through these with the child, labelling these, and then encouraging the child (and you) to mimic these expressions.
  - Ask the child to label "feelings" in other people he observes eg. while out on a shopping trip; when with other children.
  - Talk to the child about your own feelings about shared events, while not overwhelming him with "adult" issues.

## CHAPTER 12

### WAYS TO HELP RAISE SELF-ESTEEM

- Praise and a genuine interest in a child does a great deal for a child's self-esteem and sense of worth.
- However many children coming into foster care have not experienced being praised or being told how valuable they are.

#### Ways To Raise Self-Esteem

- Make the child feel a "special" member of the family through terms of endearment which gives the child a specific valuable role in the family;
  - eg: "the littlest angel" in our family.
  - eg: "my brown-eyed girl".
  - eg: "my garage mate".
  - eg: "my No. 1 helper".
- Take pride in "adorning" the child with beautiful clothes; ornaments (hair clips) and on occasions perfume, lotion etc. Many children coming out of neglectful houses have not had the experience of being "valued" in this way, ie. by a parent expressing their positivity to the child through adornments.
- Have a growth chart on the wall, so the child's height can be measured, dated and publicly recorded. Regular weighing and recording of this on the chart is also helpful. This shows the child that you are interested in his development and that he is unique.

- Display a large photo of the child in a prominent position, and draw visitor's attention to this in front of the child (the child may want to choose which photo is to be enlarged for this purpose).
- Displaying the child's artwork and merit certificates publicly eg: on the fridge.
- "Dressing up" games.
- Doing the child's hair for her, even though she may be at an age where she can do her own. This can be turned into a ritual intimacy (attachment behaviour) between the foster parent and the child.
- Doing "count-downs" on a calendar or chart for the child's birthday or other events that are uniquely hers.

## CHAPTER 13

### HELPING THE CHILD GAIN A SENSE OF CONTROL (MASTERY)

1. One of the main issues for abused children is one of control. Generally they have in the past felt powerless in the midst of abusive or rejecting experiences. However these feelings may later exert themselves as an extreme need for control in some children, or an extreme passivity/submissiveness in other abused children.

2. Ways to help such children gain a true sense of control can be through:

- Providing firm, predictable "rules" about family functioning and behaviour.
- Giving the child lots of **choices**, even though these choices may seem trivial.

*eg: "Do you want your egg hard or soft?"*

*eg: "Would you like to wear the blue dress or the orange dress?"*

While these choices may seem inconsequential to adults, these may be the abused child's first experience of his views being respected and being able to make a choice about his environment. This gives him a sense of mastery (control). Such choices will not undermine parental authority.

3. Getting into a "battle of wills" about what a child should do, usually only escalates the conflict. While there are some issues about which the child cannot really have a choice (eg. holding an adult hand while crossing the road), the elements of choice can still be invoked.

*eg. "Do you want to hold my right hand or my left hand?"*

## CHAPTER 14:

### THE CHILD WHO IS "TOO GROWN UP"

One aim of healthy development is to produce an 'independent' adult – one who has mastered his/her environment; who has initiative; and who is not too dependent on others for decision-making. True independence in adulthood comes about gradually, and in an ordered way over many years – from being wholly dependent as a baby to undergoing many transitional stages throughout childhood and adolescence gradually giving up this dependence on one's parents.

However many abused children do not go through these normal developmental processes to achieve **true** independence. Rather many have not experienced true dependence as babies / toddlers / children, and have been forced **too early** in their development to be "grown up" in order to meet their parents' needs. However this is a false (pseudo) independence / maturity and represents abnormal development.

This pseudo-independence can present itself in different ways in abused children:

- eg: The baby / toddler who can amuse himself for hours with no demands on parents; who does not seek help when hurt; who gets things (eg. food) for himself; who tidies up like a much older person; who does not ask for help when this would be appropriate.
  
- eg: The child who is "parentified" in that she is always preoccupied about the well being of others, particularly parents and younger siblings; "mothers" her younger siblings to an unusual degree; and whose behaviour is mainly focused on meeting adults' needs rather than her own.

eg: The young child who is already “streetwise” as a result of having to survive in a hostile and unsavoury environment. Such children even those of primary-school age, may have the preoccupations and behaviours of adolescents, and they may find it difficult to observe age-appropriate rules.

Some people wrongly believe that such precocious “independence” in a child is a positive thing, especially if the child is well behaved and highly attentive to adult needs (eg. making few demands on adults; cleaning up a lot; being able to hold a good “adult” conversation etc). However this is a **false** maturity and can later lead to significant personality and mental health problems, as well as precluding some of the normal enjoyment of just “being a child”.

Foster parents can help turn this around by providing an environment in which the child is able to experience “true” dependence on his carers, in the way that a young baby / toddler does. Of course this will be much easier with younger children, and may take place naturally as part of their “attachment” healing. It will be however much more difficult to reverse the “streetwise” persona of the older child.

*Example:*

*Fiona (7) and her sister Kiara (2) came into long-term care with Mr and Mrs P. Initially Fiona was very “parentified” towards Kiara. She had been used to feeding, dressing and bathing her younger sister, but was also quite controlling of her. She continued this role as “mother” to Kiara on coming into care, and seemed resentful of Mrs P’s attempts to parent Kiara. Fiona criticised Mrs P. about how she folded Kiara’s nappy and the types of food offered to her sibling. She would instruct Mrs P. about which clothes Kiara should wear and what time she should go to bed.*

*Wisely Mrs P. did not get into a battle of wills with Fiona about who would be Kiara’s “mother”. Mrs P. understood why Fiona behaved in this way and sought*

*advice from her worker about how to handle the situation. She remained respectful of Fiona's knowledge about her sister, often asking Fiona's advice about Kiara and including Fiona in some of Kiara's caretaking. However at the same time she encouraged Fiona to bring her new friends from school home so that Fiona began to focus on more age-appropriate activities. Gradually over the next few months, Fiona relinquished most of Kiara's caretaking to Mrs P., although she still tended to be quite controlling of her young sister in other ways.*

**CHAPTER 15:****UNDERSTANDING REGRESSION (SET BACKS) AND CRISES IN LONG-TERM FOSTER PLACEMENT**

While an abused child's way of dealing with distress or conflict in the foster home, may be quite inappropriate, it is well to remember that in many cases, this is how he may have learned to survive in an abusive environment. Such survival skills may not be easily given up or quickly re-programmed.

While abused children often make great gains in foster care, they may still revert to inappropriate behaviours, especially when stressed. As human beings, we all do this, in a crisis, even if we do not like how we behave.

*For example, how often have we said to ourselves "I will never talk to my children the way my mum/dad spoke to me", and yet when we are stressed or angry, we are taken aback to hear ourselves using the same dreaded words our parents used to us.*

Abused children are no different in this regard, and when stressed or angry they may often do or say things, that mimic the abuse they suffered or witnessed in their biological family.

eg: declarations of hatred or bizarre threats to the foster parents.

eg: regression to previously discarded abnormal behaviour eg: head banging; severe tantrums; self-harming behaviours.

It is important that foster parents see such regression in context, and do not feel that "all is lost" because of such temporary setbacks. Such behaviours will usually become less frequent as time goes on. However for some children these behaviours may continue to arise during times of "crisis." It will be important too that foster parents do not feel personally rejected by such outbursts, as in most cases this is not intended. If a foster parent takes on board such threats as a

personal attack on themselves – rather than a re-creation of early experiences – then this can ironically set up the cycle of rejection once again for the foster child.

Many foster parents find that it is the “**crises**” which occur in foster care that provide instances of accelerated healing even more than the ordinary routine incidents of family life. This is because a crisis can be an opportunity for the child to face the past trauma (in an attenuated form); to be comforted by a loved parent; to have his fears/anxieties acknowledged and validated; and to have “survived” such an incident. This can give him a sense of mastery and resolution.

*Example:*

*Sam (aged 7) had suffered physical and emotional abuse, before being removed from his biological home at age 5. He went immediately into long-term foster care, where he was often defiant and provocative. However from time to time he would have outbursts of distressed, angry crying for no apparent reason. The foster parents found Sam hard to handle at times, and they were concerned that Sam did not seem attached to them. One day Sam and his foster mother were involved in a heated verbal conflict, after which Sam rode off angrily on his bike, had a crash and broke his arm. He was hospitalised for several days, during which time the foster mother roomed-in with him. She was very attentive to his needs and very comforting to him. She apologised to him for her role in the conflict preceding the incident. Sam became quite “clingy” to the foster mother during this hospitalisation. She in turn felt that Sam’s distress and neediness for her, increased her attachment to him. Sam was weepy for several weeks after the incident, each time being comforted and reassured by his foster parents. Following this, Sam settled much better in the foster*

*placement, with fewer behavioural problems and a gradually increasing attachment to his foster parents.*

## **REGRESSION TO "BABY" LIKE STATES**

- Many abused / neglected children have missed out on the normal touching, cuddling, nurturing of infancy which most of us take for granted and which are the "building blocks" of healthy development.
  
- While it is not possible to completely re-create and "re-do" what has been missed with an abused child earlier in his life, sometimes aspects of this early mother-baby relationship can be recreated.  
eg: allowing an older child to suck from a bottle, if he initiates this.  
eg: allowing "baby talk" when the child is feeling very vulnerable.  
eg: rocking/stroking the child, like a baby when he is distressed or is just feeling "sooky".  
eg: actually feeding the child, even when she is capable of doing so herself.  
eg. reading "baby" books to an older child.
  
- Such "going back" to early child-parenting interactions can be very helpful in the healing process. Sometimes foster parents worry that such regression may undermine the child's competencies. However this is unlikely. Most children only regress in "short bursts" in specific areas while still maintaining age-appropriate skills and behaviours in other areas in other situations (eg. with peers, at school).

## **"REGRESSION IN THE FOSTER PARENTS"**

Sometimes foster parents too, may experience such "regressions" themselves when stressed or angry. All parents do this from time to time. In most cases, these are normal parts of family interactions, but they may be particularly frightening to the foster parents if they themselves have been abused or neglected as a child.

Sometimes in these situations the abused child may (unwittingly) "stir up" aspects of the foster parent's own abusive past which they have tried hard to forget and resolve. When faced with angry or distressed interactions with the foster child, some memories of the foster parent's own unhappy childhood – a gesture, a look, a phrase or piece of behaviour – may be evoked. The foster parent may become overwhelmed with intense negative feelings (anger, sadness, distress) which catches them completely off-guard. This may cause them to behave in ways uncharacteristic for them. This can lead to feelings of guilt, distress and shame in the foster parents. If this is an issue for foster parents, it is advisable that they seek some professional help – this may be the point at which such help is the most effective.

### *Example:*

*Carole had an unhappy childhood, following the death of her mother when she was 5, and the quick introduction of a step-mother who came to the family with children of her own. The step-mother was quite rejecting of Carole. Her emotional abuse of Carole often took the form of humiliation, especially comments about Carole's appearance.*

*Carole grew up and married a well functioning man and they had two children, who appeared to be well adjusted. When these children reached adolescence, Carole decided to foster. After several successful short-term placements, two children Grace (7) and James*

*(2) came into her care. James settled in well but Grace was missing her biological parents despite their previous rejecting behaviour towards her. Grace was quite precocious in her presentation and had previously been in a "parent" role to her own parents. Grace was quite an assertive child who was angry about being in foster care. A couple of months into the placement, Grace and Carole became involved in a hostile altercation about a minor issue. Grace was very angry and began to personally denigrate Carole, saying she was fat and ugly and hated her. Carole, at these comments, herself became overwhelmed with an intensity of rage she had not felt for many years. She smacked Grace on the back, but soon after felt great remorse and guilt. She apologised to the child, although Grace was initially reluctant to accept this apology. Carole in great distress phoned her caseworker and informed her what had occurred. She told the caseworker she had never used any physical discipline with her own biological children, and was ashamed of her uncharacteristic behaviour. The caseworker removed Grace from the placement on a temporary basis, and spent a great deal of time talking with Carole about the incident. It became apparent that Grace's verbal denigration of Carole had in a sense, evoked the very specific emotional abuse (and the accompanying feelings) which Carole had experienced as a child. She was caught quite off guard by her sudden, intense and overwhelming feelings of anger and distress. Carole agreed to attend some individual counselling which she found very beneficial. She was also able to talk to Grace (with the worker present) about her sorrow at the event. Grace was surprisingly accepting of this later apology. Following this their relationship improved, although there were still rocky times ahead. Grace and James remained in this placement for a further two years, and made significant gains there. However Carole decided that after*

*the placement ended (with restoration), she would not foster again. She and her husband maintain some contact with these children, through phone calls, gifts and occasional (Christmas/birthday) contact.*

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