Three things you need to know about the child who experienced trauma at home

And what to do about it!

A Short Introduction to the Kinship CARE Project

By Colby Pearce

©Colby Pearce
Principal Clinical Psychologist,
Secure Start®
463 Belair Road
BELAIR
SOUTH AUSTRALIA 5052
p. 618 82789358
m. 61403350411
Email: colby@securestart.com.au
Web: securestart.com.au
Blog: colbypearce.net

All rights reserved.

© Not to be reprinted, shared or disseminated in any form without the prior permission of Colby Pearce

Prologue: *Punishment is Problematic*

People do not act for no reason.

They may act in response to a thought.

They may act in response to an emotion.

They may act in response to a need that requires satisfaction.

They may act in response to something that has occurred in their environment.

They may act because the way their brain developed impairs their capacity to think before they act in the presence of a trigger (stimulus).

If we accept the truth that people do not act for no reason, then we must similarly accept that when we punish a child for their actions without any effort to try to understand why they did what they did, we are essentially communicating to them that their thoughts, feelings, needs, experiences and biological characteristics are unimportant or invalid. Repeated often enough, the child develops the belief that ***they*** are unimportant and invalid.

The consequences of invalidation include behavioural problems, emotional problems, preoccupation with needs and a lack of regard for the impact of one's behaviour on others.

We can avoid perpetuating maladaptive behaviour in children by responding with understanding to the reason for their behaviour and, in doing so, nourish connections that support their self-regulation and adherence to behaviour conventions.

Introduction to the Kinship CARE Project

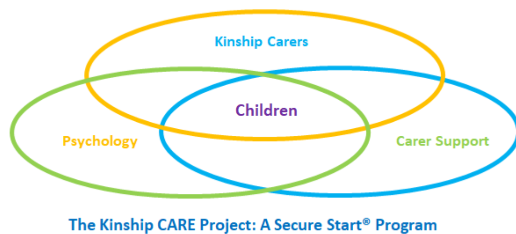
In South Australia, forty-six percent of children in out-of-home care with an authority to place are in a kinship care placement. Kinship care is the largest form of out-of-home care in South Australia and is growing almost 50% faster than foster care[1].

The Kinship CARE Project

C Consistency
A Accessibility
R Responsiveness
E Emotional Connectedness

securestart.com.au

Given the circumstances in which children enter their care, regardless of jurisdiction, kinship carers typically receive less preparatory training than foster carers. In South Australia, Kinship carers have also been recognised to have received less ongoing training support than foster carers[2]. Proportionately, kinship carers are recognised internationally as being less advantaged, and experiencing greater family complexity, than foster carers. Notwithstanding these factors, children placed with kinship carers enter care for the same reasons as children placed in other forms of out-of-home, and with similar issues[3].



The Kinship CARE Project: A Secure Start® Program

The Kinship CARE Project commenced in March 2018 to provide trauma-informed training about the characteristics and therapeutic care requirements of children in kinship care placements. As part of the Kinship CARE Project, kinship carers, kinship care support staff and selected DCP Psychology Staff receive training in the CARE Therapeutic Framework (Consistency, Accessibility, Responsiveness, Emotional-Connectedness)[4].

Training for kinship carers incorporates four half-day workshops, scheduled two-weeks apart, followed by a call-back session three months after the initial four sessions. The format of the implementation sessions is as follows:

Session 1:

- What is therapeutic care and what does it require of you?
- The importance of achieving *connection* as a *primary task.*

Session 2:

- Enriching children's experience of caregiver *consistency* and *accessibility*.
- Self-Care (Part 1)

Session 3:

- Enriching children's experience of caregiver *responsiveness*.

Session 4:

- Enriching children's experience of caregiver *emotional connectedness*.
- Self-Care (Part 2)

Call-Back:

- Addressing behaviours of concern using the CARE Therapeutic Framework

Training for kinship carers recognises that, though it shares many similarities with foster care, kinship care has its own unique characteristics. The language used when delivering the CARE Therapeutic Framework is tailored to the unique characteristics of kinship care. Though the program is trauma-informed, reference to concepts such as *trauma*, *abuse* and *neglect* is de-emphasised, in favour of more generic concepts, such as *adversity* and *children having had a tough start to life*. This is considered to be extremely important in the kinship care space, where a sense of family *shame* is a salient factor. There is an imperative to attract and retain kinship carers in such initiatives, rather than alienating them by invoking experiences of shame.

In addition, there is a focus on supporting carers to develop an understanding of how to implement therapeutic re-parenting in their own individual circumstances. That is, there is a focus on assisting carers to *know what to do*, and to develop a tailored therapeutic re-parenting Plan. Psychological theory is presented sparingly and only in support of the rationale (and evidential basis) for recommended approaches. Accessibility of the content is supported through a multi-modal approach to delivery that includes practical activities, demonstrations and audio-visual content in support of verbal content. Regular individual and group reflection activities also support understanding of the program content. Kinship care support workers regularly attend sessions with carers on their caseload, further supporting caregiver accessibility to the content and shared experience of the program.

Training for kinship care support workers and psychology staff is similar to that which is delivered to kinship carers, except that there is a focus on the implementation of the Framework in kinship care support workers' practice with kinship carers, and psychologists' practice with kinship care support workers. That is, there is a layered approach to implementation, whereby kinship carers experience CARE from their support workers, and support workers experience CARE from psychologists trained in the Framework. This approach is followed to support embeddedness of the Framework in the kinship care program, and fidelity to the Framework.

The CARE Therapeutic Framework promotes human *Connection* as a primary task[5], where the *primary task* is defined as the one task that we need to get right and upon which the success of all endeavour rests. There is a robust and ever-growing evidence base for the role of connection in supporting optimal emotional and behavioural outcomes for young people and adults alike[6,7,8].

The Kinship CARE Project aims include:

- Implement the CARE Therapeutic Framework in the Kinship Care Program in South Australia;
- Establish a common knowledge, language and approach among kinship carers, kinship care support workers, and psychologists who support both;
- Develop competencies related to trauma-informed, therapeutic re-parenting of children in kinship care, and competencies in the implementation of a practice framework that supports fidelity to the therapeutic re-parenting approach;
- Develop competencies in self-care;
- Support empowerment and self-efficacy in the respective roles of participants of the program; and
- Improve connections between kinship children and their carers, and connections between kinship carers and Agency staff who work in the kinship care space.

Three things you need to know about the impact of trauma at home

Trauma at home adversely impacts three key factors that play an important role in the developing child's approach to life, learning/development, and relationships:

- Attachment (or, how the child thinks about, and interacts with, themselves, others and their world);
- Arousal (or, the psycho-physiology of performance, emotion and behaviour activation systems);
- Accessibility to needs provision (or, what the child has learnt about the accessibility and responsiveness of adults in a caregiving or caretaking role).

Attachment refers to the dependency relationship an infant develops to his or her primary caregivers during the first years of life. Our knowledge of attachment derives from Attachment Theory. Attachment Theory was initially developed in the 1940's, in part to account for observations that were being made of institutionalised children and those who experienced prolonged separation from their primary caregivers; including by reason of lengthy hospital admissions and those children displaced from their families during World War II[9]. Since its early development, Attachment Theory has been the focus of an enormous amount of research and has become widely used in child protection as it offers an explanatory framework for differential outcomes for children based on caregiving practices. In addition, Attachment Theory informs us about a child's relationship with themselves, others and their world.

Relationship with:

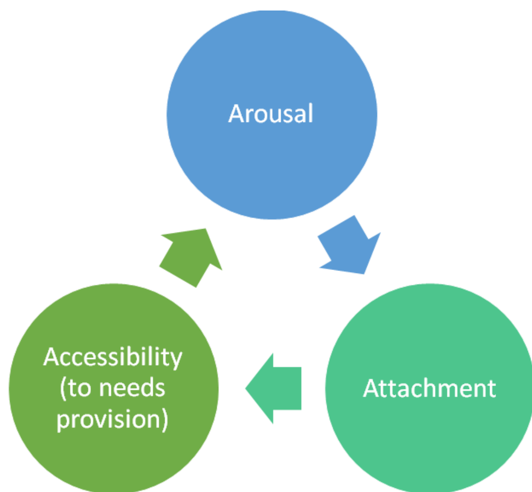
- Self
- Other
- World

Arousal refers to the level of activation of the nervous system. From a psychological point of view, arousal is significant for (at-least) three reasons. Firstly, arousal affects how well we perform tasks, and activities more generally. Secondly, arousal is implicated in how we feel. Thirdly, arousal is implicated in how we behave, including our approach to life and relationships. In particular, arousal is implicated in the behaviour activation system that is activated when individuals perceive a threat to themselves or someone close to or close by them and their associated feeling of anxiety (known as the *fight-flight-freeze response*).

- Performance
- Feelings
- Behaviour

Accessibility to needs provision refers to what children have learnt about the reliability and predictability with which their needs will be addressed by adults in a caregiving role, and learnt behaviours that serve to reassure the child that their needs will be satisfied. Accessibility to needs provision is based on Learning Theory and the Operant Conditioning paradigm[10, 11].

What children have learnt



In combination, I refer to these three factors as the "Triple-A Model"; or "Triple-A" for short[12]. In the Kinship CARE Project training we support awareness of these factors and how they are impacted by caregiving practices. We offer guidance and reflective learning in support of each participant developing a tailored Plan for implementing therapeutic care and practice in the role they perform; whether that be in the home or in support of a therapeutic home. In doing so it is our intention to support secure attachment, optimal arousal, and trust in accessibility to needs provision for children who are recovering from trauma at home.

Supporting Strong Connections that Heal

The connection we have with others, and their connection with us, is a powerful form of influence over behaviour. When a person feels connected to others, the expectations and standards of those others exert a powerful influence over the person's behaviour. The stronger the connection, the stronger the influence. The same applies to a sense of connection to groups, and to society. The more connected and integrated a person feels in their society, the greater the influence of the society's rules and norms over their behaviour[13].

Connection influences more than just behaviour. In a 2012 survey of 14,500 young people in Ireland aged 12-25 years, those young people who did not report having at-least one person in their life who listens, can be relied upon, and is trusted to help in times of difficulty (often referred to as *One Good Adult*) reported higher levels of:

- Depression and Anxiety
- Anti-social behaviour
- Risk of suicide . . .

. . . than those young people who reported having at least one adult that they can depend on[14]. *Connection matters*!

Sadly, many troubled children who have experienced trauma at home are growing up without making and maintaining close connections with others; especially adults. As such, they are at increased risk of emotional and behavioural problems that adversely impact functioning and adjustment. We can facilitate improved life outcomes for these children by making connections with them that support them having *at least one person in their life who listens, can be relied upon, and is trusted to help in times of difficulty*. We can all be that One Good Adult that makes a difference to the developmental and life trajectory of a troubled child.

In the Kinship CARE Project, connection is the *primary task*[15]; or that one thing that we need to get right in order to have the best chance of success in our endeavours.

Making Connections

Connecting with a troubled child who has experienced trauma at home involves facilitating, for them, the experience that they are in their carers' head and in their heart. That is, their carer is thinking about them, cares about them, and is there for them.

Primary Task:

Connection

I am with you. You are in my head and in my heart.

Making connections starts with adopting a certain mindset:

- That nobody does anything for no reason;
- That behaviour is communication;
- That it is not what a person does, but why they do it, that is important;
- That we learn from experiences (and it is from new experiences that new learning occurs); and
- It is the relationship we share with others, and their relationship with us, that is the most powerful form of influence we have over their behaviour.

Mindset:

Nobody does anything for no reason.

Behaviour is communication.

We learn from experience

This mindset gives rise to required thinking:

- What is going on for you?
- What can I do to communicate that you are in my head and in my heart?

Thinking:

What is going on for you?

What can I do to show that you are in my head and in my heart?

©Colby Pearce 2019

In the Kinship CARE Project, answers to what is going on for the child who has experienced trauma at home is drawn from the Triple-A Model[16]. That is, their behaviour is likely to be under the influence of one or more of:

- Their experience of themselves, others and their world;
- Their arousal level; and,
- What they have learnt about accessibility to needs provision.

In terms of what to do to address the performance and adjustment of children who have experienced trauma at home, in the Kinship CARE Project we recommend the implementation of a CARE[17] Plan:

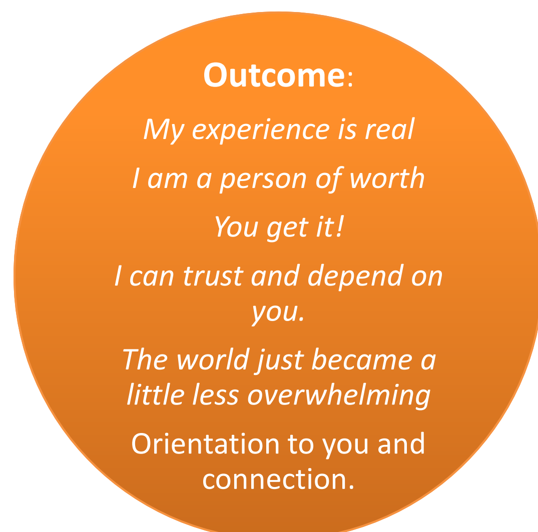
- Consistency
- Accessibility
- Responsiveness
- Emotional-Connectedness.

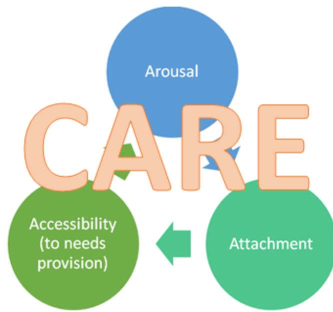
In the Kinship CARE Project, we guide participants though the development and implementation of a CARE Plan in a step-by-step way.

The CARE Plan

By implementing a CARE Plan, participants have five strategies for supporting the child's experience of connection. Anticipated outcomes for the child are thoughts that:

- their experience is real;
- they are a person of worth
- you get it;
- they can trust and depend on you; and,
- the world just became a little less overwhelming.

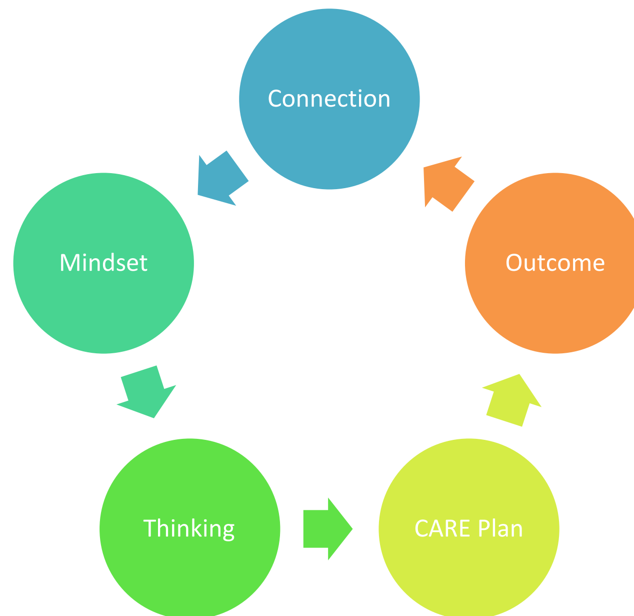




Implemented consistently, the strategies recommended in the CARE Plan promote secure attachment representations, optimal arousal for performance and wellbeing, and trust in accessibility to needs provision. Implemented consistently, the child who has experienced trauma at home will connect back with their carer, with the result that their functioning will increasingly be regulated by a concern for their relationship with their carer and with being and remaining on good terms with their carer.

.

Relationships are the most powerful form of influence we have over the behaviour of children. Where deficiencies in care created the problem, enriched CARE will address it!



A final comment

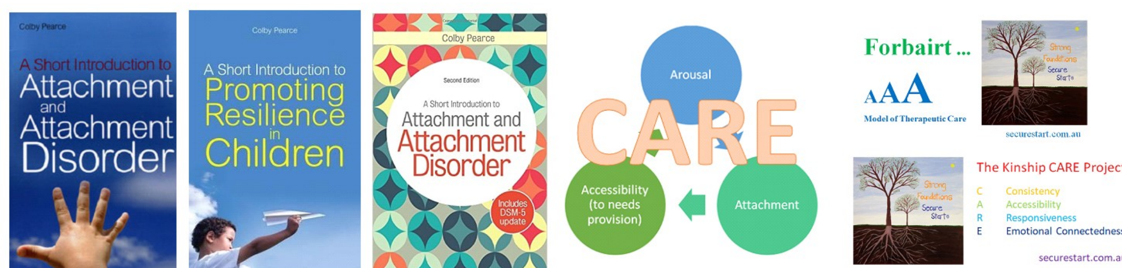
Thank you for taking the time to read and consider this *Short Introduction to the Kinship CARE Project*. For more information about the Project, and the thinking and practice behind it, visit securestart.com.au or colbypearce.net.

Locations and scheduling of upcoming carer training sessions can be found at http://securestart.com.au/kinship-care-project-2018-19/

If you are an employee of the Department for Child Protection (DCP) in South Australia it would be great if you could share information about the Kinship CARE Project with carers of children on your caseload who are kinship carers.

If you are reading this and are not in South Australia, please email me to discuss a potential implementation project. My email is colby@securestart.com.au.

Colby Pearce – Project Principal
On behalf of the Protect Team
April 2019



---

[1] Department for Child Protection, Reporting and Statistics

[2] *The Life They Deserve*, Hon. Justice Nyland, 2016

[3] Delfabbro, P. (2017). Relative/kinship and foster care: A comparison of carer and child characteristics. Pathways of Care Longitudinal Study: Outcomes of Children and Young People in Out-of-Home Care. Research Report Number 7. Sydney. NSW Department of Family and Community Services.

[4] Pearce, C (2016*). A Short Introduction to Attachment and Attachment Disorder (Second Edition).* London: Jessica Kingsley

[5] Kahn, W. A. (2005). *Holding Fast: The Struggle to Create Resilient Caregiving Organisations.* Hove and New York: Brunner-Routledge

[6] Dooley, B & Fitzgerald, A (2015). *My World Survey: National Study of Youth Mental Health in Ireland.* UCD School of Psychology, Headstrong

[7] Ottman, G, Dickson, J, & Wright, P. (2006). *Social Connectedness and Health: A Literature Review*. Cornell University GLADNET Collection

[8] O'Rourke, H. M., & Sidani, Souraya. (2017). Definition, Determinants, and Outcomes of Social Connectedness for Older Adults: A Scoping Review. *Journal of Gerontological Nursing, 439*(7), pp 43-52.

[9] Bretherton, I. (1992) The Origins of Attachment Theory: John Bowlby and Mary Ainsworth. *Developmental Psychology,* 28: 759-775.

[10] Skinner, B. F. (1938) *The Behaviour of Organisms: An Experimental Analysis*. New York: Appleton-Century

[11] Ferster, C.B. and Skinner, B.F. (1957) *Schedules of Reinforcement*. New York: Appleton-Century-Crofts

[12] Pearce, C.M. (2010) An Integration of Theory, Science, and Reflective Clinical Practice in the Care and Management of Attachment-Disordered Children: A Triple-A Approach. *Educational and Child Psychology (Special Issue on Attachment),* 27 (3): 73-86

[13] Pearce, C. (2016), A Short Introduction to Attachment and Attachment Disorder (Second Edition). London: Jessica Kingsley Publishers

[14] *My World Survey*; Dooley and Fitzgerald (2012)

[15] Kahn, W. A. (2005) *Holding Fast: The Struggle to Create Resilient Caregiving Organisations*, Hove and New York: Brunner-Routledge.

[16] Pearce, C.M. (2010) An Integration of Theory, Science, and Reflective Clinical Practice in the Care and Management of Attachment-Disordered Children: A Triple-A Approach. *Educational and Child Psychology (Special Issue on Attachment),* 27 (3): 73-86

[17] Pearce, C (2016) *A Short Introduction to Attachment and Attachment Disorder (Second Edition).* London: Jessica Kingsley Publishers