

Promoting Social and Emotional Well-Being by Facilitating Healing and Recovery

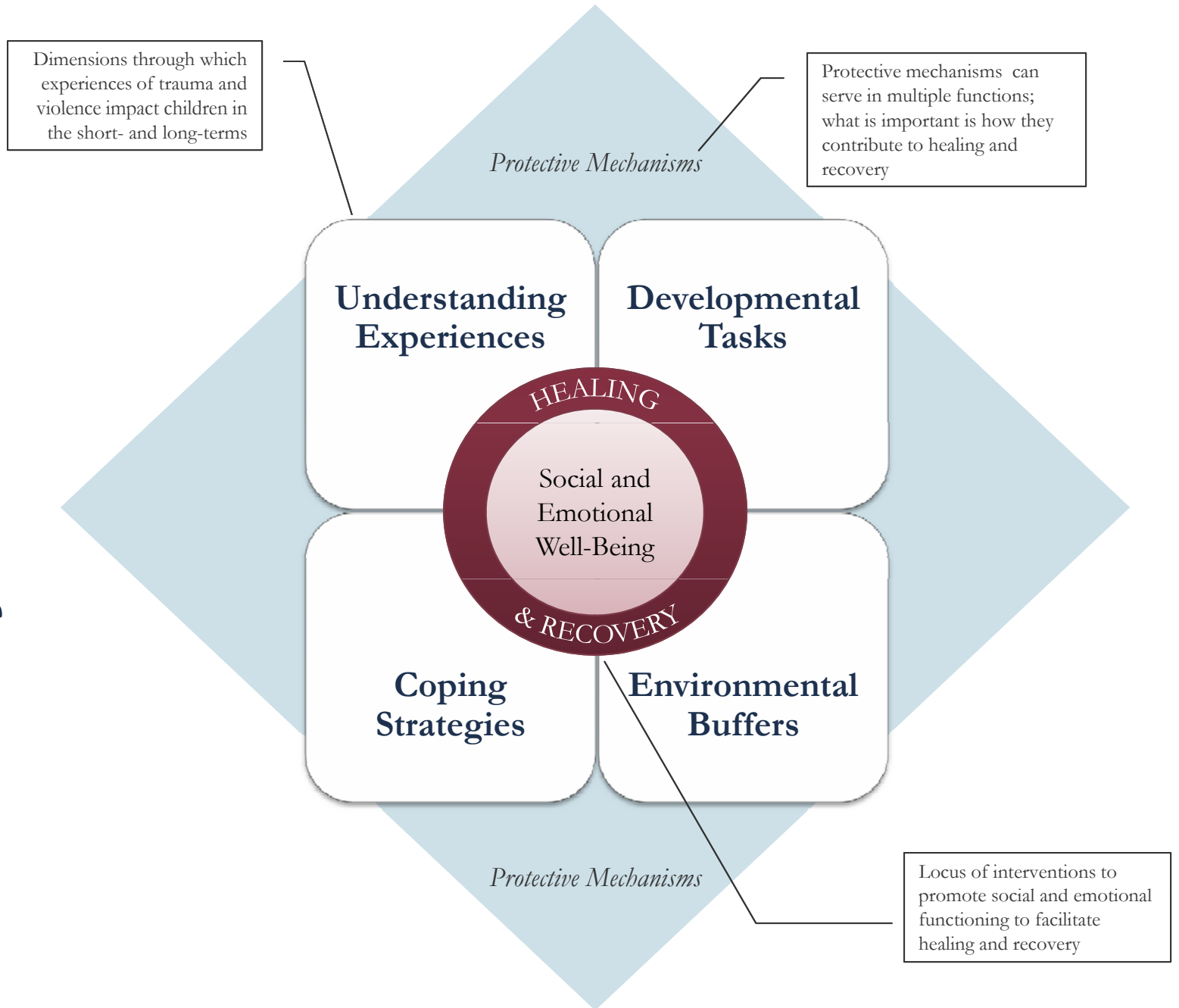
THE CRITICAL INTERPLAY OF RELATIONSHIPS AND BRAIN DEVELOPMENT

*Bryan Samuels, Commissioner
Administration on Children, Youth and Families*

U.S. Department of Health and Human Services
Administration for Children and Families



Promoting Social and Emotional Well-Being to Facilitate Healing and Recovery



Child welfare interventions should focus on the repair or establishment of protective, supportive, and emotionally responsive adult relationships.

Through these emotionally positive and strong, fundamental relationships, children and youth will thrive in safe, permanent homes with access to the physical health, mental health, and educational resources necessary for long-term well-being.

Facilitating Healing and Recovery to Promote Social & Emotional Well-Being

FY 2012: \$28 MILLION

- **Integrating Trauma-Informed and Trauma-Focused Practice in Child Protective Service Delivery** (\$3.2 million, 5 grantees)
- **Improving Service Delivery to Youth in the Child Welfare System** (\$1.4 million, 4 grantees)
- **Child Welfare-Early Education Partnerships to Expand Protective Factors for Children with Child Welfare Involvement & Child Welfare-Education System Collaborations to Increase Educational Stability** (\$4.3 million, 18 grantees)
- **Family Connections Grants: Using Family Group Decision-Making to Build Protective Factors for Children and Families** (\$3.4 million, 7 grantees)
- **Permanency Innovations Initiative, Year 2** (\$15.3 million, 6 grantees)

Child and Family Services Improvement and Innovation Act of 2011 (P.L. 112-34)

Reauthorization of Promoting Safe and Stable Families (PSSF) includes new language addressing trauma and vulnerable populations:

- State plans shall include an outline of “how health needs identified through screenings will be monitored and treated, ***including emotional trauma associated with a child’s maltreatment and removal from home.***”
- State plans shall describe “***how the State identifies which populations are at the greatest risk of maltreatment and how services are targeted to the populations.***”

“Traditional child welfare approaches to maltreatment focus largely on physical injury, the relative risk of recurrent harm, and questions of child custody, in conjunction with a criminal justice orientation. In contrast, when viewed through a child development lens, the abuse or neglect of young children should be evaluated and treated as a matter of child health and development within the context of a family relationship crisis, which requires sophisticated expertise in both early childhood and adult mental health.”

National Scientific Council on the Developing Child (2004). *Young Children Develop in an Environment of Relationships: Working Paper No. 1*. Retrieved from www.developingchild.harvard.edu

Childhood Trauma and Physical Health

- CDC Adverse Childhood Experiences (ACE) Study:
 - Over 17,000 men and women surveyed.
 - Average age = 57 years
 - Members of San Diego HMO
 - Participants surveyed on 10 types of adverse childhood experiences
- Impact of 4+ ACEs
 - 1.3x physical inactivity
 - 1.6x severe obesity
 - 1.9x any cancer
 - 2.2x heart disease
 - 2.4 x stroke
 - 2.5x STDs
 - 7.4x alcoholism
 - 10.3x injected drug use
 - 12.2x suicide attempt

Felitti, J. et al. (1998). Relationship of Childhood Abuse and Household Dysfunction to Many of the Leading Causes of Death in Adults The Adverse Childhood Experiences (ACE) Study. *American Journal of Preventive Medicine*. 14(4):245.

Impact of Chronic Fear and Anxiety on Brain Development

- Advances in the science of child development tell us that significant fear-eliciting experiences early in life can disrupt the typical development of stress regulation as well as learning, memory, and social behavior.
- Heightened stress has been shown to impair the development of the prefrontal cortex, the brain region that, in humans, is critical for the emergence of executive functions—a cluster of abilities such as making, following, and altering plans; controlling and focusing attention; inhibiting impulsive behaviors; and developing the ability to hold and incorporate new information in decision-making.
- The extent to which children with a heightened attention bias to threat view the world as a hostile and threatening place can be viewed as both a logical adaptation to an abusive environment and a potent risk factor for behavior problems in later childhood, adolescence, and adult life.
- Children who have had chronic and intense fearful experiences often lose the capacity to differentiate between threat and safety. This impairs their ability to learn and interact with others, because they frequently perceive threat in familiar social circumstances, such as on the playground or in school.

National Scientific Council on the Developing Child (2010). *Persistent Fear and Anxiety Can Affect Young Children's Learning and Development: Working Paper No. 9*. Retrieved from www.developingchild.harvard.edu

Chronic Interpersonal Trauma and Relational Health

- Children experience their world as an environment of relationships, and these relationships affect virtually all aspects of their development – intellectual, social, emotional, physical, behavioral, and moral.
- Healthy development depends on the quality and reliability of a child's relationships with the important people in his or her life, both within and outside the family. Even the development of a child's brain architecture depends on the establishment of these relationships.
- Children who have healthy, sensitive, and responsive relationships with their primary caregivers are more likely to develop empathy, stronger cognitive skills, enhanced social competence, and work skills

National Scientific Council on the Developing Child (2004). *Young Children Develop in an Environment of Relationships: Working Paper No. 1*. Retrieved from www.developingchild.harvard.edu

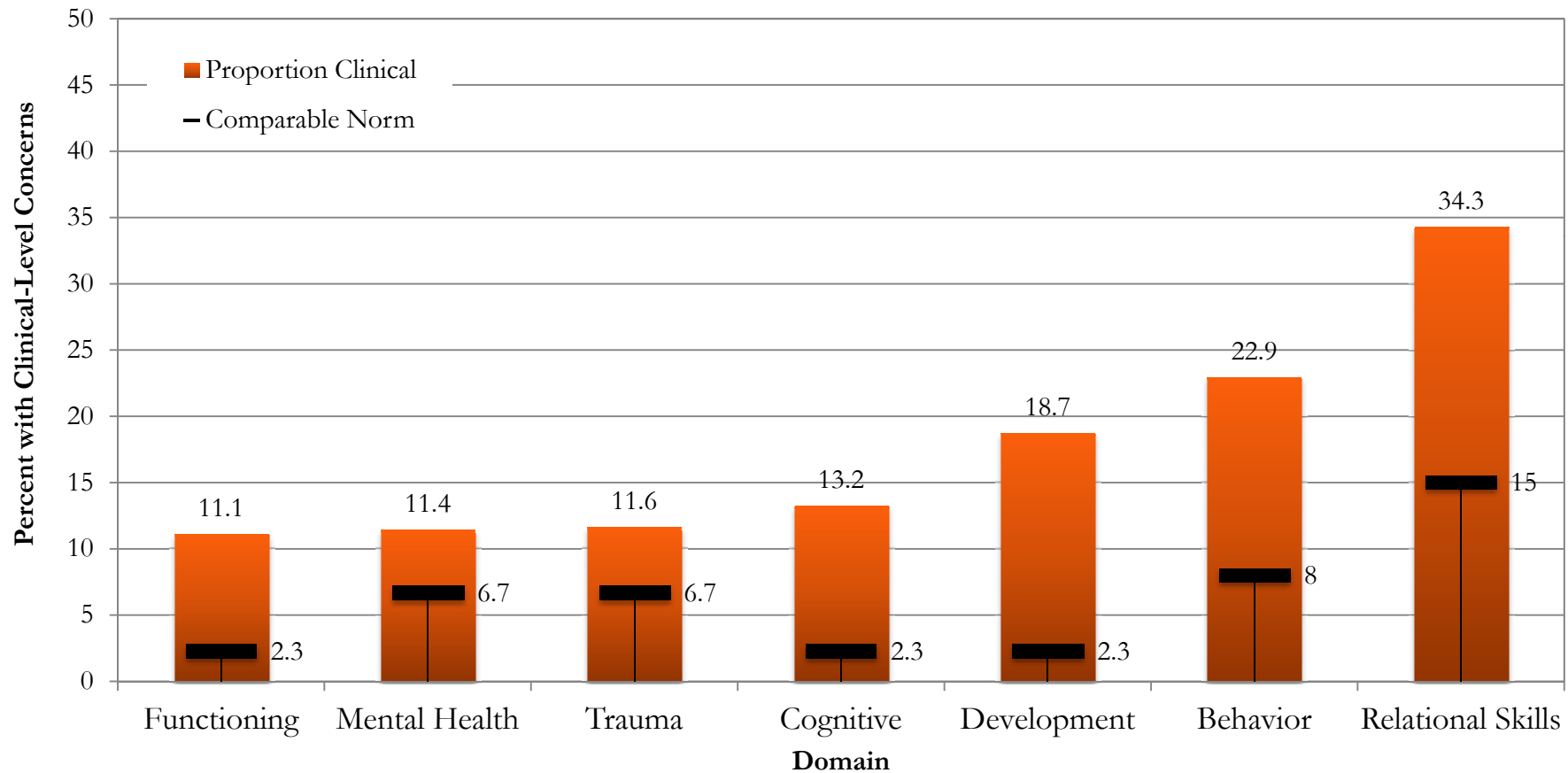
Chronic Interpersonal Trauma and Relational Health, *cont'd*

- The effects of maltreatment can influence relationships across a person's lifetime,¹ and they are particularly salient when a maltreated child attempts to form a new relationship with a primary caregiver or later romantic or marital partner.²
- In a study of maltreated 9- to 13-year-old children, Milan and Pinderhughes found that those with the most negative representations of their relationships with biological parents had less positive perceptions of their foster parents as well.³
- Foster children frequently demonstrate externalizing behaviors or poor emotion regulation, which can be interpreted by the foster parents as rejection of the foster family.⁴

1. Cicchetti, D, & Blender, JA. (2004). A multiple-levels-of-analysis approach to the study of developmental processes in maltreated children. *Proceedings of the National Academy of Sciences*. 101(50):17325.
2. Mikulincer, MI Shaver, PR. (2007). *Attachment in Adulthood: Structure, Dynamics and Change*. New York, NY: The Guilford Press.
3. Milan, SE & Pinderhughes, EE. (2000). Factors influencing maltreated children's early adjustment in foster care. *Development and Psychopathology*. 12(1):63.
4. Dozier, M , Stovall, KC, Albus, KE, Bates, B. (2001). Attachment for infants in foster care: The role of caregiver state of mind. *Child Development*. 72 :1467.; Hughes, D. (2004). An attachment-based treatment of maltreated children and young people. *Attachment & Human Development*. 6(3):263.; Kagan, R. (2004). *Rebuilding Attachments with Traumatized Children*. Binghamton, NY: The Haworth Maltreatment and Trauma Press.

The experience of maltreatment compromises the well-being of children across multiple domains

Clinical-Level Concerns across Domains for Children Reported to CPS, General Population Comparison, 0-17



Source: National Survey of Child and Adolescent Well-Being II, US Department of Health and Human Services

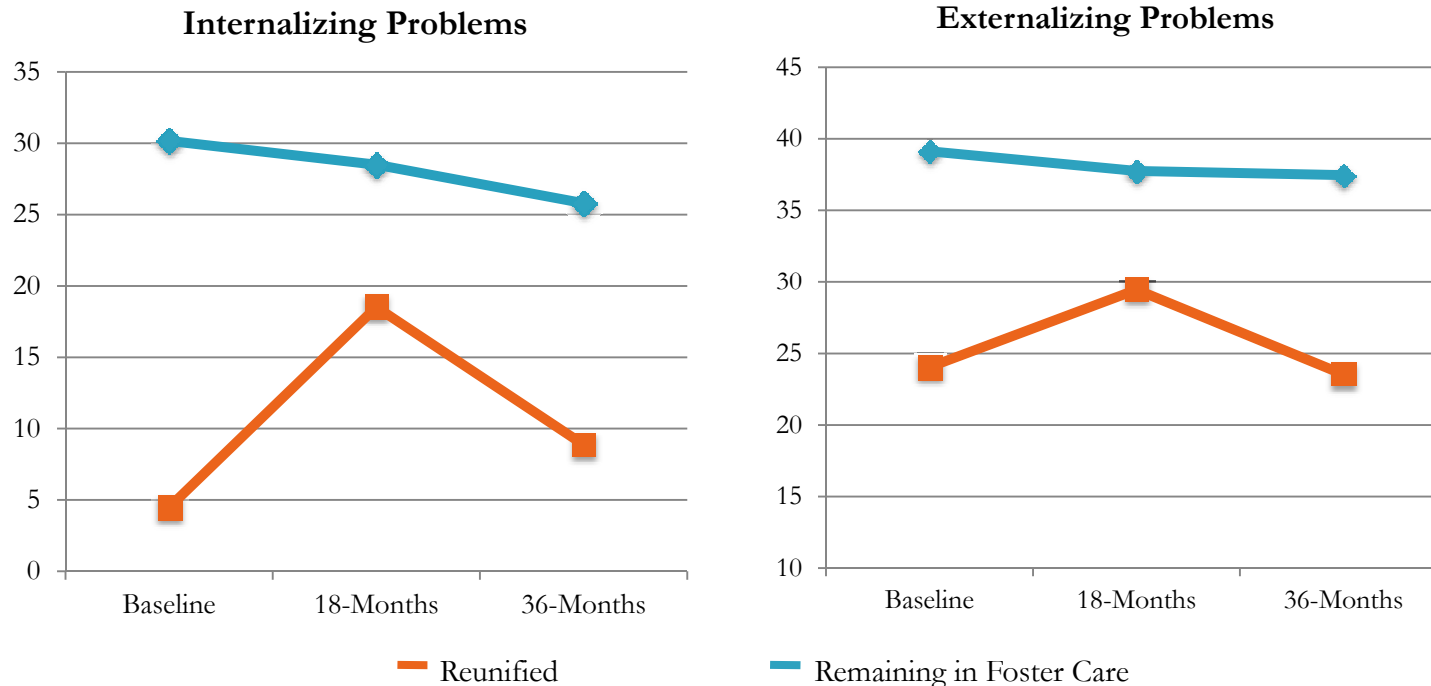
Functioning: Vineland Adaptive Behavior Scale (VABS; Screener Daily Living Skills Domain), 0-17 years; Mental Health: Children's Depression Inventory (CDI; depression), 7-17 years; Trauma: Trauma Symptom Checklist for Children (TSCC; post traumatic subscale), 8-17 years; Cognitive: Kaufman Brief Intelligence Test (K-BIT; cognitive composite), 4-17 years; Development: Battelle Developmental Inventory, 2nd Edition (BDI-2; cognitive developmental quotient), 0-47 months; Behavior: Child Behavior Checklist (CBCL; problem behaviors total), 1.5-17 years; Relational Skills: Social Skills Rating System (SRSS; social skills), 3-17 years;

“Simply removing a child from a dangerous environment will not by itself undo the serious consequences or reverse the negative impacts of early fear learning. There is no doubt that children in harm’s way should be removed from a dangerous situation. However, simply moving a child out of immediate danger does not in itself reverse or eliminate the way that he or she has learned to be fearful. The child’s memory retains those learned links, and such thoughts and memories are sufficient to elicit ongoing fear and make a child anxious.”

National Scientific Council on the Developing Child (2010). *Persistent Fear and Anxiety Can Affect Young Children’s Learning and Development: Working Paper No. 9*. Retrieved from www.developingchild.harvard.edu

Persistence of Problems after Permanence: Reunification

- Compared with youth who were not reunified, youth who returned home displayed increasing levels of self-destructive behavior, substance use, and total risk behaviors. Reunified youth were more likely to have received a ticket or have been arrested, to have dropped out of school, and to have received lower grades . Reunified youth reported more current problems in internalizing behaviors, and total behavior problems and lower total competence¹
- Following reunification, children who have been in long-term foster care are more likely to have increases in the severity of internalizing problems due to increased exposure to risk factors and decreased system supports²



1. Taussig, HN; Clyman, RB & Landsverk, J. (2001). Children who return home from foster care: A 6-year prospective study of behavioral health outcomes in adolescence. *Pediatrics*. 108, e10.
 2. Bellamy, J. (2008). Behavioral problems following reunification of children in long-term foster care. *Children and Youth Services Review*. 30:216.

Persistence of Problems after Permanence: Kinship Care

Kinship placements are not predictive of mental health outcomes. When compared to other patterns of placement, kinship care alone did not show significant effects on adult mental health outcomes.

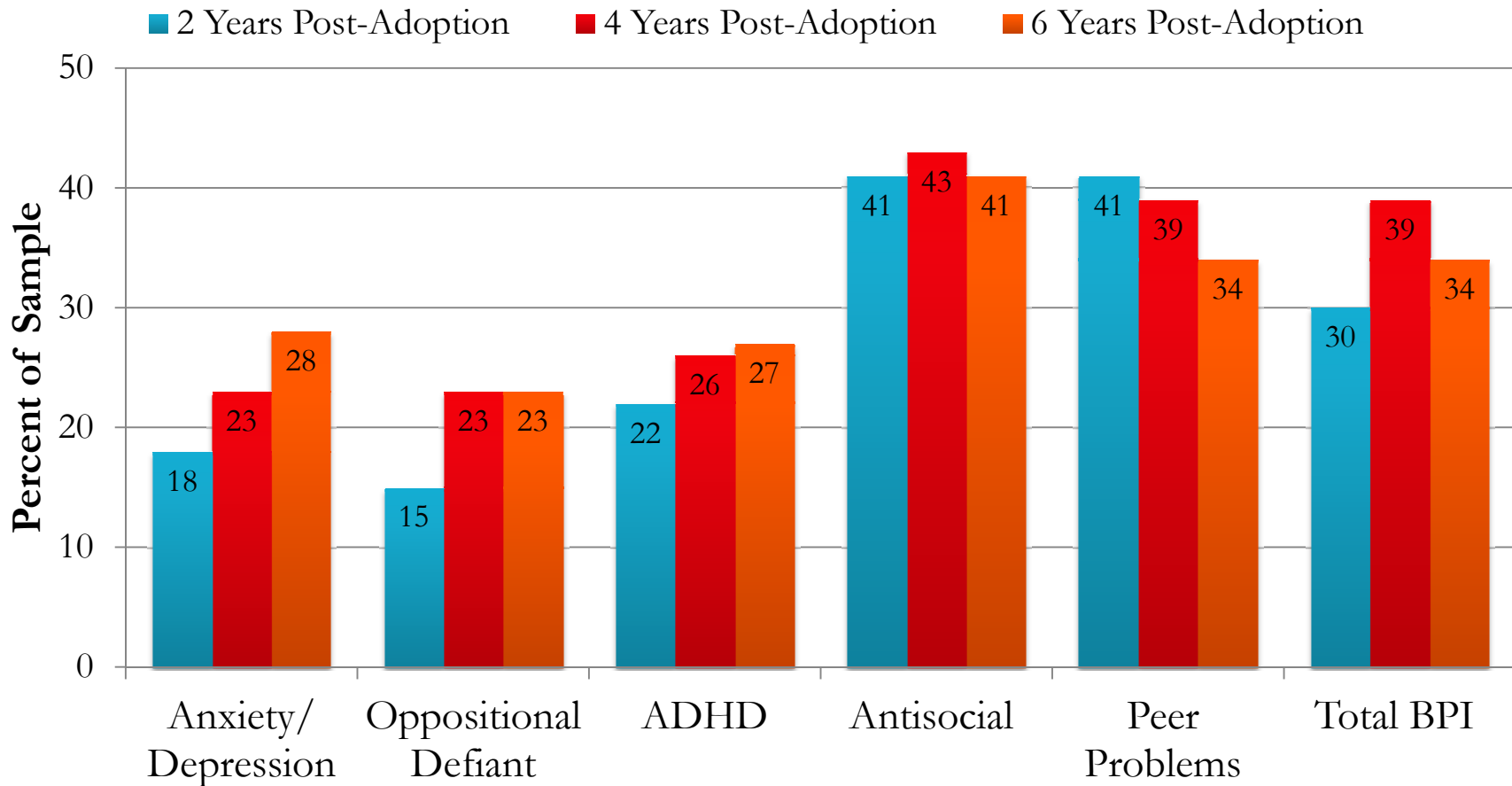
Outcome	Kinship Groups					Overall
	100% of time in kinship care	More than 50% of time in kinship care	50% or less time in kinship care, fewer than 9 placements total	50% or less time in kinship care, 9 or more placements	No time in kinship care	
CIDI DSM diagnosis	50%	45%	46%	48%	46%	46%
Three or more Diagnoses	12%	18%	12%	18%	12%	13%
Major Depression Episode	12%	17%	14%	18%	15%	15%
Panic syndrome	4%	5%	12%	6%	12%	12%
Modified Social Phobia	12%	14%	10%	13%	12%	12%
Generalized Anxiety Disorder	4%	8%	13%	12%	9%	9%
PTSD	23%	18%	17%	30%	22%	22%

Average age was 30.5 years old, ranging from 20 to 49.

Source: Roller White, C; Havalchak, A; Jackson, L; O'Brien, K & Pecora, P. (2007) *Mental Health, Ethnicity, Sexuality, and Spirituality among Youth in Foster Care: Findings from the Casey Field Office Mental Health Study*. Casey Family Programs.

Persistence of Problems after Permanence: Adoption

Difficulties at 2, 4, and 6 years post-adoption from foster care

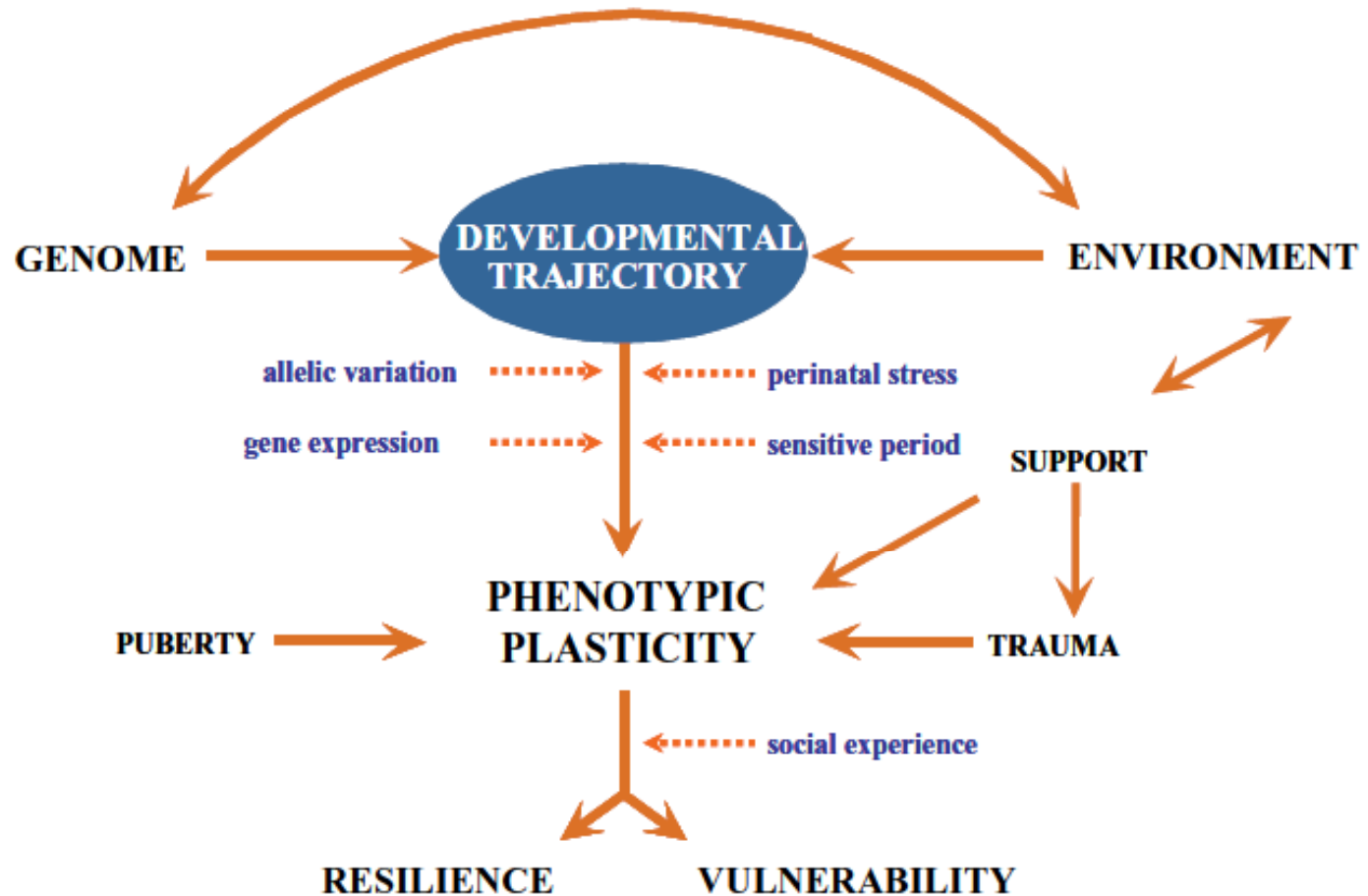


Source: Simmel, C.; et al. (2007). Adopted youths psychosocial functioning: A longitudinal perspective. *Child and Family Social Work*. 12(4):336. BPI: Behavior Problems Index

“[There is a] complex interplay between social experiences and brain development wherein the brain’s malleability to experiences like abuse or neglect can result in maladaptive outcomes such as neurodevelopmental impairment, and its malleability to experiences encountered in the average, expectable environment can result in improvements in language abilities or behavior, even given initial biological and social constraints (Cicchetti & Curtis, 2006).”

Jaffee, SR. (2007). Sensitive, stimulating caregiving predicts cognitive and behavioral resilience in neurodevelopmentally at-risk infants. *Development and Psychopathology*. 19(3):631.

Resilience is a function of genetic and environmental influences



“Exposure to violence and trauma alone, regardless of stage of development, does not produce adverse effects in all maltreated children, and the risk of development of mental health disorders, in part, clearly heritable. ... For those individuals exposed to early life trauma, both genetics and environment interactions likely influence the development of depression and other disorders. Notably, the genetic variants described by several studies only confer the risk of depression and PTSD in the setting of childhood maltreatment. These data highlight the critical role of developmental timing and environmental influences on the expression of genetic risk of psychiatric illness. Continued efforts to elucidate the genetic variables that confer risk and resilience on individuals exposed to stress during development may enhance our ability to protect and more effectively treat young women and to identify “at-risk” populations.”

Neigh, Gillespie & Nemeroff, The Neurobiological Toll of Child Abuse and Neglect, Trauma Violence Abuse 2009 10: 389-410.

Establishing or repairing of a protective, emotionally responsive child–adult relationship for a maltreated child or a child at risk of maltreatment should be the central focus of child welfare services.

- If we choose to intervene on behalf of maltreated children, it is incumbent on us to rehabilitate the capacity of these children to engage in healthy relationships.
- “Acute care” forms of child and adolescent mental health services are poorly matched to the service needs of a disadvantaged child population presenting with complex attachment- and trauma-related psychopathology, and unstable living arrangements.¹
- Moreover, child welfare professionals may be acutely aware of the traumatic events that brought the child to the system’s attention, they may be far less cognizant of the complete trauma history the child has experienced or of the connection between that history and the child’s current behavior or emotional response to stresses.²

1. Leslie LK; Kelleher KJ; Burns BJ; Landsverk J; & Rolls JA. (2003). Foster care and Medicaid managed care. *Child Welfare*. 82(3): 367-392.

2. Taylor, N et al. (2005). “Helping children in the child welfare system heal from trauma: A systems integration approach.” Los Angeles, CA and Durham, NC: The National Child Traumatic Stress Network.

Overcoming Adverse Context & Modeling Healthy Relationships

- Even with the emotional deficits maltreated children bring to placements, sensitive and warm foster or surrogate parents can make a difference in developing quality relationships with maltreated children in their care. Responsive and sensitive caregiving from professional caregivers predicts the development of secure attachment relationships, similar to findings from biologically intact child–mother dyads¹
- Dozier et al. (2001) found that very young maltreated children (i.e., 20 months and younger) may initially push foster mothers away, but are able eventually to organize their attachment behavior to fit with the caregiving behavior of a nurturing foster mother. If the foster mother is not responsive and nurturing, a maltreated child is at high risk of developing a disorganized attachment to the foster mother. But a security-enhancing parent or surrogate parent who can look beyond a child's disruptive behaviors and emotional volatility may promote the development of a secure attachment orientation in a child.²
- In general, the level of commitment to a child from a surrogate parent along with sensitive and responsive parenting appear to be the critical components associated with placement stability or placement disruption (Dozier & Lindhiem, 2006).³

1. Dozier, M, & Rutter, M (2008). Challenges to the development of attachment relationships faced by young children in foster and adoptive care. In Cassidy, J & Shaver, PR (Eds.). *Handbook of Attachment: Theory, Research, and Clinical Applications* (2nd edn). New York, NY: Guilford Press.; Goossens, FA & van Ijzendoorn, M H. (1990). Quality of infants' attachments to professional caregivers: Relation to infant-parent and day-care characteristics. *Child Development*. 61(3):832.
2. Dozier, M , Stovall, KC, Albus, KE, Bates, B. (2001). Attachment for infants in foster care: The role of caregiver state of mind. *Child Development*. 72 :1467.; Hughes, D. (2004). An attachment-based treatment of maltreated children and young people. *Attachment & Human Development*. 6(3):263.; Dozier, M. , Stovall, K.C., Albus, K.E., Bates, B. (2001). Attachment for infants in foster care: The role of caregiver state of mind. *Child Development*.72:1467.
3. Dozier, M. & Lindheim, O. (2006). This Is My Child: Differences Among Foster Parents in Commitment to Their Young Children. *Child Maltreatment*. 11(4):338.

Social Emotional Well-Being: What does it look like?

Domains/Constructs	Indicators	Sources for Extant Measures
Self-management	Age-appropriate autonomy, emotional self-regulation, persistence, constructive time use	(Seligman, 2002); PISA, TIMMS
Agency	Planfulness, resourcefulness, positive risk-taking, realistic goal-setting, motivation	(Matthews et al., 2006; Rychen & Salganik, 2001; Snyder, 2005)
Sense of purpose	Believing one's life is meaningfully connected to a larger picture	(Damon et al., 2003; Matthews et al., 2006)
Confidence	Positive identity and self-worth	(Lerner et al., 2005; Lerner et al., 2008)
Social Intelligence	Communication, cooperation, conflict-resolution skills, trust, intimacy	PISA; National Survey of Children's Health (NSCH)

Adapted from: Lippman, LH; Moore, KA & McIntosh, H. (2011). Positive indicators of child well-being: A conceptual framework, measures, and methodological issues. *Applied Research in Quality of Life*. Accessed on August 16, 2011. <http://www.springerlink.com.proxy.uchicago.edu/content/tr32721263478297/>.

Social Emotional Well-Being: What does it look like? (Cont'd.)

Domains/Constructs	Indicators	Sources for Extant Measures
Environmental awareness and behavior	Knowledge, positive behaviors	ECEP
Risk management skills	Skills and knowledge to avoid drug and alcohol use and risky sex	HBSC; National Longitudinal Survey of Youth (NLSY); National Longitudinal Survey of Adolescent Health (Add Health)
Critical thinking	Evaluation/analytical/problem-solving skills	PISA
Knowledge of essential life skills	Financial management, decision-making skills, home maintenance, etc.	
Positive relationships with peers, siblings, family, etc.	Warmth, closeness, communication, support, positive advice	(Volling & Blandon; 2005), EU-SILC; (Matthews et al., 2006); Add Health; What Young People Think (UNICEF Opinion Poll)

Adapted from: Lippman, LH; Moore, KA & McIntosh, H. (2011). Positive indicators of child well-being: A conceptual framework, measures, and methodological issues. *Applied Research in Quality of Life*. Accessed on August 16, 2011. <http://www.springerlink.com.proxy.uchicago.edu/content/tr32721263478297/>.

Effective Approaches to Promoting Social and Emotional Well-Being

Essential Considerations	Activity
<i>Elements of Healing and Recovery</i>	
Understanding Experiences	Cognitive-Behavioral Interventions Teach Identification of Controllable and Uncontrollable Circumstances
Developmental Tasks	Developmental Screening Developmental Intervention Provide Meaningful Responsibilities to Promote Mastery and Accomplishment
Coping Strategies	Cognitive-Behavioral Interventions Relaxation and Self-Control Strategies Encourage Expression of Feelings, Positive and Negative
Environmental Buffers	Protective Factors Assessment Promotion of Protective Factors Parenting Interventions
<i>Clinical Considerations</i>	
Trauma	Screening De-escalation Psychological First-Aid Trauma-focused Interventions
Behavioral Health	Screening Cognitive-Behavioral Interventions
Mental Health	Screening Psychological First Aid Mental Health Interventions

Evidence-Based Interventions

Diagnosis/Concern/Activity	Evidence-Based Interventions
Screening Activities	
Identification of Mental Health and Behavioral Health Issues	<div style="display: flex; align-items: center;"> <div style="writing-mode: vertical-rl; transform: rotate(180deg); font-weight: bold; padding-right: 5px;">SCREENING TOOLS</div> <ul style="list-style-type: none"> • Strengths and Difficulties Questionnaire • Pediatric Symptom Checklist • Child Behavior Checklist Behavior Assessment for Children • Etc. </div>
Most Common Mental Health Diagnoses for Children in Foster Care	
Attention Deficit Hyperactivity Disorder	<ul style="list-style-type: none"> • Children’s Summer Treatment Program
Posttraumatic Stress Disorder	<ul style="list-style-type: none"> • Cognitive Behavioral Intervention for Trauma in Schools (CBITS) • Combined Parent-Child Cognitive Behavioral Therapy for Families at Risk for Child Physical Abuse • Prolonged Exposure Therapy • Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)
Major Depression	<ul style="list-style-type: none"> • Adolescents Coping with Depression • Alternative for Families-Cognitive Behavioral Therapy (AF-CBT, formerly known as Abuse-Focused-Cognitive Behavioral Therapy) • Etc.
Conduct Disorder/Oppositional Defiant Disorder	<ul style="list-style-type: none"> • Brief Strategic Family Therapy (BSFT) • Familias Unidas • Parent-Child Interaction Therapy (PCIT) • Strengthening Families Program (SFP)
Behavioral Concerns	
Internalizing/Externalizing Behaviors: Behavioral Problems and Relational Concerns	<ul style="list-style-type: none"> • Brief Strategic Family Therapy • Child Parent Psychotherapy • Functional Family Therapy • Nurturing Parenting Programs (NPP) • Parenting Wisely • Triple P • Etc.

Promoting Social and Emotional Well-Being to Facilitate Healing and Recovery

