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Childhood Foundation  
Protecting Children

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# What do we know about the children and young people in OoHC?



# Children in Out of Home Care



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- At 30 June 2009, there were **34,069** children in out-of-home care in Australia. This compares with 31,166 children in out-of-home care at 30 June 2008 (an increase of 9.3%).
- Nationally, the number of children in out-of-home care in Australia has increased each year since 2005 when there were 23,695 children in out-of-home care.



# Types of Care Children Live In



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The vast majority of children (94%) in out-of-home care at 30 June 2009 were in home-based care:

- 47% in foster care
- 45% in relative/kinship care and
- 1.4% in some other type of home based care.

(AIHW 2009)

- Kinship care is the fastest growing placement type nationally and the most common form of placement for Indigenous children (Spence, 2004; Australian Institute of Health and Welfare, 2008).



# Increasing Complexity of Children in Out of Home Care



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- *“the task of caring is more demanding, stressful and complicated today than at any other time in history. Increasingly, children in out of home care present with a complex matrix of needs and challenges that are often not well understood or responded to, resulting in their poor psychological, emotional, social and academic functioning” (Bromfield et al, 2005; Sinclair et al, 2005; Department for Education and Skills, 2007).*



# Increasing Complexity of Children in Out of Home Care



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In 2003, in Victoria 56% of foster carers identified children in care as becoming more difficult to care for. This complexity was attributed to:

- Children presenting with more complex needs.
- Aggressive behaviour.
- Different problems.
- System savvy.
- Sexualised behaviour.
- Drug and alcohol addictions (DHS, 2003).



# Increasing Complexity of Children in Out of Home Care



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- Children entering care increasingly have family backgrounds characterised by a high prevalence of domestic violence, parental substance abuse and mental illness (Australian Senate, 2005; Delfabbro et al, 2007) paralleling the international experience (Holland and Gorey, 2004).



# Placement Stability



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- Bromfield et al (2005), in their review of Australian out of home care research, concluded that outcomes for children in care demonstrated a worrying trend of extensive placement instability, with the severity of emotional, behavioural and social problems increasing the longer children spend drifting in care.



# Age and Gender



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- 25% were aged less than 5 years (8500)
- 30% were aged 5–9 years (10200)
- 30% of children in out-of-home care were aged 10–14 (10200)
- 15% were aged 15–17 years (5100)
- 52% were males and 48% were females.



# Traumatised Children in The Out of Home Care System



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## What We Know About The Traumatised Children and Young People With Whom We Work





- In the absence of a diagnosis that accurately captures the pervasive nature of disturbances that relate to early childhood trauma, children tend to receive a hodgepodge of labels for any number of symptoms that are treated as separate conditions.
- Approaching any of these problems as piecemeal rather than as expressions of internal disorganisation, runs the risk of losing sight of the forest in favour of one tree.

Dr Van der Volk



# Most Frequent Diagnosis Given to Chronically Abused Children



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- Separation Anxiety
- Oppositional Defiance Disorder
- Phobic Disorders
- Post Traumatic Stress Disorder
- Attention Deficient Hyperactivity Disorder



# Complex Trauma



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- “children exposed to complex trauma often experience lifelong problems that place them at risk for additional trauma exposure and cumulative impairment....in childhood, adolescence and adulthood.

Cook goes on to describe how the impact of complex trauma goes beyond posttraumatic stress alone, typically occurring in a number of domains -- biological, attachment, affect regulation, dissociation, cognitive, behavioural control, and self-concept.



# Comparison of Simple Trauma versus Complex Trauma



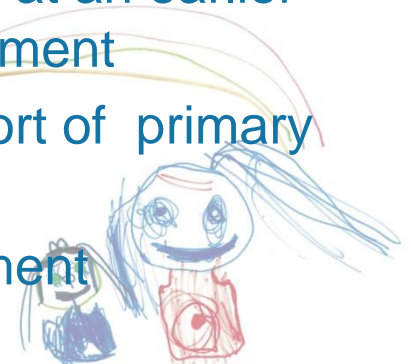
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## Simple Trauma

- Non-interpersonal
- Limited exposure---may be a single incident
- Shorter duration
- Onset of traumatic exposures more likely to be at later stage of development
- Support of caretaker/family
- Secure attachment with primary caretaker(s)

## Complex Trauma

- Interpersonal
- Multiple exposures of different types of trauma
- Longer duration
- Onset of traumatic exposures may have begun at an earlier stage of development
- Less or no support of primary caretaker/family
- Insecure attachment





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The brain normalizes  
repeated experiences.



# What We Know About The Traumatised Children and Young People With Whom We Work :



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- Single incident trauma is rare
- Some have lived in utero stress/chaos.
- Many have had a bio parent with attachment deficits.
- Many have lost a primary caregiver multiple times.
- Some feel limited connection to any other human, and have difficulty accepting care or nurturing.
- Most live in sensory deprived environments.



# What We Know About The Traumatised Children and Young People With Whom We Work :

- Poor Peer relationships.
- A compulsive need to control others.
- Boundaries are confused.
- Ability to discern a safe relationship is compromised.
- Sense of belonging is compromised.



# What We Know About The Traumatised Children and Young People With Whom We Work :

- Habitual hypervigilance or dissociation
- Attuned to danger in the environment
- Minimal understanding of facial expressions, tone of voice, body language messages given to others
- Heightened observation with narrowly developed interpretation.



# What We Know About The Traumatised Children and Young People With Whom We Work :



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- Any new situation or person is perceived as threat.
- Body functioning disturbances (eating, sleeping, urinating, defecating).
- Interactions lack mutual enjoyment and spontaneity.
- Fight, Flight, Freeze are the behavioural responses to threat



# What We Know About The Traumatised Children and Young People With Whom We Work :



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- Live in survival mode.
- Limited experience with adults who respect their boundaries, their play, their needs, their feelings, their thoughts.
- Pervasive shame, with extreme difficulty re-establishing a bond following conflict.
- Lack of empathy



## SURVIVAL

When you are in deep trouble,  
say nothing, and try to look like  
you know what you're doing.



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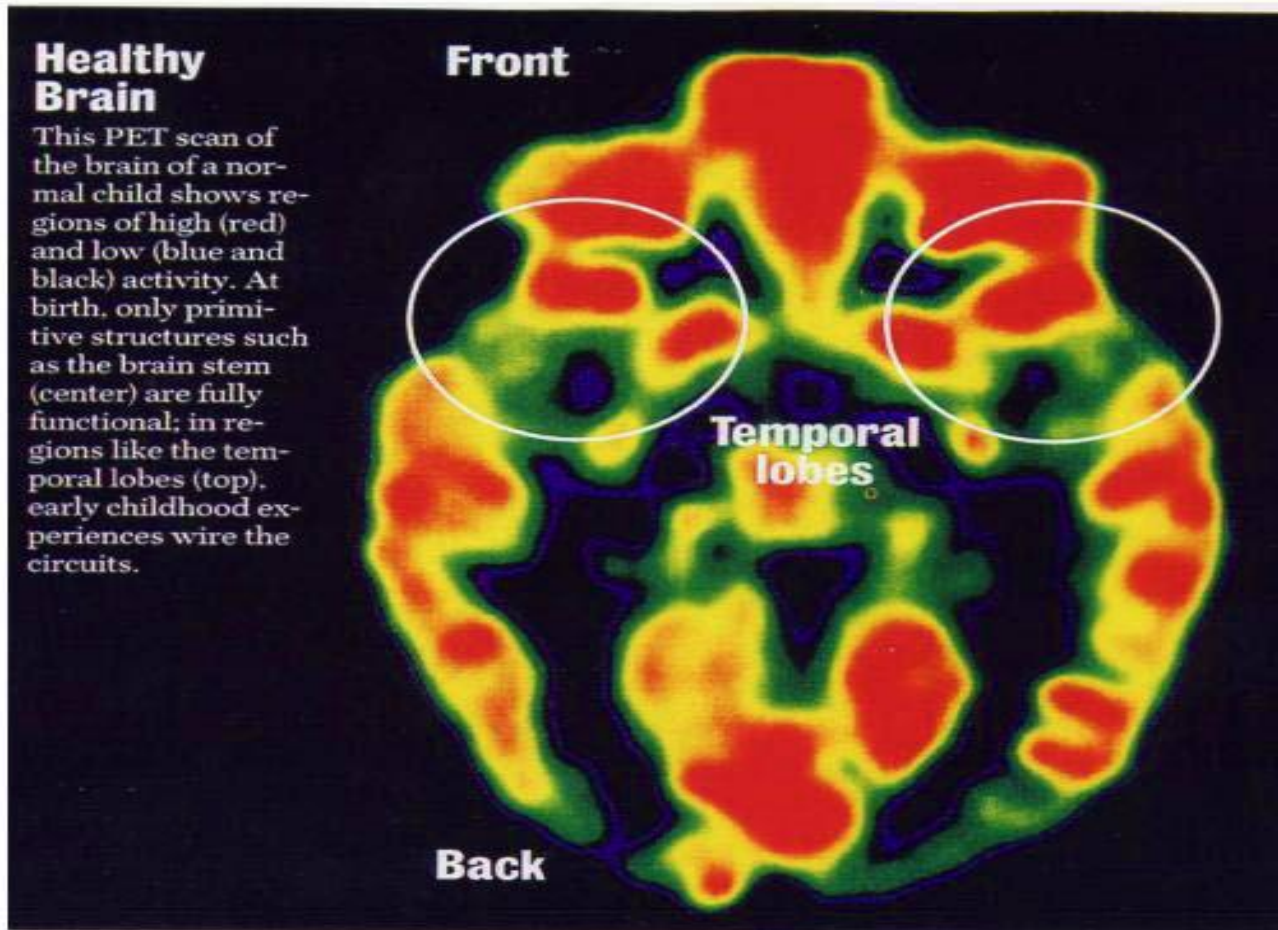
**The brain normalizes  
repeated experiences.**



# Impact on Brain Development



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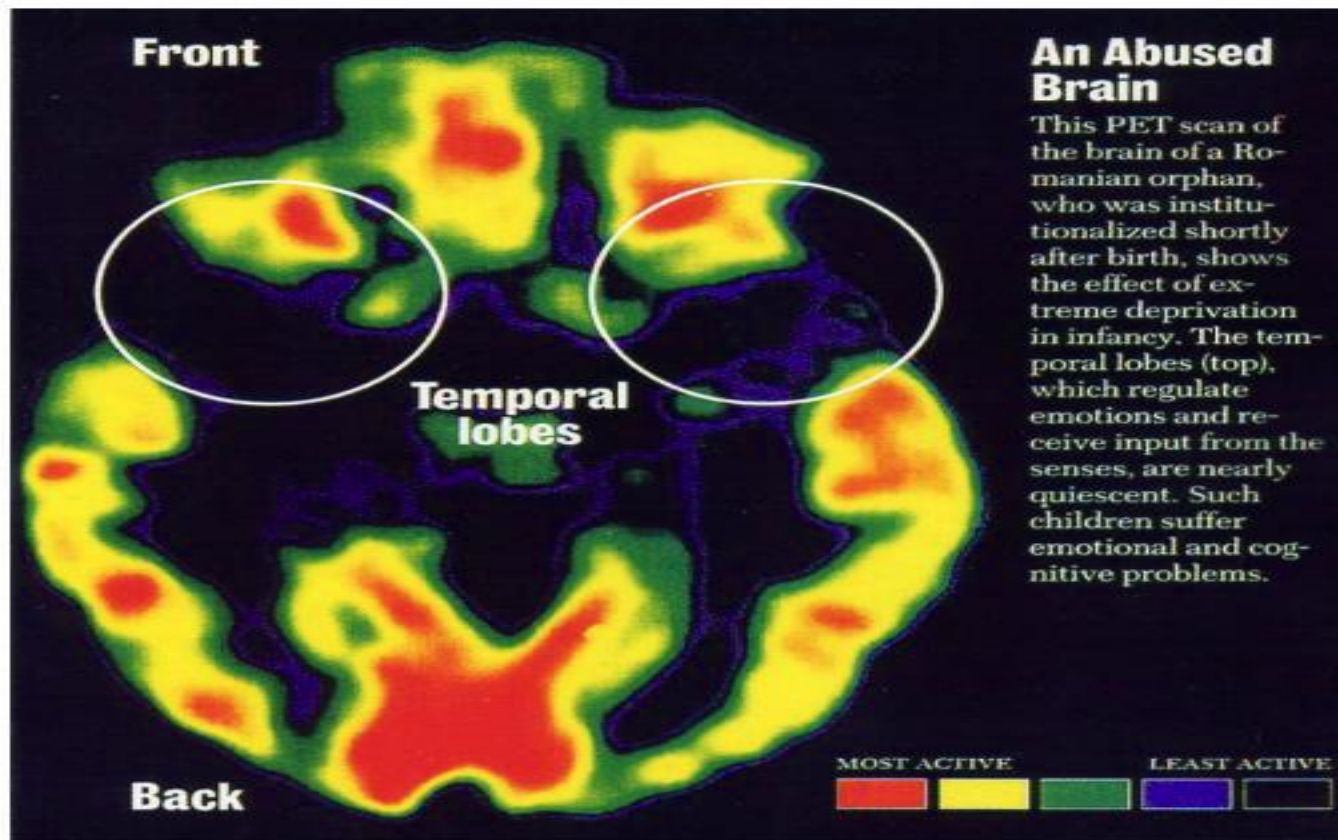


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# Impact on Brain Development



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# To sum-up...



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- *“...without internal maps to guide them, they act instead of plan, show their wishes in their behaviours, rather than discussing what they want. They take, rather than ask. Unable to appreciate clearly who they, or others are, they do not know how to enlist other people as allies on their behalf; people are sources of terror or gratification ...without a map to compare and contrast, anything new is potentially threatening. What is familiar tends to be experienced as safer, even if it is a predictable source of terror...(p.905)”*

Streeck-Fischer and Van der Kolk (2000)



# These Children Dare Us:



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- Dare us to see.
- Dare us to feel.
- Dare us to listen to a child's unspoken message.
- Dare us to question.
- Dare us to face the trauma a child cannot bare.
- Dare us to care.
- Dare us to stand up for a child in distress.
- Dare us to give up myths about ourselves.



# Essential Elements of Therapeutic Care



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1. Maximise the child's sense of safety.
2. Predictability, stability, consistency, structure, routines, pattern repetitive experiences in all aspects of the child's life.
3. Assist children in reducing overwhelming emotion.
4. Help children make new meaning of their trauma history and current experiences.
5. Address the impact of trauma and subsequent changes in the child's behaviour, development, and relationships.
6. Coordinate services with other agencies/services.



# Essential Elements of Therapeutic Care



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7. Utilise comprehensive assessment of the child's trauma experiences and their impact on the child's development and behaviour to guide service provision.
8. Support and promote positive and stable relationships in the life of the child.
9. Provide support and guidance to the caregivers.
10. Manage professional and personal stress.





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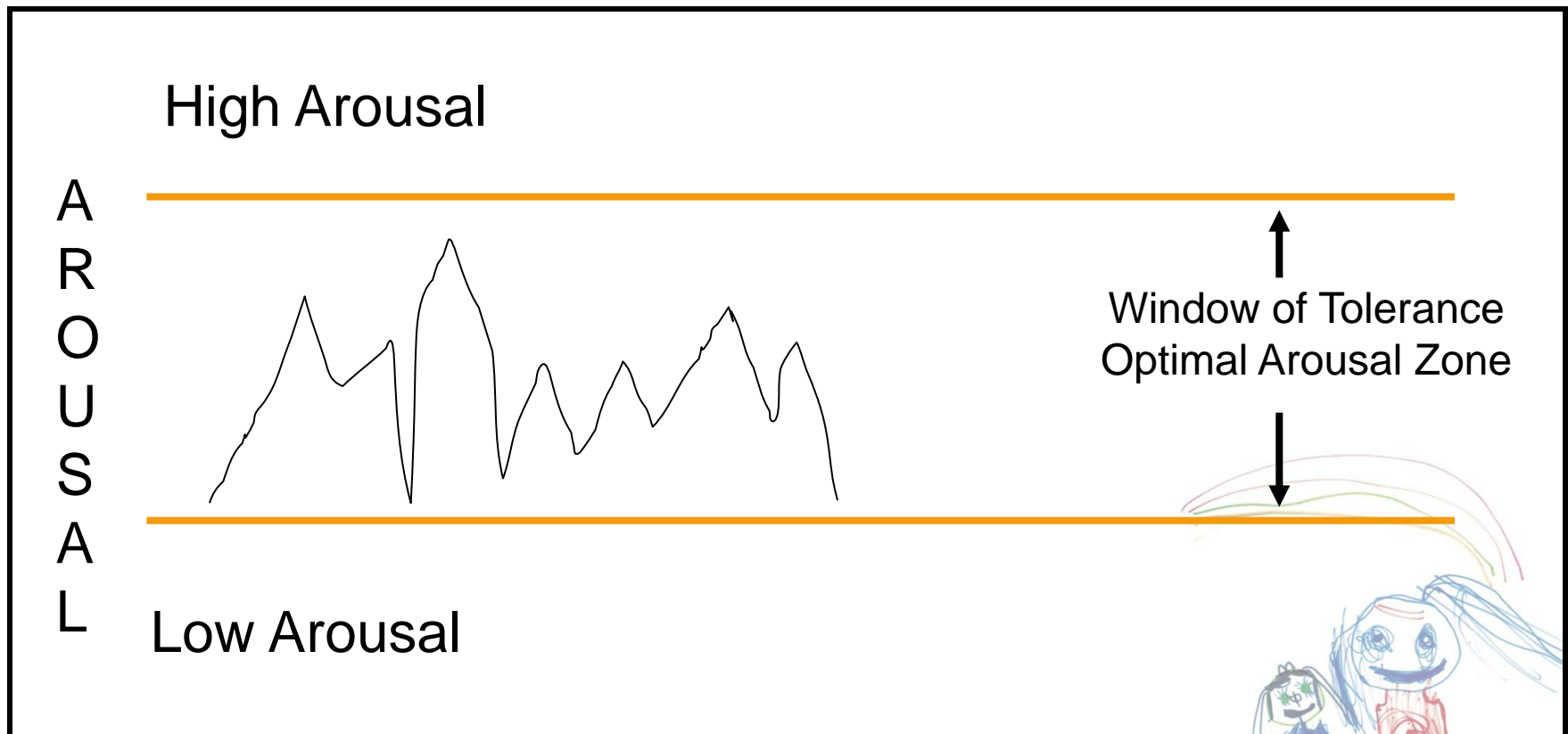
# Why is it Hard to Care for a Child Who has Suffered Trauma?



# The Window of Tolerance



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Ogden and Minton (2000)

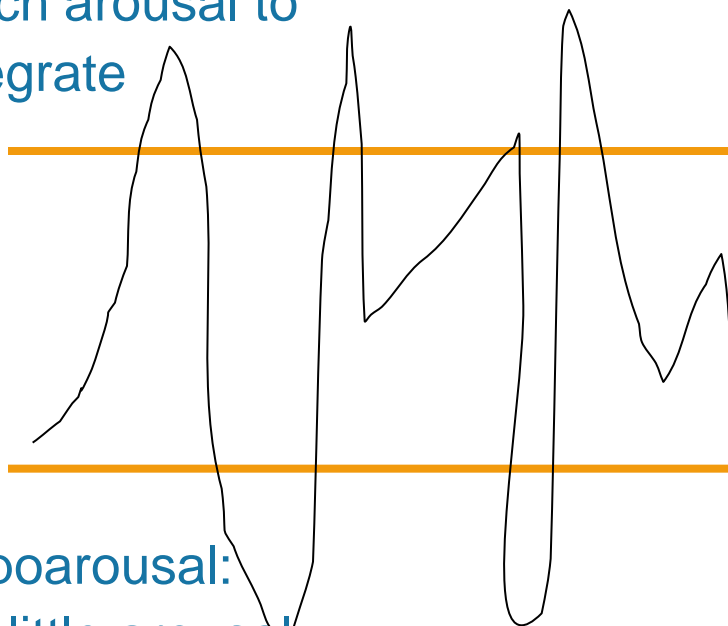
# Bi-Phasic Trauma Response



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Hyperarousal: too  
much arousal to  
integrate

Emotional reactivity  
Hypervigilance  
Intrusive imagery  
Obsessive/cyclical cognitive processing  
Tension, shaking, ungrounded.



Window of Tolerance  
Optimal Arousal Zone

Hypoarousal:  
too little arousal  
to integrate

Flat affect  
Inability to think clearly  
Numbing  
Collapse



Ogden and Minton (2000)

# Why is it Hard to Care for a Child Who has Suffered Trauma?



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Children often:

- Avoid intimacy and dependence, or become clingy and overly dependent.
- Act in ways that elicit hurt and rejection.
- Cling to premature autonomy, appearing more independent than they should for their age, or go to infantile behaviours, appearing emotionally young and dependent for their age.
- Become very manipulative and controlling, thus preventing the carer from providing security and nurturance.



# THE ANATOMY OF ANXIETY

TIME Diagram by Joe Lertola.  
Text by Alice Park

## WHAT TRIGGERS IT ...

When the senses pick up a threat—a loud noise, a scary sight, a creepy feeling—the information takes two different routes through the brain

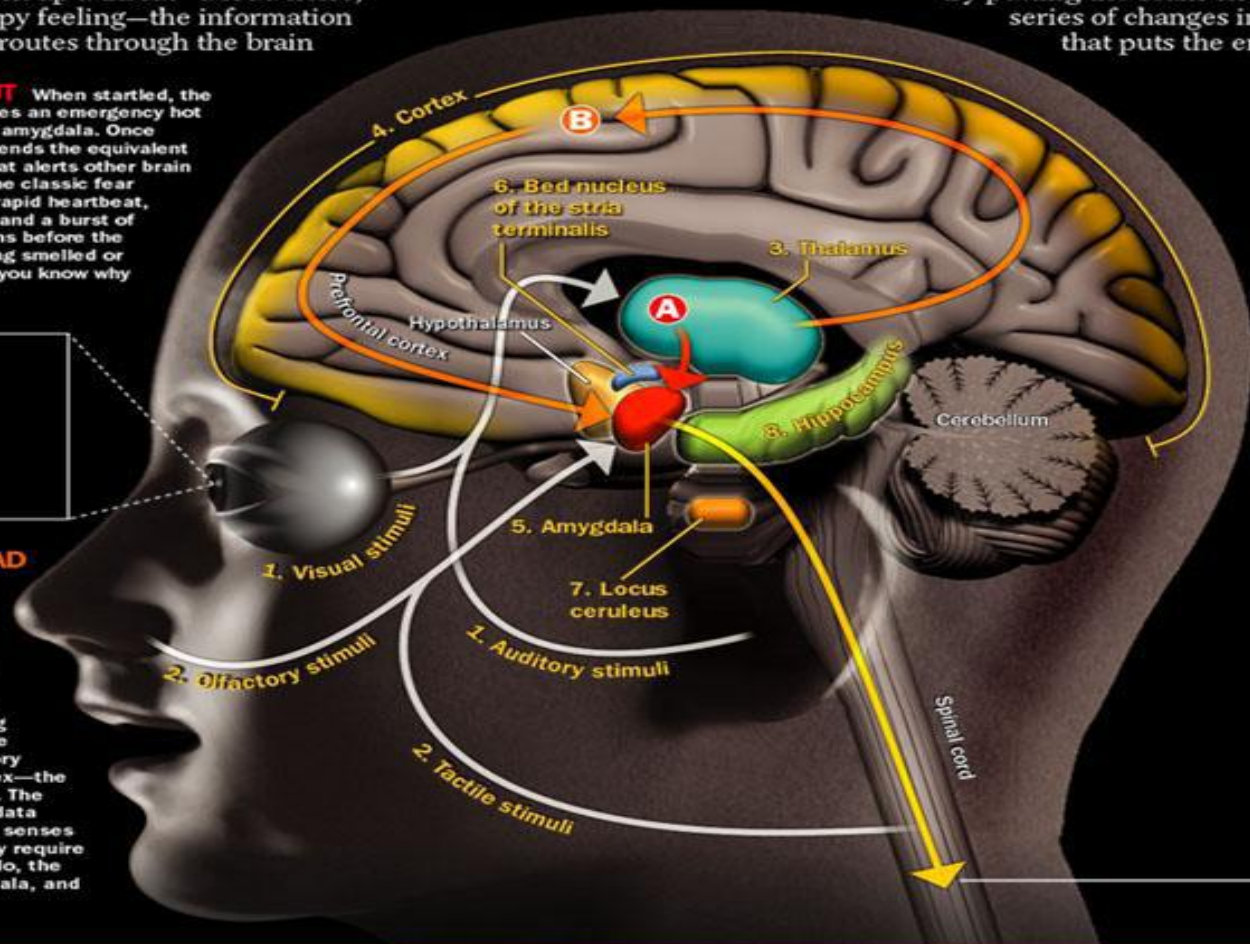
**A THE SHORTCUT** When startled, the brain automatically engages an emergency hotline to its fear center, the amygdala. Once activated, the amygdala sends the equivalent of an all-points bulletin that alerts other brain structures. The result is the classic fear response: sweaty palms, rapid heartbeat, increased blood pressure and a burst of adrenaline. All this happens before the mind is conscious of having smelled or touched anything. Before you know why you're afraid, you are

## B THE HIGH ROAD

Only after the fear response is activated does the conscious mind kick into gear. Some sensory information, rather than traveling directly to the amygdala, takes a more circuitous route, stopping first at the thalamus—the processing hub for sensory cues—and then the cortex—the outer layer of brain cells. The cortex analyzes the raw data streaming in through the senses and decides whether they require a fear response. If they do, the cortex signals the amygdala, and the body stays on alert

## ... AND HOW THE BODY RESPONDS

By putting the brain on alert, the amygdala triggers a series of changes in brain chemicals and hormones that puts the entire body in anxiety mode



### STRESS-HORMONE BOOST

Responding to signals from the hypothalamus and pituitary gland, the adrenal glands pump out high levels of the stress hormone cortisol. Too much cortisol short-circuits the cells in the hippocampus, making it difficult to organize the memory of a trauma or stressful experience. Memories lose their context and become fragmented



### RACING HEARTBEAT

The body's sympathetic nervous system, responsible for heart rate and breathing, shifts into overdrive. The heart beats faster, blood pressure rises and the lungs hyperventilate. Sweat increases, and even the nerve endings on the skin tingle into action, creating goose bumps



### FIGHT, FLIGHT OR FRIGHT

The senses become hyperalert, drinking in every detail of the surroundings and looking for potential new threats. Adrenaline shoots to the muscles, preparing the body to fight or flee



### DIGESTION SHUTDOWN

The brain stops thinking about things that bring pleasure, shifting its focus instead to identifying potential dangers. To ensure that no energy is wasted on digestion, the body will sometimes respond by emptying the digestive tract through involuntary vomiting, urination or defecation

### 1. Auditory and visual stimuli

Sights and sounds are processed first by the thalamus, which filters the incoming cues and shunts them either directly to the amygdala or to the appropriate parts of the cortex

### 2. Olfactory and tactile stimuli

Smells and touch sensations bypass the thalamus altogether, taking a shortcut directly to the amygdala. Smells, therefore, often evoke stronger memories or feelings than do sights or

### 3. Thalamus

The hub for sights and sounds, the thalamus breaks down incoming visual cues by size, shape and color, and auditory cues by volume and dissonance, and then signals the appropriate parts of

### 4. Cortex

It gives raw sights and sounds meaning, enabling the brain to become conscious of what it is seeing or hearing. One region, the prefrontal cortex, may be vital to turning off the anxiety response once a threat has

### 5. Amygdala

The emotional core of the brain, the amygdala has the primary role of triggering the fear response. Information that passes through the amygdala is tagged with emotional significance

### 6. Bed nucleus of the stria terminalis

Unlike the amygdala, which sets off an immediate burst of fear, the BNST perpetuates the fear response, causing the longer-term unease typical of anxiety

### 7. Locus ceruleus

It receives signals from the amygdala and is responsible for initiating many of the classic anxiety responses: rapid heartbeat, increased blood pressure, sweating and pupil dilation

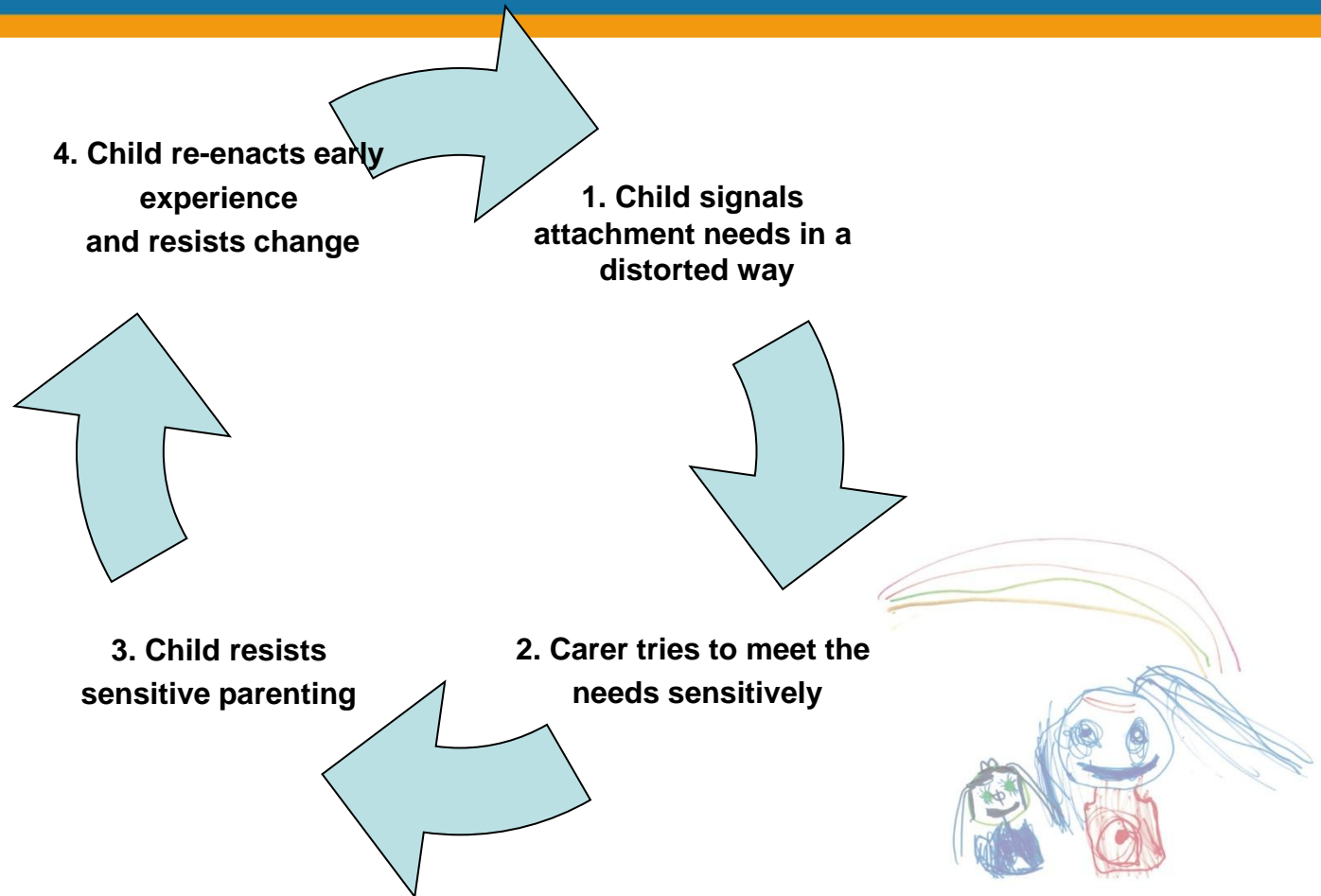
### 8. Hippocampus

This is the memory center, vital to storing the raw information coming in from the senses, along with the emotional baggage attached to the data during their trip through the amygdala

# Impact of Relational Trauma on The Caring Cycle



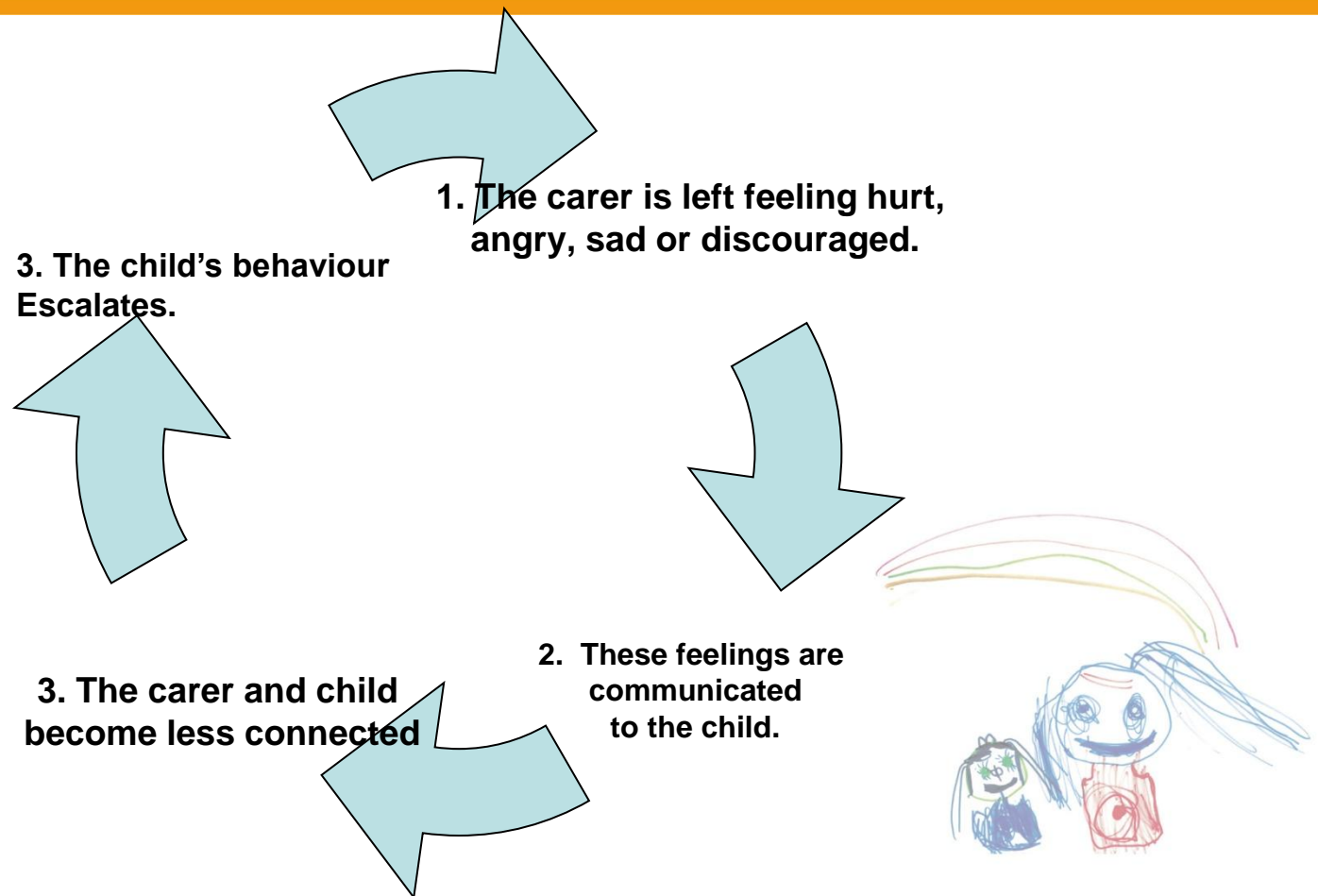
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# Impact of Relational Trauma on the Carer



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# What are the Challenges for Carer?



# Challenge for Carer



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- Responding to expressed needs.
- Gentle Challenge.
- Responding to hidden needs.
- Help child to develop into a way they can express their needs openly and respond to sensitive and empathic parenting.



# The Challenge



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## Expressed need:

- I don't need you or want you

## Hidden need:

- Help to feel comfort and safety with you.
- Support to accept nurturing.
- Co-regulate emotion that is hidden.



# The Challenge



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## Expressed need:

- I need to be in control.

## Hidden need:

- Need help to feel safe.
- Need low stress environment.
- Need for Structure and routine



# The Power Of Relationships



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- Of all the factors that operate in a young child's environment, the single most important determinant is the quality of the child's relationships with parents and caregivers.
- It is the relationship that the young child has with their caregiver(s) that literally sculpts the brain and determines the development of circuits.



# The Power of relationships: Kirsch and Colleagues (2005)



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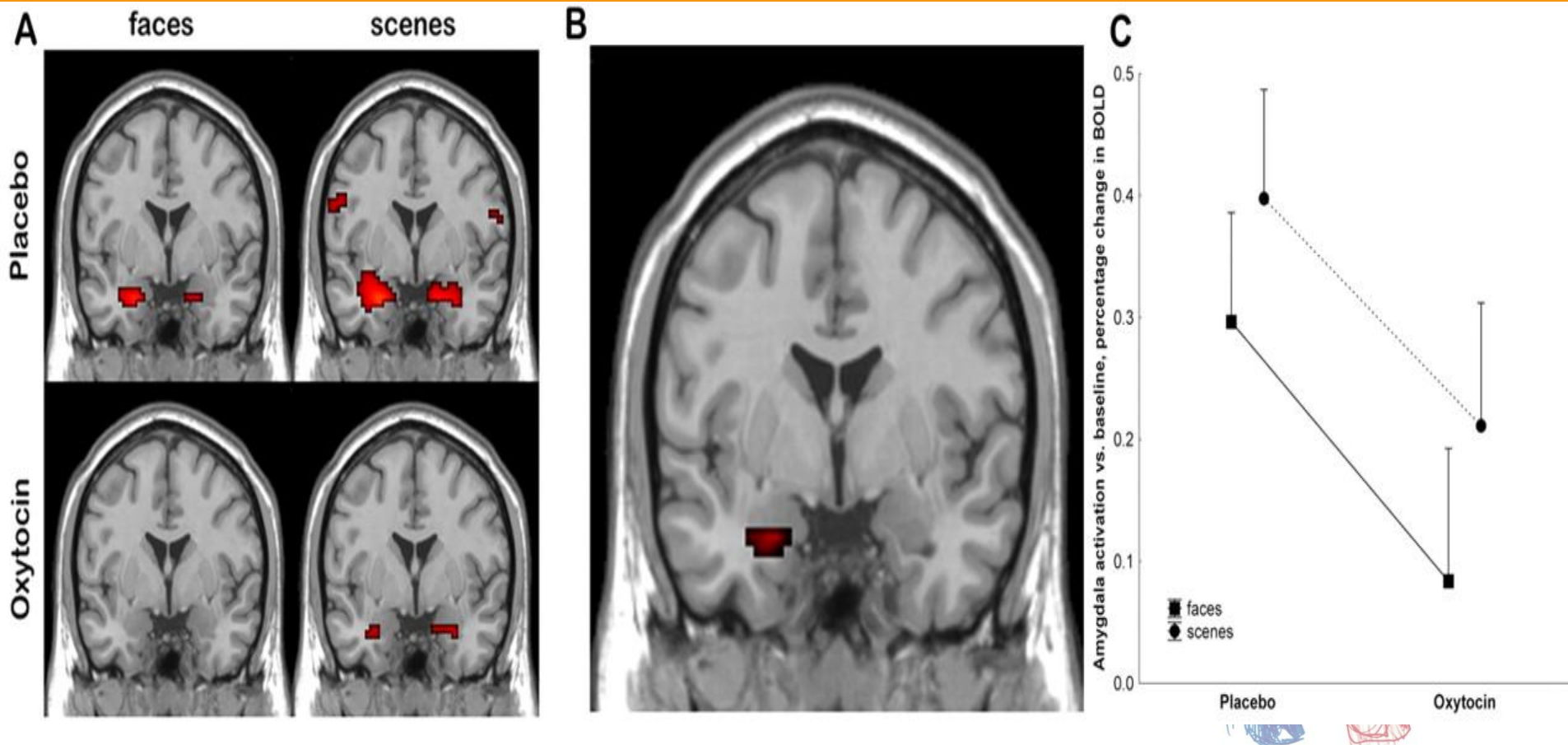
- Individuals were shown pictures of frightening faces and frightening scenes. Some of the them were given a placebo and some where given oxytocin.
- Oxytocin is critical in human life for lots of reasons. It strongly influences a women's labour and delivery of her baby. It also strongly mediates breast feeding and is a chemical known from animal and human research to be critical for bonding and healthy attachment.



# The Power of Relationships: Kirsch and Colleagues (2005)



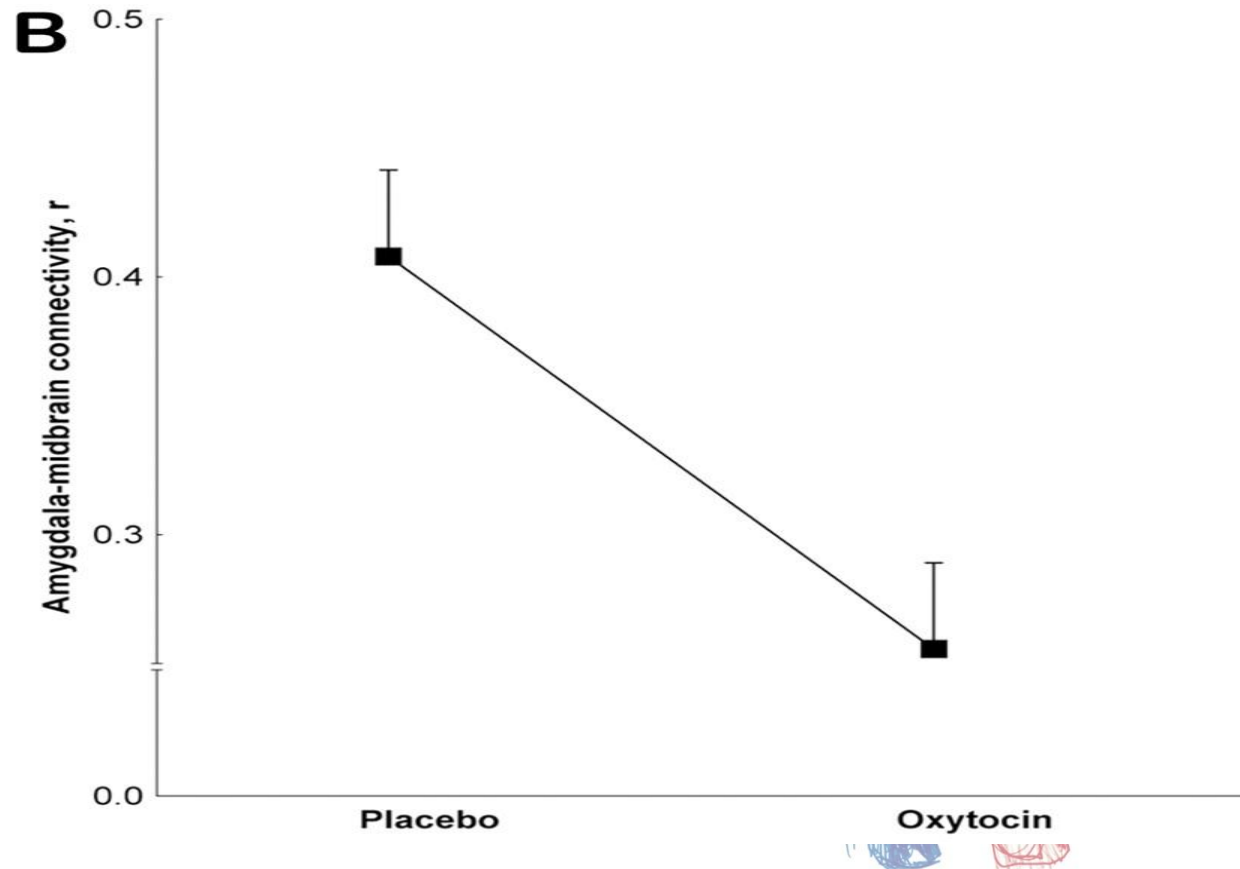
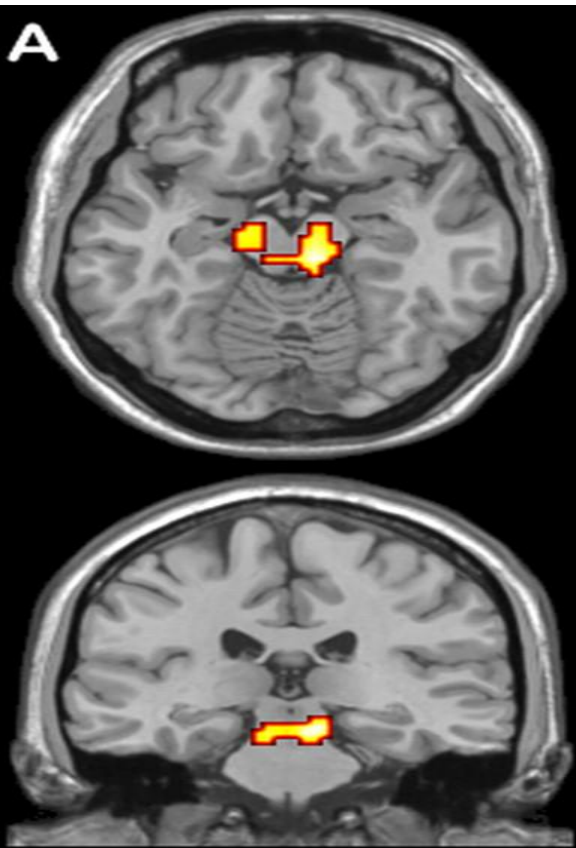
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# The Power of Relationships: Kirsch and Colleagues (2005)



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# Oxytocin



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- We all release oxytocin naturally in the context of safe and caring relationships, and the release of this chemical leads to our feelings of calm and contentment in these relationships.
- If the leader of the survival circuit is the low road amygdala, and the amygdala is regulated by oxytocin, then safe, strong, caring relationships will help to regulate the amygdala and therefore the survival circuit.





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# The Brain Normalizes Repeated Experiences.





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# WHAT DOES IT TAKE TO HELP THE CHILD TO HEAL?



# WHAT DOES IT TAKE TO HELP THE CHILD TO HEAL?



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- An empathic attunement that the child may not welcome because they have too frequently experienced betrayal, disillusionment, punitive measures, or attempts to control rather than genuine attempts to understand and to help them.
- It requires that the caregiver respond to the state of emotional contagion in certain limited and prescribed ways, forced to contain, rather than express, their own physiologically-based states of hyperarousal, fear, anger, and grief.



# WHAT DOES IT TAKE TO HELP THE CHILD TO HEAL?



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- It takes trust developed through the caring relationship where the child begins to risk closeness with another, it is through the healing experience of the carer responding in an empathic manner that the child begins to develop empathy for self and others.



# Therapeutic Parenting



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- Shifts emphasis from seeking control over child behaviour to helping children heal
- Reflects on current behaviour and emotions within a historical context
- Some methods of behaviour management which are effective with non-traumatised children escalate traumatised children's behaviour (e.g., time out strategies)
- Emphasises the importance of caregiver resources, availability and reflective capacity
- Requires a greater investment of time, energy and commitment



# Therapeutic Parenting is:



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- A comprehensive method of working with children who have extraordinary needs.
- Providing nurturing experience the child missed to heal developmental gaps

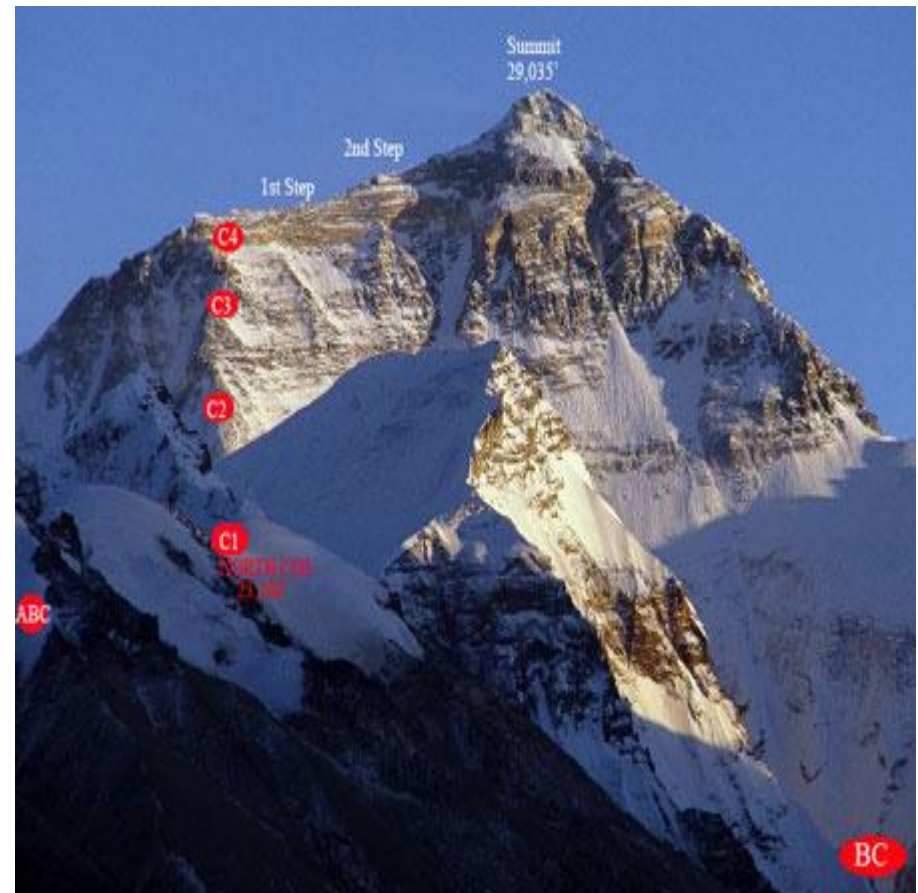


# The Therapeutic Parent Should:



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- Be Trauma Informed
- Have a Reflective Capacity
- Create a Sense of Safety and Security
- Be Emotionally and Physically Available
- Be Attuned to the Child
- Follow the Child's Lead
- Unconditionally Accept the Child
- Be Able to Promote a Sense of Belonging
- Look After Their Own well-being



# Trauma Informed



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- Trauma theory provides a framework within which the carer can understand the child and the behaviours they are displaying. All behaviour is adaptive and functional; however sometimes the behaviours that were adaptive in one environment are ill-suited for the new home.



# Case Study



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- Vicki-Lee (3) was placed in foster care when she was 18 months old, following physical abuse and emotional neglect. She was terrified of having a bath, and would scream loudly and kick whenever she had to do so. No amount of tender encouragement by the foster parents helped.
- The Foster parents used a star-chart to encourage Vicki-Lee. This did not work.



# Case Study



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- Vicki-Lee, while in the family of origin had suffered many abuses, including several episodes in which she had been violently held under water as punishment.



# Therapeutic Parenting



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- Understanding why children behave in the way they do can reduce feelings of frustration, guilt and blame. This understanding helps the carer to be able to accept the child and the difficulties he/she displays and provides a greater sense of empathy for how hard relationships are for him/her.

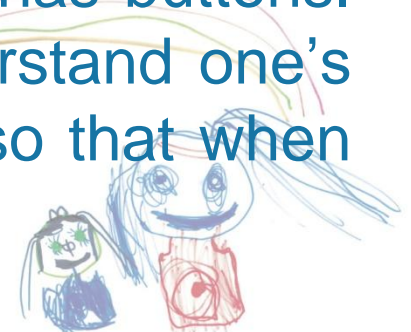


# Reflective Capacity



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- Reflective capacity is vital to placement stability and to the healing of a child. The carer must be able to reflect on the child's underlying emotions, how the past may be re-enacted in the present, and what in the carer's own past is being triggered by the child. A well developed reflective function is necessary if the carer is to respond to the child in a healthy and healing manner. Everyone has buttons. The job of the therapeutic parent is to understand one's buttons so that these can be disconnected so that when pushed, nothing happens.

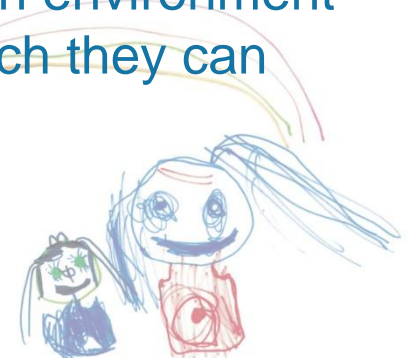


# Safety



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- Safety comes first. Unless the child is physically, emotionally, and psychologically safe, healing cannot occur. So, it is the job of the carer to create safety and security for the child. This then allows for the exploration of underlying feelings, thoughts, and memories. Without an alliance there can be no secure base. Without a secure base there can be no exploration. Without exploration there can be no integration. Without integration there can be no healing. Unless the child feels safe, exploration is not possible. Such an environment allows children to commit to the relationship within which they can heal and grow.

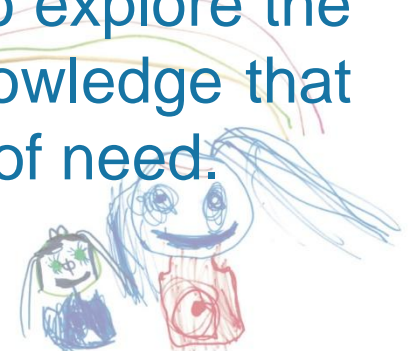


# Availability



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- It is important for the caregiver to convey a strong sense of being physically and emotionally available to meet the child's needs whether they are together or apart (keeping the child in mind). This secure base allows the child to begin to trust that they are safe and that their needs will be met warmly, consistently and reliably. Anxiety is reduced and the child gains the confidence to explore the physical and emotional world, safe in the knowledge that care and protection will be available in times of need.



# Attunement (emotional container)



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- This refers to the caregiver's capacity to 'stand in the shoes' of the child, to think flexibly about what the child may be thinking and feeling and to reflect this back to the child. The reflective, 'mind-minded' caregiver also thinks about their own feelings and shares them sensitively with the child. The child thus learns to think about their own feelings, as well as the thoughts and feelings of others, and is helped to reflect on, organise and manage their behaviour.
- A caregiver who acts in a sensitive and attuned manner and makes an effort to repair ruptures in the relationship, is modelling appropriate emotional regulation and integration.





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# Empathy is the fundamental

# “Caring”

# characteristic



# The Four Critical Elements of Empathy:



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- Awareness of the state of another.
- Understanding of this condition.
- Personal Identification with the situation.
- Appropriate affective and cognitive response.



# Empathic Carers are:



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- **Attuned** to the subtle and overt signals of children's needs or wants.
- **Respond** in empathic ways that maintain that child's dignity.
- **Consider** the child an equal in respect to the feelings.



# Attunement: Carer Comment



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- “I think Jenna (9) spent so long in self-defence and looking after herself that she never learned to look at things from any one else’s point of view. She missed that out when she was little. And even things like stories.. When you say, what do you think is going to happen next? or why is that person thinking that? she hasn’t got a clue, she doesn’t follow the motives of what people are doing, or how they are feeling. So we do a lot of story reading together and I talk it through”.



# Following the Child's Lead



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- Following the child's need. By this I mean that the carer will need to respond to the child and follow the child's lead in the sense of providing what the child is needing (comfort, affection, support, structure, etc) and at the child's pace. It is very important to move at the child's pace to create the necessary sense of safety and security that these children need.

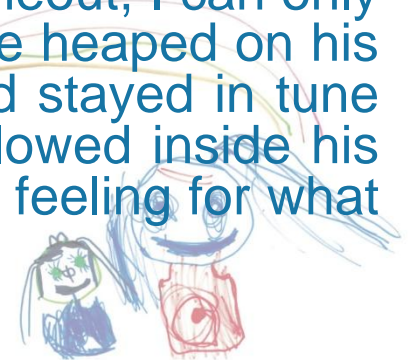


# Following the Child's lead Carer's comment...



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One evening the behavior of my foster child, aged six, prompted me to give him a 'time-in' on my bed, while I was folding washing. He was loudly letting me know that he did not like being corrected. After five minutes, I stopped folding laundry, sat on the bed and took him into my arms. Before I could utter a word, he laid his head on my shoulder, and cried "Mummy Jean, I must have done something really bad for her to do that to me." Where did that come from? We hadn't been talking about his parents, or anything even closely related. We sat for long time that evening, discussing his parents and the feelings he has about them. Had I isolated him in her bedroom for a timeout, I can only imagine what thoughts his sense of shame would have heaped on his small shoulders. Instead, because I was close by and stayed in tune with him during his 'time-in', I was privileged to be allowed inside his pain and confusion so I could help her understand the feeling for what it was.



# Unconditional Acceptance



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- All children need a specific form of positive response—*acceptance*—from their caregivers. Caregivers need to give the message that the child is unconditionally accepted and valued for who they are, for their difficulties as well as strengths. This forms the foundation of positive self-esteem, so that the child can experience themselves as worthy of receiving love, help and support, and able to deal with challenges and set-backs.



# Acceptance: Carer Comment



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- “Just look at her. She’s got such a twinkle. She’s an absolute rogue. And you would never want that squashed. It’s lovely. It’s just got to be channelled the right way”.



# Sense of Belonging



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- The capacity of the caregiver to include the child socially and personally as a family member is important for the child. The caregiver needs to help the child establish an appropriate sense of connectedness and belonging. So that the child can learn that they are loveable and loved, however aggressive or destructive is the communication of their distress, anger, shame.



# Sense of Belonging: Comment



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- “She looked at me as her son and I looked at her as my mum sort of thing. Even though when you’re 18 you officially leave care but we kept in touch. We go round there for dinner, she comes round here. She classes my kids as her grandchildren. (Christopher age 29 placed at 5)”



# Self Care



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- If a carer does not look after themselves there will be no time opportunity for re-charging batteries, thinking or planning. Rest and relaxation and reflection are all essential elements of effective parenting, especially when parenting children with relational trauma issues.
- The carer will need to be able to use the support network (Care Team) to help them understand and explore feelings evoked by the child.



# Self Care



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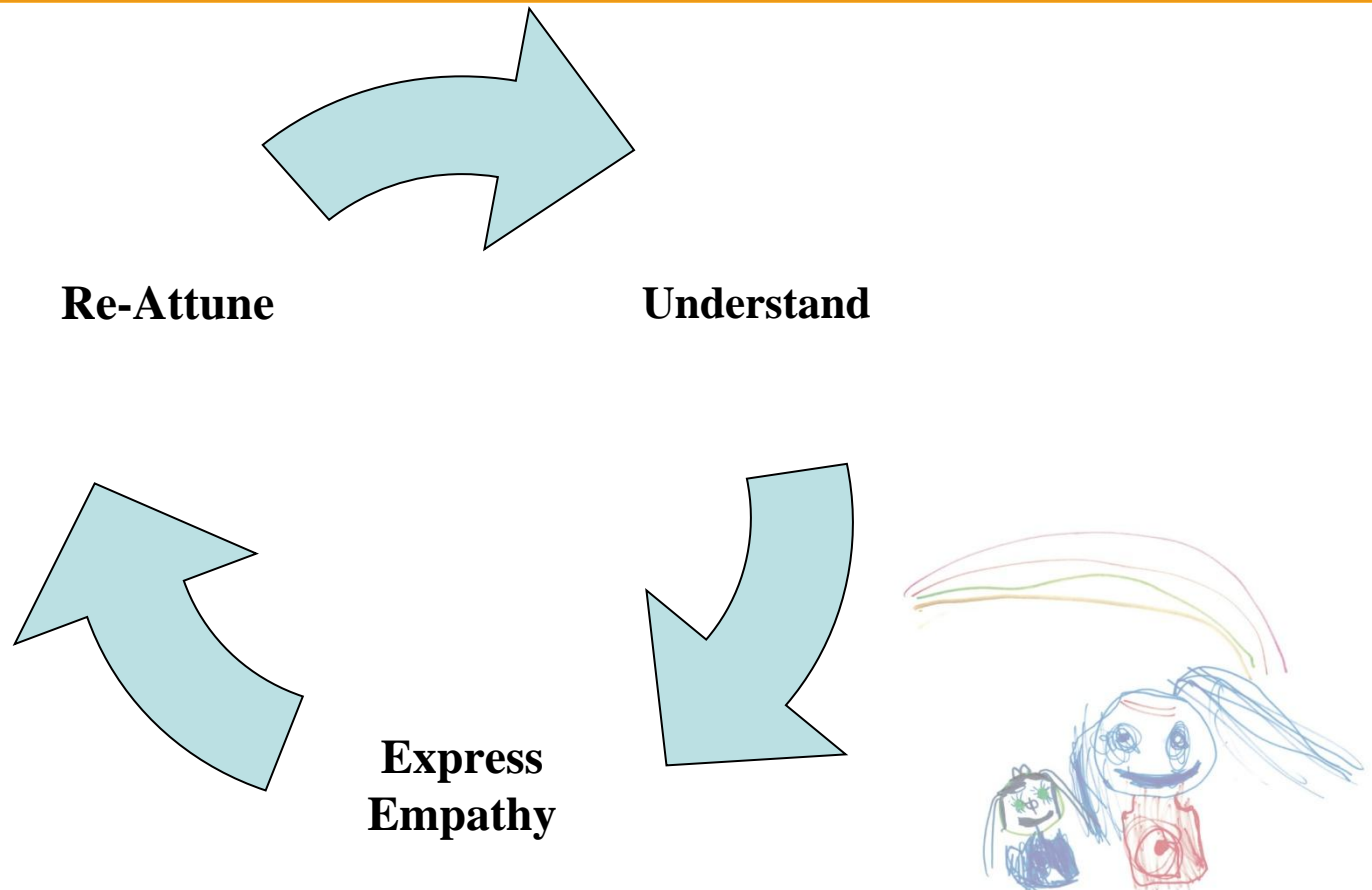
- When oxygen levels drop on an aircraft, there is an announcement to parents to put on their own oxygen mask before their child's. Why?
- The therapeutic care system is like an oxygen poor environment in which it is easy to get weakened, sick, disorientated, and hurt. In order to do what they need to do Carers must take care of themselves and be sufficiently cared for by their care team, agency and statutory agency.



# The Cycle of Care



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# The Cycle of Care



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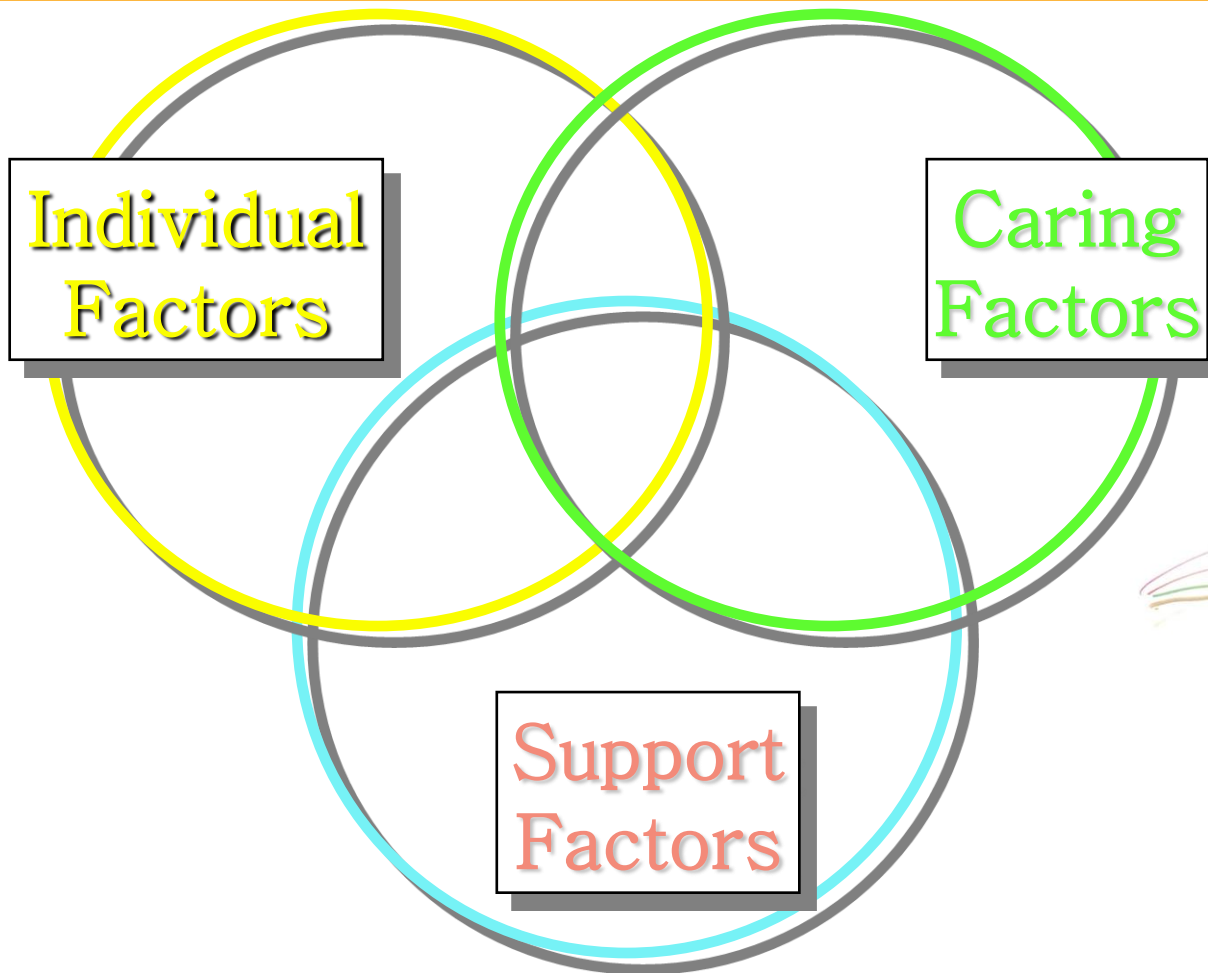
- **Understand.** It is important for foster parents to help children understand the meaning of their actions. For instance, children who were hit, slapped, kicked or restrained may replicate those behaviors under duress, without understanding why. When a child misbehaves, and you can recognise where the behavior comes from, it can be helpful to explain the relationship between his actions and his past.
- **Express empathy.** With your empathy you can help a child see that while his behavior is bad, he is not bad. When you take him into your arms and engage in meaningful dialog about the 'why' of what happened, you are not condoning his misbehavior, but rather helping him understand the origin and the meaning of his behavior.
- **Re-attune.** The child's understanding and the parent's empathy together lead to a re-attunement between parent and child, allowing for the child to express sorrow for hurting the other person. He is then able to learn and change and to openly accept your guidance and correction.



# Factors that Influence a Carer's Vulnerability to Empathy Erosion



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# Individual Factor



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- When faced with angry or distressed interactions with the foster child, some memories of the foster carer's own unhappy childhood – a gesture, a look, a phrase or piece of behaviour – may be evoked. The foster carer 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 carers.



# Individual Factors



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- A child's trauma may also serve as a trauma reminder and cause the carer to react as the child has reacts with nervousness, re-experiencing, nightmares and avoidance.
- The carer can loose perspective and have trouble differentiating their experience from the childs.
- The carer may find themselves withdrawing from the child as a way of avoiding the trauma reminders



# Case Study



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- Kylie was removed from her mother's care when she was 2 years old because of her mother's mental illness and itinerant lifestyle.
- Kylie initially settles in very easily and appears to get on well with all family members. However, her behaviour becomes increasingly difficult. She becomes very aggressive towards the foster carers' own children.
- The Carer's parents stop babysitting their grandchildren because of Kylie's behaviour.



# Case Study



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The foster carers offer Kylie a close and loving relationship and Kylie resists.

The more the carer moves towards Kylie, the more she becomes rejecting and self reliant.

This behaviour pushes the carer into a distant and frustrated relationship with her.

The carer and care team start to question if this is the right placement for Kylie.



# Case Study



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- In discussion with the carer she explained that she wanted to give Kylie the experience of a loving mother that she didn't have herself, because her mother left when she was 3 years old and that Kylie's rejection of her 'love' reignites the feelings of abandonment and rejection she had as a child and when this occurs she pulls away from Kylie to take care of her own emotional needs.



# Caring Factors



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Caring for a child who:

- Is defiant and uncooperative.
- Swears at you, calls you names on a daily basis.
- Soils themselves many times a day.
- Spits at you
- Steals from you
- Destroys their things and yours.
- Harms others.

The repeated nature of these acts can erode your empathic capacity.



# Support Factors



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- The lack of support
- The lack of acknowledgement within the carers family and friendship groups
- Relationship difficulties





- “To keep the lamp burning we have to keep putting oil in it.”

## Mother Theresa





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# The Brain Normalizes Repeated Experiences.

