
SAFE AND SOUND:

Responding to the Experiences of Children Adopted or in Foster Care

A Guide for Caseworkers





INTRODUCTION

As a child welfare professional, you will care for many children who have had all kinds of trauma.

Trauma comes in many forms: It might involve drug or alcohol contact before the child is born. It might be a history of neglect or poor nutrition. It can include physical and emotional abuse.

Children who have been adopted or who are in foster care can grow up very healthy and happy. But some of them may have trouble fitting in, due to a history of trauma. In particular, they may see and react to things in a different way. Research tells us that when harmful events happen in childhood, it changes how the brain grows and works. These brain changes guide children's learning, actions, and health. Because of this, the effects of trauma can last a lifetime.

Those who come into a child's life later may not understand how past trauma can change how the child acts. Adoptive and foster families may struggle in helping their children manage

at home and in school. Some of these children may need extra help learning social and school-related skills. In your role as a caseworker, you have a great opportunity to assist others (like teachers, adoptive and foster parents, and mental health professionals) in understanding the child and helping the child heal.

The purpose of this guide is to help child welfare workers like you improve your skills to help adoptive and foster families. The goals of this guide include:

- Recognize and understand children who have experienced trauma.
- Understand the negative effects of toxic stress on learning, actions, and social skills.
- Encourage families to learn about the effects of toxic stress (the harmful health effects of traumatic events in the child's life).
- Support families in teaching their children how to react better to stress.



CASE SCENARIO

As you read through this guide, keep this story and questions in mind.

Arthur is 3. He lives with his grandparents under a guardianship arrangement, because his mother and father struggle with domestic violence and alcohol use disorder. At first, Arthur's behavior was great: he was easy to handle, and things were going well. Now, after about 3 months of living with his grandparents, he has started having tantrums where he is inconsolable. He has been throwing these tantrums every day, sometimes several times a day, both at home and at preschool. His grandparents are really struggling about what to do—he was fine for the last 3 months.



Q:

Friends say the “honeymoon” is over. What is actually going on?



Q:

What can his grandparents do to help?



Q:

What can his preschool do to help?

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The Neurobiology of Trauma

The children in your caseload have probably had a lot of hard things happen to them. Science is just starting to explain how these types of trauma change the bodies and brains of children. If you learn more about what trauma does and about the benefits of supportive and nurturing environments, you will be better able to help the kids you work with.

Here's what we know now:

- Babies' brains are not really ready to take on the world when they are first born. While the brain starts with all the nerve cells it needs, those nerves need to grow and link to each other to make useful connections.
- The things that children see, hear, and feel with their families affect which nerves connect to each other and how well the connections are made.
- For the brain to make these connections, children must play, talk, and be loved by family. The connections don't just happen. So when kids don't have families to love and care for them early on, their brain growth can be altered.
- Trauma can also change which of the body's genes turn on and how those genes work. This can multiply the harm caused by trauma.
- Trauma, brain growth, and child behavior can affect each other in a big circle. Trauma can change brain growth, which will change behavior. Behavior problems can make kids more likely to have more trauma, which will change brain growth more.



Science is just starting to explain how these types of trauma change the bodies and brains of children.



It is so important to consider the effects of trauma, even if you don't know exactly what happened to a child before you met her.

TOXIC STRESS

Stress is not all bad. In fact, kids need some stress to grow and learn. Positive stress might be something that pushes a child to try something new or do their best, like a final exam or sports competition. Other stress is more like an injury: it isn't helpful, but it doesn't usually harm kids over the long term, especially if a family member helps the child get past it.

Toxic stress, on the other hand, is a kind of stress that hurts kids as they try to deal with it. Things like child abuse, parental substance use, or living in an orphanage can be so bad that the child's brain and body are changed as she tries to cope.

Why? It has to do with fear. Fear tells the body that it needs to freeze, run, or fight to stay safe. When scary things happen often, the body gets used to being in that state: ready to freeze, run, or fight. The child's brain makes sure that she doesn't forget what happened. This is why a child may act like she is still not safe, even though she really is safe now. She may have trouble paying attention. She may not sleep well. She may fight a lot, "zone out," or have big tantrums.

It's important to understand that, if the child were actually in danger, these behaviors could help keep her safe. But when the child is safe at home or in school, it may look like she is just "being bad." However, if you know that she is acting that way because her body learned to do that when she was scared in the past, then it will be easier to help the child.

Many children who have been adopted or are in foster care have had early toxic stress and trauma. These events or situations might not be written down, and details may have been lost by the time you work with a child. That's why it is so important to consider the effects of trauma, even if you don't know exactly what happened to a child before you met her.

ADDRESSING TOXIC STRESS

In the 1990s, a medical study called the Adverse Childhood Experiences (ACE) study was completed. Adults who were members of a large health insurance plan in San Diego, California, were asked about 10 significant types of trauma they might have experienced as children (such as abuse, neglect, or a parent with substance use disorder).

The researchers then looked at the health problems of the adults. Two-thirds of the adults reported that they'd had at least one of the 10 adverse experiences when they were kids. **What was surprising was this: the more hard things people had lived through in childhood, the more likely they were to be sick as adults—with things like heart disease, liver disease, and depression.**

In fact, many studies since then have shown the same thing—the more toxic stress you have as a child, the more likely you are to be sick as an adult. Childhood toxic stress is associated with problems with mental health, physical health, and productivity. It turns out that, when hard things have happened to you as a child, you're more likely to take risks and do things like smoke and drink alcohol, all of which can hurt your body. But the other thing we know now is that when trauma happens to you, your body responds in ways that make it harder for you to fight sickness, and that can harm how your organs function.

Here's the good news: when we know a child has had toxic stress, there are treatments that can help his brain and body heal and can improve his health, behavior, and ability to learn. And from your role in the life of the child, you're in a great place to help.



As a caseworker, you can help because:

- You see the child often.
- You understand how families can help kids grow and be healthy.
- You understand how it's better to prevent problems than trying to fix them later.
- You understand the many systems that play a role in the child's life (like school, the courts, child welfare, and others).
- You can provide families with information about trauma-informed counselors and other helpful resources in your area.

In addition, by talking to families about trauma and explaining its impact on children, you can:

- Help kids and families understand that trauma is common.
- Help kids and families feel less alone with the trauma-related issues that they're dealing with.
- Let kids and families know that there is help, so that they can get better.
- Help families understand that, if they don't pay attention to trauma, it can affect the child's health and growth.

You can also help families, teachers, and child care providers understand that some of the problems that these kids are having are related to the hard things that have happened to them in the past. If you can explain that a child is not acting this way on purpose, but rather because of toxic stress, then you can help the child and family get the right help.

Not every child who has trauma in his past will have problems. But if you make it a habit to think about the effects of trauma, then you won't miss them when you see them.

UNDERSTANDING HOW TRAUMA MAKES A CHILD'S BRAIN WORK

BEHAVIORS THAT MAKE SENSE IF YOU KNOW THAT THERE HAS BEEN TRAUMA

- Not sleeping
 - Eating a lot (so your body has energy)
 - Being ready to run or fight
 - Being easily distracted (so you can keep looking for danger)
- These are all ways to protect yourself if you are scared.**

HOW THE BODY WORKS WHEN THERE IS DANGER

- The heart races
 - The muscles get ready to freeze, run, or fight
 - The body gets organs ready to deal with injury
 - The brain is not ready to learn, because it's busy with fear
 - The parts of the brain that send alarms to the body and brain are turned on
 - The parts of the brain that help you calm down are turned off
- This state is only supposed to last for 20 minutes, because actual danger will either hurt you or go away in a short time.**

HOW THE BRAIN AND BODY CHANGE WHEN THERE IS DANGER ALL THE TIME

- The body is more likely to get sick or get asthma
 - Learning is difficult all the time, because the fear keeps the brain from using its learning centers
 - The brain's alarm system stays on or turns on too easily
 - It's hard to get the brain and body to calm down so that the child can sleep, learn, play, or be a friend
- The body doesn't turn off these reactions because the danger is too bad or happens too often.**

WHAT THESE CHANGES MAY LOOK LIKE

- Attention-deficit/hyperactivity disorder (ADHD)
- Learning problems
- Aggression
- Anger problems
- Depression
- Sleep disorders
- Anxiety and nervousness
- Withdrawal or anti-social behavior

Prenatal Exposures

Children who have been adopted or placed in foster care may have had a birth mother who used cigarettes, alcohol, or other drugs during her pregnancy. In fact, this may be why the child was placed in foster care. In other cases, there may be no record that the child's birth mother used drugs or alcohol. However, even if drug or alcohol use is not reported, it's still reasonable to keep that possibility in mind.

Commonly used substances include cocaine, heroin and other opioids, methamphetamine, and prescription drugs. A birth mother may use drugs and alcohol together, and it can be difficult to separate the effects of these substances. Kids who have been exposed to drugs or alcohol before birth are at risk for problems with their development,

behavior, and learning. It's important to think about prenatal exposures as a possible reason for some of a child's problems. This may help you figure out why a child is having a hard time; it may also give you ideas to help you support the child.

It's important to think about prenatal exposures as a possible reason for some of a child's problems.



DRUG EXPOSURE

When a woman uses drugs during pregnancy, the fetus is exposed to these drugs during the time when the body and brain are developing. Studies show that, after birth, the impact of these drugs on how the body and brain function is still present. For some children, no obvious effect is seen. For other kids, some of the difficulties improve as they mature and learn skills, and for others, the challenges can be lifelong.

OUTCOMES AFTER PRENATAL EXPOSURES

		NEWBORN	INFANT	TODDLER	SCHOOL AGE
SUBSTANCE	COCAINE	<ul style="list-style-type: none"> • Small head size • Low birth weight • Poor suck and lethargy 	<ul style="list-style-type: none"> • Irritability • Strong response to stimuli • Higher risk of SIDS • Increased muscle stiffness 	<ul style="list-style-type: none"> • Developmental delay • Motor problems and poor coordination • Increased muscle stiffness 	<ul style="list-style-type: none"> • Developmental delay • Learning problems • Motor problems and poor coordination • Increased muscle stiffness • ADHD
	HEROIN, METHADONE, AND OTHER OPIOIDS	<ul style="list-style-type: none"> • Small head size • Low birth weight • Neonatal abstinence syndrome, or NAS (symptoms include shaking, high-pitched crying, vomiting, irritability, poor feeding, poor sleeping) 	<ul style="list-style-type: none"> • Extreme fussiness 	<ul style="list-style-type: none"> • Slower learning and motor skills, but still in normal range • Behavioral issues 	<ul style="list-style-type: none"> • Higher rates of ADHD
	METHAMPHETAMINE	Limited data; some studies suggest possible poor growth, and possible difficulties with sleep, movement, and stress responses		Limited data	
	TOBACCO AND NICOTINE	<ul style="list-style-type: none"> • Low birth weight 	<ul style="list-style-type: none"> • No specific identifiable effects 	<ul style="list-style-type: none"> • Negative impact on early language development and behavior 	<ul style="list-style-type: none"> • Higher rates of ADHD • Negative impact on cognition, memory, language, and learning

ALCOHOL EXPOSURE

Even if there is no report that a birth mother drank alcohol during pregnancy, it can be important to keep it in mind.

It doesn't matter when or how much the birth mother drank alcohol during the pregnancy: alcohol use is always considered potentially harmful to a fetus. The effects of alcohol on the body and brain range from mild to severe. There is no way to predict how any one child will do. For this reason, no amount of alcohol use during pregnancy is safe.

There are many labels used to describe the impact of prenatal alcohol exposure on a child. The term fetal alcohol spectrum disorder (FASD) is a general label that covers the full range of possible effects.

Fetal alcohol syndrome (FAS) is the term most often used to describe the most severe form of prenatal alcohol exposure.

The effect is seen in how the face looks, how the child grows, and how the child learns and behaves. Some children may have other medical problems, such as a heart problem.

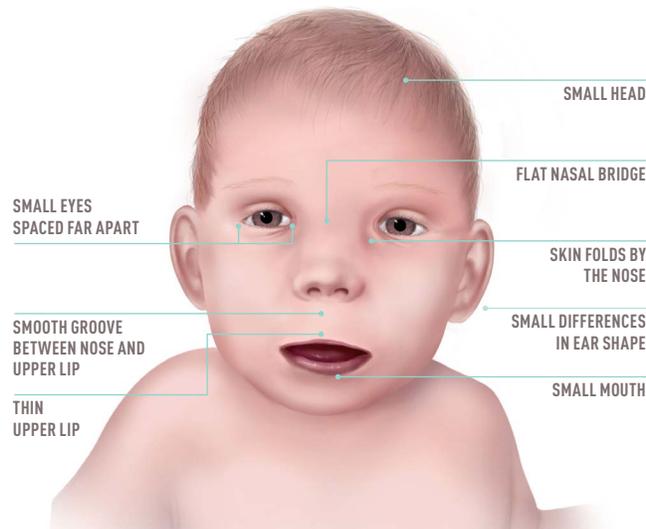
EFFECTS OF PRENATAL ALCOHOL EXPOSURE

POOR GROWTH:

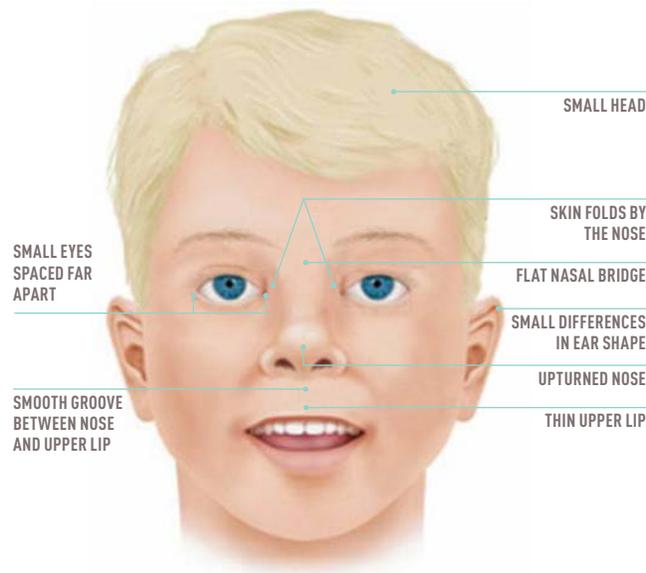
- low weight
- shorter height

INJURY TO THE BRAIN:

- small head and brain
- developmental delays
- learning problems
- behavior problems (trouble focusing, being impulsive, being stubborn, anxiety)
- poor coordination and fine motor skills



Courtesy of CDC



Adapted with permission from Darryl Leja, National Human Genome Research Institute, National Institutes of Health, Bethesda, MD

ALCOHOL EXPOSURE (CONTINUED)

Although FAS does happen, the milder forms of FASD are more common. When a child is having learning or behavioral problems, parents and others may not think about FASD and alcohol exposure, especially if the child does not have the facial features that are characteristic of FAS. But it's still important to think about FASD and alcohol exposure. Alcohol can hurt the brain and change how the brain works, even if it doesn't show in the child's facial features. As a result, a child can have problems

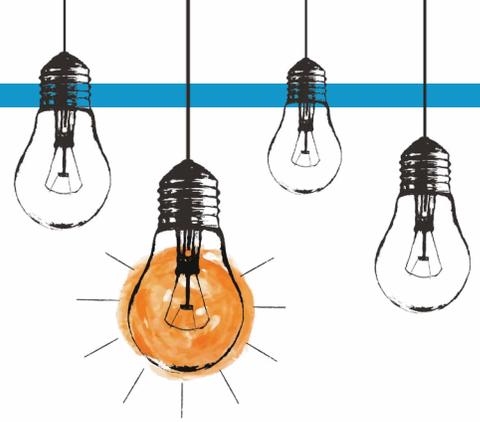
that seem to have no known cause and may not get better with usual care. With FASD, the injury to the brain does not get worse over time, but the child's problems can get worse as he gets older, because more is demanded of him. Although the main damage to the brain cannot be fixed, a child can be helped if the problem is found early and he gets support.

PROBLEMS OFTEN SEEN WITH FASD

INFANTS	TODDLERS AND PRESCHOOLERS	SCHOOL-AGE CHILDREN	ADOLESCENTS AND YOUNG ADULTS
<ul style="list-style-type: none"> • Poor sleep-wake cycles • Irritability • Difficulty calming down • Failure to thrive (poor weight gain) • Difficulties with feeding • Delays in motor skills (rolling, crawling, walking) • Delays in talking 	<ul style="list-style-type: none"> • Continued delays in motor skills • Continued delays in language • Short attention span • High activity level • Low tolerance for frustration; tantrums • Difficulty adapting to change • Poor eating • Delays in toilet training • Difficulty following directions 	<ul style="list-style-type: none"> • Cognitive delays • Specific delays in learning (memory, visual spatial skills, math, verbal expressions, organization/planning) • ADHD • Boundary issues • Low tolerance for frustration; tantrums, acting out • Difficulty understanding cause and effect or learning from prior experience • Immaturity; poor understanding of social rules • Difficulty with activities of daily living (getting ready for school, self-care, chores) • Can appear more capable than actually are • Inappropriate sexual behavior 	<p>Same issues as school age and more, due to higher demands:</p> <ul style="list-style-type: none"> • Mental health problems (anxiety, depression, low self-esteem, low motivation) • Leaving school • Victimization (being taken advantage of by others) • Aggression • Poor judgment; faulty logic, resulting in problems with the law • Difficulty with abstract concepts • Difficulty handling money • Substance use • Lying and stealing • Socially inappropriate behavior, early sex or unintended pregnancy • Unable to maintain a job

TIPS TO GIVE PARENTS AND SCHOOL STAFF

We know that kids who have been exposed to drugs and alcohol do better in safe, supportive, loving families. They do well as part of families who are able to see the child's strengths and weaknesses. And they do well with people who can provide help both at home and in the community to support their needs.



TIP #1

Know what the child does well. Know what poses a challenge.

TIP #2

Accept the child's problems. Understand that the child is not behaving this way on purpose.

TIP #3

Make sure people who work with the child all expect the same thing of the child (family, school, and others).

TIP #4

Use daily routines.

TIP #5

Use simple, clear language and examples.

TIP #6

Use visual aids and cues (like schedules, charts, and calendars).

TIP #7

Help the child learn through hands-on experience.

TIP #8

Repeat instructions, information, and rules.

TIP #9

Use positive responses to encourage small successes (such as sticker charts).

TIP #10

Structure the child's time.

TIP #11

Watch over the child while they try to do things on their own.

TIP #12

Arrange for school supports (like IEPs) and later for job and vocational training, as well as other resources and support through disability resources.

Health for Body, Mind, and Relationships

Children who are adopted or in foster care are more likely to have significant physical health issues. Sometimes, these health problems are the reason that they were available for adoption or placed into foster care. Other times, the problems may be the result of abuse or neglect that the child has experienced, or they may be a long-term result of early toxic stress. Whatever the situation, kids need parents, caseworkers, and health care providers to work together to reduce painful or frightening treatments, and to explain things carefully so there are no stressful surprises.

When children experience toxic stress early in life, they sometimes start puberty earlier than they are supposed to. If puberty changes occur before 8 years old for girls, or before 9 years old for boys, the child should be evaluated by the child's pediatrician or health care provider.

If a child was exposed to drugs or alcohol during pregnancy, or if her birth parents had a substance use disorder, **she may be more likely to develop substance**

use problems of her own. Caseworkers can help encourage parents to teach kids from an early age that trying drugs or alcohol is not healthy, and to watch teens closely for signs of experimenting with drugs or alcohol.

In a similar way, when children have seen or experienced sexual violence, they may act sexually in ways that put them at risk, that are not socially acceptable, or that make others uncomfortable. For example, children may masturbate as a way to calm themselves down. This by itself is not harmful, but they can be taught to do this in private places rather than in public spaces. Caseworkers can encourage parents to teach children about healthy, loving, and respectful sexual behavior, and to help kids protect themselves and respect the wishes of others. Teens may need careful guidance to learn healthy behaviors with boyfriends or girlfriends, and parents should help teens prevent pregnancy and sexually transmitted infections.

Children and youth who have experienced toxic stress are more likely to have long-term mental health struggles. Children whose birth parents have mental illnesses are more likely to have them as well, since these conditions may run in families. Many children and youth who are adopted or in foster care can benefit from working with a mental health professional who is knowledgeable about early childhood trauma and toxic stress, and who is trained in [evidence-based trauma therapies](#). Caseworkers should know those professionals in their communities, and help connect families to them.



Transitions

Big changes in life are hard for everybody. For children who have lived through trauma and times of instability, changes and transitions can be even more difficult. When a child first moves into a new family, she often experiences a period of emotional shutdown while she learns the routines of a new family and household. This is (unfortunately) sometimes called a “honeymoon period,” since the child may be very calm and on her best behavior, and the new parent is feeling joyful with the addition of the new child to the family. What that calm really represents, though, is the child’s anxious efforts to learn the rules and routines of the new household, and being on guard against scary or unsafe things that may have happened with past changes.

Caseworkers can help the child and family through this stressful period by working with parents to help the child feel safe and secure. Photos and transition objects like a soft blanket or stuffed animal can help. A detailed tour of every space in the child’s new home, classroom, and

neighborhood can also help her feel more at home. It’s good to include a discussion about what happens in each space, and what sounds, smells, and sights the child might experience there.

As the child gets used to the new family and school settings, there will be some limit testing and boundary pushing.

Once a child feels relatively safe, she may even “act out” in an attempt to express her sadness and anger and heal from her trauma. This is sometimes referred to as “the end of the honeymoon.” Caseworkers can help by talking with the child and family about understanding big feelings, and healthy ways to handle them.

It is important to remember that just leaving the new home and being apart from new parents can also be stressful for kids who have lived through trauma.

Children may not fully understand that the separation is temporary, and may not yet feel sure that the new parent will return. Teaching parents to be very explicit about what will happen when parent and child are apart from each other, and when parents will come back to take the child home, can help. Some children continue to need this reassurance for months or even years after they join their new families.

It is important to remember that just leaving the new home and being apart from new parents can also be stressful for kids who have lived through trauma.



Learning

Children who are adopted or in foster care often have struggles with learning. This can be because they are still operating in “freeze-run-fight” mode, and their brains are not ready to learn. Also, if kids have missed time in school or have moved to lots of different schools, they are often behind just because they haven’t had a chance to learn things in a consistent order.

If a child is struggling academically in school, he should have a full psycho-educational or neuropsychological evaluation to help his parents and teachers understand how to set reasonable expectations, and to help him learn to his best ability. Children often benefit from having learning and emotional supports in school. Caseworkers should work with parents to make sure each child is getting the support he needs in school.

Being the parent of a child who has learning struggles can be hard, especially if school was easy for the parent. It is helpful to have realistic expectations of the child, even as parents and caseworkers work hard to help him do his best in school. Caseworkers can help by encouraging and supporting other activities (such as sports or the arts) that come easily to the child, which can help to reduce the stress that school struggles can cause for both parents and children.



Caseworkers should work with parents to make sure each child is getting the support he needs in school.

Identity

In addition to trauma, children and youth who have been adopted or are in foster care often have other differences that can make life hard. Race and ethnicity are some of the ways that they may feel different. Children can do very well in interracial adoptive families. But when a child looks different from her parents, she and her family stand out right away. Many communities, even today, have very little diversity. A child in an interracial adoptive family may be the only person of her race in her school, on her sports teams, or in her social circle. This can leave kids feeling like they do not fit in and are all alone.

Sometimes children are made to feel like they are *the* example for their entire race or ethnicity. This can create pressure for a child to be perfect, or it can cause her to just give up and act negatively. Many adopted kids say that they don't feel like they fully belong to any group, since they don't share the same culture or all of the physical features of any one group. Of course, racism doesn't just affect kids who are adopted or in foster care. But when a child's parents, family, and friends have not felt the same racism as the child, it can be difficult for the child to learn how to understand it and respond in a healthy way. It may be harder for a child to learn to love who she is, when she has no real-life role models of her race or ethnicity.

Many children who are adopted or in foster care also live in families that are non-traditional. Some families have just one legal parent, some have two parents of the same gender, and some have grandparents or other extended family members as guardians. Here too, kids may feel singled out or different based on their family structure.

Whether a child is in foster care, kinship care, or an open adoption, relationships with birth parents can be both positive and complicated. Many studies show that it can be very helpful for children to have ongoing relationships with one or both birth parents. But this can also get very complicated, especially if the birth parent is struggling with a substance use disorder or other mental health issues. It can be very helpful for families to work with a therapist or adoption specialist who has experience in helping families work out these relationships. It's good for caseworkers to know who those therapists are in the communities where they work.

Some children who have been adopted or are in foster care do not know parts of their own life stories. A child may not know her actual date of birth; a birth date may have simply been assigned to her. Many children do not know details of their early lives, and important parts of their personal and family medical histories are

often missing. They often do not have baby pictures, records of first words or first steps, or stories of silly things they did when they were little. Some may have pre-verbal memories of trauma, without the words or details to explain how nervous or upset they feel when those memories come back. Caseworkers can have a tremendous impact here, by remembering to gather both information and artifacts of a child's early life whenever the opportunity is there.

All of these differences can be very hard for children and youth who are adopted or in foster care. Kids may be bullied because they or their families stand out. They often get intrusive questions about their lives and their families. School projects that center on family history or ask for baby pictures may highlight these feelings of being different. Kids in foster care may feel added stress because they are not in a permanent family.

Caring adults can help by simply showing empathy and by creating communities that welcome and celebrate children and families of all kinds.



What Can Be Done to Help?

As we have discussed, children who have lived through trauma may react to everyday things in ways that seem like over-reacting, but those reactions are really related to their earlier trauma. When this happens, how the adults around them respond can make a big difference in helping them.

Science has shown that kids who have lived through trauma need different kinds

of support from their caregivers than kids who have not experienced trauma. In fact, if caregivers react in ways that are effective for most kids, it can make things worse, not better, for children who have had trauma.

Children who have a history of trauma often need more help from adults to deal with their feelings of frustration and anger, and they need those adults to remain very

calm and not to take things personally. There are some parenting strategies that have been shown to really help, and you can learn more about them [here](#).

The table on the next page offers some basics about how to respond to common behaviors of children at different ages, showing the “usual” ways and those that work better for children who have experienced trauma.



Science has shown that kids who have lived through trauma need different kinds of support from their caregivers than kids who have not experienced trauma.

GUIDANCE: CHILDREN WITH NO TRAUMA HISTORY VS. CHILDREN WITH HISTORY OF TRAUMA (CHART 1 OF 2)

	CHILD'S BEHAVIOR	Response for Children With NO Trauma History	Response for Children With Trauma History
INFANTS	LOTS OF CRYING	Reassure the child, but allow her to cry and learn to calm herself.	The child may need extra help to learn to calm herself (like wrapping her in a blanket, turning down the lights).
	FEEDING	Eating will usually calm the child.	The child may need help with calming down to eat (swaddling, turning down the lights) Babies with NAS in particular require minimal stimulation during feeding, with dim lights and low noise.
TODDLERS	EATING	By having meals at the same time every day and having family all eat together, the child learns good eating habits. Healthy snacking helps him learn what are good foods to eat and when he should be eating.	If the child has a history of not having enough food or a history of trauma, he may worry that he won't get food when he needs it. He may hide food or want food all the time. Make sure the child can always get healthy food (for example, a lunchbox he can carry with healthy snacks). With a history of trauma, the child may not feel full even after eating. Tell him when the meal is done and distract him so that he can take a break from eating.
	TANTRUMS	Ignore the tantrum.	The child may not calm down on her own. Take her hand to help her calm down and help her body feel safe.
	NOT SLEEPING	Make sure the child's room is just for sleep, with no TV and no electronics before bed. Have a bedtime routine. Let the child fall asleep without a parent in his bed or in his room.	Same advice on room and routines, but the child may need more help from the parent. Start by letting the child sleep near the parent, with the parent on a chair nearby, available to hold a hand if needed. Then gradually increase the distance between the chair and the bed until the parent is able to sit across the room, and then outside of the room, as the child falls asleep. Using a blanket or a stuffed toy may help.
	ACTING OUT	Use a stern "no!" and show the child the right thing to do.	A loud or stern "no" may make the child act out more. With a very quiet voice, tell her that she needs to stop and show her the right thing to do.
	ACTING YOUNGER THAN CHILD IS	Ignore the action. Tell or show the child what he should do based on his age.	The child may need to act younger for short time. Allow this behavior, then go back to the skill at another time.
EARLY CHILDHOOD	EATING	(see guidance under Toddlers)	(see guidance under Toddlers)
	DISORGANIZED SLEEP	(see guidance under Toddlers)	(see guidance under Toddlers)
	SELF-SOOTHING (ROCKING, HEAD BANGING)	Show the child another way to calm down, and get her mind off it.	The child may need the parent to hug or calm her. She may not be able to calm down on her own. Show her other ways to calm down (holding a toy or blanket).
	TANTRUMS	Take a time-out. Ignore bad behavior, reward good behaviors.	The child might not be able to do time-out if he's too upset. He may need to be held or rocked to get his brain to calm down. Quiet him with directions (not yelling).

GUIDANCE: CHILDREN WITH NO TRAUMA HISTORY VS. CHILDREN WITH HISTORY OF TRAUMA (CHART 2 OF 2)

	CHILD'S BEHAVIOR	Response for Children With NO Trauma History	Response for Children With Trauma History
SCHOOL-AGE CHILDREN	EATING	(see guidance under Toddlers)	(see guidance under Toddlers)
	DISORGANIZED SLEEP	(see guidance under Toddlers)	(see guidance under Toddlers)
	ANGER, FRUSTRATION	Teach the child to “use your words” to learn what she is feeling. Teach her how to let others know what she is feeling.	The child may not be able to use words for her feelings yet, and that can make her frustration worse. Look for when the frustration is starting. Then show the child how to use her body to calm down (jump, shake, wiggle, breathe deeply).
	DISORGANIZATION	Set up ways to keep things organized. Charts, reminders, and routines help.	Same as “No Trauma” column. Also, the child may need extra reminders of what to expect. Offer simple and specific directions. (Instead of “go get a shirt,” try “go get your blue shirt.”)
	DEPRESSION, ANXIETY, WITHDRAWAL	Have the child use words to try to say what his feelings are, and why he feels that way. Work with him on coming up with things to do to help him feel better. If he’s nervous, try to figure out the reason. Then talk about why that makes him nervous. Talk about simple ways to feel better (breathing deeply, relaxation, thinking about funny things).	Same as “No Trauma” column. Remember: This may be happening because he is thinking about or reminded of something that happened in the past.
	FREQUENT ACHES AND PAINS	Don’t pay undue attention to the complaints. Talk about what happened before the stomachache or headache, which might be the reason for the pains.	This may be happening because the child is reminded of past trauma. She may need more help to try to calm down with breathing, relaxation, massage, talking about feelings.
ADOLESCENTS	STRONG EMOTION, EMOTIONS BEYOND WHAT THE SITUATION WOULD WARRANT	This can be normal for teenagers. Talk to the teen about how to calm himself down and how to name his feelings. Discuss other ways to handle problems.	Teens who have had trauma may need help with calming down. They can use sight, sound, smell, touch, and taste to help relax (look at calming pictures, listen to relaxing music, use nice-smelling soap, squeeze a stress ball, chew on ice). If the parent sees the teen get really mad, it may seem like he’s mad at the parent. But this is not about the parent; it’s about what happened in the past. The parent needs to stay calm, and help the teen see clues that he is getting out of control, and how to calm down instead.
	IMPULSIVE ACTIONS	Teens normally are impulsive, and sometimes just having to live with the result (like breaking a favorite item) is good way to learn. When the teen is calm, talk with her about ways to think things through. Use examples of bad choices people make from movies or TV, and talk about other ways she could have acted.	The teen may not make the link between what she does and the consequences. She may need help to make the link.

RESOURCES

Safe and Sound Materials

This guide is part of a series of resources designed to help children who have experienced trauma and adversity, by helping their parents, caregivers, and other adults in their lives understand how that early trauma may have affected them. Access all of the materials at:

www.aap.org/safe&sound

National Child Traumatic Stress Network

www.nctsn.org/audiences/child-welfare-professionals

Neonatal Abstinence Syndrome (NAS)

[www.marchofdimes.org/complications/neonatal-abstinence-syndrome-\(nas\).aspx](http://www.marchofdimes.org/complications/neonatal-abstinence-syndrome-(nas).aspx)

Adverse Childhood Experiences (ACE) Study

www.cdc.gov/violenceprevention/acestudy

Trauma Treatment (Children and Adolescents)

www.cebc4cw.org/search/topic-areas/trauma-treatment-child-adolescent

Parent Training Programs

www.cebc4cw.org/search/topic-areas/parent-training-programs

Back to Sleep for Babies in Foster Care: Every Time, With Every Caregiver

www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/healthy-foster-care-america/Documents/sids.pdf

Helping Children in Foster Care Make Successful Transitions Into Child Care

www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/healthy-foster-care-america/Documents/childcare.pdf



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for Adoption®

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The Dave Thomas Foundation for Adoption is a national nonprofit public charity dedicated exclusively to finding permanent homes for the more than 150,000 children waiting in North America's foster care systems. Created by Wendy's® founder Dave Thomas who was adopted, the Foundation implements evidence-based, results-driven national service programs, foster care adoption awareness campaigns and innovative grantmaking. To learn more, visit: davethomasfoundation.org or call 1-800-ASK-DTFA.



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Jockey Being Family® is Jockey International, Inc.'s corporate initiative dedicated to providing comfort to families touched by adoption. Jockey Being Family naturally reflects Jockey's values as a family-owned company and its dedication to outfitting individuals with the comfort and support they need to live their best lives. Recognizing the unmet need, Jockey® selected post-adoption services as an issue where Jockey Being Family could make a significant impact. Jockey believes that by strengthening adoptive families, we can ensure permanence for children and strengthen families in our communities. We believe that every child deserves to grow up with a loving family in a forever home. To learn more, visit: jockeybeingfamily.com and jockey.com.

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