BLUEWATER FAMILY SUPPORT SERVICES

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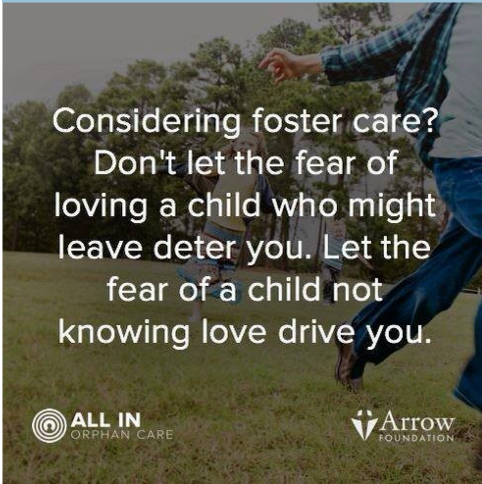

John Tyler Retires 2016

April 28, 2016 was John Tyler's last day of work with Bluewater Family Support Services, Inc. John began his service with Bluewater in October of 2001, but his career in foster care and caring for troubled children and youth had begun long before that.

Within scant years of being married, John and Gillian began as group home parents in the early-1980s. As time passed, roles and responsibilities changed. By the early 1990s, John emerged in a local leadership role with Ausable Family Services. Locally, surviving the Rae Days, became a matter of collaboration and cooperation, not competition. As the predominant private providers of foster and group care, BetaMarsh, Nairn Family Homes, Ausable Family Services, and Bluewater Family Support Services began sharing their expertise and experience with youth in placement. Working together improved outcomes for everybody, especially our children and youth and the Children's Aid Societies that supported their care. In was in this context that some of John's unique abilities became more evident.

John has always been solution focussed. Years ago, when the local school Board's special education resources were being challenged, there was an attempt to foist the blame onto private care providers. In a manner I now know to characteristic of John, he listened to the Board's position, examined their facts, and proposed a solution.

"2IC" and "InService:' words I learned from John. 2IC—second in command; InService: you train puppies and pets, not foster parents. Foster parents you educate in service.

John was a colleague and is a friend to whom I will always be indebted and whose presence will always be a part of Bluewater. John and Gillian were most certainly Bluewater's "power couple." They worked together as easily as their many years of marriage and commitment to one another. They are a special couple who gave to us far more than we have ever been able to give to them.

There is one more thing I think everyone should know about John and Gillian. John and Gillian are among the few first generation pioneers in treatment foster care. Before it was popular and widely accepted, before the beginnings of the Foster Family-based Treatment Association, just as social psychiatry was establishing a foothold, (at a time when hippies walked on the earth), John and Gillian began their careers providing foster care for emotionally challenging youth. A lot of history was made over the years since in TFC and second and third generation providers now proliferate. The debt owed those early pioneers in our field is incalcu-

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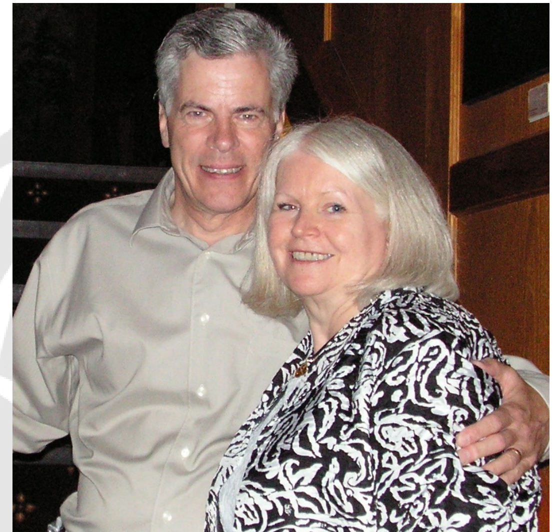
lable: truly without their compassion, concern, professionalism and commitment to children and youth, social psychiatry might easily have lost its footing and TFC might well have been stillborn. In Canada, this is a shout out to Ausable Family Services (Abe Suderman), Nairn Family Homes (Ed and Alice Driediger) and the countless, nameless others whose contribution built this model of care. John and Gillian are among the giants upon whose shoulders we now stand.

Incredible People I Have Known



April 28, 2016, came rather quickly into my life!

That afternoon, I changed my phone message for the last time and gave back my Bluewater office key. At 65, it was time to retire …to step away from people and a career I have loved. Colleagues and co-workers were generous with their kind words, but there was no question in my mind it was the right decision and the right time for me.

Our background

Gillian and I began fostering in 1974. We were 23 years old and two years married. Unlike the experience of most foster parent candidates, within a few days we had been approved and on a Friday afternoon, I opened the door at home and became the 'father' of a four year old boy and his six and eight year old sisters. Welcome to fostering!

It was a steep learning curve, but we loved it. Since then, 23 children and teenagers have lived with us (not counting those whose scheduled stays were brief). The experiences were many and varied as in any foster family. Our own three children grew up with four to six older 'brothers and sisters', so there were times when we had nine children and teens in our home. (The rules are different now).

It has been exciting, rewarding, emotionally 'high' and 'low', but certainly there have been no dull moments.

For the past 27 years, we have supported and supervised other foster families and most have become good friends. Support at all hours of the day and night leads to a close relationship with the foster parents.

It's those relationships that have kept Gillian and I interested and involved.

Children

The 14 year old boy had a file that would scare anyone. On the day he was to be placed, they couldn't find him. His father was a mentally ill street person and his mother lived in motels. The boy was used to living by himself under a city bridge! I didn't think he could ever make it in a foster family.

Years later, the foster parents said they had yet to have a major incident with him. He went to college for Computer Science, bought his own home and returned to get married in the foster parents' backyard.

I asked him what so suddenly had made the difference in his life. The simplicity of his answer is memorable. "When I first walked through the door, they respected me. I had never been respected before!"

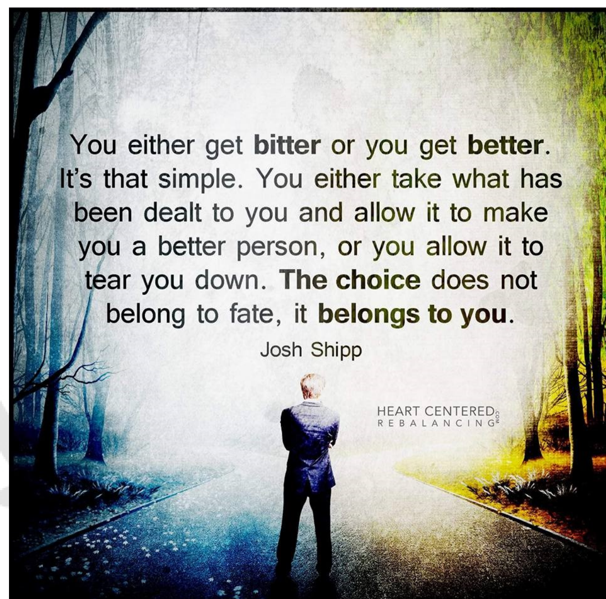
The children demonstrate a profound resilience. I cannot imagine the nightmare of their childhood experiences. Nor can I imagine expecting today to be like any other day, only to be removed from my family by people who say they are 'helping me', and then end the day in a family with quite different attitudes and routines. All the worse when it happens repeatedly!

I have been reminded of the brokenness of their childhood experiences by their misbehaviours. But I have also been reminded that their resilience is forged by a refusal to give in to their desperate circumstances. They are in an intense struggle to keep their past from shaping their future.

I have known young people who are delightful with their sense of humour, creativity and sensitivity to others. I have also known young people who were too entrenched in their detrimental habits to benefit in a family setting. Always the young people have one hope, that someone will see beyond the damage to love and respect them.

Foster parents

I call them the 'magic words' of foster parents.



Often when Wilf or I went to interview prospective foster parents, we would actively try to talk the candidates out of pursuing fostering as a lifestyle. That was because the daily demands on our type of foster parents are higher than most people can fathom. The marathon of helping a child change behaviour is certainly more taxing than most people are willing to live with.

But, during the conversation, 'real foster parent candidates' say something like, "We've been given so much in life, we need to give back. If we don't, who will?" Then our conversation immediately turns to how they will foster with Bluewater. Couples who think this way already have pretty good ideas that actually make fostering work well within their family.

Once they have been fostering for a while, the 'Best of the Best' will tell me some disastrous story about what the child has done to them or their home that would make most people throw in the towel. Just when I assume they're ready to give up, they'll say something like, "…but she's got so much potential, we want her to stay!" They look beyond the moment and see the hurt that makes sense of the behaviour, and how their skills will move the child past that moment to better future choices and results.

I have worked with many foster families, and with a few for over 25 years. One couple started in 1960 and received the Order of Ontario for fostering! They have done their 'magic' in the lives of 80 young men who are better off for having lived in that family. Many others should also receive awards for the brilliant work they have done.

Raising a child is hard. Fostering someone else's young person is an incredibly difficult lifestyle that requires superior patience, tolerance, acceptance, open-handed giving, and giving, and giving, …and endless forgiving. Fortunately, it can also be fantastically rewarding.

I applaud the incredible foster parents I have known and for that matter, foster parents everywhere who give so much of themselves to encourage hope in traumatized children.

Colleagues

There have been many professionals, CAS workers, principals, teachers, EAs, service providers and doctors who have gone above and beyond their duties (and their hours) to support foster parents and help young people. They became colleagues who I looked forward to seeing or chatting with on the phone.

Staff

Bluewater has attracted and retained some amazing people. The 'job' of supporting foster parents and children is also a 24/7 lifestyle. For example, I automatically choose an aisle seat at a theatre or at church, knowing I could be called out at any moment. A phone call can change an evening with the family as I retreat to talk to a foster parent or write up a Serious Occurrence report. Children's needs never stop, and neither does the responsibility to 'be there' with our people through everything. Occasionally, this means actually being there in person when things are happening …when a child needs to go to hospital and the foster parent wants help through a very long night, …when a teenager becomes involved with the police in another part of Ontario, and the foster father needs another driver to help retrieve her. Almost anything can happen at almost any time.

The staff laugh at the craziest things when we get together. We may seem like the most hard-hearted individuals, but laughter washes away a lot of stress. As a matter of fact, we know we have helped a distraught foster parent regulate themselves when we hear them laugh at the end of a lengthy phone call.

Leadership

Time and again, people have come to Bluewater or stayed because of Wilf Graham and his leadership style. He understands the complexities of family life and what it takes to support a foster family. He promotes creative methods in dealing with traumatized children, and knows one family's solution doesn't fit every child, or every family's situation. He trusts staff and foster parents to know what they can handle and how to deal with their own time and circumstances. He does not demand anything other than attempted excellence in helping each child. He celebrates successes, discusses options, and forgives honest mistakes with grace.

No wonder I have loved this career! It's the people! Thanks to all of you who have enriched my life.

SMART

Sensory Motor Arousal Regulation Treatment

**Excerpted from, "Elizabeth Warner, Alexandra Cook, Anne Westcott, and Jane Koomar, "SMART: Sensory Motor Arousal Regulation Treatment" from the Trauma Center at the Justice Research Institute of Brookline, Massachusetts, pp5-7.*

SMART draws from four foundational theories and bodies of knowledge: trauma theory, child development, Sensorimotor Psychotherapy, and Sensory Integration.

The primary focus of Sensory Motor Arousal Regulation Treatment (SMART) is to help children who have been traumatized develop some stability in their lives, so that they may begin to heal. Thus, the trauma framework is the first cornerstone of SMART. It is our belief that children's natural tendency is toward positive growth and adaptation. Traumatized children encounter many kinds of roadblocks that derail or distort that natural healing tendency. The National Child Traumatic Stress Network (Cook, Blaustein, Spinazzola & van der Kolk, 2003; Cook et al., 2005) described these seven primary areas of impairment seen in traumatized children:

- attachment
- biology
- affect regulation
- dissociation
- behavioral control
- cognition
- self-concept

Attachment is the first domain listed because of its far-reaching influence. Attachment is the cornerstone of child development, so that when the attachment caregiver is the source of trauma, the consequences can unfold in all areas of development. It is crucial that a child form the primary attachment relationship so as to additionally develop arousal regulation in infancy and toddlerhood (Siegel, 1999; Schore, 2003b). Research indicates "the early social environment, mediated by the primary caregiver, directly influences the final wiring of the circuits in the infant's brain that are responsible for the future social-emotional development of the individual." (Schore, 2003b p. 73).

The biology of traumatized children is affected in many significant ways. Four areas of impairment are especially relevant to SMART: the arousal system is dysregulated; the sensory and motor systems are often poorly integrated; the "communication" of left and right hemisphere is disrupted; and the executive functioning of the prefrontal cortex is compromised. The arousal system (brain stem and midbrain functioning) is developing in utero and from birth and is impacted by the caregiving system. Without responsive caregiving and in the face of abusive caregiving, the child's arousal system becomes over-reactive to stress and dysregulated (Gunnar & Donzella, 2002). Many children living with neglect and environmental deprivation have had decreased opportunities to safely explore the environment and to receive the scaffolding of caring adults. This experience of impoverishment has impaired the child's sensory motor development (Perry, 2001, 2009) and the integration of these systems. As language develops in toddlerhood, the lack of integration between left and right hemisphere functioning becomes problematic for traumatized children. More specifically, traumatized children have difficulty accessing their verbal (left brain) and analytic resources (prefrontal cortex) when they have been triggered by traumatic or highly emotional stimuli (right brain). The development of early executive functions of inhibition, cognitive flexibility and working memory (Diamond, 2002, 2006) is effected. In adolescence, executive functioning, e.g. improved decision-making, behavioural choice and control, planning, is supposed to be developing through the myelinization of the prefrontal cortex. For traumatized children, the lack of development of the earlier capacities of arousal regulation, sensory motor perception and inter-hemispheric coordination, in addition to the often still traumatizing environment, makes it impossible for the later executive functioning abilities to fully develop, which lead to serious social and behavioural consequences.

On the hopeful side, neurological systems possess amazing neuroplasticity (Doidge, 2007). Due to the multiple neurological pathways between different parts of the brain, the nervous system is capable of extraordinary regeneration of lost functions. An injured system can compensate through connectivity to new areas of the brain, or in some cases, grow new connecting dendrites between existing neurons as well as altogether new neurons from neuronal stem cells, as has been shown in the hippocampus (Doidge, 2007). This is one of the most exciting paradigm shifts supported by recent neuroscience and strongly suggests that children wounded by trauma can heal and thrive in a positive and nourishing environment.

Affect regulation is one of the most obvious issues for traumatized children. A large part of their symptoms result from their inability to, experience, identify, express, and modulate their emotions. Identification of distinct feeling states is essentially the differentiation among arousal states that occur in a context. When these emotions are too intense or too threatening, children immediately go into a defensive fight freeze response. This process robs children of the opportunity to experience their feelings and manage them with access to greater coping resources. Moreover, emotions are a critical consideration when responding to a situation, so that if a child is unable to tolerate much emotion, then it is hard for her to make good decisions about her behaviour. Because of the difficulties with experiencing and identifying emotion internally, traumatized children struggle with how to regulate these intense experiences of arousal, known as feelings. Typically, these children invoke a variety of avoidance strategies, e.g. dissociation, substance abuse, and then explosion when the emotion builds up. It is very hard for traumatized children to stay in the present.

Dissociation, a distinctive phenomenon of trauma, happens when there is a "failure to integrate or associate information and experience in a normally expectable fashion" (Putnam, 1997, p.7). In the face of overwhelming experience, children frequently use this protective defense, which then becomes an automatic biological response for managing all kinds of emotional experiences. Putnam (1997) described three main functions of dissociation: the automatization of behaviour for survival in the face of traumatic events, the compartmentalization of painful memories and feelings, and the detachment from one's self during traumatic circumstances.

The behavioural dysregulation seen in traumatized children involves either too much inhibition or, conversely, not enough inhibition. This difficulty with inhibition and control leads to a variety of impulsive, oppositional and self-destructive behaviour problems, e.g. substance abuse, self-injury, and juvenile delinquency (Anda, 2002). In young children, the lack of inhibition manifests as temper tantrums, stubbornness, and physical lashing out. The wide ranging behavioural problems are an outward expression of the underlying arousal dysregulation.

Traumatized children struggle with their cognitive functioning, in the academic realm, as well as in the social-emotional arena. Difficulties with executive functioning, e.g., inhibitory control, working memory, and cognitive flexibility (Diamond, A., 2006), are the basis for the cognitive problems seen in traumatized children. Academically, traumatized children are more likely to receive special education, obtain poorer grades and drop out of school (Shonk & Cicchetti, 2001). Lastly, given all of these areas of struggle, it is no wonder that traumatized children have a poorly defined and highly negative self-concept. From the earliest moments, most traumatized children have not received the positive mirroring necessary to develop a positive sense of one's self. Furthermore, mastery and skill development that provide a basis for a strong self-concept, is impeded by the problems of regulation.

SMART focuses largely on the four areas of attachment, biology, affect regulation, and dissociation. Through the focus on the body's experience, there is improvement in behavioural control, language, self-awareness and self-concept. Whereas many trauma treatments focus on narrative meaning making, SMART begins with the body regulation. Then, as the child's system becomes more modulated, it is possible for meaning making to grow out of a more organized state. In other words, SMART uses a bottom-up approach as opposed to a top-down approach.

Trauma treatment has evolved from a phase based approach to a components-based approach that focuses on safety, skills building, growth of positive attachment relationships, meaning making, trauma processing, and development of a positive sense of self (Cook et al., 2005). Because the nature of complex trauma happens largely within the family, establishing a safer living environment is critical to any trauma treatment. The second component focuses on building the skills necessary to manage emotions and to attend to normal developmental tasks, e.g. playing by one's self and with others, learning at school, making friends. The foundation of these skills is a positive attachment relationship. Trauma treatment must focus on repairing and developing a positive relationship with the child's caregiver. In some cases, this is a parent who was abusive or neglectful in the past. In other cases, this is a new adoptive parent or a temporary foster parent. As these areas are addressed and some stability is attained, children begin to take on the issues of meaning making about the traumatic experiences they have suffered. The final component involves developing a sense of self that includes, but is not eclipsed by, the trauma, and engaging in the tasks of normal development.

A wonderful example of a trauma-focused treatment that utilizes a components -based approach is ARC (Blaustein & Kinniburgh, 2010). In this treatment approach, the areas of attachment, regulation, and competency are addressed as needed and appropriate for the child. This gives the child, the family, and the provider the flexibility in treatment planning to adapt to the child's presenting needs.

SMART is most helpful in developing the affect regulation skills necessary for daily living and trauma processing. Typically, traumatized children are spending much of their time feeling over-aroused and anxious, or under-aroused and frozen. By teaching the child and the parents about what helps regulate a child's arousal, the therapy enables a child to move into a state of increased organization more of the time. In that state of better organization, the child then has access to more resources, e.g. language, abstraction, social engagement. With these functions available, it is possible to do the work of trauma processing and creating a strong sense of self.

16 Ways Adults Can Support Children Exposed to Violence and Trauma*

Written
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Impact of Trauma and Violence on Children & Youth

Everyday, too many children and youth are exposed to violence in their homes and in their communities. Studies suggest that 15.5 million children in the U.S. witness domestic violence annually (Whitfield et al., 2003). By age 17, over one-third of America's children will have been exposed to domestic violence (Finkelhor et al., 2009). Over 60% of children and youth have experienced at least one direct or witnessed victimization of violence generally in the previous year and almost half had experienced a physical assault in the study year (Finkelhor et al., 2009).

Growing evidence from scientific studies indicates that exposure to violence and other forms of trauma can be harmful to children of all ages (Futures Without Violence, 2013; Garner & Shonkoff, 2012). We define violence as "the intentional use of physical force or power, threatened or actual, against oneself, another person, or against a group or community that either results in or has a high likelihood of resulting in injury, death, psychological harm, maldevelopment, or deprivation" (Listenbee et al., 2012). Exposure to violence can result in the experience of trauma – hurt or harm to a person's body or mind (National Institute of Mental Health, 2006). Potentially traumatic events include being the victim of and/or witnessing the following: natural disasters, family violence, child abuse and neglect, dating violence, sexual assault, school violence or community violence (e.g., shootings and gang violence), and violence or bullying as a result of homophobia or affiliation with other social or cultural identity groups that face discrimination.

There are two different types of trauma – acute (a single event lasting for a short time) and chronic (multiple events over a longer period of time) (Grillo & Lott, 2010). Chronic trauma is also known as "complex trauma," with the occurrence of multiple negative events, often at a young age, that are either perpetrated or allowed by a child's caregiver(s) (Lieberman, Chu, Van Horn, & Harris, 2011). For children and adolescents, trauma can be particularly detrimental. They are still in the process of developing physically, mentally, and emotionally and may not have the capacity to grapple with the events experienced (National Institute of Mental Health, 2006). Chronic exposure to trauma results in the over stimulation of the stress response systems of children and can lead to toxic stress. According to the Center for the Developing Child (2014), "toxic stress response can occur when a child experiences strong, frequent, and/or prolonged adversity—such as physical or emotional abuse, sexual abuse, chronic neglect, caregiver substance abuse or mental illness, exposure to severe community or gang violence, and/or the accumulated burdens of family economic hardship—without adequate adult support. This kind of prolonged activation of the stress response systems can disrupt the development of brain architecture and other organ systems, and increase the risk for stress-related disease and cognitive impairment, well into the adult years".

Exposure to violence and other forms of trauma can impact children in a variety of ways. Recognizing some of the signs can help you identify children and adolescents who may need assistance and support. The following behaviors may indicate that a child or adolescent is experiencing problems related to trauma or chronic and on-going stress (National Institute of Mental Health, 2006; Kisiel & Lyons, 2001; Grillo & Lott, 2010; Listenbee et al., 2012; Brymer et al., 2006):

- Anxiousness and irritability
- Trouble concentrating and/or sleeping
- Easily startled (e.g., jumping in response to sudden noises that do not bother other children)
- Hyper vigilance (watchful and "on guard" for possible dangers around him)

- ► Withdrawal from social interaction
- ► Dissociation (e.g., black outs, detachment from reality, forgetfulness, emotional numbing, personality changes).
- ► Challenging behavior (e.g., aggressive outbursts, picking fights, yelling, disobeying authority figures, difficulty sleeping, trouble concentrating, sexual aggression)
- ► Refusal to return to the site of the trauma and/or avoidance of any trauma reminders
- ► Physical signs of abuse or self-injury (e.g., black eyes, cuts, limps, broken limbs, self-inflicted wounds)
- ► Feelings of powerlessness and having "no future"
- ► Traumatic play (e.g., re-enacting a traumatic event with toys and/or playmates)
- ► Trouble developing and maintaining relationships with peers
- ► Delays or regression in development, (e.g., speech acquisition, bed-wetting)
- ► The use of drugs or alcohol
- ► Onset of risky sexual behavior

These behaviors can begin after a single traumatic event, or can appear to be characteristic of children who live with persistent or chronic trauma. Children who live in communities with high rates of gun violence may exhibit challenging behaviors that aren't new or are not connected to a specific incident, but are still cause for concern as they could be a result of experiencing chronic trauma. For other children, any out-of-character behavior may be indicative of a larger issue such as child or adolescent trauma and should not be taken lightly.

Every child is different, and every child responds differently to trauma. Age, developmental stage, gender, and culture can all influence how a child responds to a traumatic event. There can be an overlap of traumatic symptoms across ages – all children and teens can become depressed, exhibit aggression, have nightmares, experience feelings of guilt – but some age groups can have unique responses. For example, younger children may cling to caregivers and other adults, cry and scream, and resort to behaviors they had previously outgrown (e.g., thumb-sucking, bedwetting, and fear of the dark) while adolescents may resort to drug and alcohol use, have suicidal thoughts, and wish to seek revenge (depending on the trauma) (National Institute of Mental Health, 2006). Teens that have experienced multiple traumatic experiences in childhood are also more likely to engage in risky behaviors during adolescence such as using drugs and alcohol (Dube et al., 2006). Challenging behavior is often common in adolescence, which is why adolescent trauma symptoms are sometimes overlooked (Crane & Clements, 2005). Adolescents are in the process of creating their identities, which may lead to risky behavior and potentially traumatizing experiences.

Considering gender, boys tend to respond to trauma differently than girls and have different rates of exposure to potentially traumatizing events. Girls are more likely to experience sexual assault, dating violence, and child abuse while boys are more likely to witness death or injury, scenes of war, fire, and natural disasters (Tollin & Foa, 2006). Studies indicate that as many as two-thirds of adolescents who become pregnant were sexually or physically abused some time in their lives (Liederman & Alom, 2001). Studies have also shown that girls are more likely to experience ,- traumatic symptoms than boys – a fact that you should consider in your daily interactions with children (Green et al.,

Am I getting to be that age?

I was in a store that sells sunglasses, and only sunglasses. A young sales lady walks over and asks, "What brings you in today?" I looked at her, and said, "I'm interested in buying a refrigerator." She didn't quite know how to respond.

I was thinking about how a status symbol of today is those cell phones that everyone has clipped onto their belt or purse. I can't afford one. So I'm wearing my garage door opener instead.

I was thinking about old age and decided old age is when you still have something on the ball, but you are just too damn tired to bounce it.

I thought about making a fitness movie for folks my age and calling it "Pumping Rust."

When people see a cat's litter box they always say, *"Oh, have you got a cat?"* Just once I want to reply, *"No, it's just for company!"*

Employment application blanks always ask who is to be called in case of an emergency. I think you should write, "*An ambulance*."

Birds of a feather flock together and then potty on your car.

The older you get the tougher it is to lose weight because by then your body and your fat have gotten to be really close friends.

The easiest way to find something lost around the house is to buy its replacement.

Did you ever notice: The Roman Numerals for forty (40) are XL?

The sole purpose of a child's middle name is so he can tell when he's *really* in trouble..

Did you ever notice: When you put the 2 words ' The' and ' IRS ' together it spells 'Theirs…'?

Aging: Eventually you will reach a point when you stop lying about your age and start bragging about it.

Some people try to turn back their "odometers." Not me. I want people to know 'why' I look this way. I've traveled a long way and some of the roads weren't paved.

You know you are getting old when everything either dries up or leaks

1991; Tollin & Foa, 2006).

Children from certain backgrounds and experiences (e.g., racial, ethnic, religious, sexual or gender identity, and language diversity) may be exposed to a greater number of potentially traumatizing events (e.g., refugee experiences, immigration, racism, homophobia, and acculturation – getting accustomed to a new culture). For American Indian and Alaska Native children and youth, historical or intergenerational trauma should also be taken into account. Historical trauma is cumulative and collective. Domination and oppression of native peoples increased both economic deprivation and dependency through retracting tribal rights and sovereignty. Consequently, American Indian and Alaska Natives today are believed to suffer from internalized oppression and the normalization of violence (Burbar & Thurman, 2004). The impact of this type of trauma manifests itself emotionally and psychologically, in members of different cultural groups (Brave Heart, 2011).

African American children and other communities of color also experience historical trauma and are impacted by structural racism and institutional violence. For example, African American students are suspended and expelled at a rate three times greater than white students (U.S. Department of Education Office for Civil Rights, 2014). As a collective phenomenon, those who never even experienced the traumatic stressor, such as children and descendants, can still exhibit signs and symptoms of trauma or experience internalized oppression (SAMSHA, 2012). For some communities the legacies of historical trauma is a current and on-going traumatic experience. For certain children, there may be certain risk factors – language barriers, family conflict over cultural differences, struggling to fit in at school, and mistrust of police and systems – associated with reconciling their new culture and their cultural origin that may exacerbate any posttraumatic symptoms (The National Child Traumatic Stress Network, 2013).

Negative attitudes toward lesbian, gay, bisexual, transgender, and queer people (LGBTQ) result in an increased risk for victimization of violence for LGBTQ people, compared with other children (Coker, Austin, & Schuster, 2010). LGBTQ children are also at a higher risk for suicidal thoughts, ideation, and attempts as they may feel rejected by their peers or family and often internalize feelings of shame and isolation. A nationally representative study of adolescents in grades 7–12 found that LGBTQ youth were more than twice as likely to have attempted suicide as their heterosexual peers (Russell & Joyner, 2001).

While trauma and exposure to violence can impact children in a variety of ways, many children are not traumatized or permanently harmed – a sign of resiliency. Resilience is an amalgam of "genetic predispositions and personal, familial, and environmental risk and protective factors" (Rutter, 1999, as cited in Lieberman et al., 2011). A child's protective factors are attributes that reduce the effect of stressful and/or traumatic events on a child's life (Center for Disease Control, 2013). Protective factors promote resiliency and include individual strengths (e.g., conflict resolution skills, temperament, and the ability to make sense of difficult experiences); family strengths (e.g., strong child-caregiver relationships, a physically and mentally healthy caregiver, and a stable living environment) and community strengths (e.g., a positive school climate and feeling connected to their school, role models, safe places to play in their neighborhoods, and mentors who create safe, nurturing environments). Children need "consistent, supportive, and loving" adults who create resilient environments (Futures Without Violence, 2013; Masten, 2009). The following 16 recommendations were developed to foster the strong relationships and safe, nurturing environments that support that resiliency.

It is important to note that, in your supporting role, you should never pressure a child to relive or disclose their traumatic experience. Follow their lead on the level of detail they choose to share. As a non-clinician, you should be aware of your limits and when to help a child obtain professional clinical services. If a child shows acute mental health issues (e.g., an inability to function in his daily life or threatening to harm himself or others) or continues to exhibit posttraumatic symptoms 4 weeks or more after a traumatic event, connect him and his caregivers with professional clinical services as soon as possible (Brymer et al., 2006). Places you may refer them include their school (connect them with a teacher, social worker, or guidance counsellor), child welfare services, local community health centers/clinics, non-profit organizations, neighborhood centers, domestic violence programs, tribal organizations, and faith-based organizations. Any health care organization in your community should have the resources to meet their needs, or the knowledge to help the child and their caregiver access needed services.

The following recommendations are designed to help kids exposed to trauma and violence, but they could also be useful to help all kids develop resilience for current and future challenges. Providing care and support, you can be a powerful force for good in children's lives!

Recommendations

1. **Take care of yourself.** Working with children can be uniquely rewarding, but there is no question that it is also hard work. This is especially true of working with children exposed to trauma, violence, or adversity. Dealing with difficult behaviors can be stressful, and listening to a child's traumatic story can be troubling in the extreme, and sometimes listeners can become vicariously traumatized (Cole et al., 2005). Vicarious trauma, also called secondary trauma, can be defined as the emotional impact of hearing trauma stories and becoming witnesses to the pain, fear, and terror that survivors have experienced, (American Counseling Association, 2011). Vicarious trauma can lead to compassion fatigue, numbness, trouble sleeping, hyper arousal, and other physical or emotion-

al issues. Working with children who have experienced trauma can also trigger your own past experiences with violence or trauma and can interfere with your ability to support and engage with certain children or youth. Beyond these specific stressors, we all face stress and anxiety related to work, finances, and family. Violence in the media and on the Internet can also add to this stress and become overwhelming for adults as well as children (Groves, 2002). Sometimes it can be easy to allow stress to seep through into other parts of your life. Remember that children are observant. They notice if you are irritable or impatient with them or with other children or adults. Taking care of yourself will help you be at your best – calm and caring – to meet the needs of children you encounter each day. Make self-care a priority: get enough sleep, exercise, or talk to a trusted friend, faith leader, or mental health professional to process and manage your stress.

2. **Reach out, connect, and support.** Check in regularly with the children you encounter each day – kids exposed to trauma may become socially isolated and not receive the social support they need (Kataoka et al., 2012, p. 125). Studies have found that feeling supported by others strengthens resiliency in children (Masten, 2009). Something as simple as greeting a child by name (or in some Indigenous cultures, call the child by a kinship term) every morning can make them feel seen, known, and valued. By creating a welcoming environment, you can help a child develop a sense of belonging in his community (Cole et al., 2005). The children that need us the most often push us away the hardest, so continue to try to connect. Think about your role in relation to this child's life and make that role supportive and involved.

Psychiatrist vs. Bartender

Ever since I was a child, I've always had a fear of someone under my bed at night. So I went to a shrink and told him: "I've got problems. Every time I go to bed I think there's somebody under it. I'm scared. I think I'm going crazy."

"Just put yourself in my hands for one year, said the shrink. Come talk to me three times a week and we should be able to get rid of those fears."

"How much do you charge I asked"

"One hundred fifty dollars per visit," replied the doctor.

"I'll sleep on it," I said.

Six months later the doctor met me on the street. "Why didn't you come to see me about those fears you were having?" He asked.

"Well, $150 a visit, three times a week for a year, is $23,400.00. A bartender cured me for $10.00. I was so happy to have saved all that money that I went and bought a new pickup truck."

"Is that so?" With a bit of an attitude he said, "and how, may I ask, did a bartender cure you?"

"He told me to cut the legs off the bed. Ain't nobody under there now."

It's always better to get a second opinion.

3. **Be a good listener.** In your day-to-day interactions with children, listening sympathetically and respectfully shows a child that they are heard and valued. Actively listening – showing "interest, empathy, and availability" – shows a child you respect them and can prevent their social isolation (Kataoka et al., 2012, p.124). Establishing an emotional, non-judgmental connection with a child is a way to build their trust in you (Paris, 2012). When it comes to discussing trauma, allow the child to take the lead and set the tone of the conversation. Some children may not wish to discuss what has happened to them. Do not pressure a child to talk; they may not wish to share, and it is not your responsibility to make them do so (Grillo & Lott, 2010). If a child wants to talk about a difficult topic, whether they are elementary age or an adolescent, listening is a critical tool that you can use to help them express their thoughts and makes sense of their experience. Consider your own background, perspective, and biases – think about how they may impact a child with whom you are engaging (Paris, 2012). Try to be supportive yet neutral – focus solely on the child's needs without judgment (Strasburger, Gutheil, & Brodsky, 1997). If a child wants to share their story, allow the child to share without interruptions. When they have finished, you may request permission to ask follow-up questions (Paris, 2012).

4. **Observe the child's requests and body language to determine the best approach to respond.** Some appropriate language examples include: "From what you're saying, I can see how you would be…" and "It sounds like it's been hard for you…." (Brymer et al., 2006). Younger children may want to tell stories or draw a picture describing the events (Groves, 2002). Helping children to identify their emotions through words can promote healing. Consider your environment if a child wants to talk, and consider moving to a location with privacy to avoid other people from over-hearing your conversation. As a reminder, if a child discloses abuse, you are held to your state's mandatory reporting laws.

4. **Answer a child's questions honestly but age appropriately.** The age of a child will determine how you talk to him and respond to any questions he may have regarding a recent or on-going traumatic event (National Institute of Mental Health, 2006). For example, for an elementary-age child, you should use basic, understanding language. If a child says, "I don't know why this bad thing happened (or is happening)", you could answer with, "Sometimes bad things happen that we can't explain." (Groves, 2002). For adolescents, you can use more direct language that is informative, yet supportive, and matches the adolescent's emotional state. If they are hostile, or expressing aggressive and impulsive behaviors – as teens often do; try to remain calm and through dialogue, attempt to get to the root of their aggression (Crane & Clements, 2005). Respect a child's cultural background. Even if there are

Trouble at the Canadian border . . .Crisis at the U.S. - Canadian Border

The flood of American liberals sneaking across the border into Canada has intensified in the past week, sparking calls for increased patrols to stop the illegal immigration. The Republican Presidential primary campaign is prompting an exodus among left leaning citizens who fear they'll soon be required to hunt, pray, and live according to conservative ideas about the Constitution.

Canadian border farmers say it's not uncommon to see dozens of sociology professors, global warming activists, and "green" energy proponents crossing their fields at night.

"I went out to milk the cows the other day, and there was a Hollywood producer huddled in the barn," said Southern Manitoba farmer Red Greenfield, whose acreage borders North Dakota . "The producer was cold, exhausted and hungry. He asked me if I could spare a latte and some free-range chicken. When I said I didn't have any, he left before I even got a chance to show him my screenplay, eh?"

In an effort to stop the illegal aliens, Greenfield erected higher fences, but the liberals scaled them. He then installed loudspeakers that blared Rush Limbaugh across the fields, but they just keep coming.

Officials are particularly concerned about smugglers who meet liberals near the Canadian border, pack them into electric cars and drive them across the border where they are simply left to fend for themselves after the battery dies.

"A lot of these people are not prepared for our rugged conditions," an Ontario border patrolman said. "I found one carload without a single bottle of Perrier drinking water. They did have a nice little Napa Valley Cabernet, though, and some kale chips."

When liberals are caught, they're sent back across the border, often wailing loudly that they fear retribution from conservatives. Rumors have been circulating about plans being made to build re-education camps where liberals will be forced to drink domestic beer and study the Constitution.

In recent days, liberals have turned to ingenious ways of crossing the border. Some have been disguised as senior citizens taking a bus trip to buy cheap Canadian prescription drugs. After catching a half- dozen young vegans in blue-hair wig disguises, Canadian immigration authorities began stopping buses and quizzing the supposed senior citizens about Perry Como and Rosemary Clooney to prove that they were alive in the '50s. "If they can't identify the accordion player on The Lawrence Welk Show, we become very suspicious about their age," an official said.

Canadian citizens have complained that the illegal immigrants are creating an organic-broccoli shortage, buying up all the Barbara Streisand c.d.'s, and renting all the Michael Moore movies. "I really feel sorry for American liberals, but the Canadian economy just can't support them," an Ottawa resident said. "How many art-history majors does one country need?"

cultural and/or language barriers between you and a child, you can still be a supportive presence through reassuring body language and basic conversation that shows your interest (The National Child Traumatic Stress Network, 2007). Ask if the child has any family/cultural traditions that make them feel happy (e.g., singing, dancing, praying) and if they would tell you about them. A strong cultural identity can be a powerful protective factor for children and should be supported (Futures Without Violence, 2013). In terms of resources, many cities have organizations that connect newly immigrated individuals with mental health professionals/cultural brokers such as Project SHIFA in Boston, MA, which supports the physical and mental health of Somali immigrant families. For American Indian children, organizations such as Indian Country Child Trauma Center or the National Native Child Trauma Center offer many resources for serving Native families. Health care centers, community cultural organizations, and local non-profit organizations may offer similar services.

6. **Don't make promises you can't keep.** After experiencing a traumatic event(s), children will need to feel safe, and they will look to adults such as you for that safety (Groves, 2002). However, you cannot promise children safety because that may be impossible, especially in the case of children who live with chronic gang or community violence. But, you can use careful, specific language such as the following: "I will do everything in my power to keep you safe" (Brymer et al., 2006). Children see and comprehend more than you think. If possible, use concrete and positive language to establish a sense of safety. For example, you could say, "When I am sad, I do [insert activity] to make myself feel better" or "I have some ideas about what we can do to help you feel better" (Brymer et al., 2006). You can also brainstorm ideas for what children can do if they feel unsafe, scared, or overwhelmed. For example, where are safe places they can go at home or at school? Are there alternate routes to and from school that avoid known gang territory? Who are people that make them feel safe? Discuss with children what they should do if they ever feel in danger. Brainstorm a plan to stay safe together, including when it would be important to call 911. Remember to encourage them to talk to a trusted adult when situations or experiences are scary or troubling to them. At the end of the conversation, remember to thank them for sharing what was likely a difficult issue with you, offer words of praise, such as, "It was really brave of you to share [insert issue talked about]) with me. Thank you for trusting me with this information."

7. **Reduce stress and build coping skills.** Chronic stress can have a negative impact on a child's development, but "supportive adults who create safe environments" can help children reduce chronic stress and overcome adversity (National Scientific Council on the Developing Child, Working Paper #3, 2005, p. 1). You can help a child develop his own problem-solving and coping skills to manage stress (e.g., "When I feel stressed, I [insert soothing activity]") (Grillo & Lott, 2010). Help a child identify ways to find support at home, at school, and in her community by asking the following questions: What has helped you feel better in the past? Does talking with your caregiver, friend, teacher, etc. help? Do certain kinds of music help you calm down, or cheer up? How about playing a sport, making art, writing in a journal, playing with a pet, or going for a walk? (Fox et al., 2012, citing IASC, p. 251). For older children, using technology or breathing apps on their phone can help them in moments of stress or crises. If a child is currently escalated or agitated, suggest some simple ways to relax in the moment. Pause together, and take several long, deep breaths (Grillo & Lott, 2010). Or, you can ask a child if they have a favorite place where they feel safe and see if they can imagine being there, doing

a favorite activity. Sometimes children (especially adolescents) turn to unhealthy coping devices, such as drinking, taking pills, or smoking, to manage overwhelming stress. Try to divert them to safer, more productive outlets. All children need patient, supportive guidance to help them better manage stress and develop healthier behaviors (Cole et al., 2005). Some children may be managing their stress by engaging in behaviors that are unproductive in certain environments. For example, they may tap their pencil on their desk repetitively, ignoring the teacher's request to stop. This young person needs safe adults to support them in replacing that behavior with one that meets the same need for soothing/stress reduction, and is appropriate for the environment.

8. **Connect children to what they love.** As a supportive adult in a child's life, you can help a child identify their strengths and natural talents, and you can connect them with programs to help them develop these strengths. For example, are there art or dance classes, clubs, slam poetry nights, or teams at school or in the community that might be a good fit for this child? Perhaps volunteering or giving back to the community in some way could help a child develop a sense of purpose? Mastering a skill or expressing themselves through art or music can be a powerful experience that fosters resiliency (Masten, 2009). Help a child find an activity through which they can believe in themselves or develop and practice their leadership skills. By listening and learning about a child, you can discover the activities they most enjoy, allowing you to make useful suggestions if they become stressed in the aftermath of a trauma. Being involved in extra-curricular activities can also help break their isolation and help them create relationships with peers and other supportive adults.

9. **Help children manage their emotions.** Children who have experienced trauma may exhibit challenging behaviors and have difficulty seeing the connection between their behaviors, feelings, and thoughts; understanding their own emotional reactions; and reading other people's emotions (Grillo & Lott, 2010). Recognizing and regulating one's emotions is a key part of resilience for all children and adolescents (Payton et al., 2000). You can help build emotional health in children by teaching them to differentiate between their thoughts, emotions, and feelings (Pool, 1997). You can be a model of emotional expression and behaviors. Establish trust by validating a child's feelings and helping them identify the emotions behind their actions (e.g., "I hear what you are saying and I understand" and "How did that make you feel?") (Grillo & Lott, 2010). You can use tools like a feelings thermometer (have them draw how "hot" or angry they are feeling), games, or storybooks to discuss how the child can regulate emotions when they feel stress. If the child identifies feelings related to a trauma and their challenging behavior, use supportive language such as, "If that happened to me, I might feel the same way too. It is okay to be sad, but it is not okay to [insert unsafe behavior]."

10. **Support peer relationships for children exposed to trauma.** Children exposed to trauma may be reactive, impulsive, regressive, or withdrawn – characteristics that may inhibit their relationships with others, including friends (Cole et al., 2005). Inquire about the child's friend network and help them identity friends that make them feel happy and confident (Masten, 2009). Modeling healthy relationships can be beneficial to any child who can derive support by seeing examples of healthy relationships at school, at home, and in his community. If children struggling with the aftermath of a trauma or are facing on-going trauma have access to supportive peers, they may feel inspired to mimic the behaviors of their peers (Cole et al., 2005).

11. **Be a role model.** You can be a role model for the children you interact with every day. Show them how to deal calmly and productively with any stressors that may arise in their daily lives. By example, you can demonstrate productive ways for children to problem solve in their own lives and treat others with respect (Kataoka et al., 2012). Set an example of the behaviors you expect and praise the child when they exhibit those behaviors (Grillo & Lott, 2010). Signs of positive relationships include: respecting others, listening to others, showing affection for others, demonstrating compassion, and being optimistic (Stosny, 2011). You can also talk with the child about signs of unhealthy relationships such as emotional abuse (yelling, name calling, disrespectful language, harassment) and physical abuse (hitting, kicking, sexual coercion, or use of weapons).

12. **Be a mentor.** One proven way to enhance resiliency in kids is through mentoring. For children exposed to trauma, positive and nurturing relationships with adults are especially important (Cole et al., 2005). Mentors can provide consistent, caring support over the long term (relationships of at least one year have a greater impact). Mentorships can be formal or informal, and mentors can serve as role models, resources, and givers of advice. In the United States, more than 5,000 mentoring organizations connect approximately 3 million youth with caring adults annually (Interagency Working Group on Youth Programs). Take direction from the child you are mentoring and suggest activities for the two of you that draw on their individual strengths and interests. The National Mentoring Partnership offers a comprehensive definition for what makes a good mentor (e.g., a sincere desire to support kids, respect, active listening, empathy, and flexibility) as well as resources for starting and joining mentoring programs in your community.

13. **Identify a child's "anchors."** An "anchor" is a member of a child's support network. Potential anchors can include: parents, grandparents, relatives, foster parents, siblings, mentors, parents, faith leaders, coaches, teachers, other school staff, friends, caregivers, neighbors, and others. Discovering who the child has in their life or who they look up to or trust is important to establish the strengths and weaknesses in the child's network (Kataoka et al., 2012). You are part of this team of anchors working to create a resilient environment for this child. By sharing information and working together, this team can support a child more effectively. A child's primary caregivers are the most important sources of resiliency, so think about ways you can also support the caregivers (Masten, 2009). When a family has experienced trauma, research has shown that maternal posttraumatic symptoms can perpetu-

ate similar symptoms in children. Therefore, offering support to a traumatized child's caregiver is critical (Shonkoff & Garner, 2011; Ostrowski, Christopher, & Delahanty, 2007). Sometimes a simple check-in will suffice. For instance, does a child's mom look like she could use someone to talk to? Are there small ways you could help out, such as giving the family a ride home if transportation is a struggle (if appropriate given your relationship or role with the child)? You can serve as a supportive conduit for a family in need by connecting a child's caregiver to resources in the community, such as community mental health services or a domestic violence shelter.

14. **Create calm, stable, and predictable environments.** Children exposed to trauma may be hyper vigilant or in a constant state of sensory overload as they are always scanning the environment around them for possible threats. This heightened state of alertness can affect their attention and ability to engage with material at school, home, and in other settings (Cole et al., 2005). To create a calm, stable environment, minimize unnecessary noises (e.g., loud music, yelling, slamming doors, etc.) that kids exposed to trauma may find threatening or distracting. In addition, try to calm the physical environment through lower lighting; warm, soft color schemes; and inviting furniture arrangements (Grillo & Lott, 2010). Ask the children what kind of space works best for them as there may be some stimuli in the environment that may trigger reminders of their trauma. Create structure by helping children know what to expect (e.g., supporting a regular schedule or letting them know in advance if someone is leaving or someone new is coming) (DeBoard-Lucas, Wasserman, Groves, & Bair-Merritt, 2013). In the case of peer relationships, establish a no bullying or teasing environment. "Most traumatized children do best in a calm environment that accepts no bullying or teasing and in which firm limits are set on negative behavior" (Cole et al., 2005, p. 35). Creating predictable environments is important for all kids but particularly for children exposed to trauma (Grillo & Lott, 2010).

15. **If a child uses challenging or difficult behavior, do not resort to shaming or isolating punishments.** Acts of aggression in children may be signs of struggling to cope with trauma (National Institute of Mental Health, 2006). If a child acts aggressively, they may be testing the authority of adults for possible underlying reasons such as avoiding trauma reminders and the emotions associated with that trauma – "a sense of powerlessness and vulnerability… hypersensitivity of danger or…identification with the aggressor at home" (Cole et al., 2005). While misbehavior should not be tolerated, it should also be recognized as a potential sign of posttraumatic stress. Traumatized children exhibiting challenging behaviors need to feel safe, secure, and in control, so try to set "clear, firm limits for inappropriate behavior and develop logical – rather than punitive consequences" (National Child Traumatic Stress Network Schools Committee, 2008, p.5). These kids may not be able to establish control and need supportive adults like you to help them regain a sense of control and stability, which should help inhibit negative behavior.

16. **Be pro-active and search out child-supporting resources in your community.** You are not a clinician and are not expected to provide clinical support to the child. It is important to be clear with children about your role regarding how you can and cannot help them (National Institute of Mental Health, 2006). However, you can be pro-active and find the clinical resources available in your community (local community health and mental health organizations, school social workers, faith-based organizations, child advocacy groups). One resource is the "Map My Community" tool at http://findyouthinfo.gov/maps/map-my-community. For children or adolescents who have experienced sexual abuse, their health and healing may be supported by connecting them to a community health care provider who has a trauma-informed practice. Help children and adolescents connect with available resources. Depending on your role, you may find it easier to access some resources than others. If there are inadequate mental health services in your community, maybe you should try to organize programming that supports children affected by trauma.

Additional Resources for Community Members

"Map My Community" tool:

http://findyouthinfo.gov/maps/map-my-community.

Substance Abuse and Mental Health Services Administration's (SAMHSA) Mental Health Treatment Locator:

http://findtreatment.samhsa.gov/MHTreatmentLocator/faces/quickSearch.jspx

Find mentoring resources in your area:

http://www.mentoring.org/get_involved/become_a_mentor

How community members can support children and adolescents:

http://www.nimh.nih.gov/health/publications/helping-children-and-adolescents-copewith-violence-and-disasters-community-members/helping-children-and-adolescentscope-with-violence-and-disasters-what-community-members-can-do.pdf

BE SAFE: A Program Climate Self-Assessment Tool to help you assess the nature of your environment and the youth with whom you work:

http://barcc.org/assets/pdf/BeSafe_Program_ClimateSelf-Assessmen_Question.pdf

The National Child Traumatic Stress Network Acculturation and Trauma Assessment Tool for Children and Adolescents:

http://learn.nctsn.org/mod/book/view.php?id=4518&chapterid=17

Parrot Ramblings

A number of people have asked why Sam has been biting me and/or if the biting has stopped. I think Sam has been biting me because he is dysregulated. I believe the discharge of energy and tension that occurs with the display of aggression reduces the energy and tension sufficiently to allow Sam to feel like himself again. Post describes regulation as "the ability to experience and maintain stress within one's window of tolerance." To my way of thinking, the reduction of tension and the energy discharged through his aggression are sufficient to bring him back within his window of tolerance.

Importantly, this does **not** mean that aggression helps Sam regulate or become regulated.

Within days of publishing the original story, Sam's aggression toward me stopped. He is a very communicative creature. He has come to use the sound, '*coffee,'* to describe or request hot fluids; he uses the sound, '*juice*,' to describe or request cold fluids. It is not uncommon for my wife or I to construe his use of those sounds to signify what she or I might signify with those words. We begin to think when he uses the sound, *coffee*, that he wants coffee and that when he uses the sound, *juice*, he actually wants juice. More often than not, it is true. When he wants coffee he asks for coffee (Sam want coffee?) and we give him coffee. When he wants juice he asks for juice (juice! juice!) and we give him juice. Sometimes, however, it is not coffee he wants nor is it juice, despite the sound he uses. Sometimes, *coffee* means hot water, *juice* means cold water.

Sam's 'typical' aggression with me occurred in the morning. He would be calling, "Juice! Juice! Juice!" I would attempt to give him juice, orange juice; he would attack. I would reach into his house with a glass of orange juice and BAM! He was also trying to attack me when I gave him juice through the side of his house, without ever reaching into his house. And let me tell you, orange juice, spilt over the floor, inside or outside of his house, makes a wet, sticky mess to clean. So… in frustration, I simply decided to stop giving him orange juice and brought him cold water from the refrigerator. The biting stopped; another day or two of aggressive posturing and then that stopped, too. Turns out, he didn't want orange juice.

At one point Sigmund Freud is alleged to have said, "Sometimes a cigar is just a cigar." And sometimes not liking Sunny D juice is just not liking Sunny D juice!

So… how is any of this relevant for BluesNews readers? Not sure that it is, except ... that a wide variety of behaviours can be regulating without themselves being regulatory behaviours.