CENTER FOR CHILD & FAMILY HEALTH

CHILDREN'S DEVELOPMENT: 6-12 YEARS OLD

TRIPP AKE, PHD

2024

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- Kelly Sullivan, Ph.D.
- Kate Murray, Ph.D
- Lisa Amaya-Jackson, M.D., MPH

Agenda

- Some about the NCTSN
- Definitions
  - Middle Childhood
  - Developmental tasks
- Introduction of Case Scenarios
- Review of Typical Development
  - Cognitive
  - Physical
  - Social/Emotional
- Additional Factors that Impact Development
- Application to Case Scenarios

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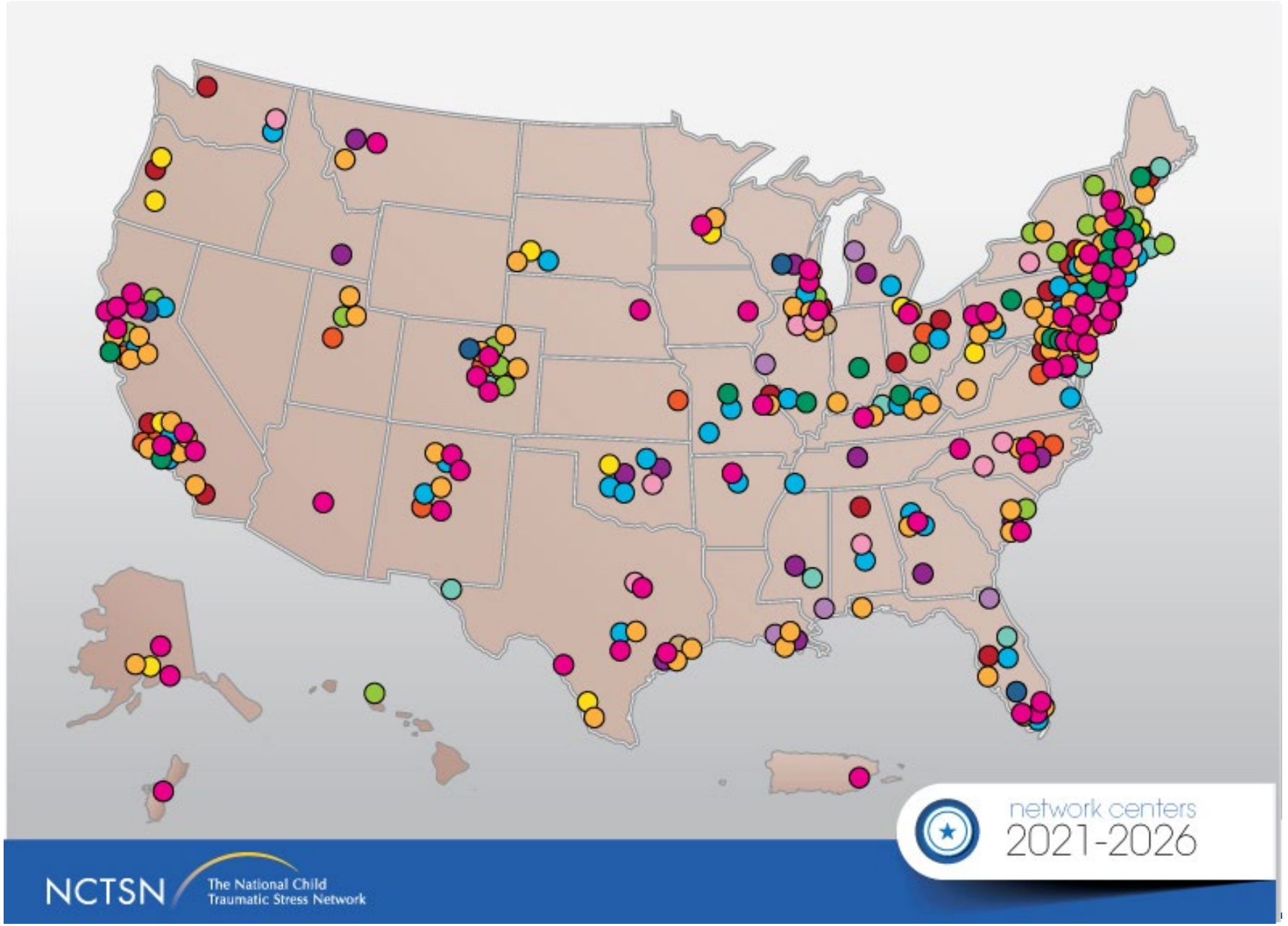
Who We Are

NCTSN Mission

The NCTSN works to accomplish its mission of serving the nation's traumatized children and their families by:

- Raising public awareness of the scope and impact of child traumatic stress
- Advancing a broad range of effective services and interventions
- Working with systems of care to ensure they are trauma-informed
- Fostering a community dedicated to collaboration within and beyond the NCTSN
- Building partnerships with youth, families, and providers


NCTSN
The National Child
Traumatic Stress Network
network centers
2021-2026

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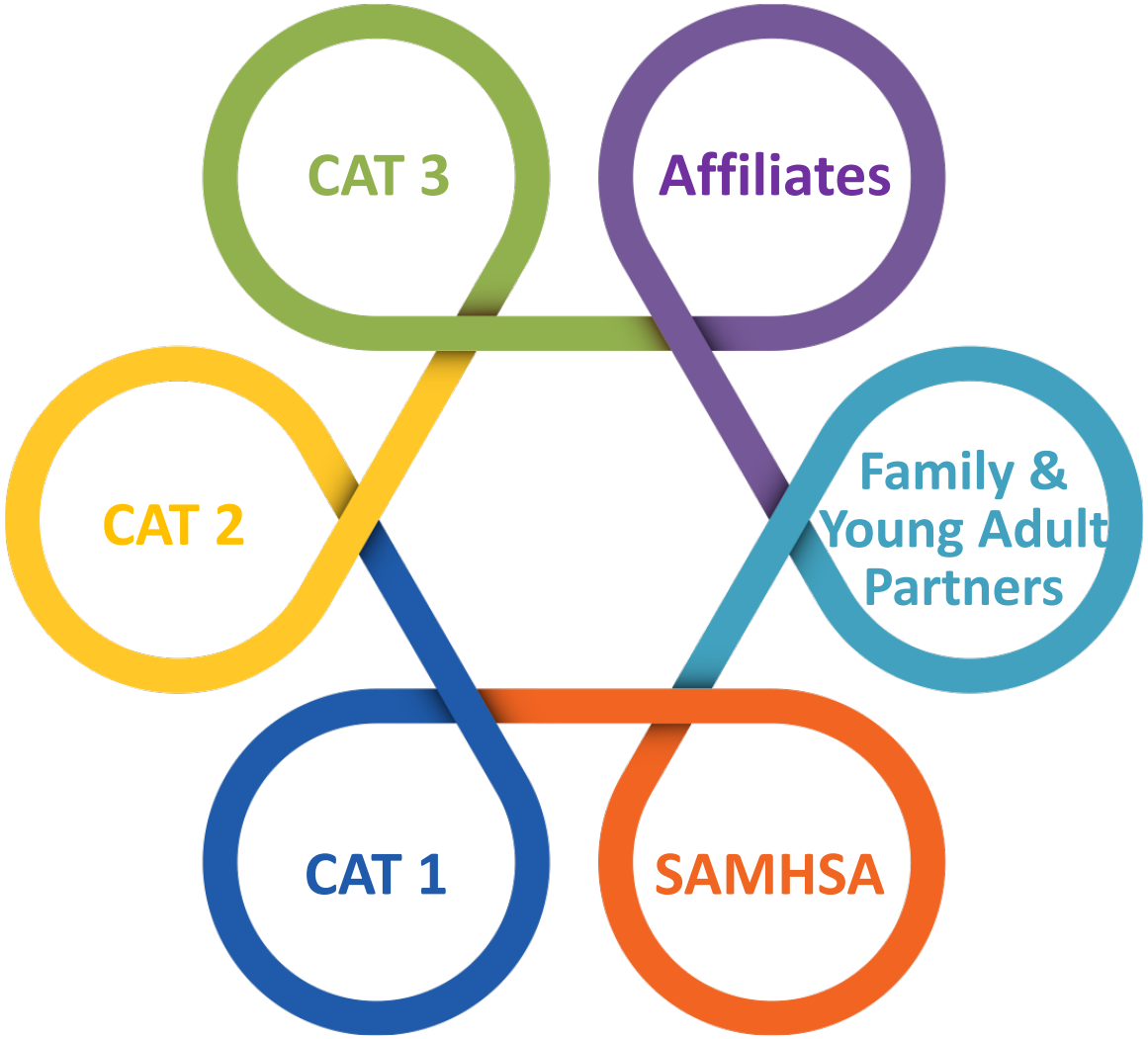
Structure and Governance

The NCTSN: Structure

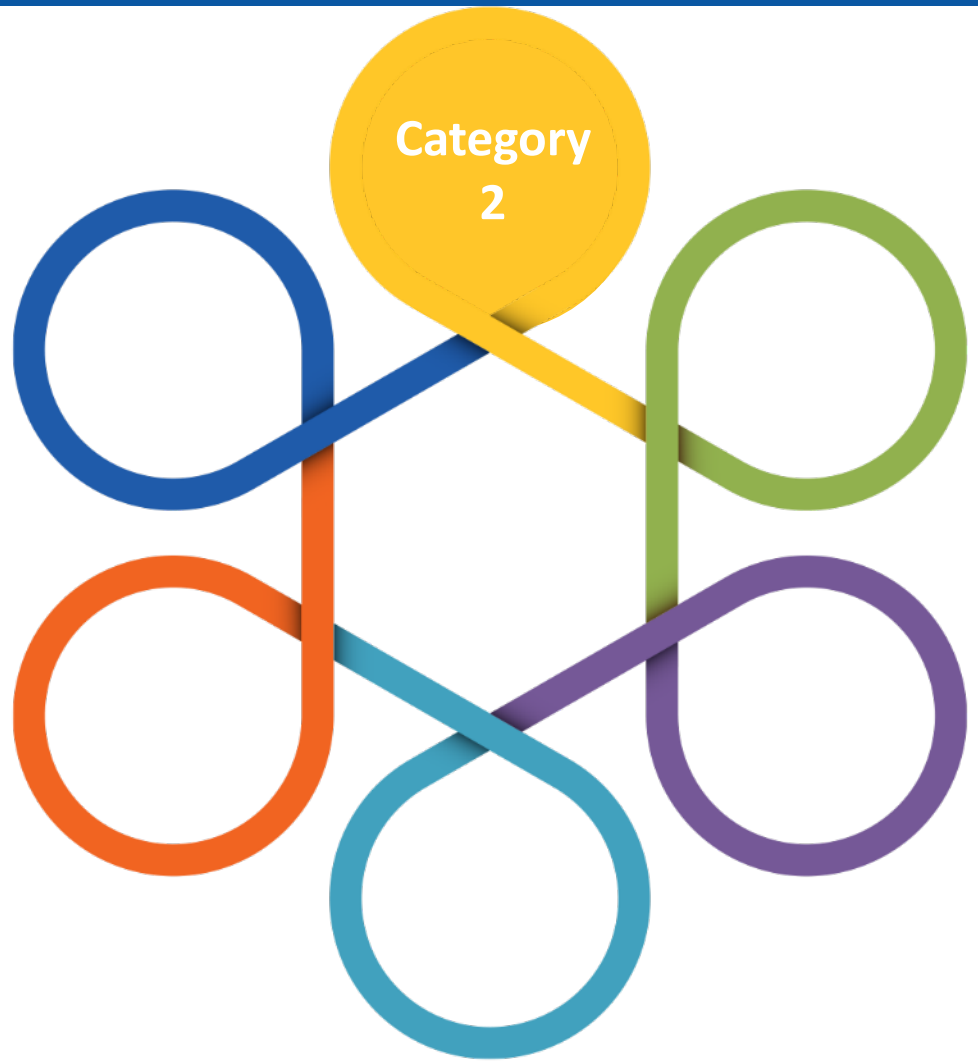


Category 1 Center

- The National Center for Child Traumatic Stress (Nickname: The National Center)
- Continuously funded since October 2001
- A team of more than 50 staff at Duke and UCLA
- “Knit the Network together,” and guide major collaborative initiatives

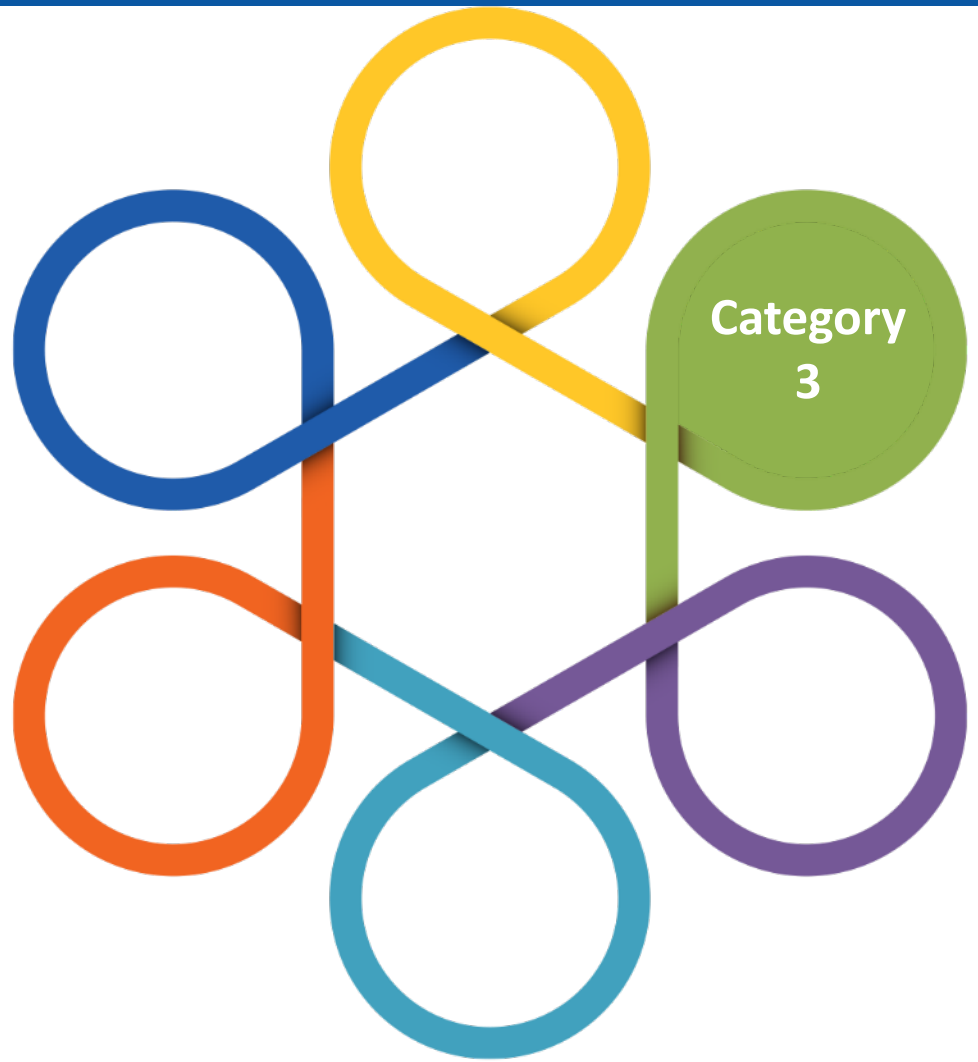
Category 2 Center

- Treatment and Services Adaptation Centers
- 46 Centers
- Promote wide-scale dissemination and implementation of effective treatments and services approaches
- Serve as a resource in their areas of expertise



Category 3 Center

- Community Treatment and Services Centers
- 93 Centers
- Provide direct services and training on trauma-informed practices to child-serving systems
- Provide community education and prevention services



Affiliates

- Formerly funded in the NCTSN
- 200+ affiliate members
- Remain members of the NCTSN
- Expand the reach and impact of the Network

Family and Young Adult Partners

- Partner with Network members
- Gain access, learning, leadership
- Ensure services are helpful

SAMHSA

- Substance Abuse and Mental Health Services Administration
- Government Project Officer (GPO)
- Provide oversight and monitoring to ensure grant goals are met.

The NCTSN Steering Committee & Advisory Board

- The Steering Committee
  - Is reflective of the Network
  - Each member serves a 2-year term
- The Advisory Board
  - Aims to raise the national visibility of the issue of child traumatic stress and enhance the capacity of the Network to identify its priorities for action.
  - Each Board member serves a 3-year term

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The National Center for Child Traumatic Stress

NCCTS: Co-located at UCLA and Duke University

Duke

- Data and Evaluation Program
- Policy Program
- Site Integration and Collaboration Program
- Training and Implementation Program
- Technology
- Finance
- Special Projects

UCLA

- Military and Veteran Families Program & DOD Academy
- Service Systems Program
- Terrorism and Disaster Program
- Product Development
- Technology
- Finance
- Special Projects
- Core Curriculum

Questions for You

- How has knowing more about development of kids helped you in your work to date?
- If this is the first time you are thinking about development of kids, how might this be helpful to you in your day-to-day work?
- What is something you really want to know about 6-12 year old kids before we finish today?

General Overview of Middle Childhood

- Age range = **6-12 years**
- Several milestones during this time:
  - More exposure to school settings (varies)
  - Start of puberty
  - Worldview extends outward from **family** to **relationships with peers and other adults** – contact with the larger world
    - Receive feedback from the outside world
  - Important time to develop confidence and self-concept
  - Friendships become more important
  - Preparing for adolescence

(Tunno, 2020)

Stanford Children's Health; National Research Council,; Iowa State University Extension

Important to Note…

- Development is a continuous process and children develop at different rates
- Description of milestones cover what is typically common during this age
- **What are some things that could delay typical development?**
  - Individual differences of children
  - Difficulties with providing appropriate caregiving
  - Environmental stressors
  - Trauma
  - Other risk factors (e.g., intellectual developmental disorder, medical difficulties)

(Tunno, 2020)

(Healthy People 2020)

Developmental Tasks

Examples of Havighurst's Developmental Tasks

Age Range	Developmental Tasks
Infancy and Early Childhood 0-5 years old	• Learn to walk • Learn to use the toilet • Learn to talk • Learn to form relationship with others
Middle Childhood 6-12 years old	• Learn school-related skills such as reading • Learn about conscience and values • Learn to be independent
Adolescence 13-17 years old	• Establish emotional independecce • Learn skills needed for productive occupation • Achieve gender-based social role • Establish mature relationships with peers
Early Adulthood 18-35 years old	• Choose a life partner • Establish a family • Take care of a home • Establish a career
Middle Age 36-60 years old	• Maintain a standard of living • Perform civic and social responsibilities • Maintain a relationship with spouse • Adjust to physiological changes
Later Maturity Over 60 years old	• Adjust to deteriorating health • Adjust to retirement • Meet social and civil obligations • Adjust to loss of spouse

The Psychology Notes Headquarters - https://www.PsychologyNotesHQ.com

- What are typical questions parents of 6-12 year old kids have about their child?
  - Is this behavior normal?
  - They just asked me this…what do I say?
  - Why are they so literal about right and wrong?
  - How do we teach them to be kind to friends?
  - Why are we already dealing with puberty?

What We Expect from this Age Group

- Generally…
  - These kids have a lot of questions!
  - They are eager to learn
  - They are interested in rules and why they exist and while they want others to follow rules, they may not follow them
  - They might relate more to games (cooperation with others) in their day-to-day play
  - They are growing and developing quickly!

Adapted from the Center for Parenting Education, 2022

Ways Caregivers Support Development

- **Setting Limits**
  - Establish understanding about rules and connection to safety
  - Helping kids understand what are real limits vs. pretend
  - Providing developmentally and trauma-informed responses to behavior management needs
  - Encouraging cooperation, responsibility, and feeling like they are part of and needed in the family
- **Encouraging Emotional and Cognitive Development**
  - Educating kids about feelings identification and noticing reactions in others in others
  - Encouraging activities that reflect interests, build skills, and increase confidence
  - Praising any approximation of behaviors we want to see increase
- **Supporting Social Development**
  - Providing time with friends.
  - Introducing them to role models other than their parents
- **Normalizing Physical Changes**

Adapted from the Center for Parenting Education, 2022

Introduction of Cases

- 12 and 14-year old boys alleged to be delinquent for wantonly and willfully burning a school building after setting a fire in the school bathroom.
  - Outside of the decisions in the scenario (will get to later), **what are your guesses** about considerations for the boys (12 year old in particular) regarding emotional, physical, and social development that are important to keep in mind?

- 8 and 11-year old girls who are in the primary custody of their biological mother and have visits with their biological father on alternating weekends…who are now in the middle of a situation with a potential move to step-father's home 2 hours away.
  - Outside of the decisions in the scenario (will get to later), **what are your guesses** about considerations for the girls regarding emotional, physical, and social development that are important to keep in mind?

Major Markers of Cognitive/Learning Development

- Ability to understand world continues to grow – branching out from family to other adults and peers
- "Rapid developmental of mental skills"
- Differentiates between fantasy and reality better
- Tells time
- Understands commands with multiple instructions
- Shifts attention between tasks
- Gives more thought to decisions and can think about the future

(Tunno, 2020)

Stanford Children's Health; Iowa State University Extension

Additional Considerations Cognitive Development

<u>6-12 year old children are able to:</u>

- *Focus on several aspects of a problem at a time, concentrate on what they do for longer periods of time. And have Increased problem-solving ability, but not yet like an adult.*
  - (This is important to remember as adults may have higher expectations of these kids because they are starting to problem solve and have more abstract thought…but they are just developing these skills. Adults need to remember this as they interact with these kids.)

- *<u>Begin</u> to understand time and the days of the week; by age 10, children can place events in time sequence.*
  - (This is important to remember when asking children to recount or share about something that happened in the past…what they are able to communicate could be limited)

Adapted from the American Psychological Association ACT program, 2022

Additional Considerations
Cognitive Development

<u>6-12 year old children are able to:</u>

- *Can speak and also write; by age 10, children have a vocabulary of 20,000 words and learn an average of 20 new words a day; can also understand that a word may have different meanings.*
  - (This is important to remember as adults may assume if kids have a certain vocabulary that they understand more than they do)

- *Can better understand and internalize moral rules of behavior (right/wrong; good/bad; wonderful/terrible)*
  - (This is important to remember as kids may have more absolute ways of thinking re: right and wrong)

Adapted from the American Psychological Association ACT program, 2022

Major Markers of Physical Development

- Girls tend to develop faster than boys
- More physical abilities and desire for independence
  - CDC – highlights safety risk for this age – importance for supervision
  - Learn how to look for traffic, knowing when to ask for help
- Can play and benefit from organized sports/games
  - Understand rules and cooperation with others
- Beginning of puberty

(Tunno, 2020)

(Iowa State University Extension; National Center on Birth Defects and Developmental Disabilities, Centers for Disease Control and Prevention)

Puberty During Middle Childhood

- When does puberty typically begin for girls and for boys?
  - Girls = between 8 and 13
  - Boys = between 9 and 14
- At what age is puberty **<u>considered early</u>** for girls and for boys?
  - Girls = before 8 years
  - Boys =before 9 years

(Tunno, 2020)

(National Research Council; Duke Health, 2013; Mayo Clinic, ND)

Video on Early Puberty

https://www.thedoctorstv.com/articles/3186-early-puberty-what-parents-should-know

(Tunno, 2020)

Major Markers of Social/Emotional Development

- Can cooperate and share
- Occasional temper tantrums are normal –ability to express self develops
- Likes to play games – understands rules
- Enjoys clubs and groups
- Growing **importance of friendships/relationships** with outside world
  - Will look to feedback on own self-perception
  - Impact development of self-esteem and self-efficacy
  - Worry about what others think
- Desires more independence from family as friendships grow
- Increased interest in opposite gender
- Likes talking to others – communication is more effective as they grow

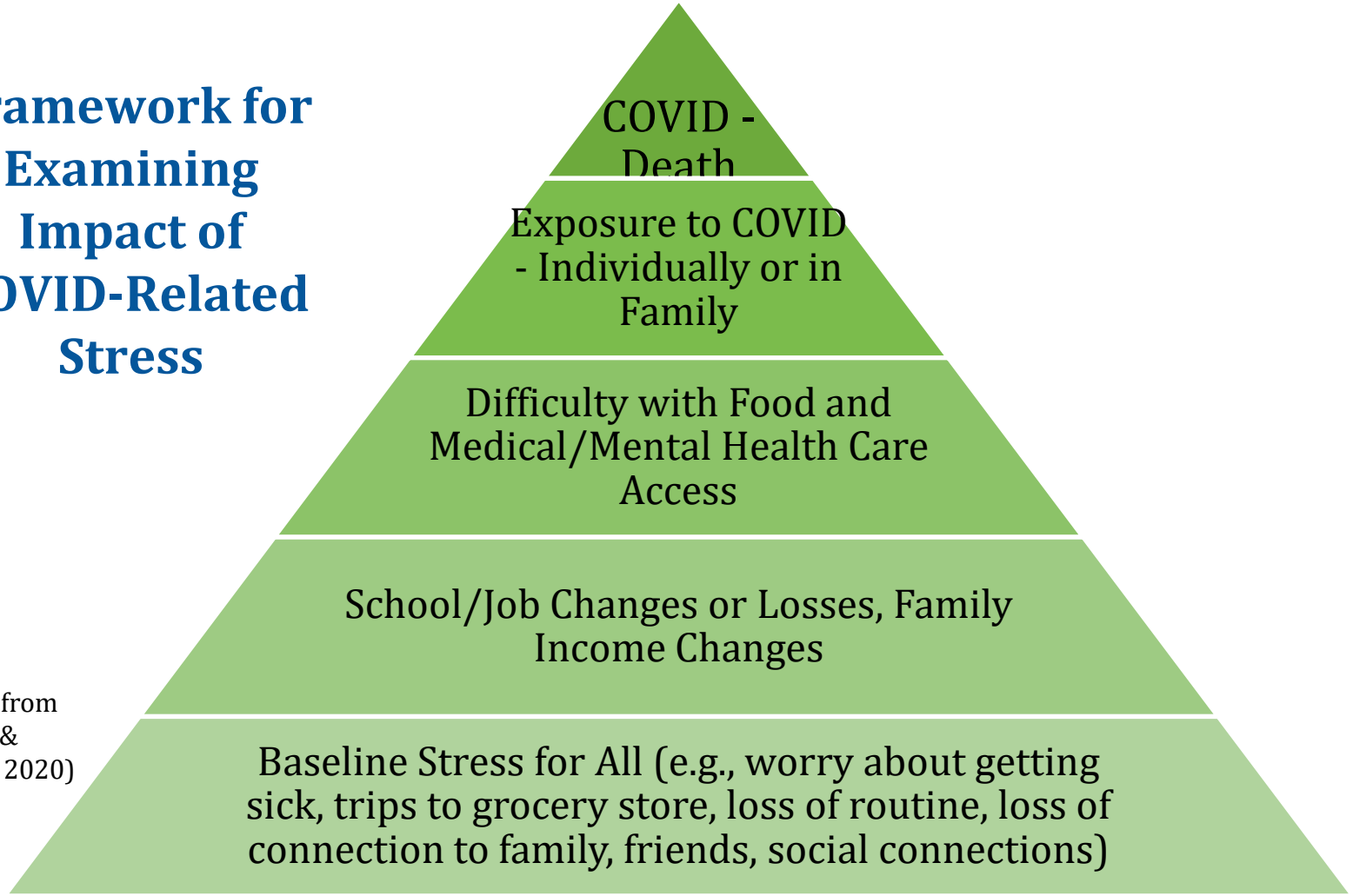
Iowa State University Extension; Overstreet, ND; National Center on Birth Defects and Developmental Disabilities, Centers for Disease Control and Prevention

Additional Factors that Impact Development

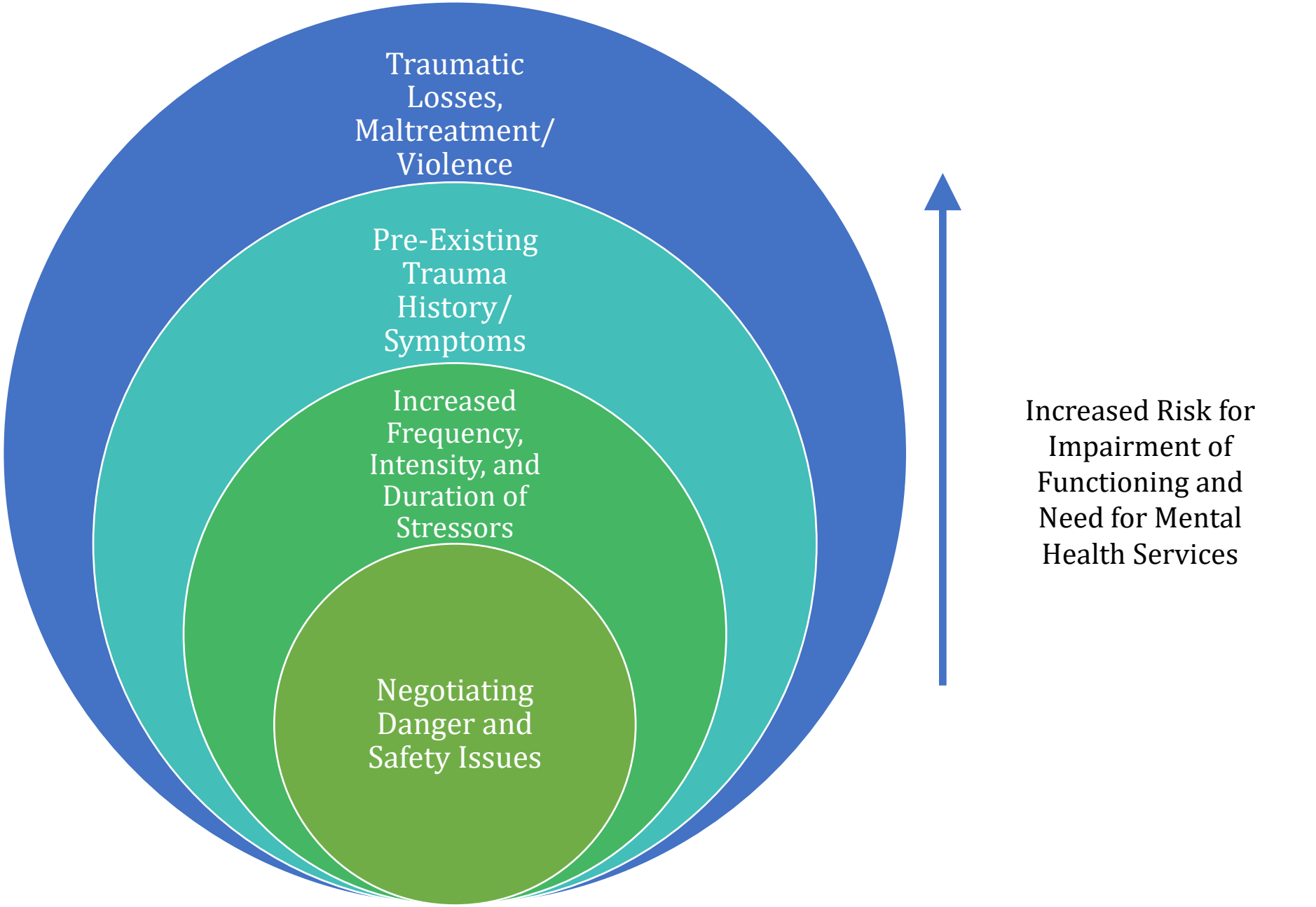
- Early Life Stress
  - Exposure to Traumatic Events
  - COVID and COVID related losses
- Socioeconomic Status
- Relationships with parents and caregivers
- Community supports
- Access to education programming

Adapted from the Office of Disease Prevention and Health Promotion , 2022

Framework for Examining Impact of COVID-Related Stress



(Adapted from Stoddard & Kaufman, 2020)


Traumatic Losses, Maltreatment/ Violence
Pre-Existing Trauma History/ Symptoms
Increased Frequency, Intensity, and Duration of Stressors
Negotiating Danger and Safety Issues
Increased Risk for Impairment of Functioning and Need for Mental Health Services

Estimates of Children and Youth Who Experienced the Loss of a Parent to COVID-19

- **142,637** US children and youth between **April 1, 2020-June 30, 2021** lost a parent, custodial parent, or grandparent caregiver to COVID
- Includes COVID-19 deaths and indirect fatalities such as those due to a pandemic related difficulty accessing healthcare.

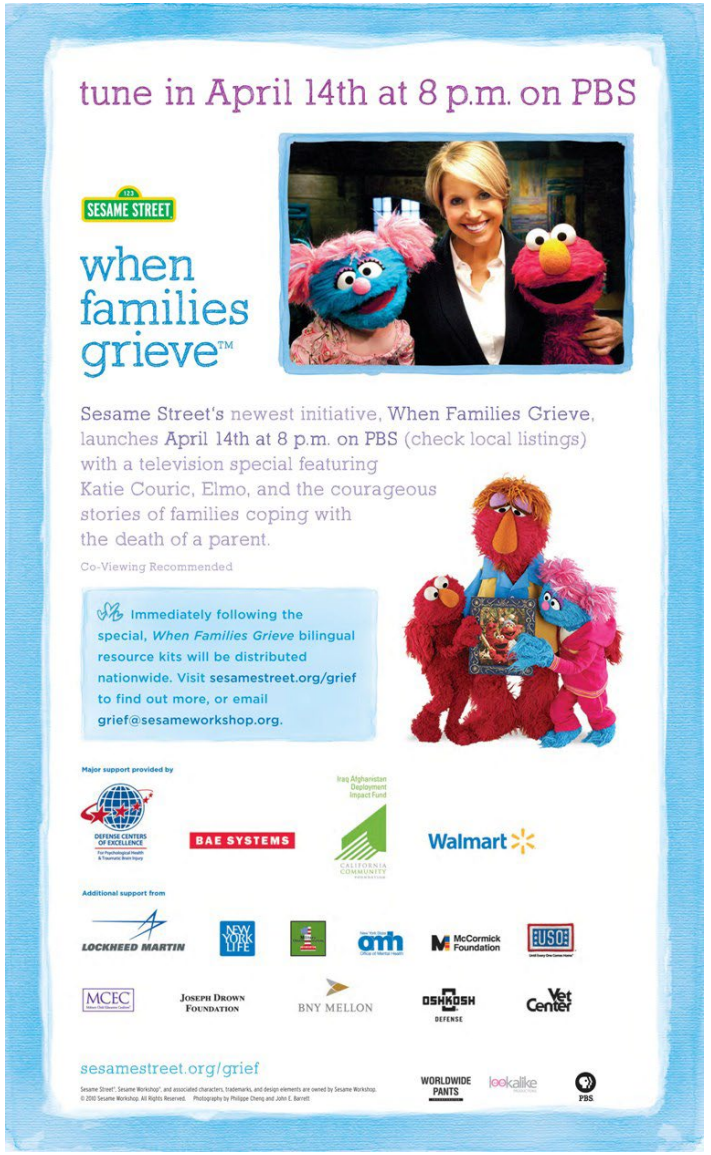
Hillis et al, 2021-Pediatrics

- **Worldwide**, more than **1.1 million children** lost at least 1 parent or custodial grandparent in the first 14 months of the pandemic
- Modeling study

Hillis et al., 2021- The Lancet

HTTP://WWW.SESAMEWORKSHOP.ORG/GRIEF

- The death of a parent is one of the most challenging things a child can face, and shockingly an estimated 2.5% of children under age 18 have experienced the death of a parent (approximately 2.5 million children)* and on March 10, 2010 TAPS (Tragedy Assistance Program for Survivors) estimated that the 5,398 U.S. military deaths in Iraq and Afghanistan had left 3,779 children without a parent, while 2,669 spouses had been widowed. In response, Sesame Workshop, the nonprofit organization behind *Sesame Street*, is launching ***When Families Grieve***, an outreach initiative that provides free resources in support of families with young children, in the military and the general public, coping with the death of a parent. A preview of the materials was presented today at the offices of New York Life Insurance with **Katie Couric; Gary E. Knell**, President and CEO of Sesame Workshop; **Casey Holstein** with his daughters Charli and Lia, who were featured in the special; and ***Sesame Street's Muppets* Elmo**, **Rosita** and **Jesse** (Elmo's cousin). The initiative is presented in conjunction with the ***Month of the Young Child*** & the ***Month of the Military Child. (April 2010)***

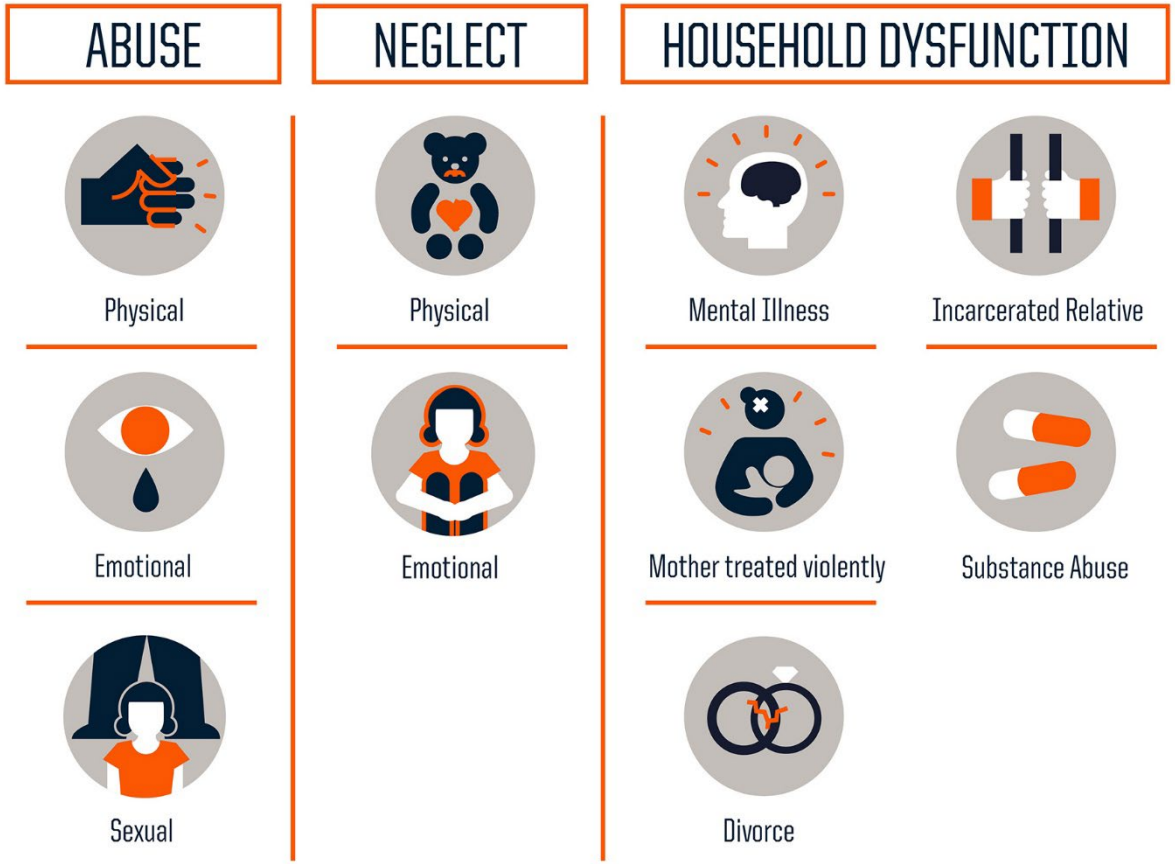


BACKGROUND OF THE ACES STUDY

- Original ACEs study conducted at Kaiser Permanente from 1995 to 1997
  - Studied over 17,000 HMO members from Southern California
  - Participants received physical exams and completed surveys regarding childhood experiences and current health status and behaviors
- Participants were predominantly White (74.8%), over 60 (46.4%), and college graduates (39.3%)

(Felitti et al., 1998)

TYPES OF ADVERSE CHILDHOOD EXPERIENCES (ACES)



OTHER TYPES OF TRAUMA

- Traumatic loss, separation, bereavement
- Sexual assault
- Physical assault
- Community violence
- Serious illness or medical trauma
- Accidents/fires
- Natural disasters
- War, terrorism, political violence
- School violence
- Bullying

(Felitti et al., 1998)

SIGNIFICANCE OF ACES:
HELPFUL BUT NOT SUFFICIENT

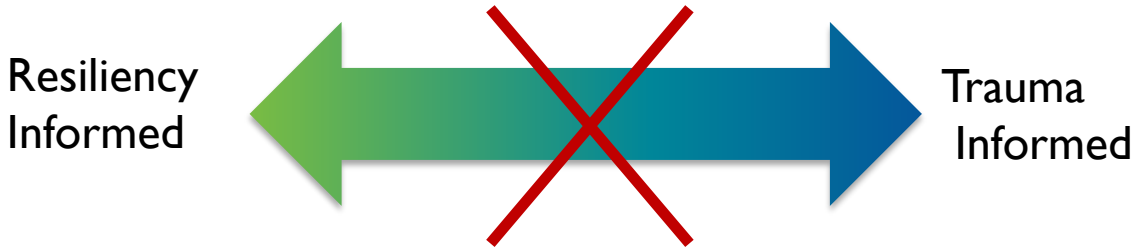
- Original study raised public awareness of the high prevalence and impact of negative life events in children's lives.
  - Developed as an epidemiological (public health) research tool, not as a mental health screening tool for children and adolescents.
- The ACEs questionnaire does not:
  - Address all types of trauma exposure and adversity
  - Consider the frequency, duration, and intensity of childhood experiences
  - Address strengths and resilience of children and families

(NCTSN ACEs Work Group, NCTSN, 2016)

WHAT RESILIENCY IS AND IS NOT

RESILIENCY IS NOT

on the opposite end of the continuum from being Trauma-Informed



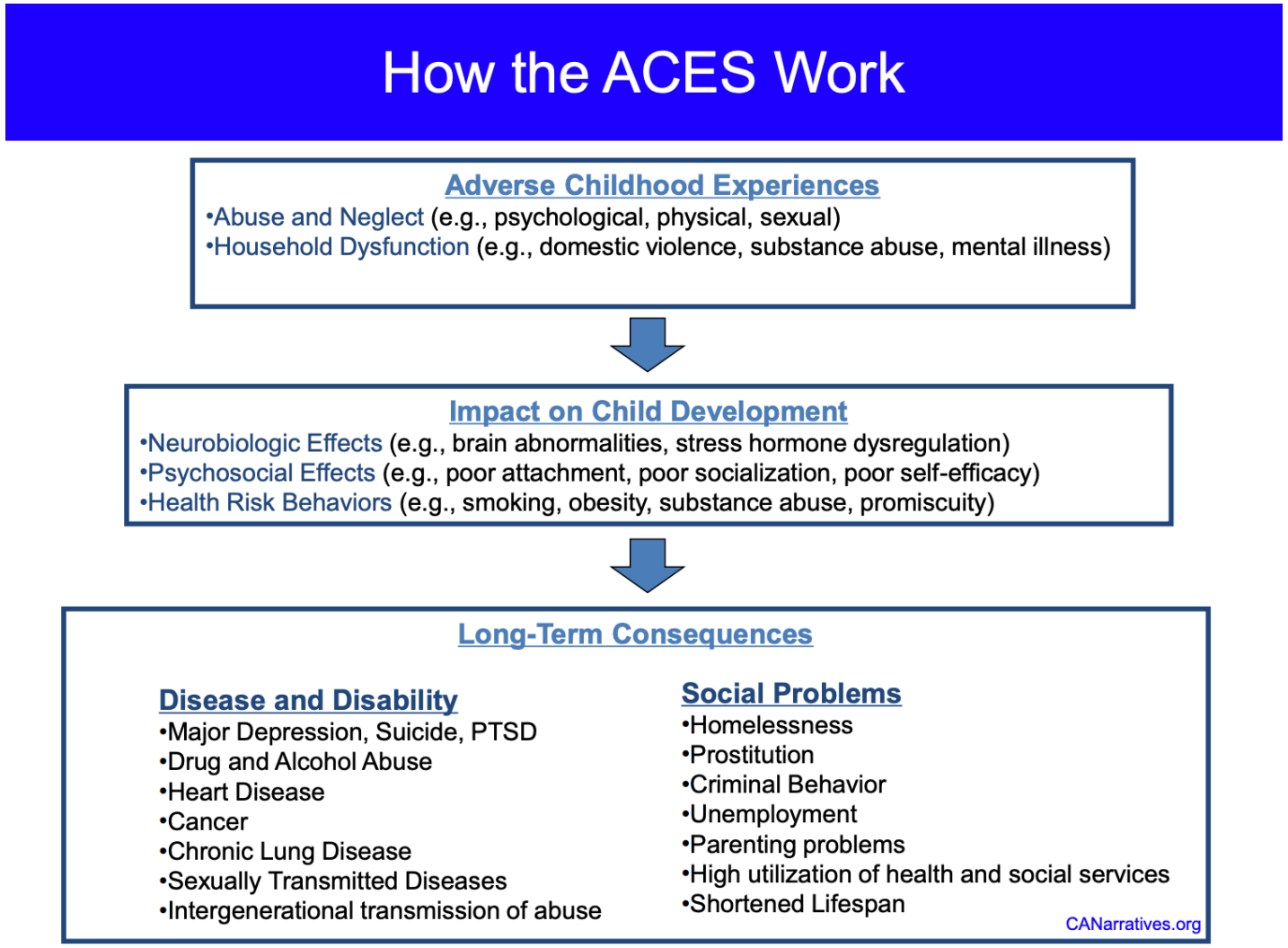
RESILIENCY IS

a part of being Trauma-Informed

NCTSN The National Child Traumatic Stress Network

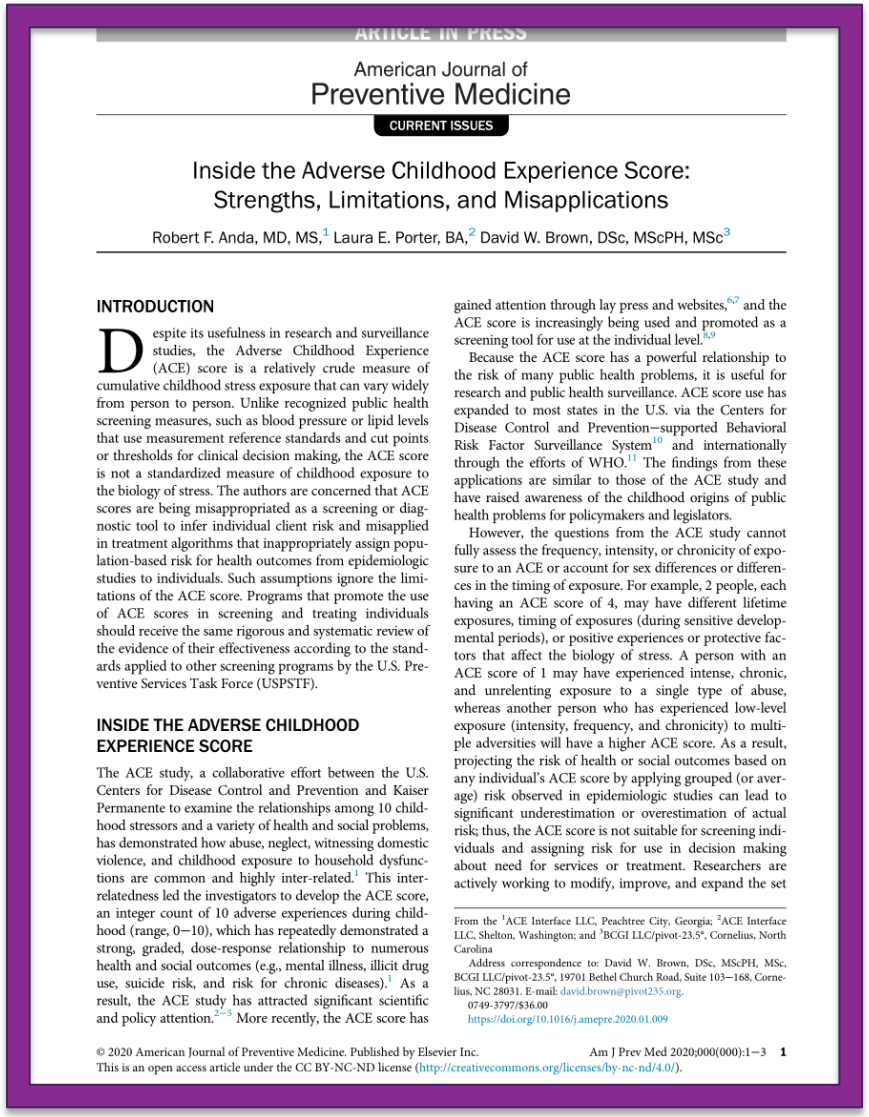
Trauma Screening	Assessment, Care-Planning and Treatment	Workforce Development
Strengthening Resilience and Protective Factors	Addressing Parent/Caregiver Trauma	Continuity of Care and Cross-System Collaboration
Addressing, Minimizing, and Treating Secondary Traumatic Stress	Partnering with Youth and Families	Addressing the Intersections of Culture, Race, and Trauma

THE SIGNIFICANCE OF ACES



BEING CAUTIOUS ABOUT INFERENCES

- In 2020, one of the ACES original study lead authors published this paper:
- "Inferences about an individual's risk for health or social problems should not be made based upon an ACE score, and no arbitrary ACE score, or range of scores, should be designated as a cut point for decision making or used to infer knowledge about individual risk for health outcomes.
- California's recent release of statewide guidelines for MediCal patients as part of the ACEs Aware initiative provides a useful example for consideration of these issues."



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American Journal of
Preventive Medicine

CURRENT ISSUES

Inside the Adverse Childhood Experience Score: Strengths, Limitations, and Misapplications

Robert F. Anda, MD, MS,[1] Laura E. Porter, BA,[2] David W. Brown, DSc, MScPH, MSc[3]

INTRODUCTION

Despite its usefulness in research and surveillance studies, the Adverse Childhood Experience (ACE) score is a relatively crude measure of cumulative childhood stress exposure that can vary widely from person to person. Unlike recognized public health screening measures, such as blood pressure or lipid levels that use measurement reference standards and cut points or thresholds for clinical decision making, the ACE score is not a standardized measure of childhood exposure to the biology of stress. The authors are concerned that ACE scores are being misappropriated as a screening or diagnostic tool to infer individual client risk and misapplied in treatment algorithms that inappropriately assign population-based risk for health outcomes from epidemiologic studies to individuals. Such assumptions ignore the limitations of the ACE score. Programs that promote the use of ACE scores in screening and treating individuals should receive the same rigorous and systematic review of the evidence of their effectiveness according to the standards applied to other screening programs by the U.S. Preventive Services Task Force (USPSTF).

INSIDE THE ADVERSE CHILDHOOD EXPERIENCE SCORE

The ACE study, a collaborative effort between the U.S. Centers for Disease Control and Prevention and Kaiser Permanente to examine the relationships among 10 childhood stressors and a variety of health and social problems, has demonstrated how abuse, neglect, witnessing domestic violence, and childhood exposure to household dysfunctions are common and highly inter-related.[1] This interrelatedness led the investigators to develop the ACE score, an integer count of 10 adverse experiences during childhood (range, 0–10), which has repeatedly demonstrated a strong, graded, dose-response relationship to numerous health and social outcomes (e.g., mental illness, illicit drug use, suicide risk, and risk for chronic diseases).[1] As a result, the ACE study has attracted significant scientific and policy attention.[2–5] More recently, the ACE score has gained attention through lay press and websites,[6,7] and the ACE score is increasingly being used and promoted as a screening tool for use at the individual level.[8,9]

Because the ACE score has a powerful relationship to the risk of many public health problems, it is useful for research and public health surveillance. ACE score use has expanded to most states in the U.S. via the Centers for Disease Control and Prevention–supported Behavioral Risk Factor Surveillance System[10] and internationally through the efforts of WHO.[11] The findings from these applications are similar to those of the ACE study and have raised awareness of the childhood origins of public health problems for policymakers and legislators.

However, the questions from the ACE study cannot fully assess the frequency, intensity, or chronicity of exposure to an ACE or account for sex differences or differences in the timing of exposure. For example, 2 people, each having an ACE score of 4, may have different lifetime exposures, timing of exposures (during sensitive developmental periods), or positive experiences or protective factors that affect the biology of stress. A person with an ACE score of 1 may have experienced intense, chronic, and unrelenting exposure to a single type of abuse, whereas another person who has experienced low-level exposure (intensity, frequency, and chronicity) to multiple adversities will have a higher ACE score. As a result, projecting the risk of health or social outcomes based on any individual's ACE score by applying grouped (or average) risk observed in epidemiologic studies can lead to significant underestimation or overestimation of actual risk; thus, the ACE score is not suitable for screening individuals and assigning risk for use in decision making about need for services or treatment. Researchers are actively working to modify, improve, and expand the set

From the [1]ACE Interface LLC, Peachtree City, Georgia; [2]ACE Interface LLC, Shelton, Washington; and [3]BCGI LLC/pivot-23.5®, Cornelius, North Carolina

Address correspondence to: David W. Brown, DSc, MScPH, MSc, BCGI LLC/pivot-23.5®, 19701 Bethel Church Road, Suite 103–168, Cornelius, NC 28031. E-mail: david.brown@pivot235.org.

0749-3797/$36.00
https://doi.org/10.1016/j.amepre.2020.01.009

REMINDER OF THE ORIGINAL PURPOSE

Another lead author of the original ACES Study:

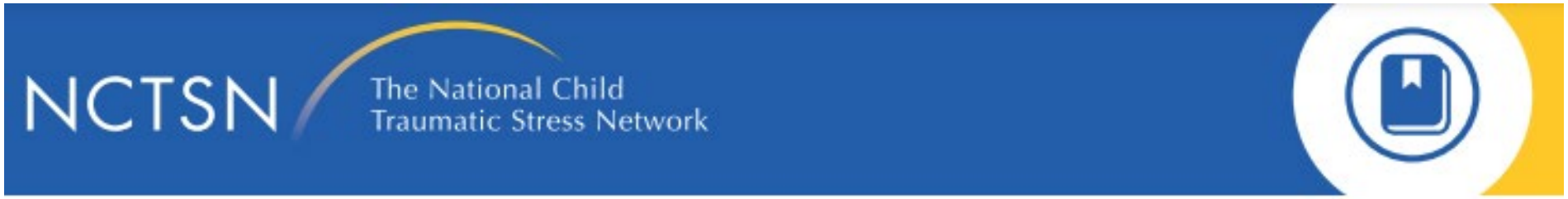
- "Some experts have advocated for use of the original 10-item ACE survey as a means to explore possible childhood trauma.
- The original ACE survey was developed and used as a research tool to explore the relationships between ACEs and health consequences. It is neither a comprehensive nor a diagnostic clinical tool.
- Research has demonstrated that additional stressors such as being the victim of bullying or racism and being exposed to community violence are equally or more traumatic than some of the original ACEs."

Adverse Childhood Experiences: Informing Best Practices
Online Collaborative Living Document Version 1.0 – 3/14/15

Clinical Approaches for Adult ACE Survivors Experiencing Unexplained Physical Symptoms and Health Problems

David Clarke, MD; Elliott Schulman, MD; David McCollum, MD; and Vincent Felitti, MD

NEW NCTSN RESOURCE ON ACES SCREENING



Beyond the ACE Score: Perspectives from the NCTSN on Child Trauma and Adversity Screening and Impact

Amaya-Jackson, L., Absher, L.E., Gerrity, E.T., Layne, C.M., & Halladay Goldman, J. (2021)

TAKEAWAYS FROM NCTSN RESOURCE ON ACES SCREENING

- Terms overlap but are not interchangeable
- Not all ACES are created equal
- Exposure to trauma and adversity interacts significantly with child development
- Early intervention and prevention can stop progression of problems

Amaya-Jackson et al, 2021

WHAT THE SCORE CAN AND CAN'T TELL YOU

What Counting ACEs Can Tell You	What Counting ACEs Can't Tell You
ACEs allows us to talk about prevalence, risk, and related outcomes of 10 common traumas, adversities, and household difficulties that occur within families.	Other traumas are not included as standard ACEs and are therefore unaccounted for. Many types of trauma not typically included in ACEs checklists have high prevalence rates and are strongly associated with negative outcomes.
The ACE Study demonstrated that adverse childhood experiences (focused on those that occur in one's household) carry significant risks for a broad range of major long-term physical and mental health consequences.	Counting ACEs using ACE score checklists do not allow consideration of frequency, duration, severity, age of onset, synergy between ACEs, current distress and functioning, or interrupted developmental tasks, that are often critical mediators of short and long-term consequences.
The ACE Study showed that ACEs have a cumulative impact with a stepped increase with each additional ACE, such that the higher the ACE score, the higher the risk with a broad range of negative physical and mental health outcomes. Thus, an ACE score (total number of ACEs types) provides useful information in surveys about general risk in a large community, state, or national population.	Simple screens generating ACE scores are not clinically useful, as they are incomplete trauma profiles and leave out information regarding distress (e.g., posttraumatic stress reactions), risky behavior, and functioning. This information is needed to determine next steps, including assessment, treatment, referral, or legally mandated child abuse reporting.
In provider-client discussions about ACEs, obtaining ACE histories can "open the door" to helping parents and child clients understand that adverse household (intrafamilial) experiences carry some risk of negative physical and mental health outcomes.	Risks identified in large-scale epidemiologic studies do not necessarily generalize to, or support the use of, individual ACE scores to gauge risks for specific individuals. Serious questions have been raised over the use of ACE scores for individual screening, assessment, or eligibility thresholds for services (e.g., scores of 4 or more ACEs qualify). [20,21,22]
Asking about ACEs can provide some clients with the language to articulate what they have experienced and why it is important. Labeling their experiences in this manner can be empowering. For some individuals, "ACEs" as a concept also carries less stigma than "trauma."	Some family, youth, and adults don't know what to do with the idea of an ACE score. Resistance to labeling, e.g., *"I am not a score,"* and feeling doomed are concerns clients express that require appropriate processing about what the score means or assisting them when action is warranted.

Amaya-Jackson et al, 2021

Exposure To Traumatic Events
School-aged Children (6–12)

Key Developmental Tasks	Trauma's Impact
▪ Manage fears, anxieties, and aggression ▪ Sustain attention for learning and problem solving ▪ Control impulses and manage physical responses to danger	▪ Emotional swings ▪ Learning problems ▪ Specific anxieties and fears ▪ Attention seeking ▪ Regression or reversion to younger behaviors

CENTER FOR CHILD & FAMILY HEALTH

Continuing With The Cases-
What Are Some Additional Considerations

12 and 14-year old boys alleged to be delinquent for wantonly and willfully burning a school building after setting a fire in the school bathroom.

- What is the significance of the 12-year-old's developmental level, maturity, and psychological status?
- How would those factors be evaluated?
- What evidence do you want? What more do you want to know?
- What will you decide?

Continuing With The Cases- What Are Some Additional Considerations

12 and 14-year old boys alleged to be delinquent for wantonly and willfully burning a school building after setting a fire in the school bathroom.

- What is the significance of the 12-year-old's developmental level, maturity, and psychological status?
  - Additional Question: What do we know about 6-12 year olds and their connection to peers? Does that impact what we would expect from the 12 year old in this case?
  - How would those factors be evaluated?
- What evidence do you want? What more do you want to know?

  -Additional Question: What do we know about this child's history of making and keeping friends, other behavioral problems, or family history? If we knew these things how would it impact our approach?
- What will you decide?

Continuing With The Cases-
What Are Some Additional Considerations

- 8 and 11-year old girls who are in the primary custody of their biological mother and have visits with their biological father on alternating weekends…who are now in the middle of a situation with a potential move to step-father's home 2 hours away.

- What child development issues addressing best interests of the child are raised in this scenario?

- What additional information would you like to know before deciding?

- What will you decide?

Continuing With The Cases- What Are Some Additional Considerations

- 8 and 11-year old girls who are in the primary custody of their biological mother and have visits with their biological father on alternating weekends…who are now in the middle of a situation with a potential move to step-father's home 2 hours away.

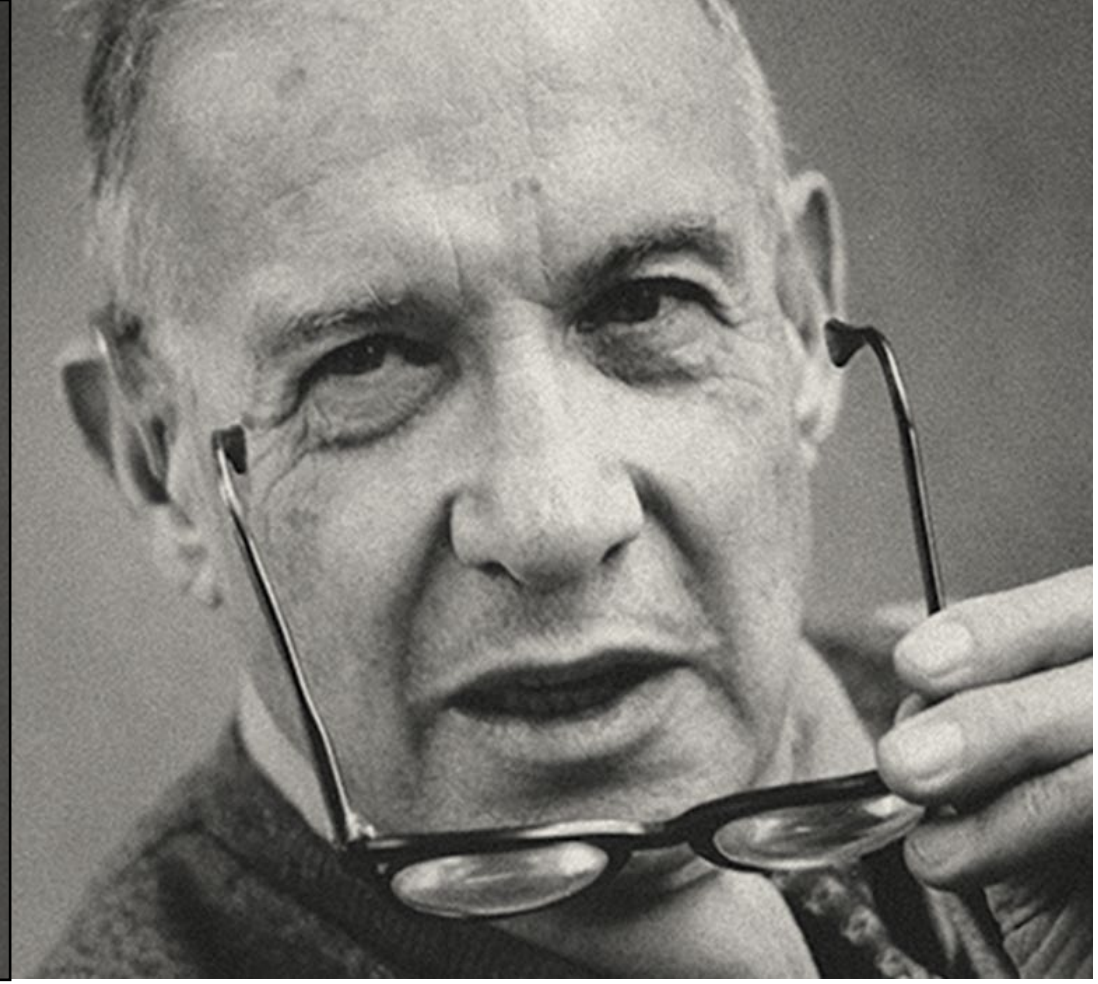
- What child development issues addressing best interests of the child are raised in this scenario?
  - Additional Question: What do we know about physical development during this time for the girls? How might that impact the decisions in this case?

- What additional information would you like to know before deciding?

- What will you decide?

"Culture eats strategy for breakfast"

-Peter Drucker



Usually this quote is used when talking about organizations and culture…what about this quote might be important to think about in terms of the families in these cases?

What Resources Could Be Shared with Parents Connected to these Cases?

OVERVIEW OF BEHAVIOR MANAGEMENT

Directions/Commands

- Statements vs. Questions
- Setting an agenda and having session 'rules'
- Choices when appropriate and acceptable

Praise/Rewards

- Refocusing on positive behavior: "catch them being good"
- Creativity in rewards: at home and in session
- Specifics about rewards: Provide as immediately as possible, related to child's interests or control/ability to make a choice, *parents and therapists have to hold up their end of the bargain*

OVERVIEW OF BEHAVIOR MANAGEMENT (CONTINUED)

- Differential Attention
  - Any behavior you pay attention to WILL INCREASE (e.g., Positive behavior, Negative behavior, Avoidance, Odd/unusual behaviors
  - Pay attention to the *opposite* of the behavior you are ignoring/want to go away
  - What behaviors *can* you ignore?
  - What behaviors *can't* you ignore?
  - What happens when you give in after a period of ignoring?

EFFECTIVE CONSEQUENCES

- Time out
  - Ages 2-6
- Work chores
  - Ages 7-12
- The "iron-clad contract"
  - Adolescence

GIVING EFFECTIVE COMMANDS

- Cue child to pending command: "Sally, please…"
- Make it simple
- Make it developmentally appropriate
- Phrase it positively
- Give it in a neutral tone of voice
- Provide an explanation BEFORE command is given
- Give one command at a time
- Praise immediately after compliance

WHEN NO COMPLIANCE:

- Limit warnings to ONE!!!!!
- "Sally, you have two choices. You can either *do this behavior* or you can *take this consequence*

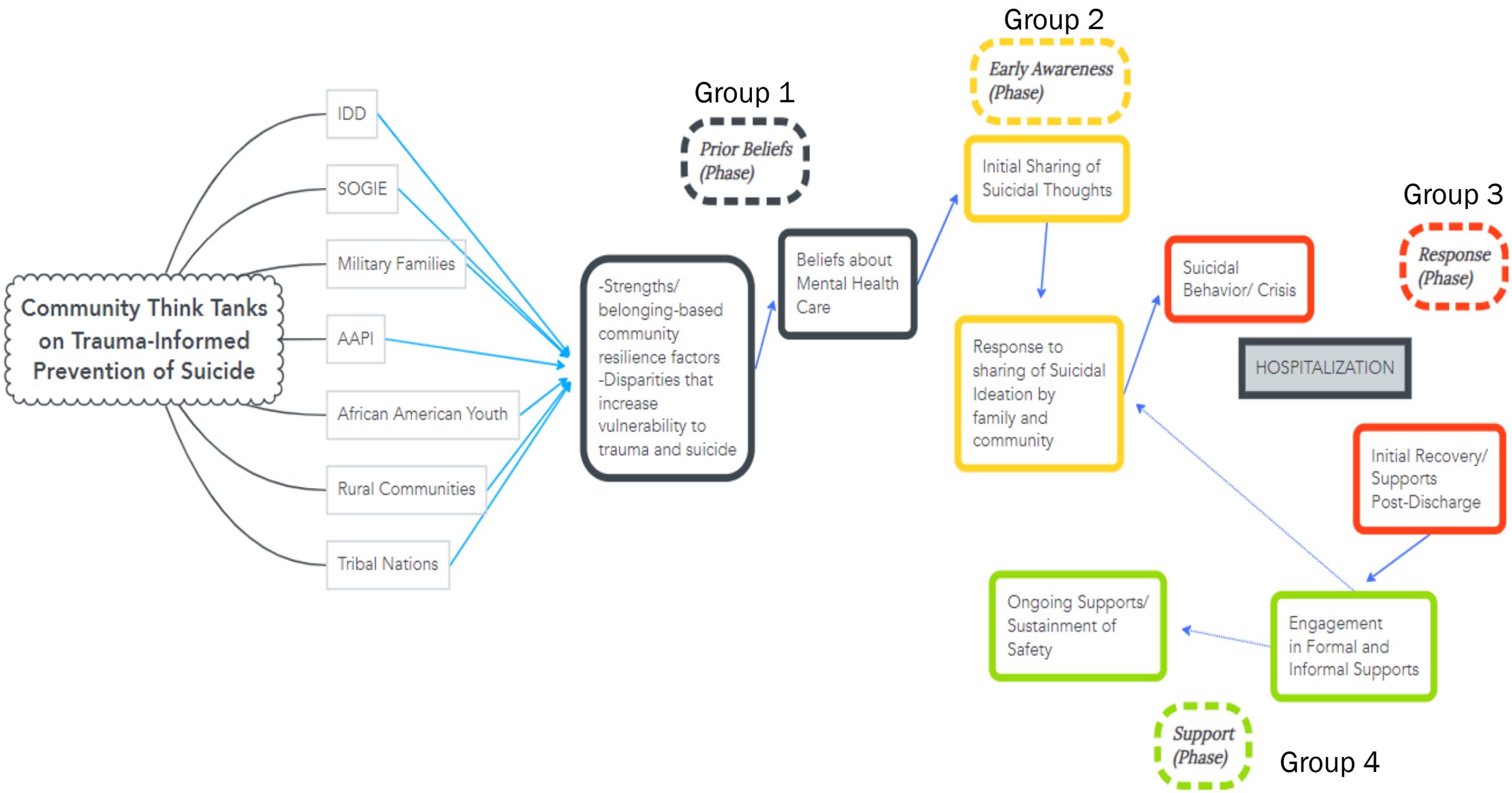
HOW DO YOU TEACH BEHAVIOR MANAGEMENT TO CAREGIVERS?

- Modeling
- Role Plays with parent
- The Feedback Sandwich
- *Repeated Practice* with increasingly difficult child behavior/responses
- Watch parent with the child to see the skills in action and be able to problem solve with the parent

TWO CURRENT ISSUES/NEEDS

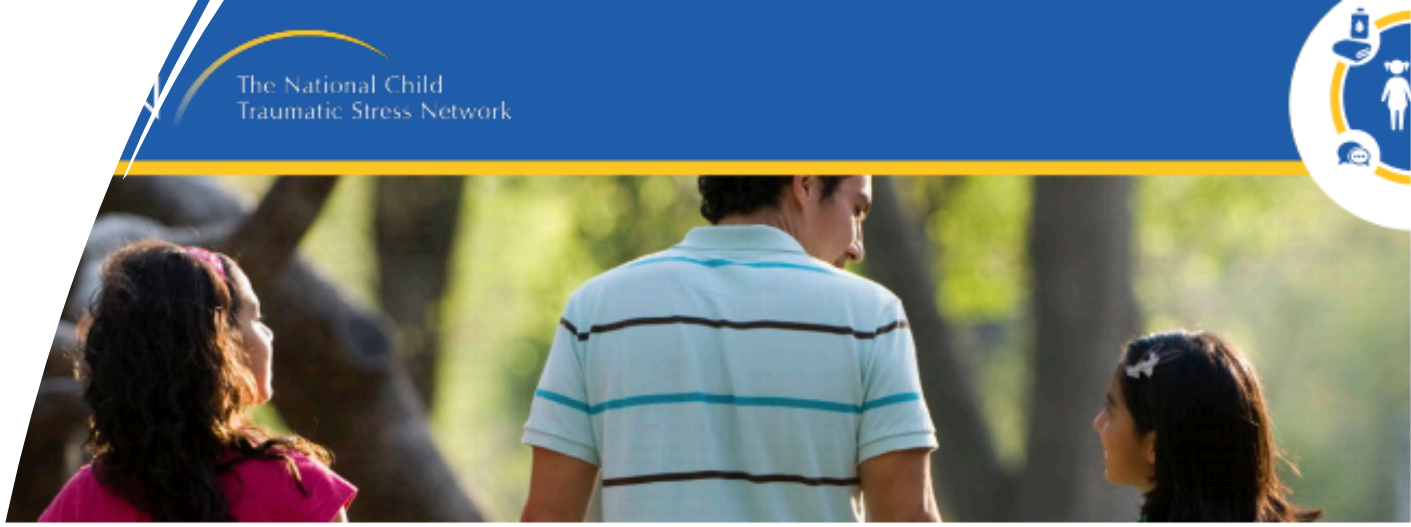
- What is the current make up of our EBT trainers?
- Who has access to become a trainer?
- Who has access to become a provider?
- What is the process to become a trainer and how do we ensure more equitable access?
- Why is it important to have trainers and providers that are representative of the communities they serve in?
- Why would this be important for you in your work and connection to providers?

- Significant numbers of children, youth, and adults who are at risk for or who have died by suicide?
- How does the NCTSN make changes in the way we screen, assess, and partner in communities to prevent suicide?
- How do we look at our approach differently given what we are doing now is not working?
- How do we address the fact that some groups are more impacted by trauma and suicide than others?


Community Think Tanks on Trauma-Informed Prevention of Suicide
IDD
SOGIE
Military Families
AAPI
African American Youth
Rural Communities
Tribal Nations
Group 1
Prior Beliefs (Phase)
-Strengths/ belonging-based community resilience factors
-Disparities that increase vulnerability to trauma and suicide
Beliefs about Mental Health Care
Group 2
Early Awareness (Phase)
Initial Sharing of Suicidal Thoughts
Response to sharing of Suicidal Ideation by family and community
Suicidal Behavior/ Crisis
HOSPITALIZATION
Group 3
Response (Phase)
Initial Recovery/ Supports Post-Discharge
Engagement in Formal and Informal Supports
Ongoing Supports/ Sustainment of Safety
Support (Phase)
Group 4

NCTSN Resource: Coping in Hard Times for Parents

- Link: https://www.nctsn.org/sites/default/files/resources/fact-sheet/coping_in_hard_times_parents.pdf



Coping in Hard Times: Fact Sheet for Parents

at happens when you or your spouse or partner are laid off, are out of work for months, and the unemployment ins
ds? What happens when—every place you look for work—they're not hiring or they have stacks of applications?

hat happens? You worry about what will happen to you and those you care for. About having money for groceries and
rtation. About paying for medication or medical appointments. About the next emergency that you can't foresee.
u have children, it is likely that they will worry too. During hard times, worries like these can cause frustration, stres
ger for everyone in the family.

is fact sheet will help you understand how economic difficulties may affect you and your family and help you find w
e—and help your family members cope—during these uncertain times.

Understanding Economic Downturns

n people face financial difficulties, it affects these qualities:

Sense of safety

bility to be calm

f-efficacy and community-efficacy

nectedness

Potential Referral Resources

- Parent/Family Mediation – if trying to resolve legal disputes
- Books for Parents on Impact of Divorce
  - "We're Still Family – What Children Have to Say About Their Parents' Divorce" by Dr. Constance Ahrons
  - "The Good Divorce" by Dr. Constance Ahrons
- UNC Carolina Institute for Developmental Disabilities (developmental assessments): http://www.cidd.unc.edu/services/clinical/
- Duke Children's Evaluation Center (general mental health assessment and informed referral): https://www.dukehealth.org/locations/duke-childrens-evaluation-center?utm_source=google&utm_medium=organic&utm_campaign=Directory+Management
- Duke Child and Family Study Center (variety of treatment and assessment for youth/young adults/families): https://www.dukehealth.org/locations/duke-child-and-family-study-center?utm_source=google&utm_medium=organic&utm_campaign=Directory+Management
- Center for Child and Family Health (CCFH; multiple services for youth/young adults/families who have experienced trauma and for young children with oppositional behavior): https://www.ccfhnc.org/programs/urbaniak-clinic/
- North Carolina Child Treatment Program (clinicians rostered in Trauma-Informed, Evidence-Based Practices): https://ncchildtreatmentprogram.org/

Any Questions

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CENTER FOR CHILD & FAMILY HEALTH