

Learning Circle



Create and maintain environments that promote physical and emotional safety and well being.

Preparation for Adulthood: Supervising for Success

Learning Circle: Create and maintain environments that promote physical and emotional safety and well being.

Agenda

9:00 a.m. – 4:00 p.m.

9:00 am	Welcome and Overview of Day
9:15 am	Introduction to Learning Circle and Review of Past Action Plans
10:00 am	Focus Questions
10:30 am	Digital Stories and Discussion
10:45 am	Break
11:00 am	Presentation on complex trauma
12:00 pm	Lunch
1:00 pm	Skill Building Activities
2:15 pm	Supervision Cycle and Emotional Intelligence
3:15 pm	Final Activity and Debrief
4:00 pm	Creating Action Plans

Learning Circle: Create and maintain environments that promote physical and emotional safety and well being.

Supervisory Competencies:

- Appreciates that physical and emotional safety are of paramount importance to young people.
- Appreciates the significant impact of separation, loss and trauma on a youth's ability to achieve safety and well being.
- Knows and understands that youth need support from caring adults to maintain safety and achieve well being.
- Knows how to incorporate goals around safety and well being into the transition plan.
- Can and is able to work with youth to address issues that threaten their safety and well being.
- Can and is able to work with youth to resolve issues related to separation, loss, and trauma.

Guiding Principles:

- Living arrangements, activities and programs are environments that maximize the safety and well-being of youth.
- Youth are encouraged to try new experiences through positive risk-taking.
- Rules, expectations and consequences are clear, consistent, developmentally appropriate and applied fairly.
- Help youth identify supportive adults to maintain personal safety and wellness.
- Provide youth opportunities to address issues of separation, loss and trauma in an effort to promote emotional health and well being.

Practices:

- Involve youth in determining and setting expectations for participation.
- Help adults appreciate the need for fair enforcement of rules.
- Develop rules and plan programs that encourage appreciation of diversity and diverse opinions.
- Develop transition plans that prioritize personal safety and emotional health.
- Provide support services that address the unresolved feelings or issues that have the potential to negatively impact the youth's preparation for adulthood.

Complex Trauma in Children and Adolescents-understanding the psychological and physiological effects of multiple traumatic stress experiences on the developing brain.

Complex trauma describes the dual problem of children's exposure to multiple traumatic events and the impact of this exposure on immediate and long-term outcomes. Typically, complex trauma exposure results when a child is abused or neglected, but it can also be caused by other kinds of events such as witnessing domestic violence, ethnic cleansing, or war. Many children involved in the child welfare system have experienced complex trauma.

Consequences of complex trauma exposure are devastating for a child. This is because complex trauma exposure typically interferes with the formation of a secure attachment bond between a child and the caregiver. Normally, the attachment between a child and caregiver is the primary source of safety and stability in a child's life. Lack of a secure attachment can result in a loss of core capacities for self-regulation and interpersonal relatedness. Children exposed to complex trauma often experience lifelong problems that place them at risk for additional trauma exposure and other difficulties, including psychiatric and addictive disorders, chronic medical illness, and legal, vocational, and family problems. These difficulties may extend from childhood through adolescence and into adulthood.

The diagnosis of **post traumatic stress disorder (PTSD)** does not capture the full range of developmental difficulties that traumatized children experience. Children exposed to maltreatment, family violence, or loss of their caregivers often meet diagnostic criteria for depression, attention-deficit/hyperactivity disorder (ADHD), oppositional defiant disorder (ODD), conduct disorder, anxiety disorders, eating disorders, sleep disorders, communication disorders, separation anxiety disorder, and/or reactive attachment disorder. Each of these diagnoses captures only a limited aspect of the traumatized child's complex self-regulatory and relational difficulties. A more comprehensive view of the impact of complex trauma can be gained by examining trauma's impact on a child's growth and development.

Complex Trauma in Children and Adolescents

Impact on Development

A comprehensive review of the literature suggests seven primary domains of impairment observed in children exposed to complex trauma. Each domain is discussed below.

- ***Attachment***

Complex trauma is most likely to develop if an infant or child is exposed to danger that is unpredictable or uncontrollable because the child's body must devote resources that are normally dedicated to growth and development instead to survival. The greatest source of danger and unpredictability is the absence of a caregiver who reliably and responsively protects and nurtures the child.

The early care giving relationship provides the primary context within which children learn about themselves, their emotions, and their relationships with others. A secure attachment supports a child's development in many essential areas, including his capacity for regulating physical and emotional states, his sense of safety (without which he will be reluctant to explore his environment), his early knowledge of how to exert an influence on the world, and his early capacity for communication.

When the child-caregiver relationship is the source of trauma, attachment relationship is severely compromised. Care giving that is erratic, rejecting, hostile, or abusive leaves a child feeling helpless and abandoned. In order to cope, the child attempts to exert some control, often by disconnecting from social relationships or by acting coercively towards others. Children exposed to unpredictable violence or repeated abandonment often learn to cope with threatening events and emotions by restricting their processing of what is happening around them. As a result, when they confront challenging situations, they cannot formulate a coherent, organized response. These children often have great difficulty regulating their emotions, managing stress, developing concern for others, and using language to solve problems.

Over the long term, the child is placed at high risk for ongoing physical and social difficulties due to:

1. Increased susceptibility to stress (e.g., difficulty focusing attention and controlling arousal),
2. Inability to regulate emotions without outside help or support (e.g., feeling and acting overwhelmed by intense emotions), and
3. Inappropriate help-seeking (e.g., excessive help-seeking and dependency or social isolation and disengagement).

- ***Biology***

Toddlers or preschool-aged children with complex trauma histories are at risk for failing to develop brain capacities necessary for regulating emotions in response to stress. Trauma interferes with the integration of left and right hemisphere brain functioning, such that a child cannot access rational thought in the face of overwhelming emotion. Abused and neglected children are then prone to react with extreme helplessness, confusion, withdrawal, or rage when stressed.

In middle childhood and adolescence the most rapidly developing brain areas are those that are crucial for success in forming interpersonal relationships and solving problems. Traumatic stressors or deficits in self-regulatory abilities impede this development and can lead to difficulties in emotional regulation, behavior, consciousness, cognition, and identity formation.

It is important to note that supportive and sustaining relationships with adults—or, for adolescents, with peers—can protect children and adolescents from many of the consequences of traumatic stress. When interpersonal support is available, and when stressors are predictable, escapable, or controllable, children and adolescents can become highly resilient in the face of stress.

- ***Affect Regulation***

Exposure to complex trauma can lead to severe problems with affect regulation. Affect regulation begins with the accurate identification of internal emotional experiences. This requires the ability to differentiate among states of arousal, interpret these states, and apply appropriate labels (e.g. “happy,” “frightened”). When children are provided with inconsistent models of affect and behavior (e.g., a smiling expression paired with rejecting behavior) or with inconsistent responses to affective display (e.g., child distress is met inconsistently with anger, rejection, nurturance, or neutrality), no coherent framework is provided through which to interpret experience.

Following the identification of an emotional state, a child must be able to express emotions safely and to adjust or regulate internal experience. Complexly traumatized children show impairment in both of these skills. Because they have difficulty in both self-regulating and self-soothing, these children may display dissociation, chronic numbing of emotional experience, dysphoria and avoidance of emotional situations (including positive experiences), and maladaptive coping strategies (e.g., substance abuse). The existence of a strong relationship between early childhood trauma and subsequent depression is well established.

Recent twin studies, considered one of the highest forms of clinical scientific evidence because they can control for genetic and family factors, have conclusively documented that early childhood trauma, especially sexual abuse, dramatically increases risk for major depression, as well as many other negative outcomes. Not only does childhood trauma appear to increase the risk for major depression, it also appears to predispose toward earlier onset of depression, as well as longer duration, and poorer response to standard treatments.

- ***Dissociation***

Dissociation is one of the key features of complex trauma in children. In essence, dissociation is the failure to take in or integrate information and experiences. Thus, thoughts and emotions are disconnected, physical sensations are outside conscious awareness, and repetitive behavior takes place without conscious choice, planning, or self-awareness. Although dissociation begins as a protective mechanism in the face of overwhelming trauma, it can develop into a problematic disorder.

Chronic trauma exposure may lead to an over-reliance on dissociation as a coping mechanism that, in turn, can exacerbate difficulties with behavioral management, affect regulation, and self-concept.

- **Behavioral Regulation**

Complex childhood trauma is associated with both under-controlled and over-controlled behavior patterns. As early as the second year of life, abused children may demonstrate rigidly controlled behavior patterns, including compulsive compliance with adult requests, resistance to changes in routine, inflexible bathroom rituals, and rigid control of food intake. Childhood victimization also has been shown to be associated with the development of aggressive behavior and oppositional defiant disorder.

An alternative way of understanding the behavioral patterns of chronically traumatized children is that they represent children's defensive adaptations to overwhelming stress. Children may reenact behavioral aspects of their trauma (e.g., through aggression, or self-injurious or sexualized behaviors) as automatic behavioral reactions to trauma reminders or as attempts to gain mastery or control over their experiences. In the absence of more advanced coping strategies, traumatized children may use drugs or alcohol in order to avoid experiencing intolerable levels of emotional arousal. Similarly, in the absence of knowledge of how to form healthy interpersonal relationships, sexually abused children may engage in sexual behaviors in order to achieve acceptance and intimacy.

- **Cognition**

Prospective studies have shown that children of abusive and neglectful parents demonstrate impaired cognitive functioning by late infancy when compared with nonabused children. The sensory and emotional deprivation associated with neglect appears to be particularly detrimental to cognitive development; neglected infants and toddlers demonstrate delays in expressive and receptive language development, as well as deficits in overall IQ. By early childhood, maltreated children demonstrate less flexibility and creativity in problem-solving tasks than same-age peers. Children and adolescents with a diagnosis of PTSD secondary to abuse or witnessing violence demonstrate deficits in attention, abstract reasoning, and problem solving.

By early elementary school, maltreated children are more frequently referred for special education services. A history of maltreatment is associated with lower grades and poorer scores on standardized tests and other indices of academic achievement. Maltreated children have three times the dropout rate of the general population. These findings have been demonstrated across a variety of trauma exposures (e.g., physical abuse, sexual abuse, neglect, and exposure to domestic violence) and cannot be accounted for by the effects of other psychosocial stressors such as poverty.

- **Self-Concept**

The early caregiver relationship has a profound effect on a child's development of a coherent sense of self. Responsive, sensitive care taking and positive early life experiences allow a child to develop a model of self as generally worthy and competent. In contrast, repetitive experiences of harm and/or rejection by significant others and the associated failure to develop age-appropriate competencies are likely to lead to a sense of

self as ineffective, helpless, deficient, and unlovable. Children who perceive themselves as powerless or incompetent and who expect others to reject and despise them are more likely to blame themselves for negative experiences and have problems eliciting and responding to social support.

By 18 months, maltreated toddlers already are more likely to respond to self-recognition with neutral or negative affect than non-traumatized children. In preschool, traumatized children are more resistant to talking about internal states, particularly those they perceive as negative. Traumatized children have problems estimating their own competence. Early exaggerations of competence in preschool shift to significantly lowered estimates of self-competence by late elementary school. By adulthood, they tend to suffer from a high degree of self-blame.

- ***Family Context***

The family, particularly the child's mother, plays a crucial role in determining how the child adapts to experiencing trauma. In the aftermath of trauma, family support and parents' emotional functioning strongly mitigate the development of PTSD symptoms and enhance a child's capacity to resolve the symptoms.

There are three main elements in caregivers' supportive responses to their children's trauma:

1. Believing and validating the child's experience,
2. Tolerating the child's affect, and
3. Managing the caregiver's own emotional response.

When a caregiver denies the child's experiences, the child is forced to act as if the trauma did not occur. The child also learns she cannot trust the primary caregiver and does not learn to use language to deal with adversity. It is important to note that it is not caregiver distress per se that is necessarily detrimental to the child. Instead, when the caregiver's distress overrides or diverts attention away from the needs of the child, the child may be adversely affected. Children may respond to their caregiver's distress by avoiding or suppressing their own feelings or behaviors, by avoiding the caregiver altogether, or by becoming "parentified" and attempting to reduce the distress of the caregiver.

Caregivers who have had impaired relationships with attachment figures in their own lives are especially vulnerable to problems in raising their own children. Caregivers with histories of childhood complex trauma may avoid experiencing their own emotions, which may make it difficult for them to respond appropriately to their child's emotional state. Parents and guardians may see a child's behavioral responses to trauma as a personal threat or provocation, rather than as a reenactment of what happened to the child or a behavioral representation of what the child cannot express verbally. The victimized child's simultaneous need for and fear of closeness also can trigger a caregiver's own memories of loss, rejection, or abuse, and thus diminish parenting abilities.

- ***Ethnocultural Issues***

Children's risk of exposure to complex trauma, as well as child and family responses to exposure, can also be affected by where they live and by their ethnocultural heritage and

traditions. For example, war and genocide are prevalent in some parts of the world, and inner cities are frequently plagued with high levels of violence and racial tension. Children, parents, teachers, religious leaders, and the media from different cultural, national, linguistic, spiritual, and ethnic backgrounds define key trauma-related constructs in many different ways and with different expressions. For example, flashbacks may be visions,” hyperarousal may be “un ataque de nervios,” and dissociation may be “spirit possession.” These factors become important when considering how to treat the child.

- ***Resilience Factors***

While exposure to complex trauma has a potentially devastating impact on the developing child, there is also the possibility that a victimized child may function well in certain domains while exhibiting distress in others. Areas of competence also can shift as children are faced with new stressors and developmental challenges. Several factors have been shown to be linked to children’s resilience in the face of stress: positive attachment and connections to emotionally supportive and competent adults within the family or community, development of cognitive and self-regulation abilities, and positive beliefs about oneself and motivation to act effectively in one’s environment. Additional individual factors associated with resilience include an easygoing disposition, positive temperament, and sociable demeanor; internal locus of control and external attributions for blame; effective coping strategies; a high degree of mastery and autonomy; special talents; creativity; and spirituality.

The greatest threats to resilience appear to follow the breakdown of protective systems. This results in damage to brain development and associated cognitive and self-regulatory capacities, compromised caregiver-child relationships, and loss of motivation to interact with one’s environment.

Six Core Components of Complex Trauma Intervention

Regardless of the type of trauma that leads to a referral for services, the first step in care is a comprehensive assessment. A comprehensive assessment of complex trauma includes information from a number of sources, including the child's or adolescent's own disclosures, collateral reports from caregivers and other providers, the therapist's observations, and standardized assessment measures that have been completed by the child, caregiver, and, if possible, by the child's teacher. Assessments should be culturally sensitive and language-appropriate. The Complex Trauma Workgroup of the National Child Traumatic Stress Network has identified six core components of complex trauma intervention.

1. *Safety*: Creating a home, school, and community environment in which the child feels safe and cared for.

2. *Self-regulation*: Enhancing a child's capacity to modulate arousal and restore equilibrium following dysregulation of affect, behavior, physiology, cognition, interpersonal relatedness and self-attribution.

3. *Self-reflective information processing*: Helping the child construct self-narratives, reflect on past and present experience, and develop skills in planning and decision making.

4. *Traumatic experiences integration*: Enabling the child to transform or resolve traumatic reminders and memories using such therapeutic strategies as meaning-making, traumatic memory containment or processing, remembrance and mourning of the traumatic loss, symptom management and development of coping skills, and cultivation of present-oriented thinking and behavior.

5. *Relational engagement*: Teaching the child to form appropriate attachments and to apply this knowledge to current interpersonal relationships, including the therapeutic alliance, with emphasis on development of such critical interpersonal skills as assertiveness, cooperation, perspective-taking, boundaries and limit-setting, reciprocity, social empathy, and the capacity for physical and emotional intimacy.

6. *Positive affect enhancement*: Enhancing a child's sense of self-worth, esteem and positive self-appraisal through the cultivation of personal creativity, imagination, future orientation, achievement, competence, mastery-seeking, community-building and the capacity to experience pleasure.

In light of the many individual and contextual differences in the lives of children and adolescents affected by complex trauma, good treatment requires the flexible adaptation of treatment strategies in response to such factors as patient age and developmental stage, gender, culture and ethnicity, socioeconomic status, and religious or community affiliation. However, in general, it is recommended that treatment proceed through a series of phases that focus on different goals. This can help avoid overloading children—who may well already have cognitive difficulties—with too much information at one time.

Early Adolescence (10 – 12 years old)

Developmental Milestones:

Physical

- Have increased coordination and strength
- Are developing body proportions similar to those of an adult
- May begin puberty—evident sexual development, voice changes, and increased body odor are common.

Emotional/Social

- Increased ability to interact with peers
- Increased ability to engage in competition
- Developing and testing values and beliefs that will guide present and future behaviors
- Has a strong group identity; increasingly defines self through peers
- Acquiring a sense of accomplishment based upon the achievement of greater physical strength and self-control
- Defines self-concept in part by success in school

Intellectual/Cognitive

- Early adolescents have an increased ability to learn and apply skills.
- The early adolescent years mark the beginning of abstract thinking but revert to concrete thought under stress.
- Even though abstract thinking generally starts during this age period, preteens are still developing this method of reasoning and are not able to make all intellectual leaps, such as inferring a motive or reasoning hypothetically.
- Youth in this age range learn to extend their way of thinking beyond their personal experiences and knowledge and start to view the world outside of an absolute black-white/right-wrong perspective.

- Interpretative ability develops during the years of early adolescence, as does the ability to recognize cause and affect sequences.
- Early adolescents are able to answer who, what, where, and when questions, but still may have problems with why questions.

Middle Adolescence (13 – 17 years old)

Developmental Milestones:

Physical:

- 95% of adult height reached
- Less concern about physical changes but increased interest in personal attractiveness
- Excessive physical activity alternating with lethargy
- Secondary sexual characteristics

Emotional/Social:

- Conflict with family predominates due to ambivalence about emerging independence
- Strong peer allegiances – fad behavior
- Experimentation – sex, drugs, friends, jobs, risk-taking behavior
- Struggle with sense of identity
- Moodiness
- Rejection of adult values and ideas
- Risk Taking – “it can’t happen to me”
- Experiment with adult roles
- Testing new values and ideas
- Importance of relationships – may have strongly invested in a single romantic relationship

Intellectual/Cognition:

- Growth in abstract thought reverts to concrete thought under stress
- Cause-effect relationships better understood
- Very self absorbed

Solution Focused Tasks

"It seems quite clear that one cannot solve the problem with the same kind of thinking that has created the problem" (Berg and Shazer, 1993, p. 9).

Here are a number of theories concentrated in moving from the problem to the solution. Essentially, solution-focused tasks move from 'problem talk' to 'solution talk.' Many of these examples are 'simple' activities but don't confuse them with being 'easy' tasks. They take a great deal of professional practice in order to fine tune your skills. Simplicity does take a great deal of self-discipline.

Tasks and Activities:

- 1. Three Wishes**
I regularly ask youth, "If I had a magic wand, and could grant three wishes, what would their three wishes be?" The answers supply a wealth of information and set-up a number of related questions.
- 2. Scaling Questions**
These questions are useful because words have a different meaning than numbers. No doubt there. A 7 is higher than a 5. The following discussing is taken from Berg and Shazer (1993). Ask, "How confident are you about this? Let's say ten means you're confident and one means not at all." Then ask the same question about what other important people in their life may think about your confidence. Is it a different score? Why? The value of scales can also be used in a group because of their nature.
- 3. Miracle Questions**
You ask, "suppose all of you go home tonight and while you are asleep a miracle happens and your problem is solved. How will each of you be able to tell a miracle happened the next morning?" You get into the details and make it real. Add their family cat that wakes someone up; ask what will be different (how people talk, look, etc.). Ask what changes have happened and how will others know just by looking at them that the miracle happened. Goal setting (Selekman, 1993; Selekman, 2002)
- 4. Exception-Finding Questions**
Work together and discover times when it seems the problem does not exist. These 'exceptions' allow us as therapists to explore personal attributes and values that underlie the problem-free outcomes in the past; thus, leading to the hope of new possibilities in the future (Freeman and Lobovits, 1993).
- 5. Talk about What Problem is Not**
Talk about what the problem is not is one of the ways of using misunderstanding in a creative fashion. This begins to construct a solution based on experiences that are outside the problem area.
- 6. Magic Wand**
A different version of the miracle question, you say, "if we could wave a magic wand and everything was wonderful and terrific, how would you know when you get there and things are resolved and how would other people, if they were following you around with a video camera know that it's all resolved?" This helps get an idea of where the client is and where they want to be. (O'Hanlon, 1993)
- 7. Possibility Frame vs. Problem Frame**
In the problem frame, we ask, "What is wrong" or "What is the problem"; in the possibility frame, we ask "what do you want" and "How do you want to get there" (Fanger, 1993)
- 8. Identify Stuck Behavior**
Simply, but asking "what is stopping you from hitting your goal or your possibility answer is one... Once identified, need to reframe it.

9. **Maintaining Progress**

Consistent with Exception finding, say that "Between now and the next time we meet, I would like you to observe so you can describe to me what happens in your life that you want to continue to have happen" (Meichenbaum, 2001).

10. **Appropriate and Unusual**

Anderson (1993) suggests that "Conversations have to be different from what youth are used to in order to bring about change but not too different or unusual" or conversations stop.

11. **In addition to vs. instead of**

Use "In addition to what you have tried to do, I wonder if you might try this . . ." instead of "This is what I suggest you do." (Anderson, 1993).

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Engaging in the Supervision Cycle

1. Focusing on Experience

The emphasis is on facilitating an accurate and detailed recall of events. A partial description of the situation will undermine the rest of the cycle. Worker can be assisted to recall more than they think they can recall if the right questions are asked. In these lists, the “you” is the supervisee.

- What happened before the interview?
- What was your role?
- What was your aim? What planning did you do?
- What did you expect to happen?
- What happened? Identify perceptions of youth, co-workers, etc.
- What did you say and do? What methods or interventions did you try?
- What did the young person say, do or show?
- What reactions did you notice to what you said/did?
- What surprised or puzzled you?
- What stuck out for you? What were the key moments?
- What did you notice about yourself, the client?
- What observations or concerns do other agencies have?
- What went according to plan? What didn't happen?
- What changes or choice did you make?
- What did you say, notice or do immediately after the meeting?

These questions can be enhanced by using other methods: video or audio recording, detailed observation and process recordings.

2. Focusing on Reflection

Here the emphasis is on eliciting feelings, partly because they may bring out further information, or may reveal the worker's underlying attitudes. They may also give clues to other personal factors complicating the worker's experience. Reflection helps the worker make links between the current situation and his/her prior experiences, skills or knowledge.

- What did you feel at the start of the meeting? What feelings did you bring to the meeting?
- Describe the range of feelings you had during the session.
- What did the meeting/your feelings remind you of?
- What previous work, processes, skills, knowledge are relevant?
- What patterns did you see in the meeting?
- Describe a time when you last experienced that – what happened?
- What did you think the client was feelings – based on what?

- What feelings might you carry on behalf of the client – e.g., what transference of projection might be occurring?
- What other factors might influence how you, the client felt or reacted, e.g., gender, race?
- Where and when did you feel most or least comfortable?
- What thoughts went through your mind during the session?
- What ideas can to you during the session?
- What are the continuities or discontinuities between this meeting and previous work with the case?
- What metaphor or analogy would describe your experience of working with case?
- What was left unfinished?

Other methods to assist reflection: role playing, genograms, eco maps, person centered plans.

3. Focusing on Analysis

Here the emphasis is on analysis, probing the meanings that the supervisee and the client attributes to the situation, consideration of the other explanations, the identification of what is not known or understood, and areas for further assessment.

- List three assumptions you brought with you to the meeting.
- How would you explain or understand what happened in that meeting?
Note: It is important to identify and probe different perceptions.
- How did this meeting fit or not fit into the overall aims of the work?
- What aims/outcomes for the meeting were or were not achieved?
- What went well, or not well, and why?
- What other, possibly unexpected outcomes, did the meeting produce?
- How else could you explain what happened?
- How would the client explain what was happening in the meeting?
- What was the nature of the power relations during the meeting?
- Did power relations shift during the session – if so, why? What might this tell you about assumptions around gender, race, sexuality, etc?
- What new information emerged? What was the critical moment?
- What bits of theory, training, research, policy, values might help you make sense of what was happening in the meeting?
- How else might you have managed the meeting?
- What are the current strengths, needs, risks for the client?
- What is not known?
- What conclusions are you drawing from this work so far?
- How do you define your role in this situation?
- How does the client define your role in this situation?

Other methods to assist analysis: sharing articles, references, case presentations, attending training as a team.

4 . Focusing on Action Plans

The focus here is on translating the analysis into planning, preparation and action. This includes identification of outcomes and success criteria as well as consideration of potential complications and contingency plans.

- In the light of the reflection and analysis we've done, what's your overall summary of where things are at, and what needs to be done next?
- Can you identify what you are and are not responsible for in managing this situation?
- What information still needs to be obtained?
- What are your goals in this next phase of work with this young person?
- What is urgent and essential?
- What would be desirable?
- What is negotiable and what is non-negotiable in this situation?
- What would be a successful outcome at the next meeting from the client's perspective?
- What are the different ways in which you could approach this?
- What might your strategy be for the next meeting?
- What are the possible best or worst responses from the client?
- How can the young person be engaged – what does s/he need from you?
- What contingency plans do you need – what is the bottom line?
- Who else needs to be involved?
- What would you like from them?
- How well equipped do you feel to undertake this? What would you need to support you?
- Where do you feel more or less confident?
- How can prepare for this?
- What can I do as your supervisor that would be helpful at this stage?
- Are there any safety issues for you or others?
- What and when does feedback and debriefing need to take place?

Other methods include: role play, case planning, contacting other professionals involved.

Adapted from Staff Supervision in Social Care © Pavillon 2005

Developing Empathetic Listening Skills

An important aspect of building relationships is the ability to listen well. Here are five areas to pay attention to and some tips in each area:

1. Listen

- Focus on the individual: put aside phone, paper, pen, other tasks; look at the person—
- Don't be distracted or allow your eyes to wander; convey with your body language and facial expression that “this conversation is the most important thing to me right now.”
- Suspend judgment—turn off your logic/rationality check.
- Strive to understand, to see from within the other's perspective
- Pay attention, notice the other's emotions about the issue; watch for non-verbal clues; listen to the words and for the images behind them
- Ask information questions: Can you give me some specific examples? How does this affect you? How do you feel when this happens? Help me understand.
- Give non-verbal and verbal support: lean forward; let your face be expressive— smile, frown, nod, say things like, “yes”, “go on”, and “please say more about that”.
- Before answering a question, ask more to be sure you know what they are really asking.

These behaviors on your part do not indicate agreement. They convey that you care about the other person and that you want to hear what they are saying and experiencing.

Do this step—listen—about ten times longer than feels necessary or reasonable to you.

2. Acknowledge

- Express verbally and non-verbally your understanding of the other's perspective—let the person know you have heard them
- Make clear that you see the importance of the issue to them
- State the impact you think this has on them: “It seems you really feel frustrated with what's going on.”
- Say, “I can understand how you feel” (if it's true), or “I can see that.”
- If it's true, say something like, “I'm having some of the same kinds of feelings” or “I've had experiences like that; I know how you feel.”

The point in acknowledgement is to let them know that you see them as individuals, with their particular experience and perspective.

3. Respect

- Never discount another's experience—it's real for the person
- Avoid saying things such as, "I think you're making too much of this"; "Just overlook it, it's not that important"; "I think you are misunderstanding what's going on"; or, "Well, I know it's hard, but that's just the way it is."
- Never use sarcasm or ridicule.
- Treat their perceptions as their reality—do not try to reason it away or to persuade the other person to feel differently about it

4. Appreciate

- Say, "I appreciate your coming to me with this."
- Say, "I know it's hard to discuss these things; I appreciate your making the effort to talk with me about them."
- Say, "Thanks for giving me this information; it's helpful to me."
- Say, "It's important for me to know what's going on; I appreciate your bringing me this information."
- Say, "Thanks for letting me know what is going on for you."

5. Follow Through

- If you've offered to send them some information, do it immediately with a note.
- If you've promised an action, get it underway and leave them a voice mail or note letting them know what you've done.
- Make a note on your calendar to check back with them in a week or some other appropriate-for-them timeframe. Ask. "Did you find that information helpful?" "Do the things we agreed on seem to be working?" "How are you feeling about things now?"

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RESOURCES

LONGSCAN (Longitudinal Studies of Child Abuse and Neglect) is a consortium of longitudinal research studies on the causes and impact of child abuse and neglect. www.iprc.unc.edu/longscan

NSCAW (The National Survey of Child and Adolescent Well-Being) is a project of the Administration on Children, Youth and Families to describe the child welfare system and the experiences of children and families who come in contact with the system. www.acf.hhs.gov/programs/opre/abuse_neglect/nscaw/index.html

Giving Foster Youth Their Say *My Voice, My Life, My Future* is a booklet of art, essays, and poetry by youth living in foster care. The collection was assembled by Home At Last, with the Children's Law Center of Los Angeles, in conjunction with the May 2006 Foster Care Awareness Campaign. The booklet provides an opportunity for foster youth to express their feelings about the foster care experience, being separated from family, wanting a voice in decisions that affect their lives, and dreaming of better futures.

Home At Last is a national, nonpartisan education and outreach project, supported through a grant from The Pew Charitable Trusts to Occidental College. The booklet is available online:

<http://fostercarehomeatlast.org/reports/MyVoice.pdf>

Examining the Effects of Child Trauma The Winter 2006 issue of the *Juvenile and Family Court Journal* is a special issue devoted to the long-term effects of trauma and abuse on children. The articles focus on information to help courts and judges deal effectively with these difficult cases. Articles include:

- The Impact of Trauma on Child Development by F. W. Putnam
- Pathways from Traumatic Child Victimization to Delinquency: Implications for Juvenile and Permanency Court Proceedings and Decisions" by J. D. Ford, J. Chapman, M. Mack, and G. Pearson
- Children Exposed to Domestic Violence: Making Trauma Informed Custody and Visitation Decisions by P. Van Horn and B. M. Groves
- Protecting and Supporting Children in the Child Welfare System and the Juvenile Court by B. Ryan, C. Bashant, and D. Brooks
- Trauma Interventions and Systems Change in Rural Areas: The Role of the Juvenile Court Judge in Collaboration with Mental Health Professionals by T. Kliebert et al.

www.ncjfcj.org/content/blogcategory/138/180/

The Research and Training Center on Family Support and Children's Mental Health at Portland State University, Portland, Oregon is dedicated to promoting effective community-based, culturally competent, family-centered services for families and their children affected by mental, emotional or behavioral disorders.
<http://www.rtc.pdx.edu>

The Child Trauma Academy, a not-for-profit organization based in Houston, Texas is a unique collaborative of individuals and organizations working to improve the lives of high-risk children through direct service, research and education. http://www.childtrauma.org/CTAMATERIALS/Vio_child.aspChild Welfare Information Gateway -Children's Bureau/ACYF

A service of the Children's Bureau, Administration for Children and Families, U.S. Department of Health and Human Services, we provide access to print and electronic publications, websites, and online databases covering a wide range of topics from prevention to permanency, including child welfare, child abuse and neglect, adoption, search and reunion, and much more.
http://www.childwelfare.gov/pubs/factsheets/long_term_consequences.cfm

The AACAP (American Academy of Child and Adolescent Psychiatry) is the leading national professional medical association dedicated to treating and improving the quality of life for children, adolescents, and families affected by these disorders.
http://www.aacap.org/cs/root/policy_statements/policy_statements