refocus

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In This Issue

Caring for Caregivers: Personal, Supervisory, and Organizational Approaches to Addressing Compassion Fatigue

By Christina L. Scanlon

Along with countless others in the helping field, those working in residential treatment are charged with the role of compassionately responding to those in need of care. Often, we find ourselves providing care and treatment for children and youth who have experienced significant trauma in their lives. In doing so, we encounter both positive and negative aspects of working in such an emotionally demanding field. When considered together, these positive and negative aspects of a person's professional life comprise that person's overall ***professional quality of life*** (Stamm, 2010).

Stamm (2010) defines professional quality of life as the "quality one feels in relation to their work as a helper" (p. 8). As residential workers, our professional quality of life hangs in the balance between the satisfaction and stress that we feel as a result of working with challenging children and youth. Such positive and negative experiences in the helping fields are called ***compassion satisfaction*** and ***compassion fatigue*** (Stamm, 2010).

While compassion satisfaction refers to the pleasure one derives from working to help others, this article focuses on the more nefarious component of professional quality of life: compassion fatigue.

Compassion Fatigue: The Cost of Caring

In 1995, Charles Figley coined the term compassion fatigue to refer to the 'cost of caring' experienced by those working with people affected by traumatic experiences or suffering. Compassion fatigue consists of two elements: burnout and secondary traumatic stress (Figley, 1995).

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Keeping the Child in Mind: Learning About Childhood Trauma from Personal Experience and Neuroscience

By John Gibson

Motivation to write this article was born at a one-day workshop led by Dr. Bruce Perry, Child Psychiatrist, and Senior Fellow at the Child Trauma Academy, Houston, TX, (www.childtrauma.org). The one-day workshop hosted by the European Society for the Scientific Study of Foster and Residential Care held in Glasgow, Scotland, presented an approach to understanding and working with maltreated children based on the Neuro-Sequential Model of Therapeutics (NSMT). The article is in part, personal reflection, in part descriptive but as a whole, is designed to whet the reader's appetite for discovery. Discovery for themselves about the relevance of exciting developments in the field of neuroscience that are deeply relevant to both Therapeutic Crisis Intervention, and to the CARE Program Model, and indeed, to any work focused on children's development.

It took a personal episode of clinical depression to concentrate my attention on the inter-connectedness of mind, brain, consciousness, and interaction with one's own life-space. Recovery from depression leads some people to label the experience as "a blessing". I am happy for them to do so. I do not choose that language, but am grateful for the learning and change in how I look at life. The personal realisation of the dark places of the mind, the frightening and awful power of intrusive and unwanted thoughts, sleep-deprivation, the confusion of strained relationships, living with misunderstanding others' intentions, experiencing hyper-vigilance. The terror of experiencing fear in safe and familiar places where no basis for such fear existed. All this combined with an inability to make decisions, has I hope, sharpened my understanding of and empathy toward children and adults who have lived a life of trauma. I had the unconditional love of family and the support of friends in work and socially. My emotional anchors remained in place, I held to a personal faith in God and somehow managed to continue to play in church band. As I recovered and began to research depression, anxiety, trauma, and the mind and brain, my research and reading led me to the impact of trauma on children.

Children and youth in crisis frequently perplex, confuse, trouble, and challenge carers whatever their personal or professional role in the lives of children. Carers often struggle with how to make sense of a child's thrust and demand to, "fxxx off and leave me alone because I hate you and don't trust you" while simultaneously communicating, "I need you so don't leave

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The most beautiful thing we can experience is the mysterious, it is the true source of art, science, and friendship.
–Albert Einstein

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me." Since starting work in child-care in 1972 I tried just about every therapeutic modality in existence to aid understanding and therapeutic endeavour. The growing knowledge base about the nature and impact of childhood trauma (Arvidson & Evans, 2011; D'Andrea et al., 2012; Dutton, 1999; Perry, 2006; Tishelman & Geffner, 2011) underpinned by developments in neuroscience combine to offer a unique framework for understanding how to help children back in the direction of a positive developmental trajectory. I believe it is possible now, to say with confidence, that the field of child care, education and policy development has at last available to it a "formal theory" (Myrick & Walker, 2006) and way of thinking about helping children that it has not had, heretofore.

There is now a significant volume of literature on childhood trauma (for example Van der Kolk, 1989; Tishelman & Geffner, 2011; Arvidson & Evans, 2011; D'Andrea et al., 2012; Dutton, 1999; Perry & Szalavitz, 2008; Szalavitz & Perry, 2010). The Neuro Sequential Model of Therapeutics (NSMT) as developed Dr. Bruce Perry (2006) and the team at Child Trauma Academy in Houston is particularly helpful because the complexities of brain science are presented in a way that is uniquely accessible and useable. Perry (2010) describes NSMT as, "a developmentally sensitive, neurobiology formed approach to clinical problem solving. NSMT is not a specific therapeutic technique or intervention. It is an approach that integrates core principles of neurodevelopment and traumatology to inform work with children, families and the communities in which they live."

NSMT comprises three components and six principles (Perry, 2006). The three components are training / capacity building, assessment, and the specific recommendations for the selection and sequencing of therapeutic, educational and enrichment activities that match the needs and strengths of the individual. The rest of this article summarises and comments on the six principles of NSMT.

Principle 1. The brain is organized in a hierarchical fashion, such that all incoming sensory input first enters the lower parts of the brain.

At birth, the lower part of the human brain, the brainstem, has to be functional in order for the new-born infant to breathe, have heartbeat, correct blood pressure and body temperature control. Close by, above and of course connected to all other brain structures is the limbic system. This area of the brain is responsible for flight-fight-freeze responses and is sensitive to internal and external threat. A predominate theory in brain science is that these "deep structures in the brain respond with a sense of safety and receptivity or with a sense of danger or life threat" (Siegel, 2012 p 17). The second principle, that follows shortly, develops the relevance of this, but first, and to finish this section, it is important to understand that it takes time and experience to fully develop higher brain functioning that "mediates more complex information processing functions such as perception, thinking and reasoning" (Siegel, 2012 p 18).

Principle 2. Neurons and neural systems are designed to change in a "use-dependent" fashion.

When the developing infant grows in a nurturing and protective environment and learns to grasp, look at and name an object, crawl, climb onto the sofa, say "mama", receive cuddles, stimulate smiles in others and in turn experience the pleasure of a smile returned the architecture of the brain is actually building. So too, when the developing infant grows in a play impoverished, linguistically impoverished, nurturing impoverished, emotionally, physically and or sexually abusive and neglectful environment, brain architecture also is developing. The forgoing sentences describe different states or use dependent settings for brain development. In the first, the "use-dependent state" for the growing child's brain is normative, developmentally appropriate, and "biologically respectful" (Perry, 2006). All things being equal the child learns self-regulation and a host of other competencies. The "use dependent state" in the second scenario described above can mean that the developing brain architecture and neural systems become set for survival in highly unpredictable and threatening environments. Perry (2006) states it like this, "As the brain organizes and changes as a reflection of the patterned nature and intensity of experience, fear and chaos, for example, will result in persistent, repeated activation of the stress response system". Thus maltreated and traumatized children may have an overly sensitised alarm response. This sensitive response system can lead to, "dramatic changes in behaviour in the face of seemingly minor provocative cues" (Perry, 2006 p 32).

Principle 3. The brain develops in a sequential fashion.

With amazing beauty and incredible functionality the new-born's brain continues its pre-birth development from the bottom up and in sequence. By mid 20's the top most part of the brain, pre-frontal cortex is generally fully developed. This is not to say that mental development ceases at this stage (Kegan and Lahey, 2009, Kegan and Lahey, 2001). The NSMT approach provides reasoned argument as to how this principle connects to therapeutic interventions. Firstly, the best intended therapeutic interventions will fail if the child's lower brain system is poorly regulated and running on overdrive. A quote from Bruce Perry makes the point, "… the sensitized stress response system in maltreated children keeps them in a persistent state of high arousal … when a traumatized child perceives any challenge

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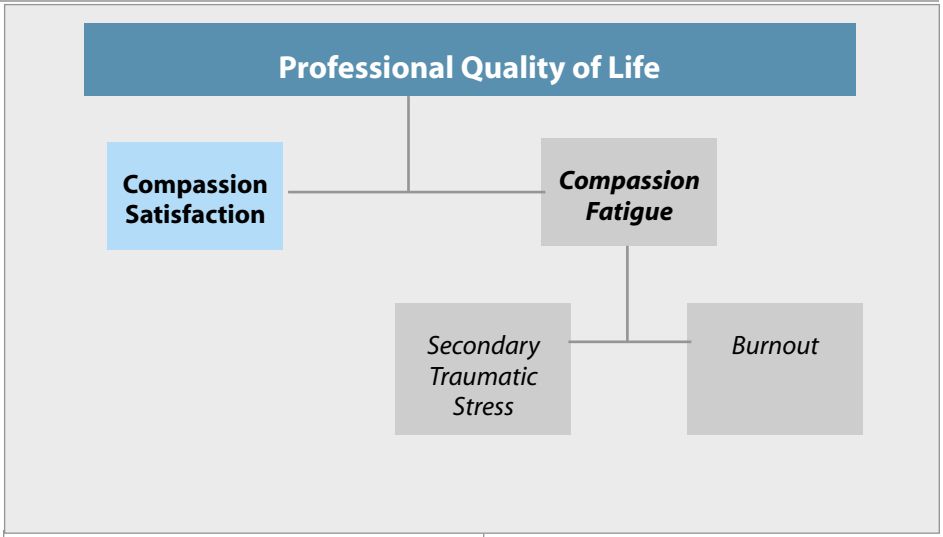
Burnout refers to a state of exhaustion resulting from repeated exposure to emotionally demanding situations (Maslach, Schaufeli, & Leiter, 2001; Pines & Aronson, 1988). The concept of burnout has been studied extensively by organizational psychologists and has long been linked with the components of emotional exhaustion, depersonalization, and job dissatisfaction (Maslach et al., 2001). Whereas people intuitively seem to grasp the concept of burnout, secondary traumatic stress, the second element of compassion fatigue, is less well understood and is unique to the helping professions.

Before being able to fully understand the concept of secondary traumatic stress, one must first understand what might constitute a traumatic event. Per the American Psychiatric Association (2000), a traumatic event involves some level of exposure to an incident that involves actual or threatened death, injury, or harm. Directly experiencing, witnessing, or learning about any such events may result in traumatic stress for an individual (APA, 2000). Most people recognize that direct personal experience or first-hand witnessing of traumatic events connect to the experience of acute or post-traumatic stress. However, few recognize that second-hand, or vicarious, experiences of someone else's trauma can result in traumatic stress as well. When a person experiences traumatic stress as a result of learning about someone else's trauma, they are facing secondary traumatic stress.

Figley (1995) defined secondary traumatic stress as "the natural consequent behaviors and emotions resulting from knowing about a traumatizing event experienced by a significant other—the stress resulting from helping or wanting to help a traumatized or suffering person" (p. 7). Simply stated, those who work with the traumatized may in turn become traumatized themselves as a result of their vicarious exposure to trauma.



This secondary traumatic stress mimics the symptoms of post-traumatic stress, with the only difference between the two being the level of exposure to trauma (Figley, 2002a). When traumatic stress as a result of direct exposure to trauma causes significant impairment to an individual's ability to carry out normal functions or activities, a person may be diagnosed with post-traumatic stress disorder (APA, 2000). Similarly, if a professional in the helping field experiences significant stress or impairment in relation to secondary exposure to trauma, they are said to be experiencing secondary traumatic stress disorder (Figley, 2002a), a term inextricably linked to compassion fatigue.

Thus, compassion fatigue is the combination of the emotional exhaustion associated with burnout and traumatic stress resulting from vicarious exposure to trauma. Because many of the children entering residential treatment have histories that include trauma in addition to the intense emotional and physical demands of the residential milieu, it is safe to assume that residential treatment workers are likely to experience compassion fatigue.

Compassion Fatigue: Signs and Symptoms

The effects of compassion fatigue permeate both professional and personal life. Figley (2002b) described numerous cognitive, emotional, behavioral, spiritual, relational, somatic, and professional impairments that were related to the compassion fatigue. The main symptoms of compassion fatigue as tension, preoccupation with trauma, intrusive imagery, avoidance, hyper-arousal, anxiety, and emotional numbing (Figley, 2002a, 2002b).

Other notable symptoms of compassion fatigue include decreased self-esteem, irritability, inability to concentrate, withdrawal from friends and family, depression, sleep disturbances, anger, and fear (Figley, 2002a, 2002b). While there are too many symptoms to provide a complete list in this article, you will recall that the symptomology of secondary traumatic stress align directly with those of post-traumatic stress.

In addition to Figley's work, a large body of literature addresses the effects that compassion fatigue has on professional capabilities. Compassion fatigue affects a caregiver's ability to provide care due to increased risk of poor professional

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All you need is love. But a little chocolate now and then doesn't hurt.
– Charles M. Schulz

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judgments (Bride, Radey, & Figley, 2007), and high levels of compassion fatigue can lead to decreased quantity and quality of work, low motivation, higher likelihood of mistakes, avoidance of trauma-related tasks, and obsessive attention to details (Yassen, 1995).

Furthermore, those experiencing compassion fatigue and burnout are prone to absenteeism, chronic lateness, and resignation (Collins & Long, 2003; Meldrum, King, & Spooner, 2002). It should come as no surprise that in environments where staff members are experiencing compassion fatigue, staff morale is compromised (Meldrum et al., 2002). Interestingly, both those experiencing compassion fatigue and their non-afflicted co-workers report low morale in these environments.

Finally, compassion fatigue has been shown to affect the relationship between the caregiver and the client (Valent, 2002). Valent (2002) proposed a cycle in which a caregiver's compassion fatigue may manifest in "nonrecognition, denial of client traumas, fragmented attention, lack of empathy, intellectualization, dehumanization of victims as cases or research subjects, and partial and foreclosed diagnoses and treatments" (p. 29). Because the caregiver-client relationship is reciprocal, these caregiver behaviors result in changes in the client, and the client may begin to view their caregiver as "naïve, ignorant, limited, patronizing, denigratory, unsympathetic, lacking understanding and compassion, and at worst more traumatic than the original trauma" (Valent, 2002, p. 29). Client's views of caregivers experiencing compassion fatigue may spawn negative client interactions, including client "distress, acting out, intensification or symptoms, decompensation, and premature termination of treatment" (Valent, 2002, p. 29). These factors create a more tenuous work environment, likely contributing to the caregiver's continued experience of compassion fatigue.

Clearly, the symptoms associated with compassion fatigue not only affect caregivers personally and professionally, but they also have a detrimental impact on the client-caregiver relationship that impedes progress in a treatment program.

Addressing Compassion Fatigue

The emergence of compassion fatigue symptoms in those who work with disturbed or traumatized people is likely, and these professionals have an increased risk of negative changes occurring in their own psychological functioning (Chrestman, 1995). With compassion fatigue affecting caregiver well-being and potentially the efficacy of treatment programs, the prevention and management of both burnout and secondary traumatic stress is a critical component of maintaining a therapeutic environment. The following paragraphs outline how individuals, supervisors, and organizations can address compassion fatigue.

Many researchers endorse self-care practices in order to treat and prevent symptoms of compassion fatigue (Eastwood & Ecklund, 2008; Figley, 1995, 2002a; McCrea & Bulanda, 2008; Meyers & Cornille, 2002; Radey & Figley, 2007). Eastwood and Ecklund (2008) provided a comprehensive list of suggestions for preventing and coping with compassion

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The Personal Qualities Needed For Child Care

Readers of last year's Refocus, and those who attended my workshop at the May 2012 CARE conference, will know that I've been doing some work of staff selection. This was motivated by an awareness of how child care is not a job for everyone and how there are many in the profession who are in the wrong job. Some informal research I've conducted has confirmed that many others hold this view. This has led me to try and identify the qualities needed to do the job well. I've been researching this for some while and checking this out (with help from John Gibson) through various internet discussion groups.

One thing I've discovered is that it's hard to get people to think in terms of qualities – what staff should be like – rather than actions – what staff should do. My conclusions so far, based on modern personality research, are that I believe child care staff should be:

- Empathetic, sympathetic, warm, kind, trusting
- Mature, resistant to stress, optimistic, calm
- Friendly, talkative, funny, sociable, confident
- Self controlled, trustworthy, focussed
- Broadminded, tolerant, flexible

This is an ongoing project, so if you have any thoughts about this, if you disagree that any of these qualities are relevant, or if you think an important trait is omitted, please get in touch. I would be please to hear from you: nickpidgeon@btinternet.com

The final part of the project is that I'm developing objective assessment methods to measure these traits in job candidates. This will be part of a process of staff selection that can be added to traditional interviewing. The process is nearly ready to pilot. I know of only one agency, the MacIntyre adult care organization in the UK, that uses anything similar. Their process is rather different from what I'm planning but they speak of good results so far.

Nick Pidgeon, *TCI Instructor, Scotland*

All children alarm their parents, if only because you are forever expecting to counter yourself.
– Gore Vidal

Who Is Punishment For?

By Nick Pidgeon

"And if there's bad behavior," Mma Potokwane went on. "If there's bad behavior, the quickest way of stopping it is to give more love. That always works, you know. People say we must punish when there is wrongdoing, but if you punish you're only punishing yourself. And what's the point of that?"

From, "*The Good Husband of Zebra Drive*" by Alexander McCall Smith.

What's the point of that? What's the point of punishment? The point, some neuroscientists now believe, is that punishing gives the punisher pleasure. Recent work by the neuroscientist Paul Zak, and others, indicates that the point of punishment, the reason why so many people rely on it, even when it doesn't work, is that punishing alters the brain chemistry of the punisher. It provides a shot of pleasure. When we punish we fire up the dopamine pleasure circuits in the brain and it feels good. We give ourselves a buzz.

If this is correct then Mma Potokwane is wrong. We do not punish ourselves when we punish others. We do the opposite. We give ourselves pleasure.

Many of us are concerned about the overuse, and the inappropriate use, even when it's not working, of punishment as a way to correct behavior problems in children. Sandra Bloom referred to this at the recent CARE conference as the, "If it's not working do more of it," technique. It's as if there's a belief that adults can deal with pain based behaviors by punishing children straight. How many times, as TCI trainers, do we ask for examples of what triggers children and we're given examples that involve the imposition of a punishment? A recent incident on a TCIF course brought home to me how deeply ingrained is our desire to punish. An intelligent, kind, experienced foster carer asked at the start of the course whether we would look at consequences. I said we would. Good, he said. Because what he wanted from the training was to discover a punishment so severe it would make his foster child behave. He had not found a punishment nasty enough, he said, "to touch my foster child." (I'm pleased to be able to say that two days later he threw up his hands and cried from the back of the room, "Oh my goodness! Now I understand.")

It has seemed to me for a while that punishment is instinctive, a default reaction when faced with challenging behavior from children. But this only raises two further questions, why is it instinctive? And how does it work? We might now know the answers.

Paul Zak became interested in punishment through studying the other side of the coin. He studied the brain chemistry of cooperation and trust. Say kind words to someone, cooperate with someone, hug someone, or just touch them on the arm and you change their brain chemistry and you also change your own brain chemistry. Experiments by Zak, and others, have shown that these actions, and many others we can perform towards fellow human beings, lead to the release of the hormone oxytocin. So we now know the biochemistry of caring gestures. Caring gestures release oxytocin in both the giver and receiver. Oxytocin makes you feel good towards someone else in a warm, trusting sort of way.

Evolution has designed us to cooperate. We're a social species so there are benefits to cooperation. Evolution rewards us when we cooperate through the release of oxytocin which feels good because it is linked to the brain's dopamine pleasure circuits. (Of course evolution doesn't actually do this. Putting it this way is just a short hand to explain incremental changes over millions of years.)

Evolution wants us to cooperate but it doesn't want us to be taken advantage of. So there's another hormone that makes us competitive, suspicious and fuels our desire to punish. Humans with higher levels of this hormone, either naturally, or temporarily in experiments, trust less and punish more. You know about this hormone. It is called testosterone. And you probably also know that, on average men have ten times more testosterone than women, although natural levels vary and some men have low levels and some women high levels. You probably also know that the "no one messes with me, I'm going to get even" type of behavior is more common in men, particularly men with higher than average testosterone. But you probably didn't know about the experiments conducted by Zak, and others, that link testosterone to the desire to punish. And you probably didn't know about the link between punishment and pleasure. Evolution makes high testosterone people quick to punish because punishment brings them pleasure. Zak calls it a system of reinforcement for "not being nice", and refers to this brain system as TOP: Testosterone Ordained Punishment. Experiments have shown that TOP works through the dopamine pleasure circuits in the brain. People with high testosterone are more likely to punish because they get more pleasure from punishment.

If you think about this for a moment it might make you conclude that imposing a punishment is a selfish act. We might know it won't work. We might know all the punishments we have imposed on this child in the past haven't worked. We might know all the research shows this is not the way to deal with pain based behaviors. But imposing a fine, or sending someone to their room, or taking away someone's points, will do something for us. It will make us feel good. "You've got to be seen to be doing something," is often the excuse. "You can't let the child

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or threat, he or she will be easily moved along the arousal continuum", (Perry, 2006, p 39). The second part of the argument is that therapeutic interventions must follow the sequential development pattern of the brain. Watch almost any adult pick up a new-born baby. With child in arms, most adults will soon adopt a rhythmic rocking motion designed to calm and soothe. In this action lies a model for the care of traumatized children. They first require, soothing rhythmic patterns that aim at calming a overly sensitized stress response system. After that, or sometimes along with that cognitive-behaviour and insight oriented treatment modalities may have their place.

Principle 4. The brain develops most rapidly early in life.

There is no other stage in life during which so much learning takes place, e.g., walking, talking, language and grammar, counting, gross and micro-motor development, balance, etc. By age four a child's brain is 90% adult size (Perry, 2010). It is a short step then to the realization that early experience, during which the human brain develops most of its mass has a profound influence on shaping brain organization. "The younger the child is, the more likely the child is to have enduring and pervasive problems following trauma" (Perry, 2006 p. 42).

Principle 5. Neural systems can be changed, but some systems are easier to change than others.

I call this the "good news" principle for its truth communicates hope and optimism – within limits. I encourage the reader to research the citations above and others (for example Siegel, 2012; D'Andrea et al., 2012) to learn about "brain plasticity". Here are some observations. As noted above, the brain development does not stop when we reach mid-twenties (Kegan and Lahey, 2009). Development is possible. The area of the brain that is most malleable after age 3 is the cortex. Thus, it may be easier to help a person change what they think than it is to change emotional responses laid down in early experience and which are easily cued by current environmental stimuli. Areas in the lower brain are less responsive to change. However, repeated, new experiences, which are in sympathy with earlier brain development stages that thrive on rhythm and soothing, can go some way toward creating new neural networks that perhaps strengthen the brain's capacity to distinguish between past and present. That is to think and feel, my history was bad, but that is "then" and "this" is now.

Principle 6. The human brain is designed for a different world.

Human beings were designed for a relational world. A world of community, kinship, neighbourhood, mutuality, as Dr. Perry says, "the clan". It takes very little thought to construct aspects of modern living that are the opposite of a truly relational environment. Put modern technology and the cyber age at the top of the list; on the one hand, it has increased communication, but on the other hand, cyber communication has diminished real relational communication. Add the stress of modern living and you arrive at a recipe that is not "biologically respectful" (Perry, 2006, Perry, 2010). Biologically respectful is a term that deserves elaboration.

Return for a moment to the picture just painted of an adult gently rocking a month old child that has just been fed, had its nappy (diaper!) changed and is satisfied. There are no demands put upon the child that it cannot "meet" or that are not beautifully congruent with the infant's needs. The image speaks of a biologically respectfully encounter. Now step from that picture and look at another picture. In this second picture there is a child who has experienced "complex trauma" (Arvidson and Evans, 2011) and she or he encounters relational and environmental demands and expectations that are outside the child's "zone of proximal development" (Holden, 2009). The child's stress response system is triggered and sets off harmful body-based psycho-biological and behavioural responses that ends in restraint! I hope that these contrasting pictures give definition to the term, "biologically respectful".

Biologically respectful interactions between adults and children segue nicely into consideration of where NSMT links with TCI and CARE. Consider some of these strategies from TCI, e.g., "hurdle help", a "prompt", a "caring gesture", etc., done in the context of a caring relationship. Consider the import of "emotional first-aid" when a child is struggling to self-regulate. Consider crisis co-regulation when a child's stress response system has them on the brink of violence or self-harm. Consider saying to a child who resorts to pro-active aggression as a means to secure a legitimate goal, "I support your goal, but let me help you work out how to achieve it without violence and aggression". Consider helping a child to make connections between feelings and behaviour. If delivered in the context of "healing community" (Perry and Szalavitz, 2008, p 231-246) then there is a good chance of emotional connections that will help build competence. The CARE Program Model is an organization wide intervention that aims to create conditions for change, in other words, a "healing community" that is "biologically respectful".

I chose the title of this article to emphasise the importance of broadening perspective in thinking about children to include more than behavior, more than what the child is doing or not doing. Ironside (2012) refers to the discipline of keeping the child's mind in mind as "mentalising" however, I find his longhand way of saying this more meaningful. He uses a definition of "mentalising" as "making-sense-of-why-a-person-is-behaving-this-way-by-imagining-what-is-going-on-in-their-mind". Mind is more than what the brain is doing (Siegel, 2012). NSMT and the literature on traumatology provides a different and deeper perspective on understanding children's challenging behaviour by paying more attention to mind and brain than behaviour.

References

Arvidson, J., Kinniburgh, K., Howard, K., Spinazzola, J., Strothers, H., Evans, M. Andres, B., Cohen, C., & Blaustein, M. E. (2011). Treatment of complex trauma in young children: Developmental and cultural considerationsin application of the arc intervention model. *Journal of Child & Adolescent Trauma*, 4: 1, 34 – 51.

D'Andrea, A., Stolbach, B., Ford, J.,

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Spinazzola, J. & Van der Kolk, B. A. (2012). Understanding interpersonal trauma in children: Why we need a developmentally appropriate trauma diagnosis. *Journal of American Orthopsychiatry* 82, 187-200.

Dutton, D. G. (199)9. Traumatic origins of intimate rage. *Aggression and violent behaviour,* 4, 431-447.

Holden, M. (2009). *Children And Residential Experiences (CARE): Creating conditions for change.* Arlington, VA: Child Welfare League of America.

Ironside, L. (2012). Meeting of minds: Using the Tavistock model of child observation and reflective group work in the advanced training of foster cares. *Adoption and Fostering* 36, 29-42.

Kegan, R. & Lahey, L. (2001). *The real reason people don't change.* Boston, MA: Harvard Business Review.

Kegan, R. & Lahey, L. (2009). *Immunity to change.* Boston, MA, Harvard Business Press.

Myrick, F. & Walker, D. (2006). Grounded theory: An exploration of process and procedure. *Qualitative Health Research,* 16, 547-559.

Perry, B. D. (2006). Applying principles of neurodevelopment to clinical work with traumatized and maltreated children: The neurosequential model of therapeutics. In: Boyd W. N. (Ed.) *Working with traumatized youth in child welfare.* NY: The Guilford Press.

Perry, B. D. (2010). *Overview of the neurosequential model of therapeutics.* http://www.childtrauma.org/images/stories/docs/nmt_description_overview_6_22_12x.pdf

Perry, B. D. & Szalavitz, M. (2008). *The boy who was raised as a dog: What traumatized children can teach us about loss, love and healing.* NY: Basic Books.

Siegel, D. (2012). *The developing mind: How relationships and the brain interact to shape who we are.* New York/London: The Guilford Press.

Szalavitz, M. & Perry, B. D. (2010). *Born for love: Why empathy is essential and endangered.* NY: William Morrow

Tishelman, A. C. & Geffner, R. (2011). Child and adolescent trauma across the spectrum of experience: Research and clinical interventions. *Journal of Child & Adolescent Trauma*, 4, pp. 1-7.

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RCCP Conference Highlights

By Andrea Turnbull

The Residential Child Care Project's third international conference, ***In the Best Interests of The Child: Caring for Them—Caring for Us***, was held May 9-11, 2012. Located beachfront at the beautiful Embassy Suites Myrtle Beach in South Carolina, the conference brought together individuals from around the world. Three hundred participants from 10 countries including Canada (6 provinces), England, Scotland, Northern Ireland, Wales, Ireland, Bermuda, Australia (5 states/territories), South Africa and the US (27 states) were in attendance. The program included 35 workshops, 3 panel discussions and 5 keynote addresses focused on improving the quality of care and treatment for children, youth and their families.

Our keynote and featured speakers were truly a highlight of the conference. After our conference welcome from Dr. John Eckenrode, Director of Cornell's Bronfenbrenner Center for Translational Research, Dr. Larry Brendtro Ph.D., Founder, Circle of Courage Institute began the conference with a fascinating view of the wisdom of youth work pioneers in his keynote *The Quest for the Best Interests of the Child*. Dr. Sandra Bloom, founder of Sanctuary Institute, helped us consider how we can create trauma informed environments to treat our children and families with her address: *Creating, Destroying, and Restoring Sanctuary*. In his keynote, *Reconnecting With the Lives of our Children: Pathway to New Partnerships*, Dr. Kenneth Hardy, Professor of Family Therapy, Drexel University and Director of Eikenberg Institute for Relationships, challenged us to ask ourselves will we be jailers or healers? Dr. Paul Baker, Director NorthStar Educational and Therapeutic Services, had us thinking about trauma and the brain and how to help young people with practical approaches in his talk on *Transforming Trauma: A NeuroRelational Approach to Strength-Based Support*. Dr. David Allen, Associate Clinical Director, Directoriate of Learning Disability

CARE Day Event

Services, Abertawe, Bro Morgannwg University Health Board took us into the experience of foster carers with his keynote *Training Family Carers in the Safe Management of Challenging Behaviours–A UK Perspective*. Howard Bath, former TCI Instructor and the current Children's Commissioner in Australia's Northern Territory presented *The Three Pillars of TraumaWise Care*, an approach to develop healing environments. Finally, and in no small feat, Dr. James Anglin, Associate Vice President Academic and Director of International Affairs, University of Victoria, British Columbia, Canada, provided us with an endnote address entitled *An Appreciative Inquiry on the Cornell Fresh Air Camp 2012*. In his very skilled way, he was able to capture the essence of the conference keynotes and presentations and reminded us of how much we had experienced in just a few days. Jim Anglin closed the conference with the following wish for us all, "I hope you will return to your places of work, your families, and your communities renewed, reinvigorated and re-inspired to continue to struggle with the best interests of the child."

Beyond presenting and leading workshops, several of the featured speakers remained accessible throughout the conference talking with participants on breaks, at receptions and at book signings. When Jim Anglin reached the podium after his introduction for the endnote address, one woman was overheard, "I sat next to him at lunch and we had a great conversation, but I didn't know who he was!" It was wonderful to see Larry Brendtro, Howard Bath and Sandra Bloom attending workshops and keynotes. Participant feedback reflected the unique opportunity these days provided, "I love

Conference Highlights, continues on page 8

Conference Highlights, continued from p. 7

that we had the ability to hear from and question experts in the field."

This expertise was evident not only in the keynote addresses, but in the 35 workshops and 3 panel discussions offered to participants. The workshops focused on both TCI and CARE related topics. Workshops included Deep Brain Learning, Implementing the Sanctuary Model: Lessons Learned, Creating a Peaceful Community: Strategies for Care Model Sustainability, TCI Team Building—An Interactive Approach, Speak to the Hand: Engaging Hard to Reach Young People with the Life Space Interview, Incorporating the ICMP into School Behavior Intervention Plans: Process and Product, Grief and Loss: Implications for Crisis, Using a Visual Approach in the Life Space Interview for Asperger/High Functioning Autism, Creating Your Best Setting Conditions, Living in Crisis and Leaving the Crisis in the Holy Land, CARE Implementation in Northern Ireland Children's Services and so many more. The only complaint I can remember hearing at the conference was "How do you expect me to choose which workshop to attend!"

Friday's panel discussions allowed participants to hear from and engage with presenters regarding the themes of: Strengthening Our Workforce: Preventing Compassion Fatigue by Supporting Our Staff, Family Engagement, and Restraint Reduction Strategies That Work. Led by a moderator, these discussions provided a broad spectrum of perspectives, both national and international, regarding issues seen as common struggles within our workplaces.

This was the first RCCP international conference to include the work being done with the program model Children and the Residential Experience: Creating conditions for change (CARE). The conference began with a pre-conference CARE event on May 8th and was attended by over 100 professionals from CARE agencies in the USA, Canada, Northern Ireland, and Australia. The CARE event focused on exploring and sharing what has been learned from the implementation of CARE in programs around the world over the past 5 years. With an emphasis on learning from one another's experiences, an afternoon panel discussion focused on sustaining the CARE model. The CARE day also provided the first opportunity for CARE trainers to gain certification with 47 CARE trainers becoming the first group to be certified. Workshops throughout the conference highlighted both struggles and successes involved in implementing CARE in a variety programs.

Our TCI trainers also had an opportunity to use the conference as an Update for their re-certification. Choosing among all the workshops and panel discussions, TCI trainers had the freedom to explore topics outside of TCI as well as learning more about new directions for TCI including the much anticipated TCI for Schools (TCIS). On Friday afternoon, it was time for testing and it was quite a sight to see 111 trainers sit together for the written test. Also, as you can imagine, quite a challenge to test out almost that many in the physical skills!!

As any good trainer knows, you must keep people well fed and moving so we had lots of good snacks at the breaks, two evening receptions and a big Carolina Beach Party with an authentic Carolina low country buffet and oyster roast. The DJ provided the entertainment and kept the dance floor busy until the party ended.

As one of the organizers, my greatest satisfaction came from the following comment I read on an evaluation in response to the question about what they liked best about the program: The feeling of a wonderful community of people passionately connected to the healing of our children. With great pride we look back at this opportunity we all had to gain knowledge, share experiences, improve practice and renew ourselves for our continued work with youth all around the globe. Thank you to all who contributed, those who presented, those who worked behind the scenes, and those who attended. It was an amazing experience.

Jim Anglin

Kenneth Hardy

Larry Brendtro

TCI Testing

Andrea Turnbull *is on the Faculty of the RCCP and manages the TCI program. Andrea has over 15 years of experience working with young people in residential treatment settings.* ✷

Ask Eugene: Implementation of TCI for Schools (TCIS)

TCI for Schools (TCIS) is a system not just a training curriculum, so there are some things to consider about implementation.

If you decide to proceed in using TCIS, RCCP will need some information before we can advise you as to how to go about TCIS:

- How large is your school?
- Do you plan to train your staff in the physical restraints which is always optional? If so, there is a behavior audit that we will in advance to help you determine your needs in that regard. If you do choose to use the TCIS System, one of our instructors will contact your principal or superintendent about the behavior audit process.

We will also need a copy of your physical restraint policy if you have one. If you do not have a policy and you are choosing to use the physical restraints, we can help you develop one. There is a lot of information about this in the TCIS system bulletin, available on our website, rccp.cornell.edu.

Next, you will need to have people trained as trainers in TCIS so that they can train your staff. RCCP only provides the training of trainers. We do not come to a school and provide direct TCIS training for staff. TCIS is a co-trainer model so you will need at least two trainers, possibly more depending on the size of your school and your school's needs based on the behavior audit.

There are two ways for people to be trained as trainers in TCIS:

1. If you have a small school and you need a small number of trainers, you can send people to an open-enrollment TCIS training of trainers.
2. The second way to do this is by sponsoring an on-site TCIS TxT. We come to your school and provide a TCIS training of trainers for up to 20 people. This also includes a separate assessment and planning day when we meet with key people in your school to assess your needs and assist you in planning how to implement the TCIS System.

There is also an implementation package available that includes the above on-site TCIS training of trainers, a TCIS assessment and planning day, and additional technical assistance days to assist you with the process of implementing TCIS. ✸

Keeping the Child in Mind, continued from p. 7.

Van der Kolk, B. A. (1989). The compulsion to repeat; Re-enactment, revistimization, and masochism. *Psychiatric Clinics of North America* 12, 389-411.

John Gibson *is qualified in social work, in social work management and applied social learning theory in childcare. His main professional interest remains residential child care. He has twenty years experience of working with troubled young people in residential care settings. He is a faculty member of the Residential Child Care Project. He is the lead consultant in Ireland for TCI and for CARE.* ✸

Punishment, continued from p. 5.

get away with it." But perhaps that's just a rationale for a selfish act that will change our brain chemistry and give us a buzz.

The point of a lot of punishment, then, is that it's not for the child. It's for us. Punishing brings adults pleasure.

References

Zak, P. (2012). *The moral molecule: The source of love and prosperity.* NY: Bantam Books.

De Quervain, et al. (2004) The neural basis of altruistic punishment. *Science* 305 1254-58.

Rockenbach, B. & Milinski, M. (2006) The efficient interaction of indirect reciprocity and costly punishment. *Nature* 444 718-23

McBride, J. & Dabbs, M. G. (2000) *Heroes, rogues and lovers: Testosterone and behavior.* NY: McGraw-Hill.

Nick Pidgeon, *BSc, CQSW, Director Nick Pidgeon Consultancy and Training Ltd., UK. Nick has many years experience in social work and over 15 years experience as an independent consultant. He has provided training and consultancy throughout Britain and in Ireland, the USA, Canada, Australia, and Russia.* ✸

REFOCUS is an occasional newsletter. It is our way of communicating to you, TCI and CARE trainers and interested professionals, information about current issues and events that emerge from work in crisis management and residential child and youth care. Information from the field provides important feedback for us. You can send questions and comments and ideas to us at: REFOCUS c/o The Residential Child Care Project, Bronfenbrenner Center for Translational Research, Cornell University, Beebe Hall, Ithaca, NY 14853 Tel: (607) 254-5210 / Fax: (607) 255-4837 / Email: eas20@cornell.edu

Obstacles are those frightful things you see when you take your eyes off your goal.
–Henry Ford

From the Instructor's Booth

Professional Certification Announcement

Congratulations to the newest TCI trainers to have achieved professional level certification:

Denis Beaulieu. Denis has worked for Algoma Family Services, a provider of specialized, evidence based services for children, youth, adults and families in Northeastern Ontario, Canada since 1989 in a variety of roles. Since 2003, he has been a foster parent recruiter/trainer for the agency's Treatment Foster Care program in 2004 when Denis attended TCIF Trainer training in Ithaca, NY. He was inspired by the underpinning principals of attunement, empathy and acceptance that the model was evidently founded upon and he attended a TCI Trainer training in 2005. "TCI has not only guided me to be more effective in my professional role, but personally helped me to behave my way into healthier thinking, as well as think my way into healthier behavior."

Richard Crane. Richard lives in Lincolnshire UK and has worked with children and young people since 1995 in both the public and private sectors. His experience includes Residential Care (including offending and challenging behaviours), Therapeutic Milieu Therapy Work, Family Support Work and he has also been a Co-ordinator for the Family Group Conference Service. In 2006 Richard became a TCI Trainer when the local authority adopted this programme for residential care. Since then he has been instrumental in having TCI promoted into the wider community and has trained other professionals including Foster Carers, Targeted Youth Workers and Family Support Workers. He gained his professional qualification in 2012 and is co-director of Crisp & Crane Training Ltd. Richard can be contacted via email at richard.crane@candctraining.co.uk.

Lee Crisp. Lee is a Children's Home Manager and TCI trainer working in Lincolnshire UK. He began working in children's services in 1995 and has been delivering TCI training to residential and community-based staff and foster carers since 2006. He manages a service that has consistently been graded as providing "outstanding" outcomes for young people. Lee also works as a consultant for BILD physical intervention accreditation scheme; work that is instrumental in raising standards of care for vulnerable children and adults in the UK. Lee is co-director of Crisp and Crane training ltd and can be contacted through email – lee.crisp@candctraining.co.uk

Diane J. Guckemus, B.S. Diane is the Staff Training & Development Coordinator for The House of the Good Shepherd in Utica, NY. Diane has worked for the House nearly 23 years in various positions; including direct-care, supervisory, and training. In her current position, she oversees the Training Department; coordinates internal and external training, and is the Lead Trainer for TCI within the agency. Diane has been a certified trainer in TCI since 1999 and received her Professional Certification in February 2012. Diane is currently enrolled in the Masters of Education Program: Corporate & Community at Elmira College, NY. Diane is also certified in Life Space Crisis Intervention, Effective Supervisory Practice I & II and is currently working on becoming certified in Mediation. Additionally, Diane is a member of the Oneida County Professional Training Coalition and Toastmasters International, Inc. Diane can be reached at dianegu@hgs-utica.com or guke13@yahoo.com

Chris Herbert, Chris has worked with young people and adults in Residential and Supported Living environments for over 20 years in the public, private and charitable sectors. His roles have ranged from Residential Social Worker to Managing Care units and Group Homes for persons with Learning Difficulties/Complex Needs and Autism. Over the past 6 years Chris has specialised in Staff Learning & Development, becoming a TCI Trainer in 2006, Supported Living Trainer in 2007 and Person Centred Trainer in 2008. Chris has recently continued his professional development through Cornell University by becoming a Facilitator of the Citizen Centred Leadership Development Series (CCLDs), Employment & Disability Institute, Cornell.

Terri Mac Donald, an intervention specialist, master teacher, and mentor, has worked for 19 years in teaching positions with students in categories ranging from at-risk to severely disabled. She began as a teacher for students with hearing disabilities and enjoyed teaching within self-contained and mainstreamed

learning settings for 11 years. Terri began employment with Madison-Champaign ESC in Urbana, OH, as a transition-to-work teacher in 2006. She developed a program and curriculum to provide social, independent living, and work skills training to students with autism and multiple disabilities in preparation for life after graduation. Terri began teaching TCI classes to staff in 2009, reaching professional level certification in 2011. Her future goal is to be trained in TCIF to support families in need.

Margaret Smith, M.Ed, Ph.D., has over 20 years experience as a teacher, trainer, and facilitator. She taught for many years in secondary colleges in Melbourne, Australia – predominately in senior level Psychology and primary and secondary teachers and school counsellors at an anti-bullying program for Victorian schools. She has experience as a corporate trainer in leadership and communication skills, and utilised an experiential tool to explore, demonstrate and develop these skills. Margaret has been practicing mindfulness and meditation for over 20 years and has been teaching these practices for over 10 years. For the last 3 years she has been working as a State Trainer with Life Without Barriers (a non-government Out-of-Home Care agency in Australia). She has been a TCI trainer for residential workers, case managers, carers, and a range of other staff who work in foster care, residential care, and disabilities. Email: margaret.smith@lwb.org.au

Sheila Roberts has spent 18 years in the school setting, teaching and supervising programs for students with disabilities. She originally graduated with a degree in Hearing Impaired education in 1993 and continued her education to receive her Masters in special education in 2001 and then her Superintendent's License in 2002. She is employed as the Low Incidence Supervisor for Madison-Champaign Educational Service Center in Urbana, OH. For ten years, Sheila worked as a supervisor in a program for students with behavioral/emotional disabilities. Since her employment with Madison Champaign ESC, she has served on several committees to improve programming for students with disabilities. She has been a Therapeutic Crisis Intervention Trainer since 2009 and was certified as a Professional Level trainer in 2012.

RCCP Instructor Announcement

The RCCP is pleased to welcome Eddie Mendez and Michele A. Pierro as our newest instructors.

Eddie Mendez. Eddie has worked with young people, including young offenders, over the last 23 years and the last 16 years has been with Marist Youth Care (MYC), a non-profit organization based in Sydney, Australia. He has fulfilled various roles from youth worker to manager with high needs young people in residential care settings. The last 4 years Eddie has been in the position of Professional Development Coordinator developing training workshops, facilitating training and coordinating the agencies training calendar. With both a Diploma of Community Services and Cert IV in Training and Assessment, Eddie has been able to combine both his studies and work into the delivery of training. Over the last ten years as an Associate Certified TCI trainer, Eddie has been the primary TCI trainer for MYC and with the commitment of MYC has ensured a whole of agency approach to the TCI system. In addition to his long engagement with the welfare sector Eddie is also a foster carer. eddiem@maristyc.com.au.

Michele A. Pierro, M.S., received her M.S. in Educational Psychology, Secondary Education, and certificate of Advanced Studies in Educational Administration from the College of Saint Rose in Albany, NY. For the past 40 years Michele has worked in Middle and High schools, Programs for Gifted and Talented and a maximum security facility for juvenile offenders in Iowa, FL and NY. Ms. Pierro developed and taught the County Jail Youth Program at the Columbia County Jail and the School of Choice Interdisciplinary Arts in Education Program at the Hudson Middle School, and was a faculty member of Columbia Greene Community College. Michele has been a Principal and Director of Special Education at the Questar III BOCES in Castleton, NY, Director of School Safety and Positive Behavior Supports in D75 in NYC and Director of Security Resources for the NYCDOE, providing technical assistance to schools on the NYS Persistently Dangerous List. She was also a member of the NYS Leadership Team for PBIS at the NYS Education Department. She resides in NY and is the proud mother of four daughters. ✷

Serious Fun and Games: Mirage by Jack C. Holden

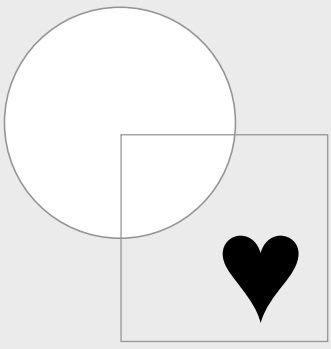
This is a fun activity designed to use different types of communication; one-way verbal only; two-way but non-verbal from speaker and verbal from recipients; and completely open two-way with a question from each participant. This can also be used as an activity for creativity, accurate listening, and understanding vocabulary.

One participant is chosen from the group to be the leader and given a piece of paper with a design on it. The leader must describe the design to the rest of the group so that they may draw it on their own papers. You may decide that people should concentrate on their own work, or allow the group to collaborate.

This activity should be done more than once, with each variation allowing different forms of communication. Some variations you might choose include:

#1 The leader can say anything, may make no gestures, and must face away from the group. Drawers may not speak or ask questions.
#2 The leader may only make gestures, no speaking. Drawers may ask as many questions as they want.
#3 The leader may speak and gesture. Drawers may ask one question each.

Here is a sample design, you can create others as well:



Butler, S. & Rohnke, K. (1995). Quicksilver: Adventure Games, Initiative Problems, Trust Activities and a Guide to Effective Leadership. Dubuque, IA: Kendall/Hunt Publishing Company.

***Jack Holden** is a TCI Instructor from Ithaca, NY and has a PhD in Education, specializing in Adult Learning.* ✷

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fatigue, with most of their suggestions falling into one of four categories of general practice:

- Develop and use a social support network;
- Make time for yourself, both while at work and at home;
- Take care of yourself physically and emotionally; and
- Seek help when you need it.

Eastwood and Ecklund also offered more specific strategies for engaging in self-care, suggesting practices such as taking vacations, taking short breaks while at work, engaging in hobbies, planning activities with friends and family, eating well, exercising, getting enough sleep, and evaluating the meaningfulness of the helping profession through conversations with supervisors and coworker support. Stamm (2010) reiterates the importance of reflecting upon the meaningfulness of one's work as a helper, emphasizing the role of compassion satisfaction in one's professional quality of life.

Because of the insidious nature of compassion fatigue and its intricate ties with the helping field, residential workers will often not recognize the warning signs of compassion fatigue in themselves; hence, it becomes vitally important for all staff to be knowledgeable about the signs and symptoms of compassion fatigue so as to recognize a coworker's potential struggle (Figley, 2002a).

However effective self-care measures might be, individual self-care cannot be the only mediation against risk for compassion fatigue. Researchers have found that burnout in particular is based more on situational and organizational factors rather than on individual factors due to the different demands imposed upon the individual while in the work setting (Maslach et al., 2001). Collins and Long (2003) asserted that "personal, professional, and organizational support may provide protective factors to mediate against some of the risks relating to the development of secondary traumatic stress" (p. 423).

Lakin, Leon, and Miller (2008) stress the importance of education and prevention programs about compassion fatigue and call for management to play an active role in addressing the issue. In attempts to provide guidance for prevention and intervention for helpers experiencing compassion fatigue, Meyers and Cornille (2002), highlight five key elements for effective programming, including improving training, handling on-the-job victimization, providing a supportive work environment, limiting work hours, and encouraging personal care.

Several researchers have identified proactive strategies for addressing compassion fatigue from a supervisory perspective. For example, Eastwood and Ecklund (2008) emphasized the importance of open discussions about compassion fatigue and emotional competence, professional development, maintaining adequate staffing ratios, conducting thorough incident debriefings, and encouraging self-care.

Stamm (2010) advocates for the active monitoring of

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secondary traumatic stress, burnout, and compassion satisfaction using the Professional Quality of Life Scale (ProQOL). Available for free online (www.proqol.org), the ProQOL can be used as a means to promote self-monitoring amongst staff members. The ProQOL can also be used to gather information about a group of employees to discern general levels of secondary traumatic stress and burnout on an organizational level.

Figley (2002c) describes preventative institutional policies and procedures to proactively address compassion fatigue at an organizational level. Many of these policies and procedures, such as stress debriefings, stress management plans, and an awareness of the risks and costs of working with traumatized populations (Figley, 2002c), echo those outlines in popular trauma-informed care models. In addition, Figley (2002c) recommends that organizations

- Screen applicants for resilience and awareness of the way the field affects personal and family life;
- Promote the 5:1 ratio rule in which employees are encouraged to spend one hour of personal processing, whether during or after work, for every five hours spent working with cases of those who have been traumatized;
- Incorporate humor and stress reduction into daily routine;
- Encourage staff members to promote coworker health and self-care and discourage unhealthy coping strategies, such as substance abuse; and
- Routinely recognize personal and group achievement and accomplishments.

Figley's (2002c) final suggestion for preventative strategies for organizations in regards to compassion fatigue is to encourage staff members to leave their work at work, emphasizing the role of the worker as devoted to personal life over their role as a helping professional. However, in my professional experience, the workplace mantra tends to be one where employees are expected to abandon personal and family life at the door on the way in to work, rather than to leave their work life behind when going home for the day. By recognizing that the personal circumstances of the employee outside of work outweigh the importance of work-related circumstances, organizations prioritize the personal over the professional, which in turn promotes self-care and a supportive organizational culture.

Concluding Thoughts

When on an aircraft, passengers are warned during safety protocol reviews that in case of a loss of cabin pressure, a person should apply his or her own oxygen mask before assisting others. As residential workers, assisting others is at the core of what we do; yet, as we strive to care for children and youth in residential treatment, we have to first remember to take care of ourselves. In doing so, we create an environment that supports the best interests of the child by supporting the best interests of those working in it.

References

American Psychiatric Association [APA]. (2000). *Diagnostic and statistical manual of mental disorders* (4th ed., text rev.). Washington, DC: Author.

Bride, B. E., Radey, M., & Figley, C. R. (2007). Measuring compassion fatigue. *Clinical Social Work Journal,* 35(5), 155-163. doi: 10.1007/s10615-007-0091-7.

Chrestman, K. R. (1995). Secondary exposure to trauma and self-reported distress among therapists. In B. H. Stamm (Ed.), *Secondary traumatic stress: Self-care issues for clinicians, researchers, and educators* (pp. 29-36). Lutherville, MD: Sidran Press.

Collins, S. & Long, A. (2003). Working with the psychological effects of trauma: Consequences for mental health-care workers – A literature review. *Journal of Psychiatric and Mental Health Nursing,* 10, 417-424. doi: 10.1046/j.1365-2850.2003.00620.x

Eastwood, C. D., & Ecklund, K. (2008). Compassion fatigue risk and self-care practices among residential treatment center childcare workers. *Residential Treatment for Children & Youth,* 25(2), 103-122. doi: 10.1080/08865710802309972

Compassion Fatigue: Signs and Symptoms

- ☐ Absenteeism
- ☐ Anger
- ☐ Anxiety
- ☐ Avoidance
- ☐ Chronic lateness
- ☐ Decreased quantity and quality of work
- ☐ Decreased self-esteem
- ☐ Depression
- ☐ Emotional numbing
- ☐ Fear
- ☐ Hyperarousal
- ☐ Impaired client-caregiver relationship
- ☐ Inability to concentrate
- ☐ Intrusive imagery
- ☐ Irritability
- ☐ Low motivation
- ☐ Obsessive attention to detail
- ☐ Poor professional judgments
- ☐ Preoccupation with trauma
- ☐ Sleep disturbances
- ☐ Tension
- ☐ Withdrawal from family and friends

Figley, C. R. (1995). Compassion fatigue as secondary traumatic stress disorder: An overview. In C. R. Figley (Ed.), *Compassion fatigue: Coping with secondary traumatic stress disorder in those who treat the traumatized* (pp. 1-20). New York, NY, Brunnar/Mazel.

Figley, C. R. (2002a) Compassion fatigue: Psychotherapists' chronic lack of self-care. *Journal of Clinical Psychology,* 58(11), 1433-1441. doi: 10.1002/jclp.10090

Figley, C. R. (2002b). Introduction. In C. R. Figley (Ed.) *Treating compassion fatigue* (pp.1-13). New York, NY, Routledge.

Figley, C. R. (2002c). Epilogue. In C. R. Figley (Ed.) *Treating compassion fatigue* (pp. 213-218). New York, NY, Routledge.

Caring for Caregivers, continues on page 14.

Professional Certification Frequently Asked Questions: Enhancing Our Relationship with Professionally Certified TCI Trainers

by Andrea Turnbull

Recently all TCI trainers were emailed a copy of the revised TCI Trainer Certification brochure so that both Associate and Professionally Certified Trainers have the necessary information about the TCI certification process and our high standard of professional practice. This brochure can be found on the Residential Child Care Project website at: http://rccp.cornell.edu

The guidelines for the Professionally Certified Trainer (PCT) have been revised and include some additional support as well as new requirements for all PCTs. It is our hope that these new guidelines will help support the PCT and guide them through the process of assessment and planning that is critical when working with an agency. Please see below for a quick view of the revised portion of the guidelines. The full rights, responsibilities, and re-certification guidelines can be found in the TCI certification brochure.

RCCP Communication With Professionally Certified Trainers

- The RCCP ***will maintain the mentor assigned*** to each PCT in the pre-application process for telephone and email consultation ***and support through their "fee for service" contracts.***
- Professionally certified trainers will be contacted and ***assigned a mentor*** to offer telephone and email consultation for their "fee for service" contracts.

Changes to the Certification Responsibilities of the Professionally Certified Trainers

- Prior to beginning training outside of their home (employing) organization, PCTs will contact their ***assigned mentor*** to discuss the assessment and planning needs as well as documentation requirements when training staff at other organizations or schools.
- ***Before delivering*** training outside of their home (employing) organization, PCTs ***will submit evidence*** to the RCCP from the contracting organization or school of adherence to TCI implementation guidelines. This evidence may be a copy of an agreement between the PCT or home organization and the contracting organization or school and a copy of the policies and procedures that comply with the implementation guidelines. This documentation should be sent to the RCCP with the order form for Student Workbooks for the TCI course.
- ***Within 30 days of the completion*** of all training courses delivered outside of their organization, PCTs will submit the agenda, attendance records, and a summary of the evaluation records to the RCCP.
- ***The RCCP reserves the right to quality assure any TCI training delivered by a PCT.***

We hope that this mentor relationship will allow for the PCTs to feel more supported and connected with the Residential Child Care Project in the coming years. To obtain more information or ask questions, please contact Thomas Endres at te24@cornell.edu.

Andrea Turnbull *is on the Faculty of the RCCP and manages the TCI program. Andrea has over 15 years of experience working with young people in residential treatment settings.* ✷

The Residential Child Care Project seeks to improve the quality of residential care for children through training, technical assistance and evaluation. The project has been at the forefront of efforts to strengthen residential child care programs for children since 1982 when it was established under a grant from the U.S. Department of Health and Human Services, National Center on Child Abuse and Neglect. The RCCP is administered by the Bronfenbrenner Center for Translational Research, the College of Human Ecology at Cornell University. The Center's Director is John Eckenrode, PhD. The project's Principal Investigators are Michael Nunno, DSW, and Martha Holden, MS. The Residential Child Care Project web site address is http://rccp.cornell.edu/

Caring for Caregivers, continued from p.13.

Lakin, B. L., Leon, S. C., & Miller, S. A. (2008). Predictors of burnout in children's residential treatment center staff. *Residential Treatment for Children & Youth,* 25(3), 249-270. doi: 10.1080/08865710802429697

Maslach, C., Schaufeli, W. B., & Leiter, M. P. (2001). Job burnout. *Annual Review of Psychology,* 52, 397-422. doi: 10.1111/1467-8721.01258

McCrea, K. T., & Bulanda, J. J. (2008). The practice of compassion in supervision in residential treatment programs for clients with severe mental illness. *The Clinical Supervisor,* 27(2), 238-267. doi: 10.1080/07325220802487907

Meldrum, L., King, R., & Spooner, D. (2002). Compassion fatigue in community mental health case managers. In C.R. Figley (Ed.), *Treating compassion fatigue* (pp. 83-106). NY: Brunner/Rutledge.

Meyers, T. W., & Cornille, T. A. (2002). The trauma of working with traumatized children. In C.R. Figley (Ed.), *Treating compassion fatigue* (pp. 39-54). NY: Brunner/Rutledge.

Pines, A., & Aronson, E. (1988). *Career burnout: Causes and cures.* NY: The Free Press.

Radey, M, & Figley, C. R. (2007). The social psychology of compassion. *Clinical Social Work Journal,* 35, 207-214. doi: 10.1007/s10615-007-0087-3

Stamm, B. H. (2010). *The concise ProQOL manual* (2nd ed.). Pocatello, ID: The ProQol.org

Valent, P. (2002). Diagnosis and treatment of helper stresses, traumas, and illnesses. In C.R. Figley (Ed.), *Treating compassion fatigue* (pp. 17-37). NY: Brunner/Rutledge.

Yassen, J. (1995). Preventing secondary traumatic stress disorder. In C. R. Figley (Ed.), *Compassion fatigue: Coping with secondary traumatic stress disorder in those who treat the traumatized* (pp. 178-208). NY: Brunner/Mazel.

Christina Scanlon *is a doctoral student and teaching fellow at the University of Pittsburgh where she studies Applied Developmental Psychology. During her seven year career in residential treatment, Christina has worked in direct care, supervisory, administrative, and training capacities. Currently, she works as a TCI trainer in the Pittsburgh area.* ✷

From the Book Shelf

The Better Angels of Our Nature: The Decline of Violence in History and Its Causes

by Steven Pinker

Published by London: Penguin Books in 2012

Everyone knows the world is becoming more violent.

Everyone knows we are living in particularly violent times.

Everyone knows the world was more peaceful in the past.

But everyone, or almost everyone, is wrong according to this book by Steven Pinker.

I want to briefly review Pinker's book here to tell you about an important work, but also to point out the relevance for our field.

The *Better Angels of our Nature* is about "what may be the most important thing that has ever happened in human history," according to Pinker. We humans tend to get our opinions on trends in violence from conversation and the media. One story, one shooting, one serial killer uncovered, and it is too easy to conclude that we live in unusually violent times. The good news is that this is wrong. Pinker's book includes 60 graphs plotting every type of violence over time. He admits he was surprised to discover every one displays, "a line that meanders from the top left to the bottom right." Every type of violence has declined.

Some figures might help to illustrate this. Pinker averaged the percentage of deaths from violence in hunter-gatherers and hunter-horticulturalists in 22 cultures around the world from 14,000 BC to 1770 AD. The average death rate from violence was 15 percent. In other words, if you lived in one of those societies you had a 15% chance that your death would be violent. Your chance of dying a violent death in America in 2005 was four-hundredths of one percent.

Another useful measure is the number of people per 100,000 a year who die from violence. The safest place ever to have lived is Western Europe right now. Here only one person per 100,000 dies from violence a year. The average for non-state societies is 500 deaths per 100,000.

Pinker catalogues human violence. It is depressing and disturbing to read. He describes human history as "a cavalcade of bloodshed". But the awesome research by Pinker and his team reveals that we are lucky to be alive now. Every type of violence has declined. He is not alone in pointing this out. Pioneering work by Lawrence Keeley and Steven LeBlanc began to reveal the appalling death rates of the past at a time when it hard to get universities to fund research into the crazy idea that the past was more violent than the present. But Pinker takes these ideas further. He looks at the biggest possible picture – all of human history and every type of violence.

This includes violence against children. These 32 pages alone are a considerable achievement, a comprehensive analysis of violence against children throughout history from infanticide in prehistory to physical punishment now.

Pinker has coupled his historical enquiry with the perspective of an evolutionary psychologist. He doesn't just point out that violence has declined but he asks why. To understand this, he says, we need to understand human violence. This is where the book becomes relevant to our field. He dismisses the 19th century hydraulic theory of violence, embraced by Freud and still around now, that violence is blowing off steam. From an evolutionary perspective, this does not make sense. Evolution (figuratively speaking) does not design creatures with excess energy to vent. Evolution designs creatures to behave in certain ways, even certain violent ways, to achieve goals. So we should be careful about a sharp distinction between proactive behavior as goal orientated and reactive behavior as driven by emotion. Reactive behavior is also goal orientated, and the emotion – for example anger or fear – produces physical changes in the body that help achieve the goal. Pinker lists five types of violence: predation, dominance, revenge, sadism, and ideological violence. There are clear goals behind every type of violence, he says

This analysis highlights the importance of asking ourselves about a violent person's feelings, needs, and wants during even the most chaotic emotional and violent outburst. Surprisingly, however, in the 802 pages of Pinker's monumental work there is no mention of the second TCI assessment question.

Reviewed by Nick Pidgeon, *TCI Instructor, Scotland.* ✷

TCI USA 2013 COURSE OFFERINGS

TCI: TRAINING OF TRAINERS (TXT)

Jan. 14-18/13 ..... Ithaca, NY
Mar. 4-8/13 ..... Denver, CO
Mar. 18-22/13 ..... Peoria, IL
Apr. 15-19/13 ..... Cincinnati, OH
May 6-10/13 ..... Warwick, RI
Jun. 17-21/13 ..... Charlotte, NC
Jul. 15-19/13 ..... Pittsburgh, PA
Jul. 29-Aug. 2/13 ..... Baltimore, MD
Aug. 26-30/13 ..... Ithaca, NY
Sep. 16-20/13 ..... Peoria, IL
Oct. 7-11/13 ..... San Jose, CA
Nov. 11-15/13 ..... Warwick, RI
Dec. 9-13/13 ..... Ithaca, NY

TCI FOR SCHOOLS: TRAINING OF TRAINERS (TXT)

Jan 14-18 ..... ithaca
Aug 26-20 ..... Ithaca

TCI UPDATES

Developing Professional Level TCI Training Skills
May 14-15/13 ..... Warwick, RI
Jul. 25-26/13 ..... Baltimore, MD

TCI For Developmental Disabilities
Feb. 28-Mar. 1/13 ..... Denver, CO
Sep. 12-13/13 ..... Peoria, IL
Dec. 5-6/13 ..... Ithaca, NY

TCI for Families (TCIF)
Mar. 25-26/13 ..... Peoria, IL
Aug 5-6/13 ..... Ithaca, NY
Oct. 3-4/13 ..... San Jose, CA

Designing Refresher Training
Apr. 11-12/13 ..... Cincinnati, OH
Jun. 13-14/13 ..... Charlotte, NC

Post Crisis Response
Jan. 21-22/13 ..... Ithaca, NY
Jul. 11-12/13 ..... Pittsburgh, PA
Aug. 8-9/13 ..... Ithaca, NY
Nov. 7-8/13 ..... Warwick, RI

ONE DAY UPDATES*

1-Day: Life Space Interview for Proactive Aggression
Nov. 6/13 ..... Warwick, RI

1-Day: Conflict Resolution
Apr. 10/13 ..... Cincinnati, OH

1-Day: Legal Concepts Involved in Use of Physical Restraint
Dec. 4/13 ..... Ithaca, NY

1-Day: TCI Trainer Support
Sep. 11/13 ..... Peoria, IL

1-Day: TCI for Schools (TCIS)
Mar.27/13 ..... Peoria, IL
May 13/13 ..... Warwick, RI
Jul. 9/13 ..... Ithaca, NY
Aug. 7/13 ..... Ithaca, NY

TCI CANADA 2013 COURSE OFFERINGS

TCI: TRAINING OF TRAINERS (TXT)

Mar. 18-22/13 ..... TBD

TCI UPDATES

TCI for Families (TCIF)
Jan. 28-29/13 ..... To be announced

TCI AUSTRALIA 2013 COURSE OFFERINGS

TCI: TRAINING OF TRAINERS (TXT)

Feb. 18-22/13 ..... Sydney, NSW

TCI EUROPE 2013 COURSE OFFERINGS

TCI: TRAINING OF TRAINERS (TXT)

Apr. 8-12/13 ..... Glasgow, Scotland
Jun. 10-14/13 ..... Doncaster, UK
Sep. 30-Oct. 4/13 ..... Dublin, Ireland
Dec. 2-12/13 ..... Doncaster, UK

TCIF: TRAINING OF TRAINERS (TCIF TXT)

Jun. 24-28/13 ..... Dublin, Ireland

TCI UPDATES

Developing Professional Level Training Skills
Apr. 29-30/13 ..... Doncaster, UK

TCI for Developmental Disabilities
Oct. 14-15/13 ..... Doncaster, UK

TCI for Families TCIF)
Jun. 6-7/13 ..... Glasgow, Scotland
Jun. 24-28/13 ..... Dublin, Ireland

Designing Refresher Training
May 1-2/13 ..... Doncaster, UK
May 14-15/13 ..... Glasgow, Scotland
Sep. 19-20/13 ..... Dublin, Ireland
Sep. 24-25/13 ..... Doncaster, UK
Nov. 27-28/13 ..... Dublin, Ireland

Post Crisis Response
Jun. 4-5/13 ..... Glasgow, Scotland
Jun. 17-18/13 ..... Dublin, Ireland
Oct. 16-17/13 ..... Doncaster, UK
Nov. 25-26/13 ..... Dublin, Ireland

ONE DAY UPDATES*

1-Day: Life Space Interview for Proactive Aggression
Jun. 19/13 ..... Dublin, Ireland
Oct. 18/13 ..... Doncaster, UK

1-Day: Conflict Resolution
May 16/13 ..... Glasgow, Scotland
Sep. 18/13 ..... Dublin, Ireland

1-Day: Testing, Evaluation, and the Transfer of Learning
May 17/13 ..... Glasgow, Scotland
Nov. 29/13 ..... Dublin, Ireland

1-Day: Legal Concepts in the Use of Physical Restraint
Mar. 20/13 ..... Doncaster, UK
Mar. 21/13 ..... Dublin, Ireland

1-Day: TCI Trainer Support
May 13/13 ..... Glasgow, Scotland
Nov. 18/13 ..... Doncaster, UK
Nov. 20/13 ..... Glasgow, Scotland

1-Day: TCI For Schools (TCIS)
Mar. 20/13 ..... Dublin, Ireland
May 3/13 ..... Doncaster, UK
Jun. 3/13 ..... Glasgow, Scotland
Sep. 16/13 ..... Stevenage, UK

***Note:** ONE-day updates are ONLY available to TCI trainers who have successfully completed TWO, two-day updates, preferably Designing Refresher Training and Post Crisis Response.*

PLEASE CONSULT THE RCCP WEBSITE FOR UPDATES TO THIS SCHEDULE: rccp.cornell.edu