Iatrogenic Adverse Childhood Experiences

First do no Harm in residential youth care and foster care: Avoid living instability for children placed out-of-home

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The list of Adverse Childhood Experiences is steadily growing and with it is scientific research growing about long-term toxic effects on child development (McLaughlin, 2017; Perez, Jennings& Baglivio, 2017; Wolf & Baglivio, 2017).

There is however one particular ACE that is often overlooked in this literature but very common to children born of parents especially with intergenerational problems themselves. These parental problems range from aggression, psychiatric problems, substance abuse and in particular those with a mild intellectual disability (Van der Helm, 2017).

Iatrogenic ACEs

Many children suffer from the same problems their parents faced (intergenerational problem transmission) and when problems are mounting they are being regularly moved to children's homes and/or foster care but also frequently moved to other places, creating residential living instability, a yet unrecognized ACE.

Most of these children present behavioral problems already in early childhood often in concordance with parent(s) being unable to care properly for their child because of their own ACEs. These behavioral problems are internalizing as well as externalizing (Van der Helm & Vandevelde, 2018 in press; Wolf & Baglivio, 2017) and regularly result in being placed out-of- home for their own safety and for the safety of their surroundings.
But in many cases this first transfer is followed by many more because staff is unable to handle extreme behavior, uses harsh disciplinary measures, and sometimes children are transferred as a way of punishment (Stams & Van der Helm, 2017).

Though specific numbers are unknown, estimations, based on incomplete research, in the Netherlands of children who were transferred more than four times a year range in the hundreds (approximately 2-3% of all out-of-home placed children annually; Van der Helm, 2017). This process of frequent transfers between homes is depicted in the sad documentary 'Alicia' (www.vpro.nl › programma's › 2doc), a girl with MID that was (and still is) being moved between residential care institutions. With each movement her desperation is growing visible and her behavior declines as a result of pain (Anglin, 2004). But there are many more 'Alicia's', some of very young age and beside being moved from one place to another they also have to change schools. We present a case-history here to describe typical problems staff face in treatment.

The case of Kimberly

Kimberly (not her real name), then five years old, was noticed in Amsterdam because her mother beat her in the tram and bystanders called the police. The investigation by the

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Child Care and Protection Board revealed that mother and child had wandered in the streets for some time. Mother had a history of long-term abuse and sexual abuse and had been in various youth institutions herself. Father was not known. The judge decided on a provisional supervision and family guidance, but the mother refused to cooperate. Then it was decided to place Kimberly at a medical day nursery after which mother disappeared with Kimberly. Both were recovered by police in Belgium and Kimberly was placed in foster care. She could, however, suddenly exhibit extremely aggressive behavior (stabbing with a knife), making the situation in the foster family unsustainable. Then she was transferred to an institution, but even there the situation quickly became untenable. It was decided to place Kimberly in an (open) youth institution, very against the will of mother who attributed the behavior of Kimberly to the out-of-home placement. In the institution Kimberly's behavior became even more extreme and her self-defining and compelling behavior meant she could not be in the community and had to be accompanied on a one to one basis. She also showed worrying sexually engaging behavior to employees and pole-dancing skills, probably as a result of sexual abuse. Research from the Center for Consultation and Expertise (CCE) pointed to serious trauma and sexual abuse. Eventually, she was transferred to a secure youth care institution. Kimberly was then six years old. In the secure youth care institution, however, her behavior went even further downhill with strong incidents (again stabbing and arson) and disciplinary measures only worsened her behavior. Frequently, several employees had to fixate her and put her in a separation unit. Eventually it was decided to place her in a family home. The family house parents initially did not get all the information, but when Kimberly was waving a knife in the kitchen again, they cleared a neighboring house for one to one supervision with a team of pedagogical staff. It was noticed that the worst periods of violence arose after mother's visit, so these visits were stopped. After an intense six months in which the employees always walked around with bruises, her aggressive behavior slowly declined after she had been given a sleep ritual she did not wake up screaming every night. And the following year she could carefully return to school.

Because the municipal funding for a large part stopped the family householders were forced to sell the second house. But this turned out for Kimberly a step too far to live in the 'ordinary' family house with other children and the problems came back with all vehemence. Kimberly had to move to another family home. Momentarily this is going well for the time being because both foster parents have a lot of experience in youth care and work with her in a very structured way. Her prognosis, however, is not very favorable, the chances that she will end up in crime or prostitution when she gets older are looming, but for the time being, every stable year is one gained.

This case description may sound extreme, especially considering Kimberly's young age. But it also shows there is an urgent need to stop adding more ACEs to already compromised lives. Not knowing where you will be and with whom (living instability) at your next birthday is devastating for a child.

To counter the moving around of difficult children in care, we have developed climate survey's the children in residential care can fill in (https://www.hsleiden.nl/residentiele-jeugdzorg-english) and discuss outcomes with staff and children in order to improve residential climate for children. We also have developed team-coaching and intervision-methods to help staff cope with challenging behavior (Stams & van der Helm, 2017; Van der Helm & Vandevelde, 2018 in press).

Psycho-education for staff, conveying aggressive behavior is 'pain based' and giving them professional alternatives such as Non-Violent Resistance is part of an evidence based

approach (Stams & van der Helm, 2017). Together these results show improving climate will reduce aggression and improve development for these children, thereby giving them hope for their future and stop adding more ACEs. We need to stop harming children as the old adage ('Primum Non Nocere'): 'First do No Harm' says. We cannot change children's past but maybe we can change their future and the future of their children.

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