

# SAFE PLACES, THRIVING CHILDREN

Embedding  
Trauma-Informed  
Practices  
into Alternative  
Care Settings

**PRACTICE  
GUIDANCE**



**SOS CHILDREN'S  
VILLAGES**

**CELCIS**

Centre for excellence  
for Children's Care and Protection



Co-funded by the Rights,  
Equality and Citizenship  
(REC) Programme of the  
European Union



**Safe  
Places  
Thriving  
Children**





# Safe Places, Thriving Children

**Embedding Trauma-Informed Practices  
into Alternative Care Settings**

**PRACTICE  
GUIDANCE**



**Safe  
Places  
Thriving  
Children**

# IMPRESSUM

©SOS Children's Villages International and CELCIS, Centre for Excellence for Children's Care and Protection, University of Strathclyde, 2021

Published in Austria by SOS Children's Villages International

First edition published in April 2021

All rights reserved. No part of this publication may be reproduced, stored in a retrieval system, or transmitted, in any form by any means, without the prior permission in writing of SOS Children's Villages International and CELCIS, or as expressly permitted by law, or under terms agreed with the appropriate reprographics rights organisation. Enquiries in the first instance concerning reproduction outside the scope of the above should be sent to SOS Children's Villages International at the address below.

## **SOS Children's Villages International**

Hermann-Gmeiner-Str.51  
A-6020 Innsbruck  
Austria  
Email: [train4childrights@sos-kd.org](mailto:train4childrights@sos-kd.org)

## **Quotes**

The quotes from young adults with care experience, professionals and caregivers included in the practice guidance are from responses to questionnaires administered during the scoping exercise, conducted in the six partner countries participating in the project *Safe Places, Thriving Children: Embedding Trauma-Informed Practices into Alternative Care Settings* (2020-2022).

## **Design and layout**

Bestias Design

## **Illustrations**

Stipe Kalajžić

## **Authors**

Centre for Excellence for Children's Care and Protection (CELCIS)



This publication has been produced with the assistance of the European Union. The contents of this publication are the sole responsibility of SOS Children's Villages International and can in no way be taken to reflect the views of the European Union.

# ACKNOWLEDGEMENTS

SOS Children's Villages International and CELCIS would like to thank all those who have been involved in this project.

## PROJECT TEAM AT PARTNERS' LEVEL

**CELCIS:** Linda Davidson, Marian Flynn, Miriana Giraldi, Sarah Hume-Anthony, Ian Milligan, Leanne McIver, Susan Reid, Irene Stevens.

**SOS Children's Villages International:** Teresa Ngigi, Artūrs Pokšāns, Francine Stansfield, Lubos Tibensky, Florence Treyvaud-Nemtsov, Elisabeth Ullmann-Gheri.

**SOS Children's Villages Belgium:** Annelien Coppieters, Adeline Puerta, Kristien Schoenmaeckers.

**SOS Children's Villages Bulgaria:** Denitsa Avramova, Marin Zarkov.

**SOS Children's Villages Croatia:** Ljiljana Ban, Krešimir Makvić, Kruno Topolski.

**SOS Children's Villages Greece:** Kostas Papadimitropoulos, Patricia Schoenweitz.

**SOS Children's Villages Hungary:** Edit Koles, Orsolya Szendrey.

**SOS Children's Villages Serbia:** Jelena Tanasijević, Nikola Tanasković.

SOS Children's Villages International would like to express special thanks to the European Commissions' DG Justice, for their financial support and continuing assistance in the achievements of the project.

# FOREWORD

This practice guidance has been developed with the aim of contributing to the knowledge and skills of those who care for and work with children who live in alternative care and who have been affected by trauma. It recognizes that although children coming into alternative care are more likely to have experienced trauma, the ways in which it affects them are not always well understood.

Recognizing that there are many factors that influence trauma recovery, nurturing and stable relationships with adults are a vital component in helping children and young people to overcome the effects of trauma. Peer interviews undertaken during previous EU co-financed projects led by SOS Children's Villages International have demonstrated that young people with care experience want to feel cared for, while recognizing the need for professional boundaries. While the most devastating trauma happens within relationships, healthy relationships are the key to healing. This practice guidance will explore why this is the case and give some helpful advice on how to work with trauma.

This practice guidance arises out of a collaborative, European Commission funded project, *Safe Places, Thriving Children – Embedding Trauma-Informed Practices into Alternative Care Settings*, that seeks to improve the understanding and practice of those who care for and work with children who live in alternative care on the issue of trauma and, in particular, its psychosocial impact. The project is a partnership between SOS Children's Villages International, the Centre of Excellence for Children's Care and Protection (CELCIS) based at the University of Strathclyde in Scotland and SOS Children's Villages national associations in Belgium, Bulgaria, Croatia, Greece, Hungary and Serbia.

This project is made up of several interrelated components. They include:

- A scoping exercise undertaken with young people with care experience and those who care for and work with them. This was done via questionnaires and a desk review.
- This practice guidance.
- An e-learning awareness-raising programme.
- A number of training elements, including a Training of Trainers programme, as well as training materials for those who care for and work with children in the six project partner countries.
- An organizational development blueprint that aims to guide the embedding of trauma-informed practice in organizations and systems. It is recommended, therefore, that this practice guidance is not used in isolation to these other components.

---

**NOTE:** Words and phrases in green with a wavy underline can be found in the **Glossary** at the end of this practice guidance.

# TABLE OF CONTENTS

<b>CHAPTER 1</b>	<b>Introduction to the practice guidance</b>	<b>8</b>
<b>CHAPTER 2</b>	<b>Principles underpinning the practice guidance</b>	<b>14</b>
<b>CHAPTER 3</b>	<b>Putting trauma into context</b>	<b>20</b>
3.1	Influential factors in our understandings of trauma	20
3.2	Bronfenbrenner's ecological model	21
3.3	Acknowledging community-based traumas	23
3.4	How trauma shows-up in child welfare environments	26
<b>CHAPTER 4</b>	<b>Understanding the human trauma response</b>	<b>30</b>
4.1	Ways of categorising trauma	30
4.2	Some definitions of trauma	31
4.3	Why and how the human body responds to trauma	33
4.4	The theory of latent vulnerability	38
4.5	Factors that affect people's responses to trauma	39
4.6	Window of tolerance: One way to understand trauma responses	40
<b>CHAPTER 5</b>	<b>Complex trauma: Its meaning and impact on children's development</b>	<b>48</b>
5.1	Critical components of children's psychosocial development	48
5.2	Autism and mentalizing	52
5.3	How the psychosocial impact of trauma can affect children's development	53
5.4	How trauma can manifest in children	57
5.5	Showing compassion for parents	61
<b>CHAPTER 6</b>	<b>What young people, and those who care for and work with them, told us</b>	<b>66</b>
6.1	The scoping exercise outline and some caveats	66
6.2	What young people told us helped them	67
6.3	What those who care for and work with children told us	70
<b>CHAPTER 7</b>	<b>Trauma-informed practice in everyday care</b>	<b>76</b>
7.1	Components of trauma-informed practice	76
7.2	Putting theory into practice	77
<b>CHAPTER 8</b>	<b>Caring for caregivers: Sustaining good practice in alternative care</b>	<b>96</b>
8.1	The impact of trauma on those who care and work with children	96
8.2	Particular issues for those who provide direct care	97
8.3	Particular issues for those with indirect care responsibilities	98
8.4	Developing trauma-informed organisational responses	99
<b>APPENDICES</b>		
1.	Glossary of additional terms not explained in the text	104
2.	Suggested helpful websites	111
3.	Ideas/tools to spark connection and regulation	112
4.	Additional suggested reading	117



CHAPTER 1



# Introduction



# CHAPTER 1

## INTRODUCTION

“In my training, I was never told how childhood trauma has an impact on the child’s development and adult life.”

*(Quote from professional, scoping exercise, 2020)*

“A traumatized child is extra vulnerable. Understand this.”

*(Quote from young person, scoping exercise, 2020)*

The purpose of this practice guidance is to improve understanding and practice in relation to working with trauma experienced by children who live in **alternative care settings**. It primarily focuses on those who care for or work with children directly, but it also speaks to the wider range of professionals e.g. managers, budget holders, policymakers etc., whose roles shape and govern how children experience care in their daily lives.

A previous EU co-financed project led by SOS Children’s Villages International<sup>1</sup> indicated that **trauma and the psychosocial and mental health needs of children are not well understood** and that there is a need to raise the understanding of trauma for those who work with or care for children in alternative care settings. Experience also indicates that too often good practice only happens because of committed individuals. System change at organizational level, prompted by legislation and guidance from municipal and national authorities, is the best way to ensure that a trauma focus becomes consistently embedded in practice.

The practice guidance has been designed to meet two clear functions:

1. **To act as a continuing support and reference document** to assist those who care for and work with children who live in alternative care and who have been affected by trauma to recognize and understand trauma and to begin to address its consequences.
2. **To form part of a wider learning and change project** that aims to prompt change in practice, policy and legislation. As such, it has been designed to be applicable and adaptable to participating countries and to sit alongside the other components of the *Safe Places, Thriving Children* project.

---

1. “Prepare for Leaving Care: A Child Protection System that works for Professionals and Young People” (2017-2019).

This practice guidance recognizes that **good practice will exist in each of the participating countries** and that readers will come with **different levels of knowledge and experience**. For those with little or no knowledge of the topic, we hope it provides a helpful baseline of knowledge and suggestions for practice. For those with a good grounding of the subject, we hope it encourages you to look at this topic with fresh eyes and to explore how knowledge can be used to reframe practice and be used more effectively. As such, the guidance has three main aims:

- Firstly, it seeks to **build on people's understanding of trauma from a psychosocial perspective** and the various ways that it impacts adversely on the development of children.
- Secondly, it **encourages readers to reflect** on what they can do within their own contexts and cultures to develop warm and nurturing relationships within which children can be supported to take their first steps in their healing journey.
- Thirdly, it **provides tools and information** to promote thinking about the ingredients that make up quality day-to-day care as a prerequisite for enabling children to develop to their fullest potential.

Due to the complex nature of trauma, **no single agency can hope to cover all the needs that children may have or provide all the supports necessary**. Children's needs have to be seen **holistically**, i.e. the needs of the whole child must be considered. As such, this practice guidance encourages **key agencies and professions to plan and work together to develop a shared understanding** of the impact of early childhood trauma and to **work collaboratively** to ensure that the necessary supports and services are available.

In terms of structure, the guidance falls into two distinct parts. Chapters 2-5 place **a heavy emphasis on understanding** the various ways that trauma can be thought about and the factors that influence its impact. Chapters 6-8 focus more on **real-world practice**, looking initially at feedback given to us by young people and professionals as part of the scoping exercise. In addition to the content, you will see icons that prompt further engagement:

- Points to consider:** reflection questions for use individually or as a group
- Comments:** short dialogue by the authors on the reflection questions posed in the "Points to Consider"
- Watch + consider:** suggestions of additional video material, which may enhance the reader's understanding. (This material is in English)
- Read + consider:** suggestions of additional reading material, which may enhance the reader's understanding. (This material is predominantly in English)

## LIMITATIONS OF THIS PRACTICE GUIDANCE

Before moving on, it is important to acknowledge the limitations of the practice guidance.

1. Given the breadth and complexity of the subject matter, this document **cannot cover every detail on any given topic**. What it seeks to do, however, is provide a coherent narrative that can be built upon and encourage further exploration.
2. The practice guidance draws upon a **research and practice evidence base relating to trauma that is substantial, but is evolving and contains many gaps**. In particular, the concept of trauma-informed practice is a new and developing field of work and early findings are mixed.<sup>2</sup>
3. Depending on the age of the child and the nature of the trauma, its occurrence and its effects can be **stored in a child's subconscious**. For example, there is a greater likelihood of this happening if a child experiences trauma before they can talk. The suggestions in this practice guidance, therefore, **are not a substitute for specialist therapeutic support** that can work with children at this subconscious level. Best practice would suggest that involvement of qualified, developmental mental health practitioners in multi-agency care assessment and planning provides the optimal possibility of children's holistic needs being addressed.
4. This practice guidance **makes only passing reference to clinical diagnostic categories** associated with trauma. Many children in alternative care settings are filtered out of formal mental health services as their presenting problems do not neatly fit into or meet diagnostic categories. Margaret de Jong, a child psychiatrist based in the UK provides a useful discussion on the need to re-think established clinical approaches.<sup>3</sup>
5. The practice guidance does not explore preventative work that could be undertaken with children in their families of origin, which may have prevented the need for alternative care.



2. Early Intervention Foundation (2020). Adverse childhood experiences: What we know, what we don't know, and what should happen next <https://www.eif.org.uk/report/adverse-childhood-experiences-what-we-know-what-we-dont-know-and-what-should-happen-next>.

3. DeJong, M. (2010). Some reflections on the use of psychiatric diagnosis in the looked after or "in care" child population. *Clinical Child Psychology and Psychiatry*, 15(4), 589-599.

## A WORD ON TERMINOLOGY

We recognise that children are identified in the UN Convention on the Rights of the Child as, ‘every human being below the age of 18 years unless under the law applicable to the child, majority is attained earlier’. WHO define young people as aged between 10 to 24 years old. However, for ease of reading in this practice guidance, we use the word “children” as shorthand for all children, as well as young people and young adults aged 0-24 years, who live or have lived in alternative care settings. In addition, we use the phrase “those who care for and work with children” as shorthand for the range of child and youth caregivers and professionals who have different responsibilities for children’s care and who will be described differently across the six partner countries.

A glossary of key terms that are highlighted throughout the practice guidance can be found at **Appendix 1**.





## CHAPTER 2



# Principles underpinning the practice guidance

# CHAPTER 2

## PRINCIPLES UNDERPINNING THE PRACTICE GUIDANCE

“I can suggest that they should familiarize themselves with the psychological development of the child, as well as with their struggles. They should get to know the child’s background as thoroughly as possible. They should be patient and loving with the child. But they should never lie. Not with deeds and not with words, because we can sense it.”

*(Quote from young person, scoping exercise, 2020)*

### INTRODUCTION

This chapter brings together in one place the five cross-cutting and interrelated principles that inform the development of this practice guidance. These principles constitute “threads” throughout the guidance and are recalled, explicitly or implicitly, at various points when they are particularly relevant to specific issues being discussed. Detailed explanations of words and concepts will be given later in the document.

#### Principle 1

#### **TRAUMA RECOVERY IS ONLY POSSIBLE WITHIN CONSISTENT CARING RELATIONSHIPS**

Many children in alternative care have experienced trauma in the context of relationships. This happens not only in their family of origin but it is then, too often, compounded further by their experiences in alternative care. It is important therefore when we seek to become trauma-informed that we pay attention to **the importance of building strong relationships as well as the content of what is provided**. Relational-based approaches recognize that **children are unique and so responses need to be flexible and attuned to individual circumstances (see section 5.1 part (e))**. Children’s immediate care experiences need to be warm, stable, safe and loving so that “trust” and a “secure base” is nurtured (see section 5.1) and alternative ways of relating to self and others are developed. Through such relationships, children can **build on their strengths and talents**, thereby allowing them to **develop new self-narratives** (stories about themselves) and make wider and healthier community connections.

### Principle 2

#### TRAUMA NEEDS TO BE UNDERSTOOD FROM A CHILD DEVELOPMENTAL AND ECOLOGICAL PERSPECTIVE

This practice guidance suggests that trauma is **best understood in a child developmental and ecological context** (see section 3.2). From a child developmental perspective, we need a comprehensive understanding of how children typically develop so that we are able to appreciate **how trauma interrupts this developmental journey**. Within this, we need to be particularly mindful of other factors, e.g. a disability or neurodevelopmental condition, which also shape a child's developmental progress. Within this frame, we suggest that we need to pay **more attention to the impact of trauma on the development of children's minds**, particularly in relation to a person's sense of self and how they relate to others.

We also need to ensure that **we do not separate individual trauma experiences from their much wider societal, cultural and economic contexts**. It is here, in this much wider realm, where we can begin to understand the multiple influences that shape the occurrence of trauma, its impact and the "meanings" that are ascribed to it. These all impact the individual and shape our personal responses and those at organizational and state levels. **An ecological perspective helps us to move beyond only seeing trauma as an individual experience and opens up additional ways in which trauma can be addressed** e.g. working with groups, through **"public health" population-based approaches** etc.

### Principle 3

#### THE TRAUMA RECOVERY JOURNEY SHOULD BE A PARTNERSHIP

Children who have trauma histories have often experienced powerlessness, helplessness and isolation. It is therefore important that "helping professions" do not fall into the mindset of "doing something to" the recipient. To counter this, trauma recovery should be about enabling a sense of **"felt safety" and "agency."**

Children and young people must be partners in their care plan, a plan that must contain a clear understanding of how trauma has affected them and explicit commitments to trauma recovery. A trauma-informed approach recognizes that **participation and partnership can contribute significantly to the child's sense of empowerment** and that children's role as "actors" in this process **is vital for their recovery journey**.

### Principle 4

#### TRAUMA-INFORMED PRACTICES ARE GROUNDED IN CHILDREN'S RIGHTS

The United Nations Convention on the Rights of the Child clearly states that children in alternative care are **entitled to special help and protection from the state** if their families are not able to care for them (Article 20). In addition, it states that children should be supported to participate fully in their care and have the right to "express their

views freely in all matters” (Article 12) and that decisions must be made in the best interests of the child (Articles 3.1). To fulfil these duties, this practice guidance asserts that **children in alternative care are entitled to have their trauma addressed**. It is suggested that **adopting trauma-informed practice is one important means by which states can fulfil their responsibilities under this Convention**. The United Nations has also issued the Guidelines for the Alternative Care of Children. The Guidelines reaffirm, and set out guidance that will enhance the implementation of, the UN Convention on the Rights of the Child with a specific focus on children in, or at risk of entering, alternative care.

### Principle 5

#### THE LANGUAGE WE USE ABOUT CHILDREN’S TRAUMA NEEDS TO BE RE-FRAMED

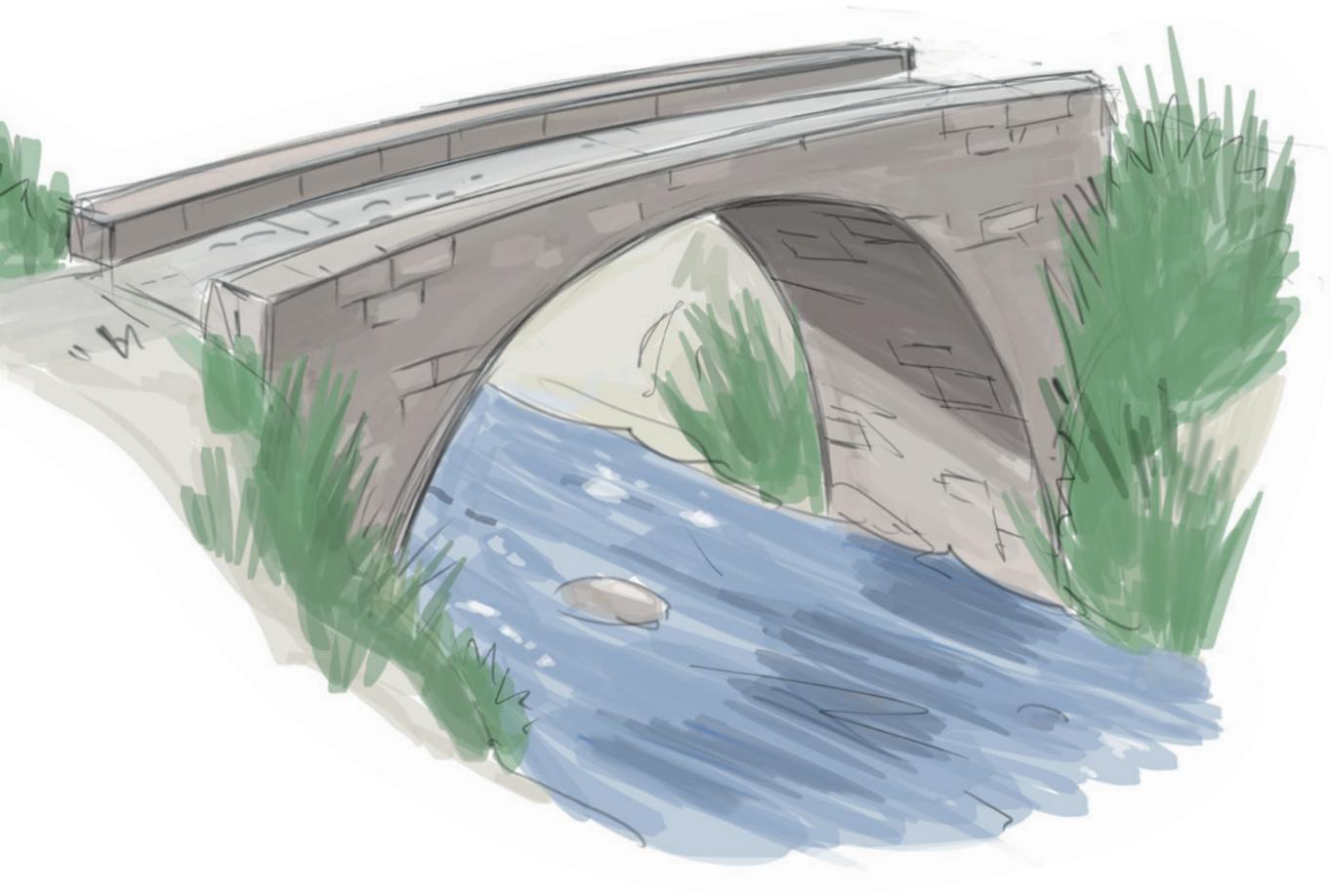
The language we use to describe and explain children’s trauma experiences and their consequences is powerful. **It symbolizes our understanding, shapes what we think is possible and influences how people think about their own trauma.**

This practice guidance therefore seeks to shift thinking from a “deficit” model, where children’s responses to trauma are seen as pathological, disordered or abnormal, to an “adaptive” model, where children’s responses are seen as adaptations that contributed to their survival under extreme circumstances. Examples include:

- **Re-framing “challenging behaviour” as “distressed behaviour”** has the potential to shift a response attributing negative intentions and motivations to one in which adults’ compassion and curiosity are engaged.
- **Re-thinking the language of “disorders” found in many clinical diagnostic categories** may assist to explore issues that exist beyond that of the child.
- **Moving away from language and thinking that is deterministic** in its outlook (i.e. seeing things as “fixed”) opens up the possibility of “hope” and exploration of opportunities for change.

As alternatives, we suggest we **understand children’s behaviour as communication** with adults, taking a stance of curiosity as to what lies beneath the presenting behaviour. We recognize that “adaptive” strategies that have helped children to survive in the short term may not serve them well in the long term or in wider settings. However, **alternative coping strategies need to be introduced with sensitivity**. Our language needs to **promote the possibility of change** based on children’s abilities to adapt and flourish in new environments.









## CHAPTER 3



# Putting trauma in context

# CHAPTER 3

## PUTTING TRAUMA IN CONTEXT

“Many live in a deep poverty from which there is no way out for generations. On estates, values disappear, wear and tear, and families are built around exploitation.”

*(Quote from professional, scoping exercise, 2020)*

### INTRODUCTION

This chapter seeks to illustrate that our understanding of trauma (how it develops, how it is defined, where it is most likely to occur etc.) is influenced by a range of historical, social, cultural and political factors. Equally, it seeks to emphasize that trauma is but one of many components that can influence the development of children’s lives. In working with children, it is important therefore that we are constantly alert to how children’s experiences of trauma and their need for re-connection both shapes and is shaped by these wider structural and environmental factors.

### 3.1 Influential factors in our understandings of trauma

Understanding trauma can be far from straightforward because it **draws on a diverse range of research and practice from the human and social sciences**, its knowledge base is **constantly expanding**, and it is **influenced by multiple voices and environmental factors**. For example, in the 1970s there was a considerable interest around trauma with the return of American soldiers from the Vietnam War. Work in this area eventually led to the creation of the diagnosis of post-traumatic stress disorder (PTSD). This, alongside other diagnostic categories, has had a powerful influence on shaping the trauma narrative. At around the same time, an alternative narrative was emerging out of the respective work of American psychiatrist, Judith Herman, and American professor, Sandra Bloom, with adult survivors of child sexual abuse and domestic violence. Here, greater attention was given to affirming “lived experience,” to shining a light on previously taboo issues, and to placing the abuse and violence experienced by women and girls within a wider understanding of gender. In the 1980s, technical innovations in brain mapping led to an explosion of research within the field of neurology. Scientists were therefore able to progress from animal experimentation to seeing real-time human brain and nervous system functioning.

In 1998, an important large-scale population study, by Felitti and Anda, into the long-term impact of **adverse childhood experiences (ACEs)** was undertaken. It demonstrated a clear association between the existence of traumatic events in childhood and the **greater likelihood of negative physical, mental and social outcomes across all stages of adulthood** (although it was keen to point out that such outcomes are not inevitable at an individual level). In addition, it found that ACEs:

- **Are common** in the population.
- **Their impact is lifelong.**
- They often **do not occur alone.**
- **Their effect is cumulative** (i.e. the impact increases with each additional adversity).

While the original study has been criticized for its narrow population sample and its focus on ten specific types of adversity, subsequent studies across the globe have extended its range on both of these counts and produced similar results. Although its findings were not initially well-received nor gained particular attention, recently, it has served to highlight the widespread and significant impact of trauma and move the discussion into a much wider public space. Many public health authorities are increasingly adopting the broad findings of ACE research to shape their “prevention” and “mitigation” strategies, and this has become one of the driving narratives behind the move to trauma-informed policy and practice.



#### Watch + consider:

A useful presentation by Dr. Robert Anda, one of the principal investigators of the original ACE study. He talks about his research and how it has been misinterpreted and misapplied.

*Inside the ACE Score: strengths, limitations and misapplications (April 2020)*

<https://www.youtube.com/watch?v=Kfx5vOHFfxs>

### 3.2 Bronfenbrenner’s ecological model

A useful model that can be used to understand how trauma **sits alongside and interacts with a host of other social, economic and political factors**, is that devised by the developmental psychologist, Urie Bronfenbrenner. In it, he identifies five key systems that influence children’s growth and opportunity. What the model suggests is that attention should be paid not just to how the components in **each system work, but how the various systems interrelate and influence one another.**

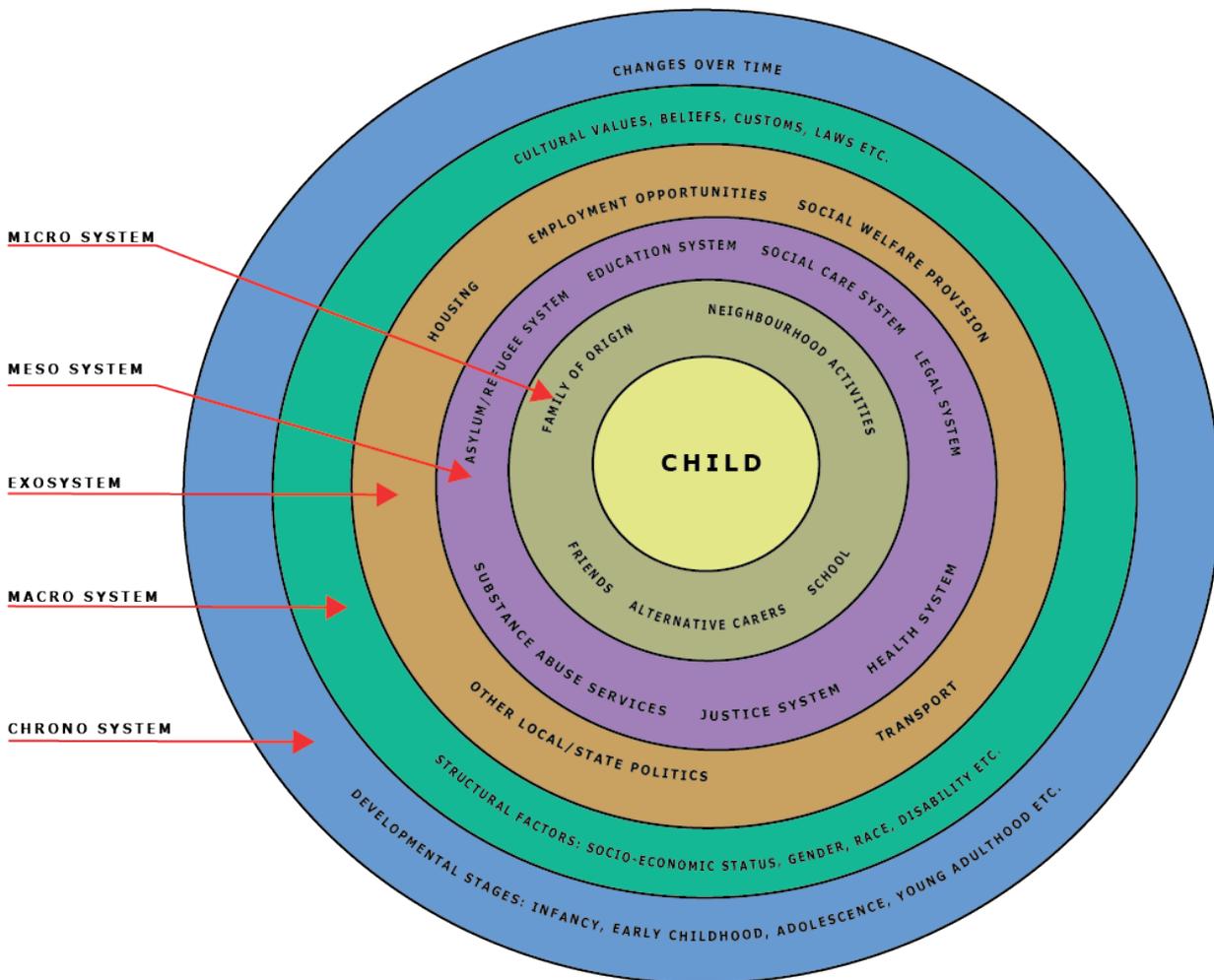
The five systems are:

1. **Microsystem** includes the relationships and spaces that children routinely interact with e.g. their family, friends, school, neighbourhoods, activities etc.
2. **Mesosystem** is where two of these microsystem components interact e.g.

links between the child's school and family, the family's sense of safety and connectedness within their community.

3. **Exosystem** includes factors that do not directly interact with children, but which influence the quality of their lives e.g. stability of parental employment, employment opportunities, housing provision, transport connections, social welfare provision, availability of education etc.
4. **Macrosystem** refers to the broad cultural and structural factors that shape children's experiences and environments e.g. gender, race, socio-economic conditions, disability etc.
5. **Chronosystem** draws attention to the transitions and shifts in children's lives that occur across time. Examples include settling into a new community, change brought about by parental separation or bereavement, attitudes that change over time, children's developmental stages etc.

Figure 1 illustrates how an ecological understanding might be applied within a social care system.



**FIGURE 1**  
**CELCIS - AN ADAPTATION OF BRONFENBRENNER'S ECOLOGICAL MODEL FOR A SOCIAL CARE SYSTEM**

As a developmental psychologist, Bronfenbrenner suggested that the **greatest influence on children occurs within their immediate environment (microsystem)**, as it is here that relationships, social skills, talents and a sense of belonging are nurtured. These provide the building blocks that then **help children build resilience and coping strategies for operating in the wider world.**

This ecological systems model helps us to do two important things. Firstly, it helps us to hold in mind the multiple risks and protective factors that shape children's outcomes. Secondly, organizations and state authorities can use it as a framework to think about trauma through an environmental lens and then to identify the potential multiple points of entry for interventions that **mitigate** the impact of trauma and/or reduce the likelihood of trauma occurring in the first place.

Within the literature, there is considerable attention paid to the links between poverty and trauma, and some tension can arise between authors if it is felt that one issue is being given greater priority at the expense of the other. Undoubtedly, there is a close association between poverty and trauma: **poverty can play a significant role in exacerbating how trauma is experienced and can prevent access to the very services that could mitigate its impact.** However, while there is a strong relationship between the two issues, **we need to be careful that we do not conflate (i.e. combine) them.** This is important for two reasons:

- Firstly, if we do so, there is a risk that we can stigmatize families who live in economic hardship and make unfounded assumptions about their abilities to provide warm and nurturing care for their children.
- Secondly, trauma is experienced at all levels of society and to focus disproportionately on its association with one group of people ignores the levels of harm that occurs across the spectrum and the additional cultural and structural inequalities that are also at play.

### 3.3 Acknowledging community-based traumas

Within the literature, there is a growing awareness about how individual traumas are collectively experienced by groups and communities and, indeed, how trauma can be transmitted at all these levels across generations. In this context, “communities” can be defined geographically (as in neighbourhoods), virtually (as in a shared identity, ethnicity, or experience) or organizationally (as in a place of work, learning, or worship). A current example of a community “naming” and seeking change in relation to historical and current trauma and injustice is witnessed in the *Black Lives Matter* movement. Other examples are also reflected in the fight for equality across the globe of indigenous people and national and ethnic groups that experience natural disasters, war or forced migrations. Teresa Ngigi, a clinical psychologist, describes these patterns of transmission as **intergenerational or ancestral trauma**. In addition, a branch of science called **“epigenetics”** is beginning to explore the possibility of trauma experience being transmitted across generations through the way in which our genetic material is read in our bodies. The degree to which communities both have the capacity, knowledge, and skills to understand and respond to trauma and the

assistance and dignity they are given by state authorities can have a significant impact on children's lives.

Seen in this context, work on trauma at a community level can be highly beneficial and far-reaching. Drawing on her experience of working with trauma in multiple international contexts, Ngigi (2019)<sup>4</sup> acknowledges that some cultural practices can have negative effects on children's development and can interfere with the healing process where trauma has occurred. However, she found that when people are helped to re-frame unhelpful practices through an understanding of trauma, they were able to change their approach. She gave an example from Sierra Leone where the concept of "the children belong to society" allowed children to be moved among and between different caregivers from a very early age. When kindergarten teachers learned about trauma, they were able to see the harmful effects of this practice, and re-frame their understanding using their new knowledge of early childhood adversity. From her work, it is clear that **communities that are enabled to provide a context of understanding may facilitate trauma recovery.**



#### Points to consider:

Thinking of one child with whom you have worked, use the adapted version of Bronfenbrenner's model at Figure 1 to draw a rough ecological map identifying the multiple influences that impacted on their trauma experiences e.g. poverty, gender discrimination, quality of care received, community-based violence, being abandoned, being ostracized by the community, intergenerational trauma, fleeing war, displacement due to a natural disaster etc.



4. Ngigi, T. (2019) Breaking the Cycle: The Role of Auntie Rosie in Childhood Trauma-Informed Care.



**Points to consider:**

Many strategies can help us to develop self-awareness, especially in relation to race, gender, disability or sexual orientation. We all hold stereotypes and prejudices which form part of the judgements we make in everyday life. This simple exercise will help you to become more aware of some of your own prejudices or stereotypes. Briefly write down your answers to the following questions as honestly as you can.

1. Are the ways in which I describe myself (e.g. race, gender, class, sexual orientation, ability etc.) valued by the society and culture in which I live?
2. How do I connect with others who would use similar descriptions of themselves as me?
3. How do I connect with people who are not valued where I live?
4. Do the groupings I belong to help or hinder progress in my professional career?
5. How are people who belong to different groupings helped or hindered in their professional careers?
6. How does my perceived status affect my behaviour and motivation to make progress in my life?
7. Do you think there is a dominant ethnic or racial culture in your country that influences who has or does not have access to power, resources etc.?



**Comment:**

It is not easy to confront parts of ourselves that we are less aware of or that are contradictory to our values. It can fuel painful emotions such as guilt, shame, anger, or defensiveness. However, the first step in the process of change is awareness. We should learn to observe our reactions with curiosity rather than judgement. Continue to ask yourself about the social capital you hold and how you can use it to highlight the many ways in which structural inequalities operate in everyday life.

### 3.4 How trauma shows up in child welfare environments

Within child welfare systems, trauma can show up in multiple domains.

Unfortunately, many of the psychosocial impacts of children's trauma experiences are replicated in the very structures around the child that should provide support and safety.

- **For children** – trauma experiences can promote a sense of shame, stigma, isolation, disconnection and a lack of self-worth and mastery over their own lives.
- **For parents** – children's trauma experiences can promote a sense of shame (as they were unable to protect their child), stigma (as their actions may have harmed their child), isolation and disconnection (as they may feel or are judged to have failed in their parenting duties) and triggering (as it may consciously or unconsciously spark memories of their own trauma).
- **For those who care for or work with children** – children's trauma experiences can also reignite their own trauma responses, create a sense of helplessness, lead to vicarious trauma or compassion fatigue (see Chapter 8) and provoke feeling overwhelmed by dealing with the pain a child who experiences trauma can feel.
- **For professional groups / organizations / systems** – children's trauma experiences can bring tension and frustration to professional relationships, bring a sense of being overwhelmed by increasingly complex demands and lead to the development of “blame cultures” (i.e. where individuals are held accountable for failings in the wider system). In addition, structures and processes that are developed, can inadvertently exacerbate children's pain or add to a sense of “being different.”
- **For communities and society** – trauma raises important questions about power, injustice and inequality, factors that can undermine people's coping strategies. In addition, a collective denial of the abuse and maltreatment experienced by children will serve to deepen their distress.

More will be written about these issues throughout this practice guidance and the other components of this project. For now, it is important to acknowledge that **at all levels seeking to address issues of trauma is difficult** because of the pain, blame and disconnection that it creates.



#### Read + consider:

What do you agree with and disagree with in this opinion piece from Adam Burley, a clinical psychologist based in Scotland.

*“Childhood Adversity Studies as an Antidote to the Predominance of Neo-liberal Thinking in the Field of Mental Health” (2020)*

<https://www.eupublishing.com/doi/pdfplus/10.3366/scot.2020.0344>

### Keep in mind

- Our understandings of trauma are constantly evolving and expanding and are drawn from multiple sources of knowledge including lived experience, academic research and professional disciplines.
- While the drive for the adoption of trauma-informed approaches is a relatively new phenomenon, there is a robust evidence base that highlights the prevalence of childhood trauma and its potential life-long social, health and economic consequences.
- Multiple narratives shape how we understand and talk about trauma experiences. While the diagnostic model used in clinical practice is a powerful and influential narrative, growing voices both from within the profession and from those with lived experience are beginning to offer alternative understandings.
- Children's trauma experiences and indeed those of their families need to be understood holistically and within the context of their wider environments.
- Trauma-informed responses should seek to identify the multiple points of intervention at which trauma can be reduced and protective factors can be strengthened.





## CHAPTER 4



# Understanding the human trauma response

# CHAPTER 4

## UNDERSTANDING THE HUMAN TRAUMA RESPONSE

“This topic seems to be avoided by social workers. It seemed irrelevant to them, even though as a young person this is always haunting you.”  
(Quote from young person, scoping study, 2020)

### INTRODUCTION

This section will explore some of the many ways in which trauma can be described and understood. By focussing on the human condition in general, it reminds us that trauma plays out across the lifespan and that to improve our practice in relation to children, we also need to be aware of, and alert to, how our behaviours and responses as adults may also be shaped by trauma.

### 4.1 Ways of categorizing trauma

There are many different definitions of, and ways of understanding, trauma. Throughout the literature, the term is used in various ways to describe:

- A significant **adverse event or trauma exposure**
- A person's **subjective experience** of an event
- A person's **response** to an event and/or
- **The impact** of an event.

Sometimes trauma is used interchangeably with the terms “adversity” or “severe or toxic stress.” In much of the literature, definitions tend to be generic to the human condition as a whole and, while they talk about trauma experienced in childhood, their focus is often from an adult perspective, looking at potential impacts and outcomes of trauma later on in life. We therefore need to be mindful that sufficient attention and resource is given to children's needs in the here and now.

Trauma that is defined with reference to the **event or trauma exposure** is often illustrated through a lengthy list of assaults, abuses and harms and includes experiences as varied as sexual abuse and exploitation, fleeing war, community-based violence and physical or emotional neglect, among others. Alternative views suggest that **“trauma” occurs not in the event itself but from the impact that that event has on a person's life.** Here, the focus becomes more about a person's subjective experience of trauma and how they “make meaning” (the story they tell themselves) of what has occurred.

Some explanations differentiate between different types of trauma i.e. whether the trauma was a single, one-off incident, described as acute trauma, or repeated events, referred to as complex trauma. Acute trauma could arise from, for example, a car accident or witnessing an explosion. Complex trauma, on the other hand, is associated with events that are **chronic and repeated, often occur during childhood and crucially, happen in the context of relationships**. Examples in this category could include a child being exposed to domestic violence or experiencing physical or sexual maltreatment. (It is also used, on occasion, to describe the experience of adult victims in situations of intimate partner violence.) The Child Trauma Stress Network suggest that trauma is the:

*“...severe, pervasive, and interpersonal nature of repeated abuse and neglect that creates levels of complexity.”<sup>5</sup>*

#### 4.2 Some definitions of trauma

One **widely used definition of trauma** comes from the American Substance Abuse & Mental Health Service Administration. Capturing both acute and complex experiences and covering “the event” and “impact over time,” it defines trauma as:

*“A single event, multiple events, or a set of circumstances that is experienced by an individual as physically and emotionally harmful or threatening and that has lasting adverse effects on the individual’s physical, social and emotional wellbeing.” (SAMHSA, 2014)<sup>6</sup>*

A variation on this definition (here using the descriptor of “Adverse Childhood Experiences”), but developed with children in mind, suggests:

*“Adverse Childhood Experiences (ACEs) are defined as highly stressful events or situations that occur during childhood and/or adolescence. It can be a single event or incident, or prolonged threats to a child or young person’s safety, security or bodily integrity. These experiences require significant social, emotional, neurobiological, psychological and behavioural adaptations to survive.” (Young Minds, 2019)<sup>7</sup>*

Here, the impact that trauma has on a person’s sense of safety, security and bodily integrity are highlighted, as is the “adaptive” survival response that people need to draw on across a range of domains. Bodily integrity refers to the importance of personal autonomy, self-ownership and self-determination of human beings over their own bodies.



5. Trauma types (2014). <https://www.nctsn.org/>.

6. SAMHSA (2014). Concept of trauma and guidance for a trauma-informed approach. Page 7 [https://ncsacw.samhsa.gov/userfiles/files/SAMHSA\\_Trauma.pdf](https://ncsacw.samhsa.gov/userfiles/files/SAMHSA_Trauma.pdf).

7. Young Minds (2019). Adversity and trauma-informed practices. Page 5. <https://youngminds.org.uk/media/3091/adversity-and-trauma-informed-practice-guide-for-professionals.pdf>.

An easily remembered definition about trauma is that it is:  
 "...a normal response to abnormal circumstances." (source unknown)

This simple but powerful definition reminds us that trauma responses are reasonable and part of the human condition: it is the trauma event or act that lies outside of the values and expectations of ordinary human experience.

 **Points to consider:**  
 The following diagram by NHS Education for Scotland seeks to illustrate the different and overlapping ways in which trauma can be understood. What do you think about this illustration? Do you think it is a helpful way to tease out the various elements associated with trauma?

**FIGURE 2**  
 NHS NES - THE LANGUAGE OF TRAUMA & ADVERSITY (ADAPTED)



### 4.3 Why and how the human body responds to trauma

The evidence about “why” and “how” humans respond to trauma is **vast, complicated and evolving**. It reaches across multiple disciplines (evolutionary theories, biology, neuroscience, genetics, developmental psychology etc.) and, even within these fields, there is **much debate**. While in recent times there has been significant attention given to the brain-based, neurological responses to trauma, there is consensus and growing evidence around **two broad points**:

1. When trauma is experienced, it creates a range of neurological, biological and psychological reactions which means that **we need to pay attention to what is happening in people’s minds and bodies as well as their brains** and
2. That a person’s **environmental circumstances and genetic make-up** will give rise to a range of “protective” and “risk” factors that will shape both the **likelihood of exposure to trauma in the first place** and what **resources they can access to help them recover should they experience trauma**.

Dan Siegel, an American professor of psychiatry, has coined a new term “interpersonal neurobiology” in an attempt to capture how the mind, brain and relationships integrate to alter one another.

While this practice guidance is focused on the psychosocial impact of trauma, it is recognized that trauma memories can be stored in the body. Bessel van der Kolk writes of the possibility of a mind-body disconnection caused by trauma and asserts that the person needs support to name what is happening in their body:

*“Trauma victims cannot recover until they become familiar with and befriend the sensations in their bodies. Being frightened means that you live in a body that is always on guard... In order to change, people need to become aware of their sensations and the way that their bodies interact with the world around them. Physical self-awareness is the first step in releasing the tyranny of the past.”<sup>8</sup>*

A key task for those in helping roles is to find ways to assist those who have experienced trauma to reconnect with their bodies. Developing a sense of mastery over their body can help to restore health, strength and well-being. Regular activities that include an element of teamwork (e.g. football, climbing, collective singing etc.) are also useful in that they promote a connection to others and a sense of belonging.



8. Bessel Van der Kolk (2015). *The Body Keeps the Score: Brain, Mind, and Body in the Healing of Trauma*. Penguin/Random House; New York. <https://www.brainpickings.org/2016/06/20/the-body-keeps-the-score-van-der-kolk/>.

Like other species and other mammals, how humans respond to threat is largely shaped by our evolutionary history and is tightly bound-up with our fundamental need for survival. Here we consider the outline of two neurological explanations about how our bodies respond to threat:

- a) Brain driven response to threat.
- b) Autonomic nervous system response to threat.



**FIGURE 3**  
GENERAL ILLUSTRATION OF REGIONS OF THE HUMAN BRAIN

### a) Brain driven response to threat

From a neurological perspective, when a threat is perceived, our brains immediately respond to assess the situation either using **conscious awareness or subconscious cues**. When using conscious awareness, we are able to detect the nature of the threat using our conscious awareness and adjust our responses accordingly. For example, if we are driving and see an accident ahead, we are able to use our “thinking” brain to adjust our road position, speed and attention to ensure our safety and that of other road users. If, however, we perceive the threat to be acute and immediate, our conscious awareness is by-passed and our brain quickly triggers **responses in our brains and bodies that prioritizes safety**. Commonly referred to as our “fight”, “flight” or “freeze” responses (some also include “feign” or “flop”), these manifest in numerous ways:

- In **“fight” or “flight” mode**, our heart rate increases to pump blood faster to our larger limbs; our pupils dilate to assist our vision; a surge of adrenaline provides us with an instant burst of strength; and another hormone, cortisol, increases blood

sugar to suppress the immune system and direct energy to address the perceived threat by confronting it or leaving the situation.

- In **“freeze” mode** a person’s heart rate drops, they breathe slower and they may become limp or very still.

The “fight,” “flight” and “freeze” responses **are unconscious protection strategies**. When the brain detects that it is unhelpful for a person to attempt to “fight” or “flee” (often the case in which children find themselves), it can cause the body to “freeze” (showing that they are no threat). If the situation is so overwhelming for the individual, it can lead to the person psychologically withdrawing into themselves and even disconnecting entirely from what is happening.

Usually, once the immediate danger has passed, our brains send out chemical signals to allow the body to return to some sense of balance. However, for people who experience repeated trauma, their **internal systems (particularly through the production of the hormone cortisol) may remain on high alert long after the danger has passed**. When babies and young children routinely have their needs unmet and/or signals of danger are consistently present in their environments, their neural pathways will reflect these experiences.

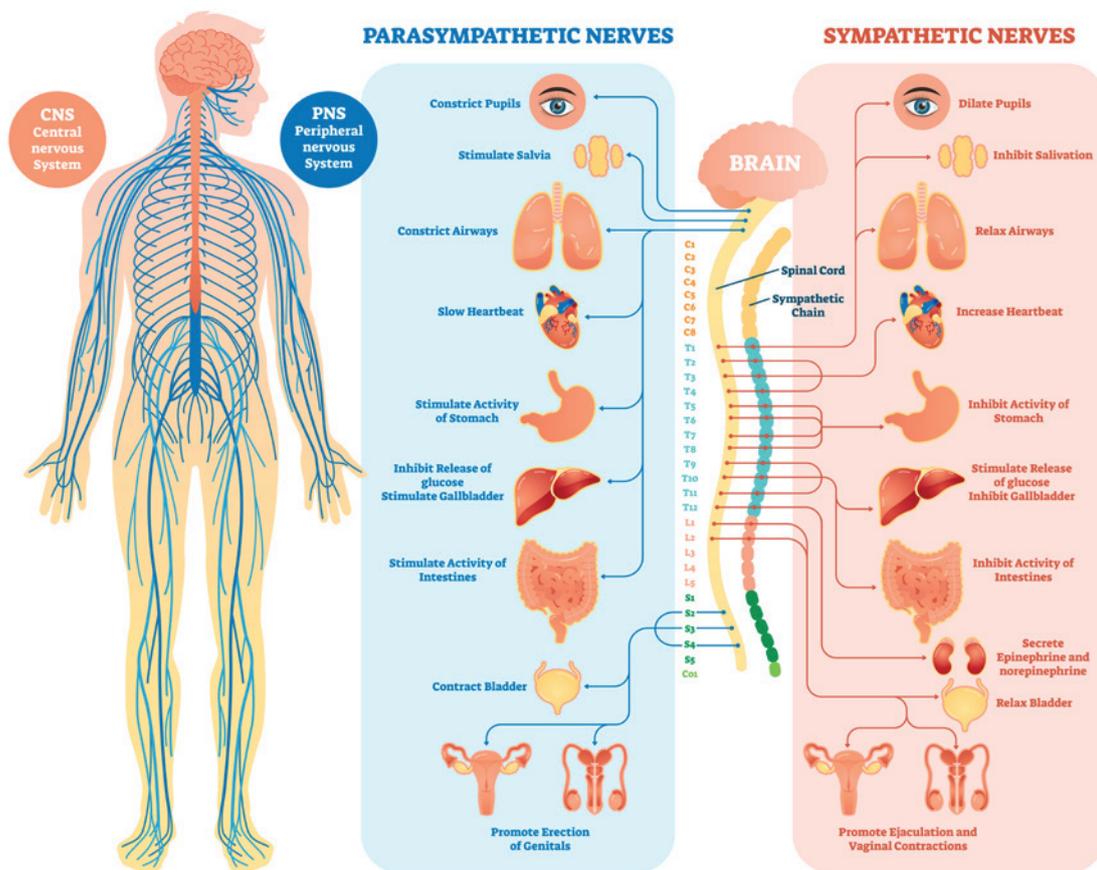
### b) Autonomic nervous system response to threat – The Polyvagal Theory

A second neurological explanation as to how and why humans respond to threat comes from the work of Stephen Porges, a US-based scientist and professor of psychiatry, and is known as the **Polyvagal Theory**. Sometimes referred to as “the science of connection or compassion,” this evidence-based theory has many similarities with brain-oriented approaches, but places a greater emphasis on the role of the **autonomic nervous system** as the main interpreter of cues of protection and danger and on our bodily responses. The autonomic nervous system is a control system that acts largely unconsciously and regulates bodily functions. It is linked to all the major organs of the body and therefore controls heart rate, digestion, respiratory rate etc. This **system** is the primary mechanism in control of the fight-or-flight response. The theory has three guiding principles:

- **Hierarchy** – our autonomic nervous system has three key states that **help us navigate through the world and are activated in a predictable order**. These are the social engagement system that guides our connection with others (ventral vagus system), mobilization or fight/flight responses (**sympathetic system**) and collapse/disconnection (**dorsal vagus**).
- **Neuroception** – what Porges describes as “detection without awareness.” Our autonomic nervous system is constantly **alert to cues of safety, danger and life threat** from within our bodies, from our environment and from the social world around us. Because it **happens below the realm of conscious thought**, he suggests that before the brain understands, the nervous system has assessed the situation and has already started to react.

- Co-regulation** – it is through reciprocal regulation of our autonomic states with another person that **we feel safe to move into connection and create trusting relationships**. Dana uses the African phrase “Ubuntu” loosely translated as “a person becomes a person only through other people” to emphasize the nature of this connection.<sup>9</sup>

## HUMAN NERVOUS SYSTEM



**FIGURE 4**  
GENERAL ILLUSTRATION OF COMPONENTS OF THE HUMAN NERVOUS SYSTEM

9. Dana, D. A. (2018). *The Polyvagal Theory in Therapy: Engaging the Rhythm of Regulation* (Norton Series on Interpersonal Neurobiology). WW Norton & Company, page 48.

While all three states of the autonomic nervous system need to cooperate to develop an embodied sense of well-being, it is the **ventral vagus pathway or social engagement system** that brings us to that place of safety and connection. The ventral vagus pathway describes the parts of the nervous system that:

- Connect the heart and muscles in the eyes, ears, voice and head. It controls how we look and interpret facial expressions, how we listen and hear beneath the words, how we hear and use tone of voice and how we tilt our heads to indicate concern for another. It **primes us to not only signal cues of safety, but also to search for them in others.**
- **Help us to regulate our heartbeat and maintain** the rhythm of the heart during spontaneous breathing. Referring to this as the **“vagal brake”**, Porges suggests that it offers our autonomic nervous system the flexibility and ability to move from a bodily state of stress to one of calmness.

When grounded in the social engagement system of the ventral vagus pathway, **not everything may be perfect in our world, but we are able to acknowledge our distress and reach out to others for support.** However, if our neuroception begins to pick up signals of threat, our sympathetic system becomes activated and we begin to mobilize to fight or flee. If the danger signal is low level (e.g. we hear a car backfire or react to a spider), our ventral vagal pathway applies the vagal brake and we return to a state of calm. This process happens routinely throughout our day.

If our **neuroception detects the signal as being life threatening**, the dorsal vagus pathway will respond to immobilize us (the “freeze” response), to take us out of connection and into a protective state of collapse. Over time, the presence of a co-regulating figure helps to restore equilibrium to our autonomic nervous system by activating the social engagement system. However, in situations where trauma is chronic and repeated or a co-regulating figure is absent, our autonomic nervous system may be unable to apply the vagal brake and, therefore, we remain in a state of high alert or even shut down.

Polyvagal Theory **provides an alternative narrative as to how our bodies respond to trauma** and may help explain how:

- A person **may struggle to access the relational help** that cue signals of safety.
- Muscles in the middle ear **become attuned to sounds of danger** and not sounds of connection.
- **Facial cues can be misread** so that neutral expressions can be interpreted as threatening or dangerous.
- The release of the stress hormone cortisol can lead to a chronic state of alertness so that a person is **unable to concentrate, or become fidgety or respond with aggression.**
- In a dissociated state, a person may exhibit **an unresponsive demeanour, have a vacant gaze or a collapsed posture.**

In line with the principles of this practice guidance, this theory suggests that a person who has experienced trauma needs to be helped to access the calming effects of their social engagement system through connection with that of another.



### Watch + consider:

#### *Polyvagal Theory*

In this video, Stephen Porges gives a brief outline of the Polyvagal Theory: <https://www.youtube.com/watch?v=ivLEAlhBHPM>  
From the discussion, note down 3 things that you could use to help you improve how you relate to someone with a possible trauma history.

#### 4.4 The theory of latent vulnerability

Both of these neurological explanations resonate in the work of Eamon McCrory (Professor of Developmental Neuroscience and Psychopathology) and his colleagues at University College London. Working with young people who had experienced varying degrees of trauma in their lives, McCrory has been able to demonstrate that abuse and maltreatment **affects young people's representations of themselves and others**. Keen to stress that understanding in this field is at an early stage, their work has demonstrated that adolescents who have been exposed to early adversity:

- Display **heightened activity in specific areas of the brain (limbic system)** comparable to that of soldiers who have experienced combat and adults with diagnosed mental ill-health. The limbic system is responsible for evaluation of information from senses (for example, hearing or seeing) in order to detect threat and prevent dangerous situations or trigger protective actions.
- **Experience this activity sub-consciously.**
- Demonstrate an over-generalized autobiographical memory which means that they are not able to draw on details from previous experience to help them navigate current situations. This may affect children's abilities to **problem-solve in social situations and to negotiate future threats and stressors**.
- Tend to **adopt a more negative inference and ruminative style. This means that they may tend to focus and dwell on negative thoughts and experiences** even when recalling everyday positive memories. These patterns are also seen in adults with depression and post-traumatic stress disorder.

McCrory suggests that these findings are examples of how children learn to adapt to trauma experiences. For example, if a child's trauma memory has been triggered or activated, they may respond in ways that helped to protect them when the original trauma occurred. However, in the long-term, these adaptive responses may not serve them well in different environments. McCrory uses the term **latent vulnerability** to suggest that without appropriate help being offered to children, these adaptive responses may lay the foundations for future mental health difficulties. They may **pre-dispose children to later harms** e.g. additional stressors and/or traumas and **may affect their abilities to form protective relationships** with adults and peers.

Along with other researchers, McCrory emphasizes that due to the brain's **neuroplasticity** (the brain's ability to create new neural pathways), **outcomes are not deterministic i.e. they are not inevitable**. Therefore, while trauma can be devastating for the developing brain, the changes made can be overcome if the right kind of **reparative relationships** and experiences are provided. McCrory and colleagues suggest that this evidence indicates the need for a **fundamental shift away from existing treatment models** to ones that are more **preventative in approach** and which seek to better understand children's experiences.



#### Watch + consider:

##### *Childhood trauma and the brain*

Based on the work of Professor Eamon McCrory, this animated video looks at how trauma in childhood can affect different brain systems. How could you use this information to help adults think about how they might respond differently to children with trauma histories? What might children think of this animation?

<https://uktraumacouncil.org/resources/childhood-trauma-and-the-brain?cn-reloaded=1>

### 4.5 Factors that affect people's responses to trauma

The **ways in which people respond to trauma is highly diverse and unique to the individual**. Two people experiencing the same event or being part of a sibling group exposed to the same family circumstances will have different responses. In addition, their reactions may change over time. Four broad paths or trajectories have been developed to help us keep in mind the possibility of differentiated responses.<sup>10</sup>

- **Resilient:** the trauma has little impact on the person's level of distress or ability to cope with the situation, immediately after the event or later on.
- **Recovery:** initially the person may be very distressed and struggle to cope with the trauma. Over time this decreases, and they begin to manage again.
- **Delayed:** at first, there may be little obvious impact of the trauma, but at a later stage, difficulties and distress begin to develop.
- **Enduring:** people experience difficulties and distress during, or soon after, the trauma and these difficulties remain.

10. Brennan, R. et al. (2019). Adversity and Trauma-Informed Practice: a short guide for professionals working on the frontline. Young Minds publications, page 8. <https://youngminds.org.uk/media/3091/adversity-and-trauma-informed-practice-guide-for-professionals.pdf>.

It is highly likely that people affected by complex trauma will most probably fall into the “enduring” category, however it should not automatically be assumed that this will be the case. Similarly, while it is highly likely that people who experience single-incident trauma are less likely to have enduring issues, this, for a small minority, may not always be the case. The experience of trauma is subjective.

Many factors **can influence how a person responds to trauma**. These can either be risk or protective factors. Examples can include:

- A person’s **genetic make-up, age and intellectual ability**.
- The level of **internal resources** upon which a person can draw e.g. whether they have a positive sense of self.
- The **nature and circumstances of the trauma** e.g. is the trauma relational, a shared-experience or has the person been compelled, through threats or a sense of stigma, to keep silent.
- If the person already experienced one or more traumatic events in their life.
- **How those around the person respond** e.g. whether they are believed, whether they have someone to help regulate their emotions and whether there is another person present who can help to “make-meaning” of the experience.
- The **responses of local and state authorities** e.g. how well relief agencies operate in times of a natural disaster or the availability of integrated specialist support services around sexual assault.

#### 4.6 Window of tolerance: one way to understand trauma responses

A framework that is popular within psychology circles and is a useful way of understanding the impact of, and people’s response to, trauma is that of the “window of tolerance,” developed by Dan Siegel (2010), a clinical professor of psychiatry based in Los Angeles, USA. Using the idea of 3 zones, the window of tolerance is a metaphor and a visual representation illustrating how people **manage stress in general but particularly in the context of trauma**. To illustrate the concept, we have drawn on diagrams developed by NHS Education for Scotland<sup>11</sup> organized as follows:

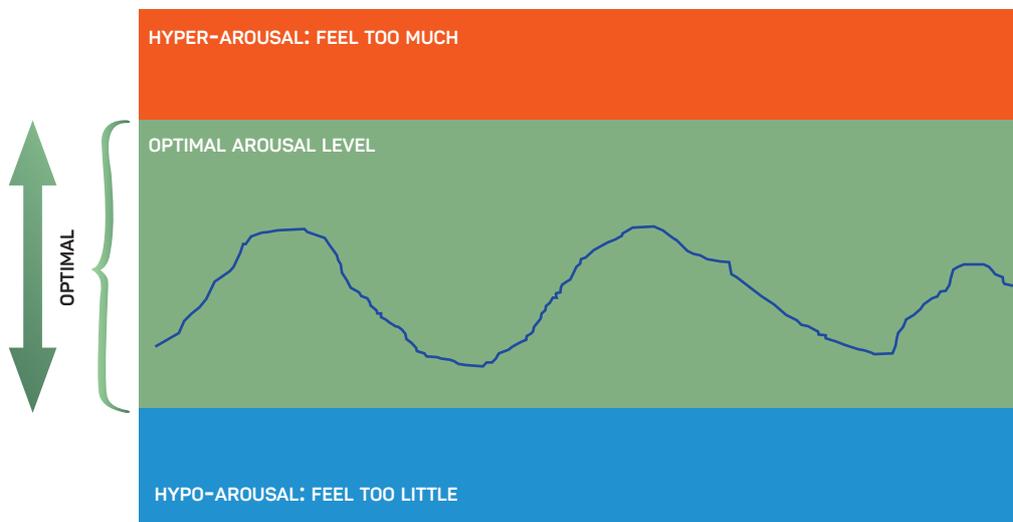
- a) Green zone – represents an optimal arousal level in which we can cope and manage the ups and downs of daily life.
- b) Red zone – represents a hyper-aroused state (feeling too much).
- c) Blue zone – represents a hypo-aroused state (feeling too little).



11. NES (2019). Window of tolerance. <https://www.nes.scot.nhs.uk/education-and-training/by-discipline/psychology/multiprofessional-psychology/national-trauma-training-framework/scottish-national-trauma-training-video-series.aspx>.

**a) Optimal arousal level (Green zone)**

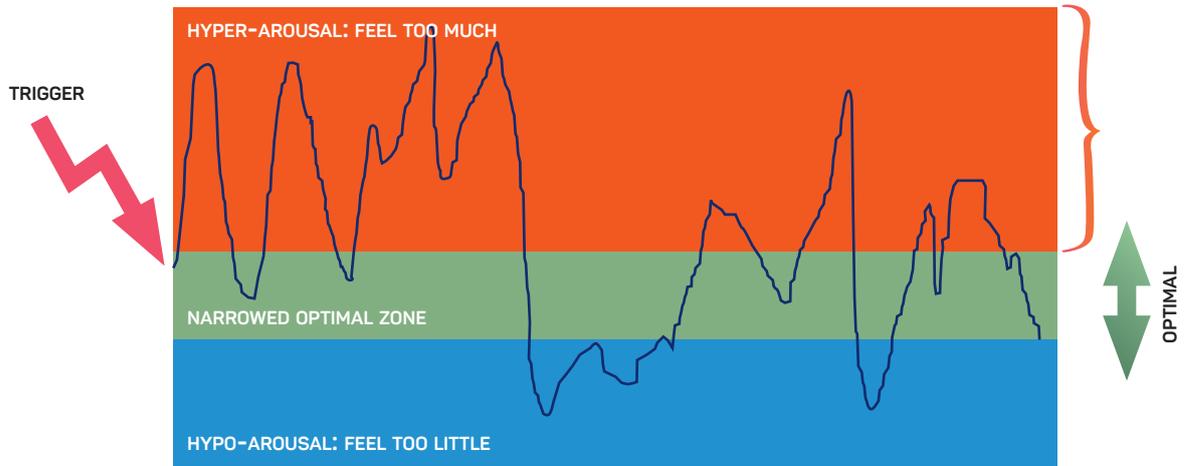
Echoing Porges’ social engagement system, Figure 5 highlights the green zone, the optimal level of arousal, in which we feel a sense of stability and calmness and in which we are able to think, plan and connect with others. While in this zone we can also experience difficulties (e.g. pain, hurt, grief, anger, anxiety etc.) which may bring us to the edges of our Window of Tolerance. However, we are broadly able to tolerate these stressors and, although our daily functioning may be affected, we are able to draw on internal and external sources of support to get us through difficult times.



**FIGURE 5**  
 NHS NES, WINDOW OF TOLERANCE – OPTIMAL AROUSAL LEVEL (ADAPTED)

**b) Having a narrower window of tolerance as a result of trauma**

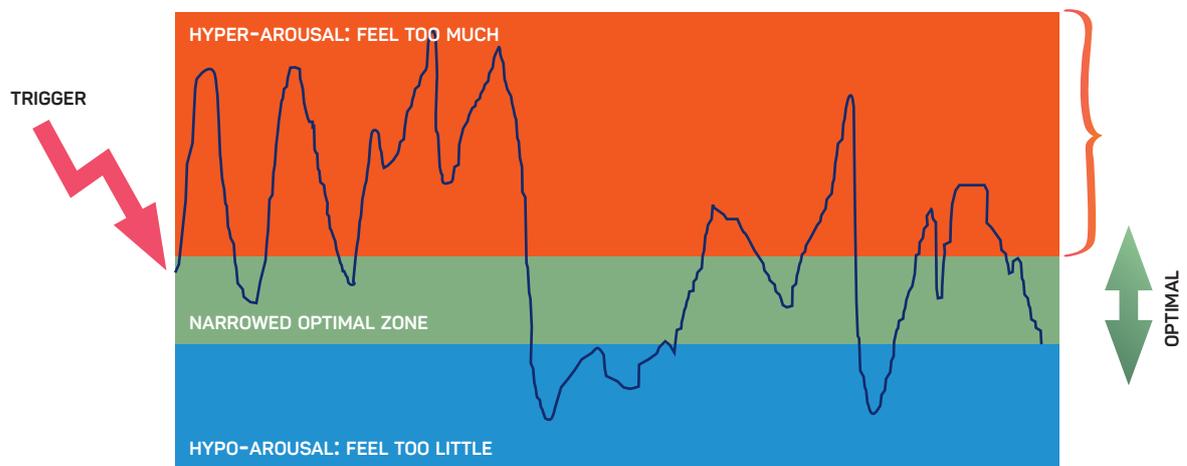
This window however is not a fixed state: people who have experienced chronic trauma and experience the world as unsafe may have a narrower window of tolerance, which is also less flexible (Figure 6). In these circumstances, a person may respond to even minor stressors by quickly becoming hyper- or hypo-aroused. What triggers a person’s stress levels may be a conscious memory, but is more likely to be an unconscious sensation or stimulus e.g. a smell, a tone of voice, a feeling of shame or humiliation etc. Triggers are numerous and unique to each person.



**FIGURE 6**  
 NHS NES, WINDOW OF TOLERANCE – NARROWER WINDOW AS A RESULT OF TRAUMA (ADAPTED)

**c) Becoming hyper-aroused (Red zone)**

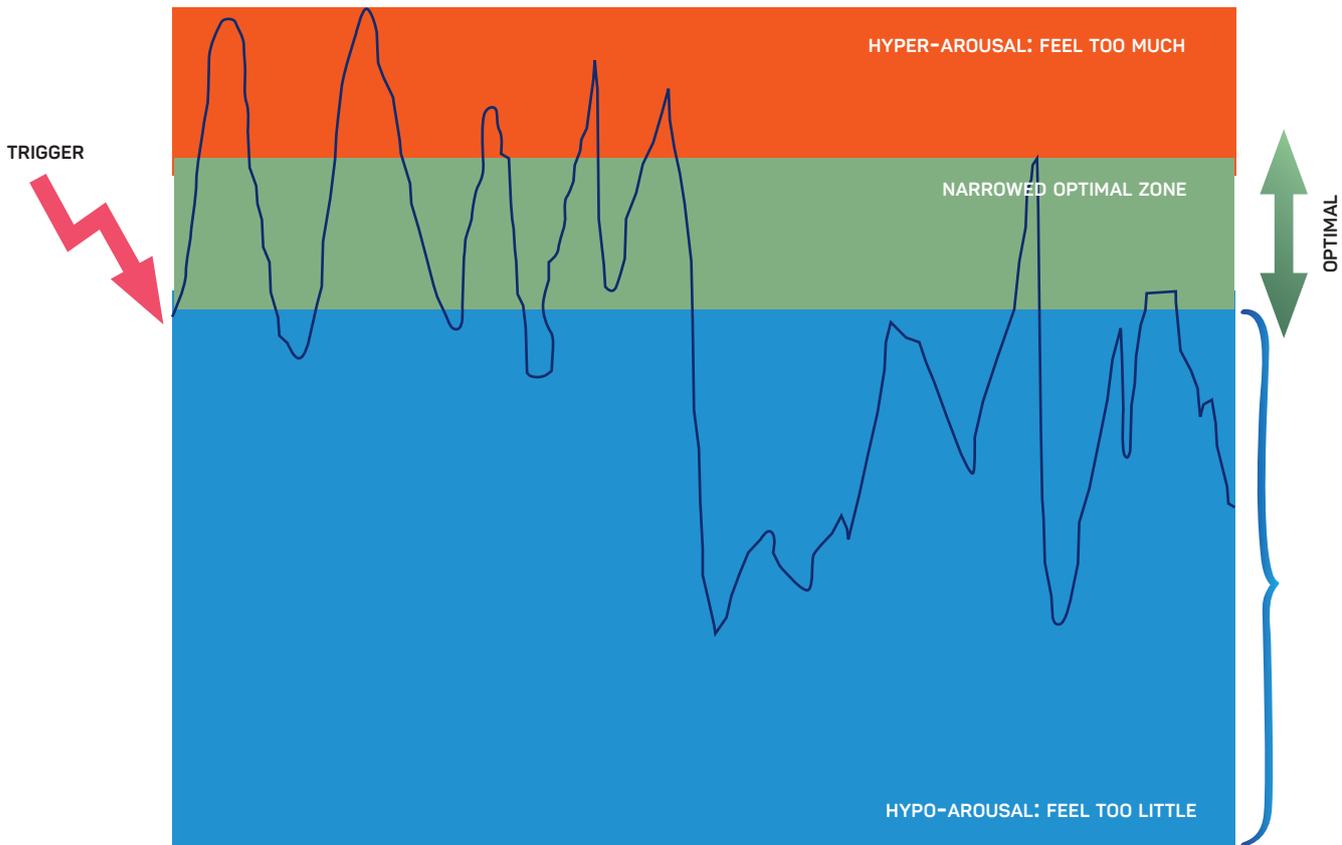
When we become hyper-aroused due to trauma (Figure 4) (what Porges called the mobilization, sympathetic state), our feelings can be heightened and intensified and we are less able to draw on strategies that might help us to self-soothe i.e. bring ourselves to a position of calmness. Our abilities to think straight and problem-solve can be diminished, and we may experience excessive energy/activation that lead to feelings of anxiety, panic and restlessness. This can manifest as difficulties with sleeping, eating and digestion and with managing our emotions. Working with people in this state can be difficult, as they appear not to be listening or willing to follow advice. This is not intentional on their part; they are just not able to move back into that optimal green zone.



**FIGURE 7**  
 NHS NES, WINDOW OF TOLERANCE – BECOMING HYPER-AROUSSED (ADAPTED)

**d) Becoming hypo-aroused (Blue zone)**

When our responses to trauma cause us to “freeze,” numb or shut down, we are said to be in an hypo-aroused state, what Porges described as activation of the dorsal vagus pathway (Figure 5). Here, depleted of energy, we can feel exhausted, depressed and disconnected, and our emotions can feel blunted. Again sleeping (too much), eating and digestion can all be affected. Similarly, working with people when they are hypo-aroused is not easy as they can appear unmotivated, bored and unresponsive to offers of help.



**FIGURE 8**  
 NHS NES, WINDOW OF TOLERANCE – BECOMING HYPO-AROUSAL (ADAPTED)

It is important to note that people can move from a hyper-aroused state to one of hypo-arousal possibly due to the mind, brain and body becoming so overwhelmed that it can no longer stay in that state of arousal. People may also seek to shift states themselves though the use of external substances or by engaging in activities, often risky, either to make themselves feel more alive or calmer e.g. substance use, self-harm etc.

The window of tolerance is a useful concept because it:

- Invokes a sense of compassion and understanding in those who act in a helping capacity.
- Reminds us that responses that fall into the “hypo-aroused” category are also signs of distress, even though they may provoke less of a hyper-aroused reaction in us. The quiet child may have learned to stay “off the radar” so that they do not come to harm.
- Prompts us to pay attention to our own experiences and responses.
- Encourages us to re-frame the language we use when reporting on or recording people’s behaviour.
- Provides an accessible tool to share with children and parents to help them understand their behaviour and identify their mental states.
- Assists us to understand which strategies might be helpful to bring a person back into a sense of balance.



**Watch + consider:**

Here, Caroline Bruce, a clinical psychologist, NHS Education for Scotland, applies the window of tolerance to how witnesses who have experienced trauma may be better supported when giving evidence in court. What does she suggest can be done to avoid “re-traumatization?”  
*Ways to avoid re-traumatizing witnesses part 3: Window of tolerance*  
<https://vimeo.com/378985172>.

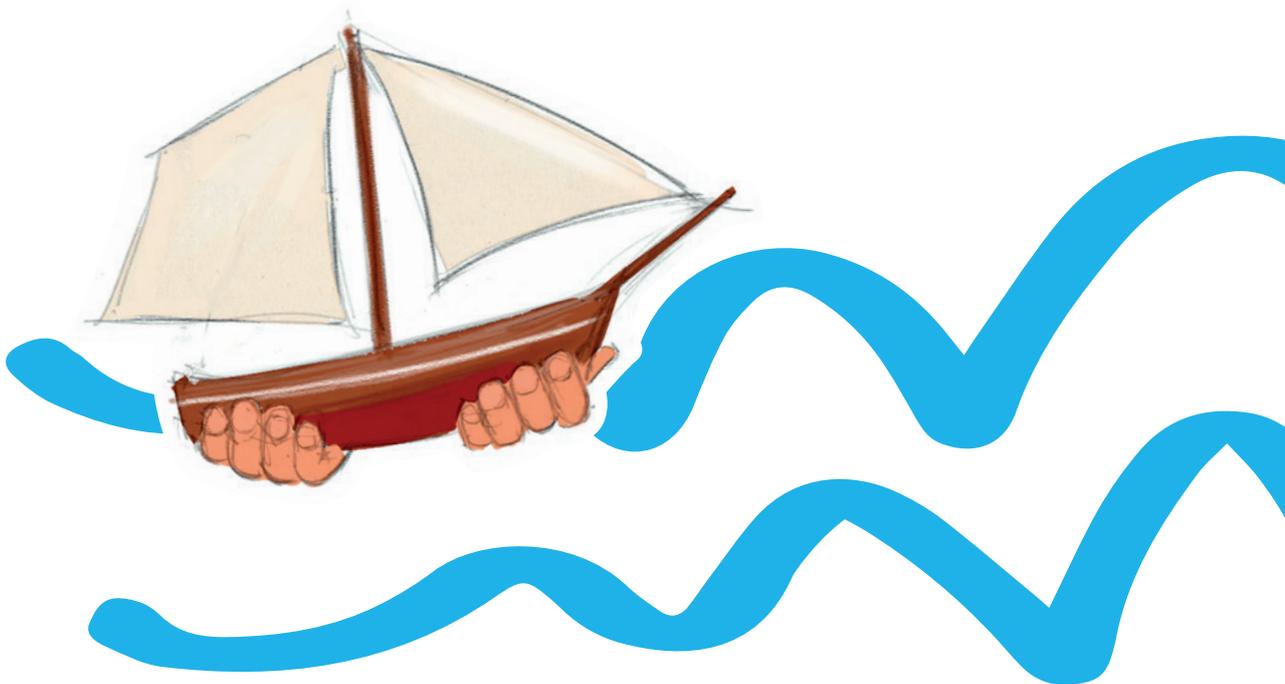


**Points to consider:**

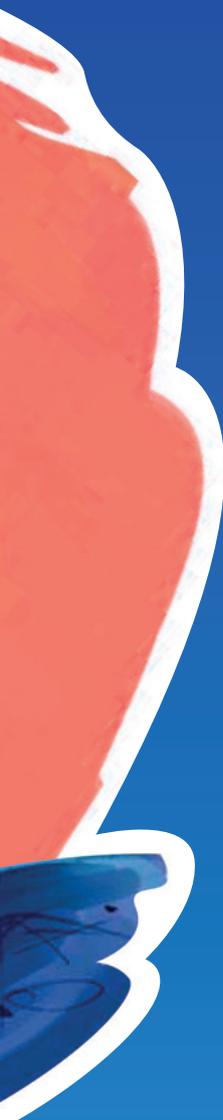
Think of a recent encounter in your work with a child or an adult when their behaviour gave you some cause for concern. Try to remember as much detail about the encounter as you can. How might the window of tolerance help you to re-shape how you think about or describe what is happening for a) the child/adult and b) for you? Reflecting back on this encounter, what would you now do differently to help both you and the other person stay in or come back to their window of tolerance?

### Keep in mind

- The literature offers multiple ways to “frame” or define trauma. Some emphasize the “event” while others focus on the “impact” of the event. It is helpful to differentiate between “acute” and “complex” trauma. They both affect a person’s “sense of safety,” but they are substantially different with regards to the impact on a person’s sense of self and how they relate to others, particularly if trauma is experienced at a young age.
- Trauma responses are part of the human condition and are best seen as “adaptive behaviours” that have allowed a person to survive their trauma experience. They occur often at a subconscious level and so people may not always be able to readily explain in words why they reacted in a particular way.
- People will respond to trauma in various ways depending on the balance of “risk” and “protective” factors that are present in their environments. Relational trust and support are key components in people’s abilities to recover from trauma and yet these may be the very components that have been most affected in situations of complex trauma.
- Helping people to understand how the brain, body and mind respond to trauma may assist people to have a more self-compassionate understanding of their trauma histories and aid them to develop new narratives about what happened to them.
- Armed with this knowledge, practitioners and organizations should begin to review and evaluate how their current practices, processes, structures etc. may inadvertently re-traumatize people with trauma histories.







CHAPTER 5



**Complex  
trauma:  
Its meaning  
and impact  
on children's  
development**

# CHAPTER 5

## COMPLEX TRAUMA: ITS MEANING AND IMPACT ON CHILDREN'S DEVELOPMENT

"I think professionals sometimes underestimate what children can understand. Professionals can sometimes not imagine what children have already had to deal with."

*(Quote from young person, scoping exercise, 2020)*

### INTRODUCTION

This section explores in more detail the concept of complex trauma, as it is this type of trauma that children in alternative care are more likely to have experienced. In line with the principle that trauma needs to be understood from a child developmental perspective, we will initially pay attention to some of the critical components that shape a child's psychosocial development and will then look at the potential impact of complex trauma and how it might present in children's thoughts, feelings, actions and in their physical health.

### 5.1 Critical components of a child's psychosocial development

Children's development can be understood from various distinct but overlapping perspectives. In the literature, attention is often given to different domains of development e.g. physical, psychological, neurodevelopmental, cognitive, sexual, spiritual etc. or by thinking about different developmental stages e.g. antenatal, infancy, toddlerhood, middle childhood, adolescence, young adulthood etc. Here, we pay particular attention to children's psychosocial development, mindful of the fact that this is only one aspect of children's holistic needs.

A child's brain development is strongly influenced by life experiences, especially those that occur when the child is in utero (before they are born) and in early childhood. The brain develops **sequentially**, which means that through repetitive actions, pathways and connections are built in logical steps within, and between, different brain areas, which allow for a **progressive growth** of skills, talents and abilities.

From a psychosocial perspective, child developmental thinking draws heavily from the work of John Bowlby, an English psychologist and psychoanalyst. His **theory of attachment**, which describes how children, in pursuit of their need to survive, **seek comfort and reassurance** from their primary caregiver(s) in **times of distress**, provides the foundations of understanding the nature and impact of complex trauma

in children's lives. **Attachment theory** suggests that when children's survival needs are met through the establishment of a secure base (their relationship with their primary caregiver(s)), only then are they free to explore their world, safe in the knowledge that their needs for comfort and connection will be met when required.

In the early phases of attachment theory, much attention was given to identifying and responding to the type of "attachment style" that a child might develop in response to their early parenting and which they will replicate across the lifespan. In more recent times, attachment science suggests that attachment styles are more nuanced and, due to the brain's ability to change (neuroplasticity), they are perhaps less fixed (deterministic) than has previously been described. Today, theorists seek to combine the original narrative about "survival" with one in which attachment is understood as **an ongoing "process" in which interrelated developmental skills are acquired and nurtured.**

We suggest that understanding complex trauma through a child developmental lens is essential because it places us in a better position to both understand how trauma can de-rail children's development and what we can do to assist children to get back on their developmental pathway. While below, we talk about a number of psychosocial components through children's earliest relational experiences, it is important to note they are features of daily living throughout childhood and beyond. The training element of this initiative will explore these issues in more detail.

### a) Humans are innately social animals

We have already learned that due to our evolutionary history, **humans are innately social animals and have a need "to belong:"** it is what has allowed us to survive and develop as a species. As such, **many of our bodily systems are geared toward social connection and relationships.** Unlike other animals, human offspring take a long time to mature and operate independently and so they rely on their primary caregiver(s) to be a constant source of safety, stability and nurturance. Any actions therefore that cause a child to feel disconnected or adrift from their social network will feel threatening and will prompt the human stress response.

### b) Children are active players in their development

Babies and young children are not passive bystanders in their development. **From the moment they are born, babies actively seek to attach to their primary caregiver(s), bringing them ever closer for safety and protection.** These are the early signs of children expressing a **"sense of agency."** As the National Child Trauma Stress Network notes, developing a "sense of agency" (or **"mastery"**) is critical in children's development, as it establishes an:
   
"...ability to see one's actions as having meaning and value."<sup>12</sup>



12. The National Child Trauma Stress Network [www.nctsn.org/effects](http://www.nctsn.org/effects)

### c) Children learn to regulate through co-regulation

An important skill that is **vital for children to attain**, and one that is nurtured within the attachment relationship, is self or **emotional regulation**. **Children's regulation always requires the presence of a co-regulating adult**. In early development, everything in the baby's world is new and therefore offers many potential threats. By providing **comfort, calmness and nurture within moments of joy and intimacy**, a primary caregiver establishes a relationship that assists to regulate their baby's emotions. This pattern of consistent and repetitive care, in which the **parent notices the baby's emotional state and reflects it back through tone of voice, facial expression, touch and gesture**, helps the child to learn over time that emotional states are temporary, have names and can be managed. (Note here the overlap with how the social engagement system operates in Porges' Polyvagal Theory.)

### d) Mentalizing: How children need others to help them develop a mind

The concept of "**mentalizing**" comes from the work of Peter Fonagy,<sup>13</sup> a Hungarian psychologist and psychoanalyst based at University College London and The Anna Freud National Centre for Children & Families, and centres on **how children's minds develop**. Mentalizing refers to the **effort an individual makes to understand other people in terms of their thoughts, beliefs, knowledge, desires and intentions**: in other words, what goes on in their subjective world. A primary caregiver's abilities to recognize their child as having a mind with thoughts, feelings, desires etc. helps the child to develop this understanding and, over time, realize that the behaviour of others is also underpinned by these mental states. If a child **experiences their primary caregiver(s) accurately reflecting back to them their true thoughts, beliefs, desires, intentions** etc., this not only helps the child to **organize their mental states** (the response matches their intention), but it also provides the child with a sense of **being known and understood**. Fonagy suggests that it is this experience of "being understood," of **recognizing themselves in their primary caregiver's understanding**, that a child **develops a sense of trust and belonging**. It is not essential that a parent "gets" the child's mental state correct all of the time, but that it is in the exchange between the two parties about what was intended, that trust is built. Children who rarely or who do not experience this exchange in their relationships with their primary caregivers may struggle to understand and read their own and other people's intentions.

13. Fonagy and Target (2002). Early Intervention and self regulation. *Psychoanalytic Inquiry*, 22:3, 307-335  
<http://dx.doi.org/10.1080/07351692209348990>.

### e) Attuned care

Acting as the vehicle for regulation, **attuned care** refers to **how well primary caregiver(s) are able to recognize the child’s “sense of agency” and to match their emotional states and attention.** Building on the work of Fonagy and others, Elizabeth Mein,<sup>14</sup> a professor of psychology at the University of York, UK, has developed the concept of **“mind-mindedness” to help us think about what attuned care looks like in practice.** Through her studies on young child/parent interaction, she suggests that primary caregiver(s) who **interpret their child’s behaviour as meaningful** can not only **tune into their child’s emotions, desires, and interests more accurately**, but also **respond to** their child about mental and emotional states. Babies thrive when primary caregiver(s) **assume that their baby has a mind of its own**, are **curious** about what their baby is thinking and feeling, and **make appropriate mind-minded comments** e.g. a parent may say to a baby “I see you’re bored with that toy.” The appropriateness of that comment depends on whether or not the child really is bored. If the child is showing any signs of interest, e.g. gazing at the toy, reaching for it etc., the comment is not appropriate. Mind-minded parents need to do **more than talk about thoughts and feelings.** They need to make comments that are **attuned and sensitive to the child’s initiatives.**

### f) How the “rupture and repair cycle” aids regulation and sociability

Children and their primary caregiver(s) are not constantly in attunement or alignment with one another. Throughout childhood, but particularly when a child is pre-verbal, there will be frequent **“ruptures”** throughout the day where signals are misinterpreted or the primary caregiver(s) takes a while to figure out the source of a child’s distress (is that a cry of hunger, of tiredness, or pain). What is important is that the **relationship is brought back into alignment (“repaired”) by virtue of the fact that the child’s needs are met with care that is tender, soothing and comforting.** Once the child becomes mobile and begins to explore their world, the incidents of **“rupture and repair”** rise considerably as children’s curiosity requires their primary caregiver(s) to be constantly vigilant. Throughout the day, as children are told “not to touch something hot/ hit the family pet/ put something dirty into their mouth” etc., there are frequent opportunities for “ruptures” and “repair.” Thus, the “rupture and repair” cycle serves two important functions:

- Over time, it assists children to **explore safely, manage impulses and comply with social norms.**
- It helps the child to make a **clear distinction** between unwanted behaviour, **what they have done**, and that they are still loved and valued for **who they are.** The child’s sense of security and connection, founded on their relationship with their primary caregiver(s), remains intact.

14. Mein, E. (2013). Sensitive attunement to infants’ internal states: operationalizing the construct of mind-mindedness [https://www.york.ac.uk/media/psychology/mind-mindedness/Meins%20\(2013\).pdf](https://www.york.ac.uk/media/psychology/mind-mindedness/Meins%20(2013).pdf).

### g) Epistemic trust: The foundation for learning and social integration

Fonagy suggests that the trust that develops through children's earliest attachment relationships (what he calls "**epistemic trust**") **is vital as it lays the foundations for all future learning and social integration**. He argues that because of their attachment relationship with their primary caregivers, children perceive new knowledge received from them as being trustworthy and relevant, and are willing, therefore, to integrate it into their lives. This process develops in children's minds a sense that **learning and problem-solving solutions are to be found in the social network around them**. In the early years, these experiences open the child's mind to learning and engaging in a wider social world under the guidance of their primary caregiver(s). As the child grows and their horizons expand, this **epistemic trust becomes transferable to other relationships with adults** (e.g. to teachers, sports coaches, doctors etc.) thereby allowing learning, social engagement and agency to flourish. Crucially, epistemic trust provides the underpinnings of "help-seeking" behaviours.



#### Watch + consider:

Here, Peter Fonagy provides an engaging and accessible explanation of the role and importance of understanding how children's minds develop using the ideas of "mentalization" and "epistemic trust." How could you describe these ideas to a colleague using everyday language?

Peter Fonagy – What is Mentalization – Simms Mann Institute – 18th Nov 2016  
<https://www.youtube.com/watch?v=MJ1Y9zw-n7U>

## 5.2 Autism and mentalizing

Children on the autistic spectrum or those who display atypical patterns of behaviour (sometimes referred to as children with neuro-diversity), have as much right as any other child to have their needs taken into consideration.

For children on the autistic spectrum, the ability to understand the mental states of others has received particular attention. As mentioned above, it is an important skill that helps a child connect, feel safe and flourish. **Not being able to recognise that other people may think differently to you, or not being able to understand the thoughts and feelings of others can make the world a very scary and unpredictable place.** Typically developing children tend to be able to demonstrate this skill of mentalizing by around about the age of four years, however children on the autistic spectrum may find this to be more of a challenge.

Children on the spectrum **may also experience different processing and thinking styles**. This may impact on executive functioning, which helps with decision making, attention and enables a child to see the bigger picture and infer meaning in situations.

A large-scale study (Wing and Gould, 1979)<sup>15</sup> identified three areas of functioning that may need particular thought and attention:

- **Social relations** e.g. making and keeping friendships, coping with unstructured time, working cooperatively with others.
- **Communication issues** e.g. retaining verbal information, interpreting body language, facial expressions and gestures and understanding social jokes.
- **Inflexibility of thought and imagination** e.g. coping with change, understanding generalisations.

In addition, research on **sensory processing and integration** is also beginning to create a better understanding about ways in which children on the autistic spectrum experience the world. While each child is different, **how an environment responds to their sensory needs** can impact greatly on a child's ability to function and their levels of arousal.

Although potentially neurodevelopmental in origin, it is interesting that **children on the autism spectrum may exhibit some behaviours similar to those seen in children whose early attachment experiences may have been compromised**. This demonstrates the importance of gathering good quality background information and being genuinely curious about the reasons why a child relates in a particular way. **Research into neuro-diversity has much to teach mainstream approaches in alternative care**. For example, it is known that individuals on the autism spectrum can, with time and practice, **achieve awareness of mental states by targeted learning**. From this, it is clear that mentalizing abilities can be developed in later years.

### 5.3 How the psychosocial impacts of trauma can affect children's development

To re-cap, complex trauma is substantially different to one-off, acute forms of trauma because it:

- **Is chronic and repeated**
- **Occurs during childhood and**
- **Happens in the context of a child's relationships.**

It is sometimes also referred to in the literature as "developmental trauma" or "relational trauma."

#### a) Acts of commission/omission

From a child's perspective, complex trauma can take two forms:

- Acts of commission: harmful, intrusive acts, often committed by trusted adults that serve to invoke fear in a child. Examples include physical, emotional and sexual abuse, exposure to domestic violence etc.

15. Wing, L. & Gould, J. (1979). Severe impairments of social interaction and associated abnormalities in children: Epidemiology and classification. *Journal of Autism and Developmental Disorders*, 9, 11-29.

- **Acts of omission:** where the repeated **absence** of safe, nurturing and stimulating care can lead to feelings of disconnection or abandonment.

Acts of omission or “**neglect**” are often missed and underestimated when considering trauma. Identifying patterns of neglect, that can be subtle and that occur over time, can get lost when working with families who experience a multiplicity of issues. Similarly, understanding the threat response invoked by neglect is also often overlooked. From a child’s perspective, **the impact of neglect can be severe whether it is deliberate or the consequence of problems caregivers face in their own lives.** From a psychosocial perspective, children, but particularly babies, can become highly distressed by the absence of a responsive caregiver as they can interpret the **absence of connection and protection** as highly threatening.



#### Watch + consider:

Ed Tronick’s “still face” experiments demonstrate how very young children become quickly distressed when they lose “connection” with their primary caregiver(s). Using the critical components of psychosocial development learned so far:

- a) What positive child/mother interactions do you see in this video?
- b) How does the child respond when connection is broken with their mother?

<https://www.youtube.com/watch?v=apzXGEbZht0>

#### b) Powerlessness and the absence of “agency”

When complex trauma occurs, particularly in early childhood, the child can experience **a profound and deep terror, rooted in powerlessness.** Powerlessness comes in many forms. In a recent, potentially ground-breaking work on how we respond to emotional distress, the authors note that although all forms of power can operate through relationships, **interpersonal power** can be defined as:

“...the power to look after/not look after or protect someone, to abandon or leave them, to give/withdraw/withhold love.”<sup>16</sup>

**Children have little power due to their status as children, their age and their size.** For all children, but for young children in particular, their **ability to “fight” or take “flight” in the face of trauma is limited and so a “freeze” response may be**



16. Johnstone, L. & Boyle, M. et al (2018). The Power Threat Meaning Framework: Towards the identification of patterns in emotional distress, unusual experiences and troubled or troubling behaviour, as an alternative to functional psychiatric diagnosis. Leicester: British Psychological Society, page 95.

**more common (please refer to section 4.3).** Examples can include babies that rarely cry (as they have learned that their attempts to communicate will be ignored), young children who are “watchful” or those who are overly compliant as they live in fear of provoking the anger or violence of others. **Children with disabilities are even more powerless.** Those who are physically disabled may be unable to remove themselves from situations: those with learning or communication disabilities may have their communication about distress misinterpreted or ignored.

This sense of powerlessness can have a **profound effect on a child’s sense of agency.** As the previous section noted, “agency” builds a sense of hope, control and that your actions have value and meaning. As children grow and develop, a sense of agency contributes to decision-making, planning and building resilience and, from a child rights perspective, it contributes to children’s abilities to participate, make choices and determine the path of their own lives.

### c) Feelings of terror and the absence of trust

It is hard to imagine just how terrified a child feels if the trauma threat they are experiencing is coming from an adult in a position of trust, whether that is a parent, foster caregiver, wider family member or a professional worker (e.g. teacher, sports coach, faith leader etc.). D’Andrea (2012), when considering trauma experience in early childhood, commented that the sense of powerlessness is even more **devastating when:**

**“...terrifying experiences, caused by someone who should be a figure of trust, are the norm in children’s lives.”<sup>17</sup>**

Furnivall suggests that children who experience trauma at the hands of their caregivers:

**“...are faced with an irresolvable dilemma as the person they are dependent upon for safety is the very person who is the source of their distress.”<sup>18</sup>**

It is this feature of complex trauma that makes it substantially different to other forms of trauma.

The impacts of trauma for children whose source of protection is also their source of fear are potentially numerous, developmentally significant and cumulative e.g.:

- They are **more likely to experience higher and more frequent states of arousal** (hyper/hypo) that take them outside their “window of tolerance.” It is known

17. D’Andrea et al. (2012). Understanding interpersonal trauma in children: why we need a developmentally appropriate trauma diagnosis.

18. Furnivall, J. (2011). Attachment-informed practice with looked after children and young people, Insights, Paper 10. <https://www.iriss.org.uk/resources/insights/attachment-informed-practice-looked-after-children-young-people>.

that high production rates of one of the stress hormones, cortisol, can contribute to inflammation in the body and the suppression of our natural immunization responses.

- Without the presence of a consistent, regulating adult, their **ability to develop the regulatory skills that could help them to self-soothe** (come back into their window of tolerance) **and control impulses may be impaired.**
- They may have **less energy and attention to allocate to other developmental tasks** e.g. language acquisition, social skills, concentration etc.
- Their mental states may be in a constant state of confusion if their need for proximity and protection is met with varying responses of warmth, indifference or harshness. As a result, children may begin to develop a sense of **disintegration i.e. a disconnection between their feelings, experiences and thoughts.**

#### d) “Splitting” and feelings of shame

- In her book, *The Simple Guide to Understanding Shame in Children* (2019), Betsy de Thierry explores this sense of disintegration. Describing the response as “dissociative” (hypo-aroused response) and subconscious, she explains that children can develop a survival strategy that enables them to continue to relate to their primary caregiver even though they are a source of threat and terror. Using **the psychological idea of “splitting,”** de Thierry explains how the child’s mind splits off painful memories, physical sensations and emotions into the subconscious **so that they can continue to have their basic needs met.** While this survival strategy allows them to function day-to-day, it can **invoke emotional and physical confusion and a deep sense of shame and worthlessness.** It can also invoke feelings of complicity or not doing enough to stop the abuse, which may compound children’s abilities to speak out. Should opportunities arise, it is therefore very important that children who have experienced trauma hear that their **trauma responses were not rational and conscious decisions, but were controlled by innate survival mechanisms that were triggered when their body was in a state of complete overwhelm.**

Echoing the “rupture/repair cycle” above, de Thierry, when writing about shame talks of understanding the **distinction between “guilt”** – “you have done something bad” **and “shame”** – “you are fundamentally bad and unlovable.” She suggests that feelings of shame can trigger in children an **urgent signal of danger** as they generate the **possibility of rejection, failure, exposure and abandonment.** It is once again, this threat of social disconnection that “threatens the very basic human experience of being alive and **needing to belong, be loved and be accepted.**”<sup>19</sup>



19. de Thierry, B. (2018). *The Simple Guide to Understanding Shame in Children: What it Is, what Helps and how to Prevent Further Stress Or Trauma.* Jessica Kingsley Publishers, page 15.

## 5.4 How trauma can manifest in children

Before going on to look at the ways in which trauma can show up in children's lives, it is worth reminding ourselves of some important points from earlier sections.

- **Trauma experiences tend to be stored in different ways to non-traumatic ones**
  - Traumatic memories are often stored **beneath consciousness** and may intrude into our conscious minds without warning.
  - Trauma memories may be light on “narrative” (words) but instead are **made up of detailed sensations and feelings** surrounding the experiences e.g. sights, sounds, smells, tastes, numbing, breathlessness etc. Brennan et al (2019) comment that “...this difference between the way we retain everyday and traumatic memories “explains **why memories of trauma feel so unpredicable and vivid.**”<sup>20</sup>
- Throughout childhood, growth and change is highly dynamic and occurring across many integrated domains (physical, social, emotional, psychological, spiritual etc.). Trauma can **impact differently depending on the child's developmental stage: the earlier the trauma occurs, the more potentially harmful are its effects.**
- There are **numerous ways** in which trauma can play out in the lives of children, **affecting the way they think, feel and act.** Sometimes, because of the way that trauma memories are processed, the connections between the trauma experience and the trauma response are **not always obvious**, either to the child themselves or the adults around them.
- Trauma responses often **play out in children's behaviour** as well as in their **bodily functioning.** It is sometimes easier to spot signs of trauma when children become **hyper-dysregulated** because their behavioural responses are more obvious to see. Less obvious, sometimes, are the children who dysregulate in a more **dissociative way (hypo-dysregulated).** These responses, which can be quieter and centre around “being compliant” or “under the radar” of adult attention, can **easily go unnoticed.**

What follows are some examples of how children's adaptive response to trauma may play out in their thoughts, feelings, actions and physical health. It is not an exhaustive list and is given with the caution that it should not be automatically assumed that trauma is the only possible explanation underlying these behaviours.

- **Sense of self** - children may have a negative self-image in which they feel different or disconnected to others, worthless, unlovable or that they are at fault for no longer living with their families.
- **Emotionally** - children may have difficulties identifying and managing emotions, and they may have limited language to express their mental states i.e. their

20. Brennan, R et al. (2019). Adversity and Trauma-Informed Practice: a short guide for professionals working on the frontline. Young Minds publications, page 9.

thoughts, feelings, intentions and desires etc. They may appear depressed, anxious or be constantly “on edge.” Equally, they can be impulsive or have difficulty calming down after an incident. In addition, they may appear as emotionally numb or tune out to threats, which may make them vulnerable to re-victimization.

- **Bodily functioning** – children may experience unexplained recurring headaches, stomach aches, bedwetting (enuresis) or bowel functioning (encopresis) difficulties. They may also have poor sleep, experience nightmares and have eating/digestion problems. They may be hypersensitive to sensory information or unaware of pain, touch or internal physical sensations. In addition, bodily sensations may appear suddenly or appear to be confused with reality e.g. they may not feel cold even though the temperature is really low.
- **Attention** – children may appear as easily distracted, prone to daydreaming or seem “somewhere else.” Some may have particular problems within a school setting and may struggle with concentration, problem-solving, planning and executing plans.
- **Behaviour** – children may appear as either avoidant or controlling, or develop risky coping strategies (e.g. self-harm or substance misuse).
- **Relating to others** – children may appear watchful, guarded and overly sensitive to the moods of others. They may hide emotions and struggle to assert or keep boundaries in relationships. Some children may be overly compliant and constantly strive for perfection, while others may lose their temper and display disproportionate anger. Children may also seek to control their circumstances, which can appear as stealing, hoarding food or bullying.

These features echo in assessments undertaken by SOS Children’s Villages International with 250 caregivers.<sup>21</sup> They identified the following issues as challenging for themselves as staff:

- Understanding behaviours of children.
- Attentional and motivational problems in learning processes.
- Hyperactivity and poor emotional development.
- Children’s withdrawal and mistrust in relationships and problems in adaptation.
- Compliance with daily structure and rules.
- Communication problems/missing words to express or cope with emotions.

Because the impact of trauma is held in a child’s internal world and their **adaptive behaviour has allowed them to survive**, it is often difficult to say with certainty whether behaviour has its roots in trauma or not. What is important is that children’s **holistic needs**, including their histories, patterns and strengths are **assessed and considered by a supportive social network**, in which adults are warm, caring and



21. SOS Children’s Villages International (2019). Analysis of training needs of caregivers and professionals regarding trauma of children. Internal document.

curious. Unless these behaviours are recognized as adaptive responses, children may be formally labelled with **inaccurate psychiatric diagnoses, which** can, in turn, lead to inappropriate drug or behavioural interventions. Attention deficit hyper-activity disorder (ADHD) or attention deficit disorder (ADD) is a case in point. It is commonly used to describe children who have experienced considerable complex trauma. Children can also be informally labelled as “troublesome,” “attention-seeking,” “manipulative” or “delinquent.” Such labels, whether formal or informal, can prevent the development of **effective relational responses that build on children’s resilience.**

Blaustein and Kinniburgh (2010)<sup>22</sup> looked at the **development of how well children develop in terms of their ability to make positive social relationships** and demonstrated how its progress can be disrupted and have a cumulative impact:

- **Pre-natally**, maternal trauma experiences can have a significant impact on fetal development. The developing child can be adversely affected if the mother is exposed to extreme or continuing stress, or if they use substances like drugs or alcohol.
- **In early infancy**, babies are utterly dependent on their primary caregivers for their survival and require regular practical loving care to feel safe and learn to trust. They form attachments and begin to recognize feelings in themselves and others in a sensory way. If their needs are unmet because of traumatic events, children’s experiences can feel unpredictable and dangerous.
- **In early childhood**, children strive to become more independent, and through play, they try out new things and learn to cooperate with others. Becoming more assertive, they begin to develop a sense of purpose and realize that others may not approve of some actions. They need patience, encouragement, guidance and boundaries to develop and test out skills. If these needs are unmet through trauma, and they already have mistrust in the world, they may develop strong feelings of shame.
- **In later childhood**, children want to learn new skills, particularly in educational settings. Their expanding social network allows them to know their abilities and compare them with others and to develop a sense of pride and more rational ways of thinking. Trauma, at this stage, can disrupt this growing sense of competency and can lead to poor self-esteem and a sense of inferiority.
- **In adolescence**, young people experience the second most rapid period of development. Their higher mental functions have the possibility of considerable expansion. They begin to experiment with their self-identities. However, if they have experienced trauma earlier in their lives, their self-identity can be very confused and their previously adaptive survival strategies may become unhelpful and expose them to greater risks and harms as adult supervision decreases.



22. Blaustein, M. E., & Kinniburgh, K. J. (2010). Treating traumatic stress in children and adolescents. New York, NY: The Guilford Press.

Children in alternative care are often described as having a developmental age that is different to their chronological age. While this may accurately describe the level of a child's maturity in comparison to their peers, it is suggested that this is an unhelpful way of describing children's needs, and may provoke feelings of shame and undermine a sense of agency. It is perhaps more compassionate to talk of adaptive behaviours that have served them well in the past, but which now need further adaptation in new settings and for future challenges.

Particular attention should also be given to the needs of children who have a disability, as Miller and Brown<sup>23</sup> indicate that they are **more likely to experience abuse than their able-bodied peers**. This experience of abuse may also be **compounded by additional traumas** that can include prematurity at birth, painful medical interventions, extended times away from their primary caregiver(s) etc. In addition, children with disabilities may also have the experience of being judged by their disability rather than their potential. Attitudes are changing, but in some countries, children with disabilities are over-represented in institutional care and may be seen, because of discrimination and a lack of supportive services, as a burden on their families, communities and society. It is important for those with responsibility for children to consider if the behaviour of children with disabilities may be about early childhood trauma and not their disability.



#### Points to consider:

Think about a child you are currently looking after or working with who has experienced trauma. With a particular focus on their psychosocial needs (and using the information above):

- What do you know about their very early childhood? How well do you think their early psychosocial needs were met by their parent(s) or another attachment figure?
- In what ways might the child's early trauma experiences show up in their thoughts, feelings and actions now?
- If you were to describe this child to another person, how could you use your knowledge about complex trauma to "re-frame" how you might speak about his or her history and current issues of concern?

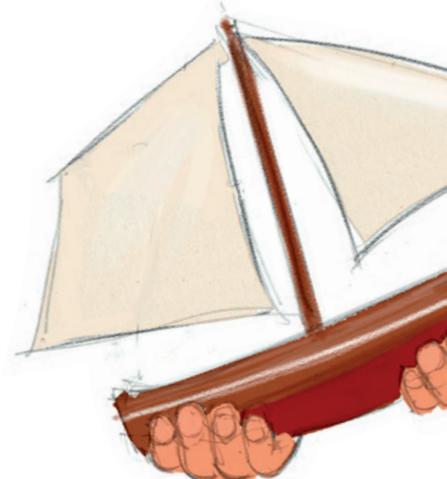
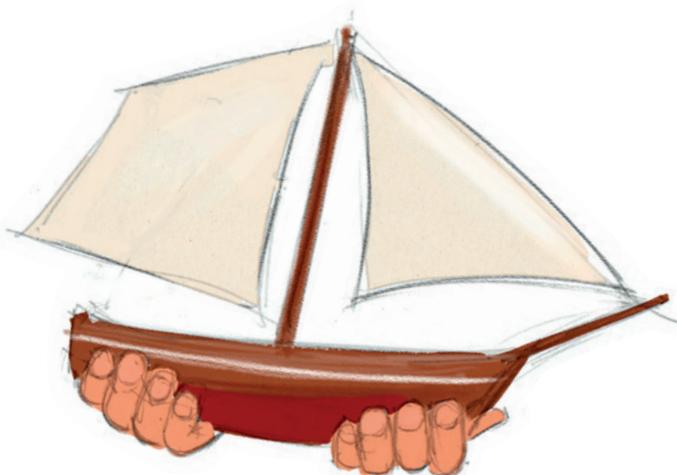
23. Miller, D. and Brown, J. (2014). 'We have the right to be safe': protecting disabled children from abuse <https://www.nspcc.org.uk/globalassets/documents/research-reports/right-safe-disabled-children-abuse-report.pdf>.

**Comment:**

For disabled children in alternative care, their trauma experiences may have arisen from multiple sources i.e. because of acts of commission/omission carried out by people in positions of trust from repeated, intrusive medical procedures, fleeing war etc. Do we routinely factor in this consideration when interpreting their behaviour or carrying out intimate personal care? Equally, when a teenager, who is physically strong, may physically act out, do we consider if their behaviour may have been triggered by a trauma “memory?” If their behaviour is seen as a potentially adaptive strategy subconsciously developed in response to trauma instead of “violence,” it would lead to different approaches to their support and care. Yet sadly, many children and adults with learning difficulties are medicated, kept in isolation because their behaviour is primarily interpreted as violent or aggressive. How often do we try to see beyond the disability and into the heart of the behaviour, which may be about trauma?

### 5.5 Showing compassion for parents

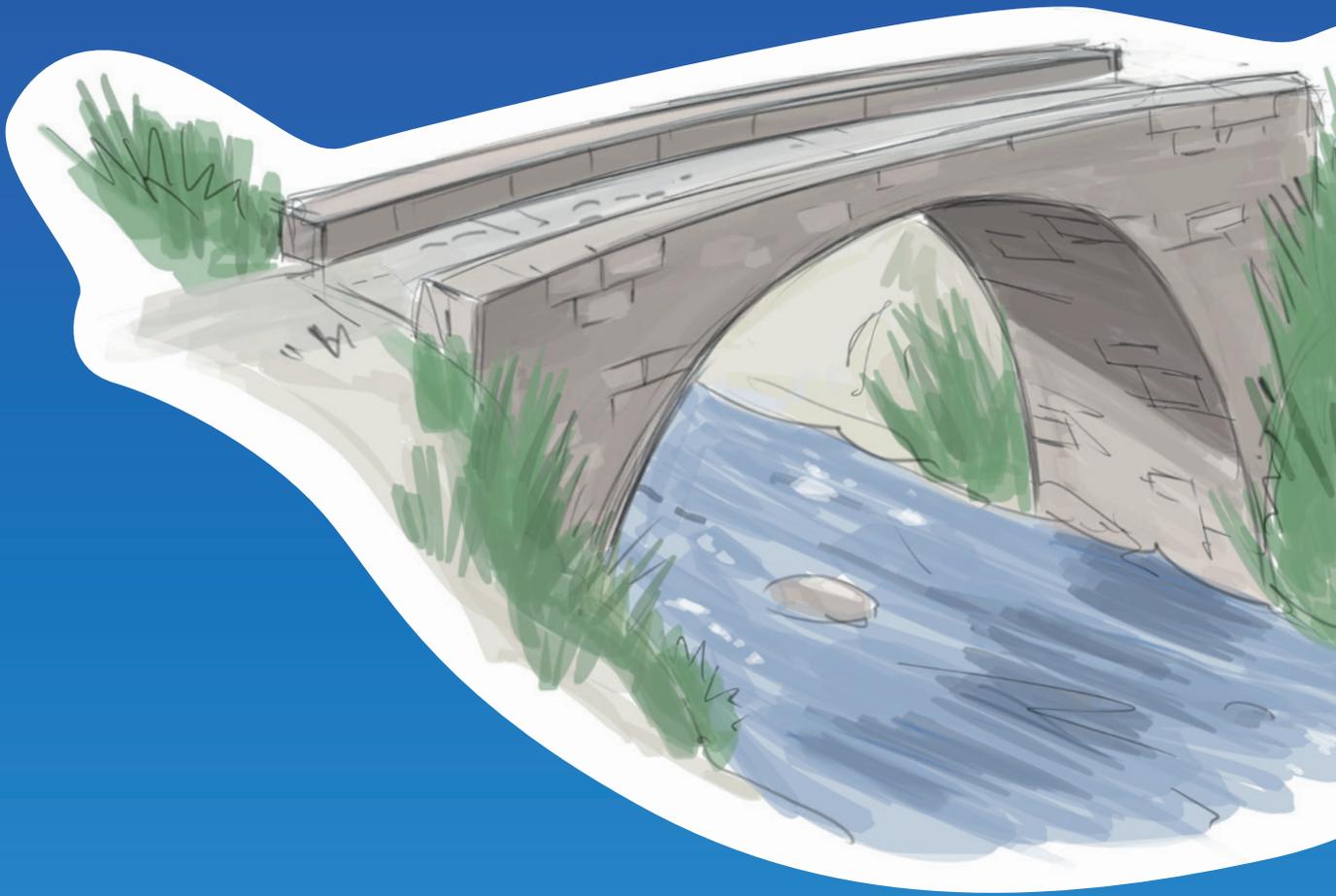
Before concluding this chapter, it is important to acknowledge that in considering the pain that children may experience as a result of their trauma histories, we need to be careful that we do not “slip into” unhelpful thoughts or descriptors about parents and families of origin. Not only is this unhelpful for how a child perceives themselves, their birth family, and the culture from which they have come, but it also potentially perpetuates feelings of shame, blame and punishment in a group of adults, many of whom will be carrying the burdens of both unresolved childhood and adult trauma. We therefore need to bring our trauma-informed knowledge and compassion to the ways we understand, assess and talk about what has prevented parents from providing safe, nurturing and predictable care for their children.



### Keep in mind

- Complex trauma is substantially different to other forms of trauma because it takes place in relationships that should be sources of trust and protection. When the source of trauma is rooted in a child's main attachment relationship, it can lead to feelings of terror, powerlessness and overwhelm.
- Due to our fundamental need as humans for connection and safety with others, children can experience trauma as a result of acts of commission and acts of omission. The impact of the absence of consistent, nurturing care can be significant:
  - It can trigger feelings of rejection, abandonment and shame and can cause the child to think of themselves as unloveable and worthless.
  - It can affect the child's developmental capacities to self-soothe, control impulses, focus attention, problem-solve etc.
- Complex trauma also requires our attention because it occurs at a time when we are developing or "becoming." We are in a process of shaping our sense of identity and personality, exploring our world and discovering who we are and where we belong. The impacts of trauma can, therefore, be profound, which underlines even more why early intervention and trauma-informed approaches are of such importance.
- Understanding complex trauma through a child developmental lens is an essential part of becoming trauma-informed. Not only does it place us in a better position to understand how trauma can de-rail children's development, but it also guides us as to what children need to get back on track in their developmental journey.
- By developing a compassionate curiosity about how trauma shows up in the thoughts, feelings, behaviour and physical health of children, we can begin to re-frame how we describe adaptive survival strategies and develop more effective ways of working with children.
- In our work with children who have experienced trauma, we need to be mindful that we extend a similar compassionate understanding to the experiences of many of their parents, who may also be carrying considerable unresolved trauma from their pasts. We therefore need to be alert to how our own thoughts, feelings and actions can trigger, inadvertently, feelings of blame, shame and punishment in parents.







## CHAPTER 6



**What young  
people, and  
those who care  
for and work  
with them,  
told us**

# CHAPTER 6

## WHAT YOUNG PEOPLE, AND THOSE WHO CARE FOR AND WORK WITH THEM, TOLD US

### INTRODUCTION

This section will focus on some broad themes arising out of the scoping exercise undertaken with young people, professionals and caregivers in the six participating countries of this project. It is not an attempt to represent the full findings of this report but rather to highlight some of the general themes that emerged. To gain a more detailed understanding of the remit and process of the scoping exercise, please refer to the Scoping Report that will be made available alongside this practice guidance.

### 6.1 The scoping exercise outline and some caveats

Alongside the substantial evidence base that exists around trauma, the project also sought to gain input from young people with care experience (often referred to as “lived experience”) and from those who care for and work with children in alternative care (often referred to as “practice wisdom”). A scoping exercise was therefore undertaken with these two groups through the national project teams of the six participating countries (Belgium, Bulgaria, Croatia, Greece, Hungary and Serbia). Shaped by what was possible given the sensitivity of the subject matter, the geographical spread of participating countries, and operating in the context of the COVID 19 pandemic (which restricted movement and face-to-face meetings), the chosen methodologies were:

- **Online questionnaires** for young people with care experience, professionals and caregivers.
- **A desk review**, undertaken by partners in participating countries using a variety of methods to gather broader information about how trauma is understood and put into practice in children’s social care services and systems.

In total 234 individuals contributed their opinions via the questionnaires: 89 young people and 143 professionals/caregivers respectively. The young people were aged between 18-32 years of age, hence the use of the term “young people” rather than “children.”

**Two important things to bear in mind** in relation to the findings from the scoping exercise:

- Those who responded are **not a representative sample** and therefore cannot be said to reflect in any way the situation in any partner country as a whole. Their responses, nevertheless, provide important information about their individual experiences.

- **Professional respondents are not reflective of those who care for or work with children in alternative care** (e.g. around 23% were psychologists/ psychotherapists, while only 15% were residential care workers / house parents).

## 6.2 What young people told us helped them

Although this section will focus on the various ways in which practice could be improved, it is worth noting that, in general, **most young people were positive about their overall experiences of alternative care**, reporting that they had had:

- A consistent adult in their lives throughout their care journey.
- Support to understand and manage their emotions.
- Encouragement to engage in hobbies and interests.
- A sensitive response from at least one schoolteacher.

However, there is a **consistent 20-30% of young people who indicate that their individual experience of alternative care was not so positive**.

Young people suggested that the **best ways that professionals and caregivers can help a child to feel loved and accepted** were to:

- Recognize and accept individuality e.g. know what makes individual children feel happy, support their personal hobbies and interests etc.
- Treat children equally while also being able to respond to them as individuals.
- Build relationships e.g. allowing the child time and space to adapt, understand and accept their background, adopting a friendly and informal approach, spending time together and doing shared activities.
- Demonstrate, through their attitudes and behaviours, a love for their job that goes beyond the financial rewards and which shows a genuine interest in a young person. Be supportive, encouraging and respectful of the children through their manners and the language they use.

One young person stated, “Care professionals always give us all their love and they act as if we are their own children, so the children feel loved there and we don’t lack for anything.”

Some respondents recognized the potential sensitivity and complexity around discussions of “love” in care settings. One young person commented, “There’s a bit of a taboo on that word in this context and I regret that enormously. It seems important to me that children and adolescents learn how adults can love you in a correct and safe way. [...] someone who stands up for you and honestly tells you what they think about something [...] Being celebrated and challenged to keep giving the best of yourself is also part of that.”

When asked to reflect on **how young people in alternative care can be supported**, the most prominent theme was the importance of talking. However that “talking” must be in the context of established, trusting relationships with adult caregivers who know the young person well, can relate to them respectfully, and who are able to be their authentic selves.

Young people were clear **that adults who blamed or shamed young people for expressing difficult feelings through their behaviour were not best placed to help young people recover from their trauma.** When asked about how children could be helped to understand the reasons for being in alternative care, young people again referred to the **qualities of how professionals and caregivers related to them. They should be:**

- Truthful and honest.
- Sensitive, understanding and gentle.
- Responsive to the individual young person's questions, level of interest, and level of understanding.

They were however clear that any discussions or explanations should **fit with the child's needs and wishes**, that assumptions should not be made and that there should be an emphasis on helping the child to understand that the situation is not their fault. Some young people noted that professionals did not always have time and attention for the child, a supportive relationship, or the necessary skills and attitudes for this support to take place in the most appropriate way.

Young people **adopt a range of self-care methods** to help themselves reduce feelings of worry, fear, anxiety, or stress. Connecting through conversation with a range of friends, caregivers and professionals helped, as did keeping active and busy through sport/physical activity, being creative, studying or spending time with friends. Other young people acknowledged that they repressed these feelings, or became withdrawn or isolated.

When asked what caregivers/professionals can do to help when children feel worried, scared, anxious, or distressed about something, **young people again emphasized the importance of a good relationship between the adult and child.** Adults need to know the child well enough to recognize what prompts these feelings for that individual child, and what their behaviours are communicating about their feelings. It was suggested that talking and healthy discussion should be routine and proactive and should not only occur when problems arise. **Young people recognized that solutions might not always be possible, but that children will still benefit from talking with a non-judgmental listener.** Respondents also highlighted the importance of adults showing their own feelings and modelling how to manage difficult feelings.

Young people were specifically asked about **how adults could be helped to better understand and respond to the distress behind a child's behaviour.** Answers again drew on the importance of relationships and talking in a sensitive and empathetic way in order to help the child explore the causes of the behaviour and working together to find ways to help. One young person commented "...by not avoiding the themes that the youngsters struggle with. Such matters cannot be tackled only at times when things get difficult, but rather should be discussed before, so that at the moment of crying or anger, a social worker already has sufficient insight into what works for that young person. Keep asking questions is the message."

More broadly, respondents felt that **adults needed education and continuous learning to understand children and their emotions and behaviours better.**

Suggested approaches for this included seminars, training, and reading. One respondent highlighted the importance of adults in this type of work feeling motivated to learn, and to make things better for the children in their care.

In relation to **actions “when something goes wrong,”** again the pattern of responses was similar to previous questions, emphasizing the:

- Need to discuss, identify problems, work together to find solutions.
- Importance of an accepting and supportive, calm and understanding atmosphere.
- Ability to access help when it is needed e.g. from psychologists.

Finally, young people with care experience gave **advice about what the training and other materials developed in the context of this project should include.** They could equally apply to things to which organizations, professionals and caregivers should pay particular attention. Themes that emerged were:

- Trauma: what is it, how it happens, how to prevent and address it.
- Children's behaviour and what underpins it; supporting children's mental health; avoiding behaviour management approaches e.g. violence, punishment without explanation and isolation.
- Using real-life stories and examples, hearing from individuals with care experience, including positive stories to show that young people with care experience “are neither strange nor shameful.”
- How to show or build acceptance, understanding, empathy, love, trust, feelings of safety and security.
- Treating children and their families individually and not making assumptions or taking actions, which might make things worse.
- Collaboration with other professionals.
- Developing young people's self-confidence, independence, resilience, talents and interests.
- Family support and keeping families together.
- Recruiting caregivers and professionals who see their role as not “just a job” and/ or who have personal experience and understanding of what it means to have experienced care.

One young person stated that what caregivers and professionals need to show is: “Humanity – this job should really be done with love. This is what we as children need more than anything else in moments of weakness.”

### 6.3 What those who care for and work with children told us

This section will focus more on the collective themes arising out of the questionnaires and desk review responses. It is perhaps noteworthy that **responses to questions about individual knowledge and practice were more positive than views expressed about wider practice and the functioning of the broader child care system.** This could be reflective of the skills and knowledge levels of those who had access to and completed the questionnaires in the available timeframe.

In broad terms, findings suggest that, overall, there is a **very variable understanding about trauma in general, but particularly in relation to children.** Respondents indicated that there was **little consensus across professional disciplines** and no agreed definitions of how trauma could be understood. Even where the term does appear in policy or legislation, people commented that this was often without a deep-shared understanding of what it means. While some people did indicate that some professionals would have an understanding of attachment theory, more broadly, knowledge on trauma as a whole was described as basic, superficial and narrow. One person commented “...the behavior children display remains unrecognized as one resulting from trauma.”

While respondents suggested that trauma might show up differently in children than it does in adults, **children’s distress is often not understood within a trauma-based frame of reference.** One person stated “...we speak about development delay or a psychological problem or it is treated as a manifestation of a mental health issue. But it is never interpreted as a result of a trauma.” Another person indicated that, “For those who do not know enough about trauma, there is a belief that children are very resilient and that they are able, only on the basis of separation from the family or change of accommodation, to forget the traumatic experience and that it will not manifest itself in further development. This type of understanding is especially widespread when we talk about very young children.”

Some **individual cases of good practice were noted** but these were often accompanied with comments about trauma only being discussed in specific or the “most severe” cases. One person commented that, “Some professionals [in one area] have implemented trauma-sensitive practices for children and sometimes their parents as well in their organizations. However, in most organizations trauma is not discussed for every child as part of their planning/decision-making or it is not discussed at all; the main reason for this is that an expert on trauma would be needed to implement new practices. Children are still often diagnosed with multiple disorders but not ACEs or trauma (often the root cause).”

Given these responses, it is not surprising that **respondents also noted that the impact of trauma very rarely appears in child care planning, policy or decision-making.** Some responses suggested that due to children’s high level of need, but the corresponding lack of appropriate resources, decisions are often influenced by political considerations as well as a lack of understanding. Taking a wider systems understanding

of trauma, one person suggested that, "...if the child welfare system could recognize and address the traumatization of the parents – that could prevent the ongoing circle of traumatization within the families that causes so much harm to the children."

This **perception of a low level of understanding about trauma is not peculiar to the participating countries and is reflected in the literature as a whole.** Respondents proposed a variety of explanations that underlie this reality: explanations that touch upon interrelated aspects of child care systems. They can be grouped as follows:

**a) Gaps in university/professional education**

Many respondents commented that trauma as a subject does appear in some undergraduate/professional qualifications, but that this is not always the case. Where present, it can be covered in general or theoretical ways, omitting to make connections to real-life applications and children's behaviour.

**b) Limited access to continuing professional development for caregivers and professionals**

Many respondents highlighted that access to continuing professional development can be very limited due to cost, availability, levels of expertise and access to information in national languages. In addition, courses may be limited to particular professional groupings (psychologist was mentioned) or may only happen through personal research and financing.

**c) Issues with implementation**

Some respondents noted that training can be superficial and is often not translated into practice. One person also reiterated that training by itself can have only partial affect when they noted "...training for foster parents does not provide enough [skills] to prepare them to make considerate decision and to provide care with attention to needs of the children. The goodwill and loving environment is not enough without professional assistance and knowledge. Without these, this burden should not be placed on the foster parents."

**d) Trauma and its impact is viewed through a diagnostic lens**

Responses indicated that trauma is broadly understood in diagnostic "disorder" terms such as attention deficit hyper-activity disorder (ADHD), post-traumatic stress disorder (PTSD), and conduct disorder etc. With a focus on "symptoms," discussion around wider causes does not take place. Some responses highlighted a concern about increasing uses of medication rather than other approaches, the age of children being diagnosed and the focus of treatment at the most severe end of difficulty. Many comments indicated long waiting lists for assessment and therapeutic treatments.

**e) Recruitment and status of those who provide direct care to children**

While some responses noted good standards of understanding and training in some alternative care settings, the prevailing view was this was not the case universally. Responses noted issues in recruitment, preparation processes, educational qualifications, status, pay standards and high turnover.

**f) Routine data collection and publication**

Very few responses indicated that data around trauma events or exposure levels

within participating countries was routinely collected or published. Where data collection does exist, it was described as basic, not timely and partial. Professionals and caregivers are therefore operating in an information vacuum in relation to the issues their services are dealing with. One respondent suggested that due to anxiety and fear about centrally collected data, there is a need for more open discussion around language and how trauma is understood, in order for researchers to develop more unified and comparable measures.

**g) Sporadic multidisciplinary or integrated practice**

Responses indicate integrated or multi-disciplinary practices for children in alternative care are partial and only happen occasionally. Some suggested that even where legal requirements exist around joint working, this does not always happen in practice. While a formal exchange of information may take place, this rarely leads to real cooperation and common thinking between partners. Possible barriers to multi-disciplinary approaches were identified as professional confidentiality, professional status and a concern that, "...professionals only cooperate with others, when they are in trouble. Professionals should communicate with each other and cooperate as early as possible, and not only when they feel paralyzed to act alone."

**Keep in mind**

- Young people's individual responses to the care they received was largely positive. However, there is a consistent 20-30% of young people who indicate that their individual experience of alternative care was not so positive.
- The young people who responded placed considerable emphasis on adults building trusting relationships with them as the basis for providing care that was loving and respectful and was the means by which sensitive subjects could be addressed.
- Young people's responses placed a high value on caregivers' and professionals' personal qualities that promoted safe and trusting relationships. Young people need to feel that those who care for them do so with complete commitment and see their role as "more than just a job."
- The caregivers and professionals who responded to the scoping exercise largely indicated high levels of personal knowledge about trauma and its impact but suggested that this was not replicated across the system as a whole. Here, there was little consensus around definitions of trauma across disciplines and only irregular practice around joint working.
- Respondents suggested a number of systemic issues that provided some explanations as to why trauma and its impact does not play a central role in our understanding of the needs of children in alternative care. These ranged from gaps in university/professional education, barriers to continuing professional development, implementation issues of embedding learning in practice, the predominance of diagnostic understandings etc.
- The Scoping Report provides a fuller, more detailed analysis of the scoping exercise undertaken with young people, caregivers and professionals.





## CHAPTER 7



# Trauma- informed practice in everyday care

# CHAPTER 7

## TRAUMA-INFORMED PRACTICE IN EVERYDAY CARE

“Show tenderness and affection through their actions. Show their love every moment, because even a small gesture plays a major role.”  
(Quote from young person, scoping exercise, 2020)

### INTRODUCTION

This section will look at ways in which those who care for or work with children in alternative care settings can use their daily interactions and relational skills to contribute to children’s recovery from trauma experiences. It will focus specifically on components of trauma-informed practice that promote psychosocial well-being and will provide suggestions as to how everyday care can be used to build on children’s resilience and strengths.

### 7.1 Components of trauma-informed practice

There are many different models of trauma-informed practice, some of which focus on professional practice while others adopt a wider organizational, strategic approach. While the substance of this chapter will focus on the former, it is important to note that advocates of trauma-informed approaches stress their importance, as they are a means of:

- Highlighting that trauma is **everyone’s business**, irrespective of their role.
- **Removing barriers** to children accessing the care they need rather than suggesting that everyone has to be a “trauma expert” or be concerned with “treating trauma”.
- **Reducing the likelihood of trauma occurring in the first place.**
- **Being able to talk openly about issues that have been taboo and that cause unnecessary feelings of shame.**
- Acknowledging that those affected by trauma **are the least likely to seek or receive help** due to issues of trust and being hurt in relationships.
- Ensuring that each encounter is an **opportunity to reverse the negative association between trauma and relationships.**
- Helping those who have experienced trauma to make-meaning of that experience so they can move on with their lives.
- Providing support for caregivers so that they are enabled to be attuned, nurturing and safe in their care for children.

- Asking organizations to develop a **strong knowledge-base** so that services do not **inadvertently re-traumatize those whom they serve**.

Applying a trauma-informed lens to the provision of alternative care requires reflection upon the wider series of processes, procedures, policies and systems that **influence the quality and standards of care that children receive**. Here, attention needs to be given to the **range of activities at municipal and national government levels** that either **helps or hinders those immediately caring for children** to provide what children need. Examples of this activity includes:

- Care planning processes and procedures.
- The resourcing and availability of alternative care provision.
- How alternative caregivers are recruited, assessed, supported and reviewed.
- Legal processes.
- How professional disciplines operate within care systems and cooperate with other sectors etc.

Often, amongst other things, approaches that look at change in isolation, funding variations and differing professional outlooks and procedures etc. result in state care systems that have a tendency to become **highly bureaucratic and fragmented**. In so doing, **systems may, inadvertently, create barriers to access and/or re-traumatize children** who have already experienced significant loss and upheaval in their lives. It is important, therefore, that organizations at local and state levels consider:

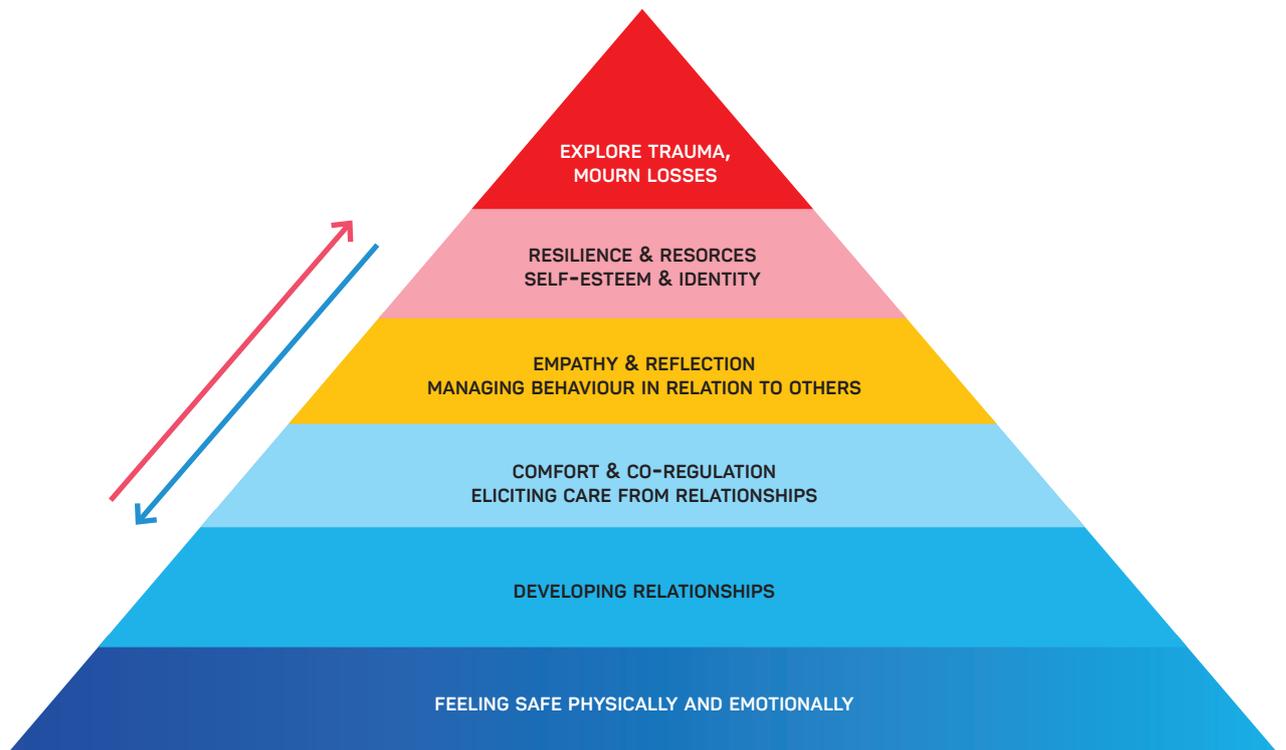
- To what extent are the systems and procedures surrounding the care of children trauma-informed?
- To what extent do systems and procedures facilitate the provision of holistic, comprehensive assessments and service provision for children who need alternative care?

## 7.2 Putting theory into practice

Having looked at some of the components of trauma-informed practice, we will now look at some practical examples of how to implement trauma-informed approaches. (These will be explored in more depth in the accompanying training element of this project.) For some people, these examples may not be new, but what we invite you to do is to **bring a psychosocial lens** to consider how everyday care can contribute to trauma recovery. Most of what is suggested is **not about addressing trauma “head-on,”** but focuses on how **relationships can be used to build trust and security** so that, in time, children **may** feel more able to directly address their trauma histories.

A useful framework for understanding and assessing the needs of children is that provided by **Kim Golding**, an English developmental psychologist, who bases much of her work within the **dyadic developmental psychotherapy (DDP) model**. DDP is a model that specifically seeks to enable children who have experienced relational trauma to benefit from new relational experiences. While we will return to Golding's

assessment guide at the end of this chapter, it is worth noting here how her “**Pyramid of Need**”<sup>24</sup> (Figure 11) reminds us of the elements of relational care that require particular attention. Golding reiterates the view that **in the absence of safety, it is difficult to reach those parts of ourselves that allow us to build connections and understanding with others**. Further, the pyramid is hierarchical which means that although children will not necessarily progress upwards in a clear linear fashion, **they require their needs for physical and emotional safety to be met at the lower levels before they can begin to access the higher levels**.



**FIGURE 11**  
K. GOLDING (2015) PYRAMID OF NEED (ADAPTED)

For children who live in alternative care settings, we suggest it is helpful to:

- Use the **power of relationships to promote healing**.
- Have **aspirations** that children will not just recover from trauma, but will have joyful lives and take up their place in their community and society.
- Help children to **make meaning** out of their experiences so that they challenge ideas of self-blame and recognize their strengths.
- Assist children to **become more attuned to their physical and emotional**



24. Kim Golding (2015) Meeting the therapeutic needs of traumatized children, [published online] <https://kimsgolding.co.uk/resources/models/meeting-the-therapeutic-needs-of-traumatized-children/>

**feelings and bodily reactions.**

- Create **physical environments** where children can feel safe and thrive.
- Develop practice based on **empathy, respect, perseverance and building resilience.**

Drawing on the learning in Chapter 6, what follows are some of the key **building blocks of how attachment** relationships are formed and a secure base is established. Although we have described these separately, they are all interrelated and complement one another.

**a. The power of “you”**

The single most important aspect which needs to be in place to support a child's recovery is receiving **care from a person who is warm, loving, attuned and predictable.** Many tools exist to help structure interactions with children, but unless they are used within the **context of a close and nurturing relationship**, where the child feels safe, listened to, and contained, the **tools will not be effective.** Those who care for or work with children should **use their whole personalities and creativity** to spark and engage children's natural curiosities and “meet them with delight.” Using **humour and playfulness and expressing joy should not be forgotten when working with children.**

Of equal importance for those who care for or work with children is the ability for **“reflective functioning,” which means that they are able to:**

1. Identify and acknowledge their own histories, feelings and mental states that they bring to their role, and
2. Notice what is evoked in them as a response to what has happened to the child and the child's behaviour.

Relationships are by their nature two-sided, and so it is important that those who care for or work with children be assisted in their own emotional regulation through **regular, supportive supervision/reflective space as well as through training and coaching.**

**b. Being “attuned” and using “mentalizing” to build trust**

In the previous chapter, the concept of “mentalizing” was introduced as a vital ingredient in developing Peter Fonagy's notion of “epistemic trust.” Being able to understand one's own mental states and to understand and respond to the mental states of others provides the **foundational ability to form healthy relationships and to operate successfully in the wider social environment.**

In practice, adopting a “mentalizing stance” is about making a “best guess” about the mental state of the other person. Misreading a child's cues is not only common, but can also be helpful in two important ways:

1. You are demonstrating to the child that you **may not “know”** what is going on in their head but that you are curious to find out, and

2. The act of showing interest in the child tells them that **their internal world matters and, importantly, it matters to you.**

**Marking the point where understanding has been reached is also important,** as it emphasizes to the child that you have a better sense of them and what drives them. Adopting this approach frequently with the child and role modelling this with colleagues will help to demonstrate care and interest and build trust.

Over time, you can **encourage the child to develop a “mentalizing stance.”** Firstly, they can practice with “guessing” what is in your mind or, if they are having difficulty working out what is going on in a situation, encourage them to work out what might be happening by thinking about the thoughts, desires or beliefs of others involved. Do not just tell them a possible solution: help them uncover this for themselves. As mentalizing develops, this becomes more and more sophisticated. We can make guesses about what other people think about our thoughts, beliefs and motives. By helping a child to “mentalize” you are offering them a better chance to read social situations and relationships accurately.



### CASE VIGNETTE ON MENTALIZING

Theo is a twelve-year-old boy who has been living with his foster family for six months. He was born with cerebral palsy and is a wheelchair user. He was also severely neglected as a child, before being taken into care at the age of two. One day, Theo returns from school very angry and upset. His foster father asks him what's wrong and he shouts that his best friend, Andrei, didn't play with him at lunchtime and that no one likes him or wants to be friends with him. Recognizing Theo's distress, his foster father follows him to his room, bringing Theo's favourite drink. He listens in an interested way while Theo shouts angrily that his foster father "just doesn't get it." His foster father recognizes the hurt that Theo is experiencing. He notices how Theo has quickly moved to a way of thinking that reflects a negative sense of self. After a few moments of listening, his foster father says, "I can see you're really upset about this. I'm wondering if Andrei had something else to do at lunchtime. Maybe he had to see his teacher. Theo says that his friend didn't need to see anyone else, because he saw him with Mika. His foster father says, "OK I didn't get that. Perhaps Andrei had to make arrangements about the football game they are both playing in tomorrow?" Theo says no, that isn't it either, and breaks down crying. After a while of comforting Theo, his foster father says, "Ah, I wonder if you felt worried that Andrei no longer wants to be your friend?" Theo wasn't able to respond with words, but cuddled a bit closer to his foster father. After a few moments, his foster father says, "I can see why you might have felt annoyed and perhaps a little bit hurt. Sometimes, we can all feel a bit lonely when our friends have other plans that we don't know about. But I know that Andrei really likes you and enjoys coming around to our house to play. Why don't you ask him to come over on Saturday?" After a while, Theo comes round to this suggestion, and agrees to invite Andrei tomorrow. Wanting to provide further reassurance and provide a feeling of safety, Theo's foster father invites him to help prepare dinner that he knows Theo loves and then for the two of them to watch their favourite TV show together.

### c. Helping children to develop a sense of "felt security"

Routines and rituals play an important role in alternative care and provide an important backdrop in which children can develop a sense of "felt security" and belonging. Routines enhance predictability, which in turn provides safety. Meal times, bed-time routines, food shopping or film nights provide **opportunities for those who care for children to demonstrate "love," "interest" and "nurture" and see how these are received and responded to by children.** They also provide everyday opportunities in which children can **test out relational skills.** Predictable, repeated actions allow children to develop **patterns of familiarity** that can be used in other social situations.

Over time, children can begin to feel a **“sense of place” that is special and unique to them** and to which they can return in times of difficulty. Routines can assist to **free children’s minds, brains and bodies** to explore their wider world, safe in the knowledge that they have a secure base to which they can return. Examples that help to nurture a sense of safety include:

- Paying close attention to how children are introduced to the care setting and are helped to **feel welcomed** on their first visits/day.
- Developing routines around great food. **Food has significant social and symbolic meaning** beyond physical nourishment. Children should be involved in creating these meanings and rituals, which provide them with options to show kindness and care to others.
- Providing privacy. Children should be enabled to **develop a sense of personal privacy** and safety for their personal possessions. If they have to share bedroom space with others, think about how this is managed to provide as much personal space as possible. It is also helpful to create expectations about time spent together, personal time and time spent on social media.
- **Develop good endings.** Clear messages and active invites that children can always return (e.g. for celebrations, weekly meals, to do their laundry or for over-night stays) will not only assist the child who is moving on, but also sends a message to remaining children about how they are loved.

#### **d. Holding in mind: A key feature of “felt security”**

The “out-of-sight” but not “out-of-mind” idea is also known as **“holding children in mind.”** It can convey powerful messages of felt security to children. It tells them that even though you may not always be present, you are with them in spirit. For children who have experienced trauma, this can act as something that **soothes in times of stress.** This is about small **symbolic acts that** indicate that the child matters to you. Examples need to be age-appropriate and could include:

- Making a key ring for them that has a photo of a special time.
- Putting a surprise note of affection, praise, or reassurance in a book or lunch-box.
- Sending a post-card if you are away on holiday.
- Using phrases like “...I was thinking about you yesterday when...”
- Recalling something to the child that they might have told you last week.
- Ensuring there are lots of photos and mementos in the living space so the child knows they have a presence even when they are not bodily present.

### e. Reciprocity

An additional means of building attunement is **reciprocity**. The concept of reciprocity is usually used to describe the process of communication between a baby and their parent. It can however be applied to child-caregiver relationships of any age and indeed to other relationships more generally. Reciprocity is essentially **a process of mutual adaptation** in which caregiver and child come to know one another and learn to read the other's signals.

Reciprocal relationships not only develop social competencies but also often occur in times of joy. Reciprocity **signals predictability, responsiveness and safety**. In addition, as the child is an active partner in these exchanges, they grow and experience a sense of agency or mastery. As both parties in the relationship are unique, **this “dance” is built over time and for mutual benefit**.

An alternative way of describing “reciprocity” in relationships has been developed by the Centre for the Developing Child<sup>25</sup>, which describes this exchange as **“serve and return” (like a game of tennis). Focusing on interactions with children who are pre-verbal, it likens the “dance” between the child and their caregiver that helps build a child's skills as follows:**

1. Notice the “serve” (what the child has shown interest in) and share the child's focus of attention.
2. Return the serve by paying attention to and taking delight in what the child is showing interest in.
3. Give what the child is interested in a name.
4. Take turns and wait to see what else the child next pays attention to, keeping the interaction going back and forth.
5. Practice beginnings and endings to these “serve and return” interactions.



25. Centre for the Developing Child (2019). Introduction to serve and return <https://developingchild.harvard.edu/science/key-concepts/serve-and-return/>.

### CASE VIGNETTE ON RECIPROCITY USING “SERVE AND RETURN” WITH AN OLDER CHILD

Jana was a fifteen-year-old girl who was quiet and kept to herself. Her time in the home was limited to sleeping, eating and staying in her room. She wasn't viewed as troublesome in the home, but she avoided staff. She rarely said much and any responses to questions were brief and limited on detail. Over time, a staff member called Ben developed a connection with Jana, consciously using “serve and return.” He noticed that Jana loved pizza and often sought this out (the serve). He suggested making a pizza from scratch and asked Jana where they might find a recipe for a pizza and encouraged her to find this (the return). When she found a recipe, he asked her if she'd like to help him buy the ingredients and put the pizza together (naming). In the kitchen, Ben created an environment where Jana could take control of the process. When she read out aspects of the recipe, he responded to her and encouraged further interaction by asking open questions. He chatted to her gently, asking if she knew the best flour for pizza or where the tomatoes came from, and he shared a few things about his own favourite foods (keeping it going). When she didn't want to continue her input, he was sensitive to this, allowing her to end the interactions on her own terms. Over time, Ben created other opportunities around Jana's interest in food, during which he encouraged her to take the lead and to practice this reciprocal skill in relationship building (practice beginnings and endings).

#### f. Promoting emotional regulation

As has been established, emotional regulation (the ability to soothe yourself in times of arousal or distress) is **not an innate skill** humans are born with, but is **a capacity that is developed through early attachment relationships** and becomes more sophisticated over time. In alternative care, it is developed in the context of **stable environments and consistent relationships with reliable caregivers who soothe and model co-regulation**. In these environments, children are assisted to manage immediate emotions and develop long-term self-control.

The fundamental prerequisite for assisting children to develop self-regulation is the **presence of a well-regulated adult(s)**. Children take their cues from the attachment figures in their lives and place importance on the views and beliefs of those who are important to them. This **connection cannot be presumed** in relationships, even in birth relationships. It is a trust that is **earned and worked at consistently**. In settings where there is more than one caregiver, it is important that those caring for children **are consistent in approach, while recognizing difference in styles**. How the adults relate to one another and how they relate to the children will all influence how children respond and will establish “expectations” within the caring environment. The calmer and more peaceful the home setting, the less likely it is that children who have experienced trauma will be triggered by environmental stressors i.e. a psychological stimulus that prompts recall of a previous **traumatic** experience.

One way in which staff and caregivers can promote regulation, is to **talk about their own emotions in general everyday ways**. Reading stories together, using television programmes or films are great ways of encouraging **emotional dialogue but with distance**. **Sharing learning** with children is also a powerful way of normalizing emotional conversation. Using concepts like the “window of tolerance” (as discussed in Chapter 4 of this practice guidance) can **give children a language to express what is going on in their mind**. Sharing this knowledge with others in the child’s caring network also helps to bring consistency and opens avenues for the child to seek help where they choose.

In calmer periods, and in the spirit of supporting them to be active in their own recovery, consideration should be given as to how a child can be assisted to **not only notice triggers but also to develop skills that bring a sense of healing and self-regulation in their minds and bodies**. Through guidance and coaching from attachment figures, children should be **offered opportunities to try out a range of techniques** to identify what might be effective and comfortable for them to use. Techniques to explore include:

- Breathing exercises.
- Self-massage or safe-massage techniques.
- Mindfulness practices.
- Storytelling.
- Tai chi, yoga or other exercises that pay attention to body relaxation.
- Music that allows us to explore or change mood.
- Communal singing that brings connection and attunement to others.
- Percussion, walking, dance or sports activity that involves repetitive beats and rhythm.

Those who care for and work with children can also develop a series of age-appropriate **games and exercises that specifically look at identifying and talking about emotions**. **Appendix 3** provides some examples of the types of fun things you could try or suggest a child might try to help them regulate or promote self-care.

### **g. Helping a child come back to regulation**

When a child becomes dysregulated, it is important for caregivers and staff to **focus on the emotions driving the behaviour rather than the behaviour itself**. The child may be focusing almost entirely on the perceived threat and the need for safety and **may not be fully in control** of how they are behaving. In these circumstances, the immediate goal is not to get the child to explain what has happened nor to punish. Rather the **immediate goal is to de-escalate the situation**. To do this, caregivers and staff can practice “**containment**,” a theory adapted from the work of a psychoanalyst, Wilfred Bion, in which the adult demonstrates their **willingness to acknowledge strong emotions and to reflect them back to the child in a managed, calm way**. An example of dialogue may go something like “... I can see that what has happened has

made you really angry and upset and I hear that you're not happy with me right now. I want us to take a minute, to calm things down and then we'll look at what has upset you and find a way of sorting it out." In this way, you are **acknowledging the child's distress, naming feelings** and indicating that whatever has been said has **not been taken personally** by you. **Children need to hear this "repair" coming quickly after the "rupture" has occurred.**

Caregivers and staff can also draw on the work of Porges when he talks of offering children **"cues of safety"** that include:

- Presenting a warm and unthreatening posture.
- Using soft facial expressions and a soothing tone of voice.
- Sitting beside a child, without direct eye contact, which can feel less threatening or intense.
- Using supportive silence to allow the child reach some balance and time to gather their thoughts.
- When the stress has abated, using a reflective or "mentalizing stance" to explore the child's interpretation of events and a sense of moving forwards.



**Watch + consider:**

Making use of non-verbal cues of safety is important for all children, but particularly so when working with children who have learning or sensory disabilities. Techniques such as intensive interaction are helpful in building relationships, trust and communicative intent with children who have communication difficulties.

This short clip demonstrates the non-verbal cues of safety and use of intensive interaction for children with learning disabilities. How could you apply this in your care of children?

*Encouraging interaction (3) – Leyla - Nasenonline – 27th July 2014*  
<https://www.youtube.com/watch?v=enJtHkIBGC8>

## **h. Making meaning**

As was noted in Chapter 5, one of the psychosocial impacts of trauma is that it can promote an internalized sense of **"disintegration" in relation to feelings, experiences and thoughts**. When considering how making-meaning can address feelings of disintegration, the Institute of Recovery from Childhood Trauma comments that:

"...when an adult holds a child in mind and helps them to **put their experiences into words**, the brain can integrate. As we tell ourselves the story of the life we are living,

our minds shape our brains. Trusted adults can help the child to create this healing narrative out of the experiences of everyday life.”<sup>26</sup>

One way in which “making-meaning” can occur arises out of **opportunistic and unplanned** conversations that may arise in the course of daily life. These are likely to be **indirect conversations** about trauma that are not specific to a child’s individual circumstances. **Sharing your knowledge from this guidance and elsewhere** in a calm and reassuring manner will demonstrate that **trauma is not a “taboo” subject**. General messages to draw upon could include:

- Trauma experiences are common.
- They often occur in childhood.
- Children are never responsible or to blame for any trauma experience.
- How people respond to trauma is unique to the individual and is an adaptive, often unconscious, response that has helped the person survive.
- There is more to people than their trauma experiences.

Children with trauma histories may be **highly attuned** to how questions or conversations are dealt with and indeed **may be “testing out the water”** to see how the topic is handled by you. Even if you suspect, or indeed know, that it is the child’s actual experience that lies beneath the conversation, it is very important that you do not try to rush the child into “a disclosure” but **allow the child to dictate the pace**. The **two possible exceptions to this general rule** would be:

- a) If the child has prompted indirect discussions around trauma on a number of occasions, you may form the impression that they may be trying to prompt you to ask them directly if something like this has ever happened to them. If this is the case, you should talk with a manager/supervisor, so you are able to plan how you might sensitively open up the conversation.
- b) If there is suspicion that any abuse is currently happening, the organization’s child safeguarding procedures should be followed.

The more formal and planned way of helping a child make meaning of their trauma histories/care journeys is through **life story work**. Life story work is essentially a way of telling stories: stories that help a child understand their past, how the past has shaped their present, but how their past does not have to define their future. Life story work can take many forms and variations depending on the age of the child, how settled they are, what information is accessible, whether additional resources can be put into acquiring new information, who information is gathered from, how information is shared etc. Ideally, life story work should arise out of children’s natural curiosity about their background, when they begin to ask a lot of “why” questions. Together, the child and their primary caregiver(s), who is able to “contain” children’s



26. Institute of Recovery from Childhood Trauma - <https://irct.org.uk/>.

responses, whatever they are, should use the information they have to create a narrative about the child's life to date. Alternatively, more intensive life story work can be initiated if a child is very unsettled and/or has experienced a number of placement moves. Here the additional purpose of life story work is to externalize the confusion, pain and misapprehensions a child might be carrying about their trauma histories and care journeys.



#### Watch + consider:

Richard Rose is one of the UK's leading thinkers and practitioners around therapeutic life story work. Although this video clip is quite long (1.03 hours), it is a good overview of the issues involved and how he approaches this work. What ideas might be transferable to your setting? *Therapeutic Life Story Work - Sharing Lives/Sharing Stories* - CELCIS - 16th December 2019

<https://www.youtube.com/watch?v=LNNZpeduLOQ>

### i. Fostering wider connection and building strengths

As noted in Chapter 5, one of the greatest impacts of trauma in childhood is that it can create for the child an **internal sense of disconnection or difference** from their peers and others around them. Children who live in alternative care have the additional burden of experiencing **repeated relationship losses and of being uprooted from their original communities and school environments**. It is vital, therefore, that children are enabled to **develop links and a sense of place in their local environments**. Lev Vygotsky, a Russian psychologist operating in the early 20<sup>th</sup> century, created the useful concept of "**scaffolding**" to indicate how, with help and guidance from nurturing adults, children can be supported to learn new sets of skills and knowledge that they would not be able to manage on their own. For children who have experienced trauma it may take additional time to gain confidence and trust, but the importance of building **on strengths and capacities** cannot be underestimated. Robbie Gilligan, Professor of Social Work and Social Policy at Trinity College, Dublin, Ireland, when looking at what builds resilience, has stressed the importance of **helping children to nurture early talents and interests outside of the care environment**. Not only does this allow children to build new stories about themselves, but it also provides a vehicle through which they can **express their identity through meaningful activity and through their own endeavour**.<sup>27</sup> Approaches such as experiential learning and outdoor pedagogy work on these principles.



27. Gilligan, R. (1999). Enhancing the resilience of children and young people in public care by mentoring their talents and interests. *Child and family social work*, 4, 187-196.

Echoing the principles laid out in Chapter 2, one final way for children to build talents and capacities is through **meaningful participation**. Good trauma-informed practice is grounded in child rights, and all children, in line with their evolving capacities, have the right to participate in things that are important to them. Those caring for or working with children with trauma histories should open themselves to listening to and learning from children's insights and expertise that adults may not identify or prioritize. Children's participation should not merely be tokenistic. Rather, it should be seen as an obligation for which adults, at all levels, are accountable. In order to support children in their trauma recovery journey, **we should move away from a perception of children as "objects of intervention" to subjects with the right, capacity and willingness to influence their own lives**. Ensuring that children have opportunities to play a leading role in their own lives, including being partners in decision-making about their recovery, will improve their sense of agency and empower them for the future.

#### j. Assessing and reporting on children's needs

For those who care for or work with children in alternative care settings, observational skills and being attuned to our own responses are crucial means of helping us see beyond the presenting behaviour and to understand **what children are communicating to us beneath words**. To do this, we need to notice **how children respond**, to **listen with intent** and to **be curious** about what behaviour is signalling to us. Children's actions may be a means of helping them make sense of adversity and trauma as well as protecting them from connecting to painful "memories."

We have already referred above to the need to ensure that children are active participants in any assessments or reporting that involve them, but it is also worth re-iterating here that we need to be mindful of the language that we use to describe children's experiences. **Trauma is something that a child has experienced or has happened to them: it is not something that should define them**. Labels like "oppositional," "defiant" or "conduct disorder," "attention-seeking," "manipulative," "delinquent" or "promiscuous" are deeply unhelpful and shaming and imply something fixed about the child's character. **Alternative language** could include:

- "Challenging behaviour" being described as "distressed" or "dysregulated" behaviour.
- Language that reflects notions of "damage", "fixed", "irreversible" and "deterministic" thinking need to be replaced with knowledge of "neuroplasticity" and offers of "hope" and "opportunities for change and growth."
- Labels used in psychiatric disorders could be re-framed as "adaptations," "signs of resilience," and "tools of survival."

If our roles require us to undertake routine or regular recordings about children's lives, it can sometimes be useful to "frame" any record as if we were addressing the child directly. This can be helpful for a number of reasons:

- It ensures that we have the child to the forefront of our mind when we are writing about them.
- It may help us to be more sensitive in our use of language when writing about incidents or events that concern them.
- Children who live in alternative care may access their records at some stage in their lives. For many, it can prove to be an important, or in some cases, the only “keeper of their memories.” It is vital therefore that any records are written from a place of compassion and understanding.

It can help to make it clear to a child that records are kept and to support them to add to the records themselves. Within a trusting relationship, a co-produced record can be very helpful for a child and can reinforce that what matters to them, matters to you.



**Points to consider:**

A good exercise is to put yourself in the child’s shoes when recording anything about them and to try to read it back from their perspective. Will they see themselves in what you have written or understand any jargon you have used? Have you noted their wishes, feelings and views? Have you shown that you are trying to understand what is going on for the child (“I’m worried that you may be feeling isolated”), or what might be having an impact on them (“I wonder if the comments you received before you lost your temper, reminded you of how you were treated when you were a young child?”)? Look at a recent recording or report you have written about a child. What changes could you make to ensure that your piece is more trauma-informed?

The frameworks we use to assess children’s needs are also critical as to how we represent children’s experiences and lives. Not only can these influence how children think about themselves, they also shape their individual and collective narratives in a host of external processes and systems that exert considerable power over children’s lives e.g. legal processes, education provision, societal perceptions etc. It is crucial, therefore, that we use frameworks that are both trauma-informed and developmental in their orientation so that children’s stories are relayed with sensitivity and compassion.

Examples of such frameworks include:

1. Kim Golding’s assessment matrix (see (1), **Appendix 3**).
2. Margaret Blaustein and Kristine Kinniburgh’s Attachment, Regulation and Competency approach that seeks to work through children’s caring networks (see **Appendix 4**).
3. AMBIT – a framework based on mentalization, developed by staff at the Anna Freud National Centre for Children and Families and specifically developed to work with people who have multiple needs (see no. 11, **Appendix 2**).



### Points to consider:

While assessment of the child is very important when carrying out trauma-informed planning, it is also important to critically examine your care setting as well, in order to gauge its readiness to implement trauma-informed practices. Using the template in **Appendix 3**, think about what your care setting does well and what it needs to work on in order to provide care in a trauma-informed way.

### k) Sustaining children's relationships with their families of origin

As the preceding information has indicated, many children who live in alternative care settings may have **complicated thoughts and emotions about their families of origin**. (While this may primarily focus on relationships with their parent(s), it can also include relationships with grandparents, siblings etc.) These thoughts and feelings are likely to be conflicted, intense, confused, and painful and may change over time. As the scoping study indicated, some children recognize that experiences and relationships were unsafe and see alternative care as providing them with stability, love and opportunity. For others, living in alternative care creates a void, or a sense of loss in their lives that never really goes away.

From experience, we also know that many children who live in alternative care eventually return to their families of origin when any legal orders are removed or they reach an age when their state authorities are no longer obliged to provide accommodation for them. In addition, in an increasing social media age, we know that some children are independently establishing contact with family members, without the knowledge of those who care for or work with children in alternative care settings. For all these reasons, it is important that the care provided in alternative care settings actively acknowledges and addresses children's relationships with their families of origin. (This is distinct from life-story work.) How, when, who and with whom this work occurs will depend on many variables but is likely to be an issue that needs some thought, will be dynamic i.e. will change, and may require specialist therapeutic support.

Alongside the healing or relational repair work that needs to be facilitated for children in alternative care, generally, where it is safe to do so and depending on the wishes of the child, alternative care settings should support regular contact between children and members of their families of origin. This should be done to ensure that children do not experience further disconnection and loss in their lives. Contact can take many forms (direct/indirect, face-to-face, by phone, email, text, sending letters/photos/drawings etc.) and can occur at varying rates of frequency. What is important is that arrangements are:

- Planned to ensure predictability, as far as is possible e.g. checking with the parent on the day of contact that they can still fulfil the arrangement.
- Clear, so that everyone's expectations are managed.

- Built into the routines and rhythms of a child's life.
- Supported, so that a sense of coherence and integration is embedded in a child's relational support network.
- Managed, so that children's experiences of contact are positive and are not a source of additional stress in their lives.

### Keep in mind

- Trauma-informed practice is a relatively new concept, but much of what underpins its content draws from an established evidence base. Depending on the width or depth of change that trauma-informed approaches seek to influence, their aims can include one or more of the following:
  - Reducing the likelihood of trauma occurring in the first place.
  - Helping people who have experienced trauma to make meaning of that experience and to positively move on with their lives.
  - Ensuring that service responses actively prevent re-traumatization.
- Adults who care for or work with children who have experienced trauma can contribute to children's recovery through building safe, predictable and trusting relationships that pay attention to the psychosocial components of "attachment" that underpin all of children's development.
- The "rupture and repair cycle" and taking a "mentalizing stance" can help those in a caring role to take a position of curiosity in relation to understanding the mental states of children. Not knowing and not always feeling the need to get things "right", can "free up" adults to work alongside children rather than feel the need to "fix" them.
- Trauma-informed practice can be applied at all levels of the various systems that surround the care of children who live in alternative care settings. While much of this chapter focuses on what adults can do through every-day care, we should also pay attention to the assessments we make, how we work with families of origin, the support that is provided to those adults who care for children on a daily basis etc. Unless each of these elements become trauma-informed, there is a risk that the quality of children's alternative care experiences may be reduced.
- Many tools exist to help structure interactions with children, however, they will count for nothing unless they are used within the context of a trusting relationship in which the adult delights in the child's presence and is able to offer a sense of safety and containment.





## CHAPTER 8



# Caring for caregivers: Sustaining good practice in alternative care

# CHAPTER 8

## CARING FOR CAREGIVERS: SUSTAINING GOOD PRACTICE IN ALTERNATIVE CARE

“A key element is the open dialogue and the effort to cover the legitimate needs of the first-line professionals regarding their training, their remuneration and their development perspective [...] because they provide a great amount of their professional expertise, as well as many aspects of themselves, which are not valued, and because they do not set a limitation to what they offer. On the contrary, they give their lives, often at a personal cost and with personal exposure.”

*(Quote from professional, scoping exercise, 2020)*

### INTRODUCTION

This section will be looking at the impact that children's trauma can have on those who care for and work with them. It will explore the potential impact of trauma on those who provide direct care as well as those who have more indirect roles, managing or coordinating care. We will then consider some ways in which we can improve support for adults in these positions.

### 8.1 The impact of trauma on those who care for and work with children

Caring for and working with children who have experienced trauma is difficult and requires a **high degree of personal commitment and connection** to build and sustain relationships. Use of self is the key tool for helping children on the path to recovery, and so this type of work can become **personally draining, and, at times overwhelming**. Adults who engage empathetically with children may begin to be affected by what they are hearing, may be unable to meet the demands placed on their emotional resources and/or may feel unable to make a connection with the child in their care. As has been noted earlier in the practice guidance, relationships are two-way connections that rely on trust and reciprocity to allow them to flourish.

In the literature, adults who begin to feel overwhelmed as a result of their connection with trauma are variously described as experiencing **vicarious or secondary trauma**, which, depending on their role in caring for or working with children, can lead to **burnout, compassion fatigue or blocked care**. Blocked care, often used in the context of fostering and adoption, occurs when prolonged stress reduces an

adult's capacity to sustain loving and empathic feelings towards their child. This is an instinctive, protective response to children's trauma, which, as has been noted in previous chapters, can show itself in fearful, distressed and dysregulated behaviours. Where blocked care arises, caregivers tend to become reactive: responding to the child's behaviour rather than to their mental states i.e. their thoughts, beliefs, desires, intentions etc. In these scenarios, caregivers' attention can begin to focus on the "negative" and, if not given sufficient attention, can lead to placement breakdowns.

Sandra Bloom (2003)<sup>28</sup> from her work with adult survivors of sexual assault reminds us that our responses to trauma are based on a variety of factors that may **make us vulnerable** to the possibilities of experiencing vicarious or secondary trauma:

- Personal past history of unresolved trauma.
- Overwork.
- Ignoring healthy boundaries.
- Taking on too much.
- Lack of experience in trauma work.
- Dealing with large numbers of traumatized children.

## 8.2 Particular issues for those who provide direct care

Ottaway & Selwyn in their 2016 study of compassion fatigue and foster caregivers<sup>29</sup> recognized that while there are common elements experienced by both professionals (social workers) and foster caregivers, they identified three factors that suggest that **foster caregivers may be impacted differently**. They noted:

- The lack of opportunity for foster caregivers to carve out **physical and emotional space to reflect or re-energize**.
- **High levels of stress, from which it is difficult to get a break**, as children are cared for in the place where caregivers and their families reside.
- Foster caregivers may **experience greater isolation** as the complexities of children's trauma histories can affect their social life.

Depending on the way that foster care is organized in a country, caregivers' resources may also become depleted, as they have to adjust to the needs of new children on a regular basis.

Despite the fact that the study identified that compassion fatigue could be **severe and negatively impact** caregivers' mental and physical well-being, the quality of



28. Bloom, S. L. (2003). Caring for the Caregiver: Avoiding and Treating Vicarious Traumatization. (in press) In *Sexual Assault, Victimization Across the Lifespan*, edited by A. Giardino, E. Datner and J. Asher. Maryland Heights, MO: GW Medical Publishing (pp. 459-470).

29. Ottaway, H., & Selwyn, J. (2016). No-one told us it was going to be like this: compassion fatigue and foster caregivers. Fostering Attachments Ltd.

care provided to children and the stability and continuity of placements etc., **foster caregivers rarely experienced support that could alleviate its effects**. In general, it was reported that foster caregivers did not feel that the professionals supporting them had the **appropriate knowledge and understanding of issues**, which only served to deepen compassion fatigue.

The authors identify a number of recommendations from their research to **improve the level and quality of support that should be available as a matter of course for those in direct caring roles**. They include:

- Openly acknowledging the possibilities of compassion fatigue.
- Creating safe spaces for caregivers to process the child's and their own trauma without the threat of judgement or sanction.
- Recognizing that foster caregivers have expertise and in-depth knowledge of the children for whom they care.
- Offering a range of support - individually and in groups, peer support, professional support and supervision.
- Recognizing the efforts made by foster caregivers.
- Offering support to wider family members also.
- Re-thinking the notion of "respite" so that caregivers are offered "time out" on a flexible basis and in a child-centred way.

### 8.3 Particular issues for those with indirect care responsibilities

Adults who may not work with children on a daily basis but who see them regularly and who have responsibility for managing or coordinating their care can also experience vicarious or secondary trauma. Here, trauma can arise for a variety of reasons, which can then be exacerbated by working environments. Examples can include becoming overwhelmed by children's experience, being drawn into complex and chaotic family circumstances, being triggered by unresolved trauma, feelings of failure, the burden of decision-making, the pace and volume of work-loads etc. Common signs of vicarious or secondary trauma in these circumstances can include:

- Experiencing lingering strong emotions of anger, rage and sadness about the child's traumatic experiences.
- Becoming overly emotional when talking about or managing day-to-day care.
- Difficulty in maintaining boundaries and becoming preoccupied by children's experiences.
- Questioning capability and capacity to undertake tasks.
- Loss of hope or an increase in pessimism or cynicism.
- Distancing, numbing, detachment or avoiding situations.
- Creating "busy-ness" as a means of avoidance.

Echoing suggested improvements noted above, the impacts of vicarious or secondary trauma could be prevented or mitigated at a number of interrelated levels. Examples include:

- **On a personal level**, adults can be supported to: acknowledge and address their own trauma experiences; practice self-compassion and engage in relaxing and self-soothing activities that help maintain a sense of balance; pay attention to early signs of stress; develop healthy routines on physical activity, food, sleep etc.; build a network of family and friendship support.
- **Professional training** should explore values, expand trauma knowledge, encourage reflection skills, allow learners space to address own trauma experiences.
- **Professional environments** should provide routine support and supervision, opportunities for connections with colleagues, professional learning and development, realistic expectations of caseloads, mentoring for newly qualified workers; ensure annual leave is taken and safe working schedules; ensure counselling/therapy services are available.

#### 8.4 Developing trauma-informed organizational responses

Trauma-informed practice goes beyond individuals taking responsibility for their own care or trying to make connections with peers and colleagues for mutual support and reflection. Trauma-informed practice needs to be built into systems, policies and procedures so that it becomes “business as usual” and not an additional “add-on” that some individuals attempt to adopt. As the recent national review of the care system in Scotland noted:

“The workforce needs support, time and care to develop and maintain relationships. Scotland must hold the hands of those who hold the hand of the child.”<sup>30</sup>

As part of this project, a blueprint to help organizations to think about what actions can be taken to promote trauma-informed practice will be produced. In relation to how we care for the caregivers, some key points to which we need to pay particular attention are:

- We need to acknowledge that vicarious or secondary trauma exists and adopt practices that actively seek to mitigate its impact.
- As well as its personal impact on those who care for and work with children, we need to view vicarious trauma as a mechanism through which re-traumatization of children can occur. Seen through this lens, addressing vicarious trauma becomes a significant priority.
- We need to build practices e.g. multi-disciplinary working, routine supervision/ reflection space, opportunities for peer connection etc. that actively respond to



30. The Promise, Independent Care Review, Scotland 2020, page 20.

the complex nature of trauma and that promotes cohesion and learning, and challenges shaming and blaming attitudes.

- Organizations need to develop strong feedback loops between frontline caregivers/workers and senior managers so that the reality of issues arising out of children's experiences drive organizational decision-making.



**Points to consider:**

Thinking back on a child's placement that ended in an unplanned way, use the following information to re-assess if features of "blocked care" could have been a factor in how the placement ended?

Did you observe or get a sense from the caregiver of:

- Defensiveness or guardedness to protect against rejection?
- A chronic sense of overwhelm or being deflated?
- Meeting the child's practical needs, but being unable to reflect upon the potential meaning behind their behaviour?
- The child/caregiver relationship being quite "stuck" with the caregiver unable to consistently keep an open or curious mind?
- Indicators of stress in their wider family?
- Losing connection with their social network?
- Not being able to avail of the support or advice that was on offer?
- An inability to access feelings of compassion or nurture for the child followed by feelings of guilt?

Knowing what you now know about vicarious trauma, how might you respond differently if a similar situation arose in the future?

### Keep in mind

- When we consider the potential significant impact that trauma can have on children's lives, it is unrealistic to assume that those in caring positions will be able to meet children's needs with little or no therapeutic help. We need to acknowledge the existence of vicarious or secondary trauma and develop practice to mitigate or prevent its effects.
- Feelings of shame, blame and disconnection felt by children who experience trauma can have ripple effects in the networks of care that are created around them. It is not surprising that those who are closest to providing or coordinating children's care will have their own defence mechanisms triggered in an attempt to mitigate the impact of vicarious trauma.
- We need to listen to and act on the lived experience of those who care for and work with children so that the quality of care and decision-making about children's lives is of a consistently high standard.
- Learning & development practices need to move beyond isolated training events to more blended methods that also include routine coaching and feedback.
- We must develop multi-disciplinary practice that seeks to support those who are working directly with children or who have key responsibilities for managing or coordinating their care.







# Appendix

# APPENDIX 1

## GLOSSARY OF KEY TERMS

TERM / PHRASE	MEANING
<b>Acts of commission and omission</b>	Harmful, intrusive acts such as abuse (acts of commission), or the absence of safety and care (acts of omission, or neglect).
<b>Acute trauma</b>	Trauma that happens as a result of a single, one-off incident that is unexpected and causes considerable distress. E.g. a car accident, a terrorist incident.
<b>Adaptive behaviours</b>	Social, emotional and practical skills developed by a person in order to help them cope with or survive their trauma experience. These adaptive behaviours may be useful in the short-term but may create difficulties in the long-term.
<b>Adverse Childhood Experiences</b>	Adverse Childhood Experiences (ACEs) is another way of describing traumatic events experienced by children. They are defined as highly stressful events or situations that occur during childhood and/or adolescence. It can be a single event or incident, or prolonged threats to a child or young person's safety, security or bodily integrity. These experiences require significant social, emotional, neurobiological, psychological and behavioural adaptations to survive. (Reference: Young Minds, 2019)
<b>Alternative Care settings</b>	Those offering care provided in a family environment which has been ordered by a competent administrative body or judicial authority, and all care provided in a residential environment, including in private facilities, whether or not as a result of administrative or judicial measures.
<b>Attachment theory (John Bowlby)</b>	A theory which suggests that children's survival needs are met through the establishment of a secure-base through their relationship with the primary caregiver(s), which also serves as a foundation for children's exploration of the external world knowing that they can seek comfort and reassurance from their primary carers in times of distress.

<b>Attuned care</b>	The ability of caregivers to tune-into their child's emotions, desires, and interests, as well as recognise the child's 'sense of agency' to match their emotional states and attention and to respond to their child about mental and emotional states.
<b>Autonomic nervous system</b>	The body's nervous system that regulates bodily functions and interprets cues of protection and danger. This system is responsible for fight, flight and freeze responses.
<b>Blocked care</b>	Blocked care occurs when a protective response to children's trauma reduces a caregiver's capacity to sustain loving and empathetic feelings towards their child.
<b>Bronfenbrenner's ecological model</b>	A model of five key systems that influence children's development and opportunity. E.g. relationships with others, how services are organised, socio-economic conditions, etc.
<b>Burnout</b>	Burnout occurs when a person experiences high levels of stress for an extended time, resulting in exhaustion and negative impacts on the psychological wellbeing and health of a worker.
<b>Children</b>	Children are identified in the UN Convention on the Rights of the Child as, 'every human being below the age of 18 years unless under the law applicable to the child, majority is attained earlier'. WHO define young people as aged between 10 to 24 years old. However, for ease of reading in this practice guidance, we use the word "children" as shorthand for all children, as well as young people and young adults aged 0-24 years, who live or have lived in alternative care settings.
<b>Clinical diagnostic categories</b>	Ways in which clinicians organize how they think about different types of mental ill health. Two different systems are used: DSM-5 (USA) and ICD-10 (World Health Organization).
<b>Compassion fatigue</b>	Compassion fatigue occurs when care givers suffer from physical and mental exhaustion and emotional withdrawal due to being overwhelmed by caring for children with a history of trauma over an extended period of time.
<b>Complex trauma</b>	Trauma that happens as a result of repeated and prolonged traumatic experiences, particularly in the context of relationships during the developmental years. E.g. being exposed to domestic violence, neglect, sexual abuse.

<b>Containment (Wilfred Bion)</b>	The practice in which caregivers demonstrate their willingness to acknowledge the strong emotions of a child or young adult, and reflect them back to them in a managed, calm way.
<b>Co-regulation</b>	The mutual regulation of emotions between a child and caregiver. This pattern of consistent and repetitive care, in which the parent notices the baby's emotional state and reflects it back through tone of voice, facial expression, touch and gesture, helps the child, over time, to learn that emotional states are temporary, have names and can be managed.
<b>Cortisol</b>	One of the hormones that we produce to help our body to function e.g. regulation of our immune response. It also has a very important role in helping the body respond to stress.
<b>Cues of safety</b>	Signs perceived subconsciously by a child's autonomic nervous system, which determine they are in a safe environment. E.g. warm and unthreatening posture, soft facial expressions and a soothing tone of voice.
<b>Developmental trauma</b>	A term that is sometimes used instead of 'complex trauma'. Developmental trauma is chronic and repeated, occurs during childhood and happens in the context of a child's relationships.
<b>Disintegration</b>	Disconnection between a child's feelings, experiences and thoughts.
<b>Dorsal vagus</b>	The part of the autonomic nervous system that is responsible for the 'freeze' response.
<b>Dyadic Developmental Psychotherapy (DDP) model</b>	A model that seeks to enable children who have experienced relational trauma to benefit from new relational experiences.
<b>Ecological</b>	Understanding that multiple things influence children's development e.g. relationship with others, things that affect them in their environment etc.
<b>Emotional regulation</b>	The ability of a person to have control of their own emotional state.

<b>Epigenetics</b>	The study of changes in our bodies caused by how our genes are read or expressed, rather than alteration to our genetic code.
<b>Epistemic trust</b>	Trust that is developed through children's earliest attachment relationships and which helps children to understand that problems can be managed through connection with others, in a social context.
<b>Fight, flight and freeze responses</b>	The body's automatic protection responses that occur when a person is faced with a perceived threat.
<b>Holistic approach</b>	A holistic approach means to provide support that looks at the whole person, not just one particular aspect of a person. The support should consider their physical, emotional, social and spiritual wellbeing as well as wider environments.
<b>Hyper-aroused state</b>	A state of heightened and intensified feelings, experience of excessive energy and activation resulting in limited abilities to problem-solve and draw on strategies for self-soothing.
<b>Hypo-aroused state</b>	A state of feeling exhausted, depressed and disconnected and experiencing emotions as blunted.
<b>Intergenerational trauma, historical trauma or ancestral trauma</b>	Trauma that exists across generations and can be experienced on an individual level and in a community context. Trauma can be passed on genetically, through behaviours and through unresolved discrimination.
<b>Interpersonal power</b>	The power of one individual 'over' another. E.g. the power to look after/not look after or protect someone, to abandon or leave them, to give/withdraw/withhold love.
<b>Life story work</b>	A psycho-social method which helps children to bring information about their past together with their thoughts, feelings and memories to create new understandings and narratives about their life to date and hopes for the future.
<b>Limbic system</b>	A set of structures in the brain that deal with emotions and memory. It is the part of the brain involved in our behavioural and emotional responses, especially when it comes to behaviours we need for survival.
<b>Meaning-making</b>	The process of how people understand and make sense of their life events, relationships, etc.

<b>Mentalizing</b>	This concept states that a primary caregiver's abilities to accurately reflect back their children's true thoughts, beliefs, desires, intentions etc. helps the children to organise their mental states, understand others as well as create a sense of trust and belonging.
<b>Mind-mindedness</b>	A practical application of attuned care in which the caregiver sees the child as an individual with their own thoughts, feeling and desires.
<b>Mitigate/mitigation</b>	To attempt to make the impact of trauma less severe, serious or painful.
<b>Multiple domains</b>	Refers to the different areas of children's development e.g. physical, emotional, cognitive, sexual, spiritual etc.
<b>Neuroception</b>	A term created by Stephen Porges to describe the body's subconscious process of staying alert to cues of safety and danger.
<b>Neuroplasticity</b>	The brain's ability to create new neural pathways in response to new experiences.
<b>Polyvagal theory (Stephen Porges)</b>	A neurological explanation that emphasises the importance of the autonomic nervous system on how and why the body responds to threat.
<b>Protective relationships</b>	Nurturing and caring relationships that serve as a protective factor in the course of development of a child.
<b>Public health based approaches</b>	Way of understanding the health needs of people by looking not at individuals, but the health and overall wellness of the broader population.
<b>Pyramid of Need (Kim Golding)</b>	A hierarchical distinction of the elements of relational care that are needed to respond to trauma in children and young adults.
<b>Relational trauma</b>	Trauma that occurs within the context of a child's important relationships.

<b>Reparative relationships</b>	Nurturing and caring relationships that create new or reparative experiences for children who have been affected by early childhood trauma.
<b>Re-traumatization</b>	When a person re-experiences a previously traumatic event, either consciously or subconsciously.
<b>Rupture and repair cycle</b>	An important aspect of how caregivers build caring and regulating relationships with children.
<b>Scaffolding (Lev Vygotsky)</b>	The concept of how children, with help and guidance from nurturing adults, can be supported to learn new sets of skills and knowledge that they would not be able to manage on their own.
<b>Self-soothing</b>	Behaviour a person uses to regulate their emotional state by themselves.
<b>Sense of agency, or mastery</b>	A key task of a child's development that relates to a child's ability to see their actions as having meaning and value.
<b>Sequential development</b>	The way that the pathways and connections of the brain develop from the "lower" parts that mediate functions like breathing, heart rate and body temperature to the "higher" parts that mediate complex functions like language and abstract thinking.
<b>Splitting</b>	A survival strategy of the child to 'split' off painful memories, physical sensations and emotions into the subconscious so that they can continue to have their basic needs met.
<b>Sympathetic system</b>	The part of the autonomic nervous system that is responsible for 'fight' or 'flight' responses.
<b>Theory of latent vulnerability (Eamon McCrory)</b>	A theory that demonstrates how childhood abuse and maltreatment affects young people's representations of themselves and others and potentially lays the foundations for future vulnerability to mental-ill health.
<b>Those who care for or work with...</b>	Shorthand to describe a range of adults who either provide direct daily care of children in alternative care settings e.g. foster parents, residential staff, SOS parents etc. or who provide services for children and/or who have responsibility for managing or coordinating their care e.g. social workers, social pedagogues, psychologists etc.

---

<b>Trauma</b>	There are many ways to define trauma, but one of the most widely used definitions is, 'a single event, multiple events, or a set of circumstances that is experienced by an individual as physically and emotionally harmful or threatening and that has lasting adverse effects on the individual's physical, social and emotional wellbeing'. (Reference: SAMHSA, 2014)
<b>Trigger</b>	An unconscious sensation or stimulus e.g. a smell, a tone of voice, a feeling of shame or humiliation etc. that activates the person's trauma memory and significantly affects their emotional state, often causing extreme distress or overwhelm.
<b>Vagal brake</b>	The ability of the ventral vagus pathway to regulate the body's heartbeat and breathing, which enables the body to move from a state of stress to one of calmness.
<b>Ventral vagus pathway, or the social engagement system</b>	The part of the autonomic nervous system that guides our connections with others.
<b>Vicarious trauma, or secondary trauma</b>	Indirect trauma that occurs when a person is overwhelmed by another person's experiences of trauma.
<b>Window of tolerance (Dan Seigel)</b>	A metaphor illustrating how people manage stress in general but particularly in the context of trauma. This term can be also used to describe an optimal arousal level in which a person is able to function most effectively.

---

# APPENDIX 2

## SUGGESTED HELPFUL WEBSITES

This section gives details of some helpful websites containing resources and information, which may be helpful for you if you wish to explore some of the topics more fully.

1. [Centre of the Developing Child – Harvard University](https://developingchild.harvard.edu/)  
<https://developingchild.harvard.edu/>
2. [Anna Freud National Centre for Children & Families](https://www.annafreud.org/)  
<https://www.annafreud.org/>
3. [NHS Education for Scotland \(NES\)](https://www.nes.scot.nhs.uk/our-work/trauma-national-trauma-training-programme/)  
<https://www.nes.scot.nhs.uk/our-work/trauma-national-trauma-training-programme/>
4. [UK Trauma Council](https://uktraumacouncil.org/)  
<https://uktraumacouncil.org/>
5. [National Child Traumatic Stress Network](https://www.nctsn.org/)  
<https://www.nctsn.org/>
6. [Substance Abuse & Mental Health Services Administration](https://store.samhsa.gov/product/SAMHSA-s-Concept-of-Trauma-and-Guidance-for-a-Trauma-Informed-Approach/SMA14-4884?referer=from_search_result)  
[https://store.samhsa.gov/product/SAMHSA-s-Concept-of-Trauma-and-Guidance-for-a-Trauma-Informed-Approach/SMA14-4884?referer=from\\_search\\_result](https://store.samhsa.gov/product/SAMHSA-s-Concept-of-Trauma-and-Guidance-for-a-Trauma-Informed-Approach/SMA14-4884?referer=from_search_result)
7. [ACEs Connections – Limitations and misuses of ACE scores](https://www.acesconnection.com/resource/inside-the-ace-score-strengths-limitations-and-misapplications-with-dr-robert-anda-23-min-ace-interface?nc=1)  
<https://www.acesconnection.com/resource/inside-the-ace-score-strengths-limitations-and-misapplications-with-dr-robert-anda-23-min-ace-interface?nc=1>
8. [Dyadic Developmental Psychotherapy \(DDP\) Network \(UK\)](https://ddpnetwork.org/about-ddp/meant-pace/)  
<https://ddpnetwork.org/about-ddp/meant-pace/>
9. [Jigsaw – Young people’s health in mind \(Ireland\)](https://www.jigsaw.ie/)  
<https://www.jigsaw.ie/>
10. [Trauma Recovery Centre - Betsy de Thierry \(UK\)](https://www.trc-uk.org/)  
<https://www.trc-uk.org/>
11. [AMBIT – Theory and practices of mentalisation \(UK\)](https://manuals.annafreud.org/ambit/)  
<https://manuals.annafreud.org/ambit/>
12. [The Power, Threat, Meaning Framework – Lucy Johnstone \(Clinical Psychologist\) \(UK\)](https://www.youtube.com/watch?v=tkNWQdVB4F0) <https://www.youtube.com/watch?v=tkNWQdVB4F0>
13. [Independent Care Review, Scotland \(UK\)](https://www.caregiverreview.scot/)  
<https://www.caregiverreview.scot/>

# APPENDIX 3

## RESOURCES: IDEAS/TOOLS TO SPARK CONNECTION AND REGULATION

The following are suggestions that can be used by children or by those who care for and work them.

- a) [Mindfulness breathing exercise - NHS - Every Mind Matters](https://www.youtube.com/watch?v=wfDTp2GogaQ&app=desktop)  
<https://www.youtube.com/watch?v=wfDTp2GogaQ&app=desktop>
- b) [Mental health and self-care for young people - NHS - Every Mind Matters](https://www.nhs.uk/oneyou/every-mind-matters/youth-mental-health/)  
<https://www.nhs.uk/oneyou/every-mind-matters/youth-mental-health/>
- c) [Mindfulness practice - Professor Mark Williams - The Mental Health Foundation](https://www.mentalhealth.org.uk/podcasts-and-videos/mindfulness-10-minute-practice-exercise)  
<https://www.mentalhealth.org.uk/podcasts-and-videos/mindfulness-10-minute-practice-exercise>
- d) [Mindfulness Techniques for Children and Young People - Stan Godek](https://www.stangodek.com/order/)  
<https://www.stangodek.com/order/>
- e) [Self-care tools and ideas - Anna Freud National Centre for Children & Families](https://www.annafreud.org/on-my-mind/self-care/)  
<https://www.annafreud.org/on-my-mind/self-care/>
- f) ["I'm more than my mental health" - Anna Freud National Centre for Children & Families](https://youtu.be/-HGNmwao7m8)  
<https://youtu.be/-HGNmwao7m8>
- g) [Dance & song - young people's flash mob for NHS UK Mental Health Week 2014](https://youtu.be/Q3OFbq9IZCU)  
<https://youtu.be/Q3OFbq9IZCU>
- h) [Self-care materials - Anna Freud National Centre for Children & Families](https://www.annafreud.org/schools-and-colleges/resources/)  
<https://www.annafreud.org/schools-and-colleges/resources/>  
<https://www.annafreud.org/media/12101/final-selfcaresummer-secondary.pdf>  
<https://www.annafreud.org/media/12113/final-selfcaresummer-primary.pdf>
- i) [Multi-lingual guides to support communities who experience episodes of violence or face natural disasters - The Child Mind Institute](https://childmind.org/our-impact/trauma-response/guides/)  
<https://childmind.org/our-impact/trauma-response/guides/>
- j) [Papyrus - creating a hope box](https://www.papyrus-uk.org/wp-content/uploads/2018/09/Hope-box.pdf)  
<https://www.papyrus-uk.org/wp-content/uploads/2018/09/Hope-box.pdf>
- k) [Free ideas and tools to use with children of all ages - The Social Worker's Toolbox](http://www.socialworkerstoolbox.com/)  
<http://www.socialworkerstoolbox.com/>
- l) [Kim Golding's Pyramid of Need & Assessment Matrix](https://kimsgolding.co.uk/backend/wp-content/uploads/2016/02/Pyramid-plus-matrix.pdf)  
<https://kimsgolding.co.uk/backend/wp-content/uploads/2016/02/Pyramid-plus-matrix.pdf>

- m) Children talk about trauma experiences and tell how they got help and developed hope for the future  
<https://www.nspcc.org.uk/what-is-child-abuse/childrens-stories/>
- n) Creating a feelings box  
<https://www.lifelessonsforlittleones.com/feeling-box/>
- o) The importance of creating time-lines for children in alternative care  
<https://www.celcis.org/knowledge-bank/search-bank/blog/2017/02/children-can-easily-become-lost-system-timeline-can-help-you-see-them/>

#### **AN EXAMPLE OF CREATING A GAME TO “NAME FEELINGS”**

Naming feelings can be a big challenge to children affected by trauma. This game helps children to name feelings, recognize how the feelings affect their actions, how facial expressions connected to specific emotions differ, and encourages them to speak about their feelings. If adults play this game together with children, they can serve as role models for children in expressing emotions and coping with them. The ideal number of players is between 3-8, and they can be any age, as long as they are able to read or have someone to read to them.

**RESOURCES:** Paper and pen for each player

#### **HOW TO PLAY:**

1. Start by making a list of approximately 5-8 feelings (the number needs to be at least the same as the number of players). Some examples might be happy, angry, sad, surprised, amused/laughing, scared, confused, disgusted, in love. For the first time you can choose the more basic feelings, and add more difficult ones later. You can also leave the list of feelings on the table visible to all players to make it easier.
2. Write each feeling on a separate small piece of paper and fold the paper, so that nobody can read it. Mix the small pieces of folded paper on the table in front of the players or in a bowl.
3. Each player takes one folded paper, reads the feeling written on the paper and does not reveal it to other players. Then one by one clockwise, each participant explains the feeling on their card to other players without naming it. The other players have to guess the feeling. The way of explaining the feeling on the card differs in each round. After each round, fold the papers again, mix them and take new ones.

**ROUND 1 -** The players explain the feeling written on their card verbally without using the name of the feeling (e.g. If you feel like this, normally you scream and run away).

**ROUND 2 -** The players explain the feeling written on their card by acting it out and not using words (e.g. miming the facial expression or acting the behaviour that best represents the feeling).

**ROUND 3 -** The players explain the feeling written on their paper by drawing it on a blank piece of paper and showing it to the others in the game, and not using words (e.g. drawing an emoji or situation representing the feeling).

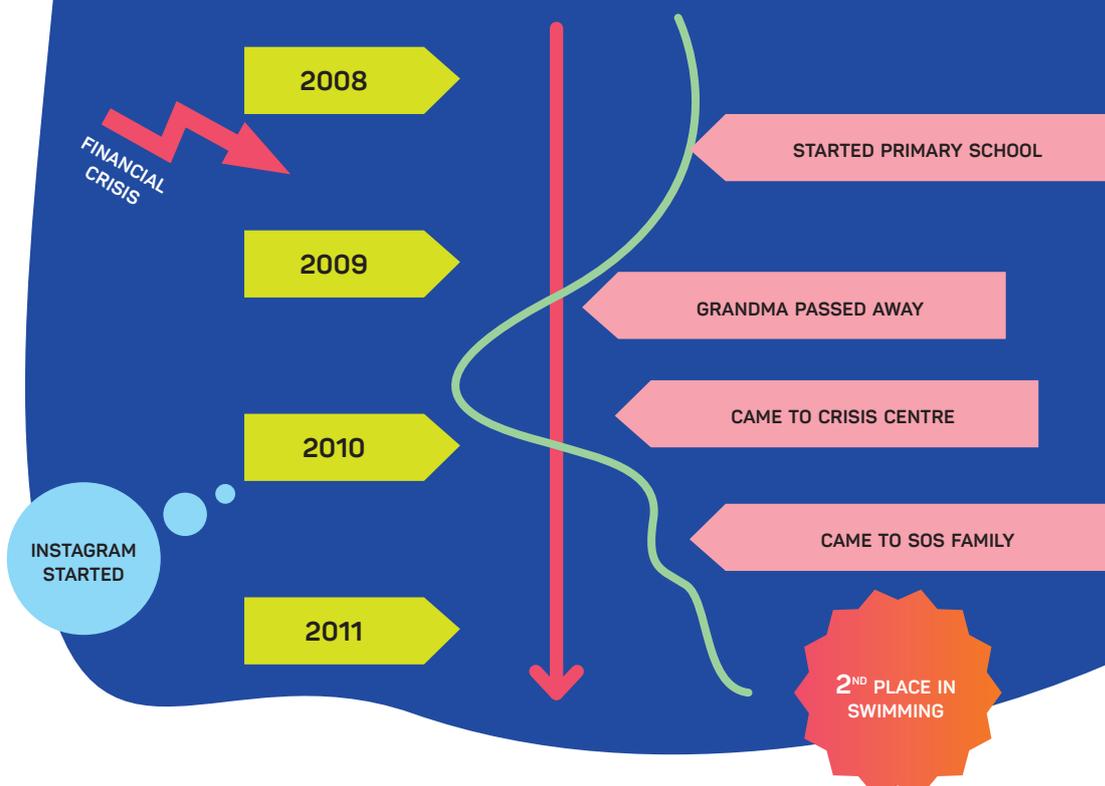
**ROUND 4 -** The players explain the feeling written on their paper by naming a situation when they felt like this (e.g. I felt like this when I failed my history test).

### AN EXAMPLE OF HOW TO CREATE A “TIMELINE” TO UNDERSTAND CHILDREN’S CARE JOURNEYS

The timeline process helps a child or young person to identify and describe important life events in chronological order. This activity should be done over at least 4 sessions, and space should be given at the end of each session for reflection on feelings:

1. Draw a straight vertical line on a large piece of paper.
2. Divide the line into equal segments representing each year in the life of the child.
3. Write important events in the life of the child on small cards (for example birth, developmental milestones as starting to walk and talk, being enrolled in the kindergarten and school, moving, coming into care, placement changes, birth or passing away of family members, meeting important people, holidays, special achievements, health problems or injuries, starting extracurricular activities etc.). You can also use symbols instead of words.
4. Place the cards over the timeline in the segment of when they happened.
5. If there are some time segments with missing information, you can look for it or try to use generalization (for example, children normally start to walk around their first birthday).
6. You can look for interesting public events that happened in different years of the child’s life and include them under the timeline. These can serve as fun facts, or if you find events that could influence the community that the child lived in (for example, financial crisis), these might be relevant to help them understand the context of their life events.
7. Older children can draw a curve that describes their well-being at a given time. When the curve is drawn on the right hand side of the timeline, it was generally a positive period of life, if it is on the left hand side of the timeline, it was mostly negative.

Give the child space to reflect on the timeline, what does he/she think or feel when looking at it. The completed timeline might look something like this.



### AN EXAMPLE OF HOW TO CREATE A FEELINGS BOX

1. Choose a box, decorate it with pictures, drawings and name it with the name of the feeling the child has chosen (anger, sadness, anxiety, etc.).
2. Discuss some examples of strategies that may help the child manage this feeling. You can brainstorm together; ask other children, young people, the biological family or other adults to help you with ideas or search in the internet.
3. Put objects that are directly needed for the management of the feelings into the box (e.g. a blanket or a stuffed animal to cuddle, an anti-stress ball, empty bottles that the child can smash against each other or crash when they are angry, favourite sweets, a specific CD or a favourite comic, a diary and crayons, etc.).
4. Add a list or other reminders like picture cards of actions that can help the child to manage this feeling. Try to find at least one from each area:
  - Expressing emotions (crying, screaming, talking, writing a diary, painting, playing music, drumming).
  - Calming and relaxing activities (watching a movie, reading a book, listening to music, taking a bath, meditation, relaxation, sleep, prayer, being alone, handy crafts, cook and eat something you like, ask someone you like for a massage).
  - Activation and movement (go for a walk, run around the house, cycle, kick a football against a wall, exercise, go to a gym, shake the feeling out, dance or jump).
  - Seeking contact and support (talk to a friend/close adult, ask for a hug, try to solve the situation that makes you feel this way, stop the person that is hurting you or making you feel bad, ask for help, call an anonymous helpline, cuddle a pet, talk to a psychologist, call police, etc.). You can make a list of trustful people and ways on how to contact them.
  - You can organize these ideas in a way so that the child selects a strategy randomly (e.g. write them on sides of a dice, or put them on small papers in an envelope so that the child can pick one).
5. Include resources that can empower the child in times of distress (e.g. family pictures – ideally laminated copies as they can easily be torn apart in anger. Collages of dreams, goals and places the child want to go. Pictures or story about a positive life event, an affirmation – e.g. “A rainbow comes after the rain!” An empowering letter written by the child’s family or his/her caregiver. Pictures and stories about child’s idols, a tree of life, etc.).
6. If the child already uses some techniques for management of their emotions, put reminders of these techniques in the feelings box (creating positive thoughts, counting to 10, remote control, safe place, relaxation techniques, mindfulness etc.).

**CHECK THE SETTING**

The template below asks you to examine your care setting, whether it is a family or an institution. Be as honest as you can when thinking about the questions. Identify areas that you think you can improve upon and choose one to analyse in more depth. Outline HOW you will make that improvement and put a time scale on when you expect the improvement to be implemented.

ARE WE READY TO IMPLEMENT TRAUMA-INFORMED PRACTICES?		
In our care setting	In our care setting	In our care setting
What do we do to provide trusting and loving relationships?	How do we help a child or young person to feel loveable?	How do we help a child to communicate effectively?
What do we do to provide structure and consistency?	How do we help children to feel powerful?	What chances do we give children to solve problems?
How do we provide good role models?	How do we help children to feel proud of themselves?	What do we do to help children learn how to regulate their emotions?
How do we make sure our physical environment is calming and promotes a feeling of safety?	How do we help children to show compassion to others?	What opportunities do we provide to help a child to mentalize?
What do we do to ensure access to health, education and social care?	How do we help the child to be hopeful and trustful?	What do we do to help a child build trust?
What do we need to do better?		
Choose one thing that you would like to improve on and outline HOW you will do it.		
Note down your time scale for when the improvement will be put in place.		

# APPENDIX 4

## ADDITIONAL SUGGESTED READING

Bath, H. (2017). The trouble with trauma. *Scottish Journal of Residential Child Care*, 16(1), 1-12.

Blaustein, M. E., & Kinniburgh, K. M. (2018). *Treating traumatic stress in children and adolescents: How to foster resilience through attachment, self-regulation, and competency*. Guilford Publications.

Brennan, R et al. (2019). *Adversity and Trauma-Informed Practice: a short guide for professionals working on the frontline*. Young Minds publications.

DeJong, M. (2010). Some reflections on the use of psychiatric diagnosis in the looked after or “in care” child population. *Clinical Child Psychology and Psychiatry*, 15(4), 589-599.

de Thierry, B. (2016). *The Simple Guide to Child Trauma: What it is and how to Help*. Jessica Kingsley Publishers.

de Thierry, B. (2018). *The Simple Guide to Understanding Shame in Children: What it Is, what Helps and how to Prevent Further Stress Or Trauma*. Jessica Kingsley Publishers.

Emond, R., Steckley, L., & Roesch-Marsh, A. (2016). *A guide to therapeutic child care: What you need to know to create a healing home*. Jessica Kingsley Publishers.

Furnivall, J. (2011). *Attachment-informed practice with looked after children and young people*. Glasgow: Institute for Research and Innovation in Social Services.

Furnivall, J., & Grant, E. (2014). *Trauma sensitive practice with children in care*. *Iriss Insight*, 27.

Furnivall, J. (2017). *The power of the everyday: supporting children and young people’s recovery and growth through attachment-informed and trauma-sensitive care*. *Foster* 3, 7-17.

Golding, K, Hudson, J, and Hughes, D. (2019) *Healing Relational Trauma with Attachment-Focused Interventions*. London: Norton.

Gray, D. et al (2017). *Innovative therapeutic life story work: developing trauma-informed practice for working with children, adolescents and young adults*. Jessica Kingsley Publishers.

Herman, J. L. (2015). *Trauma and recovery: The aftermath of violence – from domestic abuse to political terror*. Hachette UK.

Maté, G. (2011). *When the body says no: The cost of hidden stress*. Vintage Canada.

Midgley, N., & Vrouva, I. (Eds.) (2013). *Minding the child: Mentalization-based interventions with children, young people and their families*. Routledge.

Ngigi, T.W. (2019). *Breaking the Cycle: The Role of Auntie Rosie in Childhood Trauma Informed Care*.

Rose, R. (2012). *Life story therapy with traumatized children: A model for practice*. Jessica Kingsley Publishers.

Siegel, D. J. (2001). Toward an interpersonal neurobiology of the developing mind: Attachment relationships, "mindsight," and neural integration. *Infant Mental Health Journal: Official Publication of The World Association for Infant Mental Health*, 22(1-2), 67-94.

Tarren-Sweeney, M. (2010). It's time to re-think mental health services for children in care, and those adopted from care. *Clinical child psychology and psychiatry*, 15(4), 613-626.

United Nations General Assembly (2009). Guidelines for the Alternative Care of Children. Resolution A/RES/64/142.

Van der Kolk, B. (2014). *The body keeps the score: Mind, brain and body in the transformation of trauma*. Penguin UK.







**Safe  
Places  
Thriving  
Children**