

TRAUMA-INFORMED SCHOOL SUPPORTING CHILDREN AFFECTED BY TRAUMA IN THE PROCESS OF EDUCATION



SOS WIOSKI
DZIECIĘCE



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I. WHAT DO WE KNOW ABOUT TRAUMA?

1. COMPLEX DEVELOPMENTAL TRAUMA: WHAT IS IT?

In this chapter we would like to discuss the concept of trauma, to explain what it is, and to present different types of trauma. We will show both typical examples of traumatising experiences, such as being a victim or witness of abuse, and some less obvious, but also traumatising events in children's lives, e.g. experiences related to medical care, such as forced isolation (being put in an incubator), painful medical procedures, or separation when the child is hospitalised. Finally, we will briefly discuss attachment difficulties and how they are related to trauma.

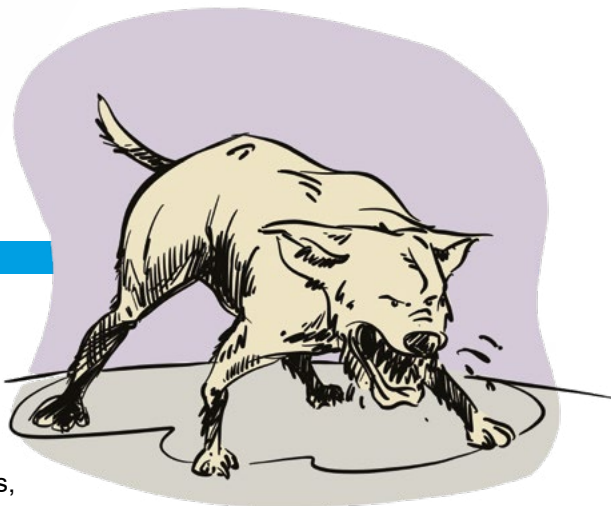
Most children who are placed in alternative care have experienced traumatic events in their lives. Trauma has long-term and diverse impact on the lives of both children and their families. Therefore, representatives of institutions supporting children and families should understand the effects of traumatic events on children's lives and be able to identify children's needs resulting from those experiences, in order to support them effectively. Traumatic experiences occur not only in the lives of children placed in alternative care. Polish research shows that 41% of children aged 11–17 have experienced violence from people close to them¹, and according to the American National Child Traumatic Stress Network (NCTSN) one out of every 4 children attending school has been exposed to traumatic events.² Such experiences may affect learning and behaviour. It is the children's challenging behaviour that is most readily noticed by teachers and other staff members.

We can talk about **trauma**, when a child is exposed to or witnesses events that **threaten their own life and health**³ or the life and health of their loved ones, such as parents or siblings, or events which are experienced by the child as **life- or health-threatening**. The child is overwhelmed by the experience and unable to cope with it emotionally. Moreover, the event is a source of stress and evokes feelings of fear and helplessness. As a result, the child may start showing disorganised, unpredictable, or overly agitated behaviour. Here are some examples of traumatising events:

- ✓ neglect
- ✓ abandonment, betrayal of trust, e.g., when a caregiver is the abuser
- ✓ community violence, including school violence, e.g. being a witness or victim of bullying
- ✓ different types of abuse, especially sexual and physical abuse, witnessing domestic violence;

- ✓ painful medical examinations
- ✓ separation from the caregiver due to hospitalisation and painful medical procedures, including premature birth followed by putting the baby in an incubator, i.e. isolating them from the caregiver
- ✓ severe, life-threatening illness

- ✓ death or loss of a loved one
- ✓ being in an accident, e.g. a car crash
- ✓ life-threatening natural disasters, e.g. a flood
- ✓ acts of terrorism.



TYPES OF TRAUMA⁴:

Acute trauma:

Acute trauma is a single traumatic event that is limited in time. Examples of events that may be regarded as acute traumas include a road traffic accident, terrorist attack, natural disaster, rape or dog bite. Each of these events may evoke a variety of complicated sensations, thoughts, and physical responses in the child, which may rapidly shift as the child repeatedly assesses and reassesses their feelings of threat and safety. As the situation unfolds, the child experiences increased heart rate, overwhelming emotions, and unexpected physical reactions, which adds up to their fear and sense of being overwhelmed.

1 Ogólnopolska diagnoza skali i uwarunkowań krzywdzenia dzieci (National assessment of prevalence and circumstances of child maltreatment), a study conducted on a representative sample of children aged 11–17 in 2018, <https://diagnozakrazywdzenia.pl/>.

2 Child Trauma Toolkit for Educators, NCTSN, Los Angeles, 2008, more on: www.NCTSN.org.

3 For example, severe injuries that may lead to disability or a terminal illness.

4 The trauma classification is based on Child Welfare Trauma Training Toolkit: Comprehensive Guide, NCTSN, Los Angeles, 2013.

Chronic trauma:

The term refers to a situation, when a child has experienced a series of multiple traumatic events, e.g., has been exposed to domestic violence, bullying at school, and then community violence. The effects of chronic trauma are cumulative, and each traumatic event reminds the child of earlier trauma and reinforces its damaging impact. With each subsequent event, the child becomes more convinced that the world is a dangerous place. Over time, a child who has experienced repeated feelings of being emotionally overwhelmed, will become more vulnerable and less able to tolerate everyday stresses.

Complex trauma⁵:

Complex trauma is a term used to describe exposure to chronic trauma, in which the perpetrators of abuse and neglect are predominantly the child's parents or caregivers, usually having their own history of childhood trauma, as well the impact of chronic trauma, its short- and long-term effects in the child's life. Children who experience complex trauma have been usually exposed to **multiple relational traumatic events**, such as physical abuse, sexual abuse, and neglect, from their earliest years.



Neglect as trauma:

Neglect is defined as behaviour by a caregiver (usually a parent) that constitutes a failure to provide adequate or sufficient care in terms of meeting the child's physical, medical, educational, and emotional needs. Neglect is the most common type of maltreatment and has serious, far-reaching consequences for the child's development. Particularly infants and young children who experience neglect may feel that their life is immediately threatened, as they are completely dependent on adults and their biological survival depends upon the behaviour and efforts of their caregivers. **Consequently, neglect should be regarded as a type of complex trauma.**

Neglect often co-occurs with other types of maltreatment and forms of adversity, such as extreme poverty or caregiver substance abuse.

Thus, when working with children in alternative care, we should assume many of them experienced chronic and complex trauma earlier in life (in their family environment) and, at the same time, were deprived of the soothing influence of a supportive caregiver. **Therefore, when working with children from adverse environments, instead of focusing on the child's specific behaviours, we should rather try to uncover their complex history and understand the effects of their past traumatic experiences on their present situation.**

A child who experienced multiple frightening events, growing up in an environment that neglected the child's needs and was permeated by abuse, may continue to experience traumatic stress after moving to a new placement.

CHILD TRAUMATIC STRESS

Child traumatic stress⁶ refers to a child's emotional and physical response to an event threatening the life or health of the child or of a person close to the child. Such an experience overwhelms the child and their ability to cope, and causes intense physical and psychological reactions that may be as frightening as the traumatic event itself. These include:

- ✓ an overwhelming sense of horror and helplessness
- ✓ a sudden increase in heart rate, trembling, dizziness, and loss of bladder and bowel control
- ✓ hypervigilance, feeling upset or sad.

⁵ In the literature, especially in Europe, „complex trauma” is also referred to as „relational trauma”, which emphasises the context in which trauma is experienced, i.e. the child-caregiver relationship. The two terms, though close in meaning, are not identical. In this brochure, however, they may be used interchangeably.

⁶ See: Van der Kolk, B., *Strach ucieleśniony. Mózg, umysł i ciało w terapii traumy*, Warszawa 2018, p. 203.

After a traumatic event, some children experience pervasive and ongoing sadness. Persistent traumatic stress in children may lead to nightmares, attention difficulties, difficulty falling or staying asleep, eating problems, agitation, depression, mood swings, and behavioural changes. These problems occur or become more intense when the child is suddenly reminded of the traumatic event or exposed to a trauma trigger. As a result, children respond inappropriately in everyday situations, which has a negative effect on their ability to form stable relationships with their peers and to have positive interactions with the environment.



REMEMBER

- ✓ Most children placed in alternative care have experienced complex trauma.
- ✓ Behind the child's challenging behaviour there is usually a history of multiple adverse experiences: acute traumas, chronic trauma, and complex trauma.
- ✓ The effects of "only" witnessing domestic violence or being "just" neglected on the child's development should never be underestimated.

2. ATTACHMENT⁷

In this section we will briefly discuss types of attachment and show the relationships between trauma and the pattern of attachment.

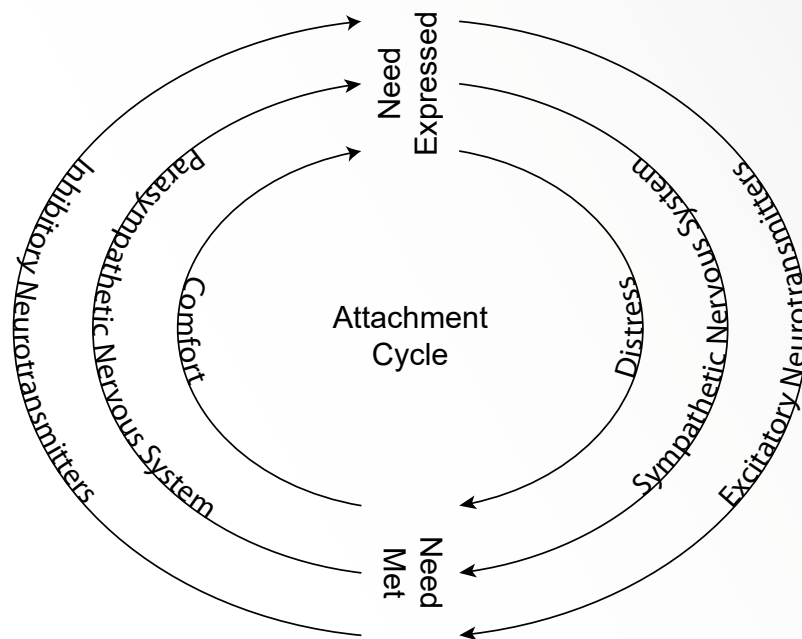
The mechanism underlying the development of the first attachment bond between a child and their caregiver, as described below, is important to understand how a student enters into relationships with their teachers and peers, since early attachment determines the individual's future relationships.

DEVELOPMENT OF ATTACHMENT

The attachment relationship develops between an infant and their caregiver, usually the mother. In the attachment theory, this primary caregiver is referred to as the "attachment figure". This primary attachment bond develops by about 2 years of age. The infant seeks the caregiver's physical proximity, which is a source of comfort and security. When physical proximity is not achieved, the child becomes anxious and upset, showing signs of separation distress. Infants are biologically equipped to form attachment relationships and they show **attachment behaviours** which serve to bring about the proximity of the caregiver and, consequently, to ensure security and protection. These include **crying, babbling, and smiling**, as well as **reaching out and following** the caregiver. These behaviours are exhibited both when the child feels safe, and in response to an actual or perceived threat.

When care is appropriate, the caregiver responds to the child's needs. The child is soothed and has a feeling of safety until the next perceived threat. This cycle of calling for the proximity of the caregiver and the caregiver's response to the child's need will repeat again and again. If the caregiver's behaviour is predictable, the child learns that their distress can be soothed, that they may rely on and trust the caregiver. The relationship with the attachment figure becomes a source of the feelings of joy and security, resulting from the fact that the caregiver will always be there to help the child, if needed.

⁷ Based on Tylor, C., A Practical Guide to Caring for Children and Teenagers with Attachment Difficulties, London and Philadelphia, 2010.



Attachment Behaviors: Trust, Self-Worth, Efficacy
 HPA Balance: Foundation for Self-Regulation
 Neurochemical Balance: Foundation for Mental Health

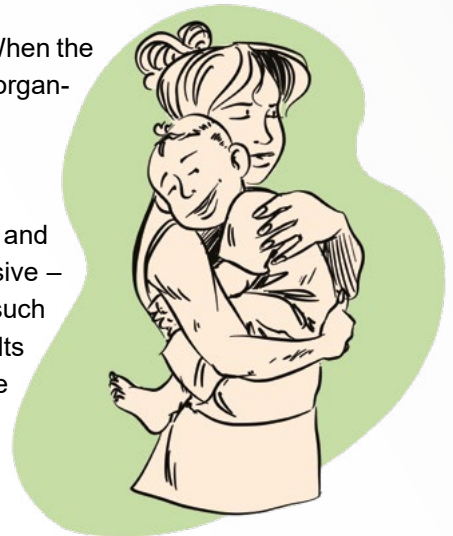
Source: Dr Karyn Purvis Institute of Child Development, <https://www.youtube.com/watch?v=7vjVpRffgHQ>.

PATTERNS OF ATTACHMENT

Attachment is a **pattern of behaviour** that the child shows within a relationship. When the child knows how to draw the caregiver's attention to their needs, they have an organised pattern of attachment.

Secure attachment

Secure attachment is an enduring bond to the caregiver, in which both the child and the adult find happiness and satisfaction. The caregiver is available and responsive – responding to the child's needs and behaving in a predictable way. As a result of such caregiving, the child thinks of the self as lovable, worthy, and effective, and of adults – and, more generally, the world – as predictable, available and responsive to the child's needs. This positive starting point, called a secure base, allows the child to explore the world and develop resilience, independence, empathy, control over their feelings, social competence, and high though realistic self-esteem.



INSECURE ATTACHMENT

Anxious-avoidant attachment: unresponsive caregiver

A child develops this pattern of attachment when the caregiver is rejecting or only available “as a reward”, but also intrusive and controlling when interacting with the child. Within such a relationship the child may virtually switch off attachment behaviour and become overly self-reliant and independent. They may tend to please the caregiver by being a “good child” – quiet and non-demanding. In the face of a threat, the child seems devoid of emotion, hiding their emotions from others. They tend to inhibit negative feelings and display only positive ones to attract the caregiver's attention and avoid rejection. The child thinks of the self as worthless and unlovable, and sees the caregiver as unavailable and, at the same time, intrusive and interfering. At school, children with this pattern of attachment may be perceived as “well-behaved”, quiet and slightly withdrawn, trying to avoid drawing others' attention and situations of social exposure.

When working with a student with a fixed pattern of anxious-avoidant attachment, it is recommended to show a positive, encouraging, and non-rejecting approach. Teachers may try to find out what is soothing for those children, and give them safe, stimulating tasks. At the same time, they should resist the temptation to be overly active in trying to interact closely with the child and be prepared to step back if the student cannot stand the teacher's attempt to shorten the distance.

Anxious-ambivalent attachment: inconsistent caregiver

In this case the caregiver is inconsistently available to the child and insensitive to their needs. Within such a relationship the child may be afraid of being emotionally abandoned. As a result, they may experience unregulated stress, which leads to hyperarousal and irritability. They seem to be a "mixture of all kinds of feelings". Unable to see any connection between their own behaviour and the caregiver's responses, the child will develop poor social competence and low independence. In relationships, they will show ambivalence and try to impose their will on others. The child thinks of the self as unlovable and ineffective and sees the caregiver as unavailable and unresponsive – ignoring and not responding to the child's needs.

Students with a fixed pattern of anxious-ambivalent attachment may show untypical responses and behaviours in order to draw both their teachers; and their peers' attention. These may take the form of rebellion and provocation, but the child may also become overly active in various areas in order to win recognition, admiration, and acceptance.

Students with this pattern of attachment need a low-stress environment with predictable safety. They require a clear, well-defined, and friendly structure, without excessive criticism or rejection, which will soon lead to escalation. Teachers should avoid being overprotective or trying to "rescue" their students. These children need to learn to trust their own competence by making small steps and succeeding in small tasks.

DISORGANISED PATTERN

Disorganised attachment

This type of attachment develops when the child cannot work out an organised strategy to have their needs met by the caregiver, because the caregiver uses multiple parentings methods and strategies in unpredictable ways. The caregiver's behaviour is usually related to substance abuse, domestic violence, or mental illness. The caregiver can also be a source of fear, for example in cases of incest or domestic violence. Thus, the caregiver, who should provide safety, becomes a source of constant fear and insecurity, a situation referred to as "fear without solution". The child makes chaotic attempts to attract the caregiver's attention, making inconsistent use of strategies typical of anxious-avoidant or anxious-ambivalent children. **If the caregiver, without whom the child cannot survive, is also a source of constant fear and insecurity, the child, unable to predict danger, is always vigilant.** They live in a state of unregulated emotions and high arousal, and become helpless, fearful, and aggressive. The child perceives the self as powerful but evil, and the caregiver as unavailable and frightening. This group of children have a high risk of future difficulties or psychopathology.



Students with a fixed pattern of disorganised attachment are often seen as the most difficult by their teachers, especially due to their poor academic achievement, high anxiety and hyperactivity, aggressive or provocative behaviour, and disrespect for other people's needs and for established rules.

A practical approach to children with disorganised attachment involves providing them with an environment characterised by as much safety as possible. Fear-provoking situations should be reduced to the minimum by applying clear principles and procedures. Safety and predictability, combined with high awareness, understanding, and consistency on the part of adults, may help to change those children's experiences related to their attachment pattern formed in the past. What is particularly important is a prospect of positive, long-term relationships, and efforts to carefully prepare the child for any change in their life, to prevent feelings of isolation and rejection.

The attachment patterns described above may be corrected and changed, at least to some extent, as a result of new, positive experiences in relationships.

It is noteworthy that the strength of attachment is not related to attachment security. **The strength of attachment is reflected by the intensity of attachment displays, and is not an indicator of security.** Therefore, it is not surprising that some children are very loyal to parents who have severely abused them.

It should be added here that among the three insecure patterns of attachment described above, for both the anxious-avoidant and anxious-ambivalent patterns, the caregiver is available to the child – under certain conditions – and, consequently, there is a chance for building a positive relationship between them. The disorganised pattern is the only one that severely limits this possibility.

ATTACHMENT AND TRAUMA

Attachment develops between a child and their caregiver (the attachment figure). If, however, the caregiver is a source of fear and distress, a source of traumatic experiences, then the child's prevailing experience – instead of a loving and secure relationship – is complex trauma.



REMEMBER

- ✓ Attachment develops between a child and their caregiver, usually the mother, and is formed by about 2 years of age.
- ✓ Attachment is a pattern of behaviour that is used by the child to draw the caregiver's attention to their needs.
- ✓ Organised patterns of attachment include secure and insecure – anxious-avoidant and anxious-ambivalent – attachment.
- ✓ If the caregiver is a source of fear and insecurity, abuses the child, and shows unpredictable behaviour, the child develops a disorganised pattern of attachment.
- ✓ Among children in alternative care the disorganised pattern of attachment is seen more frequently than in the general population.
- ✓ Attachment to the caregiver determines the individual's future relationships.

3. TRAUMA AND CHILD DEVELOPMENT

In this chapter we will discuss the impact of trauma on a child's development. We will focus on school-age development and present the cognitive, psychosocial, health, and emotional effects of trauma.

Various traumatic events, especially complex trauma, have serious, long-lasting effects on a child's life, affecting its quality. First of all, however, they impair the functioning of the nervous system, our „control and communication system”, and thus disturb the child's harmonious development in the cognitive, emotional, social, physical and health areas. They impair processes that are particularly important for learning and education, i.e., attention, perception, memory, cognitive control, thinking, and language. They limit the child's ability to form relationships with others and, perhaps most importantly, they “seize” many areas of life by generating pervasive fear. Below we will discuss some aspects of the impact of trauma on children's development.

AN OVERLOADED AND OVERWHELMED SYSTEM⁸

Social engagement

When a child feels threatened, they signal the need for help from someone in the immediate environment. They attempt to make contact and attract their caregiver's attention to get the necessary support. The child changes their tone of voice, shows lively facial expression, and becomes more sensitive to sounds in the environment. When the caregiver or another

⁸ Based on Van der Kolk, B., Strach ucieleśniony. Mózg umysł i ciało w terapii traumy, Warszawa, 2018.

adult responds by offering support, the child calms down and does not need to engage in any additional activity to regain safety. Over time, as this cycle is repeated over and over again, the child develops a stable pattern of responding, which involves seeking contact and expecting support when facing a threat. It also becomes the basis for building a positive relationship, e.g. between a child and their caregiver, or between a student and their teacher.

When facing considerable threat, and thus experiencing severe stress, a child may show three involuntary responses: fight or flight, and the freeze response.

Fight or flight

When the feeling of threat increases and support from others is not coming, the pitch and frequency of sounds produced by the child become heightened (e.g., the child raises their voice, speaks faster, or starts screaming), the heart rate increases, breathing becomes rapid and shallow, and the muscles receive more blood and, with it, more oxygen, which makes them ready to fight or (when fighting seems pointless) flight. During this mobilisation response, large amounts of cortisol and adrenaline, referred to as “stress hormones”, are released into the bloodstream. Contrary to social engagement, the child develops a different pattern of responding to danger, characterised by aggressive and confrontational behaviour toward the source of threat (fight) or by avoidance (flight). In both cases, a disturbed relationship develops between the child and the other person, who is perceived as hostile and threatening, and between the child and their caregiver who has failed to provide help. Unfortunately, it may also be the case that the latter is the abuser or the perpetrator of neglect.

Freeze

The freeze response may occur, for instance, in situations of physical or sexual abuse, when the child's boundaries are violated and the child is immobilised (restrained), e.g. when they are subjected to painful medical procedures against their will or without being aware of how the procedure will help them, or when the child is physically dominated by the abuser or experiences extreme tension, e.g. being a witness of their parents' fight. Experiencing severe stress and threat, unable to fight or flight, the child may only freeze. Their metabolic rate is dramatically reduced, the heart rate decreases, the child has difficulty breathing, and their bowels are emptied or become inactive. The child “shuts down”, faints, or freezes. Their consciousness is switched off and pain sensitivity is reduced, as if the child was preparing for the inevitable. They become detached from the here and now, from the abuser, but also from themselves.

These types of responses to traumatic stress contribute to the development of the child's predominant survival strategies, which are transferred into their relationships with other people and into various areas of life. Many of those children's challenging or unusual behaviours are strategies that helped them to survive in the presence of threatening or neglecting caregivers. When children with traumatic experiences encounter people, situations, places, or objects that remind them of past traumatic events, they may experience intense, distressing feelings related to the original trauma. These “traumatic memories” often cause responses that may seem inappropriate in the current circumstances, but were perfectly appropriate, or even helpful – as they helped to survive – during the original traumatic event.

PTSD AS A DIRECT CONSEQUENCE OF TRAUMA

Consequences of traumatic events may be experienced and observed directly after their occurrence, when they are often referred to as PTSD (Posttraumatic Stress Disorder). According to the American Psychiatric Association, PTSD may be diagnosed in children who experienced, witnessed or were confronted with one or more events involving actual or threatened death, serious injury, or threat to physical integrity of self or others, and reacted to these events by developing symptoms specific for the disorder. These include:

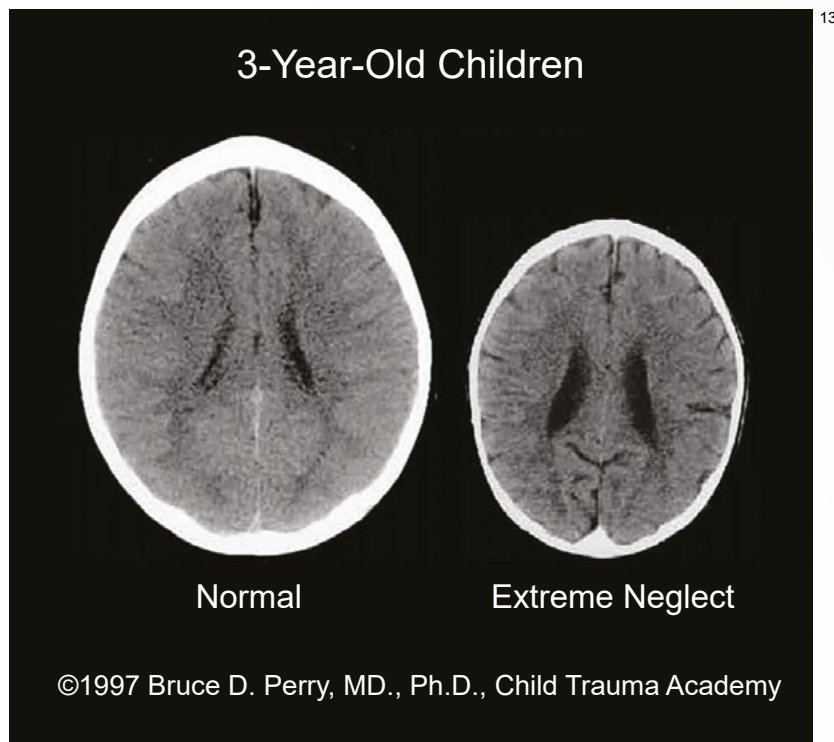
- ✓ re-experiencing the traumatic event (e.g., in nightmares or frightening dreams, and intrusive recollections of the event)
- ✓ intense psychological and physiological responses to internal or external stimuli that symbolise or remind of some aspects of the original trauma
- ✓ avoiding thoughts, feelings, places, and people associated with the trauma
- ✓ changes in thoughts and mood (e.g., inability to recall some aspects of the trauma, feelings of anxiety, guilt, sadness, shame, or confusion, loss of interest in activities)
- ✓ increased arousal (e.g., exaggerated startle response, sleep problems, irritability).⁹

9 Diagnostic and Statistical Manual of Mental Disorders DSM-5®, American Psychiatric Association, Washington, 2013.

EFFECTS OF TRAUMA ON THE DEVELOPING BRAIN¹⁰

The brain develops by forming neural connections. Interactions with caregivers play a key role in this process. The more positive interactions are experienced by the child in a relationship with a supportive caregiver, i.e., the more time and attention is given to the child in response to their signalled needs, the stronger and more numerous neural connections are formed in the child's brain. The denser the network of brain connections and the higher their quality, the better the functioning of the child's brain and of the whole nervous system. Importantly, the trauma-related attachment difficulties (discussed above) and the accompanying deficit of positive interpersonal interactions, reduce the number and quality of the neural connections being formed in the brain.¹¹

Stress affects the development and structure of the brain. The associated long-lasting high levels of cortisol and adrenaline may lead to changes both in the brain structure, and in its functioning. The experience of trauma may lead to reduced cortical volume and disrupted communication between brain hemispheres, and to dysfunctions in memory, attention, perception, thinking, language, and consciousness.¹² These problems limit the child's ability to form positive relationships with others, and hinder the processes of learning, exploration, and gaining new skills and experiences.



The human brain develops from the bottom up, from primitive structures to more complex ones.¹⁴

- ✓ The first brain part to develop is the **brainstem**, which regulates basic life processes, such as breathing, heart rate and blood pressure, body temperature, metabolism, hunger and thirst, as well as integration of auditory and sensory stimuli, and also ensures survival – referred to as the “**reptilian brain**”.
- ✓ The next brain part to develop is the **limbic system**, which serves as the centre for receiving, storing, and responding to information, and is responsible for emotional regulation, learning, and long-term memory – referred to as the “**mammalian brain**”.
- ✓ The last brain part to develop is the **neocortex**, including the **frontal lobes** responsible for tasks such as rational and abstract thinking, planning, behavioural control, or anticipating the consequences of actions – referred to as the “**human brain**”.

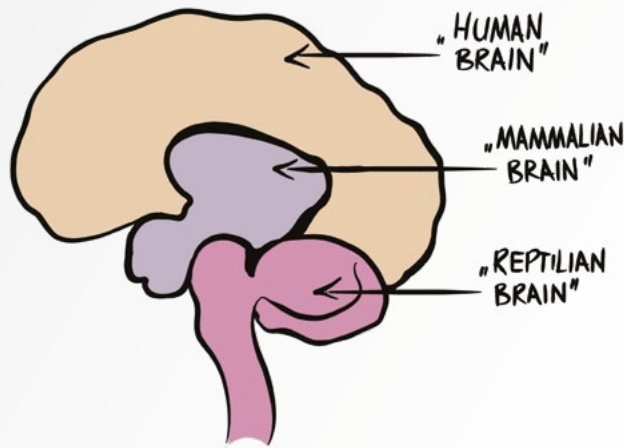
¹⁰ Based on Child Welfare Trauma Training Toolkit: Comprehensive Guide, NCTSN, Los Angeles, 2013.

¹¹ Caring for Children Who Have Experienced Trauma: A Workshop for Resource Parents, NCTSN, Los Angeles, 2011.

¹² Applegate, J. S., Shapiro, J. R., Neurobiology for Clinical Social Work: Theory and Practice, New York, 2005.

¹³ Based on Child Trauma Academy, more: <http://childtrauma.org/>.

¹⁴ Porges, S. The Polyvagal Theory: Neurophysiological Foundations of Emotions, Attachment, Communication, and Self-regulation, New York 2011, cited in: Van der Kolk, B., Strach ucieleśniony. Mózg, umysł i ciało w terapii traumy, Warszawa, 2018.



The **brainstem** and the **limbic system** constitute the so called “**emotional brain**”, whereas the neocortex (or the cerebral cortex) is our “**rational brain**”, the highest evolutionary achievement of our species.

In response to the experience of trauma, the child's brain begins to develop in a way that enables survival in a dangerous world, remaining in a constant state of alertness, ready to react to threats immediately, usually with the fight or flight response (the limbic system – the “mammalian brain”), and less frequently by freezing (the brainstem – the “reptilian brain”). Thus, the child's emotional brain is highly activated, and the “rational brain” is either unavailable, or the child has limited access to its functions.

EFFECTS OF TRAUMA DEPENDING ON AGE¹⁵

Experiences of traumatic stress and children's responses to it vary depending on age.

Psychological and behavioural effects of trauma in young children

In early childhood, post-traumatic changes in the structure and functioning of the brain may impair the development of intellectual abilities and emotional regulation, cause increased levels of fear or anxiety, and decrease the child's feeling of safety.

Young children, who have experienced trauma, may:

- ✓ show their distress through increased physiological and sensory responses, e.g., changes in eating, sleeping, level of activity, or reactions to touch and changes of place
- ✓ become passive, quiet, and sensitive to arousal
- ✓ become fearful, especially of separation and new situations
- ✓ have difficulty assessing threat and seeking protection, especially when a parent or caregiver is the abuser
- ✓ show regressive behaviour, e.g. baby talk, wetting, or whining
- ✓ show intense fear responses
- ✓ experience intense fear responses, nightmares, or aggressive outbursts
- ✓ blame themselves because of poor understanding of cause and effect or due to magical thinking.



Children who experienced trauma in infancy or early childhood, before developing language, do not have conscious memories of those experiences. What they have is **emotional memory** of the trauma. That is why physical or emotional reminders of the traumatic events may trigger flashbacks, nightmares, or other disturbing reactions. As the child develops language skills, they form the first **conscious memories** of events, so trauma experienced at this stage may be consciously remembered, though the memories are still fragmented.

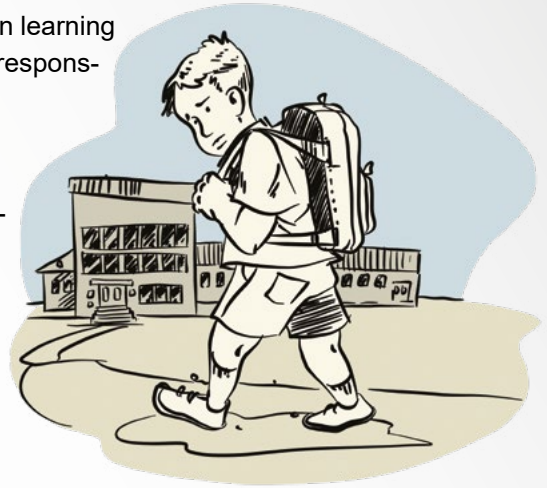
¹⁵ Based on Child Welfare Trauma Training Toolkit, NCTSN, Los Angeles, 2013.

Psychological and behavioural effects of trauma in school-age children

In school-age children, trauma disturbs the development of brain areas that would allow them to manage their fears, concerns, and aggression, to concentrate on learning and problem solving, and to control impulses and manage their physical responses to threat.

As a consequence of trauma, children may:

- ✓ experience sleep problems that impair their attention and concentration during the day
- ✓ show learning difficulties
- ✓ have problems with controlling their responses to fear-provoking stimuli
- ✓ demonstrate behaviour oscillating between over-compliant and overly aggressive
- ✓ experience unwanted, intrusive thoughts and images
- ✓ show new intense, specific fears associated with the original threat
- ✓ replay the traumatic event in their mind, over and over again, ruminating about how it could have been prevented or changed
- ✓ change their behaviour from shy and withdrawn to very aggressive
- ✓ become so frightened of the recurrent overwhelming experiences that they start avoiding their previously preferred activities
- ✓ think about revenge
- ✓ have difficulty trusting and seeking protection from adults.



Psychological and behavioural effects of trauma in adolescents

In adolescents, trauma may affect the development of prefrontal cortex, a region of the brain responsible for anticipating the consequences of behaviour, accurate assessment of threat and safety, and executive functions, such as managing behaviour, predicting, planning, and working toward long-term goals. Additionally, changes in the **dopamine** levels, typical of adolescence, lead to increased risk-taking behaviour.¹⁶

As a result of all those changes, adolescents who have experienced trauma, have an increased risk of:

- ✓ reckless, risky, and self-destructive behaviour
- ✓ lower academic performance and school failure
- ✓ making “bad choices”
- ✓ violence or criminal activity
- ✓ sleep problems covered up by studying, using electronic devices, or partying late at night;
- ✓ self-harm
- ✓ overestimating or underestimating threat
- ✓ difficulty trusting others
- ✓ re-victimisation, especially if the adolescent has experienced chronic or complex trauma
- ✓ substance abuse as a strategy to cope with stress.



Adolescents affected by trauma may also feel weak, weird, childish, or “crazy”. They may be embarrassed or confused by their anxiety attacks or exaggerated physical responses. They may have a strong feeling of being special or unique and, at the same time, feel alone in their pain and distress. They experience strong anxiety, intense anger, and helplessness. They have a tendency to low self-esteem and depression.

16 Spear, L., The Behavioral Neuroscience of Adolescence, New York, 2010.

TRAUMA AND EMOTIONS

The experience of complex trauma leads to high levels of fear, which is always present and “seizes” all areas of the child’s life. Apart from that, feelings of shame, guilt, anger, and helplessness are prevailing. Here we may even talk about toxic shame, which leads to the development of negative beliefs, predominantly about the self, e.g., “I’m bad, weak, stupid, and insufficient. I don’t deserve love, attention, or support”.¹⁷ Over time, these lead to excessive self-criticism and negative generalisations, e.g. “I didn’t succeed in one thing” = “I’m so useless, I can’t do anything”. The same applies to the feeling of guilt, which is experienced by children, especially those who were physically or sexually abused.

Overwhelming emotions may disrupt the development of age-appropriate self-regulation. They keep the child in a state of increased vigilance, hypersensitivity, and high arousal. Some stimuli present in the environment, such as sounds, images, shapes, light effects, flavours, or smells – referred to as trauma triggers – “take” the child back to the original traumatic event and “connect” them to the feelings experienced at that time. To protect themselves, the child remains in a constant state of alertness.¹⁸ A seemingly neutral situation may be perceived by the child as threatening, and the experience of the past events is powerful and overwhelming, as if it was all happening in the present. Consequently, when facing a perceived threat, associated with the child’s tension, they will often experience fear, frustration, aggression, and distress. When stress and tension are overwhelming and threatening to the brain, it may temporarily switch off some of its functions or their correlates. This process, called dissociation, works like a fuse (or an electrical safety device), enabling the “overloaded network” of the nervous system to recover.¹⁹ A child experiencing dissociation may seem absent, “detached” or “shut down”, such as a non-responding student who experiences severe stress in situations of social exposure and has been suddenly picked to answer a question in class, or a child standing still, unable to respond, when witnessing a fight or bullying.

Emotions trapped in the body

Emotions experienced as a result of trauma may be very real for the child, but difficult to express. The energy accumulated during a situation of threat to the child’s life or physical integrity or violation of their physical or emotional boundaries, may be **stored up in the body** for many years, producing a variety of somatic symptoms²⁰. Children who experienced abuse or neglect associated with their caregivers’ alcohol abuse, are more likely than others to report headaches, shallow and restless sleep, stomach aches, nausea, upset stomach, tics, fatigue, and weariness, and may also suffer from allergies, asthma, anaemia, and frequent colds²¹. Past traumatic experiences and the defence strategy developed by the child to protect themselves from potential future threats, may often lead to **chronic rigidity** or **floppiness of muscle groups** and, ultimately, to the development of a **specific body posture** – a “**protective suit**” or “**armour**” that blocks the energy flow and restricts the individual’s expression. We can talk about emotions trapped in the body as a long-term consequence, **temporary freezing, stopping or hang-up** as a result of **intense or repeated traumatic stress**²².

17 Salmon, M. Quantum Energy Coaching. Practitioner Training Manual. Change Your Thinking, Change Your Life, for more information about QEC <https://qecliving.com/>.

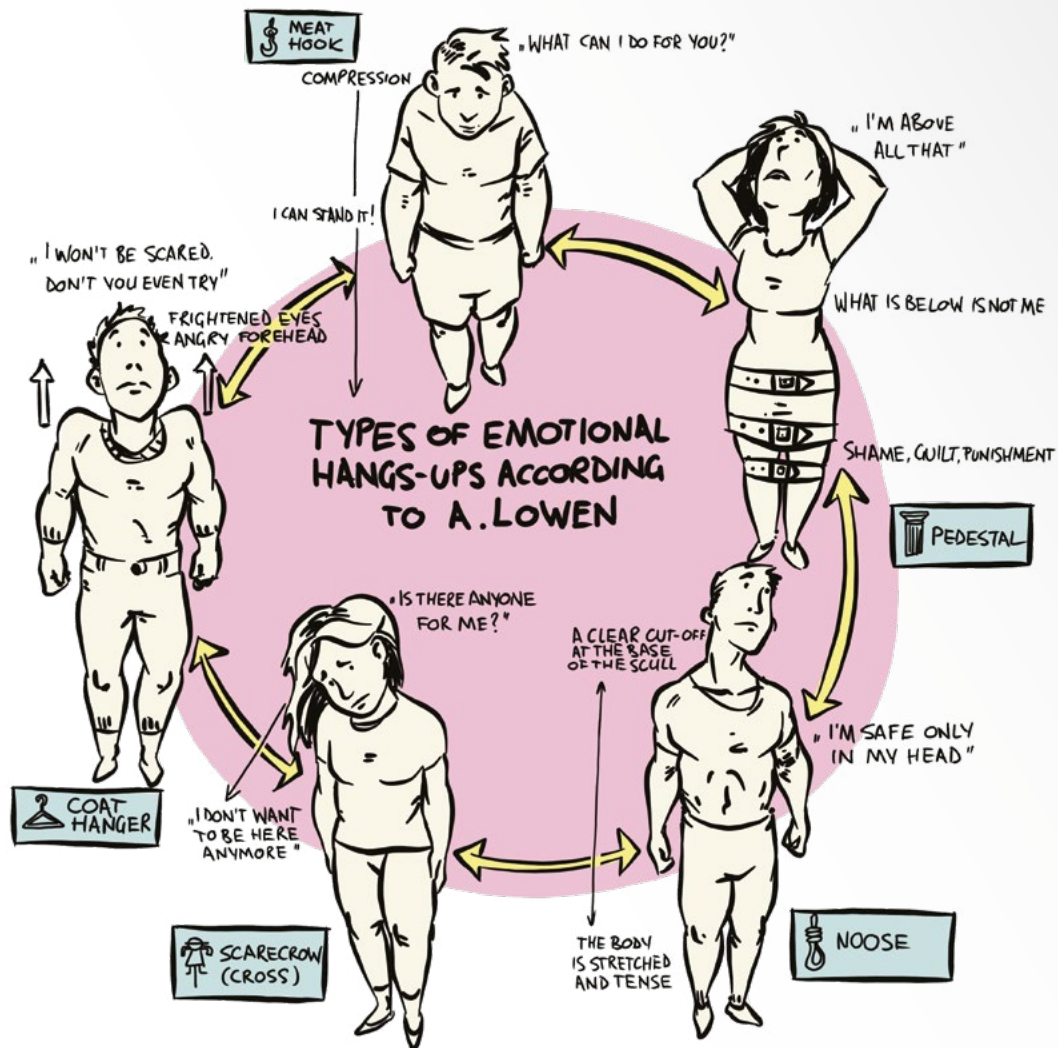
18 Teicher, M. H., Scars That Won't Heal: The Neurobiology of Child Abuse, Scientific American, 2002, no 286, pp. 68-75.

19 Trauma Informed Care – wiki page content. IOR CEE/CIS Programme Department. SOS Childrens' Villages.

20 Felitti, V. J., Anda, R. F., Nordenberg, D., Williamson, D. F., Spitz, A. M., Edwards, V., Koss, M. P., Marks, J. S., Adverse Childhood Experiences, American Journal of Preventive Medicine, 1998, no 14, pp. 245–258.

21 Widera-Wysoczańska, A., Ciało pamięta. Dlaczego traumy pozostawiają bolący ślad w naszym ciele? <http://www.psychologawygladu.pl/2015/06/ciao-pamieta-dlaczego-traumy.html>.

22 Lowen, A., Lowen, L., Droga do zdrowia i vitalności. Podręcznik ćwiczeń bioenergetycznych, Koszalin, 2011.



Source: <https://www.psychologiawygładu.pl/2017/03/emocje-zawieszone-w-ciele-jak-napiecia.html>.



REMEMBER

- ✓ Trauma has a negative impact on the structure and functioning of the nervous system, and, as such, dramatically disturbs the child's harmonious development.
- ✓ Traumatic experiences lead to the development of stable patterns of responding to significant threat: the fight-or-flight and freeze responses, which become the child's survival strategies, used across situations.
- ✓ Fear and other overwhelming emotions deprive the child of the feelings of safety and trust, and "seize" all areas of their life.
- ✓ The effects of the child's trauma are expressed by their destructive behaviour, unusual responses, difficulties in relationships with adults and peers, and "marks engraved in the body".
- ✓ Positive changes in the lives of children affected by trauma are possible, in part thanks to neuroplasticity or the brain's ability to respond and adapt to changing conditions, to form new neural connections, and to self-repair through healing relationships with other people (e.g., parents, relatives, caregivers, teachers, therapists, etc.).

II. TRAUMATISED STUDENT AT SCHOOL

1. SURVIVAL STRATEGIES IN PRACTICE: ABOUT STUDENTS' DIFFICULT BEHAVIOURS AND RESPONSES

In this chapter we will present students' behaviours which are assessed by teachers as difficult or challenging, and which are often, in fact, children's strategies to survive. We will go beyond typical examples, and discuss, for example, triangulation. We will show how these behaviours used to be adaptive in the past, so the child continues to use them. We will emphasise that a child's behaviour is something else than the child – it does not define the child and is not targeted against the teacher.

School stresses me out; too much of everything at once. I don't even know what's going on most of the time.
student, age 11²³

It is commonly thought that a child who has been placed in alternative care after having been removed from a difficult family environment, where they were exposed to abuse or violence, should immediately feel safe and start functioning well when placed in the new environment. It is certainly true, when we think about satisfying the child's fundamental needs, such as shelter, good nutrition, appropriate clothes, or nurturing caregivers. However, when working with children with the experience of complex trauma, we have to remember that **placing the child in alternative care, in itself, will not automatically change their beliefs about self, adults, and the world.** Life has taught many of those children that adults cannot be trusted, are unable to provide care or protect the child from threats, and are the ones who maltreat and abuse. This experience makes it impossible for the child to trustingly enter into a relationship with an open and caring teacher or class tutor.

School activates, educates, refines, stimulates, and socialises, but it is also a source of stress and worry, and sometimes it may be overwhelming for children. The everyday school reality includes not only well-known or new friends, multiple peer relationships, and group co-operation, but also competition, tests, marks, and progress assessments. Last, but not least, it comprises the student-teacher-parent relationships.



The process of learning assumes that initially there is something you do not know. This uncertainty is described by some authors as the essential experience of students at school.²⁴ Securely attached children approach this not-knowing and the related uncertainty with curiosity and interest, whereas for children whose caregivers were a source of fear, the same uncertainty is overwhelming and frightening, and may hinder the process of learning, or even, in extreme cases, make it impossible at all.

We should bear in mind, in this context, that knowledge is conveyed by a teacher, and it is in the teacher-student relationship that learning occurs. Without trust, the process of learning is very difficult. The problem is, a child whose relationship with the primary caregiver, usually the mother, led to an insecure pattern of attachment, a child with the experience of complex trauma, has difficulty trusting adults.

Life has taught the student to be always alert, watching out for sudden, unpredictable, and dangerous situations, that were common at home. **School, as mentioned before, is full of situations marked by uncertainty.** Various difficult situations are quite common there: conflict and fights with peers, bullying, witnessing fights, being picked by the teacher, loud voices, and chaos. Moreover, there are many people staying together in the same place, constantly interacting with one another. As a result, the state of constant alert for real and imaginary threats will continue at school, activating behaviours that the child learned in the past as their response to the dangerous and abnormal reality of their daily life. One of their goals is to take control over the situation. Having control is necessary to survive, because the child could not

²³ Schooler, J. E., Smalley, B. K., Callahan, T. J., Wounded Children, Healing Homes. How Traumatized Children Impact Adoptive and Foster Families, New York, 2010.

²⁴ Ibidem p. 128.

rely on adults and had to rely on themselves for protection. In many cases, those children had to keep family secrets, lie or steal, and manipulate with adults to prevent abuse. They may continue to use these strategies in other, safe environments, such as the school.

EXAMPLES

SUSIE AND TONY

Susan was placed with a foster family when she was 4 years old. She was taken away from addicted, abusive parents. A year later, the 5-year old Susie was joined in the same foster family by a boy her age, Tony, who had lived with his grandmother from the first year of his life. The grandma took care of Tony while her daughter, Tony's mother, stayed in hospital and later began psychiatric treatment. Unfortunately, the grandma, though doing her best to look after the boy, had severe health problems herself, and finally, after another hospitalisation and having to leave Tony with their neighbours, she gave up and the boy was placed in alternative care. Susie and Tony went to school at the age of seven. From the very beginning, school was a huge challenge for both of them. Susie attracted teachers' attention with tantrums and violent outbursts. Tony was fearful and compliant, and did not enter into relationships with his peers. He seemed to live in his own world. Susie's teacher described her as constantly seeking attention, but not interested at all in learning. Neither Susie, nor Tony made any friends at school. Tony believed he was not likeable and not interesting for anyone, whereas Susie scared other children off with her behaviour.

ADAM

Adam is a 4th form student of primary school. Since the first day at school he has started arguments with his class mates, provoked other children, pushed them, and got into fights. He has also had problems following teachers' instructions. He starts working on tasks, but does not see them through. When he was in the 2nd form, he was placed in foster care, with his aunt Eva and uncle Charlie. Eva is Adam's mother's sister. When his teacher contacted her, Eva explained that Adam was placed with them after having been taken away – as an emergency removal – from his birth parents. Adam's father is an aggressive man, prone to physical and emotional abuse. Adam witnessed domestic violence against his mother, and was also repeatedly physically abused by his father and his mother. In the past, Adam's father was in prison for assault and robbery. His father's friends from the criminal world were always around, so Adam witnessed numerous drunken parties, often ending with violent punch-ups.

What do these two cases have in common? The children described above have experienced complex trauma in their lives, i.e. situations when their own or their loved ones' life or health was threatened. Those situations were overwhelming and beyond the children's capacity to cope. Notably, what is extremely traumatising for one child, may be less emotionally disturbing for another one. The events experienced by Susie, Tony, and Adam, provoke anxiety, fear, or helplessness. Below you will find examples of children's behaviours that are deep-rooted survival strategies, i.e., social engagement, fight or flight, or freeze responses, developed as a result of complex trauma and transferred into school life. On the other hand, the three children's difficulties in relationships with adults and peers are a consequence of unfavourable patterns of attachment, developed in early childhood.

EXAMPLES OF CHILDREN'S BEHAVIOURS: EMBEDDED SURVIVAL STRATEGIES

Below you will find examples of children's behaviours that are deep-rooted survival strategies, i.e., social engagement, fight or flight, or freeze responses, developed as a result of complex trauma and transferred into school life. On the other hand, the three children's difficulties in relationships with adults and peers are a consequence of unfavourable patterns of attachment, developed in early childhood.

“Pre-emptive strike”

High levels of anxiety and hypervigilance to signals of threat in the environment, combined with difficulty reading other people's emotions, make some of the students use physical or verbal abuse as an pre-emptive attack.

“I'll abandon you to avoid being abandoned”

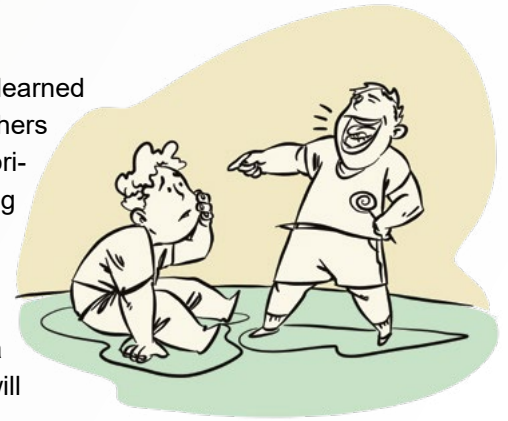
Children with attachment difficulties, especially those who have experienced multiple caregiver changes, such as children placed in alternative care, may demonstrate considerable difficulty not only forming close relationships, but also sustaining them, a problem encountered by class tutors and school counsellors who, facing those children's special needs, give them much time and attention to support them effectively. When things seem to be taking the right direction, and the adult gets closer to the child and their problems, the student suddenly moves away or withdraws from the relationship.

“Action is more effective than words”

Children who are neglected by their parents, learn from experience that words do not work. As a result, they often have difficulty expressing their needs in socially approved ways, especially verbalising them. Instead of using words, those children choose actions, usually dramatic and violent ones, full of aggression. It is often seen at school, when some students, especially in conflict situations, try to resolve problems by force.

“Notice me”

Children who were neglected, did not receive expected attention. They learned they could attract it by loud, provocative behaviour. They try to shock others with their behaviour, usually opposing and rebelling against rules and authorities. Sometimes they try to draw people's attention by fooling around, playing the goat, or making fun of others.

**“The difficult NO word”**

Students struggling with the effects of complex trauma, especially trauma related to neglect, may have especially low tolerance for the word NO. It will often cause great frustration and provoke resistance and fighting.

“Crossing boundaries”

Another common strategy in interpersonal relationships involves pushing and crossing boundaries, both physical and psychological. It is clearly visible in children's attitudes marked by high levels of aggression or compliance. Usually, it is a result of the child's prior experiences and the violation of their own boundaries (for example, by maltreatment or abuse). It may be also a way of testing the environment and assessing how safe it is.

“Triangular communication”

Another strategy used by children involves manipulating information and trying to take control over communication. Traumatized students have a tendency to get involved in communication that concerns them, e.g., communication between adults, such as a teacher and the child's parent or caregiver. Sometimes a child who is using this strategy, may give different information to each of the parties, which may often lead to conflict. Children are forced to lie or steal, or to keep secrets about what is going on in their families. They often resort to manipulation to protect themselves from abuse.

“New = dangerous”

The process of learning new knowledge and skills requires some level of flexibility, seeking solutions, and thinking outside the box. It can be difficult for traumatized children, who tend to follow rigid patterns, routines, and rituals, and cling to their old ways to make their world safer and more predictable.

“Close to an adult!”

In order to feel safer in the stressful and threatening school environment, some students, especially younger ones, seem to seek close relationships with their teacher, class tutor, or school counsellor. They may try to shorten interpersonal distance, show clinginess, and be overly ingratiating or people-pleasing, as if trying to please the adult and win their favour at any cost.

“I'm not here”

There are also students who are hypercorrect, always obeying the rules, reserved, silent, and reticent in expressing their views or needs. They avoid contact, especially in conflict situations. They seem distant and withdrawn. They strongly control their reactions, not allowing themselves to express feelings. They avoid attracting other people's attention, as if they wanted to hide and remain invisible.²⁵ There are students, for example, who give up and refuse to answer questions in class, even though they are well prepared and have done their homework. This strategy is often a result of negative beliefs about the self, low self-esteem, and distrust in their own competence.

25 Child Trauma Toolkit for Educators, NCTSN, Los Angeles, 2008.

2. POSITIVE TEACHER RESPONSE: TRAUMA-INFORMED EDUCATION

This chapter will discuss the importance of knowledge and awareness of trauma. We will identify the skills a teacher should have to respond in a grown-up, mature way to students' "survival strategies". We will highlight how important it is for the teacher to be open in the way they look at themselves to prevent the effects of professional burnout, compassion fatigue, and secondary traumatising.

CONSTRUCTIVE ADULT STRATEGY IN RESPONSE TO STUDENT SURVIVAL STRATEGY

To be able to successfully guide students with traumatic experiences through the education process, teachers should have sufficient knowledge and understanding about trauma and its possible impact both on students, and on the teacher. On the one hand, being aware of these effects will expand the „window of tolerance“ for children's "bad behaviour" and unusual reactions, which are often, in fact, their survival strategies, modified and adapted to the school environment. It helps to notice students' real, though often carefully hidden, needs, and to respond to them in a positive way within a supportive relationship. It also helps the teacher to protect themselves from the effects of overloading and stress related to working with a traumatised student. Importantly, widening the "window of tolerance" does not mean children may violate all rules.



Dysfunctional and threatening behaviour requires an appropriate response. At the same time, however, the child's needs should be satisfied and the child must not be punished for showing symptoms of trauma.

It is therefore important to know the child, their environment and life story, including the part marked by trauma.

All educational and upbringing efforts should be based on the need to work with students within a **close, supportive, and, if possible, long-term relationship with an adult** (e.g., teacher, class tutor, or school counsellor), and to provide them with **safety, stability, predictability and wellbeing**. Focusing on the student's **resources**, their **talents, interests, and strengths**, and giving them opportunities to improve their **self-esteem**, may be helpful not only in coping with the effects of trauma, but also in creating a **positive narrative** about themselves.

Teaching and working with children with traumatic experiences should address the areas affected by trauma, and be focused on restoring the child's **feelings of safety, stability, and predictability**, and improving their **wellbeing** within a **healing relationship** with a teacher, class tutor, school counsellor, and other staff members.

The suggestions and recommendations presented below may prove helpful in teaching or educating children with the experience of trauma, in the school environment.

Decode the message

Many of students' challenging behaviours and reactions at school may be learned and consolidated forms of their response to the original traumatic stress, displayed in the face of new threats. They may also result from disturbed communication of students' unsatisfied needs. Teachers may try to decode these behaviours, like an **encrypted message**, and then respond to them in a positive way. This process may be presented as follows:

- ✓ A student's behaviour/reaction (What are they doing or saying? How are they reacting?).
- ✓ The context (The circumstances of the behaviour/reaction, who or what has provoked it or what could have influenced it?).
- ✓ Identifying the student's real, but hidden need/needs (What unmet need/needs may underlie this behaviour/reaction? "What I need most now is...").
- ✓ A positive response to the student's real and hidden need (What can be done? Who can do it? What resources can be used? What kind of support is needed?).

Tell me something, or a need expressed with words

Neglect by parents or caregivers and deficits in verbalising their own needs, make the child with the experience of trauma give up any attempts to express them with words, and move straight to action. Usually it is a modified version of the **fight or flight** response. Therefore, it is important to take every opportunity to encourage the child to describe their states, feelings, needs, and desires. First of all, it will allow the teacher to interact with the student, which is always important in the broader process of developing a relationship. Moreover, it is helpful in understanding the motivations behind the student's behaviour. Finally, and most importantly, it contributes to reducing tension and activates the child's "rational brain", improving their ability to control and regulate their own behaviour. The following examples may be used here:

- *I need your words.*
- *Please tell me what is happening.*
- *What do you want at the moment? What do you care about?*
- *I think you are... Please tell me how you feel about it?*
- *Please tell me what you feel right now.*



What triggers me

In the previous sections we devoted much attention to triggers that may take different forms and activate different senses in children. It is very important for the teacher to try to identify at least the most important triggers, which may shake the student's safety. With this knowledge, the teacher will be more able to anticipate difficult situations and, whenever possible, help the child to prepare for them.

The teacher should always forewarn the students when they are going to do something unusual and involving strong auditory, visual, or olfactory stimuli, such as turning on the lights or making a sudden noise. The teacher should be also aware that some behaviours and reactions may be a trigger for them.



Re-enactment: It's nothing against you

It is important that the teacher is aware that most children with traumatic experiences tend to re-enact their traumas, often through play or interactions with others. Some students may provoke teachers and confront with them to re-enact what they experienced at home, from significant people in their lives. Teachers may play the role of attachment or authority figures. Children often associate teachers with their parents and introduce the same patterns into student-teacher relationships. It should be also remembered that the child's provocative behaviour may be their old and proven – though dysfunctional – strategy to attract adults' attention.²⁶

It is extremely important for the teacher to be able to distance themselves from this type of behaviour and not take it personally, as the child's attempts to attack or denigrate them. It is not an easy thing to do, but knowing the child's story and their history of trauma may be very helpful.



The following suggestions may prove helpful here

- ✓ Seat the child close to you, next to a quiet classmate.
- ✓ Allow movement in the classroom, incorporate physical exercise in the educational process (stretching, relaxation, games).
- ✓ Give the student a task of being your "assistant".
- ✓ Change students' activity by giving them short tasks.
- ✓ When addressing the student, say their name and wait for eye contact before making a request or asking a question.
- ✓ Use rewards to motivate the student to make an effort rather than to achieve the final result.
- ✓ Separate behaviour from the person/child.

We're tuning in: Safe teacher – safe student

As the teacher gets to know the student better and builds a closer relationship with them, they become more able to notice the student's needs, which often do not even have to be verbalised. It also helps the teacher to identify the first signals of the child's growing anxiety or distress, before the overwhelming feelings take over and throw the child into the maelstrom of fight or flight. It also gives the teacher a chance to take pre-emptive action and reduce the child's tension and distress. In a longer-term perspective, it may be helpful in developing safe strategies to release tension.

The teacher's empathy, calmness, and composure, and their ability to regulate their own emotional responses, play a key role here. Other significant aspects include body posture, gestures, facial expression, and the tone of voice. What is extremely important, is the teacher's non-verbal cues (often not fully conscious) signalling their feeling of safety or the lack of it. The student has an opportunity to tune in to the teacher, at different levels of perception, to calm down and learn how to cope with tension.²⁷ It is therefore important that the teacher is constantly prepared to work on their inner balance, their feeling of safety, and their psychophysical wellbeing.

Containment, or how not to repay in kind

When the fight response has become the child's dominant pattern of responding to threat, the teacher may be exposed to their verbally or physically aggressive behaviour. It is very important to be able to take the "blast wave" and hold it in for some time. An aggressive response to aggression would confirm and reinforce the child's destructive strategy. It would also limit the possibility to build a relationship based on trust and safety, rather than violence. It is important that the teacher is able to "unload the container of difficult emotions" after the event. For example, breathe deeply and, while breathing, imagine that the tension and difficult feelings accompanying the situation are gradually disappearing. Try to stretch and shake your tension off, take care of yourself in a way that gives you the most pleasure, or just talk about it to a friend.

The YES attitude, or the power of positive message

As previously mentioned, students with the experience of chronic or complex trauma, especially teenagers, tend to be "allergic" to the NO message, as it may bring them back to past events and experiences, when the NO message was always present in their lives, literally or as their neglectful caregivers' prevailing strategy in response to the child's developmental needs. Therefore, it may be very important and helpful to try to form positive messages using, as much as possible, the word YES. This principle should be applied not only when giving instructions, but also for interventions and disciplining. Even in situations when refusal, or saying „no“, seems the only reasonable option, it is possible to reframe the message to make it positive. For example, in response to a student's questions in the middle of a class: "Miss, can I go home?", the teacher may say: "YES, you will go home as soon as we finish the class".

I am... when I am safe

A student has to feel safe enough to have access to their "rational brain" (the neocortex), which allows them to navigate relationships with self and others, to learn, and to cope with difficulty.

Self-regulation, or coping with one's inner pain, distress, and tension, and learning to regulate one's emotions, is based on the child's close relationship with an adult, and is only possible in safe conditions.²⁸ Therefore, it is important that teachers and other members of the school staff work toward maximising students' physical and emotional safety. In particular, when children and young people have histories of maltreatment or abuse, respecting their boundaries is of utmost importance. Teachers need to bear this in mind when class activities involve physical proximity (decreased personal distance) or physical contact, e.g. when demonstrating exercises during a PE class. Respecting students' emotional boundaries is equally important. In specific cases, when feelings become too overwhelming for a student, the teacher should consider letting them leave the class to be supported by an appropriate adult staff member, such as the school nurse or the school counsellor. It may be a good idea to provide a comfortable, properly equipped "safe room" for students, where they could deal with their overwhelming emotions and regain balance in safe conditions, accompanied by a supportive adult.²⁹ The school should develop and implement clear response procedures, especially in crisis situations, e.g. when safety is threatened by students' aggression or self-aggression.

27 Van der Kolk, B., The Neurobiology of Childhood Trauma, Child and Adolescent Psychiatric Clinics of North America, 2003 no 12, pp. 293-317, cited in: Call, C., Purvis, K. B., Parris, S. R., Cross, D. R., Creating Trauma-Informed Classrooms, Adoption Advocate, 2014, no 75, more <https://www.adoptioncouncil.org>.

28 Van der Kolk, B., Strach ucieleśniony. Mózg, umysł i ciało w terapii traumy, Warszawa 2018.

29 Psychological First Aid for Schools (PFA-S) Field Operations Guide, NCTSN, Los Angeles, 2012.



In terms of providing safety, the following suggestions may be helpful:

- ✓ Maintain the usual procedures. Going back to normal will send a message to the child that they are safe and that life goes on.
- ✓ Offer increased support and encouragement to a traumatised child. Look for another adult who can provide additional support, if needed.
- ✓ Set clear limits for inappropriate behaviour; use logical, rather than punitive consequences.
- ✓ Even the most destructive behaviour may be caused by distress and anxiety related to trauma. Regard behaviour problems as temporary.
- ✓ Set a time and place for sharing to help the child understand what has happened to them.
- ✓ Give simple and realistic answers to the child's questions about traumatic events. If it is not the right moment, remember to provide time and space for talking and asking questions.³⁰

I have a choice – I have influence – I'm in control

Traumatic events lead to chaos and the loss of control. Children exposed to chronic abuse or neglect by their caregivers, were often forced to endure situations with no way out, for years. Their experience told them they had limited influence on what was happening to them and around them. As a consequence, they may have developed rigid patterns of behaviour and they may stick to their learned patterns, even though those patterns do not bring positive solutions.

The teacher may improve students' safety by giving them choice and influence, and, ultimately, allowing them to gradually regain control over their behaviour.³¹ This approach will also activate the student and motivate them to take action. It may be helpful to give them simple choices, such as: „Please, decide, are you choosing/doing ... or ...?“.

Resilience: Navigating toward things that empower

The teacher, class tutor, or school counsellor should try to identify – whenever possible – the trauma-affected students' resources, especially the ones that helped them to survive despite adversity. This awareness will help them not to focus solely on the child's deficits, but rather to reinforce the skills that allow the student to deal with everyday challenges, including for example the ability to adapt to new circumstances and frequent changes, readiness to build new relationships, or ability to cope in difficult living conditions.³²

It is important to identify any supportive relationships the child has managed to form and maintain in their life. The class tutor has a special role to play here, as they can make contact and cooperate with significant people in the child's environment and thus get closer to the child and initiate the development of a larger support network.

It is important to identify the student's strengths, talents, interests, and positive activities – all the things that provide stability and relaxation, and improve the child's emotional wellbeing.³³ Opportunities for self-fulfilment may help a student with traumatic experiences to improve their self-esteem, to create a new positive narrative about themselves, and to make sense of their story.

Notice special needs

Students struggling with the effects of complex trauma, should be treated, in some ways, as children with special needs, which implies the necessity to adopt an individualised approach to education, to the largest possible extent. Consequently, deferring the legal obligation to attend school or its short-term suspension should be considered, when adaptation to new circumstances and providing safety are the priority for the child, and when changing schools would be too stressful, for example when the child is being moved from one alternative care placement to another or has been separated from their birth family and placed in an emergency care setting.

The individualised approach to education may take the form of temporary one-to-one tuition. When, however, a student with special needs attends standard classes, it is worth considering giving them shorter tasks with more time for their completion, or providing additional teaching support during classes.

30 Child Trauma Toolkit for Educators, NCTSN, Los Angeles, 2008.

31 Purvis, K. B., Cross, D. R., The Healing Power of Giving Voice, Adoption Advocate, 2013, no. 61, for more: <http://www.adoptioncouncil.org/resources/adoption-advocate>.

32 Van der Kolk, B., Strach ucieleśniony. Mózg, umysł i ciało w terapii traumy, Warszawa, 2018.

33 Ibidem.

Although a traumatised child may not fulfil the qualification criteria for special education, this possibility should also be considered, as a temporary solution.

Recovering from trauma: Reclaiming the body, wellbeing, and relaxation

Coping with the effects of trauma, especially traumatic experiences associated with violations of physical boundaries through different types of maltreatment or abuse, and the related freeze response as the dominant way of responding to threat, involves “reclaiming the child’s own body”, restoring personal boundaries, sensation, and awareness, and creating natural opportunities for relaxation. It is essential that all that occurs in interaction with a safe adult (e.g., a teacher or school counsellor) or a peer, and – if possible – with safe and natural physical contact.³⁴ Special role can be played here by physical education classes, optional sports classes, but also games and activities used in class and during breaks. Children should have opportunities to relieve stress and tension between classes (e.g., through physical games and activities during the break or before classes, in the schoolyard or a special large room). It is worth considering after-school relaxation sessions for some children, and education in this area for other students.

Different types of dancing, singing, theatre, and art classes organised by the school play an important role in the natural expansion of the area of safety, relaxation, body awareness, and emotional wellbeing. Sports, recreation, active tourism, and the previously mentioned forms of artistic activity, especially when combined with physical exercise, lead to increased levels of endorphins, hormones of “pleasure and happiness” (e.g. serotonin). It should be also remembered that in order to keep children’s bodies and brains in good condition throughout the school day, it is necessary to provide regular nutrition and hydration, which also helps the regulate the child and facilitates relaxation.

The connecting strategy, or our relationship is an opportunity

Trauma is usually experienced in relationships. It is true both for abuse (excessive, intrusive presence marked with violence) and for neglect (absence or insufficient presence, escaping or avoidance). It is also within a relationship, in which the child receives time and attention from an adult, that healing may occur. Therefore, it is very important to apply the „connecting strategy”, i.e. to use every opportunity to form and sustain a supportive relationship with the student. A significant role in this process is played by all kinds of positive and neutral situations, occurring naturally in the process of education, such as routine interactions in the classroom or various expressions of support from the teacher.³⁵ However, crisis situations and teacher-student conflict are equally important, especially when the parties’ efforts result in agreement, which further strengthens the relationship. The traumatised child learns from experience how to have their needs met in positive ways, which helps them to rebuild trust in other people (especially adults) and the world. On the other hand, teachers should avoid using the „disconnecting strategy”, whereby instead of trying to resolve conflict in interaction with the student, they immediately send the child off to the school manager, expecting the latter to discipline or punish them. Another example of the “disconnecting strategy” is moving the student to another class or school without exhausting all available forms of support.

The “connecting strategy” is also reflected, in a way, in all forms of cooperation between the teacher (or class tutor) and the parents, other significant persons in the child’s life, and representatives of support services, if needed. This contributes to the development of the support network around the student and their needs. One example of an activity consistent with this approach is the teacher’s (or class tutor’s) participation in the work of the periodic assessment team, responsible for assessing the situation of a student who has been placed in alternative care.

Seek professional help

Short- or long-term effects of trauma may be very severe and painful for the student. Apart from considerable distress, low energy, and disability to face everyday challenges, the child may develop some health conditions or disorders, or even show suicidal behaviours. It is therefore important for a trauma-informed teacher or another staff member to try to motivate the student to seek professional help (e.g., from a medical specialist, psychiatrist, psychologist, or psychotherapist). It should be accompanied by close cooperation with the child’s parents or caregivers. It is also recommended that, if possible, the teacher themselves – if possible – should use regular consultations and supervision on supporting a student affected by trauma.

³⁴ Ibidem.

³⁵ Call, C., Purvis, K. B., Parris, S. R., Cross, D. R., Creating Trauma-Informed Classrooms, Adoption Advocate, 2014 no. 75, for more <https://www.adoptioncouncil.org>.

HOW NOT TO GIVE IN?³⁶

Teachers, class tutors, school counsellors and psychologists, administrative personnel, and other members of the school staff, who are confronted with the effects of trauma in students, are also exposed to direct or vicarious traumatisation, leading to conditions such as secondary traumatic stress (STS) or compassion fatigue.

Unlike other types of professional burnout, STS and compassion fatigue are not caused by work overload or institutional stress, but develop as a response to the trauma experienced by individuals we work with (e.g., students). Both conditions may significantly decrease life satisfaction and have a damaging effect on the individual's personal life and general feeling of safety.

Symptoms of the two types of vicarious traumatisation include:

- ✓ increased tendency to avoid stressful situations, behaviours, and student responses – in general or limited to selected students
- ✓ intense preoccupation with students and their issues
- ✓ increased irritability or impatience in interaction with students
- ✓ difficulty planning classes
- ✓ recurring, disturbing thoughts, nightmares, and flashbacks about students' traumatic experiences
- ✓ denial that traumatic events have any effect on students, feeling numb or detached
- ✓ increased arousal
- ✓ poorer concentration
- ✓ thoughts about violence or taking revenge on the student/students
- ✓ feeling lonely and alienated, having no one to talk to
- ✓ feeling trapped, "infected" with trauma, negative beliefs about self
- ✓ difficulty separating work from personal life.

Given the above, we offer some suggestions and recommendations that may prove helpful in daily work.

1. **Be aware** of the significance of symptoms of STS and compassion fatigue.
2. **Don't be alone.** Anyone, who knows about traumatic stories, should avoid isolation. Respecting your students' confidentiality, get support by working in teams, talking to others in your school, and seeking your administrators' or colleagues' support.
3. **Recognise compassion fatigue as a professional risk.** When a teacher or school counsellor approaches their students with an open heart and "compassionate ear", they may develop STS or compassion fatigue. Teachers too often regard themselves as not good enough or incompetent, due to their strong responses to students' traumas. STS and compassion fatigue are not signs of weakness or incompetence, but rather a **cost of care**.
4. **Seek help for your own traumas.** Adults helping traumatised children, who have their own unresolved traumatic wounds, are at a higher risk of STS and compassion fatigue.
5. **If you notice symptoms of STS and compassion fatigue in yourself, seek help from a professional** who has expertise in trauma.
6. **Take care of yourself.** Beware of a situation when your work becomes your only activity, defining who you are. Keep things in perspective by spending time with children and young people who do not experience traumatic stress. Take care of yourself by eating properly, exercising, and engaging in play. Remember to take breaks to relax, find some time for reflection, and allow yourself both to cry and to laugh.



36 Child Trauma Toolkit for Educators, NCTSN, Los Angeles, 2008.

**REMEMBER**

- ✓ Students are able to learn and regulate their behaviour only when they feel safe enough.
- ✓ Identifying triggers and students' real development needs behind their "survival strategies" will help you expand your "window of tolerance" and find an appropriate, positive response.
- ✓ Supporting students in coping with the effects of trauma is possible with a supportive relationship and through expanding the student's area of wellbeing and resilience.
- ✓ Cooperation with the family, significant persons in the student's life, as well as services and organisation working with children and families, contributes to the development of a coherent support network.
- ✓ Understanding trauma and its effects, being aware of your own traumatic experiences, facing them effectively, and taking care of yourself, your own psychophysical wellbeing and safety, will allow you to be a competent and successful teacher.
- ✓ The experience of a constructive relationship with the teacher, as a result of the "connecting strategy", may prove healing for the student, have a significant positive effect on their identity, and be helpful in creating a new, positive narrative about the self and the world.

III. SCHOOL: A FRIENDLY AND COHERENT SUPPORT SYSTEM

This chapter is a contribution to a systemic approach to the school's work with children with the experience of complex developmental trauma (relational trauma).³⁷

Schools' primary goal is to run the education process and to support students in their intellectual and cognitive development. For this mission to be fulfilled, students need to feel safe, receive support, and, above all, be physiologically ready to absorb new knowledge. Children who experienced or continue to experience abuse or complex developmental trauma, do not feel safe and are not prepared to learn new knowledge. Moreover, in the school context the effects of trauma affect not only the child who has experienced it, but also other students, teachers, and the whole school community. Since schools remain focused on the educational process and students' academic achievement, it is particularly important to raise school staff's awareness about the significance of students' feelings of safety and psychological wellbeing for their academic achievement. This knowledge will help them understand the behaviours of students affected by trauma and appropriately respond to difficult situations.

A trauma informed school engages in and sometimes initiates local partnerships, supporting its teachers and other staff members by raising their relative knowledge and skills.

THE MAIN COMPONENTS OF THE SYSTEM IMPLEMENTED BY TRAUMA-INFORMED SCHOOLS

1. Maximising physical and psychological safety of the whole school environment.
2. Working to improve students' safety in the following areas:
 - a. family of origin
 - b. peer support
 - c. development of skills
 - d. sense of agency/influence
 - e. self-esteem
 - f. relationships and connections within the school system
 - g. spirituality/religion.
3. Raising the school staff's knowledge and awareness about the effects of trauma on students:
 - a. ability to identify behaviours and reactions that are or may be a result of traumatic stress
 - b. ability to respond appropriately to behaviours resulting from traumatic stress. Creating a culture of sensitivity. Sharing knowledge, being open to doubt, and seeking solutions. Acknowledging that a fundamental sense of safety, which is often missing in children affected by trauma, is a necessary prerequisite for educational success.
4. Cooperating with students' parents, sharing knowledge and experience in how to support children affected by trauma.
5. Providing students with:
 - a. prevention programmes and psychoeducational classes aimed at improving their intra- and interpersonal skills
 - b. sports, recreational, cultural, and artistic activities, especially music, dancing, and theatre classes, which create opportunities to release tension, express feelings, experience self-fulfilment, and achieve success in areas other than schoolwork.
6. Developing management and response procedures to deal with crisis situations, such as displays of students' aggression or self-aggression.
7. Taking action to prevent secondary traumatic stress in teachers and to support those who are struggling with its effects.
8. Reviewing and updating school procedures and regulations to incorporate knowledge about trauma and traumatic stress; introducing changes, if needed, to principles and ways of responding.
9. Multifaceted cooperation with other organisations and institutions; forming partnerships.

³⁷ Based on Child Trauma Toolkit for Educators, NCTSN, Los Angeles, 2008.

When we think about working with a child who attends a specific school and, at the same time, lives in alternative care, it is recommended that the child's class tutor or school counsellor participates in the meetings of the team responsible for the periodic assessment of the child's situation. During these meetings, the school representative may not only discuss any problems the child may be experiencing at school, but also get a better understanding of the child's story, and improve cooperation with both the child's foster carers and representatives of other institutions taking part in the meetings, as well as the child's family of origin.

One should also remember about therapies recommended for working with individuals affected by trauma. This information may be helpful for foster carers, psychologists, and pedagogic counsellors. Therapies recommended by the American National Child Traumatic Stress Network include:

- ✓ Eye Movement Desensitization and Reprocessing (EMDR)
- ✓ Child-Parent Psychotherapy (CPP)
- ✓ Prolonged Exposure Therapy for Adolescents (PE-A).

Both children with traumatic experiences and members of school staff: teachers, educators, and school counsellors who, in their daily work, deal with individuals showing behaviours caused by trauma, may also use a variety of methods focused on working with the body or on the body–mind relationship, such as (for example) Lowen's Bioenergetics, TRE® (Trauma Release Exercises), or SE (Somatic Experiencing®).

The following therapies and forms of support may also be helpful:³⁸

- ✓ Dyadic Developmental Psychotherapy (DDP)
- ✓ Theraplay
- ✓ Mentalising
- ✓ Narrative approach in trauma treatment
- ✓ Aggression Replacement Training (ART)
- ✓ Professional Assault Response Training (PART).

38 Based on Trauma Informed Care – wiki page content. IOR CEE/CIS Programme Department. SOS Children's Villages.

IV. APPENDIX

In this section, the reader will find examples of tools helpful in a preliminary interpretation of the child's behaviour.

APPENDIX 1 ASSESSMENT OF COMPLEX TRAUMA BY PARENTS AND CAREGIVERS

Please read the statements below. If you answer yes to two or more, you may want to consider referring your child for a complete assessment for complex trauma. The survey below is a tool to help you decide when you need to seek professional help.

- ✓ Child has been exposed to many potentially traumatic experiences.
- ✓ Child has difficulty controlling emotions and easily can become sad, angry, or scared.
- ✓ Child has trouble controlling behaviors.
- ✓ Child often exhibits significant changes in activity level, appearing overactive or agitated sometimes and then calmer, or even quite slowed down at other times.
- ✓ Child has trouble remembering, concentrating, and/or focusing. He/she sometimes appears "spacey."
- ✓ Child has problems with eating, sleeping, and/or complains about physical symptoms even though doctors find nothing physically wrong to explain these symptoms.
- ✓ Child has difficulties in forming and sustaining relationships with other children and adults.
- ✓ Child seems to need and seek out more stimulation than other children and/or can be easily distracted by noises, sounds, movements, and other changes in the environment.
- ✓ Child has many mental health diagnoses but none of them quite seem to explain his/her problems.
- ✓ Child is taking medication (or many medications) for these diagnoses but the medicines are not helping.

Assessment of Complex Trauma by Parents and Caregivers
The National Child Traumatic Stress Network at www.NCTSN.org

APPENDIX 2 ASSESSMENT OF COMPLEX TRAUMA INFORMATION FOR NON-MENTAL HEALTH PROFESSIONALS

As not all children who've gone through traumatic experiences demonstrate the multiple functional impairments associated with complex trauma, the following questions can help determine whether to refer a child/family for more comprehensive assessment:

- ✓ Has the child experienced early and repeated exposure to overwhelming events in the context of a caregiver/family setting or in the community?
- ✓ Is the child having difficulty regulating or controlling behavior, sometimes appearing hyperactive, engaging in risk behaviors, or having difficulties with complying with rules? (There may be a diagnosis of ADHD treated with limited success).
- ✓ Is the child having difficulty with sustaining attention, concentration or learning?
- ✓ Is the child showing persistent difficulties in his/her relationships with others?
- ✓ Does the child have difficulty regulating bodily states and emotions, including problems with sleep, eating, sensory processing, and/or difficulties with regulating or identifying/ expressing feelings?
- ✓ Does the child have multiple mental health diagnoses without any one sufficient diagnosis explaining his/her problems?

www.NCTSN.org

APPENDIX 3

KNOW COMMON SIGNS OF DISTRESS TRAUMA RELATED

Watch and listen for any students who show signs of distress or changes in behavior and refer them to the appropriate professionals. Signs of distress vary by age and developmental level and can include:

- ✓ Poor control of emotions
- ✓ Anger and moodiness
- ✓ Frustration and anxiety
- ✓ Social withdrawal
- ✓ Change in academic performance or in attendance
- ✓ Trouble with concentration, memory, cognition, and organization
- ✓ Physical symptoms like headaches and stomachaches
- ✓ Risk-taking, unpredictable, and/or impulsive behavior
- ✓ Intense reactions to reminders of the event.

Identify Students Needing Services: If you see changes in a student, ask directly how he/she is doing. Many students will not tell someone they are having difficulty until they are directly asked. Also ask the student if he/she knows of any classmates who may need help. They are often aware of changes in their peers.

Psychological First Aid for Schools

Field Operations Guide 2nd Edition

National Child Traumatic Stress Network National Center for PTSD



NOTE: APPENDIX 4 AND APPENDIX 5 SHOULD BE COMPLETED BY A PROFESSIONAL, A PSYCHOLOGIST OR PEDAGOGICAL COUNSELLOR, DRAWING ALSO ON INFORMATION FROM THE CHILD'S TEACHER.

APPENDIX 4

CTAC TRAUMA SCREENING CHECKLIST: IDENTIFYING CHILDREN AT RISK

Ages 6-18

Please check each area where the item is known or suspected. If history is positive for exposure and concerns are present in one or more areas, a comprehensive assessment may be helpful in understanding the child's functioning and needs.

1. Are you aware of or do you suspect the child has experienced any of the following:

- ☐ Known or suspected exposure to drug activity aside from parental use
- ☐ Known or suspected exposure to any other violence not already identified
- ☐ Impaired Parenting (i.e. Parental alcohol/substance abuse or Mental Illness)
- ☐ Multiple separations from parent or caregiver
- ☐ Frequent and multiple moves or homelessness
- ☐ Physical abuse
- ☐ Suspected neglectful home environment
- ☐ Emotional abuse
- ☐ Exposure to domestic violence
- ☐ Sexual abuse or exposure
- ☐ Bullying
- ☐ Prenatal Exposure to Alcohol/Drugs or Maternal Stress
- ☐ Out of Home Placement(s) including Hospitalization/Foster Care Placement

_____ Loss of Significant people, places etc.
 _____ Other _____

If you are not aware of a trauma history, but multiple concerns are present in questions 2, 3, and 4, then there may be a trauma history that has not come to your attention. Note: Concerns in the following areas do not necessarily indicate trauma; however, there is a strong relationship.

2. Does the child show any of these behaviors:

_____ Excessive aggression or violence towards self
 _____ Excessive aggression or violence towards others
 _____ Explosive behavior (Going from 0-100 instantly)
 _____ Hyperactivity, distractibility, inattention
 _____ Very withdrawn or excessively shy
 _____ Oppositional and/or defiant behavior
 _____ Sexual behaviors not typical for child's age
 _____ Peculiar patterns of forgetfulness
 _____ Inconsistency in skills
 _____ Other _____

3. Does the child exhibit any of the following emotions or moods:

_____ Excessive mood swings
 _____ Chronic sadness, doesn't seem to enjoy any activities.
 _____ Very flat affect or withdrawn behavior
 _____ Quick, explosive anger
 _____ Other _____

4. Is the child having problems in school?

_____ Low or failing grades
 _____ Inconsistent or sudden changes in performance
 _____ Difficulty with authority
 _____ Attention and/or memory problems,
 _____ Other _____

Child's First Name: _____ Age: _____ Gender: _____ C
 County/Site: _____ Date: _____

Henry, Black-Pond, & Richardson (2010), rev: 11/13
Western Michigan University
Southwest Michigan Children's Trauma Assessment Center (CTAC)

APPENDIX 5 CONSENSUS PROPOSED CRITERIA FOR DEVELOPMENTAL TRAUMA DISORDER

A. Exposure. The child or adolescent has experienced or witnessed multiple or prolonged adverse events over a period of at least one year beginning in childhood or early adolescence, including:

- A. 1. Direct experience or witnessing of repeated and severe episodes of interpersonal violence; and
- A. 2. Significant disruptions of protective caregiving as the result of repeated changes in primary caregiver; repeated separation from the primary caregiver; or exposure to severe and persistent emotional abuse.

B. Affective and Physiological Dysregulation. The child exhibits impaired normative developmental competencies related to arousal regulation, including at least two of the following:

- B. 1. Inability to modulate, tolerate, or recover from extreme affect states (e.g., fear, anger, shame), including prolonged and extreme tantrums, or immobilization
- B. 2. Disturbances in regulation in bodily functions (e.g. persistent disturbances in sleeping, eating, and elimination; over-reactivity or under-reactivity to touch and sounds; disorganization during routine transitions)
- B. 3. Diminished awareness/dissociation of sensations, emotions and bodily states

B. 4. Impaired capacity to describe emotions or bodily states.

C. Attentional and Behavioral Dysregulation: The child exhibits impaired normative developmental competencies related to sustained attention, learning, or coping with stress, including at least three of the following:

C. 1. Preoccupation with threat, or impaired capacity to perceive threat, including misreading of safety and danger cues

C. 2. Impaired capacity for self-protection, including extreme risk-taking or thrill-seeking

C. 3. Maladaptive attempts at self-soothing (e.g., rocking and other rhythmical movements, compulsive masturbation)

C. 4. Habitual (intentional or automatic) or reactive self-harm C. 5. Inability to initiate or sustain goal-directed behaviour.

D. Self and Relational Dysregulation. The child exhibits impaired normative developmental competencies in their sense of personal identity and involvement in relationships, including at least three of the following:

D. 1. Intense preoccupation with safety of the caregiver or other loved ones (including precocious caregiving) or difficulty tolerating reunion with them after separation

D. 2. Persistent negative sense of self, including self-loathing, helplessness, worthlessness, ineffectiveness, or defectiveness

D. 3. Extreme and persistent distrust, defiance or lack of reciprocal behavior in close relationships with adults or peers

D. 4. Reactive physical or verbal aggression toward peers, caregivers, or other adults

D. 5. Inappropriate (excessive or promiscuous) attempts to get intimate contact (including but not limited to sexual or physical intimacy) or excessive reliance on peers or adults for safety and reassurance

D. 6. Impaired capacity to regulate empathic arousal as evidenced by lack of empathy for, or intolerance of, expressions of distress of others, or excessive responsiveness to the distress of others.

E. Posttraumatic Spectrum Symptoms. The child exhibits at least one symptom in at least two of the three PTSD symptom clusters B, C, & D.

F. Duration of disturbance (symptoms in DTD Criteria B, C, D, and E) at least 6 months.

G. Functional Impairment. The disturbance causes clinically significant distress or impairment in at least two of the following areas of functioning:

- Scholastic
- Familial
- Peer Group
- Legal Health

Vocational (for youth involved in, seeking or referred for employment, volunteer work or job training).

Bessel A. van der Kolk, The Body Keeps the Score: Brain, Mind, and Body in the Healing of Trauma

V. RECOMMENDED READING

The following resources may be helpful in enriching the reader's understanding of trauma and its effects in children's lives.



The Body Keeps the Score: Brain, Mind, and Body in the Healing of Trauma, Bessel van der Kolk

A Practical Guide to Caring for Children and Teenagers with Attachment Difficulties, Chris Taylor

Waking the Tiger. Healing Trauma. The Innate Capacity to Transform Overwhelming Experiences, Peter A. Levine, Ann Frederick

Wounded Children, Healing Homes: How Traumatized Children Impact Adoptive and Foster Families, Jayne E. Schooler, Betsy Keefer Smalley, Timothy Callahan

<http://christaylorsolutions.org.uk/>

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WEB SITES

<http://childstrauma.org/>
<https://qecliving.com/>
<https://www.nctsn.org/>

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