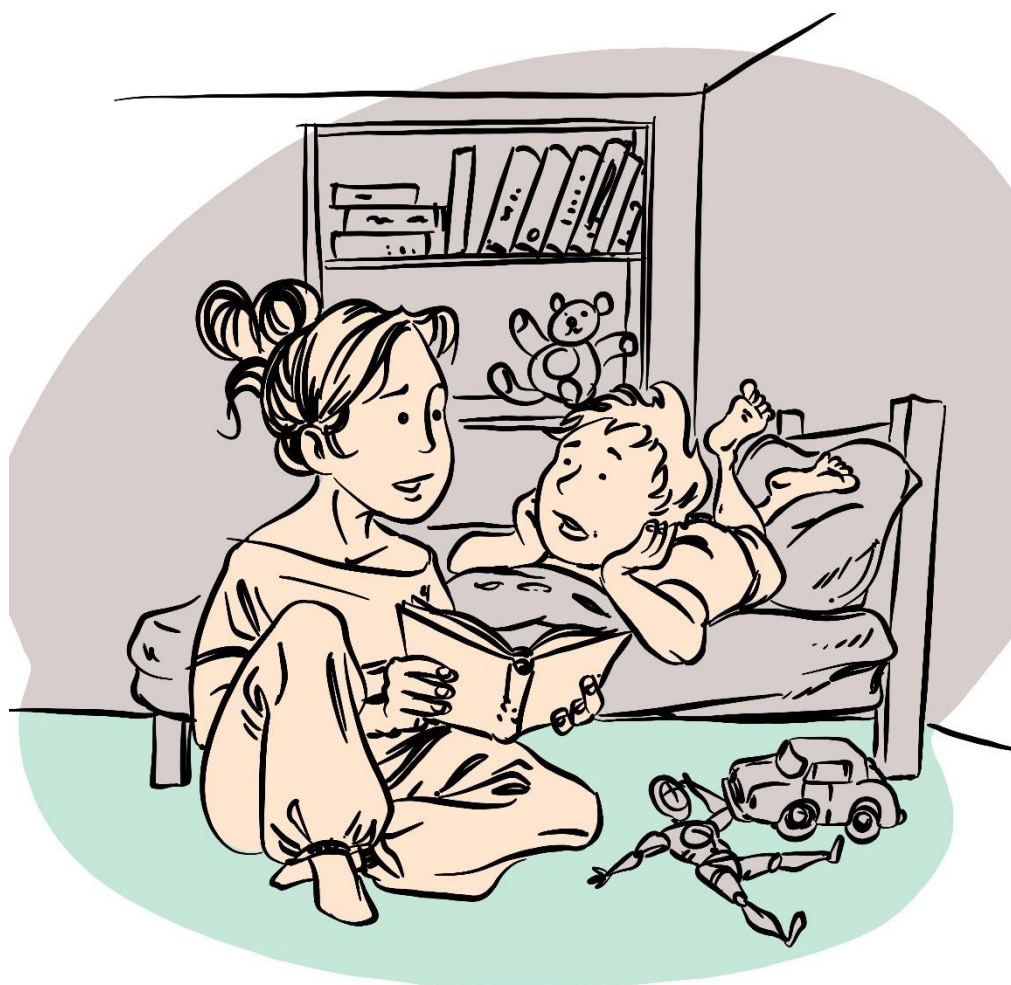


TRAUMA-INFORMED ALTERNATIVE CARE

HOW TO CARE FOR A CHILD AFFECTED BY TRAUMA



SOS WIOSKI
DZIECIĘCE



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Dear Caregivers,

Building a relationship with and caring for a child who has experienced trauma and disruptions of attachment present a particular challenge related to the child's perplexing responses to adults' friendly behaviours, their anxiety and aggression, and the necessity to constantly explain to others why the child needs an individual approach. Everyday efforts are not immediately effective and the caregiver may often feel that the more they try to get closer to the child, the more the child resists closeness and refuses to accept help. The motivation to persist in these efforts is sustained by in-depth understanding of the reasons behind the child's challenging emotions and behaviours and by professional tools for working with children affected by trauma. It is also crucial to develop and maintain a support network comprising professionals and significant others so that, while taking care to satisfy the child's needs, you remember about your own needs and about replenishing your resources.

We know that your knowledge and experience in supporting children from difficult places are enormous and that you keep looking for opportunities to broaden and systemize this knowledge. This brochure is a part of the project that aims to enhance the knowledge and skills of foster carers, professionals, and teachers in working with children affected by trauma. Building on your experiences and good practices, we have been looking for new effective ways to help children in alternative care. We believe you will find the information and tools presented in this brochure helpful and possible to convey to others with whom you co-create the system of helping traumatised children.

Authors

I. WHAT DO WE KNOW ABOUT TRAUMA?

1. Complex Developmental Trauma: What is it?

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 the families they come from. Therefore, foster carers 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 four children attending school has been exposed to traumatic events².

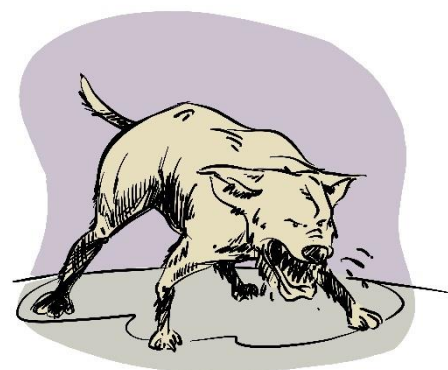
We can talk about trauma, when a child experiences or witnesses events that they perceive as threatening their own life and health³ or the life and health of their loved ones, such as parents or siblings. The child is overwhelmed by the experience and unable to cope with it emotionally. The event is 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:

- ✓ different types of abuse, especially sexual and physical abuse
- ✓ witnessing domestic violence
- ✓ 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
- ✓ painful medical examinations and interventions
- ✓ separation from the caregiver due to hospitalisation and intrusive medical procedures (including premature birth followed by putting the baby in an incubator, i.e. separating 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, e.g. 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 becomes emotionally flooded and experiences unexpected physical reactions, which add 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 (relational) trauma⁵

It 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). Complex trauma also refers to the impact of chronic trauma, its short- and long-term effects in the child's life. Children who, from their earliest years, have been exposed to multiple relational traumatic events, such as physical abuse, sexual abuse, and neglect, are victims of complex trauma

Neglect as trauma

Neglect is behaviour by a caregiver, usually a parent, that results in 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 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. Neglect should be regarded as a type of complex trauma. It co-occurs with other types of maltreatment and forms of adversity, such as extreme poverty or caregiver substance abuse.

Foster parents and caregivers should assume that many of the children in their care experienced chronic and complex trauma in their previous environments and, at the same time, were deprived of the soothing influence of a supportive caregiver. Therefore, when caring for and 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 impact of their past traumatic experiences on their present situation.

Notice: 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 their loved one. 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:

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 B. van der Kolk, *Strach ucieleśniony. Mózg, umysł i ciało w terapii traumy*, Warszawa 2018, p. 203.

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

After a traumatic event, some children experience pervasive and enduring 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 traumatic memories are suddenly evoked or when the child is exposed to a trauma trigger. As a result, children show unusual responses in everyday situations, which in turn 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.

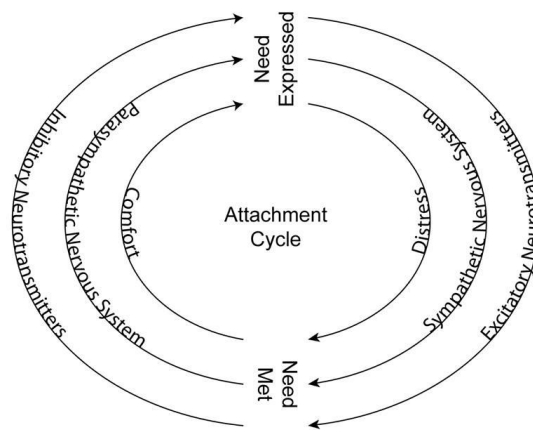
The mechanism underlying the development of the first attachment bond between a child and their caregiver, as described below, is important to understand how a child enters into relationships with adults and peers later in life, since early attachment determines the individual's future relationships.

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, which are expressed by the child. The child is soothed and has a feeling of safety until the next situation when they feel threatened. 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 C. Taylor, *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>.

The type of attachment is a pattern of behaviours that the child shows within a relationship. When the child knows how to draw the caregiver's attention to their needs and has their needs satisfied, they develop an organised pattern of attachment.

Organised Patterns 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-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 may have difficulty developing social competence and an appropriate level of autonomy. In relationships, they may show ambivalence and try to impose their will on others. The child may think of the self as unlovable and ineffective and see the caregiver as unavailable and unresponsive – ignoring and not responding to the child's needs.

Children with a fixed pattern of anxious-ambivalent attachment may show unusual responses and behaviours in order to draw both their caregivers' 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. These children need a low-stress environment with predictable safety. They need a clear, well-defined, and benevolent structure, without excessive criticism or rejection, which will soon escalate difficult feelings and behaviours. Caregivers should avoid being

overprotective or trying to “rescue” the child. These children need to learn to trust their own competence by making small steps and succeeding in small tasks.

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 their 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 feelings 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. 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 child with a fixed pattern of anxious-avoidant attachment, it is recommended to show a positive, encouraging, and non-rejecting approach. Caregivers 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 child cannot stand their attempt to shorten the distance.

Disorganised Pattern of Attachment

Disorganised attachment (no strategy or multiple strategies)

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 parenting methods and strategies in unpredictable ways or the child is looked after by multiple carers using different parenting methods. 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. 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.



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

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 rules 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.

Strength of Attachment

It is noteworthy that the strength of attachment does not depend on 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

- ✓ The attachment relationship is the most important factor shaping the child's development in the first years of life.
- ✓ Attachment develops between a child and their caregiver, usually the mother, and is formed by about 2 years of age.
- ✓ The type of 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 section we will discuss the impact of trauma on children's cognitive, psychosocial, health, and emotional development. We will focus particularly on school-age development.

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 System

Social engagement

When a child starts feeling anxious, they signal the need for support from someone in the immediate environment. They attempt to make contact and attract attention. 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 person 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 care and support. 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 (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 conscious awareness 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 are automatic, quick, and, most importantly, beyond the child's will, conscious awareness, and control. They 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 survive in the presence of threatening or neglecting caregivers. When encountering people, situations, places, or objects that remind them of past traumatic events, children 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 enabled survival – during the original traumatic event.

PTSD (Posttraumatic Stress Disorder) 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:

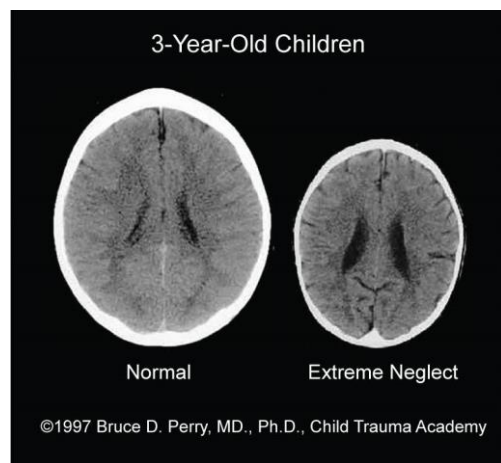
- ✓ Re-experiencing the traumatic event (e.g., in nightmares or frightening dreams, and intrusive recollections of the event)

- ✓ 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).

Effects of Trauma on the Developing Brain

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 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 neural connections being formed in the brain.

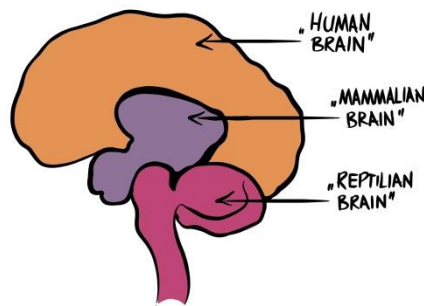
Stress affects the development and structure of the brain. The associated long-lasting high levels of cortisol and adrenaline may lead to changes both in the brain architecture, and in its functioning. The experience of trauma may lead to reduced cortical volume and disrupted communication between the brain hemispheres, and to dysfunctions in memory, attention, perception, thinking, language, and consciousness. 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.

- ✓ 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 tasks including emotional responses, 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**”.

⁸ Based on research by Bruce Perry, MD, PhD; for more information about his work on how trauma affects brain development see <http://childtrauma.org/>, the website of the Child Trauma Academy.



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.

As a result of 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, while the **“rational brain”** is either unavailable or the child has limited access to its functions.

Effects of Trauma Depending on Age

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. These negative effects will continue to be visible at later stages of development.

Younger 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
- ✓ 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.

Psychological and behavioural effects of trauma in school-age children

In school-age children, trauma disturbs the development of brain areas that would normally 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 brain region 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 **dopamine** levels, typical of adolescence, lead to increased risk-taking behaviour.

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

- ✓ Reckless, risky, and destructive behaviour
- ✓ Lower academic performance and school failure
- ✓ Making “bad choices”
- ✓ Violence or criminal behaviour
- ✓ 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.

Trauma and Emotions

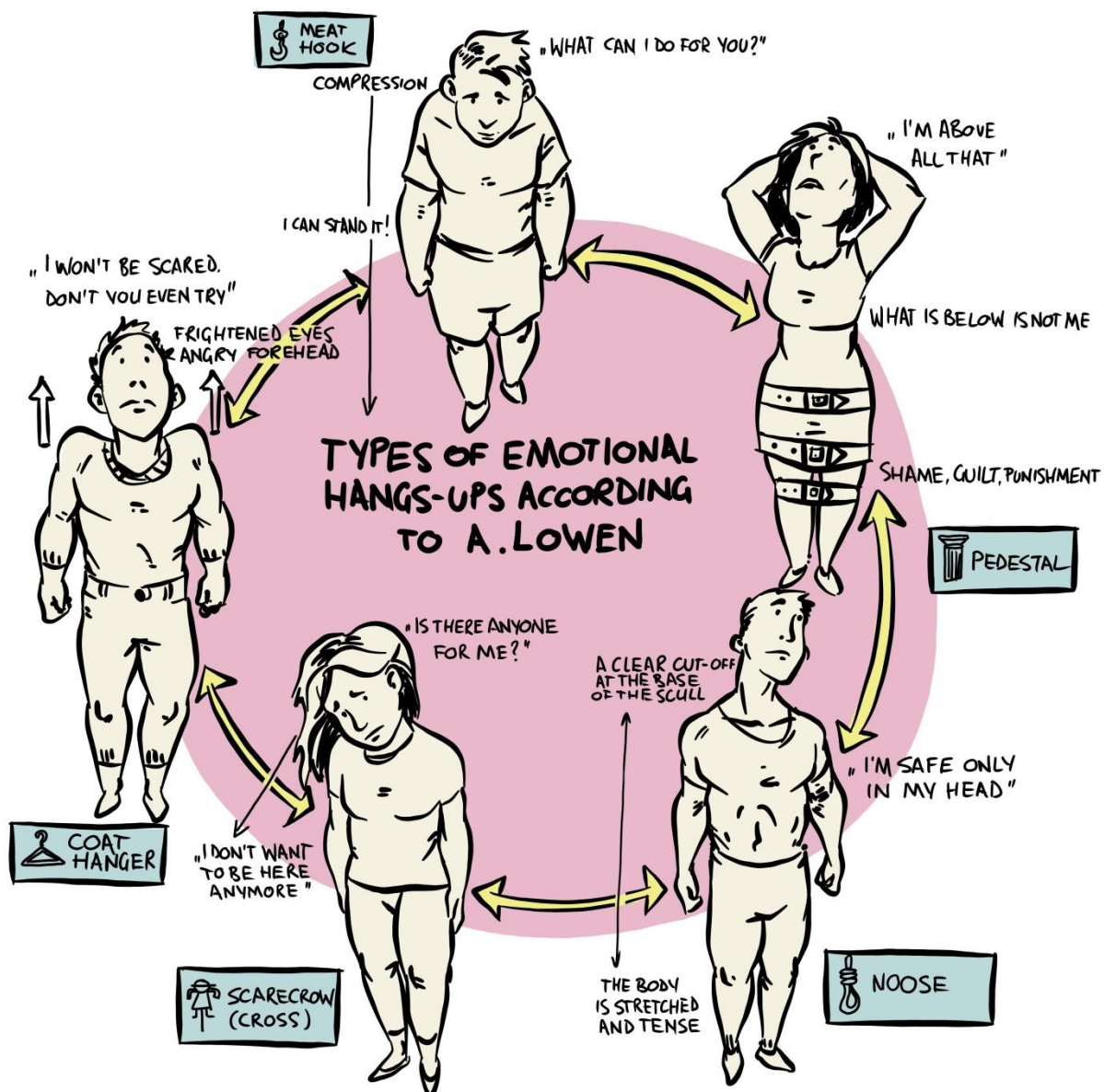
The experience of complex trauma leads to high levels of **fear**, which is always present and “seizes” all areas of the child’s life. Apart from that, feelings of shame, guilt, anger, and helplessness are prevailing. Here we may even talk about toxic shame, which leads to the development of negative beliefs, predominantly about the self, e.g., “I’m bad, weak, stupid, and inadequate. I don’t deserve

love, attention, or support". 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. A seemingly neutral situation may be perceived by the child as threatening, and the experience of the past events is so powerful and overwhelming, as if it was all happening in the present. Consequently, when facing a perceived threat and feeling the associated tension, the child 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. A child experiencing dissociation may seem absent, "detached" or "shut down", such as a non-responding child who experiences severe stress in situations of social exposure or a child standing still, unable to respond, when witnessing a fight or abuse.

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 symptoms. 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 colds. 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 or hung up in the body as a long-term effect, about **temporary freezing, stopping or hang-up** as a result of **intense or repeated traumatic stress**.



Source: <https://www.psychologia.wygladu.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 CHILD IN ALTERNATIVE CARE

1. *Survival Strategies in Practice: About Children's Difficult Behaviours and Responses*

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. However, the fact that the child IS safe does not mean they FEEL safe. Being cared for by a reliable adult does not mean that the child will automatically become securely attached to the new caregiver. Certainly, alternative care ensures, from the very beginning, that the child's basic needs are satisfied, such as shelter, good nutrition, appropriate clothes, or nurturing caregivers. However, 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, or actually 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 nurturing caregiver or teacher. The caregiver's task is to build a relationship, provide appropriate care, and create an environment in which the child may feel safe. Apart from working with the child and developing a healing relationship at home, it is extremely important to cooperate with teachers, neighbours, instructors and others in the community to create an environment that will promote the child's recovery from trauma.

When placed in alternative care, a child affected by trauma is moved to a new, unfamiliar environment and, in many cases, cared for by persons they did not know before. The child does not know or understand the rules and procedures of the new place. Securely attached children approach this not-knowing and the related uncertainty with interest and curiosity, whereas for children whose caregivers were a source of fear, the same uncertainty is overwhelming and frightening, and may hinder the process of adaptation and learning or even, in extreme cases, make it impossible at all. In the beginning, a traumatised child finds it difficult to function both at home and at school/kindergarten. 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 school⁹. Thinking about children's difficulties at school, we should bear in mind 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 child to be always alert, watching out for sudden, unpredictable, and dangerous situations, that were common at home. While providing high levels of predictability and safety at home is relatively easier, school is full of situations marked by uncertainty. Apart from that, 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. Their goals include **taking control over the situation, reducing tension, and increasing the child's sense of security**. Having control is necessary to survive, because the child could not rely on adults and had to rely on themselves for protection and, as much as possible, for emotional regulation. In many cases, those children had to keep family secrets, lie or steal, and manipulate with adults to prevent abuse or to survive. They may continue to use these strategies in other, safe environments, such as the family or the school.

Examples of Children's Behaviours: Embedded Survival Strategies

Below you will find examples of children's behaviours that are deep-rooted survival strategies, developed as a result of complex trauma.

⁹ J. E. Schooler, B. K. Smalley, T. J. Callahan, *Zranione dzieci, uzdrawiające domy. Wychowanie dzieci dotkniętych traumą w rodzinach adopcyjnych i zastępczych*, Warszawa, 2012.

“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 children use physical or verbal abuse as a 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 their foster carers and sometimes by class tutors and school counsellors who, facing those children's special needs, give them much time and effort to support them effectively. When things seem to be taking the right course, and the adult gets closer to the child and their problems, the child 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 in conflict situations, when they try, from the beginning, 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. Children affected by trauma often resort to manipulation and provocation. 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”

Children 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 response 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 to check how safe it is.

“Triangular communication”

Another strategy used by children involves manipulating information and trying to take control over communication, e.g. between adults in their environment. Traumatized children have a tendency to get involved in communication that concerns them, e.g., communication between their foster parents or caregivers. Sometimes a child who is using this strategy, may give different information to each of the parties, which may often lead to conflict. Many of those children were forced to lie or steal, or to keep secrets about what was going on in their families. They frequently resorted to manipulation to protect themselves from abuse.

“New = dangerous”

This strategy can be easily observed in the school environment. 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.

“Keep close to an adult!”

In order to feel safer in their new, and therefore stressful and threatening reality, some children, especially younger ones, seem to seek close relationships with adults, not just their caregivers. 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 children who are hypercorrect, always obeying the rules, reserved, silent, and reticent in expressing their views or needs. They avoid contact and, especially, 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. There are children, 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.

2. Positive Caregiver Response: Trauma-informed Care

This section will discuss the importance of knowledge and awareness of trauma. We will identify the skills a caregiver should have to form a relationship with a child and to respond in a grown-up, mature way to children’s “survival strategies”. We will highlight how important it is for the caregiver to be open in the way they look at themselves and their own needs to prevent the effects of professional burnout, compassion fatigue, and secondary traumatic stress.

Constructive Adult Strategy in Response to Children’s Survival Strategies

In order to be a supportive adult for children with traumatic experiences, a caregiver should have sufficient knowledge and understanding about trauma and its possible impact both on the child, and on themselves. 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 new environment. It helps to notice children’s real, though often carefully hidden, needs, and to respond to them in a positive way within a supportive relationship. It also helps the caregiver to protect themselves from the effects of overloading and stress related to caring for a traumatised child. 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 met 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 caregiving and upbringing efforts should be based on the need to help children form a close, supportive, and, if possible, long-term relationship with their foster carer and to provide them with safety, stability, predictability and wellbeing. Focusing on the child’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, primarily, in creating a positive narrative about themselves.

Providing care for traumatised children should focus particularly on restoring the child’s feelings of safety, stability, and predictability, and improving their wellbeing within a healing relationship with their caregiver. The suggestions and recommendations presented below may prove helpful in working with children with the experience of trauma, both at home and in the school environment.

Start from the beginning: Create a secure base

The first step in working with a child who has experienced trauma should involve arranging a friendly, safe, and nurturing environment, both physical and socio-emotional. This environment’s responses to the child should be equivalent to key experiences of the early childhood, enabling the child to form a trusting relationship. The essential elements include consistent, virtually constant availability of the caregiver, unconditional respect for the child, caring responses to their needs (which may be expressed in ways that are difficult to decode) and unconditioned satisfaction of the child’s basic needs. What is particularly helpful for the child is predictable responses of adults, clear expectations and explanations of rules, and active protection from threats. With such an approach, the child’s early experiences of unavailable, unpredictable, and threatening caregivers become compensated, and the

child may experience numerous positive interactions with their current caregivers. An appropriately planned environment which serves as an equivalent of an attachment figure, enables the development of secure attachment, also in children living in residential facilities and cared for by multiple caregivers.

Decode the message

Many of children's challenging behaviours and reactions 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 children's unsatisfied needs. Caregivers 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 child'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 child'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 child'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 a traumatised child 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 adult to interact with the child, which is always important in the broader process of developing a relationship. Moreover, it is helpful in understanding the motivations behind the child's behaviour. Finally, and most importantly, it contributes to reducing tension and activates the child's "rational brain", thus 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 and, as a consequence, cause many different reactions. It is very important for the caregiver to try to identify at least the most important triggers, which may shake the child's safety. With this knowledge, the caregiver will be more able to anticipate difficult situations and, whenever possible, help the child to prepare for them.

The adult should always forewarn the child when they are going to do something unusual or something that involves a sudden change or strong auditory, visual, or olfactory stimuli, such as turning on the lights or making a sudden noise. The caregiver 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 for the caregiver to be aware that most children with traumatic experiences tend to re-enact their traumas, often through play or interactions with others. Some children may provoke their foster carers and confront with them to re-enact something they experienced at home, from

significant people in their lives. Not only foster carers, but also teachers may play the role of attachment or authority figures. Children often associate them with their parents and introduce the same patterns into child–adult 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.

It is extremely important for the adult 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:

- ✓ Keep physically close to the child, in the same room, make frequent eye contact with the child.
- ✓ Provide opportunities for movement, relaxation, and play.
- ✓ Give the child a task of being your “helper”.
- ✓ Use short, clear instructions.
- ✓ When addressing the child, say their name and wait for eye contact before making a request or asking a question.
- ✓ Use rewards to motivate the child to make an effort rather than to achieve the final result.
- ✓ Separate behaviour from the person/child.

We’re tuning in: Safe caregiver – safe child

As the caregiver gets to know the child better and builds a closer relationship with them, they become more able to notice the child’s needs, which often do not even have to be verbalised. It also helps them to identify the first signals of the child’s growing anxiety or distress, before the overwhelming feelings take over and push the child into the maelstrom of fight or flight. It also gives the caregiver 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 caregiver’s empathy, calmness, and containment, 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 caregiver’s non-verbal cues (often not fully conscious) signalling their feeling of safety or the lack of it. The child has an opportunity to tune in to the adult, at different levels of perception, to calm down and learn how to cope with tension. It is therefore important that the caregiver 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 caregiver 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 sustain and reinforce the child’s destructive strategy. It would also limit the possibility to build a relationship based on trust and safety, instead of violence. It is important that the caregiver 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 or a loved one.

The YES attitude, or the power of positive message

As mentioned in the previous section, children 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, either literally or as their neglectful caregivers’ prevailing tendency 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 choice, it is possible to reframe the message to make it positive. For example, in response to a child's question in the middle of doing their homework: „Can I go and play?“, you may say: „Yes, we'll play together as soon as you finish your homework“.

I am... when I am safe

A child 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. Therefore, it is important that **caregivers work toward maximising the child's physical and emotional safety**. In particular, when children and young people have histories of maltreatment or abuse, respecting their boundaries is of utmost importance. This should be kept in mind especially when physical distance is shortened or physical contact is attempted in the process of building a relationship with the child (e.g. when the caregiver tries to hug the child or put their arm around the child). Respecting the child's emotional boundaries is equally important. In the school setting, when the child's caregiver is not present and their feelings become too overwhelming, the teacher should consider letting the child 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” in the school, where children could deal with their overwhelming emotions and regain balance in safe conditions, away from their curious peers, accompanied by a supportive adult. 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.



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

- ✓ 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 natural or logical consequences, rather than punitive ones.
- ✓ 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 meeting and sharing to help the child understand what has happened.
- ✓ 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.

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

Traumatic events lead to chaos and 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 taught 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 ways, even though those ways and patterns do not bring positive solutions.

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

Resilience: Navigating toward things that empower

The caregiver should identify the traumatised child's resources, especially the ones that allowed them to survive despite adversity. This awareness will help the caregiver not to focus solely on the child's deficits, but rather to reinforce the skills that allow the child 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.

It is important to identify any supportive relationships the child has managed to form and maintain in their life. Foster carers may help sustain those relationships and initiate the development of a larger support network for the child in their new environment, including not only helpful adults, but also peers who can become the child's friends.

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

Notice special needs

Children 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 child 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. 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, 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 or a peer, and – if possible – with safe and natural physical contact. Special role can be played here by free play at home, outdoor play, contact with nature, sports activities, and other forms of physical activity at school. It is a good idea to have a rocking chair (and other types of rockers), a hammock, a swing, a trampoline, and an exercise mat or mattress at home or in the backyard. At school, 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 and practicing mindfulness.

Different types of dancing, singing, theatre, and art classes 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 child. A significant role in this process is played by all kinds of positive and neutral situations, occurring naturally in the process of caregiving, such as everyday interactions or various expressions of support from the caregiver. However, crisis situations and caregiver–child conflicts 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. Such a positive response to the child's needs, resulting in the need being satisfied and the child experiencing comfort, must be repeated thousands of times to help the child return to the right developmental trajectory and to form healthy attachment.

On the other hand, caregivers should avoid using the „disconnecting strategy“, whereby instead of trying to resolve conflict in interaction with the child, they isolate the child or immediately send them off to another person, expecting the latter to discipline or punish them. Another example of the “disconnecting strategy” is hastily placing the child in a youth sociotherapy centre or youth educational centre or moving them to another alternative care setting or another school, without exhausting all available forms of support. Such a negative caregiver response will strengthen the child's unhealthy pattern of attachment and confirm their view of themselves as unimportant and of the caregiver as unfriendly and unavailable.

The “connecting strategy” is also reflected, in a way, in all forms of cooperation between the caregiver and the child's significant others, teachers, and representatives of support services, if needed. This contributes to the development of a support network around the child and their needs. As one example of an activity consistent with this approach, significant persons in the child's life may participate in the work of the periodic assessment team, responsible for assessing the child's situation, and thus engage in the process of supporting the child's development.

Seek professional help

Short- or long-term effects of trauma may be very severe and painful for the child and for their caregivers. Apart from considerable distress, low energy, and inability 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 caregiver to seek professional help (e.g., from a medical specialist, psychiatrist, psychologist, or psychotherapist) for themselves and for the child. A professional will help to decide whether psychotherapy is needed for the child at the given stage. It is also recommended that, if possible, the caregiver themselves – if possible – should use regular consultations and supervision on caring for a child affected by trauma.

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 their caregivers 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:

- ✓ Dyadic Developmental Psychotherapy (DDP)
- ✓ Theraplay
- ✓ Mentalising
- ✓ Narrative approach in trauma treatment
- ✓ Aggression Replacement Training (ART)
- ✓ Professional Assault Response Training (PART)
- ✓ Original Play
- ✓ TBRI (Trust Based Relational Intervention).

How Not to Give in?

Caregivers who are confronted with the effects of trauma in children in their care, are themselves 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 (children and young people in alternative care). Both conditions may significantly decrease life satisfaction and have a damaging effect on the individual's personal life and general feeling of safety.

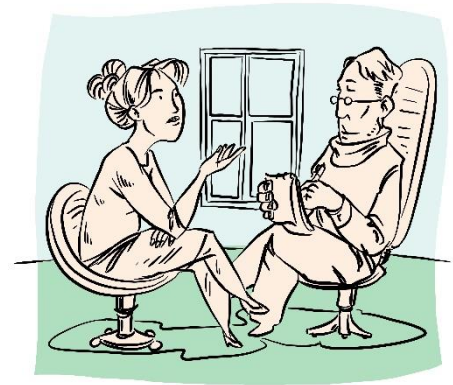
Symptoms of the two types of vicarious traumatisation include:

- ✓ Increased tendency to avoid stressful situations, behaviours, and children's responses
- ✓ Intense preoccupation with children and their issues

- ✓ Increased irritability or impatience in interaction with the child
- ✓ Difficulty planning work with the child
- ✓ Recurring, disturbing thoughts, nightmares, and flashbacks about the child's traumatic experiences,
- ✓ Denial that traumatic events have any effect on the child, feeling numb or detached,
- ✓ Increased arousal
- ✓ Poorer concentration,
- ✓ Thoughts about violence or taking revenge on the child
- ✓ 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.** Respecting the child's right to confidentiality, get support by working in teams, talking to others involved in the process of helping the child, and seeking support from professionals, supervisors, or colleagues.
3. **Recognise compassion fatigue as a professional risk.** When a caregiver approaches children with an open heart and "compassionate ear", they may develop STS or compassion fatigue. Caregivers too often regard themselves as not good enough or incompetent, due to their strong responses to children's 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 caring for a traumatised child becomes your only activity, defining who you are. 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.



**REMEMBER:**

- ✓ Children are able to learn and regulate their behaviour only when they feel safe enough.
- ✓ Identifying triggers and children's real developmental needs behind their "survival strategies" will help you expand your "window of tolerance" and find an appropriate, positive response.
- ✓ Supporting children in coping with the effects of trauma is possible within a close, supportive relationship with their caregivers, and through expanding their area of wellbeing and resilience.
- ✓ Cooperation with the child's teachers, birth family, and significant others, as well as services and organisation working with children and families, contributes to the development of a coherent support network. A trauma-informed help system is also developed through sharing knowledge and experiences among the child's caregivers, professionals, and other persons supporting the child, and through skilful application of this knowledge in their work with the child.
- ✓ 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 caregiver.
- ✓ The experience of a constructive relationship with the caregiver/caregivers, as a result of the "connecting strategy", may prove healing for the child, have a significant positive effect on their identity, and be helpful in creating a new, positive narrative about the self and the world.

III. 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.

Source:

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?

Source:

www.NCTSN.org



NOTE: APPENDIX 3 AND APPENDIX 4 SHOULD BE COMPLETED BY A PROFESSIONAL, A PSYCHOLOGIST OR PEDAGOGICAL COUNSELLOR, DRAWING ALSO ON INFORMATION FROM THE CHILD'S CAREGIVERS AND TEACHERS.

APPENDIX 3 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: _____
County/Site: _____ Date: _____

Source:

Henry, Black-Pond, & Richardson (2010), rev: 11/13

Western Michigan University

Southwest Michigan Children's Trauma Assessment Center (CTAC)

APPENDIX 4 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).

Source:

B.A. van der Kolk, Developmental Trauma Disorder: Toward A Rational Diagnosis For Children With Complex Trauma Histories, „Psychiatric Annals”, 35, nr 5 (2005): 401 – 408.

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