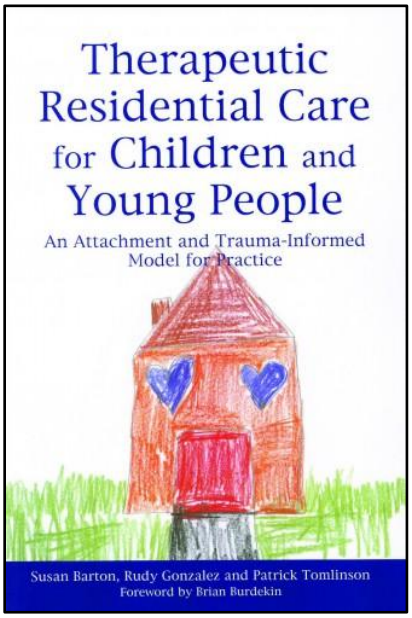
A REFLECTION ON DEVELOPMENTAL TRAUMA, TRAUMATIZATION, TRAUMA-INFORMED, AND RECOVERY - PATRICK TOMLINSON (2023, Revised 2026)

Introduction

Recently, I was asked if I could write a short explanation of what a trauma-informed approach to healing and growth might look like. This got me reflecting on the subject and led to this article.



I have been involved with therapeutic services for children and young people who have suffered trauma and other adversities since 1983. Ten years ago, in 2012, a book I co-authored with Susan Barton and Rudy Gonzalez, from the Lighthouse Foundation in Melbourne, Australia, was published - *Therapeutic Residential Care for Children and Young People: An Attachment and Trauma-Informed Model for Practice.* We included the word attachment in the title of the book as we believe that a relational approach is vital. As Farragher and Yanosy (2005, p.100) stated,

"Recovery from injuries perpetrated in a social context must occur in a social context."

Our book was about complex childhood trauma and its impact on development, therapeutic work, and recovery. Complex trauma is sometimes referred to as developmental trauma (Van der Kolk, 2005). The National Child Traumatic Stress Network (NCTSN) explains,

> Complex trauma describes both children's exposure to multiple traumatic events—often of an invasive, interpersonal nature—and the wide-ranging, long-term effects of this exposure. These events are severe and pervasive, such as abuse or profound neglect. They usually occur early in life and can disrupt many aspects of the child's development and the formation of a sense of self. Since these events often occur with a caregiver, they interfere with the child's ability to form a secure attachment. Many aspects of a child's healthy physical and mental development rely on this primary source of safety and stability.

Thinking of what we wrote in 2012 has focused my attention on what has happened in the world at large in thinking about trauma, as well as how my thoughts have evolved. I hope this article captures and affirms some of the enduring and emerging perspectives.

Definitions of trauma

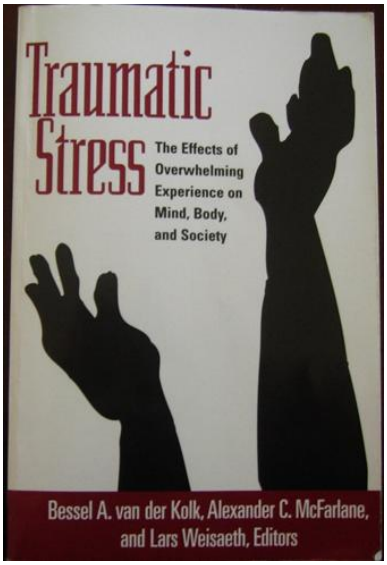
Menschner and Maul (2016, p.2) argue that there is no Universal definition of trauma and state,

> Experts tend to create their own definition of trauma based on their clinical experiences. However, the most commonly referenced definition is from the Substance Abuse and Mental Health Services Administration (SAMHSA),

> "Individual trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being".

While Menschner and Maul are correct that there may be variations on the theme of what trauma means, I think that since the late 19th century, the definition has been consistent. The interpretation of what trauma means and how it is used has been less consistent and sometimes confused. Trauma has been defined in the world of psychology for well over 100 years. But as it is an inevitable part of human nature, it has been known about and understood to different degrees for 1000s of years. For example, some of the wisdom of ancient tribal life is recognized to contain vital aspects of trauma recovery, such as movement and rhythm, and predictable rituals. It is important to recognize that, as well as science, our knowledge comes from our experience of life, from experiences shared with others we meet or hear about, and from what is written. Pynoos et al. (2007, p.332) in the book Traumatic Stress capture this well,

"From the earliest account of an adolescent's experience of a catastrophic disaster, the eruption of Mount Vesuvius, in the *Letters of Pliny the Younger* (100—113A.D./1931); through the autobiographical description of intrafamilial abuse and societal violence provided by Maxim Gorky in *My Childhood* (1913/1965); to the powerful literary rendering of the Holocaust by Elie Wiesel in *Night* (1958/1960) and the trenchant autobiographical account of childhood rape by Maya Angelou in *I Know Why the Caged Bird Sings* (1969), authors have reflected on the formative influences of traumatic experiences in childhood. Indeed, it is a common assumption that personal creativity and character are often born out of early tragedy."



One of the first psychological definitions of trauma was by Freud and Breuer in 1893.

> Psychological trauma or more precisely the memory of the trauma – acts like a foreign body which long after its entry must continue to be regarded as the agent that still is at work.

In Beyond the Pleasure Principle (1920), Freud explains that the disturbance arises when the ego is totally unprepared for a traumatizing event of an external kind. Later (1926, in Pynoos et al. 2007, p.338), he defined a traumatic situation as one,

> … in which the subject is helpless, external and internal dangers, real dangers and instinctual demands converge. Whether the ego is suffering from a pain which will not stop or experiencing an accumulation of instinctual needs which cannot obtain

> satisfaction, the economic situation is the same, and the motor helplessness of the ego finds expression in psychical helplessness.

When a traumatic experience cannot be integrated, as Freud explained and Bessel van der Kolk (2014) says, 'the body keeps the score'. Unintegrated trauma is felt in the body. Interestingly, Van der Kolk is one of the present-day neuroscientists who writes about the long tradition of neuroscience, dating back to Freud and others such as the French Psychologist Pierre Janet. Van der Kolk (2021) summarizes some key points about trauma,

> The most important thing to know is that there's a difference between trauma and stress... The problem with trauma is that when it's over, your body continues to relive it… So, unlike what we first thought, trauma is actually extremely common… There are a lot of debates about what the trauma is to this day. But basically, trauma is something that happens to you that makes you so upset that it overwhelms you. And there is nothing you can do to stave off the inevitable… But the trauma is not the event that happens, the trauma is how you respond to it.

One of the key points that Van der Kolk makes is that post-Vietnam War, trauma became associated mainly with violent events, such as those experienced in combat. Interestingly, this more literal understanding, which defined Post Traumatic Stress Disorder (PTSD), is narrower than Freud's earlier explanation. Freud paid attention to a person's internal and not only external world. It was believed that trauma could also be caused by significant but not so visibly violent events, and that the internal world is as significant as the external. Whatever the cause of trauma, Van der Kolk and Newman (2007, p.7) state its impact,

> The posttraumatic syndrome is the result of a failure of time to heal all wounds. The memory of the trauma is not integrated and accepted as a part of one's personal past.

In a review of Van der Kolk's book The Body Keeps the Score, Forte (2019) says the book establishes early on that, "Trauma is an almost universal part of the human experience".

Forte outlines the key points made in the book about the impact of trauma,

- Flashbacks and projection
- The othering of self and others
- Disembodiment
- Panic attacks
- Chronically elevated stress hormones
- Overcontrol and hypervigilance
- Dissociation and avoidance
- Difficulty integrating traumatic memories
- Sensory overload
- Addiction to trauma

I think one of the reasons so many people are interested in trauma is because we can all identify with it and will most likely have remnants of trauma we need to work through. Most of us can probably say we have experienced some of the above. To do so is a part of ordinary life; it is only a serious problem when we get stuck with these symptoms in a manner that is disabling.

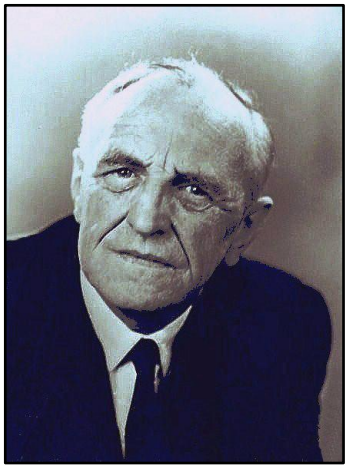
Sinason (2022, p.116) also observed that,

> George Santayana the Spanish American Philosopher (1863-1952) put this in clear terms for all (1905, p.284): "Those who cannot remember the past are deemed to repeat it."

The psychoanalyst Adam Phillips (2002, pp.146-147) talks about how one effect of trauma can be to continuously bring the past into the present so that nothing new is possible.

> Trauma is when the past is too present; when, unbeknownst to oneself the past obliterates the present. It is the traumatised person – all of us, to some extent – who says that there is nothing new under the sun; that nothing ever changes. It is the art of art to make the past bearably present so that we can see the future through it. The problem, in other words, is not in making the past present, but in making the past into history.

Continuing the focus on the power of the less dramatically visible aspects of trauma, the child psychiatrist and paediatrician, Donald Winnicott, drew attention to how, in infancy, trauma can be the result of emotional impingement. This is very different from the idea of trauma as an act of physical violence. In his paper, Morals and Education (1963, p.97), he wrote,



"At this early stage the infant does not register what is good or adaptive, but reacts to, and therefore knows about and registers each failure of reliability. Reacting to unreliability in the infant-care process constitutes a trauma, each reaction being an interruption of the infant's 'going-on-being' and a rupture of the infant's self."

Trauma during infancy may not be noticed except by the infant, who, in health, will alert the caregivers, by crying, for example, who then also notice and respond caringly. However, if the trauma is too severe and frequent, such as in severe neglect, the infant may give up alerting others who never come to meet his/her needs. Winnicott (1956, p.303) explains the consequences of impingement and the infant's reaction to it,

> If the mother provides a good enough adaptation to need, the infant's own line of life is disturbed very little by reactions to impingement. (Naturally, it is the reactions to impingement that count, not the impingements themselves.)… An excess of this reacting produces not frustration but a *threat of annihilation*. This in my view is a very real primitive anxiety, long antedating any anxiety that includes the word death in its description.

This is a critical point in helping us understand that to feel terror and helplessness does not only include physically dangerous situations. Winnicott says the infant is continuously on the brink of unthinkable anxiety. Unthinkable anxiety is temporarily impossible to integrate as an experience – it is traumatic. However, in good enough circumstances, a caregiver(s) can think about the anxiety. This gives the infant an experience of something seemingly unthinkable being managed without further consequence. What was unthinkable increasingly becomes thinkable and integrated. The moments of trauma are recovered from and contribute to the development of the infant and caregiver(s). The infant does not become traumatized. Winnicott (1962, p.57-58) explains,

> At the stage which is being discussed it is necessary not to think of the baby as a person who gets hungry, and whose instinctual drives may be met or frustrated, but to think of the baby as an immature being who is all the time on the brink of unthinkable anxiety. Unthinkable anxiety is kept away by this vitally important function of the mother at this stage, her capacity to put herself in the baby's place and to know what the baby needs in the general management of the body, and therefore of the person. Love, at this stage, can only be shown in terms of body-care, as in the last stage before full-term birth.
>
> Unthinkable anxiety has only a few varieties, each being the clue to one aspect of normal growth.
> (1) Going to pieces.
> (2) Falling for ever.
> (3) Having no relationship to the body.
> (4) Having no orientation.

These anxieties, which are part of development during infancy, are what we commonly associate with trauma. The same process with childhood trauma follows in other situations, where trauma is contained by attunement and thoughtfulness. Where there is not an attuned, containing other in the environment, trauma is more likely to lead to traumatization. This is especially so where the infant, child, or adult does not have the internal resources to provide a sufficiently containing function. If the containing function is missing, which is equally the case in withdrawn and reactive caregivers, the result can be traumatic. Referring to the work of the Harvard attachment researcher, Karlen Lyons-Ruth (2003), Van der Kolk (2014, p.120) says,

> Karlen and her colleagues had expected that hostile/intrusive behavior on the part of the mothers would be the most powerful predictor of mental instability in their adult children, but they discovered otherwise. Emotional withdrawal had the most profound and long-lasting impact. Emotional distance and role reversal (in which mothers expected the kids to look after them) were specifically linked to aggressive behavior against self and others in the young adults.

Lyons-Ruth's research looked at the development from infancy to adulthood over 18 years. Her findings suggest that for the infant, the experience of impingement through a primary caregiver's emotional withdrawal can have a more serious traumatic impact on development than the more visibly apparent event of physical abuse, for example.

Unthinkable anxiety is as good a definition of trauma as can be made in two words. It is only when unthinkable anxiety/trauma finds no containment and is repeated that traumatization occurs, and the person may live in a state of continual panic and fear. Dockar-Drysdale (1990, p.122) explains,

> I found myself considering the problems of a small boy assaulted by a violent adult. Of course, after the first occasion, such a child would feel acute anxiety and dread that the experience might be repeated. However, when such a trauma occurred constantly, this anxiety would change into severe panic states, such as we have seen in our experiences.

The same unthinkable anxiety may also occur due to the repeated lack of responsiveness to the primary needs of an infant. Freud, S. (1926, p.166), in his paper, Inhibitions, Symptoms and Anxiety, made the connection between danger and helplessness and how trauma is experienced when the two are combined. He refers to this sequence as "anxiety – danger - helplessness (trauma)". It is the addition of helplessness in a dangerous situation that makes the situation traumatic. And as he (p.167) says, helplessness is especially part of early childhood,

> … the period of life which is characterized by motor and psychical helplessness.

While we may easily associate trauma with danger and physical helplessness, psychic dangers and psychic helplessness can also be traumatic. For example, excessive fear of loss due to the unresponsiveness of the primary caregiver. Once trauma has happened, dangers in the future may be responded to with anxiety as a signal that may help anticipate and prevent further trauma. Or when the danger is strongly associated with helplessness, the situation may be perceived as if it is already a trauma waiting to happen. The two alternative responses are the difference between passivity and mastery.

Judith Herman (1992, p.33), in her classic book *Trauma and Recovery,* gives her definition of trauma, which also emphasizes helplessness/powerlessness,

"Psychological trauma is an affliction of the powerless. At the moment of trauma, the victim is rendered helpless by overwhelming force... Traumatic events overwhelm the ordinary systems of care that give people a sense of control, connection and meaning."

Similarly, Bruce Perry (2003, p.17) states,

> Trauma: A psychologically distressing event that is outside the range of usual human experience, often involving a sense of intense fear, terror and helplessness.

Ungar and Perry (2012) also say,

> Traumatic stress occurs when an extreme experience overwhelms and alters the individual's stress-related physiological systems in a way that results in functional compromise.

Levine and Kline's (2006) statement succinctly summarizes,

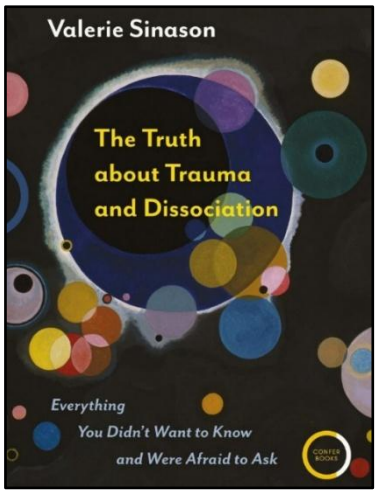
> Trauma is in the nervous system – not in the event.

This means that what is ultimately traumatic is a person's reaction to an event and inability to integrate it as an experience. While this is true, I also think that we need to acknowledge that extreme events are nearly always likely to be traumatizing. The questions that are not so clear are how long the person is likely to stay traumatized and what is needed for recovery. Not recovering from a traumatized state is when a person may be diagnosed with PTSD. To meet the criteria for PTSD, symptoms must last longer than one month, and they must be severe enough to interfere with important aspects of daily life.

James (1994, pp.10-11) makes an important point about how the meaning one attaches to an event can be as important as the event itself in determining whether one experiences trauma,

> Psychological trauma occurs when an actual or perceived threat of danger overwhelms a person's usual coping ability. Many situations that are generally highly stressful to children might not be traumatizing to a particular child; some can cope and, even if the situation is repeated or chronic, are not developmentally challenged. The diagnosis of traumatization should be based on the context and meaning of the child's experience, not just on the event alone. What may appear to be a relatively benign experience from an adult perspective – such as a child getting 'lost' for several hours during a family outing – can be traumatizing to a youngster. Conversely, a child held hostage with her family at gunpoint might not comprehend the danger and feel relatively safe.

Valerie Sinason (2020, p.135-136) offers this helpful perspective on the complexity of trauma.



"There is a trauma.
It includes a suddenness of attack that cannot be prepared for, that is intentional or perceived as such; the proximity and severity of the attack matter and it must be outside normal experience and involve a fear of dying.

When it happens, it obviously leads to internal consequences as our psyches have to react.
The impact includes biological and neurological change, terror, shame, loss of love or perceived loss, annihilation anxiety and fear, unconscious guilt, breakdown of a sense of a just world, helplessness and hypervigilance.

These processes are ameliorated or exacerbated by:
Nature of attachment, age, previous history of trauma, protective features in the environment and resilience of the self.

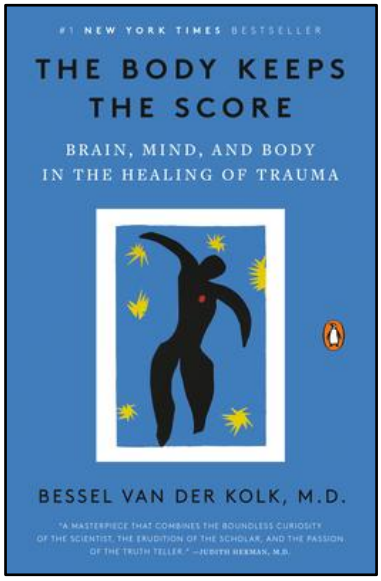
Further danger after the trauma
This includes re-traumatisation, which can occur at the moment there is cognitive awareness of the trauma, past or present; a loving relationship can activate terror of unbearable loss. There can be sexualising of fear, terror, excessive control or risk taking; all the defences needed to survive: delinquency or violent re-enactment, mental illness, phobias, somatisation, addiction. Each new stage of life reawakens old triggers, right through to old age."

The need for creativity and hope

Given this long and consistent history of understanding trauma in the fields of psychology and psychotherapy, it is interesting that Judith Herman titles the first chapter of *Trauma and Recovery* – "Forgotten History". She (1992, p.7) states,

> The study of psychological trauma has a curious history – one of episodic amnesia. Periods of active investigation have alternated with periods of oblivion. Repeatedly in the past century, similar lines of enquiry have been taken up and abruptly abandoned only to be rediscovered much later. Classic documents of fifty or one hundred years ago often read like contemporary works. Though the field has in fact an abundant and rich tradition, it has been periodically forgotten and must be periodically reclaimed.

The phrase 'no need to reinvent the wheel' is often used to imply that the re-invention is unnecessary. However, in the case of trauma, it may be necessary. It may also explain the 'episodic amnesia' that Herman refers to. Trauma is such a fundamental part of what it means to be human that it needs an equally powerful process to heal it. Creativity and hope are an antidote to trauma becoming traumatizing. Creativity requires a person to be fully present. The feelings involved in creativity are more powerful than learning about methods and facts. So, while we might learn from what has gone before, we might also need to forget, so we can experience the kind of powerful creativity and hopefulness that is so important in the recovery from trauma. If we do remember what we have learned, it is also important that we make something new from it. Creativity is a life force. Like play, creativity brings the authentic, real self alive. Creativity is a playful state in which people learn, experiment, and grow. Van der Kolk (2014, p.17) powerfully states the importance of creativity,



"Imagination is absolutely critical to the quality of our lives…. Imagination gives us the opportunity to envision new possibilities - it is an essential launchpad for making our hopes come true. It fires our creativity, relieves our boredom, alleviates our pain, enhances our pleasure, and enriches our most intimate relationships. When people are compulsively and constantly pulled back into the past, to the last time they felt intense involvement and deep emotions, they suffer from a failure of imagination, a loss of the mental flexibility. Without imagination there is no hope, no chance to envision a better future, no place to go, no goal to reach."

The human need to be imaginative, inventive, creative, and to discover is a vital energy in overcoming trauma. If we remember and know too much about what has gone before, these qualities might not be so strong. Learning history does not have the same aliveness as living it. As Anne Alvarez said in the title of her paper on the recovery from child sexual abuse, there is "The Need to Remember and the Need to Forget".

Popularization of the word trauma

While the use of the word trauma has been used regularly throughout the last century, its use has mushroomed in the last 20-30 years. The sociologist Frank Furedi (2004) researched the use of it in 300 British newspapers. He found that in 1994, the word trauma was used less than 500 times. In the year 2000, it was used over 5000 times. I expect that this trend has continued to multiply. Furedi and others (e.g., Hoff, Summers, and Satel, 2005) have highlighted how societies such as the UK and USA have shifted towards the image of a human who is vulnerable rather than one who is resilient. Furedi argues that the exponential increase in attention to trauma also increases the risk of becoming traumatized by inviting people to see themselves as vulnerable, suffering, and ill. A key factor in whether someone becomes traumatized or not is the environmental context. This includes what we think and feel. Our perceptions of ourselves and each other are influential. Winnicott (1963, p.104) said,

> The vast majority of people are not ill, though indeed they may show all manner of symptoms.

Seeing and thinking of a person as being ill compared with someone who has a symptom, which might have a purpose, is a subtle difference. And it is a difference that contributes to illness. We might argue that there are many more people diagnosed with 'disorders' today than there were 50 years ago or even 5 years ago. The first edition of the Diagnostic Statistics Manual, published in 1953, included 102 diagnostic categories. By the time of edition 5 in 2013, there were nearly 300 categories (Scot, 2022). The main change has been the inclusion of what Winnicott might have called a symptom, now being diagnosed as an illness. If there are 3 times the number of available diagnoses, we can expect a huge increase in the number of people now considered as having mental health illnesses or disorders. And in turn, people are further invited to think of themselves as being ill.

Beiner (2022) refers to the ‘mainstreaming of trauma’ and says,

> We call this human experience ‘trauma’, and it’s absolutely everywhere in popular culture today. We talk of the ‘collective trauma’ of COVID. The ancestral trauma resulting from colonialism. Acute Trauma. Complex Trauma. Attachment Trauma. Trauma Bonding. Trigger warnings, safe spaces and trauma dumping. Trauma is historic. Personal. Universal. Above all, trauma is not what it appears to be.

Referring to Bonanno (2021) and others, Beiner (2022) argues that one of the problems of the focus on trauma is that it undermines the focus on resilience and other human strengths. There is much evidence of the continual underestimation by many psychologists of the human capacity for resilience and an exaggeration of vulnerability. One of the most obvious recent examples of this was following the 9/11 disaster in New York. Despite the warning of some psychologists to not overreact and allow the community to find its strength, thousands of psychologists and millions of dollars of counselling support were poured into New York. Most of it was never taken up by the citizens. The majority went through a normal healing process without a psychological intervention. Beiner states,

> Hardly anyone sought out the (heavily advertised) free services, to such a degree that those running the campaign wondered whether it might be that people were avoiding therapy due to stigma. But even after physically sending people onto the streets to offer the therapy, the program had a very low uptake. Bonanno’s point is that the majority of us experience a traumatic event, go through a short period of symptoms as we process it, and then get on with our lives.

However, there is a significant difference between a big T trauma event and the less obvious but significant little t traumas that are usually a part of complex trauma. Complex trauma may also have big T trauma events among the everyday little traumas. In a discussion with Beiner (2022), Bessel van der Kolk helpfully explains,

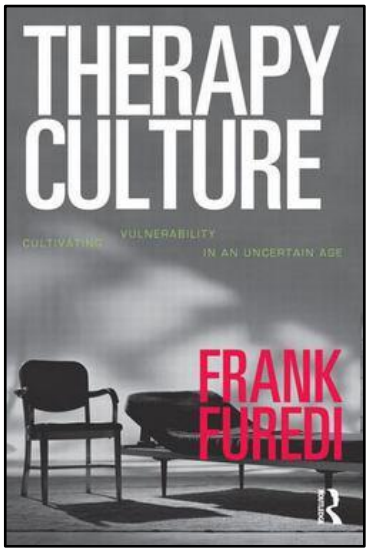
> ‘Little t’ trauma is a sloppy term and puts [those experiences] in a secondary role. In fact, what people call ‘little t trauma’, I think is really attachment trauma. It's about disrupted attachments. As long as you feel safe with the people around you, it's very unlikely you'll get PTSD…. we are collective creatures.
>
> What people call ‘small t trauma’ is a very complex issue of people being ignored, people not being seen, kids not being responded to, kids getting slapped instead of being listened to. These are major issues that shape your personality and your identity…what people frivolously call ‘little t trauma’ are really the big issues of who we are as human beings and our obligations to take care of each other and to nurture each other in that regard.
>
> The big trauma, horrendous things that leave you speechless? We are not bad at treating that. We spend a lot of time and effort into learning how to treat rape victims, how to treat torture victims. And we're moving in the right direction in that regard. But how to

> deal with having felt neglected, ignored and not seen as a child? We're not very good at prescribing what the best treatment for that is.

In the same way, too much attention to trauma can be unhelpful. It might increase anxiety and distract us from other important aspects of our lives and being. Winnicott pointed out that impingement during infancy can be traumatic and that this becomes compounded by further disruption when the mind becomes preoccupied with trauma. A child who is thinking about trauma cannot play. Though play may be a way of unconsciously working through or working out something. So, if we are excessively preoccupied with trauma, rather than facilitating what is healthy for development, such as play, we interrupt it.

Case example - Peter's Tic: Paying Attention and Not Paying Attention

Here is a brief and simple case example about paying attention and not paying attention. Peter, a 10-year-old boy, has suffered several adverse childhood experiences, some of which were traumatic. He develops a pronounced nervous tic. This becomes a concern to various adults at family gatherings who remark upon it. They also suggested to Peter's mum that she should refer him to a neurologist. The mum is anxious but does not react to the situation. Instead, she informally seeks some advice from a psychologist. The psychologist who is familiar with the family situation explains that this kind of thing is common, especially in boys, and usually goes away on its own.



Peter tells his mum that he is worried about the tic. She listens to him and says no need to worry, it is quite common for boys, and it will most likely go away soon. Within a couple of weeks, the tics disappeared and never came back. During the same period, Peter told his mum that a counsellor had approached him at school and asked him if he would like to speak to a counsellor. She said this was because she knew about some of the family difficulties. Peter told his mum that this made him feel like he had something wrong with him. He said he didn't want to talk to a counsellor. Peter got on well throughout the rest of his school and into early adulthood.

This small example is a good illustration of what Furedi says about an excessive preoccupation, inviting a person to perceive themselves as ill. Peter had this invitation coming from two directions: the family and the school. Thankfully, his mum was able to resist the projected anxiety and not add to it. Sometimes, more and more attention, as Furedi explains, can have unwanted side effects. As the title of his book implies, *Therapy Culture: Cultivating Vulnerability in an Uncertain Age.*

This example reminds me of a point made by Perry and Szalavitz (2006, p.244),

> Simply taking the time, before doing anything else, to pay attention and listen. Because of the mirroring neurobiology of our brains, one of the best ways to help someone else become calm and centred is to be calm and centred yourself – and then just pay

attention. When you approach a child from this perspective, the response you get is far different from when you simply assume you know what is going on and how to fix it.

This is important advice. However, it is not always easy to pay attention. Dockar-Drysdale (1980s) sums up the difficulty and importance of listening,

"It is a sad fact that people do not listen sufficiently to children and what they say. They often say very important things in a very simple way, and grown-ups are startled, frightened, or literally don't hear what they have said, so remarks pass unnoticed. And often, if these could be heard and understood, it would make a tremendous difference to children. I often say to therapists here that listening is the most important thing they can do. We talk about therapeutic listening, which means listening to only what the child says and not to be thinking of anything else while the child is speaking."

Listening and paying attention are especially difficult when what we see and hear is distressing, painful, and disturbing. There is also the question of how we pay attention when there are many ways. Marion Milner, who was a psychoanalyst and painter, has written of 'wide-angled attention', which is receptive by not focusing. She says, "When I paint a tree in a field, I look at everything except the tree" (in Phillips, 2019, p.14). Similarly, in therapeutic work, it is often helpful to look around the presenting symptoms and not just at them. With Peter, initially, too much attention was being paid to the symptom rather than looking around it. When less attention was paid, Peter's tics went away. So, as well as it being important to pay attention, equally important is what we do after we have paid attention. For example, do we pay more attention or less? How do we respond to what we see, hear, and notice?

With all these issues and challenges, we have science and research to ground what we are doing, but the process of therapeutic work and ordinary human responsiveness often has more in common with art. This relationship between art and science is captured by one of the renowned neuropsychologists, Allan Schore, in the title of his classic book, The Science of the Art of Psychotherapy.

Too much protection

Inevitably, an excessive focus on trauma may increase our perception of vulnerability. For example, we might be more worried about the world being damaging and harmful. There is plenty of evidence that in some societies the anxious, over-protective, risk-averse 'helicopter parent' is now common. The problem with this is that it can hinder development through a lack of challenge and learning through experience. As we know, even an individual's immune system is weakened by a lack of exposure to biological threats. Balance is needed. Lukianoff and Haidt (2018) summarize this need well with their book title, "The Coddling of the American Mind: How Good Intentions and Bad Ideas are Setting up a Generation for Failure." Attention to trauma and the improvements made because of that are vast. However, we must not assume

that being trauma-informed is like a never-ending upward line, where it is always the more the better.

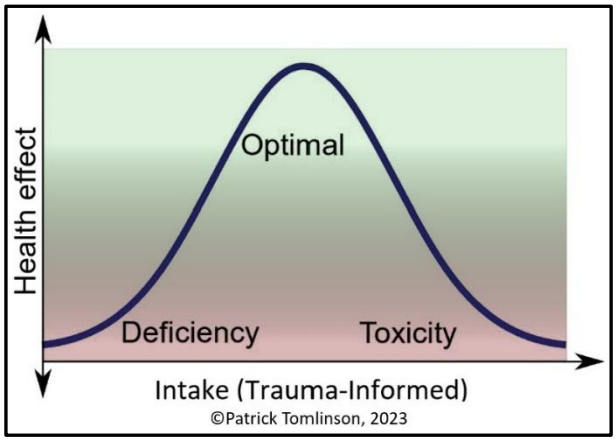
Research is beginning to emerge that highlights the risks involved in making that assumption. One example of the research has been on the use of 'trigger warnings'. These are used to warn people of potentially anxiety-provoking images and words on a TV programme, advert, article, etc. A 2020 study (Jones et al.) on trauma survivors suggests that they may increase anxiety. Beiner (2022) explains,

> That study suggests that trigger warnings may be detrimental because they increase the narrative centrality of trauma among survivors. 'Narrative centrality' or 'event centrality' is a very important concept: it means the degree to which someone identifies with their trauma, and to which it's central in how they understand their own life. Decreasing narrative centrality, so that people see a life and identity beyond what happened to them, is largely seen to be therapeutically beneficial, according to multiple studies like this one. Increasing narrative centrality is then counter-therapeutic: it risks keeping people 'stuck' in their trauma.
>
> This is the double-edged sword of increased cultural awareness of trauma. On one edge, it opens up more honest and vulnerable conversations about emotional suffering and mental health. On the other edge, it increases the narrative centrality of trauma throughout society. Considering we aren't even clear what we mean when we use the word trauma, the result is a convoluted mess that presents potentially harmful views about mental health by overshadowing our innate resilience.

The concept of narrative centrality is interesting. Others, such as Van der Kolk (2014), have highlighted how a person's perception of themselves, and an event (rather than the actual event) is a key factor in whether a person becomes traumatized or not. Van der Kolk has even shown that a person can become traumatized long after an event if the narrative around the event changes. Therefore, the more trauma becomes central to our individual and collective narrative, there is a clear risk that this may contribute to increasing traumatization. This is exactly what Furedi (2004) has argued from a sociological perspective. The more we are invited to consider ourselves as traumatized, vulnerable, and ill, the more likely it is that we will. Beiner (2022) argues,

> What we believe ourselves to be is how we will experience ourselves. That is why we have to be so careful around how we conceive of ourselves, because we will make it true. If we see ourselves as resilient, flexible and robust beings, we stand a better chance of bringing that attitude into our lives than if we see ourselves as victims of giant, all encompassing force called trauma.

The balance of being trauma-informed and healthy would most probably look like a bell curve. The curve may be flatter than this, but the aim is to illustrate the point.



If we take the word 'intake' to mean how much information on trauma we 'take in', this analogy suggests that after a certain point, the effect becomes negative. As the over-emphasis on trauma and vulnerability can undermine health and resilience, at the far end of the spectrum, trauma-informed becomes misguided and toxic, like an unintended negative consequence. It may not be that the problem is with being informed, but that the informed is not well-balanced. There may be too much negative information and not enough positive. Such as the focus on Adverse Childhood Experiences ACEs) and the exclusion of Positive Childhood Experiences (PCEs). Or the focus on damage rather than resilience. Or the harm of adversity rather than the transformational potential. The psychologist Stephen Joseph (2013), in his book, *What Doesn't Kill Us: The New Psychology of Posttraumatic Growth*, argues that,

> Posttraumatic reactions are not one-sided phenomena but multifaceted, encompassing both distress and growth.

Joseph argues that if we are to be appropriately trauma-informed, we must include the concept of *posttraumatic growth*. Other influential psychologists, such as the holocaust survivor Viktor Frankl (1959), in his book, *Man's Search for Meaning,* have written powerfully about this. The worldwide transformational benefit of the work of Frankl and others has been huge and would not have happened without tragic circumstances. This does not undermine the real suffering and distress that is experienced in trauma, nor the need to 'be with and in' the feelings, and to make sense of and work through them. Frankl (1984) succinctly named his outlook as 'tragic optimism'. Resilience and the potential of transformation are not about denial but the maintenance of hope, learning, and growth. As with trauma, the meaning of words and concepts such as resilience and transformation can also be distorted unhelpfully. More recently, neuroscientists such as Stephen Porges have also discussed and taught the concept of posttraumatic growth.

Even if we are trauma-informed in a balanced way, a bell curve such as the above could be adapted for each person and each setting, such as an organization. A person's and an

organization's intake capacity are variable and changeable. Consideration of the situation and task is also necessary to determine the shape of the bell curve. For example, trauma-specific services, such as a counselling service, need more intake than a service where trauma is not directly relevant to the task, such as an ice cream shop. As trauma is part of human life, all organizations need some level of awareness, but the exact amount can only be evaluated according to circumstances. And it must also continue to be re-evaluated as human systems are always changing, whether they be families, organizations, or societies. It would be interesting to consider where you think you/and your organization are on a bell curve like this.

Adverse childhood experiences

Perhaps the best-known study on the long-term outcomes related to childhood trauma is the Adverse Childhood Experiences (ACEs) Study (CDC, 2014; Felitti, 2002). The study was carried out in the USA and included over 17,000 people who were screened for ACEs. The ACEs included: emotional, physical, and sexual abuse; physical and emotional neglect; household dysfunction; mother treated violently; household substance abuse; household mental illness; parental separation or divorce; and incarcerated household members. It was found that these ACEs tended to occur in clusters, and the more ACEs, the greater the probability of poorer health and well-being, especially if a person had six or more.

The potential risks to well-being have been stated as serious health conditions, such as cancer and heart disease; behavioral health issues; psychiatric disorders; and a shortened lifespan relative to the life expectancy of individuals without ACEs or significantly fewer. While this research is thorough, it may also be unintentionally misleading. Recent research (Baldwin et al., 2021) has shown that while the ACEs study predicts group trends, there is no accurate correlation between ACEs and outcomes for individuals. They state,

> This study suggests that, although ACE scores can forecast mean group differences in health, they have poor accuracy in predicting an individual's risk of later health problems. Therefore, targeting interventions based on ACE screening is likely to be ineffective in preventing poor health outcomes.

This is an important fact that can help prevent making negative assumptions about an individual who has suffered trauma and other adversities. The human brain is plastic. This means that what we experience can change the way we function. It means we have hope that recovery is possible. Many people have been relieved by the findings of this research. Most notably, people who have suffered several ACEs and who felt the ACEs research implied future bad health, if not a death sentence.

One of the obvious issues for individuals is that outcomes are equally affected by other factors and not just the number of ACEs. These other factors include the age of the individual when the ACEs occur, the number and quality of positive relationships, the unique constitution of the individual, and the precise nature of the ACEs (Hambrick et al., 2018).

Positive childhood experiences

AAP (2014) explains the importance of considering adverse and positive factors together,

> Adverse experiences and other trauma in childhood, however, do not dictate the future of the child. Children survive and even thrive despite the trauma in their lives. For these children, adverse experiences are counterbalanced with protective factors. Adverse events and protective factors experienced together have the potential to foster resilience.

Bethel et al. (2019) have researched how Positive Childhood Experiences (PCEs) affect adult health. They argue that without this to go alongside ACEs, we do not have a full and helpful picture. To gather information on PCEs, they asked respondents how often they,

1. Felt able to talk to their family about feelings
2. Felt their family stood by them during difficult times
3. Enjoyed participating in community traditions
4. Felt a sense of belonging in high school
5. Felt supported by friends
6. Had at least two non-parent adults who took a genuine interest in them
7. Felt safe and protected by an adult in their home

In summary, their research found that:

- Positive childhood experiences mitigate the effects of ACEs and buffer against toxic stress.
- Positive childhood experiences promote healing and recovery.

This perspective by AAP is a helpful reminder, as Beiner (2022) states, “We can forget that we are resilient creatures first and foremost.”

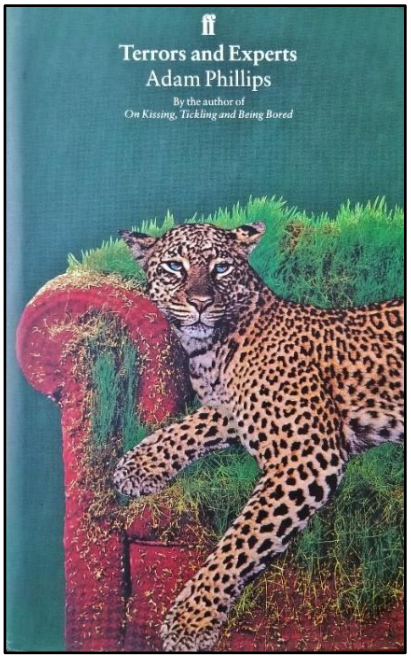
Other confusions and difficulties

As well as the above confusions around ACEs, there are other general confusions. What trauma and trauma-informed means have become confused. This is often the case when a word becomes so widely used in a short time. Perry and Ungar (2012, pp.6-7) stated the following,

> Trauma is one of the most over-used, poorly defined concepts in neuropsychiatry. Popular use of the term "trauma" or "traumatic" has further confounded a physiologically meaningful or psychologically useful definition. People refer to an event as a trauma or as an event being "traumatic." Yet we know that there are multiple individually-specific outcomes from any group experiencing the same event. Indeed most events labelled "traumatic" (e.g., school shooting, car accident, combat) don't appear to result in enduring negative mental health effects for the majority of individuals experiencing the "trauma."

Beiner (2022) explains how this over-simplification is linked to the popularization and mainstreaming of trauma,

“Unfortunately, when something goes mainstream, curiosity and nuance often go out the window. The popularisation of trauma isn’t just a result of culture becoming more aware of mental health, it also serves political and cultural functions, and as such is prone to being twisted and manipulated.”



Some would argue that the confusion has only grown further. The word trauma has become widely used for distressing and upsetting events. Trauma is not the same as distress. Trauma is overwhelming, unthinkable, and associated with danger and helplessness. As well as a basic misuse of the word trauma, trauma is also often used interchangeably with traumatized. Trauma is common, or even extremely common, as Bessel van der Kolk (2021) said, but becoming traumatized as a result is not inevitable. Trauma is part of ordinary life and development. Phillips (1995, p.49) goes as far as to say,

"Development is trauma, and trauma in its various forms is the subject-matter, the material of psychoanalysis."

Winnicott (1931, p.9) also emphasizes the ordinariness of trauma,

> Actual trauma, however, need have no ill-effect, as shown by the following case; what produces the ill-effect is the trauma that corresponds with a punishment already fantasized.

While trauma may "have no ill-effect" traumatization, on the other hand, is the result of the trauma not being integrated as part of ongoing life. Traumatization may need a specialist intervention, or it may be healed through the experience of ordinary positive life experiences. Only when traumatization becomes stuck should it be considered a disorder. Even then, we need to be careful that a diagnosis or label such as Post Traumatic Stress Disorder does not pathologize someone as if they are 'abnormal'.

As well as the word trauma being used widely to mean different things, the same has occurred with the term trauma-informed. Some authors (Mieseler and Myers, 2013, cited in Wall, Higgins, and Hunter, 2016; Treisman, 2021) have attempted a helpful clarification by distinguishing a continuum of different levels – trauma-aware, trauma-sensitive, trauma-responsive, and trauma-informed. It can be argued that, as trauma is common, all workforces should be trauma-aware. It is when we move closer to workers being actively engaged with trauma, as in trauma-specific services, that we need to move along the spectrum towards a deeper level of being trauma-informed. And a trauma-specific service cannot work effectively unless the whole organizational setting is trauma-informed. Sandra Bloom, creator of the Sanctuary Model, puts it clearly,

> Trying to implement trauma-specific clinical practices without first implementing trauma-informed organizational culture change is like throwing seeds on dry land. (in, Menschner and Maul, 2016, p.3).

Needs-informed and healthy development

An excessive focus on trauma and being trauma-informed may dominate in a way that undermines other important elements of healthy environments. For instance, it could be argued that other focuses are equally important, such as understanding and responding to general human needs. One of my colleagues, Dr. John Gibson, has suggested a needs-informed rather than trauma-informed approach. This is potentially more inclusive, less stigmatizing, and less pathologizing. Everyone has needs. Other important human needs could be ignored if trauma is overemphasized. We should attend appropriately to all needs, such as the need for healthy growth and development, as well as needs related to other difficulties that may be important but not traumatic. We should also ensure that we focus on supporting the development of people who do not appear to have difficulty. We need to avoid creating environments where the only way to get attention is by having a problem.

Often, leaders and practitioners do very well by paying attention to others in a general way with inclusive practices, valuing and respecting others, listening, caring, and creating safety. An overemphasis on trauma can introduce unnecessary anxiety into systems that are working well. As if there is something we are not doing. The key question should be, are we achieving positive outcomes? Are people, whether our clients or colleagues, getting better and developing? Being trauma-informed is important, but it is not more important than achieving positive outcomes. Therefore, in becoming trauma-informed, we need to be careful not to lose focus on outcomes. Bollinger (2021) gives a good explanation of positive outcomes where practitioners are working in a trauma-informed way, without it always being explicit.

> Therefore, while they did not use the language of trauma-informed care, they have naturally engaged in it. Furthermore, the young people interviewed also did not use the language of trauma-informed care, but also referenced the impact of what can be described as trauma-informed care. In essence, the staff participants noted that when trauma-informed practices are implemented, staff are better equipped to cope with the occurrences in the house and better maintain stability; the young people reported that they had enhanced outcomes from the staff being genuinely caring and involved with them.

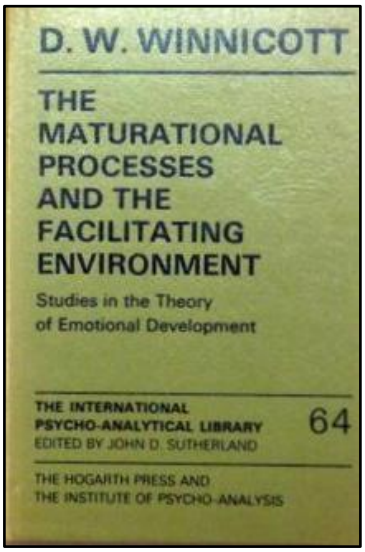
Recovery and healing

As said, most experiences of trauma do not become traumatizing in the long term. The capacity of humans to recover and to help each other recover without specialist interventions is often underestimated. Sometimes this is referred to as spontaneous recovery. It is usually aided by a combination of a person's internal and external resources. External resources are the people around the person, such as family, friends, colleagues, and community.

While we may talk of recovery, it is important to acknowledge that the past trauma never disappears as if it never happened. A person works through the trauma, and part of this means integrating traumatic experiences as part of one's history and personality. So, we may consider recovery as getting back on track with the ordinary process of living and development. Kraybill (2015) prefers the term Trauma Integration,

> I share the view of trauma scholar Robert Stolorow, that trauma recovery is an oxymoron. (Stolorow, 2011. p. 61). Things are never really the same after trauma. So, what then to name the place that can be achieved, where trauma is no longer the centre of experience and yet is acknowledged to be a part of ongoing reality? I call it Trauma Integration.

Winnicott (1963a, p.207), in his paper, Psychotherapy and Character Disorders argues,



"In the vast majority of cases the parents or the family or guardians of the child recognize the fact of the 'let-down' (so often unavoidable) and by a period of special management, spoiling, or what could be called mental nursing, they see the child through to a recovery from the trauma."

Winnicott is highlighting how trauma is often integrated or recovered from as a part of ordinary experience. Possibly, the word recovery does not do full justice to the value of integrating the experience. Referring to more complex and challenging cases, Tomlinson (2020) states,

> Where trauma has been complex, from early childhood, it is not just one relationship or one incident that has been the problem for the child. It can be argued that the problem has been the whole of the child's environmental context. In this sense, it may be that a service, which provides the whole context of a supportive network, is most important for these children. Certainly, children who have experienced such environmental failure cannot be helped by individual therapy alone. They need to experience a primary home experience and everything that goes with it.

In these cases, a trauma-informed approach is needed. An approach that understands the nature of trauma, and how it can impact child development, a person's functioning, and well-being. Most importantly, through a trauma-informed lens, it is understood what is needed for healing and recovery to take place. As Kezelman and Stavropoulos (2012, p.xxx) explain in their award-winning guidelines for the treatment of complex trauma,

> Research now shows that resolution of trauma equates with neural integration. It also shows that longstanding trauma can be resolved, and its negative intergenerational effects intercepted. But for this to occur, mental health and human service delivery (i.e., as well as direct treatments) need to reflect the current research insights. Experience is now known to impact brain structure and functioning, and in the relational context of healing, this includes **experience of services**.

Hambrick et al. (2018) state that when treating complex childhood trauma,

> Yet, even if a child's early experiences are poor, improving future relational contexts may still help. To do so, however, we must think outside of traditional 50-minute therapy

> sessions toward ways to enrich a child's entire relational world. Certainly, these findings highlight the complex ways developmental experience influences children's functioning. We must never underestimate how experiences can both hurt and heal, and how positive experiences early in life can optimize development and be preventive. Continuing to explore associations between experiences and outcomes will allow us to construct and promote clinical work that is responsive to nuance, patient-centered and increasingly effective.

Key elements of a trauma-informed therapeutic approach

This subject has been written about extensively (e.g., Treisman, 2021; Van der Kolk, 2014; SAMHSA, 2014a, 2014b; Barton, Gonzalez, and Tomlinson, 2012; Heller and LaPierre, 2012, among many others), so I will just outline some of the key elements involved. With all these issues, it is not just what we provide that is important – it is what the child makes from the environment and what might be on offer. We need to be careful to not believe that we can force-feed the child with our good intentions. We need to be available, to provide opportunities, but also to allow space for the child's process, creativity, and potential for development. Referring to the work of Winnicott, Phillips (1988, p.74) reminds us of the importance of the child's creative potential,

> Winnicott is attentive to the kind of environment the child creates for himself, how he discovers and uses what he finds, as the essential indicator of emotional development.

The following are essential in facilitating trauma recovery, integration, and development,

- Understanding the centrality of the child's 24/7 lived experience in the recovery process. Working on establishing safety in all areas of the child's life.
- Being aware of the complex and often interwoven elements of the causes of trauma, such as abuse, neglect, violence, death of an important close person, serious accidents, injuries, illnesses, racism, disability, discrimination, etc.
- Understanding the nature of complex childhood trauma and how it has impacted the child's development. What are the signs of trauma? And what kind of responses are most helpful?
- Working on being attuned. Being aware of triggers and avoiding them where possible.
- Strengthening any available family relationships.
- Recognizing and enabling children to follow their interests and build on their strengths.
- Enabling the conditions in which safe relationships can develop.
- Understanding and using what we know about trauma from the long history in the field and the different perspectives. For example, attachment, psychotherapy, neuroscience, family systems, etc. Many helpful and practical approaches can be used.
- Supporting children to develop skills and self-mastery in different areas of functioning. For example, interests, self-regulation, education, and skills development.
- Physical mastery and movement can be especially helpful to release emotion that has become stuck in the body and to help a child feel that their body is purposeful and useful.

- Integrating into the local community and building life-affirming, supportive networks.
- Providing consistent and healthy routines. A focus on healthy eating and drinking, good sleep patterns, and exercise.
- Providing opportunities for positive new experiences. For example, nurturing and enjoyable activities, especially with others.
- Having clear boundaries and expectations, learning to take responsibility, and managing oneself with others.
- Providing opportunities for communication and expression of feelings related to the past, present, and future. Integrating traumatic experiences through reflective processes.
- Adults must endeavour to work in a consistent, joined-up, and congruent manner.
- Providing all of the professionals involved with ample opportunity to process their experience and learn.

(Also, see Cook et al., 2005, Six Core Components of Complex Trauma Intervention, Treisman, 2021, NCTSN(a))

Achieving progress in these areas is challenging and complex work. It can be expected that, as well as steps forward, there will also be many steps backwards along the way. This is because a person who has suffered complex trauma will not easily be able to make use of available opportunities. For example, they may need to test relationships and boundaries before they can feel safe enough to trust them. They will have major anxieties about change, suffer self-doubt, and sometimes lack hope, etc. Therefore, those attempting to provide support must be robust in their capacity to do this work and be part of a strong team approach.

Kezelman and Stavropoulos (2012, p.xxviii) state the hopefulness of such work,

“Research shows that the impacts of even severe early trauma can be resolved, and its negative intergenerational effects can be intercepted. People can and do recover and their children can do well. For this to occur, mental health and human service delivery need to reflect the current research insights.”

A trauma-informed approach will understand these difficulties and others as expressions of need. Behaviour has meaning and needs understanding. A trauma-informed approach, while needing clear boundaries and expectations, will not be judgmental, punitive, or reactive. People using a trauma-informed approach will have a good understanding of the research-informed theory. They will also understand the importance of other theories, such as attachment theory. The importance of relationships cannot be overestimated. Therefore, a trauma-informed approach is also a relational one. As Perry and Szalavitz (2006, p.230) state,

> Relationships are the agents of change and the most powerful therapy is human love.

Outcomes

Ultimately, a trauma-informed approach must improve outcomes for service users. If it doesn't, it isn't much use being 'trauma-informed', unless at least further harm is prevented. As Stewart (1998, P.22) states,

> Services are only of value if they are of value to those for whom they are provided.

This means we need to know what positive outcomes would look like. Some might be obvious, like a reduction in nightmares, panic attacks, and aggressive and self-harming behaviour. Others might be less dramatic but very important. Such as improvement in communicating feelings, better self-regulation, emotional development in general, improved enjoyment, better self-care, etc.

To know whether the therapeutic work, which means healing, is working, the desired outcomes need to be clearly defined. The outcomes will vary according to the present situation of the service user, including their chronological as well as emotional age. The service user may also have specific outcomes that are important to them. What matters most to service users is outcomes that are going to help make their lives as fulfilling as possible. Continuing to explore associations between experiences and outcomes will allow us to construct and promote clinical work that is responsive to nuance, patient-centred, and increasingly effective.

As well as outcomes for service users, we also need to consider outcomes for other stakeholders in a trauma service, such as employees. We should pay attention to questions such as, are people developing well? Are there signs of vicarious trauma and burnout? Are sickness and absence high? What is the level of employee engagement? What is the level of staff retention?

In a healthy environment, trauma-informed or not, the most important outcome is people developing and flourishing.

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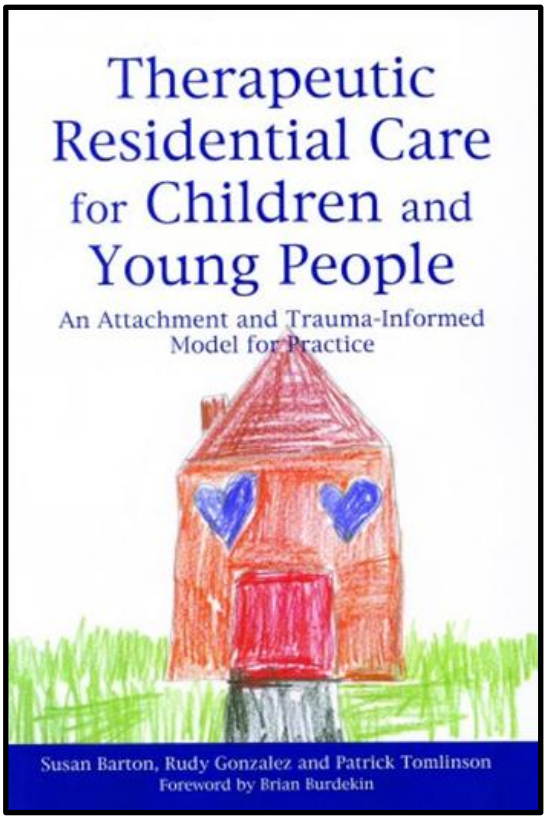
THERAPEUTIC RESIDENTIAL CARE FOR CHILDREN AND YOUNG PEOPLE: AN ATTACHMENT AND TRAUMA-INFORMED MODEL FOR PRACTICE



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CHAPTER TWO - TRAUMA-INFORMED PRACTICE

Introduction

> *Traumatized children cannot heal within traumatizing – or traumatized – organizations, and instead, such organizations can make children's problems worse. (Bloom 2005, p.63)*

Witness Justice (2011) defines psychological trauma as,

> Psychological trauma involves an experience of such intensity that it damages underlying assumptions and expectations about the world or the self and can be understood to mean a profound emotional shock (Oxford Pocket Dictionary, 1992). A 'traumatic event' has been defined by the American Psychiatric Association's (2000) Diagnostic and Statistical Manual (DSM-IV) as one in which a person experiences, witnesses, or is confronted with actual or threatened death or serious injury, or threat to the physical integrity of oneself or others. A person's response to trauma often includes intense fear, helplessness, or sheer horror. Trauma can result from experiences that are "private" (e.g., sexual assault, domestic violence, child abuse/neglect, witnessing interpersonal violence) or more "public" (e.g., war, terrorism, natural disasters).

Trauma can have a particularly profound effect when it is experienced during the formative years. Gordon (2010, p.6) argues that,

> … when traumatic experiences occur in early childhood they undermine the development of the very sense of self and the basis for future developmental stages.

If out-of-home care systems are to become more attuned and responsive to the needs of children in care, concepts of well-being must be contextualized within a trauma-informed framework of understanding.

History has shown that if children are provided with positive parenting experiences, they can recover, or at least significantly improve, from even the most severe trauma caused by abuse and neglect (Perry and Szalavitz 2010). Cameron and Maginn (2009, p.28) stated that,

> The more secure children feel, the more time, energy, and inclination they have to seek and make sense. Whereas fear constricts, safety expands the range of exploration.

How Traumatization Develops in Childhood

Though many children experience trauma, this does not mean that the child always becomes traumatized. Whenever a child or adult experiences a traumatic event, the natural responses of the body and mind to protect the person are likely to keep aspects of the experience out of consciousness. The mind takes in what is happening and responds before all the details are consciously registered. This is a normal survival response and serves to prevent the person from being overwhelmed so that he or she can take protective action. Therefore, the aspects of the

experience that are kept out of consciousness are experienced as feelings, such as anxiety, rather than as thoughts.

The potential difficulty is that these feelings can be triggered in the future by scenarios that are reminiscent of traumatic events. This happens at an unconscious level, and the person is left with unpleasant feelings that are difficult to understand. For example, a person may suddenly feel anxious or panicky, they may experience visual images such as flashbacks or nightmares, or find themselves having obsessive ruminations (Janet 1904). The feelings associated with the traumatic event will need to be understood and related to the trauma so that they can be integrated as part of the experience. This then helps the person to differentiate between a feeling that belongs to the present and one that is related to a past event. Gradually, the person is then able to regulate their emotions, and the intensity of feelings related to the past reduces.

So, for instance, a person who has been in a car crash may initially feel very anxious when getting into a car again. But over time, as she recognizes what feelings belong to the past and what belong to the present situation, she returns to her normal state of mind, albeit with maybe a little more caution. To achieve this return to a state of equilibrium a person needs several capacities and resources. They need the emotional and cognitive capacity to process the event and ideally support to help them work through their experience and feelings. Often, a partner, a family member, or a friend can provide the necessary support, and sometimes a professional, such as a counsellor, may provide the needed help. If the event was an isolated occurrence, most people recover from trauma in time.

Alternatively, as Van der Kolk and Newman (2007, p.7) explain,

> The posttraumatic syndrome is the result of a failure of time to heal all wounds. The memory of the trauma is not integrated and accepted as a part of one's past; instead, it comes to exist independently of previous schemata (i.e., it is dissociated).

Dockar-Drysdale (1990, p.122) explains one of the effects of repeated trauma:

> I found myself considering the problems of a small boy assaulted by a violent adult. Of course, after the first occasion, such a child would feel acute anxiety and dread that the experience might be repeated. However, when such a trauma occurred constantly, this anxiety would change into severe panic states, such as we have seen in our experiences.

Another key factor in determining the impact of trauma is a person's unique disposition. What may be traumatizing to one person, whether they are an infant or adult, is not always predictable, regardless of similarities in circumstances. Some children manage to survive extremely difficult experiences more positively than others. Something that might be a small difficulty to one infant could be quite traumatic to another who is more sensitive. Van der Kolk and Newman (2007, p.6) explain,

> So although the reality of extraordinary events is at the core of PTSD, the meaning that victims attach to these events is as fundamental as the trauma itself.

Trauma causes an excess of emotion, and the ability to regulate emotions is something that develops throughout childhood and to some extent adulthood. The traumatized children we work with have often experienced repeated trauma at an early age when they were most vulnerable in terms of emotional resilience. In many cases, the environments of neglect and deprivation they were living in meant that they were underdeveloped compared to a 'normal' child of their age, which would have increased their vulnerability. Often, the people responsible for their trauma were their closest carers, and therefore, there may have been no one to turn to for support. In some cases, maybe someone in the extended family provided an element of support and care. This may have made a significant difference.

Once the cycle of trauma begins, the effects begin to spiral. Rather than the trauma being a one-off event, it becomes an expected occurrence. The child becomes highly anxious and is unable to switch off from this state. This then interferes with all aspects of her daily life and makes it difficult to do any of the ordinary things, like playing, relaxing, and enjoying any nurture that might be available. The child, therefore, becomes increasingly deprived of the experiences that are necessary for growth and to redress the imbalance. The child learns to turn away from relationships and not to seek comfort. This leaves the child in a situation where she is unable to integrate her experiences and is preoccupied with danger, and where the 'split off' feelings related to trauma are being continually triggered and re-experienced. In the most severe cases, the child may completely shut down in a disassociated state. This occurs at an instinctive level to at least make the child less visible.

Children who withdraw in this way may seem as if they are not too much trouble, but they are barely living in any way that is meaningful or real. It is like curling up into a ball and waiting for the inevitable attack to pass. Traumatized children who are not so withdrawn and who are still hyperactive, waiting for the sign to take cover and run, are likely to be highly emotional. Their experiences and inability to integrate them cause fearful and defensive reactions to anything that triggers their anxiety. Often, this means that they create tension, and if they are still in an abusive environment, further abuse and punishment are likely.

Bloom (2005, p.57) explains how traumatization in childhood can develop into adult pathology:

> Recent research on childhood trauma is helping to understand how children's exposure to overwhelming stress is traumatized over time into adult psychopathology. As evidence accumulates it becomes clear that the brain organizes itself in response to an environmental pressure that may be far more potent than even genetic influences because the central nervous system is so vulnerable to stress (Garbarino 1999). For these children, what begins as an adaptive response to a threat – a fear state – becomes instead a fear trait that they carry into adulthood (Perry *et al.* 2005). Children exposed to violence show disturbing changes in basic neurobiological and physiological processes and it is postulated that these disturbances have profound developmental consequences. Bruce Perry and his colleagues have observed persistent hyperarousal and hyperactivity,

> changes in muscle tone, temperature regulation, startle response, and cardiovascular regulation as well as profound sleep disturbances, affect dysregulation, specific and generalized anxiety, and behavioral impulsivity in traumatized children. Over time, these growing children proceed down many different pathways to help themselves adapt to disordered physiological stability and emotional dysregulation. Some will become addicted to drugs and/or alcohol. Others will develop an eating disorder. For others, anxiety and depression will be the predominant presenting problem. Still, others will have recurrent difficulties with relationships that will dominate the clinical picture, while others manifest their underlying unresolved conflicts via bodily illness and dysfunction that can affect virtually any organ system. As a result, by adulthood, the presenting picture can look amazingly diverse and, consequently, the common traumatic origins of the pathological processes of development can easily be overlooked or ignored (Trickett and Putnam 1993).

It is easy to see from the way trauma develops in an abusive environment that the outcome is likely to reach a point of total breakdown. The carer's inadequacy leads to abuse and neglect, and the child becomes increasingly traumatized, which further impacts the carer's resources, and so on. If the situation is not too endemic and there is the possibility of support from extended family or professional services, it may be that some stability can be achieved, and a recovery process can begin. For the child to have any possibility of recovery within the environment, the carers will have to begin their own recovery first.

When the child is removed from the 'trauma' environment, she will continue to be traumatized until any treatment process has a positive impact. The removal may also be traumatic. The child will be in a new and unfamiliar situation, which may be equally frightening from her perspective. Adults cannot be trusted, and all manner of things are likely to trigger the child's heightened state of arousal and anxiety. As Van der Kolk and Newman (2007, p.9) state,

> Because of this timeless and unintegrated nature of traumatic memories, victims remain embedded in the trauma as a contemporary experience, instead of being able to accept it as something belonging to the past.

One of the key tasks in working with traumatized children is to reach a point where the trauma can be named, accepted, and integrated as part of the child's past. Van der Kolk and Newman (2007, p.4) state that,

> In important ways, an experience does not really exist until it can be named and placed into larger categories.

The children we work with have suffered the double impact of trauma within the context of general neglect, and both will need addressing if the child is to recover. Stien and Kendall (2004, p.138) argue that,

> Research shows that new experiences are the most effective way to change the pattern of connections between nerve cells, networks, and systems.

In practice, this means that the first task is to provide a safe, calm, and reliable environment. Once the child feels safe and contained, which may take a long time, it may then be possible to provide her with the kind of nurturing experiences she needs to fill the gaps in her development.

Trauma Causes Hyperarousal and Fear in Children

Experiences of trauma create states of hyperarousal and fear in children that cause the brain to produce adrenaline, which stimulates the mind and body to be prepared to fight or take flight. This is a normal, healthy response to danger that improves the likelihood of survival. We take flight from danger rather than stay in its proximity. However, when a child is continually in a state of danger, the brain is in a constant state of arousal, and the excess of adrenaline that is produced damages the brain's development. Additionally, the part of the brain that reads danger signals becomes hypervigilant and begins to exaggerate warning signals. Danger is increasingly read into situations that are not dangerous. Hence, the child becomes highly anxious and hyperaroused by ordinary everyday experiences. For instance, touching a sexually abused child in an ordinary way may be perceived by the child as a precursor to abuse, leading the child to become aroused. Something that the child might not even be conscious of, such as a certain tone of voice or smell, can trigger the child from being in a calm state into a sudden state of hyperarousal, anxiety, or panic.

This can be one of the most difficult and bewildering things to deal with in working with severely traumatized children. The behaviour of the child is often as chaotically unpredictable as their own experiences. As Whitwell (1998) describes,

> A typical 'frozen' child in a therapeutic milieu presents a curiously contradictory picture. He has charm, he is apparently extremely friendly and seems to make good contacts very quickly… In contrast he may become suddenly savagely hostile, especially towards a grown-up with whom he has been friendly. He will fly into sudden panic rages for no apparent reason.

Traumatized children benefit from environments that are caring and attuned to their emotional states, where the carers can adjust the environment to support emotional regulation and can provide predictable responses and routines that assist in reducing hyperarousal (Tucci *et al.* 2010). By attunement, we mean the capacity to be so in tune with a child that you can anticipate without being told what the child's needs might be and how they are feeling. This is just as a mother might anticipate the needs of her infant and understand how they are feeling (SACCS 2010). For the reasons we have described, this is particularly challenging when working with traumatized children whose moods can change so rapidly. Cameron and Maginn (2008, p.1158) emphasize the central importance of attunement to the child's development and sense of security:

> Underpinning secure attachment appears to be the key child-rearing process of 'attunement'. This occurs when a caregiver is not only aware of his or her own emotions, but can also recognize how his or her child is feeling and can convey this awareness to the

> child. An attuned relationship is a prerequisite to the development of both security and empathy in the young child.

Hannon *et al*. (2010, p.85) refer to recent research explaining the importance of 'sensitive parenting' in enabling traumatized children to achieve positive outcomes:

> Schofield and Beek (2005) studied a cohort of children placed in foster care, who were a 'high risk' group according to the age at which they were placed and the abuse and neglect they had been exposed to. They found that the degree of 'sensitive parenting' demonstrated by one or both carers was associated with whether children settled stably in their placement and made good progress. 'Sensitive parenting' was defined as: The carer's capacity to put themselves 'in the shoes of the child', to reflect on the child's thoughts, feelings and behaviour and their own thoughts, feelings, and parenting style – all features of a reflective function that links to resilience in the carers themselves as well as to resilience-promoting parenting.

Childhood Trauma Reduces the Brain's Capacity to Think and Regulate Emotions

Traumatized children are likely to find it difficult to utilize reasoning and logic to modify their behaviour or reactions. These children are also unlikely to learn from consequences when they are in heightened arousal states. During early infant development, the brain develops sequentially and hierarchically, beginning in the lower part of the brain. The first stage of development is the brainstem, and this begins in the womb. This is the part of the brain that controls basic bodily regulation functions such as heartbeat, blood pressure, and body temperature – the regulation of arousal, sleep, and fear states. Perry (2006) provides a comprehensive account of how the brain's development moves on from the brainstem during the first nine months to the diencephalon, to the limbic, and finally the prefrontal cortex parts of the brain.

> The diencephalon integrates multiple sensory and fine motor control. The limbic system regulates emotional states and the capacity to read emotions in others. 'Brain growth and development is profoundly "front-loaded" such that by age four, a child's brain is 90% adult size' (Perry 2005, p.1). The majority of this development and growth of the brain takes place during the first three years of life. Without the satisfactory completion of one stage of development, the brain cannot move on to the next. The needs of the infant during the different developmental stages are also different. For example, brainstem development requires rhythmic and patterned sensory input and attuned responsive caregiving. The diencephalon development requires the introduction of a simple narrative as well as emotional and physical warmth.

This understanding of how the brain develops has significant implications for us in our work with traumatized children. It is natural that we first relate to children chronologically. We see a sixteen-year-old, and we have normal expectations of a sixteen-year-old. However, if a child is traumatized in early childhood, her brain may not have developed at a pace with her chronological age. If a child has been so traumatized that the limbic and cortical parts of the brain are undeveloped, a sixteen-year-old may be functioning in many respects as an infant.

Even where a traumatized child does have some capacity to think, she actively avoids thinking, as her inner world is dominated by thoughts related to her traumatic experiences. Therefore, we must have a clear understanding of how the child's traumatic experiences have impacted her development. As Van der Kolk and Newman (2007, p.7) state,

> Thus, in dealing with traumatized people, it is critical to examine where they have become 'stuck' and around which specific traumatic event(s) they have built their secondary psychic elaborations.

We then need to respond to the child in a way that is relevant to their actual development rather than their chronological age. For instance, to use reasoning and logic, which requires cortex functioning, with a child whose development is stuck in the lower part of the brain, would be no more use than trying to reason with a baby. This is one of the most common mistakes made in working with traumatized children. Approaches such as talking therapies are sometimes used with children who are not able to relate in a meaningful way to this approach. More appropriate approaches might be related to physical and sensory experiences, which stimulate the lower parts of the brain. It is understandable how challenging this can be in practice, especially when we are concerned about the child's inappropriate behaviour, and we feel the need to explain this to them. Similarly, a traumatized child who is feeling 'bad' or unhappy may benefit far more by doing something physical, such as dancing or playing a game to gain a sense of physical mastery, rather than trying to talk about their experiences. As Smith (2009, p.ix) has argued,

> It is an interesting reflection on how residential child care is perceived that recruitment processes often target individuals who want to counsel children around their difficulties, rather than run around a park with them.

Seligman (2002, p.11) advises to 'Augment positive emotions in your children to start an upward spiral of more positive emotions.' This approach makes perfect sense to us in normal child development, but seems counterintuitive when working with children whose development is disrupted and held back. So, if a two-year-old was unhappy, we would not spend too long dealing with the details of her feelings. We would quickly establish what the problem was and then move on to a positive and enjoyable experience, most likely of a physical nature.

Case Example: Lee

Susan shared her experience of tucking her young daughter in bed at night. She would wrap the duvet around her daughter as if in a womb and read her a favourite fairytale. This is an ordinary childhood experience that many parents provide intuitively for their children.

A sixteen-year-old male, Lee, whom Susan cared for, began acting out one day by running out into the backyard of the home, yelling profanities, and saying he wanted to die and that the pain was too hard to bear. Susan could not work out why he reacted, and thought something terrible must have happened that she hadn't seen. In unpacking the chain of events with Lee, it became clear that he had never been tucked in by his mother and had never been read a

bedtime story. Susan was able to respond naturally and asked him if he would like to be tucked in and for her to read him a fairytale. He agreed that he would love this. Susan tucked him in the same way she had with her daughter and read him the same fairytale, which calmed him down.

This experience, repeated over time, had a huge impact on Lee's development, as he was provided with a need that was not met in his early childhood. Lee had experienced being abandoned by his family, whom he never saw again. He spent his childhood in institutional settings where his need for nurturing experiences remained unmet. Lee had missed basic primary experiences (Dockar-Drysdale 1990) that a child needs as part of early development. To enable recovery, it is vital to focus on providing children with the opportunities to experience what they may have been deprived of in their early years. What is also important to note about this example is the focus on developmental needs, rather than chronological expectations. A child at sixteen years of age who has experienced early trauma and neglect will, at times, need to be treated as if he or she were younger. The recovery process, in a sense, requires returning to provide what has not been provided in infancy.

It is interesting that Lee, who was abandoned as a child, which can feel like being completely emotionally dropped, sought a kind of provision that feels exactly like being held, both physically and emotionally. Waddell (1989) describes the significance of this to the child's treatment:

> Repeatedly demonstrated is the endless enactment by such children of the feeling of being dropped, of being got rid of (often painfully reproduced by the 'caring' agencies themselves). The task is not to offer substitute care and parenting in order to rectify past deficiencies; rather, it is to enable the individual to respond to what may now be on offer. The significance of the awareness of a space in someone's mind cannot be minimized; this kind of receptive attention may be a unique experience for such a child. As one therapist puts it: 'the legacy of the abandoned child is usually not only the burden of being abandoned but of being left with extremely inadequate mental resources to cope with a degree of pain which would overwhelm the most favourably brought-up child' (Boston and Szur 1983, p. 76).

Trauma Disconnects Children from Relational Resources

One of the consequences of trauma is that it disconnects children from relational resources that can alleviate its effects. Stien and Kendall (2004, p.149) explain that,

> … for maltreated children, abuse has shattered their ability to trust. These children must go against the grain of their prior experience to seek and expect nurturance. Usually, distraught people seek connection with others. This impulse is innate. Young children are naturally drawn to adults for protection and comfort when they feel frightened. Normally, a nurturing parent comforts a child by establishing eye contact, using soothing touch, and a calm, reassuring voice. For maltreated children, however, their cries for help were usually met with indifference or perhaps further abuse. Adults were the source of pain, not comfort. Abuse 'teaches' children that dependency is dangerous. To defend

> themselves against further hurt, they ward off their feelings of vulnerability and act as if they have no need for affection.

According to Tucci *et al*. (2010, p.5), children who have experienced trauma require 'opportunities to experience attachment relationships which offer consistency, nurture and predictability'. Carers can be trained to understand the significance of daily interactions in providing the basis for children to modify their internal working model (Levy and Orlans 1998) and previous attachment patterns. For example, a child who experiences their carer being trustworthy and reliable over a long time will begin to believe that adults can be reliable and trustworthy. The carer's sensitivity to providing attuned responses to children with traumatic backgrounds is a core competency in caring for them.

Trauma Restricts the Attention Capacity of Children

As we have discussed, traumatized children are likely to be in a state of hypervigilance. They are constantly scanning their environment for the slightest sign of danger. Inevitably, this means that they are unable to concentrate on other things and can appear to be very easily distracted. Some children who are diagnosed with attention deficit disorder are likely to have been traumatized. In addition, if the child's developmental stage is misunderstood, they may be expected to join in with an activity that is beyond their capacity. This can lead to frustration and a lack of interest, which may give the impression of not being able to pay attention. These children will benefit from environments that enable them to engage in experiences, which redirect their attention away from past trauma-oriented activation to the here and now. The environment will need to be as calm and predictable as possible so that the child's state of fear is reduced. Stien and Kendall (2004, p.137) explain that,

> Typically, treatment begins with techniques that are aimed at reducing stress and helping children find new ways to regulate their emotions and calm themselves. This step, in turn, enables children to develop their cognitive resources. Strengthening cognition further enhances the ability to regulate emotions.

The Australian Childhood Foundation's 'Response to the National Standards for Out of Home Care' informs that carers should be supported to offer children opportunities to act and react in playful ways, which are likely to provide more intensely positive experiences.

> These opportunities also relieve the burden of unrealistic expectations on traumatized children. They also powerfully connect children and carers in shared activities that promote trust and belonging. (Tucci *et al*. 2010, p.6).

Trauma-Based Behaviour has a Functional Purpose

We can understand the purpose and meaning of trauma-based behaviour in children, shifting our interpretations away from judgemental blame to a greater acknowledgement of the ongoing impact of children's traumatic experiences. Traumatized children develop responses to trauma that are, in essence, survival responses. The responses are a solution to the problem the child is faced with. The more traumatized the child becomes, the more likely it is that the child's responses will become patterned in response to any situation the child perceives to be

threatening, whether it is or not. Therefore, over time, the response that originally might have been an appropriate response and solution becomes increasingly dysfunctional. This understanding enables carers to develop the confidence to plan helpful and empathic responses to children. The aim is to help the child feel safe enough to recognize that, whilst their responses may once have been a solution to a problem, they are no longer functional in the present. This approach can also translate into other settings, such as school, where similar behaviours can intrude on children's everyday experiences.

Trauma Restricts Children's Ability to Deal with Change

Traumatized children tend to organize their experiences in such a way that makes their reading and responses to various situations simple and quick. If a child experiences regular threats to her physical and emotional safety, quick mental processing is necessary to recognize potential threats and to respond so that the child's survival is protected. Therefore, the child will tend to perceive variants of a specific situation as a threat and will have a similar response, such as taking flight. The child might respond to any situation that suggests intimacy as a threat of sexual abuse and responds by attacking and/or taking flight. The child will need considerable support from the adults in their care environment to reshape their responses. This will take time. Carers and other significant individuals will need to focus on introducing change in small increments, preparing, and supporting children to become accustomed to one change before initiating another. In this context, carers and others need to understand the benefits of predictability and routine for traumatized children. Perry and Szalavitz's (2006) extensive work with traumatized children, with a focus on trauma and its impact on the brain, highlights the importance of predictability and consistency of care in supporting the development of traumatized children.

Trauma Undermines Identity Formation in Children

The impact of ongoing trauma on children prevents them from developing a coherent sense of self. As discussed, traumatic experiences, especially in early infancy, disrupt and distort the child's development. Children become preoccupied with protecting themselves and have little concern for anything other than survival. In this state, children cannot develop interests and discover what they enjoy and what they like. They are mainly concerned with the avoidance of pain. Additionally, the lives of traumatized children are often chaotic with frequent breakdowns and changes in their circumstances. Some traumatized children may have had multiple placement breakdowns, perhaps living in ten or twenty different homes by the age of ten. All these factors result in children often having little sense of who they are, the people involved in their lives, or where they have come from (Rose and Philpot 2005).

Object relations theorists refer to this as identity diffusion. The work with these children may initially be about providing experiences that enable them to develop a positive sense of what they like, enjoy, and dislike. It also enables them to begin to assert their sense of identity. This might be achieved by providing many nurturing experiences and opportunities for the child to begin to enjoy things and to play. Many traumatized children are unable to play. Being able to play simple games can help a child begin to establish her identity. Once a child has a foundation of knowing what she likes and dislikes, what she feels, and that she is safe and loved for being who she is, she can then begin to consider the bigger questions of where she has come from

and her life journey. This work could take several years and be part of a programme of life story work (Rose and Philpot 2005).

The aim of the work is not just to establish the child's history. It is also to work through the meaning the child attaches to different aspects of her life and to correct distortions in her perception. For example, traumatized children often feel responsible for the things that have happened to them, including abuse. Whilst this might seem quite dysfunctional, by assuming responsibility, the child can replace feelings of vulnerability and helplessness with an illusion of having some control. Additionally, the child may need to preserve a positive image of the parent or caregiver responsible for the abuse. This protects the child from potentially overwhelming feelings of loss, rage, and fear (Van der Kolk and Newman 2007). Therefore, an important task in working with such a child is to help the child see where the responsibility lies, shifting the child's inappropriate sense of responsibility. To do this work, it is necessary to explore not only the child's memories and thoughts about her experiences, but also her emotions concerning different people and events in her life. This work can be particularly difficult and painful. Not only are distressing memories being worked on, but also the child's feelings about those memories. A child might feel shame and guilt about some of her feelings.

Only when these feelings are named and explored can the child be helped to put them into perspective and let go of negative self-persecutory aspects. The child's negative views about herself may be gradually replaced with other feelings, such as sadness. If the feeling of responsibility is let go of, the child may then be in touch with exactly how helpless she was, and how awful it was to be treated like that. This then requires a modification of how the child may view the abuser, which is again, particularly challenging, especially if it was someone who was supposed to love and protect the child. From this brief example, it is clear how complex and necessary the work is for the child to develop a more coherent and positive sense of identity, which now includes being cared for and understood by those working with her.

Trauma Affects Social Skills Development and Impacts Peer Relationships

Children with trauma backgrounds are likely to have difficulties in all social situations, including those with other children. They will have difficulty forming appropriate attachments, reading social cues and situations, managing disagreements, and knowing how to respond appropriately. Their state of hyperarousal and fear is likely to cause them to behave in inappropriate ways. They may be overly aggressive, controlling, or withdrawn in situations that would be considered non-threatening to other children. Some children, due to their specific experiences, may also be highly sexualized in their behaviour. Carers and other adults have a very important role in helping traumatized children manage their relationships and interactions appropriately. It is essential that carers also role model respectful and appropriate interactions with others. This will gradually enable traumatized children to build a network of relationships that promote connection and provide opportunities to reconstruct their attachment styles.

The Impact of Trauma on the Child's Internal Working Model

Traumatized and homeless children have histories that include childhood trauma, abuse, and neglect, in many cases dating back to their infancy. Early difficulties and breakdowns in their family environments have often been compounded by further negative experiences, for

example, breakdowns in foster placements and exclusion from school. Inevitably, these experiences will have a damaging impact on the child's development and internal working model. These children develop a view of the world that is unsafe, of caregivers who are hurtful, unresponsive, and untrustworthy, and of themselves as bad and undeserving (Levy and Orlans 1998). The defence mechanisms that have formed to survive and cope with this fearful and negative expectation are often entrenched and deeply rooted. In some cases, however traumatic and negative their circumstances may seem, they are at least familiar to the child. It can seem safer to the child to hang on to this familiarity rather than take the risk of letting someone offer help only to be let down again. The problems that the children present, which can be anything along the continuum of emotional disorders to mental illnesses, are therefore additionally difficult to treat.

The following two brief vignettes by young people talking about their initial experiences of moving into Lighthouse vividly show how unusual and potentially frightening it is to be in a new environment. They also highlight how being shown care and concern can feel so unfamiliar and anxiety-provoking. It is completely at odds with their internal working model.

Carol's Story: My First Day

I still remember the first day I moved into Lighthouse, I was a young girl, scared, nervous, and insecure because my life was being upheaved again. I remember my carer, Vicki. As I was heading to bed for the first time in my new environment and saying goodnight, Vicki asked me if I would like a goodnight hug. This was such a foreign concept to me, so many thoughts and emotions ran through my head.

Annie's Story: Lots of Questions

I was still painfully shy and quiet. I kept to myself a lot. It took so much energy to come out of my room and interact with others; however, slowly, I did. I had no idea how to interpret Sue's immediate kindness towards me. Why was I rushed into admittance to Lighthouse before others? Why did she offer me new, really nice clothes? Why was she giving me hugs? Why was she spending one-to-one time with me? Why was she organizing people to do things for me? Why the kind compliments when no one really knew me? Why would these people want to do things for me? Why was I being given movie tickets, free fun nights out, and Christmas presents? I don't deserve this. Why were the other children even being nice to me? Why did people want to hear me talk at these family meetings? Why didn't they get rid of me when they saw my cuts? When they knew I hadn't stopped doing it. When I had to be readmitted to the hospital over and over. Why did Sue like me? This all scared the utter hell out of me, but I also liked it. So, I kept quiet in case it all stopped.

Relationship and Attachment Difficulties

For abused and neglected children, attachment difficulties are often central to this experience. Children who have become homeless could be in a situation where they are completely detached from pro-social relationships with others. They are learning to live in a situation where they are reliant on no one besides themselves. The child's homelessness can be seen to be the end of a continuum of failed attachment, leaving the child feeling completely abandoned, alone, and isolated. The child's internal working model of attachment is likely to be

mistrustful and negative. It is one where other people let you down, hurt you, or are only interested in you for their gratification. In some cases, there will have been some positive experiences of attachment in the child's history, albeit too brief and disrupted. Helping the child connect or reconnect with the possibility of a supportive and meaningful attachment is the biggest challenge involved in the work.

Hannon et al. (2010, p.12) argue that,

> Child development literature tells us that if children are to develop in a psychologically healthy way and develop the important character traits and skills they need to succeed in life (such as application, self-regulation, empathy, and resilience), they need to experience:
> • a secure attachment
> • 'authoritative' parenting that provides a combination of 'responsiveness' and 'demandingness' (or warmth and consistent boundaries)
> • stability.

Physical Wellbeing

Traumatized and homeless children often suffer difficulties concerning their physical well-being. It is now well known that emotional trauma has a general impact on a child's ability to thrive in all senses. Perry and Szalavitz (2006) have shown how the brains of traumatized children can fail to grow normatively; other aspects of their physical development can also be affected. Perry and Szalavitz (2010, p.162) explain:

> However, a groundbreaking study of more than seventeen thousand Californians enrolled in the Kaiser Permanente health plan has shown that childhood trauma is a critically overlooked factor in the obesity epidemic – and in virtually every other major cause of death studied. The risks for heart disease, stroke, depression, diabetes, asthma, and even many cancers are all affected by trauma-related changes in the stress response system. Empathy and connection affect physical – not just mental – wellness and health.

In addition to this, traumatized children often have no appropriate model of being cared for. Being emotionally immature, with a lack of concern for themselves and others, traumatized children are likely to do things that are neglectful and harmful to themselves. This might include self-harming behaviour, lack of concern for their safety, putting themselves in dangerous positions, unhealthy diet, lack of personal hygiene, use of drugs, and so on.

The Basics of Trauma Treatment and Recovery

We have explained how childhood trauma, especially when it is recurring and within a general context of neglect, has an impact on the child. It affects all aspects of development in a profoundly damaging way. We shall summarize the basic aspects of treatment that we have referred to.

First, a child needs to be safe and protected from the risk of further trauma. The environment the child is in needs to be calming, predictable, and reliable so that the child can begin to feel

safe. Those working with the child need to understand trauma and its impact. They need to be capable of responding to the child in an attuned and sensitive way. 'To calm a frightened child first, you must calm yourself' (Perry and Szalavitz 2006, p.67). At the same time, the child needs to experience adults using their authority appropriately to set clear limits and to manage the child's behaviour when necessary. The child's destructive and violent behaviour, whether towards others or the self, will need to be stopped in a firm but empathetic way, as this behaviour may be normal for the child. This work in establishing safety will help to reduce the child's stress responses, gradually allowing the child to use parts of the brain that have more to do with relating and thinking. Once the child is settled, depending on their stage of development and needs, different elements of the work can take place. Stien and Kendall (2004, pp.135-139) refer to the ISSD Guidelines for Treatment (2004) and mention the following helpful points:

- Help the child learn how to regulate her emotions.
- Promote acceptance of painful feelings.
- Promote the direct expression of feelings in healthy attachments and relationships.
- Help the child to reduce symptomatic behaviour, e.g., withdrawing or acting out.
- Desensitize traumatic memories and correct faulty beliefs about life caused by traumatic events.
- Promote a unified identity by helping the child achieve a sense of cohesiveness about her thoughts, feelings, and behaviour.
- Enhance motivation for growth and future success.

For children who have been severely deprived and abused from infancy onwards, attachment work and the provision of experiences that will fill developmental gaps are especially important. Emphasizing the importance of this in work with deprived and traumatized children, Winnicott (1986, p.112) claimed that 'cure at its roots means care'. Working on issues related to trust and safety within relationships will be necessary before a child feels attached to anyone, in such a way that they will allow themselves to be looked after and cared for.

Therefore, patience is required to avoid the temptation to rush any kind of work before the child is emotionally ready. Important attachment relationships can be considered on the individual, group, and community levels. Severely traumatized children have often experienced inadequate and damaging relationships in all these areas, with negative experiences of the parent-child relationship, the extended family, and the wider community. This is not to say that there were no positive experiences for the child in these areas. One of the aims of treatment is to enable the child to relate on all levels, one-to-one, in a group, and to the wider community. How the child learns to relate should become something that they feel comfortable with. This enables them to achieve their aims and wishes in their own way. For instance, some children may prefer individual relationships, and others may relate better to a group.

The development of self-mastery and an appropriate sense of control is particularly important for the recovery of traumatized children. Working with children in an environmental setting like a residential or foster care home provides a wide range of opportunities to achieve this. Children can be supported and encouraged to develop their skills and interests. This can give a

feeling of physical and psychological competence. Children can be fully involved in having a say in how things should be done for them, in the running of the home, and in what their role will be. There are unlimited opportunities for working on relationships with carers, other adults, and children. Cowen (1996, p.246), talking from a 'wellness' perspective, outlines the following elements of a healthy environment for development:

> Key pathways to wellness, for all of us, start with the crucial need to form wholesome attachments and acquire age-appropriate competencies in early childhood. Those steps, vital in their own right, also lay down a base for the good, or not so good, outcomes that follow. Other cornerstones of a wellness approach include engineering settings and environments that facilitate adaptation, fostering autonomy, support, and empowerment, and promoting skills needed to cope effectively with stress.

Finally, another core aspect of treatment is helping the child to live more in the present than in the past. To be more engaged with others and her interests. To achieve this, the child may need to work through her past experiences of trauma and loss so that they become integrated as experiences that can be moved on from. As the child becomes more engaged, there are opportunities to name and acknowledge experiences, feelings, and emotions. This enables the child to develop a repertoire for understanding herself, relating to others, and exploring her traumatic experiences. As Stien and Kendall (2004, p.150) state,

> Learning to tolerate emotion depends on gaining emotional awareness. Many maltreated children need to go back to square one, that is, to learn to identify and label the emotion(s) they are experiencing.

Carol's Story: Dissociation

Carol was at Lighthouse during her late teenage years and is now twenty-eight. She describes her experience of reoccurrences of her traumatic experiences and how she survived by dissociating.

While living at Lighthouse, I had to deal with the recurrence of past traumas. These occurred in the form of flashbacks and dissociation. If it wasn't for the patience and care I received during these times, I know for a fact that I would not be alive today to tell this story. Dissociation is the brain's way of saying I've had enough. My brain could not deal with or comprehend what was happening to me as a child, so it switched itself off. Quite often, a flashback experience would lead to dissociation.

After one incident of dissociation, I had two quite deep 10 cm cuts under each breast. I was bleeding and in shock. I felt such shame and fear from this incident that I did not tell anyone. I took myself to the doctor; I knew I needed stitches. I waited for hours at the doctor's, just sitting, alone and afraid that I couldn't even remember doing this to myself. I was numb to the core of my body. I couldn't say anything to the doctor. I just stood there and slowly lifted my top, showing him the wounds on my breasts. He gave me a letter and sent me to the emergency department across the road. I walked to the hospital in a daze. Still numb, I gave the lady at the counter the letter, and they put me on a bed and stitched me up. I remember Violet, my carer,

coming into the room; she hugged me, kissed my head, and told me it was going to be OK. I was safe, and it was OK for me to feel the pain.

There were many times after this incident that I lost my memory; they were painful episodes and often brought back feelings and emotions from the abuse in my past. I have scars on my body that will never go away. I was hurt so much inside; the pain from cutting took it away. For that split second when the knife pierced the skin, all I could feel was that sensation, not the pain in my heart.

We have briefly explored some of the issues related to trauma, its impact on development, and some of the aims of treatment. The remainder of this book will explore how some of these issues can be worked with in a residential treatment setting, and how this can be particularly complex and challenging work.

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PATRICK TOMLINSON ASSOCIATES
DEVELOPING PEOPLE AND ORGANIZATIONS

PATRICK TOMLINSON BRIEF BIO: The primary goal of Patrick's work is the development of people and organizations. Throughout his career, he has identified development as the driving force related to positive outcomes for everyone, service users, professionals, and organizations.

His experience spans from 1985 in the field of trauma and attachment-informed services. He began as a residential care worker in a therapeutic community for young people and has experience as a team leader, senior manager, Director, CEO, consultant, and mentor. He is the author/co-author/editor of numerous papers and books. He is a qualified clinician, strategic leader, and manager. Working in several countries, Patrick has helped develop therapeutic models that have gained national and international recognition. In 2008, he created Patrick Tomlinson Associates to provide services focused on development for people and organizations. The following services are provided,

- Therapeutic Model Development
- Developmental Mentoring, Consultancy, & Clinical Supervision
- Character Assessment & Selection Tool (CAST): for Personal & Professional Development, & Staff Selection
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