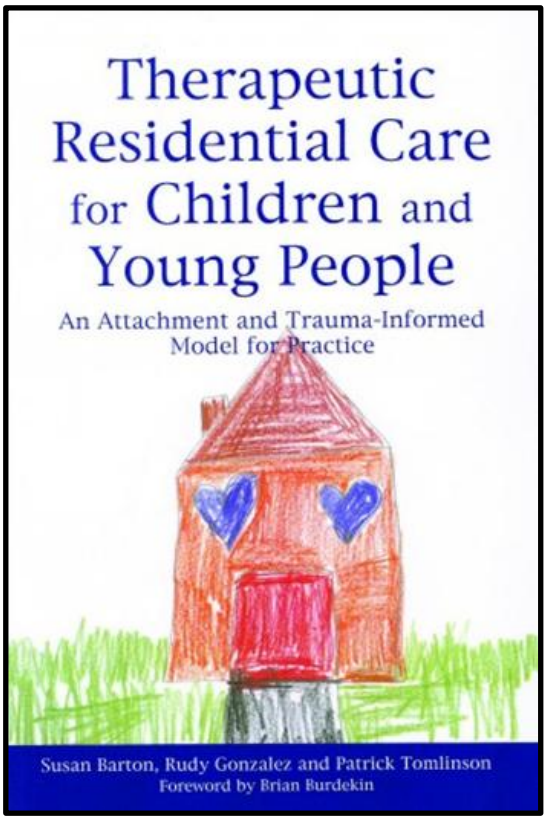
BARTON, S., GONZALEZ, R., AND TOMLINSON, P. (2012)

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



Jessica Kingsley Publishers

ISBN: 9781849052559

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.

References

American Psychiatric Association (2000) *Diagnostic and Statistical Manual of Mental Disorders (DSM IV-TR), fourth edition,* Washington, DC: APA

Bloom, S. (2005) The Sanctuary Model of Organizational Change for Children's Residential Treatment, in, *Therapeutic Communities: The International Journal for Therapeutic and Supportive Organizations, 26(1):61-78*

Boston, M. and Szur, R. (Editors) (1983) *Psychotherapy with Severely Deprived Children,* London: Maresfield Library

Cameron, R.J. and Maginn, C. (2008) The Authentic Warmth Dimension of Professional Childcare, in, *British Journal of Social Work 38*, 6, 1151–1172

Cameron, R.J. and Maginn, C. (2009) *Achieving Positive Outcomes for Children in Care,* London: Sage Publications.

Cowen, E. L. (1996) The Ontogenesis of Primary Prevention: Lengthy Strides and Stubbed Toes, in, *American Journal of Community Psychology, 24, 235-249*

Dockar-Drysdale, B. (1980s) *Interview with Barbara Dockar-Drysdale*, John Whitwell: A Personal Site of Professional Interest, https://www.johnwhitwell.co.uk/material-from-the-work-of-the-cotswold-community/interview-barbara-dockar-drysdale/

Dockar-Drysdale, B. (1990) The management of violence, in, *The Provision of Primary Experience London*: Free Association Books

Hannon, C., Wood, C., and Bazelgate, L. (2010) In *Loco Parentis: To Deliver the Best for Looked After Children, the State must be a Confident Parent…,* London: Demos, https://bettercarenetwork.org/sites/default/files/attachments/To%20Deliver%20the%20Best%20for%20Looked%20After%20Children.pdf

International Society for the Study of Disassociation Task Force on Children and Adolescents (2000) Guidelines for the Evaluation and Treatment of Dissociative Symptoms of Children and Adolescents, in, *Journal of Trauma and Dissociation*, Vol. 5, 3, pp. 119-150, https://www.isst-d.org/wp-content/uploads/2019/02/childguidelines-ISSTD-2003.pdf

Janet, P. (1904) L'amnésie et la Dissociation des Souvenirs par L'émotion [Amnesia and the Dissociation of Memories by Emotions], in, *Journal de Psychologie 1*, 417–453

Levy, T.M. and Orlans, M. (1998) *Attachment, Trauma and Healing: Understanding and Treating Attachment Disorder in Children and Families,* Washington, DC: CWLA Press

Oxford Pocket Dictionary (1992) New York: Oxford University Press

Perry, B.D. (2005) *Maltreatment and the Developing Child: How Early Childhood Experience Shapes Child and Culture*, Margaret McCain lecture on September 23, 2004, Centre for Children and Families in the Justice System, Available at www.lfcc.on.ca/mccain/perry.pdf

Perry, B.D. (2006) Applying Principles of Neurodevelopment to Clinical Work with Maltreated and Traumatized Children: The Neurosequential Model of Therapeutics, in, *Boyd, N. (2006) (ed) Traumatized Youth in Child Welfare, N*ew York: Guilford Press

Perry, B.D. and Szalavitz, M. (2006) *The Boy Who Was Raised as a Dog: And Other Stories from a Child Psychiatrist's Notebook,* New York, NY: Basic Books

Perry, B.D. and Szalavitz, M. (2010) *Born for Love: Why Empathy is Essential and Endangered,* New York: HarperCollins Publishers

Rose, R. and Philpot, T. (2005) *The Child's Own Story: Life Story Work with Traumatized Children* London and Philadelphia: Jessica Kingsley Publishers

SACCS (2010) *The SACCS Recovery Programme*, Unpublished Document

Schofield, G. and Beek, M. (2005) Risk and Resilience in Long-term Foster Care, in, *British Journal of Social Work (2005*), 35 p.1283–301

Seligman, M. (2002) *Authentic Happiness: Using the New Positive Psychology to Realise your Potential for Lasting Fulfilment,* London: Brealey

Smith, M. (2009) *Rethinking Residential Child Care: Positive Perspectives,* Portland, OR: The Policy Press

Spinazzola, J., Habib, M., Blaustein, M., Knoverek, A., Kisiel, C., Stolbach, B., Abramovitz, R., Kagan, R., Lanktree, C., and Maze, J. (2017) *What is Complex Trauma? A resource guide for Youth and those who Care About them*, Los Angeles, CA, and Durham, NC: National Center for Child Traumatic Stress, https://www.nctsn.org/sites/default/files/resources/what_is_complex_trauma_for_youth.pdf

Stien, P.T. and Kendall, J. (2004) *Psychological Trauma and the Developing Brain: Neurologically Based Interventions for Troubled Children,* New York, London, Oxford: The Haworth Maltreatment and Trauma Press

Trickett, P. and Putnam, F. (1993) Impact of Child Sexual Abuse on Females: Toward a Developmental, Psychobiological Integration, in, *Psychological Science 4*, 2, 81–87

Tucci, J., Mitchell, J. and Goddard, C. (2010) Response *to National Standards for Out of Home Care,* Melbourne: Australian Childhood Foundation

Van der Kolk, B.A. and Newman, A.C. (2007) The Black Hole of Trauma, in, *Traumatic Stress: The Effects of Overwhelming Experience on Mind, Body and Society,* New York: The Guildford Press

Waddell, M. (1989) Living in Two Worlds: Psychodynamic Theory and Social Work Practice, in, *Free Associations,* http://www.psychoanalysis-and-therapy.com/human_nature/free-associations/waddell%20-%20living_in_two_worlds.htm

Whitwell, J. (1998) Boundaries and Parameters, in, The *Journal of Therapeutic Communities, Vol. 19, No. 2,* https://www.johnwhitwell.co.uk/about-the-cotswold-community/boundaries-and-parameters/

Winnicott, D. W. (1986) Home *is Where We Start From,* Harmondsworth: Penguin

Winnicott, D.W. (1956) Primary Maternal Preoccupation, in Through Paediatrics to Psychoanalysis (1975) London: Hogarth Press and the Institute of Psychoanalysis

Witness Justice (2011) Trauma *is the Common Denominator, Healing is the Common Goal* http://www.witnessjustice.org/health/trauma.cfm