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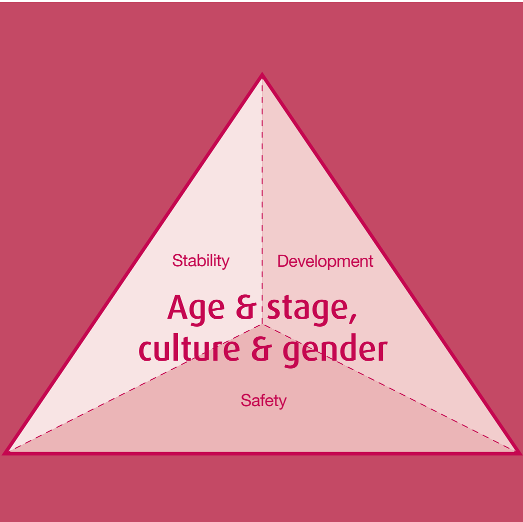

every child every chance

a good childhood is in everyone's best interests

Child development and trauma

Best interests case practice model
Specialist practice resource

A Victorian Government initiative

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Child development and trauma guide

Some important points about this guide

This guide has been prepared because of the importance of professionals in the Family Services, Child Protection and Placement and Support areas understanding the typical developmental pathways of children and the typical indicators of trauma at differing ages and stages. It is intended to inform good practice and assist with the task of an overall assessment, and of itself is not a developmental or risk assessment framework. Rather, it is a prompt for busy workers to integrate knowledge from child development, child abuse and trauma and importantly to offer practical, age appropriate advice as to the needs of children and their parents and carers when trauma has occurred.

Engaging families, carers, significant people and other professionals who know the child well as a source of information about the child, will result in a more complete picture. It is essential to have accurate information about the values and child rearing practices of the cultural group to which a child belongs, in order to appreciate that child's development.

The following points give an essential perspective for using the information in the child development and trauma resource sheets about specific age groups:

- Children, even at birth, are not 'blank slates'; they are born with a certain neurological make-up and temperament. As children get older, these individual differences become greater as they are affected by their experiences and environment. This is particularly the case where the child is born either drug dependent or with foetal alcohol syndrome.
- Even very young babies differ in temperament eg. activity level, amount and intensity of crying, ability to adapt to changes, general mood, etc.
- From birth on, children play an active role in their own development and impact on others around them.
- Culture, family, home and community play an important role in children's development, as they impact on a child's experiences and opportunities. Cultural groups are likely to have particular values, priorities and practices in child rearing that will influence children's development and learning of particular skills and behaviours. The development of children from some cultural backgrounds will vary from traditional developmental norms, which usually reflect an Anglo-Western perspective.
- As children get older, it becomes increasingly difficult to list specific developmental milestones, as the achievement of many of these depends very much on the opportunities that the child has to practice them, and also, on the experiences available to the child. A child will not be able to ride a bicycle unless they have access to a bicycle.
- Development does not occur in a straight line or evenly. Development progresses in a sequential manner, although it is essential to note that while the path of development is somewhat predictable, there is variation in what is considered normal development. That is to say no two children develop in exactly the same way.
- The pace of development is more rapid in the very early years than at any other time in life.
- Every area of development impacts on other areas. Developmental delays in one area will impact on the child's ability to consolidate skills and progress through to the next developmental stage.
- Most experts now agree that both nature and nurture interact to influence almost every significant aspect of a child's development.
- General health affects development and behaviour. Minor illnesses will have short to medium term effects, while chronic health conditions can have long-term effects. Nutritional deficiencies will also have negative impacts on developmental progression.

Specific characteristics and behaviours are indicative only. Many specific developmental characteristics should be seen as 'flags' of a child's behaviour, which may need to be looked at more closely, if a child is not meeting them. Workers should refer to the Best Interests Case Practice Model and relevant specialist assessment guides in undertaking further assessments of child and family.

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Some important points about development

The information in this resource provides a brief overview of typically developing children. Except where there are obvious signs, you would need to see a child a number of times to establish that there is something wrong. Keep in mind that if children are in a new or 'artificial' situation, unwell, stressed, interacting with someone they do not know, or if they need to be fed or changed, then their behaviour will be affected and is not likely to be typical for that child. Premature babies, or those with low birth weights, or a chemical dependency, will generally take longer to reach developmental milestones.

The indicators of trauma listed in this guide should not become judgements about the particular child or family made in isolation from others who know the child and family well, or from other sources of information. However, they are a useful alert that a more thorough contextual assessment may be required.

There has been an explosion of knowledge in regard to the detrimental impact of neglect and child abuse trauma on the developing child, and particularly on the neurological development of infants. It is critical to have a good working knowledge of this growing evidence base so that we can be more helpful to families and child focused. For a more thorough exploration of the relevant theoretical, research and evidence base, it is recommended that you read the papers on the Best Interests principles, cumulative harm and stability, which are available on the every child every chance website:
www.dhs.vic.gov.au/everychildeverychance
The following basic points are useful to keep in mind and to discuss with parents and young people:

- Children need stable, sensitive, loving, stimulating relationships and environments in order to reach their potential. They are particularly vulnerable to witnessing and experiencing violence, abuse and neglectful circumstances. Abuse and neglect at the hands of those who are meant to care is particularly distressing and harmful for infants, children and adolescents.
- Given that the infant's primary drive is towards attachment, not safety, they will accommodate to the parenting style they experience. Obviously they have no choice given their age and vulnerability, and in more chronic and extreme circumstances, they will show a complex trauma response. They can eventually make meaning of their circumstances by believing that the abuse is their fault and that they are inherently bad.
- Infants, children and adults will adapt to frightening and overwhelming circumstances by the body's survival response, where the autonomic nervous system will become activated and switch on to the freeze/fight/flight response. Immediately the body is flooded with a biochemical response which includes adrenalin and cortisol, and the child feels agitated and hypervigilant. Infants may show a 'frozen watchfulness' and children and young people can dissociate and appear to be 'zoned out'.
- Prolonged exposure to these circumstances can lead to 'toxic stress' for a child which changes the child's brain development, sensitises the child to further

stress, leads to heightened activity levels and affects future learning and concentration. Most importantly, it impairs the child's ability to trust and relate to others. When children are traumatised, they find it very hard to regulate behaviour and soothe or calm themselves. They often attract the description of being 'hyperactive'.

- Babies are particularly attuned to their primary carer and will sense their fear and traumatic stress; this is particularly the case where family violence is present. They will become unsettled and therefore more demanding of an already overwhelmed parent. The first task of any service is to support the non-offending parent and to engage the family in safety.
- Traumatic memories are stored differently in the brain compared to everyday memories. They are encoded in vivid images and sensations and lack a verbal narrative and context. As they are unprocessed and more primitive, they are likely to flood the child or adult when triggers like smells, sights, sounds or internal or external reminders present at a later stage.
- These flashbacks can be *affective*, i.e. intense feelings, that are often unspeakable; or *cognitive*, i.e. vivid memories or parts of memories, which seem to be actually occurring. Alcohol and drug abuse are the classic and usually most destructive attempts to numb out the pain and avoid these distressing and intrusive experiences.
- Children are particularly vulnerable to flashbacks at quiet times or at bedtimes and will often avoid both, by acting out at school and bedtimes. They can experience severe sleep disruption, intrusive nightmares which add to their 'dysregulated' behaviour, and limits their capacity at school the next day. Adolescents will often stay up all night to avoid the nightmares and sleep in the safety of the daylight. Self harming behaviours release endorphins which can become an habitual response.
- Cumulative harm can overwhelm the most resilient child and particular attention needs to be given to understanding the complexity of the child's experience. These children require calm, patient, safe and nurturing parenting in order to recover, and may well require a multi-systemic response to engage the required services to assist.
- The recovery process for children and young people is enhanced by the belief and support of non-offending family members and significant others. They need to be made safe and given opportunities to integrate and make sense of their experiences.
- It is important to acknowledge that parents can have the same post-traumatic responses and may need ongoing support. Workers need to engage parents in managing their responses to their children's trauma. It is normal for parents to feel overwhelmed and suffer shock, anger, severe grief, sleep disturbances and other trauma related responses. Case practice needs to be child centred and family sensitive.

Factors which pose risks to healthy child development

The presence of one or more risk factors, alongside a cluster of trauma indicators, may greatly increase the risk to the child's wellbeing and should flag the need for further child and family assessment, using the Best Interests Case Practice Model.

The following risk factors can impact on children and families and the caregiving environment:

Child and family risk factors

- family violence, current or past
- mental health issue or disorder, current or past (including self-harm and suicide attempts)
- alcohol/substance abuse, current or past, addictive behaviours
- disability or complex medical needs eg. intellectual or physical disability, acquired brain injury
- newborn, prematurity, low birth weight, chemically dependent, foetal alcohol syndrome, feeding/sleeping/settling difficulties, prolonged and frequent crying
- unsafe sleeping practices for infants eg. side or tummy sleeping, ill-fitting mattress, cot cluttered with pillows, bedding, or soft toys which can cover infant's face, co-sleeping with sibling or with parent who is on medication, drugs/alcohol or smokes, using other unsafe sleeping place such as a couch, or exposure to cigarette smoke
- disorganised or insecure attachment relationship (child does not seek comfort or affection from caregivers when in need)
- developmental delay
- history of neglect or abuse, state care, child death or placement of child or siblings
- separations from parents or caregivers
- parent, partner, close relative or sibling with a history of assault, prostitution or sexual offences
- experience of intergenerational abuse/trauma
- compounded or unresolved experiences of loss and grief
- chaotic household/lifestyle/problem gambling
- poverty, financial hardship, unemployment
- social isolation (family, extended family, community and cultural isolation)
- inadequate housing/transience/homelessness
- lack of stimulation and learning opportunities, disengagement from school, truanting
- inattention to developmental health needs/poor diet
- disadvantaged community
- racism
- recent refugee experience

Parent risk factors

- parent/carer under 20 years or under 20 years at birth of first child
- lack of willingness or ability to prioritise child's needs above own
- rejection or scapegoating of child
- harsh, inconsistent discipline, neglect or abuse
- inadequate supervision of child or emotional enmeshment
- single parenting/multiple partners
- inadequate antenatal care or alcohol/substance abuse during pregnancy

Wider factors that influence positive outcomes

- sense of belonging to home, family, community and a strong cultural identity
- pro-social peer group
- positive parental expectations, home learning environment and opportunities at major life transitions
- access to child and adult focused services eg. health, mental health, maternal and child health, early intervention, disability, drug and alcohol, family support, family preservation, parenting education, recreational facilities and other child and family support and therapeutic services
- accessible and affordable child care and high quality preschool programs
- inclusive community neighbourhoods/settings
- service system's understanding of neglect and abuse.

Resources

Other useful websites

The Raising Children Network
raisingchildren.net.au

An essential part of this resource is the references to the Raising Children Network. This is an Australian website, launched in 2006, on the basics of raising children aged 0-8 years.

Talaris Developmental Timeline
www.talaris.org

A research based timeline about how children develop in the first 5 years.

Infant Mental Health
www.zerotothree.org

Zero to Three website has a relational and mental health focus.

Royal Children's Hospital (RCH)
Phone (03) 9345 5522

www.rch.org.au

Royal Children's Hospital Centre for Community Child Health
www.rch.org.au/ccch

Parenting Research Centre
www.parentingrc.org.au

Victorian Government

Health Channel
www.betterhealth.vic.gov.au

Health and medical information for consumers, quality assured by the Victorian Government.

Child Protection and Family Services (Victorian Government)
www.office-for-children.vic.gov.au

every child every chance and Looking After Children websites
www.dhs.vic.gov.au/everychildeverychance

Child and Adolescent Mental Health Services
www.health.vic.gov.au/mentalhealth/services/child/index

Department of Education and Training Student Support Services
www.sofweb.vic.edu.au/wellbeing/index.htm

Victorian Aboriginal Child Care Agency (VACCA)
www.vacca.org.au

Trauma websites

Child Trauma Academy
www.childtraumaacademy.com

International Society for Traumatic Stress Studies
www.istss.org

Traumatology
www.fsu.edu/~trauma

Traumatic Stress Institute/Center for Adult & Adolescent Psychotherapy
www.tsicaap.com

Telephone services

Parentline 13 22 89

Maternal and Child Health line 13 22 29
(up to 6 years of age)

Nurse on Call 1300 60 60 24
24 hour health advice and information from a Registered Nurse.

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- City of Yarra MCH and Family Services

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Raising Children Network raisingchildren.net.au

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State Government Victoria Department of Human Services

human services

Child development and trauma specialist practice resource: 0 – 12 months

Developmental trends

The following information needs to be understood in the context of the overview statement on child development:

0-2 weeks

- anticipates in relationship with caregivers through facial expression, gazing, fussing, crying
- is unable to support head unaided
- hands closed involuntarily in the grasp reflex
- startles at sudden loud noises
- reflexively asks for a break by looking away, arching back, frowning, and crying

By 4 weeks

- focuses on a face
- follows an object moved in an arc about 15 cm above face until straight ahead
- changes vocalisation to communicate hunger, boredom and tiredness

By 6-8 weeks

- participates in and initiates interactions with caregivers through vocalisation, eye contact, fussing, and crying
- may start to smile at familiar faces
- may start to 'coo'
- turns in the direction of a voice

By 3-4 months

- increasing initiation of interaction with caregivers
- begins to regulate emotions and self soothe through attachment to primary carer
- can lie on tummy with head held up to 90 degrees, looking around
- can wave a rattle, starts to play with own fingers and toes
- may reach for things to try and hold them
- learns by looking at, holding, and mouthing different objects
- laughs out loud
- follows an object in an arc about 15 cm above the face for 180 degrees (from one side to the other)
- notices strangers

May even be able to:

- keep head level with body when pulled to sitting
- say "ah", "goo" or similar vowel consonant combinations
- blow a raspberry
- bear some weight on legs when held upright
- object if you try to take a toy away

By 6 months

- uses carer for comfort and security as attachment increases
- is likely to be wary of strangers
- keeps head level with body when pulled to sitting
- says "ah", "goo" or similar vowel consonant combinations
- sits without support
- makes associations between what is heard, tasted and felt
- may even be able to roll both ways and help to feed himself
- learns and grows

By 9 months

- strongly participates in, and initiates interactions with, caregivers
- lets you know when help is wanted and communicates with facial expressions, gestures, sounds or one or two words like "dada" and "mamma"
- watches reactions to emotions and by seeing you express your feelings,

starts to recognise and imitates happy, sad, excited or fearful emotions

- unusually high anxiety when separated from parents/carers
- is likely to be wary of, and anxious with, strangers
- expresses positive and negative emotions
- learns to trust that basic needs will be met
- works to get to a toy out of reach
- looks for a dropped object
- may even be able to bottom shuffle, crawl, stand
- knows that a hidden object exists
- waves goodbye, plays peekaboo

Child development and trauma specialist practice resource: 0 – 12 months

Possible indicators of trauma

- increased tension, irritability, reactivity, and inability to relax
- increased startle response
- lack of eye contact
- sleep and eating disruption
- loss of eating skills
- loss of acquired motor skills
- avoidance of eye contact
- arching back/inability to be soothed
- uncharacteristic aggression
- avoids touching new surfaces eg. grass, sand and other tactile experiences
- avoids, or is alarmed by, trauma related reminders, eg sights, sounds, smells, textures, tastes and physical triggers

- fight, flight, freeze response
- uncharacteristic, inconsolable or rageful crying, and neediness
- increased fussiness, separation fears, and clingingness
- withdrawal/lack of usual responsiveness
- limp, displays no interest
- unusually high anxiety when separated from primary caregivers
- heightened indiscriminate attachment behaviour
- reduced capacity to feel emotions – can appear 'numb'
- 'frozen watchfulness'

- loss of acquired language skills

- genital pain: including signs of inflammation, bruising, bleeding or diagnosis of sexually transmitted disease

Trauma impact

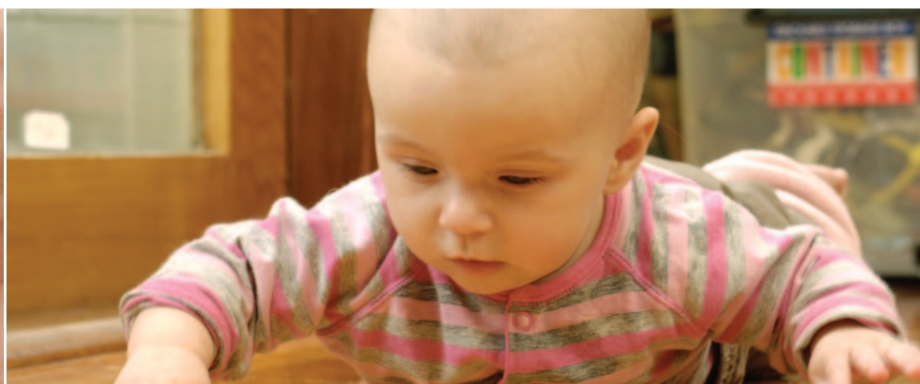
- neurobiology of brain and central nervous system altered by switched on alarm response
- behavioural changes
- regression in recently acquired developmental gains
- hyperarousal, hypervigilance and hyperactivity
- sleep disruption
- loss of acquired motor skills
- lowered stress threshold
- lowered immune system

- fear response to reminders of trauma
- mood and personality changes
- loss of, or reduced capacity to attune with caregiver
- loss of, or reduced capacity to manage emotional states or self soothe
- insecure, anxious, or disorganised attachment behaviour
- heightened anxiety when separated from primary parent/carer
- indiscriminate relating
- reduced capacity to feel emotions - can appear 'numb'
- cognitive delays and memory difficulties
- loss of acquired communication skills

Parental/carer support following trauma

Encourage parent(s)/carers to:

- seek, accept and increase support for themselves, to manage their own shock and emotional responses
- seek information and advice about the child's developmental progress
- maintain the child's routines around holding, sleeping and eating
- seek support (from partner, kin, MCH nurse) to understand, and respond to, infant's cues
- avoid unnecessary separations from important caregivers
- maintain calm atmosphere in child's presence. Provide additional soothing activities
- avoid exposing child to reminders of trauma
- expect child's temporary regression; and clinginess - don't panic
- tolerate clinginess and independence
- take time out to recharge



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Department of Human Services

Child development and trauma specialist practice resource: 12 months – 3 years

Developmental trends

The following information needs to be understood in the context of the overview statement on child development:

By 12 months

- enjoys communicating with family and other familiar people
- seeks comfort, and reassurance from familiar objects, family, carers, and is able to be soothed by them
- begins to self soothe when distressed
- understands a lot more than he can say
- expresses feelings with gestures, sounds and facial expressions
- expresses more intense emotions and moods
- does not like to be separated from familiar people
- moves away from things that upset or annoy
- can walk with assistance holding on to furniture or hands
- pulls up to standing position
- gets into a sitting position
- claps hands (play pat-a-cake)
- indicates wants in ways other than crying
- learns and grows in confidence by doing things repeatedly and exploring
- picks up objects using thumb and forefinger in opposition (pincer) grasp
- is sensitive to approval and disapproval

May even be able to:

- understand cause and effect
- understand that when you leave, you still exist
- crawl, stand, walk
- follow a one step instruction – “go get your shoes”
- respond to music

By 18 months

- can use at least two words and learning many more
- drinks from a cup
- can walk and run
- says “no” a lot
- is beginning to develop a sense of individuality
- needs structure, routine and limits to manage intense emotions

May even be able to:

- let you know what he is thinking and feeling through gestures
- pretend play and play alongside others

By 2 years

- takes off clothing
- ‘feeds’/‘bathes’ a doll, ‘washes’ dishes, likes to ‘help’
- builds a tower of four or more cubes
- recognises/identifies two items in a picture by pointing
- plays alone but needs a familiar adult nearby
- actively plays and explores in complex ways

May even be:

- able to string words together
- eager to control, unable to share
- unable to stop himself doing something unacceptable even after reminders
- tantrums

By 2½ years

- uses 50 words or more
- combines words (by about 25 months)
- follows a two-step command without gestures (by 25 months)
- alternates between clinginess and independence
- helps with simple household routines
- conscience is undeveloped; child thinks “I want it, I will take it”

By 3 years

- washes and dries hands
- identifies a friend by naming
- throws a ball overhand
- speaks and can be usually understood half the time
- uses prepositions (by, to, in, on top of)
- carries on a conversation of two or three sentences
- helps with simple chores
- may be toilet trained
- conscience is starting to develop; child thinks “I would take it but my parents will be upset with me”

Child development and trauma specialist practice resource: 12 months – 3 years

Possible indicators of trauma

- behavioural changes, regression to behaviour of a younger child
- increased tension, irritability, reactivity, and inability to relax
- increased startle response
- sleep and eating disruption
- loss of eating skills
- loss of recently acquired motor skills
- avoidance of eye contact
- inability to be soothed
- uncharacteristic aggression
- avoids touching new surfaces eg. grass, sand and other tactile experiences
- avoids, or is alarmed by, trauma related reminders, eg sights, sounds, smells textures, tastes and physical triggers

- fight, flight, freeze
- uncharacteristic, inconsolable, or rageful crying, and neediness
- fussiness, separation fears, and clinginess
- withdrawal/lack of usual responsiveness
- loss of self-confidence
- unusually anxious when separated from primary caregivers
- heightened indiscriminate attachment behaviour
- reduced capacity to feel emotions – can appear ‘numb', apathetic or limp
- ‘frozen watchfulness'
- loss of acquired language skills
- inappropriate sexualised behaviour/ touching
- sexualised play with toys
- genital pain, inflammation, bruising, bleeding or diagnosis of sexually transmitted disease

Trauma impact

- neurobiology of brain and central nervous system altered by switched on alarm response
- behavioural changes
- regression in recently acquired developmental gains
- hyperarousal, hypervigilance and hyperactivity
- sleep disruption
- loss of acquired motor skills
- lowered stress threshold
- lowered immune system
- greater food sensitivities

- fear response to reminders of trauma
- mood and personality changes
- loss of, or reduced capacity to attune with caregiver
- loss of, or reduced capacity to manage emotional states or self soothe
- insecure, anxious, or disorganised attachment behaviour
- heightened anxiety when separated from primary parent/carer
- indiscriminate relating
- increased resistance to parental direction
- memory for trauma may be evident in behaviour, language or play
- cognitive delays and memory difficulties
- loss of acquired communication skills

Parental/carer support following trauma

Encourage parent(s)/carers to:

- seek, accept and increase support for themselves to manage their own shock and emotional responses
- seek information and advice about the child's developmental progress
- maintain the child's routines around holding, sleeping and eating
- avoid unnecessary separations from important caretakers
- seek support (from partner, kin, MCH nurse) to understand, and respond to, infant's cues
- maintain calm atmosphere in child's presence. Provide additional soothing activities
- avoid exposing child to reminders of trauma.
- expect child's temporary regression; and clinginess - don't panic
- tolerate clinginess and independence
- take time out to recharge

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Department of Human Services

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Child development and trauma specialist practice resource: 3 – 5 years

Developmental trends

The following information needs to be understood in the context of the overview statement on child development:

Between 3-4 years

- communicates freely with family members and familiar others
- seeks comfort, and reassurance from familiar family and carers, and is able to be soothed by them
- has developing capacity to self soothe when distressed
- understands the cause of feelings and can label them
- extends the circle of special adults eg. to grandparents, baby-sitter
- needs adult help to negotiate conflict
- is starting to manage emotions
- is starting to play with other children and share
- has real friendships with other children
- is becoming more coordinated at running, climbing, and other large-muscle play
- can walk up steps, throw and catch a large ball using two hands and body
- use play tools and may be able to ride a tricycle
- holds crayons with fingers, not fists
- dresses and undresses without much help
- communicates well in simple sentences and may understand about 1000 words
- pronunciation has improved, likes to talk about own interests
- fine motor skill increases, can mark with crayons, turn pages in a book
- day time toilet training often attained

Between 4-5 years

- knows own name and age
- is becoming more independent from family
- needs structure, routine and limits to manage intense emotions
- is asking lots of questions
- is learning about differences between people
- takes time making up his mind
- is developing confidence in physical feats but can misjudge abilities
- likes active play and exercise and needs at least 60 minutes of this per day
- eye-hand coordination is becoming more practised and refined
- cuts along the line with scissors/can draw people with at least four 'parts'
- shows a preference for being right-handed or left-handed
- converses about topics and understands 2500 to 3000 words
- loves silly jokes and 'rude' words
- is curious about body and sexuality and role-plays at being grown-up
- may show pride in accomplishing tasks
- conscience is starting to develop, child weighs risks and actions; "I would take it but my parents would find out"

Child development and trauma specialist practice resource: 3 – 5 years

Possible indicators of trauma

- behavioural change
- increased tension, irritability, reactivity and inability to relax
- regression to behaviour of younger child
- uncharacteristic aggression
- Reduced eye contact
- loss of focus, lack of concentration and inattentiveness
- complains of bodily aches, pains or illness with no explanation
- loss of recently acquired skills (toileting, eating, self-care)
- enuresis, encopresis
- sleep disturbances, nightmares, night terrors, sleepwalking
- fearfulness of going to sleep and being alone at night
- inability to seek comfort or to be comforted

- mood and personality changes
- obvious anxiety and fearfulness
- withdrawal and quieting
- specific, trauma-related fears; general fearfulness
- intense repetitive play often obvious
- involvement of playmates in trauma related play at school and day care
- separation anxiety with parents/others
- loss of self-esteem and self confidence
- reduced capacity to feel emotions - may appear 'numb', limp, apathetic
- repeated retelling of traumatic event
- loss of recently acquired language and vocabulary
- loss of interest in activities
- loss of energy and concentration at school
- sudden intense masturbation
- demonstration of adult sexual, knowledge through inappropriate sexualised behaviour
- genital pain, inflammation, bruising, bleeding or diagnosis of sexually transmitted disease
- sexualised play with toys
- may verbally describe sexual abuse, pointing to body parts and telling about the 'game' they played
- sexualised drawing

Trauma impact

- behavioural changes
- hyperarousal, hypervigilance, hyperactivity
- loss of toileting and eating skills
- regression in recently acquired developmental gains
- sleep disturbances, night terrors
- enuresis and encopresis
- delayed gross motor and visual-perceptual skills

- fear of trauma recurring
- mood and personality changes
- loss of, or reduced capacity to attune with caregiver
- loss of, or reduced capacity to manage emotional states or self soothe
- increased need for control
- fear of separation
- loss of self-esteem and self confidence
- confusion about trauma evident in play…magical explanations and unclear understanding of causes of bad events
- vulnerable to anniversary reactions set off by seasonal reminders, holidays, and other events
- memory of intrusive visual images from traumatic event may be demonstrated/ recalled in words and play
- at the older end of this age range, children are more likely to have lasting, accurate verbal and pictorial memory for central events of trauma
- speech, cognitive and auditory processing delays

Parental/carer support following trauma

Encourage parent(s)/carers to:

- seek, accept and increase support for themselves to manage their own shock and emotional responses
- remain calm. Listen to and tolerate child's retelling of event
- respect child's fears; give child time to cope with fears
- protect child from re-exposure to frightening situations and reminders of trauma, including scary T.V. programs, movies, stories, and physical or locational reminders of trauma
- accept and help the child to name strong feelings during brief conversations (the child cannot talk about these feelings or the experience for long)
- expect and understand child's regression while maintaining basic household rules
- expect some difficult or uncharacteristic behaviour
- seek information and advice about child's developmental and educational progress
- take time out to recharge

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State Government Victoria

Department of Human Services

human services

Child development and trauma specialist practice resource: 5 – 7 years

Developmental trends

The following information needs to be understood in the context of the overview statement on child development:

Physical skills

- active, involved in physical activity, vigorous play
- may tire easily
- variation in levels of coordination and skill
- many become increasingly proficient in skills, games, sports
- some may be able to ride bicycle
- may use hands with dexterity and skill to make things, do craft and build things

Social-emotional development

- has strong relationships within the family and integral place in family dynamics
- needs caregiver assistance and structure to regulate extremes of emotion
- generally anxious to please and to gain adult approval, praise and reassurance
- conscience is starting to be influenced by internal control or doing the right thing "I would take it, but if my parents found out, they would be disapproving"
- not fully capable of estimating own abilities, may become frustrated by failure
- reassured by predictable routines
- friendships very important, although they may change regularly
- may need help moving into and becoming part of a group
- some children will maintain strong friendships over the period
- may be mood swings
- able to share, although not all the time
- perception of, and level of regard for self, fairly well developed

Cognitive and creative characteristics

- emerging literacy and numeracy abilities, gaining skills in reading and writing
- variable attention and ability to stay on task; attends better if interested
- good communication skills, remembers, tells and enjoys jokes
- may require verbal, written or behavioural cues and reminders to follow directions and obey rules
- skills in listening and understanding may be more advanced than expression
- perspective broadens as experiences at school and in the community expand
- most valuable learning occurs through play
- rules more likely to be followed if he/she has contributed to them
- may have strong creative urges to make things

Possible indicators of trauma

- behavioural change
- increased tension, irritability, reactivity and inability to relax
- sleep disturbances, nightmares, night terrors, difficulty falling or staying asleep
- regression to behaviour of younger child
- lack of eye contact
- 'spacey', distractible, or hyperactive behaviour
- toileting accidents/enuresis, encopresis or smearing of faeces
- eating disturbances
- bodily aches and pains – no apparent reason
- accident proneness
- absconding/truanting from school
- firelighting, hurting animals

- obvious anxiety, fearfulness and loss of self esteem
- frightened by own intensity of feelings
- specific fears
- efforts to distance from feelings of shame, guilt, humiliation and reduced capacity to feel emotions
- reduced capacity to feel emotions - may appear 'numb', or apathetic
- 'frozen watchfulness'
- vulnerable to anniversary reactions caused by seasonal events, holidays, etc
- repeated retelling of traumatic event
- withdrawal, depressed affect
- 'blanking out' or loss of concentration when under stress at school with lowering of performance

- explicit, aggressive, exploitive, sexualised relating/engagement with other children
- sexualised behaviour towards adults
- verbally describes experiences of sexual abuse pointing to body parts and telling about the 'game' they played
- sexualised drawing
- excessive concern or preoccupation with private parts and adult sexual behaviour
- verbal or behavioural indications of age-inappropriate knowledge of adult sexual behaviour
- running away from home

Child development and trauma specialist practice resource: 5 – 7 years

Trauma impact

- changes in behaviour
- hyperarousal, hypervigilance, hyperactivity
- regression in recently acquired developmental gains
- sleep disturbances due to intrusive imagery
- enuresis and encopresis
- trauma driven, acting out risk taking behaviour
- eating disturbances
- loss of concentration and memory
- flight into driven activity or retreat from others to manage inner turmoil
- post-traumatic re-enactments of traumatic event that may occur secretly and involve siblings or playmates
- loss of interest in previously pleasurable activities

- fear of trauma recurring
- mood or personality change
- loss of, or reduced capacity to attune with caregiver
- loss of, or reduced capacity to manage emotional states or self soothe
- increased self-focusing and withdrawal
- concern about personal responsibility for trauma
- wish for revenge and action oriented responses to trauma
- may experience acute distress encountering any reminder of trauma
- lowered self-esteem
- increased anxiety or depression
- fearful of closeness and love
- child is likely to have detailed, long-term and sensory memory for traumatic event. Sometimes the memory is fragmented or repressed
- factual, accurate memory may be embellished by elements of fear or wish; perception of duration may be distorted
- intrusion of unwanted visual images and traumatic reactions disrupt concentration and create anxiety often without parent awareness
- vulnerable to flashbacks of recall and anniversary reactions to reminders of trauma
- speech and cognitive delays

Parental/carer support following trauma

Encourage parent(s)/carers to:

- seek, accept and increase support for themselves to manage their own shock and emotional responses
- listen to and tolerate child's retelling of event – respect child's fears; give child time to cope with fears
- increase monitoring and awareness of child's play, which may involve secretive re-enactments of trauma with peers and siblings; set limits on scary or harmful play
- permit child to try out new ideas to cope with fearfulness at bedtime: extra reading time, radio on, listening to a tape in the middle of the night to undo the residue of fear from a nightmare
- reassure the older child that feelings of fear or behaviours that feel out of control or babyish eg. night wetting are normal after a frightening experience and that the child will feel more like himself or herself with time
- encourage child to talk about confusing feelings, worries, daydreams, mental review of traumatic images, and disruptions of concentration by accepting the feelings, listening carefully, and reminding child that these are normal but hard reactions following a very scary event
- maintain communication with school staff and monitor child's coping with demands at school or in community activities
- expect some time-limited decrease in child's school performance and help the child to accept this as a temporary result of the trauma
- protect child from re-exposure to frightening situations and reminders of trauma, including scary television programs, movies, stories, and physical or locational reminders of trauma
- expect and understand child's regression or some difficult or uncharacteristic behaviour while maintaining basic household rules
- listen for a child's misunderstanding of a traumatic event, particularly those that involve self-blame and magical thinking
- gently help child develop a realistic understanding of event. Be mindful of the possibility of anniversary reactions
- remain aware of your own reactions to the child's trauma. Provide reassurance to child that feelings will diminish over time
- provide opportunities for child to experience control and make choices in daily activities
- seek information and advice on child's developmental and educational progress
- provide the child with frequent high protein snacks/meals during the day
- take time out to recharge

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human services

Child development and trauma specialist practice resource: 7 – 9 years

Developmental trends

The following information needs to be understood in the context of the overview statement on child development:

Physical skills

- improved coordination, control and agility compared to younger children
- skilled at large motor movements such as skipping and playing ball games
- often practises new physical skills over and over for mastery
- enjoys team and competitive sports and games
- improved stamina and strength

Social-emotional development

- strong need to belong to, and be a part of, family and peer relationships
- is increasingly able to regulate emotions
- increasingly independent of parents; still needs their comfort and security
- begins to see situations from others perspective – empathy
- able to resolve conflicts verbally and knows when to seek adult help
- conscience and moral values become internalised "I want it, but I don't feel good about doing things like that"
- increased confidence, more independent and takes greater responsibility
- needs reassurance; understands increased effort leads to improvements
- humour is component of interactions with others
- peers seen as important spends more time with them
- friendships are based on common interests and are likely to be enduring
- feelings of self worth come increasingly from peers
- friends often same

Self concept

- can take some responsibility for self and as a family member
- increasingly influenced by media and by peers
- learns to deal with success and failure
- may compare self with others and find self wanting, not measuring up
- can exercise self control and curb desires to engage in undesirable behaviour - has understanding of right and wrong
- can manage own daily routines
- may experience signs of onset of puberty near end of this age range (girls particularly)

Cognitive and creative characteristics

- can contribute to long-term plans
- engages in long and complex conversations
- has increasingly sophisticated literacy and numeracy skills
- may be a competent user of computers or play a musical instrument

Possible indicators of trauma

- behavioural change
- increased tension, irritability, reactivity and inability to relax
- sleep disturbances, nightmares, night terrors, difficulty falling or staying asleep
- regression to behaviour of younger child
- lack of eye contact
- 'spacey' or distractible behaviour
- 'blanking out' or lacks concentration when under stress at school with l owering of performance
- eating disturbances
- toileting accidents/enuresis, encopresis or smearing of faeces
- bodily aches and pains - no apparent reason
- accident proneness
- absconding/truanting from school
- firelighting, hurting animals

- obvious anxiety, fearfulness and loss of self-esteem
- frightened by own intensity of feelings
- specific post-traumatic fears
- efforts to distance from feelings of shame, guilt, humiliation
- reduced capacity to feel emotions - may appear 'numb'
- vulnerable to anniversary reactions caused by seasonal events, holidays, etc.
- repeated retelling of traumatic event
- withdrawal, depressed affect or black outs in concentration
- blanking out/loss of ability to concentrate when under learning stress at school with lowering of performance
- explicit, aggressive, exploitive, sexualised relating/engagement with other children, older children or adults
- hinting about sexual experience
- verbally describes experiences of sexual abuse and describes the 'game' they played
- excessive concern or preoccupation with private parts and adult sexual behaviour
- verbal or behavioural indications of age-inappropriate knowledge of adult sexual behaviour
- sexualised drawing or written 'stories'
- running away from home

Child development and trauma specialist practice resource: 7 – 9 years

Trauma impact

- changes in behaviour
- hyperarousal, hypervigilance, hyperactivity
- regression in recently acquired developmental gains
- sleep disturbances due to intrusive imagery
- enuresis and encopresis
- eating disturbances
- loss of concentration and memory
- post-traumatic re-enactments of traumatic event that may occur secretly and involve siblings or playmates
- trauma driven, acting out risk taking behaviour
- flight into driven activity or retreat from others to manage inner turmoil
- loss of interest in previously pleasurable activities
- fear of trauma recurring
- mood or personality changes
- loss of, or reduced capacity to attune with caregiver
- loss of, or reduced capacity to manage emotional states or self soothe
- increased self-focusing and withdrawal
- concern about personal responsibility for trauma
- wish for revenge and action oriented responses to trauma
- may experience acute distress encountering any reminder of trauma
- lowered self-esteem
- increased anxiety or depression
- fearful of closeness and love
- child is likely to have detailed, long-term and sensory memory for traumatic event. Sometimes the memory is fragmented or repressed
- factual, accurate memory may be embellished by elements of fear or wish; perception of duration may be distorted
- intrusion of unwanted visual images and traumatic reactions disrupt concentration and create anxiety often without parent awareness
- vulnerable to flashbacks of recall and anniversary reactions to reminders of trauma
- speech and cognitive delays

Parental/carer support following trauma

Encourage parent(s)/carers to:

- seek, accept and increase support for themselves to manage their own shock and emotional responses
- remain calm. Listen to and tolerate child's retelling of event - respect child's fears; give child time to cope with fears
- increase monitoring and awareness of child's play, which may involve secretive re-enactments of trauma with peers and siblings; set limits on scary or harmful play
- permit child to try out new ideas to cope with fearfulness at bedtime: extra reading time, radio on, listening to a tape in the middle of the night to undo the residue of fear from a nightmare
- reassure the older child that feelings of fear or behaviours that feel out of control or babyish eg. night wetting are normal after a frightening experience and that the child will feel more like himself or herself with time
- encourage child to talk about confusing feelings, worries, daydreams, mental review of traumatic images, and disruptions of concentration by accepting the feelings, listening carefully, and reminding child that these are normal but hard reactions following a very scary event
- maintain communication with school staff and monitor child's coping with demands at school or in community activities
- expect some time-limited decrease in child's school performance and help the child to accept this as a temporary result of the trauma
- protect child from re-exposure to frightening situations and reminders of trauma, including scary television programs, movies, stories, and physical or locational reminders of trauma
- expect and understand child's regression or some difficult or uncharacteristic behaviour while maintaining basic household rules
- listen for a child's misunderstanding of a traumatic event, particularly those that involve self-blame and magical thinking
- gently help child develop a realistic understanding of event. Be mindful of the possibility of anniversary reactions
- remain aware of your own reactions to the child's trauma. Provide reassurance to child that feelings will diminish over time
- provide opportunities for child to experience control and make choices in daily activities
- seek information and advice on child's developmental and educational progress
- provide the child with frequent high protein snacks/meals during the day
- take time out to recharge

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Child development and trauma specialist practice resource: 9 – 12 years

Developmental trends

The following information needs to be understood in the context of the overview statement on child development:

Physical skills

- large and fine motor skills becoming highly coordinated
- enjoys risk taking
- does well at games/sports requiring skill, strength and agility
- may look more adult-like in body shape, height and weight
- risk taking

Social-emotional development

- growing need and desire for independence and separate identity
- may challenge parents and other family members
- parents and home important, particularly for support and reassurance
- growing sexual awareness and interest in the opposite gender
- may experience embarrassment, guilt, curiosity and excitement because of sexual awareness
- girls may reach puberty during this time
- belonging to a group is extremely important; peers largely influence identity/self-esteem
- often interact in pairs or small groups; each member has status and position
- groups generally one gender, although interact with the other
- strong desire to have opinions sought and respected

Cognitive and creative characteristics

- beginning to think and reason in a more logical adult-like way
- capable of abstract thinking, complex problem solving, considers alternative possibilities and broadening perspectives
- concentrates for long periods of time if interested, but needs worries to be sorted
- may have sophisticated literacy and numeracy skills
- popular culture of great interest and major influence
- uses language in sophisticated ways; for example, tells stories, argues, debates
- knows the difference between fantasy and what is real
- has some appreciation of the value of money

Possible indicators of trauma

- increased tension, irritability, reactivity and inability to relax
- sleep disturbances, nightmares, night terrors, difficulty falling or staying asleep
- regression to behaviour of younger child
- reduced eye contact
- 'spacey' or distractible behaviour
- toileting accidents/enuresis, encopresis or smearing of faeces
- eating disturbances
- bodily aches and pains - no reason
- accident proneness
- absconding or truanting from school
- firelighting, hurting animals

- obvious anxiety, fearfulness and loss of self-esteem/self confidence
- frightened by own intensity of feelings
- specific post-traumatic fears
- efforts to distance from feelings of shame, guilt, humiliation and reduced capacity to feel emotions
- reduced capacity to feel emotions - may appear 'numb' or apathetic
- vulnerable to anniversary reactions caused by seasonal events, holidays, etc.
- repeated retelling of traumatic event
- 'frozen watchfulness'
- withdrawal, depressed affect, or black outs in concentration
- 'blanking out' or lacks concentration when under stress at school with lowering of performance

- explicit, aggressive, exploitive, sexualised relating/engagement with other children
- sexualised behaviour towards adults
- verbally describes experiences of sexual abuse and tells 'stories' about the 'game' they played
- excessive concern or preoccupation with private parts and adult sexual behaviour
- hinting about sexual experience
- verbal or behavioural indications of age-inappropriate knowledge of adult sexual behaviour
- sexualised drawing or written 'stories'
- running away from home

Child development and trauma specialist practice resource: 9 – 12 years

Trauma impact

- behavioural changes
- hyperarousal, hypervigilance, hyperactivity
- regression in recently acquired developmental gains
- sleep disturbances due to intrusive imagery
- enuresis and encopresis
- eating disturbances
- loss of concentration and memory
- post-traumatic re-enactments of traumatic event that may occur secretly and involve siblings or playmates
- trauma driven, acting out risk taking behaviour
- flight into driven activity or retreat from others to manage inner turmoil
- loss of interest in previously pleasurable activities

- fear of trauma recurring
- mood or personality changes
- loss of, or reduced capacity to attune with caregiver
- loss of, or reduced capacity to manage emotional states or self soothe
- increased self-focusing and withdrawal
- concern about personal responsibility for trauma
- wish for revenge and action oriented responses to trauma
- may experience acute distress encountering any reminder of trauma
- lowered self-esteem
- increased anxiety or depression
- fearful of closeness and love
- child is likely to have detailed, long-term and sensory memory for traumatic event. Sometimes the memory is fragmented or repressed
- factual, accurate memory may be embellished by elements of fear or wish; perception of duration may be distorted
- intrusion of unwanted visual images and traumatic reactions disrupt concentration and create anxiety often without parent awareness
- vulnerable to flashbacks of recall and anniversary reactions to reminders of trauma
- speech and cognitive delays

Parental/carer support following trauma

Encourage parent(s)/carers to:

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- increase monitoring and awareness of child's play, which may involve secretive re-enactments of trauma with peers and siblings; set limits on scary or harmful play
- permit child to try out new ideas to cope with fearfulness at bedtime: extra reading time, radio on, listening to a tape in the middle of the night to undo the residue of fear from a nightmare
- reassure the older child that feelings of fear or behaviours that feel out of control or babyish eg. night wetting are normal after a frightening experience and that the child will feel more like himself or herself with time
- encourage child to talk about confusing feelings, worries, daydreams, mental review of traumatic images, and disruptions of concentration by accepting the feelings, listening carefully, and reminding child that these are normal but hard reactions following a very scary event
- maintain communication with school staff and monitor child's coping with demands at school or in community activities
- expect some time-limited decrease in child's school performance and help the child to accept this as a temporary result of the trauma
- protect child from re-exposure to frightening situations and reminders of trauma, including scary television programs, movies, stories, and physical or locational reminders of trauma
- expect and understand child's regression or some difficult or uncharacteristic behaviour while maintaining basic household rules
- listen for a child's misunderstanding of a traumatic event, particularly those that involve self-blame and magical thinking
- gently help child develop a realistic understanding of event. Be mindful of the possibility of anniversary reactions
- remain aware of your own reactions to the child's trauma. Provide reassurance to child that feelings will diminish over time
- provide opportunities for child to experience control and make choices in daily activities
- seek information and advice on child's developmental and educational progress
- provide the child with frequent high protein snacks/meals during the day
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Child development and trauma specialist practice resource: 12 – 18 years

Developmental trends

The following information needs to be understood in the context of the overview statement on child development:

Physical development

- significant physical growth and body changes
- develops greater expertise/skills in sport
- changing health needs for diet, rest, exercise, hygiene and dental care
- puberty, menstruation
- sexuality and contraception
- increased need for nutritious balanced diet, including adequate calcium, protein and iron

Self concept

- can be pre-occupied with self
- secondary sex characteristics affect self concept, relationships with others and activities undertaken
- dealing with own sexuality and that of peers
- developing identity based on gender and culture
- becoming an adult, including opportunities and challenges

Social-emotional development

- empathy for others
- ability to make decisions (moral)
- values and a moral system become firmer and affect views and opinions
- spends time with peers for social and emotional needs beyond parents and family
- peer assessment influences self concept, behaviour/need to conform
- girls have 'best friends', boys have 'mates'
- may explore sexuality by engaging in sexual behaviours and intimate relationships
- develops wider interests
- seeks greater autonomy personally, in decision making
- more responsible in tasks at home, school and work
- experiences emotional turmoil, strong feelings and unpredictable mood swings
- interdependent with parents and family
- conflict with family more likely through puberty
- able to negotiate and assert boundaries
- learning to give and take (reciprocity)
- focus is on the present - may take significant risks
- understands appropriate behaviour but may lack self control/insight

Cognitive and creative characteristics

- thinks logically, abstractly and solves problems thinking like an adult
- may take an interest in/develop opinions about community or world events
- can appreciate others' perspectives and see a problem or situation from different angles
- career choice may be realistic, or at odds with school performance and talents

Child development and trauma specialist practice resource: 12 – 18 years

Possible indicators of trauma

- increased tension, irritability, reactivity and inability to relax
- accident proneness
- reduced eye contact
- sleep disturbances, nightmares
- enuresis, encopresis
- eating disturbances/disorders
- absconding or truanting and challenging behaviours
- substance abuse
- aggressive/violent behaviour
- firelighting, hurting animals
- suicidal ideation
- self harming eg. cutting, burning

- efforts to distance from feelings of shame and humiliation
- loss of self-esteem and self confidence
- acute psychological distress
- personality changes and changes in quality of important relationships evident
- increased self-focusing and withdrawal
- reduced capacity to feel emotions – may appear 'numb'
- wish for revenge and action oriented responses to trauma
- partial loss of memory and ability to concentrate
- trauma flashbacks
- acute awareness of parental reactions; wish to protect parents from own distress
- sexually exploitive or aggressive interactions with younger children
- sexually promiscuous behaviour or total avoidance of sexual involvement
- running away from home

Trauma impact

- sleep disturbances, nightmares
- hyperarousal, hypervigilance, hyperactivity
- eating disturbances or disorders
- trauma acting out, risk taking, sexualised, reckless, regressive or violent behaviour
- flight into driven activity and involvement with others or retreat from others in order to manage inner turmoil
- vulnerability to withdrawal and pessimistic world view
- vulnerability to depression, anxiety, stress disorders, and suicidal ideation
- vulnerability to conduct, attachment, eating and behavioural disorders

- mood and personality changes and changes in quality of important relationships evident
- loss of, or reduced capacity to attune with caregiver
- loss of, or reduced capacity to manage emotional states or self soothe
- lowered self-esteem
- flight into adulthood seen as way of escaping impact and memory of trauma (early marriage, pregnancy, dropping out of school, abandoning peer group for older set of friends)
- fear of growing up and need to stay within family orbit

Memory for trauma includes:

- acute awareness of and distress with intrusive imagery and memories of trauma
- vulnerability to flash backs, episodes of recall, anniversary reactions and seasonal reminders of trauma
- may experience acute distress encountering any reminder of trauma
- partial loss of memory and concentration

Parental/carer support following trauma

Encourage parent(s)/carers to:

- seek, accept and increase support for themselves to manage their own shock and emotions
- remain calm. Encourage younger and older adolescents to talk about traumatic event with family members
- provide opportunities for young person to spend time with friends who are supportive and meaningful
- reassure young person that strong feelings - whether of guilt, shame, embarrassment, or wish for revenge - are normal following a trauma
- help young person find activities that offer opportunities to experience mastery, control, and self-esteem
- encourage pleasurable physical activities such as sports and dancing
- monitor young person's coping at home, school, and in peer group
- address acting-out behaviour involving aggression or self destructive behaviour quickly and firmly with limit setting and professional help
- take signs of depression, self harm, accident proneness, recklessness, and persistent personality change seriously by seeking help
- help young person develop a sense of perspective on the impact of the traumatic event and a sense of the importance of time in recovering
- encourage delaying big decisions
- seek information/advice about young person's developmental and educational progress
- provide the young person with frequent high protein snacks/ meals during the day
- take time to recharge

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