Discussion Paper 3

Exploring the impact of abuse related trauma on memory functioning of children

Introduction

The purpose of this discussion paper is to explore the specific impact of trauma on memory function for children who have experienced abuse related trauma.

The third SMART discussion paper encourages readers to reflect on the implications of trauma on children's ability to remember and learn.

Section 1. Memory and trauma

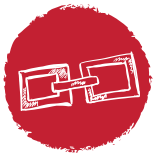
Memories help to resource children's abilities. They provide platforms for knowledge. They provide frameworks for children to learn how to respond to their own needs and those of others.

Trauma dramatically affects children's memory capacity. It serves to degrade children's memories. Children's working memory is extensively reduced. They find it difficult to learn. They are not able to remember events and the sequence in which they occurred. They are unable to build a narrative about their lives which draws out meaning and understanding. In many ways, trauma reduces children's ability to remember who they are.

In the following table, a summary of the different types of memory are described. Examples of the ways that trauma affects memory function is specifically explored in the final column.

Australian Childhood Foundation

This Discussion Paper was originally written as part of the SMART (Strategies for Managing Abuse Related Trauma) Program which is an ongoing partnership between the South Australian Government Department for Education and the Australian Childhood Foundation. Our Making SPACE for Learning is a national program that supports traumatised and vulnerable children and young people in educational settings.

Memory type	Description	Example of positive memory function	Example of trauma affected memory function
Implicit memory 	**Memories stored in subcortical areas of the brain. Stored and retrieved without our awareness.**		
Sensory memory 	Memories encoded and retrieved subconsciously based on sensory input.	The smell of the classroom on a hot day. The taste of a "Chocolate Big M".	A tone of voice that is similar to the abuser. The smell of an air freshener from a previous home.
Templates 	Other patterns of neural connection which are repeated and learned subconsciously.	Using a pencil. Hopping well enough to play hopscotch. Walking.	Hiding under a table when hearing arguing. Rising to one's feet when a threat is perceived.
Explicit memory 	**Memories stored in the cortex. Stored and retrieved with our awareness (consciously).**		
Semantic/factual memory 	Specific facts or items of knowledge.	My name. Colours. Times tables.	My nickname is "little bugger".
Episodic 	Discrete events or occurrences where the individual was present.	A sports lesson where I received praise. The school concert.	The events of the week are not retained. The child can't tell you who they played with yesterday.
Narrative 	That which enables us to connect a range of memories to make meaning of our experiences	How the capacity to be a good friend has developed.	Unable to construct a family history in the "Life and family" learning module.

Trauma and memory

The above table outlines some of the ways that memory is affected by the experience of trauma. These outcomes stem from the chronic arousal state that underpins the brain's response to trauma. Trauma causes memory systems to degrade and fail. The more complex formed systems of memory are dissolved first. The most complex form of memory is narrative memory.

Implicit memories are most easily triggered by what are called cues. The brain tags the original sensory experience of violence, such as the tone of voice of the abuser, with the emotional intensity of that experience. When the child hears a similar tone and the implicit memory state is triggered, then the child will re-experience the feelings almost as if they are occurring again. The child's brain is unable to distinguish between the original trauma and the re-triggering experience. The behavioural response to the retriggered memory is very similar to the way the child responded to the original experiences of abuse and violence. It is often said that chronically traumatized children are held hostage to their past. This can be confronting and overwhelming for the child.

Children often manage the retriggering of traumatic memories by disconnecting from those around them, engaging in behaviour that draws attention away from their feelings of confusion or shame (distracts) or being overwhelmed by their emotional reactions (distraught). The following table outlines a scenario and some of the behavioural responses that might sit within each of these categories.

Elizabeth is a quiet student but generally quite well behaved. One day another student comes into the classroom very upset because her grandma died the night before. She is crying and very distracted. *What is unknown to you and Elizabeth is that this kind of crying triggers a memory for Elizabeth of her mother's reaction to her father's violence.*			Jonathan is a bit of an isolate but you get the feeling he is trying to build a positive relationship with you. You ask him to go to the office to collect the weekly newsletters, ask the secretary for a couple of documents and collect the day's attendance sheet from the AP. He is found 15 minutes later at the back of the oval. *Jonathan headed for the office but could only remember one task….*		
Disconnects	**Distracts**	**Distraught**	**Disconnects**	**Distracts**	**Distraught**
Elizabeth crawls under her desk and stares at her fingers.	Elizabeth says loudly that she has a really good joke and everyone should listen.	Elizabeth begins sobbing and runs up to the other girl, pushing other students out of the way.	Jonathan just follows the teacher who finds him but engages in no conversation or explanation.	Jonathan tells anyone who will listen that this is a stupid class and he doesn't know why he has to be there.	Jonathan just sits on the oval crying quietly and saying he wants to go home.

The behavioural responses of traumatized children are often labeled within the school environment with a number of labels including resistant, stubborn, over-reacting, attention seeking, impulsive, confrontational or having a learning disability.

Section 2. Questions for reflection or discussion

1. How does this knowledge facilitate further understanding of a specific student at your school?
2. Does this knowledge change the ways in which you would work with this student?
3. Which element(s) of SMART PRACTICE are of most value when working with the ways that trauma can affect children's memory functioning?
4. What have you utilized as an effective strategy for working with students to support their memory functioning? Is this a strategy specifically for the individual student or a whole class or whole school plan?
5. Do you have a challenge you would like to share with colleagues in looking for a different support path?

Making SPACE for Learning

Trauma Informed Practice in Schools

Discussion Paper 5

Extending our understanding of the role of specific brain structures in responding to trauma

Introduction

The intent of this paper is to generate discussion. The paper provides an opportunity for readers to share specific knowledge. It also poses a series of critical questions to further enhance responses to students who have experienced chronic traumatisation.

One of the central platforms of understanding in the SMART program is the knowledge of how trauma affects the development and functioning of children's brains. While brain development is extensively covered in the face to face workshops and the online training, this paper seeks to extend the reader's understanding of key parts of the brain, their function and the changes caused by experiences of chronic abuse related trauma. The specific brain areas to be discussed in this paper are:

- **Thalamus**
- **amygdala**
- **Hippocampus**

Section 1. Understanding the role and function of the thalamus, amygdala and hippocampus

Thalamus

The thalamus is the sensory gate-keeper of the brain. It is connected to all parts of the brain- cortex, limbic lobe, midbrain and brainstem. The thalamus assesses the constant sensory data being received by our body and brain and then directs it to the appropriate area of the brain.

An example (non trauma related): Swimming

It is a lovely day and I have decided to go swimming at the beach. As I dive into the water, my senses send a range of data to the thalamus. This might include the cool feel of the water on my skin, the taste and smell of salty water and the air just above, the sound of the water as I dive into it as well as the sights associated with this environment. It would also receive data regarding my heart rate and blood pressure - the state of my body. All of this information would come into the thalamus as separate, discrete, pieces of information.

Australian Childhood Foundation

This Discussion Paper was originally written as part of the SMART (Strategies for Managing Abuse Related Trauma) Program which is an ongoing partnership between the South Australian Government Department for Education and the Australian Childhood Foundation. Our Making SPACE for Learning is a national program that supports traumatised and vulnerable children and young people in educational settings.

The thalamus would process much of this data as “bound” experience - all the elements are connected together. It would send the data to the to the cortex, via the **hippocampus**, which would enable a conscious experience of this event as a pleasant activity and happening at this present moment.

The primary role of the thalamus is to receive and connect sensory and arousal state information to send to the higher parts of the brain.

An example (trauma related): Witnessing domestic violence incident

I am an 8 year old girl who is watching my mother being thrown against a wall by my father. As I watch this my senses send a range of data to the thalamus. All of this data is overwhelming in its intensity as I hear my father yell abuse, see the impact of the violence on my mother, smell fear as my heart rate and blood pressure increase significantly. All of this information comes into the thalamus as separate, discrete, pieces of information but each with an overwhelming spike of intensity. The thalamus is so inundated by this data it cannot “bind” the experience and will usually direct it all, still separated, to the **amygdala** - the fear response centre of the brain. It will also shut the cortex down so it cannot be overwhelmed by this experience so there is a lack of conscious encoding- a key element of the trauma response continuum. This means there is a disconnection between the experienced state of this incident and conscious awareness of this state in the moment and at any future time this state response is triggered or activated.

It is because of this process that children’s traumatic memories are often experienced as timeless, vivid sensory fragments stemming from the original, overwhelming, experience.

Amygdala

The amygdala (situated in the limbic area of the brain) is the fear response centre of the brain. It is responsible for evaluating threat and danger. It tends to make this assessment based on blocks of data, ie: large volumes of data rather than specific nuances of information. This is reflected in the fact that there are more pathways out than into the amygdale. For example, this means it cannot differentiate between a real or perceived danger as the neural pathways into it are triggered by both. The amygdala has strong connections to the **medial prefrontal cortex** and to the brain stem- enabling it to release one of the stress hormones, acetylcholine, when required.

Non trauma related example: Walking home

I am walking home from the train station and there is someone behind me who seems to be following me. The amygdala receives a flow of information - being passed on by the thalamus - that activates a fear response. It sends a message to the medial prefrontal cortex which is primarily responsible for suppressing stress hormones and regulating my response. I continue to walk but am conscious of the person behind me. Because my cortex is not overwhelmed by this fear response I begin to plan my options - will I run, will I walk into a house with the light on, will I use my mobile phone or just stop? I am experiencing some physiological fear responses too though - my heart is beating very fast, my stomach is churning and I feel a bit sweaty. The person behind me walks into their house I begin to down regulate my responses - using a range of cortically based strategies.

The amygdala has interpreted a danger very quickly through input from the lower parts of the brain. It is critical to responding to threat to recognize it even before we are consciously aware of the danger.

Trauma related example: Experience of emotional abuse

I am a 7 year old boy and I've lost count of how many times my mother has called me a "worthless thing" and yelled, "my life would be so much better if you'd never been born." Even though these are verbal exchanges, my amygdala is primed to respond to threat because it has happened so often. The sensory data received during this exchange sets off the amygdala's fear response again. This is particularly driven by a recognition of my mother's angry face.

Because of the repeated pattern of emotional abuse, the boy's amygdala could have developed one of two patterns of responding - either an overactive amygdala response or an underactive one. In the overactive response, the amygdala is always "on alert" so there is a constant, generalized, experience of fear. In the underactive response, the amygdala has been so overwhelmed it has shut down or switched off - leaving the child with a restricted mechanism to perceive threat or danger.

One of the outcomes of this impaired amygdala response for children who have experienced abuse related trauma is that they find it difficult to recognize the emotions other people are trying to convey with their face, voice and gestures. It is also the case that the amygdala works in conjunction with the **hippocampus** to try to store these fear memories. The fear is generalized when stored such that, in the previous example, any yelling voice - not just the mother's voice - becomes a source of the fear response.

Hippocampus

The hippocampus is a key component of our memory encoding capacity. It stores experiences with the context which facilitates their storage into long term memory. The hippocampus is then able to retrieve memories from long term "storage" as required because they have been stored in a clear place based on their context. Contextual information includes time, location and the events leading up to and following an experience.

In order to consider this contextual information in a short term memory episode, think about the process you use to try to remember why you walked into a room in the house when you can't. You retrace your steps (time) back to the room you were in (location) and then think about the thought sequence you had entered into (events leading up to the experience).

Traumatic memories are encoded without this context because they are not stored explicitly (or with our conscious awareness). The hippocampus encodes the experience implicitly and without that linking information that marks this as a discrete, episodic, memory. This means that recall as a whole becomes much more difficult.

Trauma also impairs hippocampal capacity because the constant flood of stress hormones has a significantly negative impact on this capacity. Research has demonstrated this reduction in capacity can be up to 25% of non-traumatised peers.

Section 2. Questions for reflection or discussion

This paper serves to increase functional awareness of brain structures and the roles and impact of abuse related trauma on that capacity. The following series of questions ask the reader to consider what this understanding might add to our work supporting children who have experienced chronic trauma.

1. Does the information about the thalamus, amygdala and hippocampus "fit" with a child or young person with whom you work?
2. What understanding of their behaviour or learning issues do you draw from the material included in this paper?
3. Which SMART PRACTICE elements would be most relevant in supporting the child or young person you identified based on this content?
4. How might you apply those elements in your work with that child?
5. Are there any other issues regarding the impact of trauma on brain development you would like to know more about?
6. Would you recommend other resources about this content to your colleagues?

Discussion Paper 15

Working with the window of tolerance in the classroom

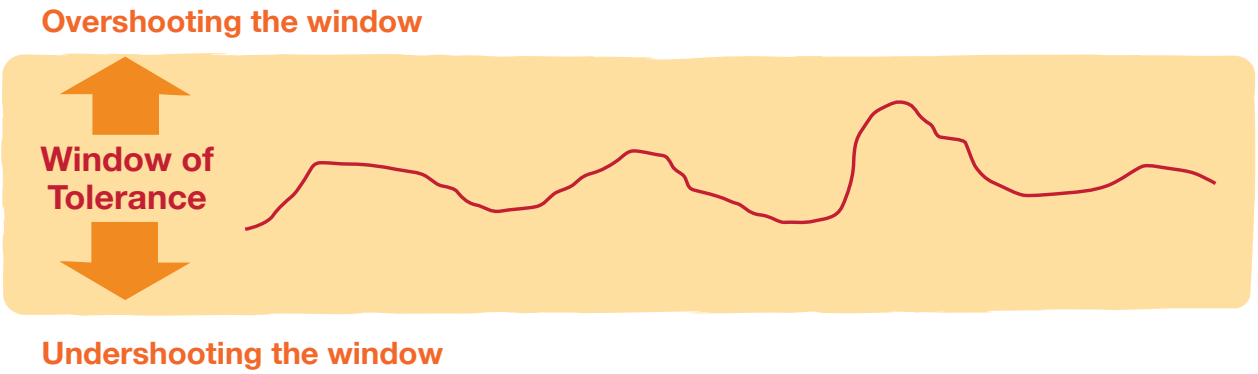
Preamble

This discussion paper is one in a series designed to stimulate discussion and sharing of experience amongst staff in educational settings working with young people who may have experienced complex relational trauma.

Introduction

How have you responded in moments of extreme stress? Were you primed for action with a surge of energy ready to challenge or escape? Alternatively you may have found yourself suddenly depleted feeling foggy or collapsed? Our responses in extremely stressful situations represent a potent mix of primitive biological drives and patterned reactions developed from prior experiences of threat. These responses are less consciously chosen as they are determined by environmental factors that shape them over time. In these moments our entire internal system becomes subsumed with one goal- survival and we lose our ability to think logically and rationally about the situation.

Thankfully most of us don't spend too much time in this state. We navigate our way through life with various intensities of emotional and physiological arousal that we process without disrupting the overall functioning of our system. These ebbs and flows of life could be described as occurring within a 'window of tolerance'. This is an optimal zone for processing and integrating our experiences of life. In this zone we can rationalize and reflect on problems and choices and are in touch with what's going on around us. In this zone our bodies are un-strained and we feel relatively calm.



Australian Childhood Foundation

This Discussion Paper was originally written as part of the SMART (Strategies for Managing Abuse Related Trauma) Program which is an ongoing partnership between the South Australian Government Department for Education and the Australian Childhood Foundation. Our Making SPACE for Learning is a national program that supports traumatised and vulnerable children and young people in educational settings.

Probably all of us could identify times when we have been outside of the boundaries of our window of tolerance. At these times our thinking or behaviour has become disrupted by our intensified emotional and physiological arousal. We may behave in ways we wouldn't normally choose and we lack flexibility in our responses. At these dysregulated times we enter into states often characterized by either excessive rigidity or chaos.

It would seem the width of our window of tolerance varies from person to person. For some the window may be quite narrow, while for others they may be able to tolerate a high degree of intensity of emotional or physiological arousal. For example, those who follow the adventurer Bear Grills in his program, Man vs. Wild will have watched him navigate his way through a range of highly challenging situations that would strike terror into the hearts of most of us. For Bear, high degrees of intensity feels ok and he is able to think, behave, and feel with balance and effectiveness revealing a wide window of tolerance. For others, however, their window of tolerance may be quite narrow. For these people, emotions such as sadness or fear may be quite disruptive to functioning if they are even mildly present.

The width of ones window of tolerance may also change depending upon factors such as context or state of mind. For example we may be more able to tolerate stressful situations when familiar people are around us and thus our window of tolerance may be broader when we are with these people.

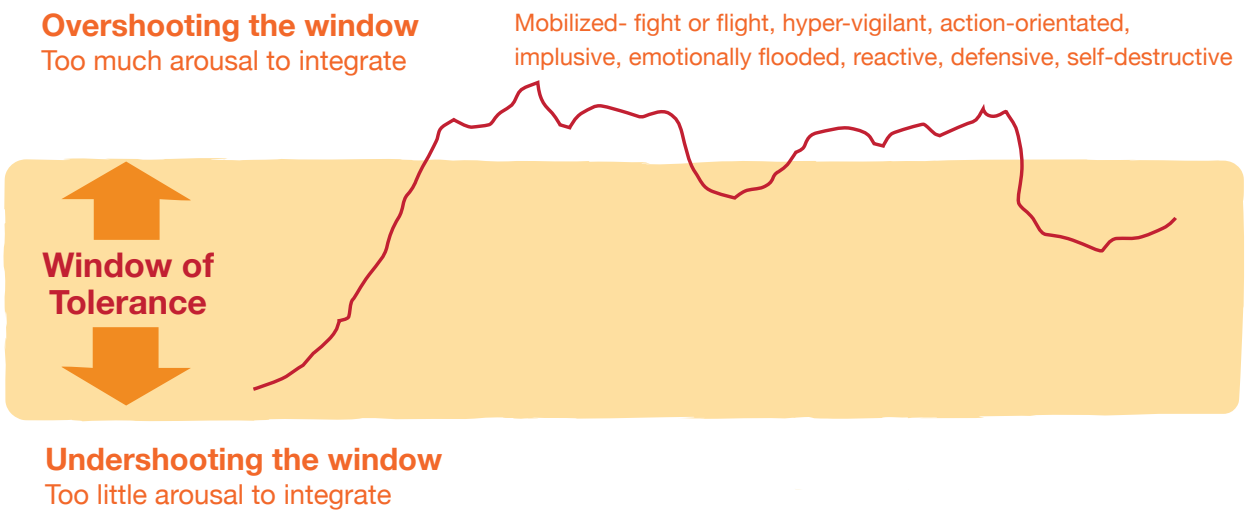
The Window of Tolerance and Trauma

For many young people who have experienced trauma their systems are too often overwhelmed. They find themselves operating outside of their window much more than the average person. They also find themselves with a window that lacks width and flexibility compared with the average person. For some this means they commonly overshoot their window, while for others they tend to undershoot it.

Both under and over shooting protections put in place by traumatised young people are probably responses that have developed over their lifetimes as useful ways to survive when threatened. These young people have become acclimatised to environments that they expect to be threatening or dangerous. Their systems have been primed too many times to work hard to survive and this becomes an overarching daily imperative that is deeply programed into their brains, so much so that they are not consciously aware of looking for threatening cues around them but their subconscious brain does anyway. We probably underestimate the amount of time young people spend in survival mode rather than learning mode in our classrooms.

Overshooting the window- Too much arousal

Many traumatised young people have difficulty finding stillness. You might have noticed their darting eyes and a tendency to fiddle with something in their hands or how easily they startle. You might even notice yourself feeling a little stirred up or ill at ease when around them. You notice this because their internal system that is primed to act to protect itself is communicating with your nervous system. These young people are likely to engage in actions such as fight or flight in the face of threat. We can expect them to move toward or away when they feel unsafe. These protective actions are deeply engrained in the most primitive part of their brains and they have likely been used successfully in the past by the young person to help keep her/himself safe.



Some bodily cues suggesting too much arousal and an overshooting of the window of tolerance:

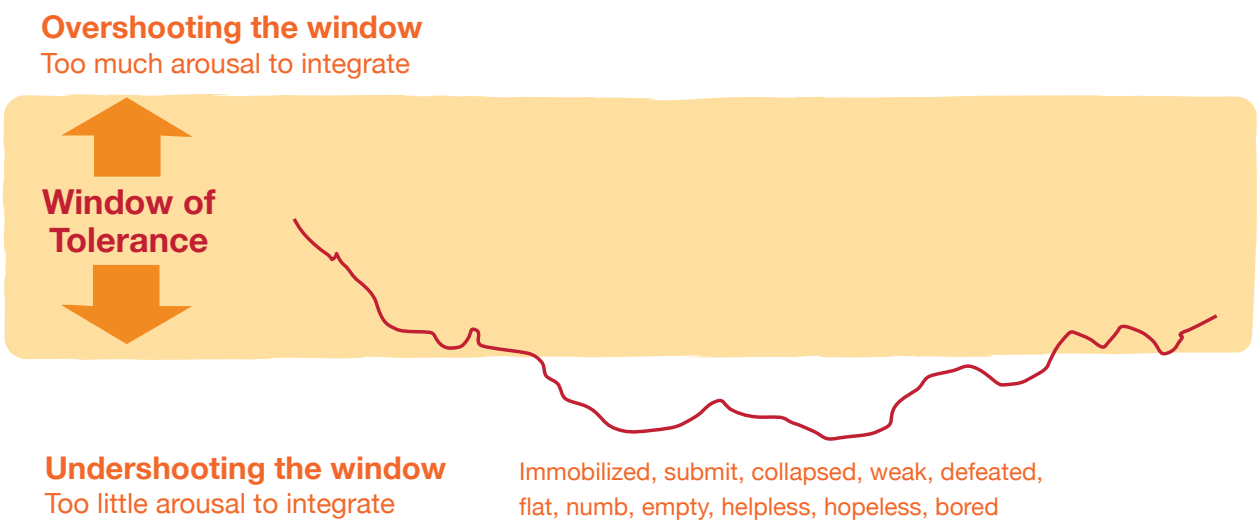
- Dilated pupils (to let light in to see better)
- Lack of saliva making mouth dry
- Shallow breathing
- Butterflies in the stomach
- Faster heart beat
- Excessive sweating
- Tensed muscles (readied for action)
- Agitated movement
- Trouble finding stillness

Garry

The bell sounds ending lunchtime. A teacher hurries towards her year 9 class having missed lunch to handle a yard duty incident. Distracted and rushed she moves into the classroom and the students flow in behind her. As she sorts out her teaching materials two students begin throwing around a cap that one student has forgotten to remove after lunch. The teacher raises her head to spy her student Garry moving around the room trying to get his cap back. The teacher recognises the cap as Garry's because he is always wearing it in the yard. She sighs to herself as she recognises Garry as a student that is frequently unsettled and unproductive in her classroom. The class has barely begun and he is already in the middle of the disruption she thinks to herself. The teacher moves forward and says firmly "I'll have that cap" and picks it up off the floor before Garry can dive for it. She announces that she will be keeping it until the end of the class as he is not supposed to have his cap in the classroom anyway. Garry squeals "that isn't fair". His chest puffs up and his eyes look wildly at her. His left fist tightens and the veins in his redenned neck become prominent. His face shows he is mad and his body seethes with anger as his arm and shoulder muscles tense. Without consiously thinking the teacher takes a step back from him. He yell's "I hate this f##ing school" towards her. She replies frustratedly tightening in her body "Garry that is not appropriate language". Garry lunges towards his cap in the teachers hand. The teacher drops the cap with a sudden surge of fear. Garry scrapes it up from the floor and takes off out of the classroom.

Undershooting the window- Too little arousal

Some traumatised young people have endured extremely high levels of trauma. These young people might describe feeling empty and hollow at times of high stress. They might lack a sense of themselves at these times and describe not feeling anything in their body. At these times they are moving into a state of protection that involves shutting down their system to protect themselves. These young people will not seek interaction with others and instead will retreat into themselves to endure the moment through a fortification of withdrawal.



Some bodily cues suggesting too little arousal and an undershooting of the window of tolerance:

- Slumped body parts
- Collapsed body
- Endless stare with pin like pupils
- Loose muscles
- Slowed heart rate
- Blank face

Miranda

A teacher pauses as he goes to write Miranda's 'Health and Human Development' semester report. For most students reports flowed easily for him but with the lack of submitted work and a large amount of absences he noticed next to Miranda's name in his attendance book he found himself struggling to find words for her. When he thought about her, the picture in his mind was of a shrunken, head lowered young person, hunched down in her chair at the back of the classroom. He found her really hard to read and he realised he had never seen her really smile like other kids. He recalled a difficult moment that occurred some time ago when he called upon her to answer a question after showing a sex education DVD to the class and how response-less she had been, just vacantly sitting there, face blank and slumped

down in her chair. He had quickly called upon another student as he had felt a sense of disconnect and awkwardness. He felt a bit exasperated when he thought about her and didn't know what to do with her, how to engage her, nothing seemed to touch her. From what he understood Miranda was involved quite a bit with the school counsellor and he imagined she had a difficult home life. He wasn't sure about the best way to teach Miranda but he knew something needed to change as presently not much was getting through to her.

Operating from within the window of tolerance

When within their window of tolerance a young person's physiological system is not stretched. They won't feel signs of fight, flight, freeze or collapse as their systems sense that they are safe. In their window of tolerance social engagement is available to them. They are better equipped to listen to others around them, interact cooperatively and learn.

Some cues suggesting young people are in their window of tolerance:

- Body feels calm, settled, neutral
- Able to be socially orientated with those around them
- Able to be reflective
- Able think clearly
- Able to set boundaries
- Able to self regulate
- Able to be mindful

Recognising those that overshoot and undershoot the window of tolerance in the classroom

It is often easier to recognise those young people in the classroom who overshoot their window of tolerance compared with those who undershoot. These are likely to be the students who show their stress by moving towards or away from you. This movement is highly visible as we are biologically primed as social beings to notice others threatened movements to then gauge our own safety. For overshooting students looking to find safety involves an active re-negotiation of relationships, while for those who undershoot their window, seeking safety often involves slipping away from others in a passive attempt to find invisibility for a time. These students do not demand a response from others. In fact they are working hard to be overlooked and with twenty four or so other students in the classroom it is easy to not spot them.

Introducing and implementing the window of tolerance into the school context

Thinking about introducing and implementing the 'window of tolerance' into a school context could be something to consider as a broader teaching group. Some questions to think about:

- Where and by whom would it be best introduced? Eg. In Homeroom or English or Math or to year level group gatherings?
- What are some ways it could be consistently supported across teaching contexts and classrooms?
- What are some ways it could be consistently supported and utilised by coordinators and principals?
- What are some ways students could be involved in its introduction and implementation?

Some ideas for introducing the window of tolerance in the classroom

- Introduce the window of tolerance model to your students. Talk about examples of when someone might overshoot or undershoot the window paying attention to what that might feel like in the body and normalising that exceeding the window happens for us all at times.
- Represent the window of tolerance concept in a concrete way. For example it might be drawn on the white board or each student might have an A4 laminated version of the window at their desks.
- Institute window 'check ins' throughout class time to gauge views about where the group is at in terms of the window.
- Acknowledge contextual events that may be influencing where everyone is at with regard to their window e.g. approaching exams or social function.
- Model reflecting upon where you are in relation to your window of tolerance. You don't need to detail underlying reasons.

Some ideas for working with young people who are frequently outside of their window of tolerance

As a first step in working with young people who frequently find themselves outside of their window of tolerance we should acknowledge the important role their protective response/s have played for them in the past. It is wonderful that when they really needed it their brain and body found a way to survive.

We also need to help young people hold on to a sense of safety in their daily life as much as possible. It is only when they don't sense safety that they will need their protective responses. With this in mind you might like to consider the following questions with the young person in a time of calmness:

- Where is the safest place for you at school?
- Where is the safest place for you in the world? Is there any way we can help you bring some of that place with you to school?
- Are there people at school that help you feel safe and ok? If so who?
- Is there anyone you wish you could bring with you to school to help feel ok? (might be from family or a friend or might be a music or sport hero etc.) How might we help you bring something of this person with you to school?

The responses to these questions could contribute to a plan built with the young person to help her/him more readily hold on to a sense of safety in their every day. The more a young person feels safe at school the less likely it is they will exceed their window of tolerance.

Some other ideas for working with young people outside of their window of tolerance:

- Learn more about the body signs of increasing stress for the young person and for yourself.
- Offer students opportunities that will increase their sense of control and power.
- Recalibrate your expectations for young person's advancement- it may be that she/he isn't able to grasp all of the course material and the focus may need to be a social/regulatory one for a time.

Some ideas for working with young people who overshoot their window of tolerance

Young people who overshoot their window of tolerance have highly primed nervous systems ready for action. Their systems require calming through activity that allows them to slow down. We need to aim to help these young people find regulating movement. Some ideas for use with these students in the classroom include:

- Intersperse directed group activity breaks- e.g. yawn and stretch breaks, everyone walk once around the room without lifting your feet off the floor or like there is no gravity in the room, initiate Mexican waves, stand up turn around and sit down again.
- Incorporate more kinaesthetic learning opportunities.
- Plan movement breaks with young person- e.g. walk around the oval or opportunity to run an errand or to be able to connect with safest place in school (wherever that is for the young person).
- Plan and practice an escape route with the young person should they need it.
- Work with colleagues and young person to create a plan for if they become activated and practice it.

Some ideas for working with young people who undershoot their window of tolerance

Young people who undershoot their window of tolerance have nervous systems that can begin to shut down when they lose a sense of safety. These are the students that can become disconnected from themselves and the classroom and require gentle engagement to re-enter their window of tolerance. Some ideas for use with these students in the classroom include:

Present moment breaks- introduce short, sharp activities that bring young people into the present moment with a focus on what is happening in the here and now. Some examples-

- Everyone point to something that's green.
- Tap your head and rub your belly at the same time, then swap.
- Find out what colour eyes the person next to you has.
- Push your big toes into the bottom of your shoes.

Sensory stimulation

- Everyone say three objects you can see, two things you can hear, and one thing you can smell.
- Incorporate kinaesthetic learning opportunities that have a sensory element to them i.e. activities that stimulate many of the senses
- Create a space in the room for a sensory break e.g. cushion corner with textured cushions and calming posters and DVD player playing calming music etc.

The window of tolerance is a model we could all apply to our lives. It may be a handy guide to help us better understand the shifting states of the young people we work with, as well as an opportunity to be more reflective about our own windows. It can help us better understand how available our students are to learning at any given time and it can provide us some direction around what a young person might need to re-establish themselves safely within their window of tolerance.

Questions for reflection or discussion

Three questions about the young person's resources:

1. In what situations is the young person most likely to be able to maintain themselves within their window of tolerance and thus utilise social engagement with others and feel safe?
2. Are there particular people that she/he feels most safe with?
3. In what situations are the young person's protective responses most likely to be shown?

Five questions to take into the classroom with you:

1. Where is the young person in relation to their window of tolerance?
2. How do I know?
3. Where am I in relation to my window of tolerance?

4. How do I know?
5. What do I need right now to maintain myself in my window of tolerance?

Three questions to share with colleagues

1. What are some ways to share knowledge about the window of tolerance framework amongst teachers and students?
2. What are some strategies you already use to help students maintain themselves within their windows of tolerance?
3. What are some things you do to maintain yourselves within your windows of tolerance?

Further reading about the 'window of tolerance'

Ogden, P & Minton, K. (2000) Sensorimotor Psychotherapy: One Method for Processing Traumatic Memory. *Traumatology,* volume VI, issue 3, article 3. Electronic version of this article: **http://www.fsu.edu/~trauma/v6i3/v6i3a3.html**

Ogden, P. Minton, K. & Pain, C. (2006) *Trauma and the Body: A Sensorimotor Approach to Psychotherapy.* New York: Norton & Co.

Siegel, D. (1999) *The Developing Mind- How relationships and the brain interact to shape who we are.* New York: Guilford. (Chapter 7 'Self Regulation' is particularly relevant)

Discussion Paper 16

Disability and Trauma in the classroom setting

Introduction

The purpose of this paper is to take into consideration the additional complexity of disability and explore the use of the framework principles of the SMART practice for working with children with disability who have experienced trauma. It is hoped that this paper gives staff working with children with disability who have experienced trauma an opportunity to reflect on how we might incorporate SMART practices into their Educational environment.

It is important to begin this discussion paper with the acknowledgment that children with disability have the same 'child' needs as any other child and the impact of trauma on the developing brain and attachment patterns are as relevant for children with disability as it is for those without disability.

Children with Disability and Trauma

There are approximately 39,058 children on care and protection orders and 37,648 children living in out-of home care. Research in the area of disability and trauma highlights that children and young people with disability are especially vulnerable to abuse or neglect. While statistics vary it is thought that children with disability may be 3.4 times more likely to be a victim of some type of abuse compared to children without disabilities, the maltreatment may start when they are very young and continue throughout childhood and the level of abuse is likely to be more severe and of longer duration.[1] The commission for Children and Young People and Child Guardian (2006) found that the rate of disability reported by children and young people in care was 22.5% for 5-8 year olds and 20.8% in 9-18 year olds.

Children are not born knowing how to manage their emotions; they rely on others to interpret their emotions and to respond accordingly. This adult-infant/child attunement supports the development of the child's self-regulation skills.[2] Children with disability, in particular those with developmental challenges (cognitive, communication, social), generally rely on others to interpret their emotions until they are much older than their non-disabled peers.

1. Sullivan, P., & Knutson, J. (1998). The association between child maltreatment and disabilities in a hospital-based epidemiological study. Child Abuse & Neglect, 22 (4), 271-288. And Howlin, P & Clements, J. (1995) Is it possible to assess the impact of abuse on Children with pervasive developmental disorders? Journal of Autism and Developmental Disorders, Vol. 25, No. 4, 1995

2. Kostelnik Stein & Whiren Soderman. (1998). Guiding Children's Social Development 3rd Ed.
* Definition of pervasive developmental disorder: Any of several disorders, such as autism and Asperger's syndrome, characterized by severe deficits in many areas of development, including social interaction and communication, or by the presence of repetitive, stereotyped behaviours. Such disorders are usually evident in the first years of life and are often associated with some degree of mental retardation.

Australian Childhood Foundation

This Discussion Paper was originally written as part of the SMART (Strategies for Managing Abuse Related Trauma) Program which is an ongoing partnership between the South Australian Government Department for Education and the Australian Childhood Foundation. Our Making SPACE for Learning is a national program that supports traumatised and vulnerable children and young people in educational settings.

For all children whose parents/carers have been the cause of their fearful states, and whose parents/carers have not responded to their needs sensitively when they have been distressed are left in a chronic state of extreme dysregulation. Their brain is overwhelmed and in response copes defensively. Over time these defensive coping strategies lead to a distorted reality and lays down partial and in complete memories and dysfunctional behavioural patterns that are reactivated when the child experiences similar situations.

> ***'the neural connections that result in defenses shape our lives by selecting what we approach and avoid, where our attention is drawn and the assumptions we use to organize our experiences' [Cozolino 2001].***[3]

As the child has not been supported while distressed they are unable to find or explore his/her own emotional self within relationship with the carer. Hence the child cannot manage emotional arousal in him/herself or in others. When maltreated children need parents to help them contain and regulate their escalating arousal they actually experience danger and emotional abandonment.

When the child has experienced trauma, their understanding of the world is that it is unsafe place. This impacts on their ability to explore their environment due to their need to focus on keeping safe from danger. This also impacts on the development of play skills which in turn leads to relationship and problem solving difficulties. Once the child is in a safe environment they can be encouraged to explore their environment safely and they can begin to further develop these important skills. For children with disability engaging and exploring their environment often has additional challenges due to the nature of their disability and they need adults to support them to adequately access and experience developmental opportunities e.g., body positioning, developing narratives, sensory opportunities.

The trauma related symptomology for children with *pervasive developmental disorder is vast and may include increased fear, anxiety and clingy or withdrawing behaviour; irritability, rigidity to change, self-injurious, aggressive and destructive behaviour's; poor compliance, mood disturbances, over activity and 'tantrums'; decreased interest in daily activities, disturb sleeping and eating disorders.[4]

Case Study

Tara is an 11 year old child with Pervasive Developmental Disorder and mild intellectual disability. In first 5 years of her life Tara had witnessed significant domestic violence and she had experienced homelessness, physical abuse, sexual abuse and neglect. When placed into care Tara was hyper-active and required constant supervision. She had multiple placements before finally being placed into a long-term placement two years ago. Tara is highly anxious; she has poor sleep patterns and frequently wakes the house with night terrors. At school Tara is not be able to sit for long periods she has approximately 7 out of seat behaviours (stand-sit, move-sit, lean-sit) within each 15 minute time period. She is hyper-vigilant of any movement or sounds in the environment and is unable to concentrate to complete most tasks. Tara has no friend. She wants and seeks friendships is unable to initiate the appropriate social contact, or maintain interactions. She will quickly begin to argue with the other children, can't wait her turn, grabs at things and always wants the equipment the other children are using. Tara regularly takes food from their bags, and says mean things to them. Tara finds any changes in the class difficult, and when a relief teacher is allocated there is a significant increase in the out of seat behaviour and she becomes enraged over minor things.

3. David Howe. (2005), Child Abuse and Neglect. Attachment, Development and Intervention. P46

4. Howlin, P & Clements, J. (1995) Is it possible to assess the impact of abuse on Children with pervasive developmental disorders? Journal of Autism and Developmental Disorders, Vol. 25, No. 4, 1995.

Section 2 SMART PRACTICE and Children with Disability

SMART PRACTICE is a framework of intervention tailored for use in the school environment. The intervention provides school staff with a range of strategies that aim to support the transformation of trauma impacts for children.

This paper provides an adapted SMART PRACTICE framework, specifically designed to support traumatized children with disability in an Education environment.

Predictable

- As with their non-disabled peers, traumatised children with disability perceive any change as a potential threat.
- Everyday patterns are often unpredictable for a child with disability. Many children with disability have additional service providers or staff who are involved in their lives e.g., taxi/ bus drivers, health workers, SSOs, therapists etc. hence there is a greater likelihood of predicted or unpredicted changes occurring.
- They may be surprised or caught off guard by others innocently moving around them, leading to anxiety and hyper- vigilance. This further reduces their capacity to attend to tasks and increases the likelihood of them using their behaviour to express their fear and frustration.

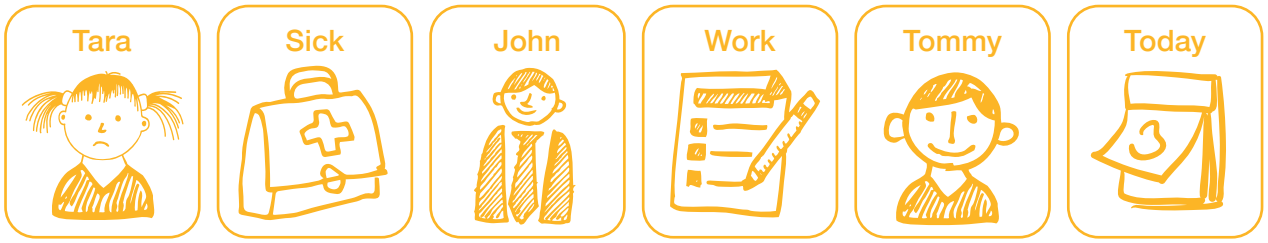
Specific Strategies

- When approaching the child, ensure they see or hear you approach.
- Use symbols that are meaningful to the child e.g., objects, photographs or line drawings targeted to the child's developmental level
- Use a visual schedule for the day, week, month. Include a change or cancelled because ….

'Swimming is cancelled because it is raining, we will do Art and Craft' (NOTE: **C** can be placed on clear laminate so it can be overlaid on swimming)

- Where and by whom would it be best introduced? Eg. In Homeroom or English or Math

- Have work stations and items clearly labeled
- Pro vide a visual story about the class and its expectations
- Explain changes within the environment using visual prompts e.g.,



Responsive

As with their non-disabled peers traumatized children with disability have not experienced adults who respond consistently to their needs leading to confusion, mixed messages and in consistent responses. Many children with disability have cognitive limitations, communication difficulties and immature social skills. Due to their developmental challenges they may use behaviour's in an attempt to communicate their needs when they become distressed and/or frustrated. These communicative attempts can present as internalized or externalized behaviour's. e.g., head banging, screaming, hitting out, withdrawing into a world of their own.

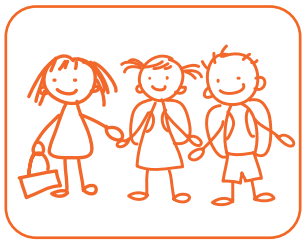
Children with disability who have experienced trauma need adults who are responsive, who are able consider the communicative purpose of the behaviour and look beyond the behaviour to see the child in need.

Specific Strategies

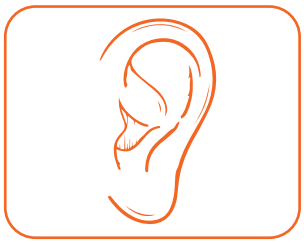
- Consider the child's developmental stage rather than chronological age.
- Remain calm and matter-of- fact should you be presented with an emotional outburst.
- Look for the meaning of the behaviour e.g., anxiety due to changes in staff, trauma memory, any underlying health issues or fears.
- Be empathic and consistent in your expectations and responses. Keeping your explanations clear, simple, and brief. The child may only be able to hear or understand the key words, the additional information or connecting words may be confusing.
- Stay present with the child, especially if they are or have been upset, so they know that an adult is there to support them.
- Be willing to approach the child following an outburst of emotion/behaviour rather than expecting the child to approach you.

- Depict the class expectations visually e.g.

In Mrs Jones'



class



we listen

and speak quietly

- Make a visual story book about who the child can go to when they need help, make a supporting cue card for the desk/tray top of wheel chair.
- Find 'magic moments' to reassure the child of their innate value, take photos/ video and make esteem lifting stories/videos.
- Be animated when showing gestures of pleasure and care for the child.
- Provide opportunities for acknowledgement for participation in a task rather than completion of tasks.

Attuned

Due to the unique challenges of the child's disability (e.g., cognition, vision, hearing, communication, sensory) the child may find it difficult to understand what is being communicated and misread gestures and cues. As with their non-disabled peers, children with disability who have complex trauma have also not experienced sensitive attunement to their needs from significant caregivers. These children need adults who sensitively read their cues and respond accordingly in understanding the child's needs and providing an experience of relationship that meets those needs.

Specific Strategies

- Work collaboratively to map what the child finds difficult, and ways of responding. E.g. using the stress model to map out signs, triggers, and responses at various stages of escalation
- Imbed emotion language within the daily activities for the child to develop a affect identification.
- Label what you perceive is the message of the child's emotion e.g., you look upset, sad etc for the child to develop affect expression skills
- Be aware of your own messages e.g., matching your emotion to your words
- Make emotions lists with the child
- Using the emotions list, role play the facial and body gestures, take photos and make emotions cards to use in games (ensuring that the child has the opportunity to 'shake off' the emotion at the end)
- For children who are non-verbal or have severe/profound disability you could develop a Personal Communication Dictionary to assist new staff to understand the child's specific

What John Does	What it might mean	What you can do
Wiggles in his chair and bangs the table while frowning	The room is to noisy and John is becoming anxious	1. Reassure him and ask 'is it too noisy?' and help him to move to a quiet space or go for a walk in the court yard
Moves back and forth near the cupboard	John may be telling you he is hungry	1. Reassure him break time is coming 2. Offer a piece of fruit

Connecting

Like their non-disabled peers, children with disability who have experienced trauma have difficulties trusting that adults will meet their needs. This results in the child having difficulties in developing an understanding of emotions, emotional responses and relationship boundaries.

System responses/expectations can at times also add to confusing double messages about trust and healthy relationship boundaries, e.g., don't go with strangers, but today you have to go in the taxi with a different driver. In the case of children with intellectual disability difficulties with problem solving and information processing adds a further layer of complexity and it may take considerably more time for them to develop these skills than their non-disabled peers.

For some children who have Autism Spectrum Disorder, Fragile X and/or severe to profound intellectual disability engaging or connecting with another person can be anxiety provoking. This does not mean they do not need relationships, it is just they may become overwhelmed by the stimuli around them which results in them withdrawing further into their own world.

Specific Strategies

- Have consistent calm staff
- Have soft furnishings that dampen noise in the room
- Positive engagement with adults
- Emotions activities that include a range of mediums, painting, drawing, movement,
- If the child is non-verbal with severe or profound disability and/or Autism Spectrum Disorder, engage the child in his/her communication world e.g., sit near the child, mimic his actions (tapping shoe, flicking a string); once you have entered his/her world and his/her attention slightly change the rhythm/action; once he/she engages you comfortably introduce a similar activity/action; build on the repertoire by introducing other activities.[5]

5. Pheobe Calwell. Intensive Interactions

Translating

Traumatised children with disability have limited capacity to tell others about their experiences, they are at risk of being over looked or dismissed due to their limited or repetitive repertoire of social conversation. They often need help to share their experiences with others. There are many simple ways to support them to share stories and to develop their social communication skills. These tools include the use of chat books, routine stories, visual story books, personal profiles, and personal communication dictionaries. These visual tools can also be adapted into a other medium such as audio books, personalized DVDs, and electronic tablets.

Specific Strategies

- Chat books which provide area for the child to collect items while out for other to use as a prompt or cue for social interactions e.g., a shell from the beach with a message 'I went to the beach on the weekend'
- Routine boards or stories which a help the child and others to know what activities they have scheduled for the day e.g., get home, play with……, go to nana's, have a bath, have dinner, go to bed.
- Personal profiles to assist the child to tell others about their likes and dislikes, strengths, fears, how best to support them.
- Personal Communication Dictionaries to assist those who support children who are non-verbal to know how the child communicates the likes and dislikes etc.

Involving

Children with disability often find it difficult to explore their world due to the challenges of their disability hence they often have immature or are developmentally delayed in the area of play. They may also misread the social cues and norms for forming friendships. This is compounded further if the child has also experienced trauma. This confirms to them that 'the world is very unsafe'. They need support to develop the building blocks of play e.g., turn taking, sharing, waiting and sportsmanship and to relate appropriately with other children. Some children may also need modified or adapted equipment to ensure they have the same physical opportunities as their peers.

Specific Strategies

- Activities that allow for with turn taking opportunities
- Modeling sharing and promoting the benefits of sharing

Calming

As with their non-disabled peers children with disability who have experienced trauma live in a constant state of elevated stress, without the capacity to regulate their levels of arousal. These children need to be supported by adults who are able to maintain a calm state themselves, and who can provide repeated experiences of activities which are rhythmical and bring their arousal levels in line with others.

Specific Strategies

- Repetitive activities such as shredding paper or photocopying
- Sensory related activities imbedded into the patterns and rhythm of the day e.g., digging for objects in a box of lupens/ dried peas/beach sand, bubble blowing, listening to music or for outside bird sounds while wearing eye shades, squeezing though foam tunnels, rocking in hammocks exercise with theraband.
- A calm area that has minimal distractions and sensory input e.g., a reading corner at the back of the library.
- 'calming bag' with relaxing objects and readers for the child to access when feeling anxious or hyperaroused.
- Relaxation training/session for the whole of class to identify tense Vs relaxed states e.g., adapted versions of progressive muscle relaxation utilizing music and visual pictures to initially teach the skills

Engaging

Children who experience trauma have not experienced appropriate modeling of social relationships leading to difficulties in social engagement activities. For children with disability this can be further complicated as their disability may make it difficult for them to read and understand the subtle nuances in what may be classified as ideal situations. To understand appropriate proximity, communication turn taking, and to be able to control impulsive statements that others find offensive is difficult for those with social immaturity. This impacts on their development of friendships through out their life span but can make them exceptionally vulnerable to being manipulated into unhealthy and/or dangerous situations when they are teenagers or young adults e.g., being used as a look out, or being pressured into unhealthy sexual practices. As such they need repeated experiences of one-one interactions with others, with clear modeling, and support to develop healthy and safe ways of engaging.

Some children with disability will require additional adult supervision until they are chronologically much older that their non-disabled peers.

Specific Strategies

- Role play and video self modeling to support the child to learn social boundaries and to practice social interactions
- Visual stories, pictures to explain appropriate relationship boundaries
- Provide empathic but clear feedback
- Mentoring opportunities
- Encourage strong healthy relationships
- Always ensure the individual(s) providing care are introduced and the child has an opportunity to get to know the person prior to activities, especially with regard to personal hygiene activities.

Section 3 Reflection

- In your current class or school environment how are everyday changes being explained to traumatised children with disability?
- How have you been able to maintain your relationship and to respond to a child with disability and trauma history when they have communicated their distress or frustration using their behaviour?
- In what way are you or your school currently sharing information that is supportive of meeting a child's with disability's needs.
- What practices does your educational setting have that may be either supportive or confusing to a child's understanding of relationships and their social boundaries?
- Are there some sensory based activities that you are able to incorporate into the curriculum? e.g., digging for treasure in the sandpit, finding the objects in a box of lupines, drumming etc
- Does your school environment have allocated calm places for students? If not how might your school provide these types of spaces?
- Does your school environment have routines or rituals that support transitioning times for these children?

For children with disability and trauma navigating everyday events can be exhausting. As children spend a large portion of their day within the school environment, there is a wonderful opportunity for all education staff to promote positive relationships and be actively engaged in the healing process. When the whole school is able to be trauma informed both the child and those who are directly supporting the child, can rest assure they can seek the help and support they require. Consistency in trauma responses across the school will ensure that the efforts made in the class and the home are upheld and respected and will support the healing and the education of the child.

We should never underestimate how each person's interaction and relationship can and will have a contribution to a child's healing.

References

Howe.D., (2005), Child Abuse and Neglect. Attachment, Development and Intervention. P46

Howlin, P & Clements, J. (1995) Is it possible to assess the impact of abuse on Children with pervasive developmental disorders? Journal of Autism and Developmental Disorders, Vol. 25, No. 4, 1995.

Kostelnik Stein & Whiren Soderman. (1998). Guiding Children's Social Development 3rd Ed

Sullivan, P., & Knutson, J. (1998). The association between child maltreatment and disabilities in a hospital-based epidemiological study. Child Abuse & Neglect, 22 (4), 271-288.

Making SPACE for Learning

Trauma Informed Practice in Schools

Discussion Paper 23

Working with other professionals to support students

Introduction

This discussion paper is one in a series designed to stimulate discussion and sharing of experience, amongst staff in educational settings working with children who may have experienced complex relational trauma. The discussion paper will examine some effective strategies that are needed to work with other professionals to support children. The information is intended to be applied flexibly and in ways that respond to the unique characteristics of your school and community.

It is of no surprise that many studies have confirmed for children who have experienced abuse related trauma and have entered the care system perform much poorer compared to their peers. Their educational outcomes are worse and incidences of emotional, psychological, behavioural and other health problems are much higher (Taren & Hazell 2006). To respond to this, these children and young people need an approach that seeks a shared responsibility.

Supporting children and young people who have experienced trauma.

By virtue of their experience of trauma, children can enter a complex service system that can have any number of professionals involved from both government and non-government services. These professionals can include child protection workers, foster care support workers, residential care workers, police, legal advocates, psychologists, psychiatrists, social workers, family therapists, school counsellors, teachers, paediatricians, mental health practitioners and others. The involvement of these professionals with the child will be different depending on their role and period of involvement. For example, a child protection worker will focus on the care and protection of the child, while the police may only be concerned with the collection of evidence for the prosecution of an offender.

The number of professionals that can be involved gives some insight as to how the care system can assist children in their healing from abuse related trauma. This is a positive in that the collaboration of these services, offers more support and more voices to advocate for the child's needs. On the other hand, unless these different services work together in a coordinated fashion, they may be useless or worse still - get in each other's way. These children commonly have multiple and sometimes competing plans, such as Families SA case plan, health plan, Individual Education/Learning Plan, cultural plan, behaviour management plan (names different depending on jurisdiction) and children can become overwhelmed with professional demands (Australian Childhood Foundation 2013).

Australian Childhood Foundation

This Discussion Paper was originally written as part of the SMART (Strategies for Managing Abuse Related Trauma) Program which is an ongoing partnership between the South Australian Government Department for Education and the Australian Childhood Foundation. Our Making SPACE for Learning is a national program that supports traumatised and vulnerable children and young people in educational settings.

Despite each professionals level involvement, it is essential for the child that they experience a network of people who are caring and attentive to their needs. Well known child psychiatrist and leading expert in childhood trauma, Bruce Perry (2003) advocates that healing comes from a network of people who provide healthy and secure connections. Considering this, it is essential that these connections provide the child with clear and consistent communication, then the child will experience maximum effect of the services and more important with the relationships which facilitate them.

There is recognition that the role of healing can be far too big for just one person, so recovery from trauma requires the creation of relational network of people who are committed and invested in the child. The teacher-student relationship is very important in this healing. Children spend approximately five to seven hours a day with a teacher for almost ten months in the year meaning that there relationship is vital. The intervention or strategies developed by other professionals may be central to supporting the child's participation in other areas such as the classroom and these often need to be followed through consistently in all aspects of the child's life.

Achieving collaboration amongst professionals can be achieved through a multitude of ways. Here are some effective practice suggestions:

1. Be proactive

It is common for educators to become frustrated with lack of contact with other professionals involved particularly with child protection staff. The role of child protection can differ immensely for each child depending on the nature of the abuse. In their initial involvement, they have limited time to investigate the alleged abuse and make decisions about the protection of the child. Demands placed on those caseworkers responsible for this are many and include ongoing supervision of present cases while acquiring new cases each day. Caseworkers are constantly responding to urgent matters, writing court reports, appearing in court, visiting with children and families, and a host of other tasks. This results often in removal of any hope of communication with school personnel. To compete with this, educators need to be proactive in their involvement and be motivated to work together. As a profession, educators must self-proclaim their roles in the lives of these vulnerable children and remind all other professionals that they, too, need to have an active role in the support of the child. Educators ought to suggest alternative forms of communication (e.g. emails, communication logs) and agree to meet at times and alternative locations that are feasible for everyone's attendance. Some critics fear that collaboration can mean just a lot of talking that takes educators away from their tasks. But the involvement of educators in supporting the child holistically will make for quality education and increased support for both the child and educator.

2. Establish a Care Team

One of the most effective ways to ensure communication and consistency across the services is a model of service provision where a range of different professionals come together to help and support a child and their family or carers. This is the creation of a care team. The model requires professionals to work in close collaboration, regardless of which service or agency they work in. It allows for information to be effectively shared amongst all members of the care team. An effective care team is characterised by everyone whom is working with the child to be informed about trauma and its impact on children. Additionally, everyone needs to have a shared understanding of the child's experiences, a commitment to partnership and work collaboratively to interpret the child's

needs. As a result, children and their family are less likely to be receive conflicting messages or become overwhelmed by the professionals who are there to help and support them. Before meeting with a care team, educators may want to consider making notes of things you want to discuss as many people forget what they want to say when they're nervous. A list will help you remember.

3. Clarify Roles & Responsibilities

Take time initially to clarify roles and responsibility of all professionals involved. Each professional should have a clear role and sense of contribution. The role of educators is clearly more than just planning and executing lesson plans, it is a key relationship that requires recognition. Clarifying roles and responsibilities can help reduce 'turf' issues by pre-planning and highlighting the positive outcomes of collaboration.

4. Be confident about confidentiality

Educators can feel confused about what information they can share with other professionals as well as with foster or birth families. The answers to these questions vary from state to state. It is highly suggested that you find the answers to your questions about confidentiality as the worst response is to not provide information that is needed to support a child. In response to this issue SA Government implemented *Information Sharing Guidelines for Promoting Safety and Wellbeing* (ISG). These guidelines have assisted to remove confusion and anxiety for staff about how information can and should be shared across government and non-government agencies (Ombudsman SA 2008). The guideline can be found at:

Suggested Reading: **http://www.ombudsman.sa.gov.au/isg/**

On the other hand, there will be elements to the child's case which cannot be shared with the school usually pertaining to information directly about the parents or other siblings. Educators and school staff may be asked to only attend part of a meeting so that other issues can be discussed. Be mindful of this and respect all professionals boundaries of confidentiality.

5. Establish trust and respect

Effective teamwork is characterized by mutual trust and respect for one another's expertise. It is inevitable professionals will experience frustrations with one another from time to time. The myriad of views about what is best for children can make it impossible to please everyone all the time. It is important that educators assert their opinions and insights, but do so in a way that elicits trust. To do this, it is important to listen to the input of all professionals, and speak about other professionals in positive terms. However, most importantly, educators should show a willingness to adopt new practices when requested and feasible.

6. Involve the child

Children are equal partners in the team process and need to have a genuine role in decision-making about matters that affect them, not a tokenistic contribution. Their participation in a meeting is a process that should include preparation, explanation, consultation, discussion and negotiation, rather than a once off attendance. Determining who should do this with the child is something that requires consideration and discussion within a care team. Remember that a child's views can still be heard whether they do not attend the meeting, attend only part of the meeting, attend via a different medium (such as phone or video), have someone or something else (like a picture, letter or photo) to present their views.

7. Engage Parents and/or Carers

Over recent years, there has been increased involvement of the primary carer and their role with healing for children. It is necessary to develop an understanding of the challenges that parents or carers have faced and take time to develop honest, respectful, and supportive relationships with them that allow you to share information about the child's progress.

8. Expand awareness

Educators often do not receive information about supporting children who have experienced abuse related trauma in their pre-service training. Some educators may feel challenged by the complex needs of these students and overwhelmed by the number of professionals who are involved. One option to combat this is to explore training and conferences that build awareness about these issues and provide the necessary training to assist you to understand the needs of children who have experienced abuse related trauma. Your school or care team may want to consider attending SMART training or participating in the SMART online training where everyone can gain a shared understanding and common language.

Suggested Training: **http://www.childhood.org.au/training/smart-online-training**

9. Be aware of splitting

In addition to the complexity of the number of professionals involved with children who have experienced abuse related trauma, children bring with them powerful emotions which are unconsciously transmitted to the network surrounding them (Conway 2009). Splitting creates instability in relationships because children may divide people into separate, often hostile, groups. Opportunities are needed to discuss and reflect on these issues to avoid professionals falling into this unhelpful approach. Children who have experienced abuse related trauma will need support to navigate and rely on relationships.

The reality of teaching in today's world is that schools must be prepared to educate children from a range of backgrounds, however, it should not be expected that one teacher or one service will have all the skills to adequately address all of the needs of the most complex students. Everyone who works with traumatised children have a role to play in best supporting them to achieve success not only in the classroom but in their wider world. No longer do we need or should want to work in isolation of each other. To best achieve what children require, professionals need to be open and

flexible to a different way of working. This may mean that educators will need to go beyond what they are currently doing but the benefits far outweigh any issues that need to be considered.

The following questions ask you to reflect on some of the issues raised and share your thoughts and knowledge with colleagues across the education system and other work environments.

Questions for reflection or discussion

1. How would you implement PRACTICE as a care team? What role can the educator play in this?
   Predictability?
   Responsiveness?
   Attuned?
   Connectedness?
   Translating?
   Involving?
   Calming?
   Engaging?
2. Is there a Care Team already established for the child or does one need to be created? Who do you need to network or liaise with?
3. What things can you do to improve relationships or communication with your colleagues, other professionals and/or the child's family? Specifically think about how you communicate a child's needs and progress to others.
4. What strength & values do you bring to a team supporting a child?
5. What professional qualities are important when participating in a care team?
6. What assistance is required to help you participate in a care team? Think about what support you might need? Are there things you need to do? Are there things that you need from others?

References

Australian Childhood Foundation (ACF) 2013 *Team Around The Child.* PowerPoint presentation. Melbourne

Conway, Paula. 2006. *Falling Between Minds: The Effects of Unbearable Experiences on Multi-Agency Communication in the Care System.* Adoption & Fostering Volume 33 Number 1

Ombudsman SA. 2008. Information Sharing Guidelines for Promoting the Safety and Wellbeing of Children, Young People and their Families. Viewed 11th December 2013. **<http://www.ombudsman.sa.gov.au/isg/>**

Perry, Bruce. 2003. Effects of Traumatic Events on Children. The Child Trauma Academy

Taren, Michael and Hazell,Phillip 2006. *'Mental Health of Children in Foster and Kinship Care in, Australia,'* Journal of Paediatrics and Child Health 42