Trauma Informed Practice with Children and Young People

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The Australian Childhood Foundation acknowledges Aboriginal and Torres Strait Islander peoples as the traditional custodians and owners of this land and waters. We pay our respects to their Elders past and present and to the children who are their leaders of tomorrow. We acknowledge their history and living culture and the many thousands of years in which they have raised their children to be safe and strong.

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Learning outcomes

- Enhanced understanding of neurobiology and the impacts of trauma from abuse, violence or neglect on development and lasting implications on child functioning.
- Be provided a conceptual model of trauma-informed work with children who have experienced complex trauma.
- Be supported to review evidence-based practice strategies for intervention with traumatised children and young people, and their parents, within this conceptual framework.
- Be supported to translate theory to practice. Participants will be aided to identify and contextualise strategies for working with children who have experienced complex trauma to their relevant work setting.

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Your personal safety

The content of this training can evoke strong emotions and may trigger **personal experiences of trauma**.

Please be mindful of your own wellbeing during this training and if you need support, please do what you need to do to feel safe. We are happy for you to talk to the facilitator if you need to.

Image: Hellovector.com

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Principles underpinning trauma responsive practice.

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Principles underpinning trauma responsive practice

- Informed by best available evidence: Childhood development and the Neurobiology of trauma; Systems change theory
- Cultural humility practice approach
- Restoring safety and development
- Prioritises therapeutic relationships
- Self-determination- Child centered, meaningful engagement and feedback
- Hope based recovery
- Acknowledges the impact on carers/workers and seeks to minimise risk

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1. Informed by best available evidence: childhood development and the neurobiology of trauma

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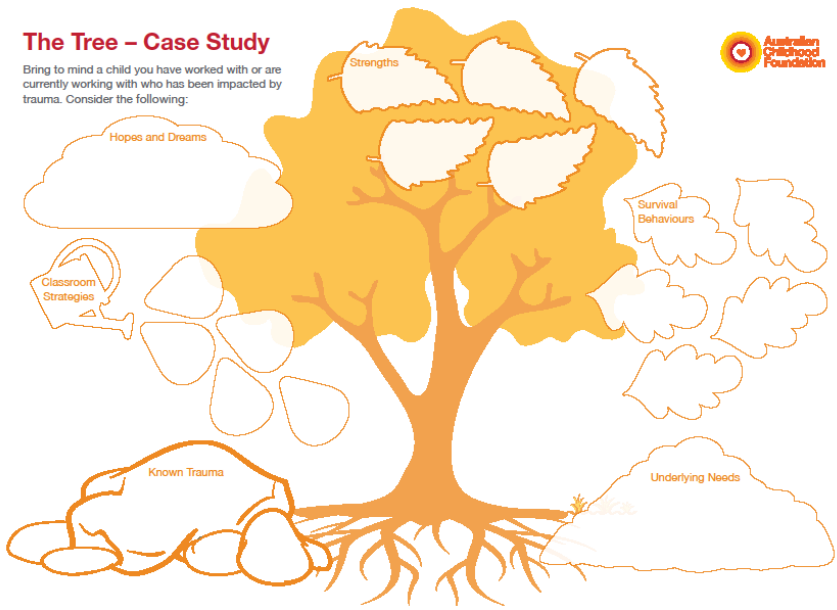
Holding a young person…..

The Tree – Case Study

Bring to mind a child you have worked with or are currently working with who has been impacted by trauma. Consider the following:



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Brain Development

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Brain Development

- https://www.youtube.com/watch?v=ZeEKLECvh9g

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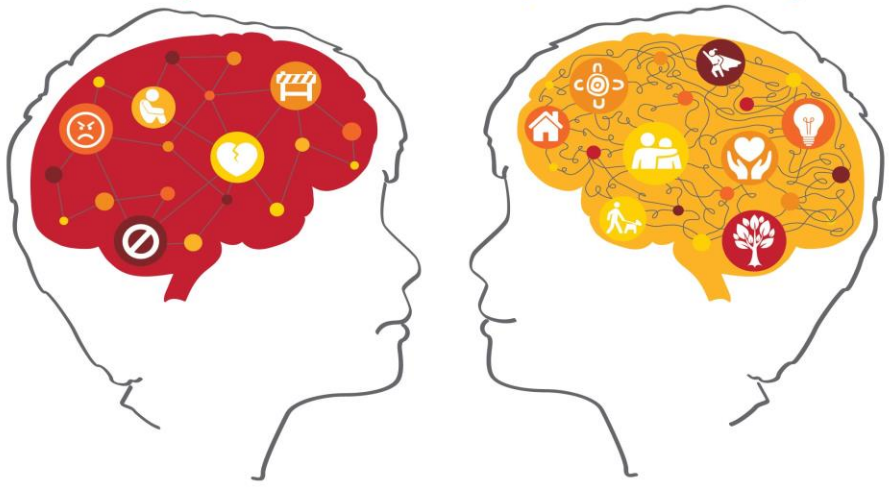
Early experiences shape the architecture of our brain

Threat and Neglect → Survival

Safety and Connection → Integration



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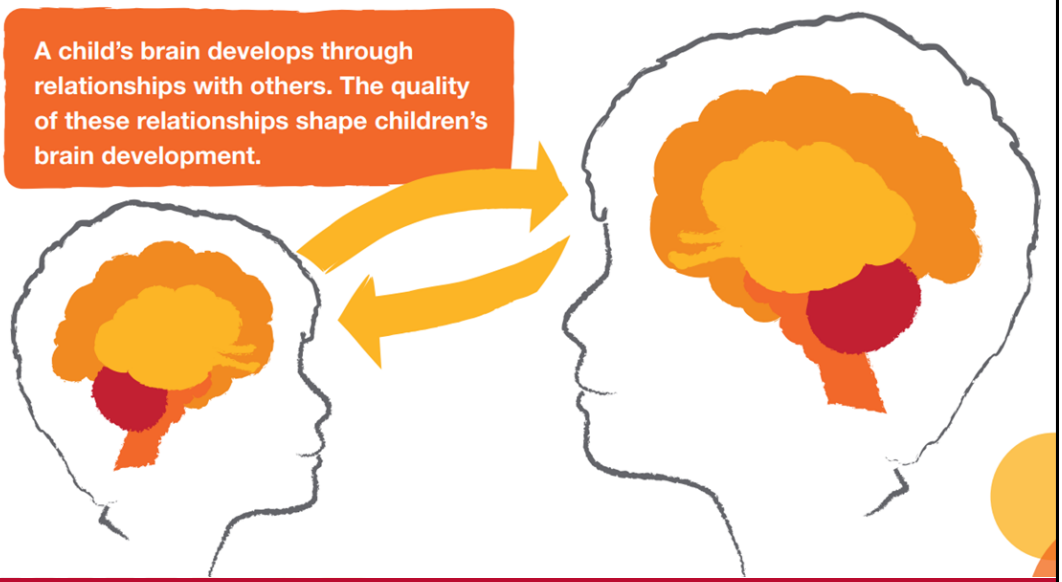
A child's brain develops through relationships with others. The quality of these relationships shape children's brain development.



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Sequential brain development

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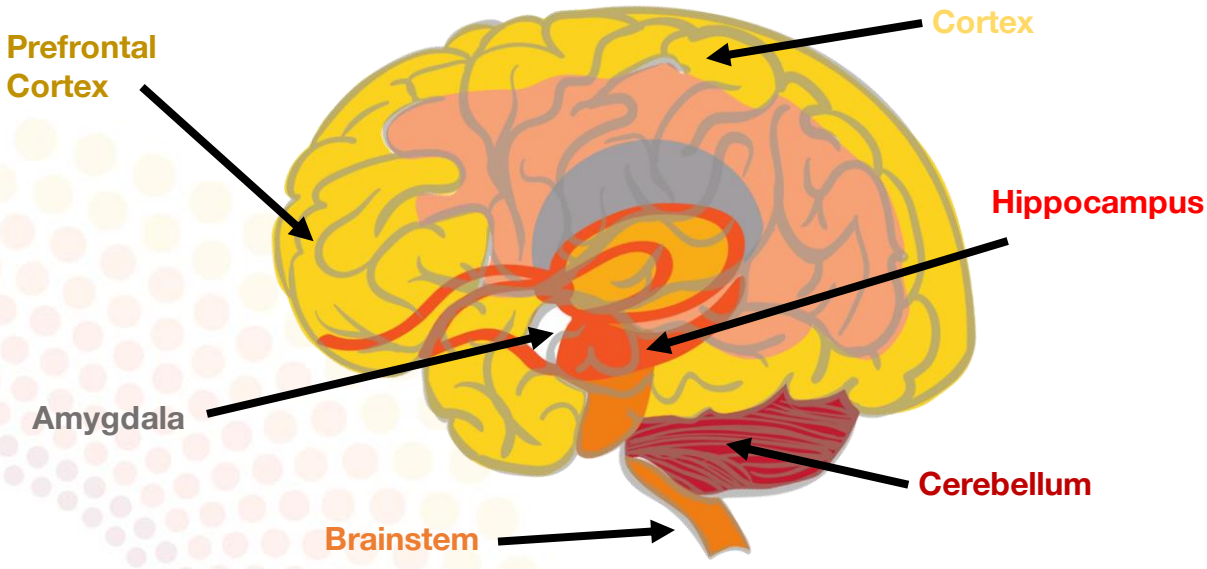

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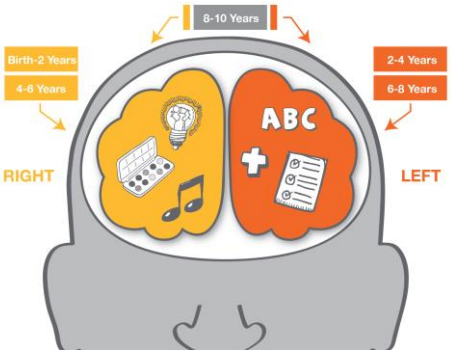
Horizontal brain development

Right Hemisphere

- In the present moment
- Eye contact
- Facial expression
- Tone of voice
- Posture
- Gesture
- Intensity

Left Hemisphere

- Evaluates language content
- Optimistic hemisphere
- Understands beginning, middle and end
- Learns from the past and expects the future
- Looks for patterns



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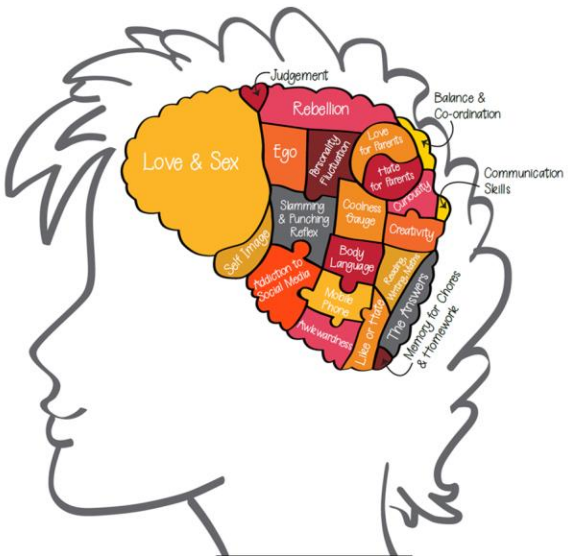
Adolescent Brain Development



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The Prefrontal Cortex

Final part of the brain to reach maturity in one's mid to late twenties

- self awareness
- reasoning and judgement
- foresight and anticipation
- focusing and sustaining attention
- planning organising and prioritising
- decision making
- reflecting
- enthusiasm, motivation and persistence
- impulse control
- working memory

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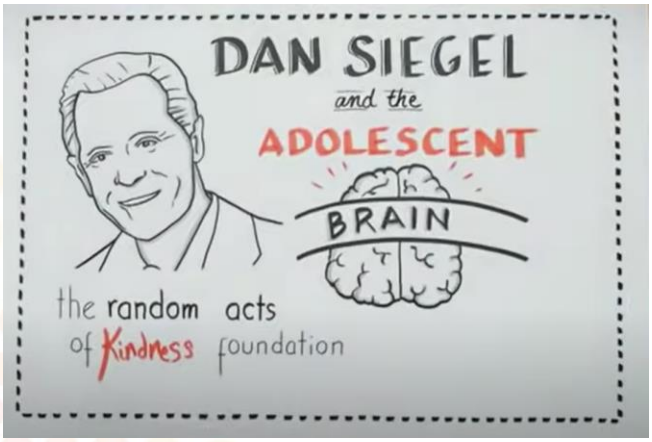
Adolescent brain development



- https://www.youtube.com/watch?v=0O1u5OEc5eY

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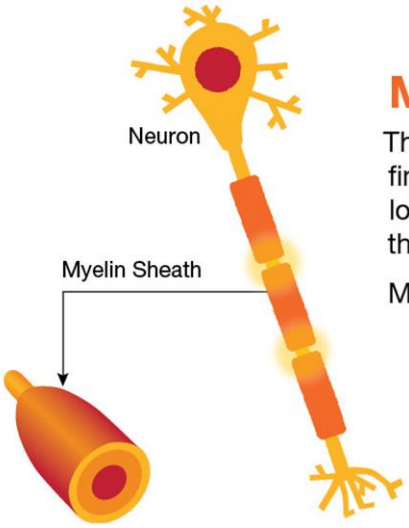

Myelination

The second change is in myelination: in adolescence, it is not finished. The last part of the brain to myelinate is the frontal lobes. And myelination is not complete in the frontal lobes of the brain until around 18 to 20 or later.

Myelination on a neuron allows it to operate more efficiently.

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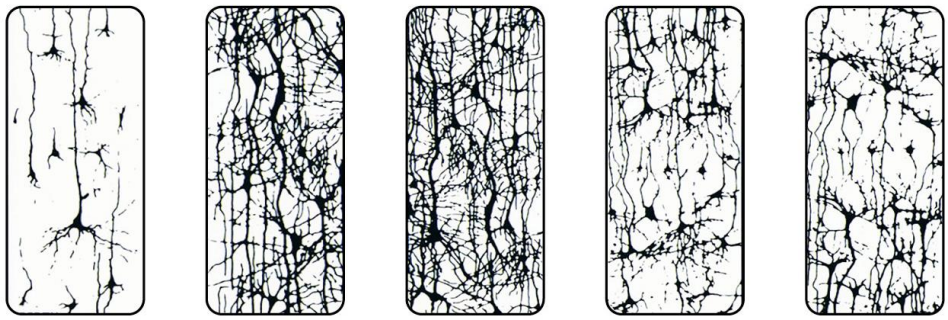
Pruning & myelination in the adolescent brain



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What does this mean for our YP - the importance of rest and sleep…

- Pruning and myelination occur during sleep
- Sleep strengthens learning and memories

What impacts our adolescents' sleep?

- Later release of melatonin during adolescence
- Lack of safety to sleep well, if at all
- Poor sleep hygiene
- Use of devices

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What can we do? – The four C's

- **Compassion and empathy** is so important. There may be many reasons why your student is turning up tired. Be gently curious as to why they may be tired.
- **Check in** with your clients – how did they sleep? Have they had breakfast? Can breakfast or food be provided? What else do they need? Check in also at the beginning of any change process.
- **Consider** adjusting morning structures /include movement and invigoration, before heavy cortical work.

  If you are working with clients in the afternoon allow more creativity rather than problem solving, or analytical work as their concentration may dip in the afternoon.
- **Create** spaces for clients to have rest breaks.

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Trauma and impacts

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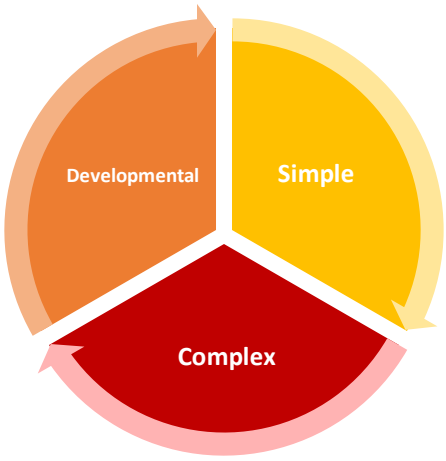
Defining trauma

Trauma is the result of any single, ongoing or cumulative experience which:

- is a response to a perceived threat, usually to survival
- overwhelms our capacity to cope
- feels/is outside our control
- often evokes a physiological and psychological set of responses based on fear or avoidance



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Developmental Trauma

- Refers to the period of time the brain is undergoing significant development; in utero through to late adolescence. Exposure to trauma during this time can alter the brains architecture.
- Usually relational in nature – the trauma happens in relationship (through abuse, neglect, domestic violence, toxic stress etc) and therefore is healed in relationship.

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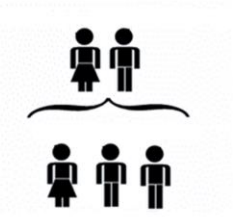
Intergenerational Trauma

- The prefix 'inter' is from the Latin meaning between, or among, together or mutually together

- Inter-generational trauma is passed down directly from one generation to the next



- Inter-generational trauma occurs directly through experiencing the trauma or from seeing or hearing about it

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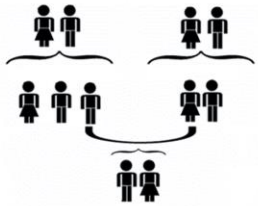
Transgenerational trauma

- The prefix 'trans' is from the Latin word meaning across or crossing, through, beyond or on the other side

- Trans-generational trauma is transmitted across a number of generations



"This type of trauma occurs without direct stimulus but is instead transmitted from a parent who has experienced a traumatic event" (Davidson & Mellor 2001 as cited in Goodman, West & Cirecie, 2008)

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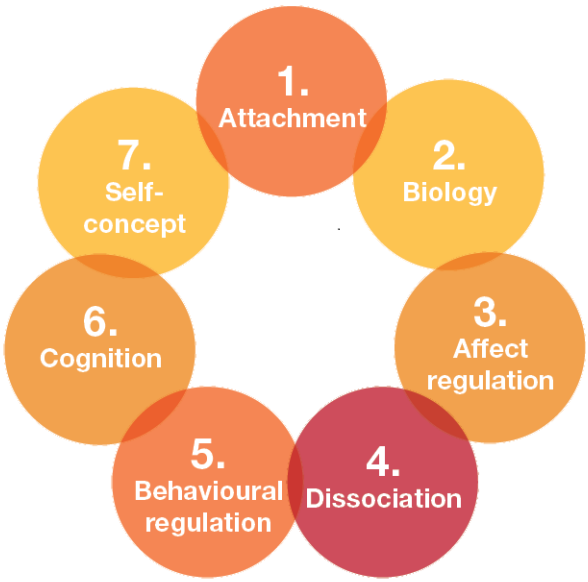
Impact of trauma

In your table groups discuss and record:

- How your clients might be impacted in each of these ways ?



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What might it look like?

- Difficulties coordinating cognitive processes such as planning & working memory
- Difficulty with voluntary movement tasks – walking or writing
- Becoming overwhelmed and not able to sort incoming sensory information
- Can't place memories in time or place – flooding & flashbacks
- Working memory, retention and recall (retrieval) capacity severely impacted
- Difficulty in emotional regulation
- Difficulty in reading facial expressions
- Constantly perceiving threat where there is none
- Might be unable to use foresight and anticipation, focus or sustain attention and focus, plan, organise or prioritise or make decisions well, reflect or have self-awareness, be enthusiastic, motivated or persist with activities, use impulse control

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Disability and Neurodiversity and the intersectionality with trauma

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How do I know what is trauma-related and what is disability or neurodivergence related?

- Various research indicates children and young people with disabilities and neurodivergence are more vulnerable to experiencing trauma and those identified as experiencing trauma often have diagnosed learning difficulties, sensitivities, and disabilities.
- Due to research into epigenetics, we also know that what life experiences the mother has had can influence the development of her unborn child.
- Misdiagnosis can occur if not all factors are taken into consideration.

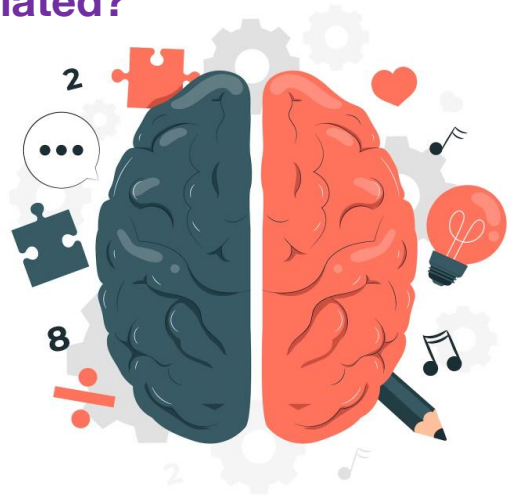

Photo credit: freepik.com

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Neurodiversity

- Neurodiversity describes the idea that people experience and interact with the world around them in many different ways; there is no one "right" way of thinking, learning, and behaving, and differences are not viewed as deficits.
- The word neurodiversity refers to the diversity of all people, but it is often used in the context of autism spectrum disorder (ASD), as well as other neurological or developmental conditions such as ADHD or learning disabilities.

https://www.health.harvard.edu/blog/what-is-neurodiversity-202111232645

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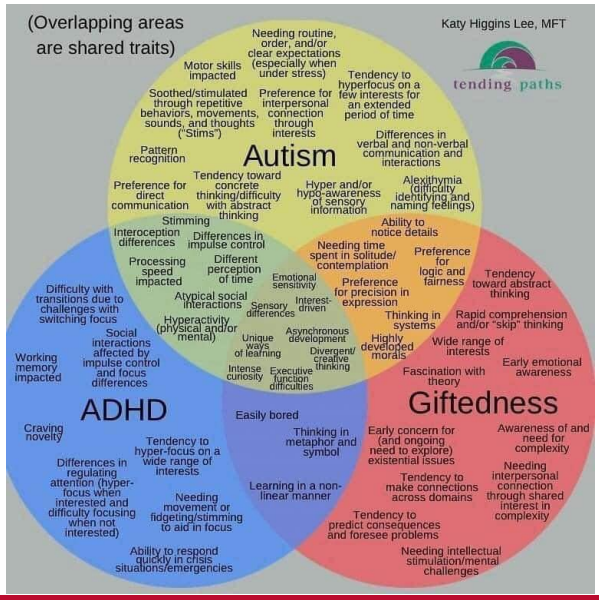
Neurodiversity and Disability

Studies indicate there is an over representation of children and young people with neurodiversity and disability in the youth justice system and out of home sector

Response to Disability Royal Commission
Criminal justice system issues paper
Children and Young People with Disability Australia
July 2020



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Foetal Alcohol Spectrum Disorder

- Fetal alcohol spectrum disorder (FASD) refers to a range of problems caused by exposure of a foetus to alcohol during pregnancy.
- There is no cure for FASD and its effects last a lifetime.
- A person with FASD can get help with their learning and behaviour to maximise their independence and achievements.

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What is FASD?

- FASD is a lifelong disability.
- Individuals with FASD will experience some degree of challenges in their daily living, and need support with motor skills, physical health, learning, memory, attention, communication, emotional regulation, and social skills to reach their full potential.
- There are more children born each year with FASD than with ASD, Spina Bifida, Cerebral Palsy, Down Syndrome and SIDS combined (Mather Wiles &O'Brien, 2015)

Photo credit: iStock

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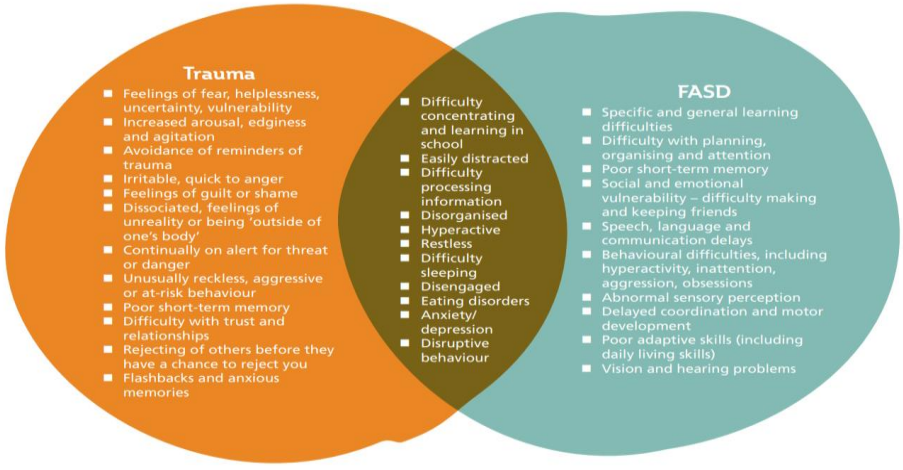
Figure 3: Symptoms of trauma and FASD and areas of overlap



Source: Adapted from National Child Traumatic Stress Network, *Is it ADHD or child traumatic stress? A guide for clinicians*, NCTSN, Los Angeles, 2016, p. 5, www.nctsn.org/sites/default/files/resources//is_it_adhd_or_child_traumatic_stress.pdf.

Image taken from Fetal alcohol spectrum disorder (FASD) and complex trauma: A resource for educators, 2018 Published by Marninwarntikura Women's Resource Centre

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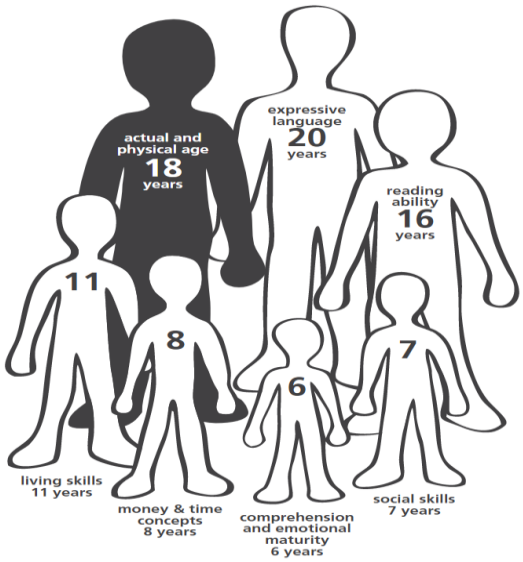
Be alert to disparities between chronological age and abilities.

Figure 6: The developmental age and ability of an 18-year-old with FASD

This diagram shows how a child's chronological age and developmental age can vary dramatically at any one time.



Source: Jodee Kulp
http://www.betterendings.org

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2. Cultural Humility and Approach

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Culture as a resource

Culture provides a protective factor

Safety: Belonging
Relationships: Connection
Meaning making: identity

- Guides our interactions with self, others and our lands
- Provides us with a navigational framework, a sense of certainty and predictability = security
- Provides a mental framework that supports meaning making- narrative of self, others and natural world

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Culture is part of development

- Be curious, practice with cultural humility; culture is a resource!
- **Person's sense of identity, belonging?** How is that supported/promoted?
- **The adult's history, identity, parenting practices, style?** Where does it come from? How do we work with this?
- Cultural awareness/competence? What does this look like in my practice?
- Cultural competence, accessibility? Programs tailored to meet cultural needs?
- Diversity - **Who has a voice in this space?**

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3. Restoring safety and development

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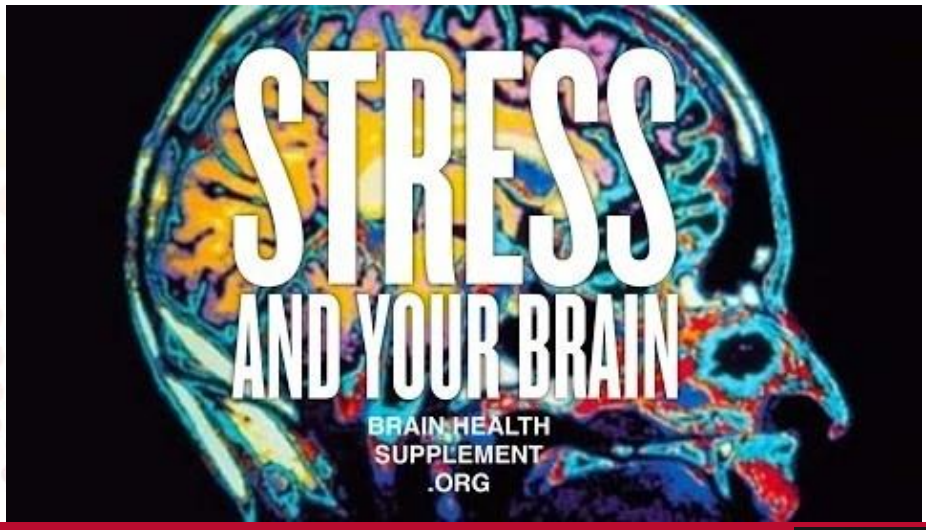
Stress and your brain



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The importance of safety

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Restoring Safety and Reducing Risk

Without 'felt safety' trauma/stress processing and healing is not possible

A felt sense of safety, the client's perception/ inner sense of safety

- Look to identify the client's perception of safety and threat
- Human safety – Do the people provide cues of safety?
- Environmental – Does the environment provide cues of safety?
- Organisational safety - Does the organisation provide cues of safety?

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Immobilisation
hypo-arousal

Parasympathetic

Ganglion

Stimulates flow of saliva

Medulla oblongata

Slows heartbeat

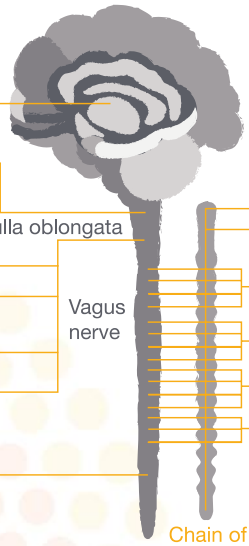
Constricts bronchi

Stimulates peristalsis and secretion

Stimulates release of bile

Vagus nerve

Contracts bladder



Chain of sympathetic gangalia

Solar plexus

Mobilisation
hyper-arousal

Sympathetic

Dilates pupil

Inhibits flow of saliva

Accelerates heartbeat

Dilates bronchi

Inhibits peristalsis and secretion

Conversion of glycogen to glucose

Secretion of adrenaline and noradrenaline

Inhibits bladder contraction

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Polyvagal Theory and Protective Responses

by Stephen Porges

Behavioural Functions	Body Functions
Social Engagement Soothing and calming Indicates safety	• Lowers or raises vocalisation pitch • Regulates middle ear muscles to perceive human voice • Changes facial expressivity • Head turning • Tears and eyelids • Slows or speeds heart rate
Mobilisation Fight or Flight Active Freeze Moderate or extreme danger	**Hyper arousal** • Increases heart rate • Sweat increases • Inhibits gastrointestinal function • Narrowing blood vessels - to slowblood flow to extremities • Release of adrenaline
Immobilisation Collapse or submission Death feigning Increased pain threshold Conserves metabolic resources Life threatening situations	**Hypo - arousal** • Slows heart rate • Constricts bronchi • Stimulates gastrointestinal function

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Creating safety – using ourselves

- Environment
- Proximity
- Eye contact
- Facial expressions
- Tone of voice
- Posture and gestures

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Polyvagal Theory

	I am showing you....	On the inside.....	I need you to....
SOCIAL ENGAGEMENT	Feeling safe, staying in relationship, connection oriented You might say I am: • Making eye contact • Listening • Engaging in play and exploration	I am feeling: • Safe, Calm, Happy, Sad, Annoyed, Reflective, Playful, Curious My body says: • Approach others • Sit still • Breathe deeply	Help me to stay engaged • Play and have fun with me • Role model positive relationships • Set boundaries and natural consequences • Use reflective and problem solving skills so I can learn them too • Notice and acknowledge my strengths and my skills
MOBILISATION	Fight, flight, active freeze, action oriented You might say I am: • Aggressive • Loud • Fighting • Running away • Hyperactive	I am feeling: • Anxious, Frightened, Lonely, Hurt Confused, Overwhelmed My body says: • Run away • I'm hot • I can't sit still • I need to move	Help me to down regulate • Keep me safe • Co-regulate – be safe, attuned and responsive to me • Use movement – big then smaller, jumping, hanging, swinging, climbing, star jumps • Create a safe space near you where I can retreat to until I calm down • Model deep breathing • Repair our relationship – 'we are ok and our relationship is strong'
IMMOBILISATION	Withdrawal, collapse, submission, dissociation, avoidant oriented You might say I am: • Withdrawn • Avoiding contact • Distant • Compliant • Hiding	I am feeling: • Disconnected, Unfocused, Flat, Withdrawn, I'm disappearing My body says: • Avoid others • I'm not in my body • I want to hide • Curl up in a ball	Help me to up regulate • Co-regulate – be safe, attuned and responsive with me • Tell me I am safe and demonstrate it with your actions, gestures and tone of voice • Help me to orient to the room we are in by looking for specific things like something green, something on the roof or something on the floor • Help me to feel my body by noticing different parts, such as my feet on the floor and my bottom on the chair • Repair our relationship – 'we are ok and our relationship is strong'

Grounded in the work of Dr Dan Siegel, Dr Stephen Porges and Dr Bruce Perry

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Brain Break Strategy

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4. Prioritise therapeutic relationships

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Using relationship to help healing

- Always start by developing a felt sense of safety for the client
- Build predictability and consistency
- Know yourself, your triggers, and how to ground yourself so that you can…
- Use your relationship – seek to connect, co-regulate, lead by example, hold space for their pain
- Learn to translate trauma related behaviours so you can understand and respond to what is needed
- Recognise their strengths and reflect this back to them

Image: hellovector.com

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Best Practice Approaches for all children…

And for those with trauma and/ or disability…

Build felt sense of safety

Meet the child/ young person where they are at, not where they 'should' be

Build safe stable relationships

Honour their voice, strengths, differences, culture, their life journey so far

Build unique profile of **needs** and work to meet them

Coregulate

Implement **additional supports** where needed such as learning supports

Build emotional literacy

Work to **translate behaviour** into meaning and adapt responses accordingly

Provide opportunities to **make meaning** of their life story

Implement **sensory support** where needed

Routine and predictability

Build necessary skill sets

Bring playfulness

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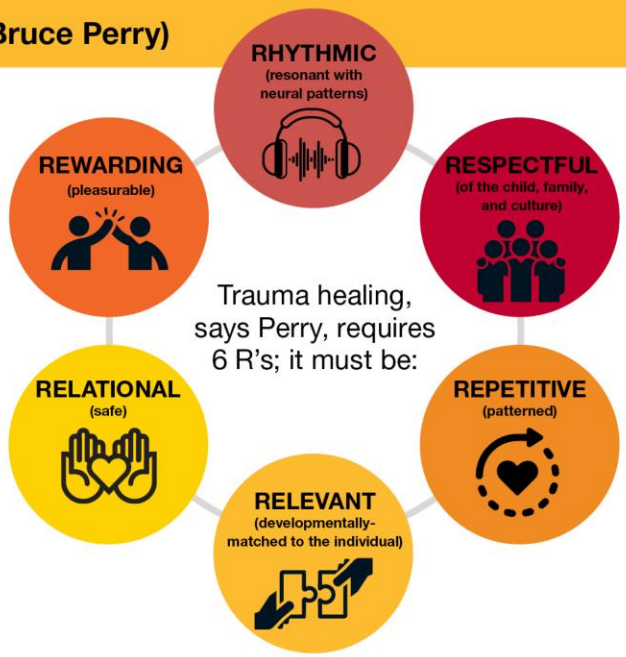
The 6 R's (Bruce Perry)



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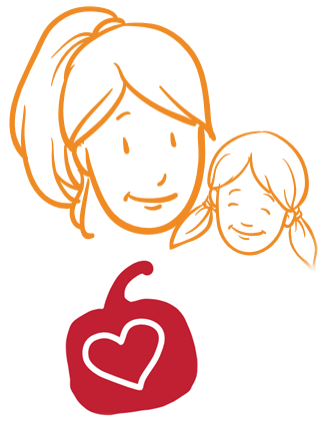
Repair after rupture - 4 steps to repairing relationship

1. See it from your child's point of view
2. Restore Calm and Safety
3. Repairing Relationships
4. Future Plans



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A helpful thought process for planning....

What is the task or expectation the child is expected to do (and failing at/"refusing" to do)?

What does the brain— anyone's brain— have to be able to do in order to successfully complete that task or meet that expectation?

What do you know about how your child's brain functions in those areas? Do they have those skills?

Make adaptations to meet the child where they are at and build from there.

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Brain Break

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5. Self determination – child centred, meaningful engagement and feedback.

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Effects of trauma on behaviour

To cope with trauma children use initial adaptive responses to survive

This is reasonable as a once off occurrence, but, if they continue they can become maladaptive patterns of behaviour

These responses will be different for an individual child at different developmental stages

Often a combination of appropriate developmental behaviours and maladaptive patterns of behaviour emerge

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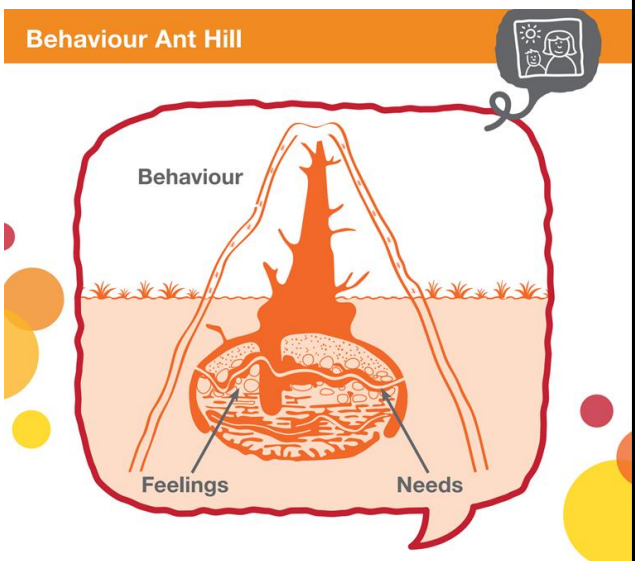
Making meaning of the behaviour

- Every behaviour has a **meaning**
- Behaviour is often a young person's way of **communicating** with us
- Learning how to **understand** a young person's behaviour is a more effective tool then only responding to the surface behaviour
- We need to learn to ask **"What is this behaviour telling me?"** and be curious about what it might mean so that we can best respond



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Be curious about the behaviour and the meaning it holds

1. What is the function behind the behaviour = meeting an unmet need?
2. Developmental stage of the child?
3. Current state of the child's nervous system? (hypersensitised, under responsive?)
4. Survival/protective response – fight, flight, freeze, dissociate
5. Coping strategy (that no longer works)
6. Structural changes in the brain
7. The demands of the environment outstripping the capacity of the person
8. How is this problem the child's solution?
9. Trauma induced thinking and conditioning (the world is an unsafe place, adults cannot be trusted, there is no hope of change, it is not safe to show vulnerability…)

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Reframing our thoughts and language

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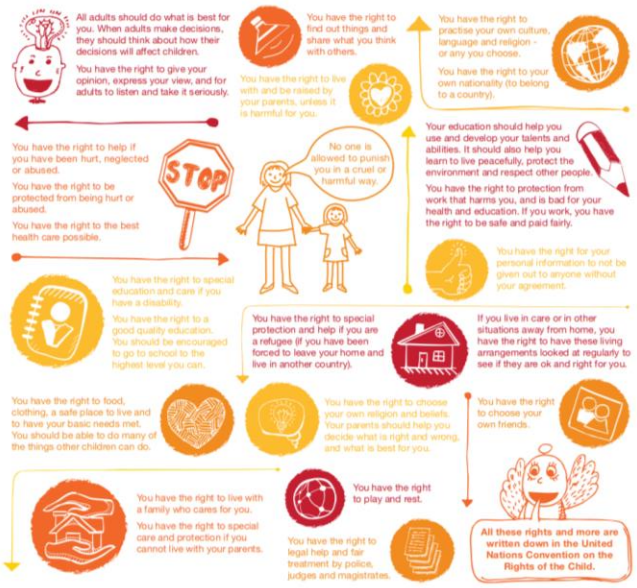
The Rights of all Children and Young People



https://professionals.childhood.org.au/resources/

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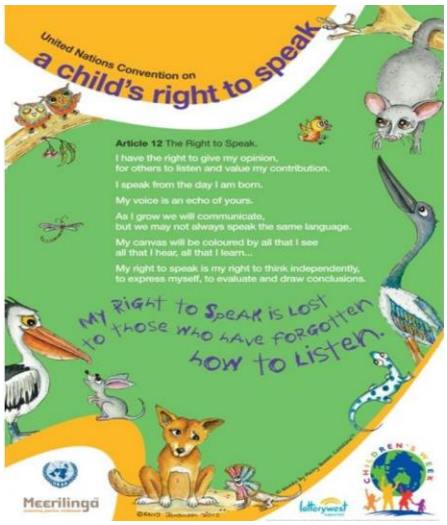
Article 12

You have the right to give your opinion, express your take it seriously.

Article 12 has two key elements

a) the right to express a view

b) the right to have the view given due weight



Lundy's Voice Model Checklist for Participation

- **Space**- Children must be given safe, inclusive opportunities to form and express their view.
- **Voice**- Children must be facilitated to express their view.
- **Audience**-The view must be listened to.
- **Influence**-The view must be acted upon, as appropriate.

Lundy's checklist aims to help organisations working with and for children and young people, to comply with Article 12. of the UNCRC and ensure that children

- have the space to express their views;
- their voice is enabled,
- they have an audience for their views; and
- their views will have influence.

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How do you honour the voices of your clients?

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6. Acknowledges the impact on carers/workers and seeks to minimise risk

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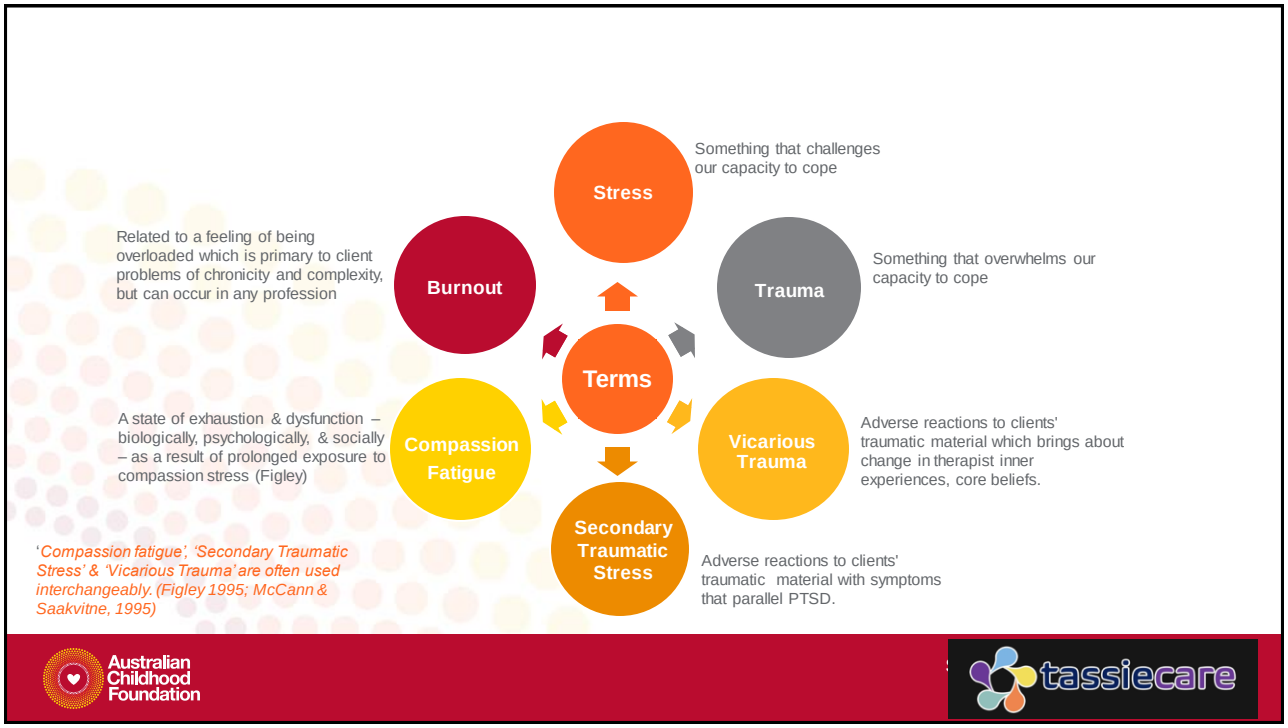

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Organisational

- Poor caseload management
- Lack of reflective supervision
- Organisational culture that is not trauma-informed (impacts are not understood or acknowledged)
- Workplace culture promotes ineffective coping strategies such as minimising, denial or 'competitive stressing'
- High level unpredictability or inflexibility

Professional

- Nature of work
- Complex client relationships
- Poor boundaries
- Not accessing or making the most of supervision

Personal

- Lack of self-awareness (re levels of anxiety, stress and fatigue)
- Poor work-life boundaries and balance
- Ineffective coping strategies
- No built in self-care/wellbeing activities
- Unresolved or non-integrated personal trauma experiences
- Lack of social support
- Additional personal stressors such as health, family or finances

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Improving Balance

Professional

?

Personal

?

Organisational

- Effective caseload management
- Regular and effective reflective supervision
- Trauma-informed organisational culture
- Workplace culture promotes effective coping strategies such as self-care and honest debriefing
- Workplace characterised by predictability and flexibility

Photo credit: iStock

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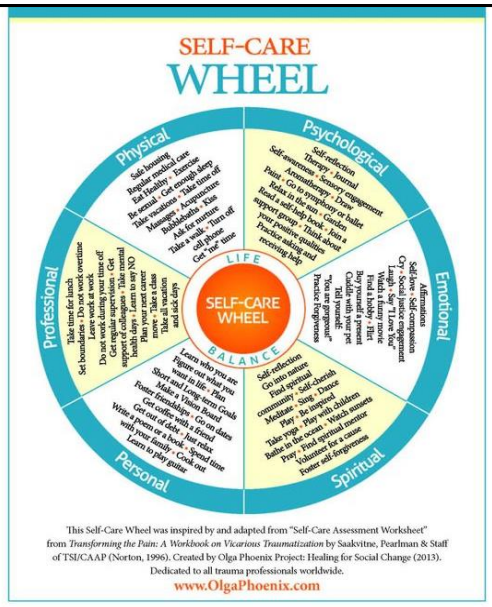

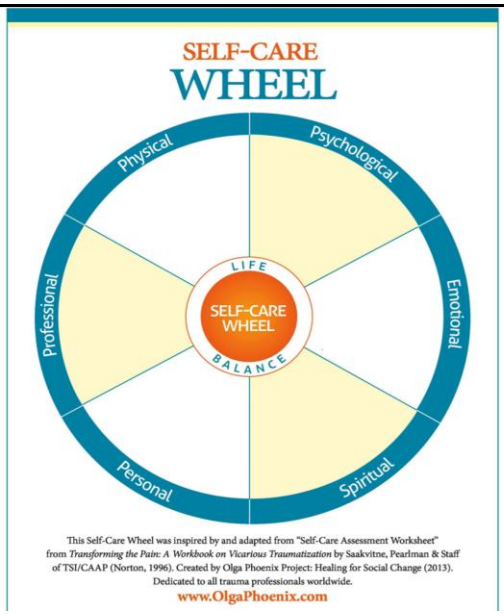

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ProQOL

Pro QOL
Professional Quality of Life

The ProQOL (Professional Quality of Life) scale asks users to respond to 30 scaled answer questions that measure the user's current compassion satisfaction, burnout and secondary traumatic stress scores. This tool has traditionally been used by foster and residential carers as well as professionals working with a range of clients who have experienced trauma.

https://proqol.org/

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7. Hope based recovery

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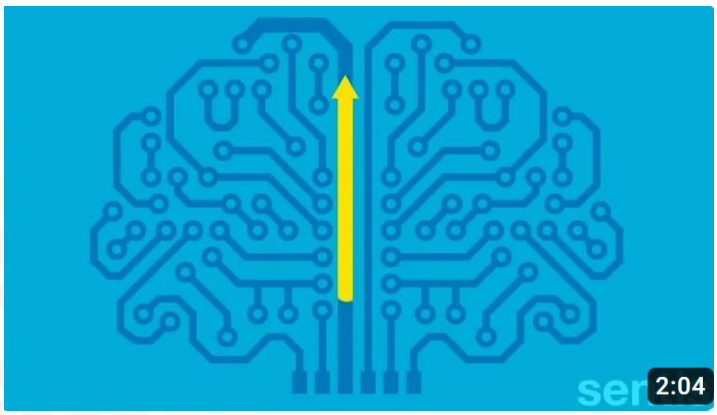
Neuroplasticity



- https://www.youtube.com/watch?v=ELpfYCZa87g

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Hope based recovery

- Hold hope for your clients until they can hold hope for the
- Strength-based approaches
- Support development of a hope-based narrative the clien
- **How does the client understand their future** and the pc them? (more appropriate for young people and adults)
- **How does the client understand their strengths**, and h How do we encourage this?

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Tree of Hope

How do you as a worker maintain hope in complex trauma-based work?

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Thank you for your participation today and your ongoing support and advocacy for vulnerable children and young people.

Image: Pinterest

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Additional Resources

Trauma Responsive Principles – Reflective Questions

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Review of the Principles underpinning trauma responsive practice

- Informed by best available evidence: Childhood development and the Neurobiology of trauma; Systems change theory
- Cultural humility practice approach
- Restoring safety and development
- Prioritises therapeutic relationships
- Self-determination- Child centered, meaningful engagement and feedback
- Hope based recovery
- Acknowledges the impact on carers/workers and seeks to minimise risk

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Understanding of neurobiology of trauma & child development

- Application of the theory into practice
- **How do you understand what's happening in the child's brain** and how will that influence your practice? i.e: *behaviour is an unmet need so how will your intervention address that unmet need rather than focussing solely on the behaviour?*
- **How do you understand the child's developmental age versus their chronological age?** How will this inform your decision-making around support and intervention for the child and the family?
- Parental brain development – given parents likely trauma history, what is happening in their brain and **how will this influence your engagement with them?**

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Cultural understanding

- Be curious, practice with cultural humility; culture is a resource!
- **Child's sense of identity, belonging?** How is that supported/promoted?
- **Parents history, identity, parenting practices, style?** Where does it come from? How do we work with this?
- Cultural awareness/competence? What does this look like in my practice?
- Cultural competence, accessibility? Programs tailored to meet cultural needs?
- Diversity - **Who has a voice in this space?**

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Key principles and actions that support a developmental trauma informed, culturally safe response to traumatised children and young people:

- Relationships are critical- individual, family, community
- Using stories and story-telling is a valuable and important tool
- Connecting to country and culture needs to be meaningful and not tokenistic
- Continual self-reflection builds cultural humility – who am I? What are my biases? What else do I need to know?
- Children and young people still all come with their own stories and we need to listen to those and not assume
- Holistic approaches, as distinct from

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Safety

- Without 'felt safety' trauma processing is not possible
- Consider child's internal world versus the external world
- Polyvagal theory – biological safety, child's perception of safety (felt safety)
- Human safety – are the people around me safe?
- Environmental – Is the environment conducive to the perception of safety? Sensory input – smells, sights, sounds, etc.
- Organisational safety - does my organisation promote policies and practices that ensure safety of clients and staff?
- Parents own trauma history and perception of safety – how will this impact on your ability to engage with them? How can you restore safety?

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Promoting safety in your role

Consider your practice…

- Do you (and your workplace) explicitly acknowledge the role of safety in supporting children and young people?
- How is the child's experience of safety understood and acknowledged?
- In what ways do you promote safety?
- What specific strategies do you implement? Verbal and nonverbal

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Therapeutic Relationships

- **Child experiences safe, attuned, consistent relationship/s.** What does this look like?
- **Worker-parent relationship** – minimising re-traumatisation, co-regulating.
- Respected, **supported work relationships**
- Program requirements enable relationship building
- **Practice frameworks** that promote therapeutic relationships – DDP, sanctuary model

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Self determination

- Child centred practice – **child's voice is heard and acknowledged**
- How is the **parent's experience understood** and acknowledged?
- How do you address **power imbalance** in your role?
- **How does the child/parent participate** in the care team process?
- Rights of child are always prioritised- safety, developmental opportunities, be involved in decisions that effect them

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Activity: reflection

Consider your practice…

- In what ways do you promote self determination?
- How is the child's experience and wishes understood and acknowledged?
- How do you acknowledge the strengths of the child/family/community?
- How do you address power imbalance in your role?
- How does the child/parent participate in the care team process?

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Honouring the voice of your clients - Key Questions to consider

- What do we hope to achieve?
- Where have we got so far
- What will children and young people get out of it?
- Are we prepared to resource it properly?
- Why have we not done it before?
- Are we being honest with the children and young people?
- What are our expectations?
- Are we prepared to share some power?
- Are we prepared to take some criticism?
- Do we recognize this as a long-term commitment? Are we prepared to build in changes long term, and not just have a one-off event?
- What is our plan for how to deal with potential harm or risk related disclosures?

Adapted from Claire O'Kane's- Children's Participation in the Analysis, Planning and Design of Programs (2013)

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Ethical Considerations

- Children and young people must understand the purpose and nature of the participatory process.
- Participation must not harm or place at risk children and young people.
- Participation needs to be voluntary.
- Workers should have procedures for dealing with children's disclosures of harm.
- Workers should have procedures for responding should they become concerned about the safety of a child.
- Children and Young People who are providing feedback should be made aware of what will happen with their feedback.
- Organizations/programs should have processes to feedback to children and young people how they have heard and integrated children's input.
- Children and young people should be made aware at the outset whether their contribution will be kept confidential if they choose to participate.

Cultural Considerations

- It is best for all children and young people to engage in an environment of trust. Consider who is best to work with with the child/young person.
- Consider the most appropriate space to meet with children/young people.
- Consider the best format for providing information.
- Use translations and interpreters where appropriate.
- Consider that in some cultures it is unusual to seek the views of children independently of adults.
- Understand that expressing negative feedback can be very uncomfortable for people of some cultures.
- Seek ways to aid children feel safer to express their views.

Consent / Agreement

It is a vitally important to get consent for involvement from children and their guardian before commencing.

- Seek children's consent in words that are child friendly and explain the extent of what is involved.
- Children and young people must understand that they can opt out at any time along the way.
- Children and Young People must have all the information they need to decide if they wish to participate.