Trauma Editorial

This issue of ChildLinks look at how trauma can impact on children's daily life and their ability to function and interact with others. Children who are exposed to traumatic events may experience a wide range of consequences that can include intense and ongoing emotional distress and behavioural problems, difficulties with attention, academic failure, problems with sleep or illness. Interventions where young children and their families learn about the impact of trauma and what they can do about it can support children to develop the skills they need to be resilient no matter what adversity comes their way. These skills can truly change the trajectory of the life of the child and the family.

The first article in this issue looks at the work of the leading federal initiative focused on child trauma in the US, the National Child Traumatic Stress Network (NCTSN). The NCTSN aims to raise the standard of care and improve access to services for traumatised children, their families and communities by raising public awareness of the scope and serious impact of child traumatic stress on the safety and healthy development of children; advancing a range trauma-informed, developmentally and culturally appropriate programmes that improve the standard of care; working with established systems of care to ensure that there is a comprehensive trauma-informed continuum of accessible care; and fostering a community dedicated to collaboration within and beyond the NCTSN to ensure that widely shared knowledge and skills become a sustainable national resource.

The articles that follow look at how traumatic events like bereavement, domestic abuse and refugee status can have long-term impacts for children. The first of these outlines the evaluation of the TLC Kidz Programme, a multi-agency, group programme for children and mothers recovering from domestic abuse. Next, Brid Carroll from the Irish Childhood Bereavement Network outlines how bereavement in childhood can have long-term consequences for children and considers how the needs of bereaved Irish children can be identified and addressed as early as possible to prevent long-term trauma. The two articles that follow focus on refugee and asylum-seeking children, who are ten times more likely to experience post-traumatic stress disorder compared to their non-refugee peers.

Robin Balbernie, Child Psychotherapist and Clinical Director of PIP UK, then considers intergenerational trauma and the cycle of negative caregiving. Sometimes the traumatic experiences of the one generation live on to affect the generation that follows but relationship-based interventions can help to break this cycle. The final article in this issue outlines the Trauma Smart® (TS) model in the US, which is designed to support very young children, and the adults who care for them, with hands-on, practical tools and effective strategies to help children to learn to express their emotions in a healthy way that prepares them for social and academic success.

Sinead Lanton

The National Child Traumatic Stress Network

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Even though adults work hard to keep children safe, dangerous events still happen. This danger can come from outside of the family (such as a natural disaster, car accident, school shooting, or community violence) or from within the family, such as domestic violence, physical or sexual abuse, or the unexpected death of a loved one.

What Experiences Might Be Traumatic?

- Physical, sexual, or psychological abuse and neglect (including trafficking)
- Natural and technological disasters or terrorism
- Family or community violence
- Sudden or violent loss of a loved one
- Substance use disorder (personal or familial)
- Refugee and war experiences (including torture)
- Serious accidents or life-threatening illness
- Military family-related stressors (e.g., deployment, parental loss or injury)

When children have been in situations where they feared for their lives, believed that they would be injured, witnessed violence, or tragically lost a loved one, they may show signs of child traumatic stress.

What Is Child Traumatic Stress?

Children who are exposed to traumatic events may experience a wide range of consequences that can include intense and ongoing emotional distress and behavioural problems, difficulties with attention, academic failure, problems with sleep, or illness. For some children, these reactions interfere with daily life and their ability to function and interact with others. These reactions sometimes develop into serious mental illnesses or serious emotional disturbance, including posttraumatic stress disorder (PTSD), anxiety, and depression. Exposure to traumatic experiences can also worsen preexisting mental health problems and disrupt children's ability to form positive relationships and handle emotions and behaviour.

Without treatment, repeated childhood exposure to traumatic events can affect the brain and nervous system and increase health-risk behaviours (e.g., smoking, eating disorders, substance use, and high-risk activities). Research shows that child trauma survivors can be more likely to have long-term health problems (e.g., diabetes and heart disease) or to die at an earlier age. Traumatic stress can also lead to increased use of health and mental health services, and increased involvement with the child welfare and juvenile justice systems. Adult survivors of traumatic events may also have difficulty in establishing fulfilling relationships and maintaining employment.

Untreated child traumatic stress can also be part of many of the most pressing problems that individuals, families, and communities face, including poverty, crime, low academic achievement, addiction, mental health problems, and poor health outcomes. The cost of child trauma is felt in human terms across the lifespan, and also in dollars and cents. As an example, the Centers for Disease Control and Prevention in the US recently reported that the total lifetime estimated cost associated with just one year of confirmed cases of child maltreatment alone is approximately $124 billion.

Reminders and Adversities

Traumatic experiences can also set in motion a cascade of changes in children's lives that can be challenging and difficult. These can include changes in where they live, where they attend school, who they're living with, and their daily routines. They may now be living with injury or disability to themselves or others. There may be ongoing criminal or civil proceedings.

Traumatic experiences leave a legacy of reminders that may persist for years. These reminders are linked to aspects of the traumatic experience, its circumstances, and its aftermath. Children may be reminded by persons, places, things, situations, anniversaries, or by feelings such as renewed fear or sadness. Physical reactions can also serve as reminders, for example, increased heart rate or bodily sensations. Identifying children's responses to trauma and loss reminders is an important tool for understanding how and why children's distress, behaviour, and functioning often fluctuate over time. Trauma and loss reminders can reverberate within families, among friends, in schools, and across communities in ways that can powerfully influence the ability of children, families, and communities to recover. Addressing trauma and loss reminders is critical to enhancing ongoing adjustment.

What Is the NCTSN Doing to Address the Problem?

Fortunately, there are evidence-based treatments and services that are highly effective for child traumatic stress. However, many children and families face barriers in receiving appropriate mental health care. Improving access to effective evidence-based treatments for children who experience traumatic stress can reduce suffering and decrease the costs of health care. As the leading federal initiative focused on child trauma in the US, the National Child Traumatic Stress Network (NCTSN) has a long history of raising the standard of care for children and families.

The National Child Traumatic Stress Network (NCTSN) was created by the US Congress in 2000 as part of the Children's Health Act to raise the standard of care and increase access to services for children and families who experience or witness traumatic events. This unique network of frontline providers, family members, researchers, and national partners is committed to changing the course of children's lives by improving their care and moving scientific gains quickly into practice across the US. The NCTSN is administered by the Substance Abuse and Mental Health Services Administration (SAMHSA), US Department of Health and Human Services, and coordinated by the UCLA-Duke University National Center for Child Traumatic Stress (NCCTS).

The NCTSN Mission: To raise the standard of care and improve access to services for traumatised children, their families and communities throughout the United States.

The NCTSN works to accomplish its mission of serving the nation's traumatised children and their families by:

- Raising public awareness of the scope and serious impact of child traumatic stress on the safety and healthy development of America's children and youth.
- Advancing a broad range of effective services and interventions by creating trauma-informed, developmentally and culturally appropriate programmes that improve the standard of care.
- Working with established systems of care including the health, mental health, education, law enforcement, child welfare, juvenile justice, and military family service systems to ensure that there is a comprehensive trauma-informed continuum of accessible care.
- Fostering a community dedicated to collaboration within and beyond the NCTSN to ensure that widely shared knowledge and skills become a sustainable national resource.

The NCTSN has grown from 17 funded centres in 2001 to 86 currently funded centres and over 150 Affiliate (formerly funded) centres and individuals in 2018, working in hospitals, universities, and community-based programmes in 44 states and the District of Columbia.

The Network has a unique collaborative structure made up of three components:

- National Center for Child Traumatic Stress (Category I). The National Center for Child Traumatic Stress works with the Substance Abuse and Mental Health Services Administration to develop and maintain the Network structure, provide technical assistance to grantees within the Network, oversee resource development and dissemination, and coordinate national education and training efforts.
- Treatment and Services Adaptation Centers (Category II). The Treatment and Services Adaptation Centers provide national expertise on specific types of traumatic events, population groups, and service systems and support the specialised adaptation of effective treatment and service approaches for communities across the country.
- Community Treatment and Services (CTS) Centers (Category III). The Community Treatment and Services Centers implement and evaluate effective treatments and services in community settings and child-serving systems and collaborate with other Network centers on clinical issues, service approaches, policy, financing, and training issues.

Since 2001, the National Center for Child Traumatic Stress (NCCTS) has had a unique, bicoastal structure, combining the resources of the UCLA Semel Institute for Neuroscience and Human Behavior and the Duke University Medical Center. Under the guidance of co-directors Robert Pynoos, MD, MPH (UCLA) and John Fairbank, PhD (Duke), the NCCTS manages an evolving, collaborative network of diverse academic and community-based centres, using the following strategies:

- Building Network culture and consensus. Together with SAMHSA (Substance Abuse and Mental Health Services Administration), NCCTS has created a complex, effective organisational structure, along with a shared Network identity, mission and vision, and governance framework. NCCTS has led NCTSN through periods of tremendous growth and change, working to ensure the continuity of core values: collaboration, transparency, family and consumer involvement, and cultural competence.
- Fostering effective collaborations. NCCTS has created multi-layer support structures for NCTSN collaboration, including a team of Network "Liaisons," dozens of collaborative groups and committees, processes for collaborative resource development, IT infrastructure, and mechanisms for information and data sharing.
- Developing innovative training and implementation protocols. NCCTS' adaptation of the Institute for Healthcare Improvement's Breakthrough Series Collaborative model has enabled the Network to move beyond "one-shot trainings" to achieve sustainable practice changes driven by implementation science principles.
- Expanding the Network's reach. NCCTS has expanded the reach of NCTSN to thousands of community and national partners, by utilising innovative technology platforms, developing resources for diverse audiences, expanding our Affiliate programme to leverage expertise regardless of funding status, providing leadership in creating trauma-informed child-serving systems, supporting NCTSN members' efforts to raise awareness about child trauma at the local and state levels, and providing policy analysis and education to federal and state policymakers and other stakeholders.

NCTSN Activities

When the US Congress launched the NCTSN, it established a national infrastructure that supports the scientific growth and dissemination of child trauma knowledge and expertise. This infrastructure is the basis for the transformation and improvement of all child-serving systems of care, accelerating the transfer of scientific knowledge to service delivery. To accomplish its mission, NCTSN grantees and Affiliates work to:

- Provide clinical services for children and families experiencing trauma
- Develop and disseminate new interventions and resource materials
- Offer education and training programmes
- Collaborate with established systems of care
- Engage in data collection and evaluation
- Inform public policy and awareness efforts

Some key activities include:

Disseminating treatment and services. The NCTSN supports the development, dissemination, and adaptation of treatment and services to prevent mental health problems among children and families who have experienced trauma, to reduce the impact of trauma on adult health and productivity. Through the work of the NCTSN, hundreds of thousands of children and families have benefitted from improvements in evidence-based treatment and promising practices.

Responding to major events. As part of its mission, the NCTSN immediately mobilises in the aftermath of national crises, including the terrorist attacks on September 11, 2001; Hurricanes Katrina, Harvey, and Sandy; and school shootings such as those at Majory Stoneman Douglas High School and Sandy Hook Elementary School. In this role, the NCTSN deploys staff, provides direct services and training where needed, and disseminates resources locally and throughout the country, supporting the coordinated interagency federal response.

Promoting trauma-informed care. The NCTSN seeks to increase awareness of child traumatic stress and to improve cultural and linguistic competence across child-serving systems, so children and families have access to safe, effective, trauma-informed services. Toward this end, the NCTSN builds strategic partnerships, educates and trains, and develops resources to address gaps in knowledge and skills among the workforce across a wide range of systems, including schools, child welfare, juvenile justice, health care, and more. NCTSN resources provide a definition of trauma-informed services, as well as tools and resources to assist organisations of all types to improve implementation of trauma-informed practices and enhance cross-system collaboration.

Establishing partnerships. NCTSN partnerships involve a dynamic range of activities with international, national, tribal, regional, state, county, city, and local community organisations in the public and private sectors. This "Network beyond the Network" is a critical component of the NCTSN mission and effectively extends trauma-informed practices and resources to all types of child-serving systems.

NCTSN members report a wide variety of partners, including private businesses, community-based organisations, advocacy groups, child welfare and other social services agencies, education partners, first responders, foundations, government agencies, professional associations, primary healthcare groups, juvenile justice agencies, child welfare programmes, mental health organisations, academic institutions, and more.

Supporting former grantees as Affiliates. The collaborative model of the NCTSN has also made it possible for formerly-funded NCTSN members to be active Affiliate members of the NCTSN and to continue to contribute to the national mission, as well as to the ongoing work in their states and local communities. Through the active Affiliate programme, the investment that the nation has made in the NCTSN programme continues to reap cost-effective benefits for child trauma centres and for those they serve.

NCTSN Impact

The national impact of the NCTSN is well documented. In recent years, estimates from the NCTSN Collaborative Change Project (CoCap) have indicated that each quarter about 35,000 individuals – children, adolescents and their families – directly benefited from services through the NCTSN. Since its inception, the NCTSN has trained more than 1.5 million professionals in trauma-informed interventions. Hundreds of thousands more are benefitting from the other community services, website resources, webinars, educational products, and community programmes the NCTSN offers.

Over 10,000 local and state partnerships have been established by NCTSN members in their work to integrate trauma-informed services into all child-serving systems, including child protective services, health and mental health programmes, child welfare, education, residential care, juvenile justice, courts, and programmes serving military and veteran families, refugee and immigrant families, and families impacted by substance use disorders.

The NCTSN has tracked the programme's effectiveness through its Core Data Set system and other evaluation efforts. Detailed information and trauma histories have been collected on more than 14,000 children and adolescents with results showing that more than 40% have experienced four or more types of traumatic events in their young lives. The majority already are showing impairments in one or more areas of life (such as academic problems, emotional distress, or behavioural problems at home or in the community), and many have been diagnosed with PTSD, depression, anxiety, and other disorders. Fortunately, the majority of children show significant improvement in functioning after treatment. Without treatment, many would continue to experience traumatic stress and engage in behaviours that undermine healthy development. With treatment and support, many will recover and return to normal activities and development.

NCTSN Resources

Through its two websites, the NCTSN provides a range of resources for professionals, policymakers, the media, and the public about child traumatic stress, including treatment guidelines, fact sheets, training materials and opportunities, and access to the latest research information.

NCTSN.org (www.nctsn.org): The primary website of the National Child Traumatic Stress Network (NCTSN), NCTSN.org offers information on various aspects of child traumatic stress, including trauma types, treatments and practices, and trauma-informed care; the site also provides access to over 875 free resources (including training curricula, fact sheets, resource guides, and videos) to help child-serving professionals as well as parents and caregivers better support children who have experienced trauma. Many resources are available in Spanish, as well as several other languages. The NCTSN.org website includes sections tailored for specific audiences, focusing on diverse child-serving systems, and highlighting the unique needs of populations at risk, including trafficked youth, youth with Intellectual and Developmental Disabilities, LGBTQ youth, and much more.

NCTSN Learning Center for Child and Adolescent Trauma (http://learn.nctsn.org): This source for online training offers free courses and resources on various aspects of child traumatic stress, including hundreds of webinars, eLearning modules, and videos (many offered for continuing education credit) on special populations, clinical training, and service systems. The Learning Center also features a 6-hour interactive course on Psychological First Aid (PFA) – an evidence-informed, modular approach to help children, adolescents, adults, and families in the immediate aftermath of disaster and terrorism – and a course on the 12 Core Concepts for Understanding Traumatic Stress Responses in Children and Families, which provides a theoretical foundation and shared vocabulary for conceptualising and talking about traumatic events.

For more information or inquiries, contact info@nctsn.org.

Evaluation of the TLC Kidz Programme for Children and Mothers Recovering from Domestic Abuse

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Introduction

The TLC Kidz programme is a group programme for children and mothers recovering from domestic abuse. It has been delivered on an interagency basis in North Tipperary since 2005 and more recently in South Tipperary, Waterford and Carlow. Barnardos, with the support of Tusla, the Child and Family Agency, commissioned an evaluation to investigate the outcomes and experiences of families and professionals in attending/delivering the programme. This paper describes the programme, its context and the findings of that evaluation.

Domestic Violence

In Ireland, 1 in 3 women have been victim to severe psychological abuse, while 1 in 4 women have experienced physical and sexual violence from a male partner (European Union Agency for Fundamental Rights (FRA), 2014). Children are particularly vulnerable to domestic violence exposure, whether it's first-hand abuse, witnessing abuse of a family member, or living in fear of abuse (Hartley, 2002; Herrenkohl et al., 2008). Exposure to trauma has short- and long-term impacts on children and young people. Depending on a child's age and developmental stage, they may experience aggression, anxiety, sleeplessness and worry about safety (Buckley, Whelan and Holt, 2007). These effects are compounded when the mother-child relationship is compromised as a result of the abuse. If left untreated, the long-term effects of trauma can last through adulthood (Black, Sussman and Unger 2010; WHO, 2007). Adults who reported an adverse childhood experience, such as domestic violence, were two to six times more likely to experience depression, illicit drug use and alcoholism (Dube et al., 2002). However, research shows that these effects can be mitigated by the provision of suitable supports. These supports are crucial for children in encouraging adaptive developmental growth (Howarth et al., 2016).

SNAPSHOT: Domestic Violence in the Irish Context

- In 2016 alone, Women's Aid recorded 20,769 disclosures of domestic violence against women and children: 16,946 cases against women and 3,823 cases against children (Women's Aid, 2017).
- Within the EU, Ireland has the second highest number of women avoiding places or situations for fear of being assaulted (FRA, 2014).
- 41% of Irish women know someone in their circle of family or friends who have experienced intimate partner violence (FRA, 2014).
- 64% of women who have experienced violence report that their children had witnessed the violence (Women's Aid, 1995).
- A meta-analysis of existing studies found that in between 33-60% of domestic violence cases, both the mother and child are abused by the perpetrator.
- Irish children who have experienced domestic violence reported feelings of anxiety for themselves, their siblings and their mother; low self-esteem; difficulties building and maintaining relationships; poor school engagement; and a sense of 'lost childhood' (Buckley, Whelan and Holt, 2007).

“If left untreated, the long-term effects of trauma can last through adulthood.”

Policy Context

There have been welcome developments in policy, legislation, policing, and service awareness in recent years to enhance the protection of victims of domestic abuse in Ireland. Some noteworthy pieces of legislation in recent years include: (1) the *Domestic Violence Bill 2017* for broadening the definition of domestic abuse; (2) *the Istanbul Convention* for criminalising domestic abuse; and (3) the creation of new government units to tackle cases of domestic abuse, such as Garda Victims Services and Tusla.

Tusla was established in 2014 and has responsibility for protecting and supporting victims of domestic abuse. Tusla has a particular remit in relation to child protection and welfare, and Children First guidance, along with the implementation of Meitheal (a national practice model for agencies working with children and families), enhances the capacity of services to identify and provide interagency supports for children exposed to domestic abuse (Cosc, 2016). In addition, the national children's policy framework – 'Better Outcomes, Brighter Futures' – recognises the importance of integrated evidence-based supports in improving the health and wellbeing of young people (Department of Children and Youth Affairs, 2014). 'Better Outcomes, Brighter Futures' identifies five key outcomes for children and six cross-cutting transformational goals needed to achieve those outcomes. Addressing these outcomes is an integral means of prevention and responding to domestic abuse. Several goals of the policy framework are directly addressed by the TLC Kidz programme. Specifically, TLC Kidz supports parents, listens to and involves children and capitalises on cross-government and interagency collaboration.

Despite these welcome policy developments, there is evidence of possible underreporting of domestic abuse in Ireland (Garda Inspectorate Report, 2014). In addition, the law is applied differently across areas and judges with little transparency, with reports indicating that stereotyping and victim blaming remains integral to how victims can be viewed and treated (Safe Ireland, 2016). Furthermore, the ongoing housing crisis has led to a lack of affordable/available accommodation, thus compromising the capacity of mothers and children to leave the abusive situation or move on from the refuge (Safe Ireland, 2016).

TLC Kidz

In response to the lack of services to meet the needs of children who experience domestic abuse in Ireland, the TLC Kidz programme was developed to support children and mothers recovering from domestic abuse. TLC Kidz is a multi-agency, group programme focused on the needs of children and how mothers can support them. The programme has roots in Canada but has been running since 2005 in North Tipperary. Recently, it has been implemented in South Tipperary, Waterford and Carlow. An integral component in the programme's success is interagency collaboration between partners, including: Ascend Domestic Violence Service, North Tipperary Community Services, Health Service Executive (HSE) Adult Mental Health, Child and Adolescent Mental Health Services (CAMHS), Primary Care, Tusla Prevention, Partnership and Family Support (PPFS), social work and family services, Tipperary Regional Youth Services, Barnardos, School Completion Programme, An Gardaí, Focus Ireland and Men Overcoming Violence (MOVE) North Tipperary. The programme is headed by a multi-agency Steering Committee and a Project Coordinator, which promotes cohesion and shared responsibility while working towards a common vision. Interagency working is a core tenet of the programme as it can improve professional practice and provide timely support to families in need.

> *"…it is strongly advised that mothers attend, raising the mother's awareness and supporting parental capacity enhances the child's ability to heal from trauma."*

In order to access the service, a referral must be made indicating that the family meets the inclusion criteria. TLC Kidz is designed for male perpetrator abuse, where the perpetrator is no longer living in the home. Both children and mothers must verbally acknowledge that there is an issue, and express motivation to engage with the programme. Children and mothers participate in the programme for 12 weeks of psycho-educational support. Children meet in groups of up to 8, with other children of similar characteristics, such as age, maturity and development. Groups for children and mothers run concurrently, though participation in the mothers group is not compulsory. However, it is strongly advised that mothers attend, as raising the mother's awareness and supporting parental capacity enhances the child's ability to heal from trauma.

Practice

Particular focus is placed on helping children heal from trauma by validating their experiences and reorienting them in the present moment, as well as assisting mothers in how to understand and support that process. TLC Kidz seeks to:

1. provide a safe space for children and mothers to discuss domestic abuse,
2. increase the safety of children and mothers, and
3. help children name and process difficult emotions to enhance communication with mothers.

In practice, TLC Kidz has several different elements that help achieve its objectives. The programme focuses on helping children recover from trauma by increasing their sense of safety and self-worth. Children learn to explore and express difficult emotions, which gives them the agency necessary to engage in conversation about the abuse and to advocate for their own needs. Moreover, the comradery developed through the group context enables the removal of stigma associated with their experiences, and increases self-confidence. Lastly, children work to label behaviours as acceptable or unacceptable, and to employ strategies to promote their safety in the future.

> *"Children learn to explore and express difficult emotions, which gives them the agency necessary to engage in conversation about the abuse and to advocate for their own needs."*

Although all elements of the programme are child-centered, specific aspects of the programme are designed to increase parental awareness and competence. Mothers participate in group discussion and learn how their own behaviour and relationships affects their children. They learn communication and emotional regulation skills that complement those taught in the children's programme, which helps to create a safe forum for conversation. Maternal confidence and awareness engenders a strong mother-child attachment, which is crucial for children.

Evaluation

Many supports and interventions for traumatised children receive are not evidence-based (Howarth et al. 2016). The implementation of empirically validated programmes is crucial in combating the effects of domestic abuse. An

evaluation of TLC Kidz was commissioned by Barnardos and Tusla and undertaken in late 2017 by a research team based in Maynooth University. The evaluation collected data from mothers and children, as well as service providers and stakeholders. A range of qualitative and quantitative data collection methods were used. Experiences of children and mothers were assessed using existing data collated by Barnardos' staff and by data collected by the research team.

Existing data included: (1) family demographic data from 2013-2017, involving 48 children and 32 mothers; and (2) anonymised closure forms from family case files, from 2015-2017, involving 36 children and 22 mothers. Data collected by researchers included the KIDSCREEN-10 Questionnaire (given to 9 children, 9 mothers) and semi-structured interviews conducted with a random sample of families (9 children, 11 mothers) who had attended the programme between 2013 and 2017. An online survey (sent to 30 professionals, of whom 11 responded) and semi-structured interviews (n = 15) assessed the experiences of service providers and stakeholders in delivering the programme. Informants included facilitators, referrers, Steering Group members, funders, as well as services involved in the early stages of implementing the programme.

Findings

The findings of the study indicated a range of positive outcomes for participants, in addition to a number of recommendations. It is noteworthy that outcomes for families were sustained and even enhanced in subsequent years. Table 1 illustrates an overview of programme outcomes for children and mothers, communities and organisations involved in delivery.

Both children and mothers reported positive changes, such as improved child well-being and behaviour, enhanced capacity of children and mothers to identify and appropriately express difficult emotions, and increased child and mother confidence, resilience and social engagement. After attending the programme a year ago, one 10-year-old girl remarked, *"I am more open to Mum because if I am scared or angry I would tell her now but before I wouldn't."* The majority of children also indicated that their school behaviour had improved and that they were now better able to concentrate. For instance, a 12-year-old girl who attended the programme in 2016 said, *"I used to be upset a lot of the time in school so it kind of helped me get over it."* Mothers also reported that understanding the impact of domestic abuse on their children and the importance of communication had helped them to develop warmer, more open parent-child relationships. For instance, a mother whose child attended in 2014 observed, *"We talk more openly, more*

to explain things, not to mind them from it." Mothers further indicated that they themselves had become more involved in their communities. For example, after completing the programme, a mother shared, *"I went off and did a childcare course after, it brought me back into doing something that I liked doing."*

The outcomes reported by mothers were substantiated by service providers. Additionally, several professionals indicated that child protection was enhanced as mothers now understood the impact of domestic abuse on their children, had learned how to keep themselves and their children safe, managed access better, and were less likely to reunite with the abusive ex-partner. As one social worker remarked, *"If the programme wasn't there, I have no doubt that some of those families would be re-referred back in."*

Enhanced child and parent well-being also led to knock on benefits for the community, such as increased school and social engagement, and a decrease in the child's need for medical services. In addition, the interagency model of delivery meant that community partners benefitted from an increased awareness of the negative impact of domestic abuse on children and realised the necessity of providing suitable supports for their recovery. Furthermore, families benefitted from the interagency model due to the enhanced care and referral plans provided when a range of skilled facilitators are involved in co-delivery. Lastly, greater organisational awareness of the benefits of the TLC Kidz programme will likely increase referrals, thereby increasing its reach and impact on services users and their communities.

Outcomes for children and mothers	Community outcomes	Organisational outcomes
◆ Breaking the silence, stigma and isolation surrounding domestic abuse ◆ Learning how to better express and regulate difficult emotions (e.g. anger) ◆ Ability to identify unacceptable behaviours and knowing what to do in unsafe situations ◆ Warm and open mother-child relationships ◆ Increased child confidence and coping skills ◆ Increased engagement with school and social activities ◆ Improved physical, emotional and behavioural well-being ◆ Evidence of generalised benefits to siblings who did not attend the programme	◆ Greater engagement of children and mothers in community activities ◆ Mothers accessing educational programmes or seeking employment ◆ Reduced child utilisation of medical and related services	◆ Increased awareness of negative impact of domestic abuse on children ◆ Recognition of need to provide suitable supports for children to recover from abuse ◆ A culture shift in the practice of interagency partners in supporting mothers ◆ Increased support for children and mothers via co-delivery and enhanced referral plans

Table 1 Outcomes from the TLC Kidz programme

Several key factors were identified as essential for desired outcomes. Mothers and children stated the importance of including the following elements in the programme:

- A group programme providing a safe and confidential space to discuss domestic abuse
- Realising they were not alone and social support
- Emphasis on communication between child and mother
- Naming and responding to difficult emotions
- The reintroduction of fun
- Support with transport, and practical support

Furthermore, professionals indicated additional factors essential to achieving positive programme outcomes. These were: fidelity to the programme, an interagency model of delivery, having a dedicated Project Coordinator and Steering Committee, conducting a careful assessment of child readiness before engaging with the programme, and efficient training and supervision of facilitators. All of these factors were present in the delivery of the programme in North Tipperary and may help to explain the positive outcomes achieved.

Recommendations

For over a decade, TLC Kidz has been supporting families impacted by domestic violence in Ireland. The evaluation of the TLC Kidz programme demonstrated implementation fidelity and many positive outcomes were achieved for families and communities. The evaluation highlighted the following recommendations in order to better support families and enhance programme effectiveness and efficiency:

Recommendation 1: Further specialised supports for mothers and children

While the findings indicate considerable benefits for both children and mothers, about half of children and one third of mothers required further support. These supports focused on further promoting and maintaining the benefits post-programme and included psychological services and youth clubs, such as Foroige or Scouts. In particular, it was found that some children were too traumatised or not ready to participate. Similarly, some mothers may have difficulty engaging with the programme due to personal issues. While additional supports are offered where available, there is a recognised need for further specialist and therapeutic supports for children and mothers engaging with the TLC Kidz programme.

Recommendation 2: Maintain and increase organisational buy-in

In lieu of hiring new staff, community partners involved in implementing TLC Kidz agreed to release staff to co-deliver the programme. In practice, some managers were reluctant to do so, and a high turnover in personnel was also an issue in sourcing facilitators. The provision of targeted workshops and discussion with managers may be useful in maintaining awareness and buy-in. Furthermore, additional facilitators could be recruited from other organisations that are in a position to refer children and mothers to the programme, including schools, crèches, providers of parent programmes, Social Work, community agencies, mental health services, public health nurses, primary care, GPs, An Gardaí, housing, and so forth.

Recommendation 3: Spread awareness to public and relevant organisations

Despite the prevalence of domestic abuse, the stigma and silence surrounding domestic abuse means that it is often not disclosed or openly discussed. Therefore, there is a need at the national and local levels to increase public and service awareness about domestic abuse, and, in particular, outline the necessity of providing recovery supports for affected children and mothers. Organisations in a position to refer children and mothers to the TLC Kidz programme should be specifically targeted and taught to recognise the signs of domestic abuse. Interagency and cross-sectoral collaboration will play an integral role in keeping children safe.

Conclusion

Historically, domestic violence has been considered as a private matter between families. Irish society no longer denies the prevalence and impact of domestic abuse on victims, although there is still some stigma attached to its disclosure. Since 2000, Ireland has increased the number and breadth of supports available to domestic abuse victims. The international evidence suggests that psycho-educational, group programmes, such as TLC Kidz, are effective in helping children and mothers recover from domestic abuse and positive outcomes include improved child wellbeing, behaviour and mental health, improved parenting competencies and family functioning. The current evaluation provides evidence for the successful implementation of the TLC Kidz progarmme in Tipperary since 2005, where sustained positive outcomes were achieved for families. Due to its record, other areas in Ireland are now in the early stages of implementing the programme and have reported preliminary successes. The reach and impact of the TLC Kidz programme may be further enhanced in Ireland through widescale organisational buy-in and implementation of the programme, as well as greater public and service awareness of the need to support children in recovering from the effects of domestic abuse.

References

- American Psychological Association, (2018) *Children and Trauma.* APA Presidential Task Force on PTSD and Trauma in Children and Adolescent, [Online], Available at: http://www.apa.org/pi/families/resources/tips.pdf
- Barnardos, (2016) What's the Harm? A child-centered response to domestic abuse, [Online], Available at: https://www.barnardos.ie/assets/files/pdf/Barnardos-whats-the-harm2016-web.pdf
- Black, D. S., Sussman, S. & Unger, J. B. (2010). A further look at the intergenerational transmission of violence: Witnessing interparental violence in emerging adulthood. *Journal of Interpersonal Violence*, *25* (6), 1022-1042.
- Buckley H, Holt S, Whelan S. (2007) Listen to Me! Children's Experiences of Domestic Violence. *Child Abuse Review.* 16(5):296-310
- Cosc: The National Office for the Prevention of Domestic, Sexual and Gender-based Violence. (2016). *Second National Strategy on Domestic, Sexual and Gender-based Violence 2016-2021*. Dublin: Department of Justice and Equality.
- Dube SR, Anda RF, Felitti VJ, Williamson DF. Exposure to abuse, neglect and household dysfunction among adults who witnessed intimate partner violence as children. *Violence and Victims.* 2002; 17:3-17
- European Agency for Fundamental Human Rights (FRA), (2014) *Violence against women: an EU-wide study*
- Furlong M, Leckey Y, O'Connor S, McMahon K. (2018) *Evaluation of the TLC Kidz programme for children and mothers recovering from domestic abuse.* Dublin: Barnardos.
- Garda Inspectorate. (2014). *Garda Inspectorate Report on Crime Investigation.* Dublin: Garda Inspectorate.
- Hartley, C. C. (2002). The co-occurrence of child maltreatment and domestic violence: Examining both neglect and child physical abuse. *Child Maltreatment*, *7* (4), 349-358.
- Herrenkohl, T. I., Sousa, C., Tajima, E. A., Herrenkohl, R. C. & Moylan, C. A. (2008). Intersection of child abuse and children's exposure to domestic violence. *Trauma, Violence, & Abuse*, *9* (2), 84-99.
- Howarth E, Moore T, Welton N, Stanley N, MacMillan, H…& Feder G (2016) IMPRoving Outcomes for children exposed to domestic violence (IMPROVE): An evidence-based synthesis. *Public Health Research*, 4(10)
- SAFE Ireland. (2016a). The State We Are In 2016: Towards a safe Ireland for women and children. Athlone, Ireland: SAFE Ireland.
- Statham, J (2011) Working Together for Children: A review of international evidence on interagency working, to inform the development of Children's Services Committees in Ireland. Department of Children and Youth Affairs
- Women's Aid, (2017) Impact Report 2016, Dublin: Women's Aid.
- Women's Aid, (1995) *Making the Links Briefing Paper,* Dublin: Women's Aid.
- World Health Organisation. (2007). Multi-country Study on Women's Health and Domestic Violence Against Women. Switzerland: WHO.

Traumatic bereavement loss and children

The Irish Childhood Bereavement Network vision for supporting children who are bereaved traumatically

Brid Carroll, Chair Advisory Committee the Irish Childhood Bereavement Network

The Irish Childhood
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It is an accepted fact that death in the life of a child – whether that of a parent, sibling or a significant other – is a traumatic event which can be stressful and cause upset for a period of time. Children look towards the adults around them as role models of how to grieve and most children who receive strong natural support from family, friends and community, with good age appropriate information, will cope and function well after such a loss. They can resume their activities in the short term and behave, think and feel as well as they did before the event occurred (Trickey, 2018).

Defining Traumatic Bereavement

If a loss is traumatic or a child is traumatised by a death, it may overwhelm their ability to cope and their reactions may last for a prolonged period after the event. In the case of traumatic loss, where a death is sudden, unexpected and/or violent, those in a child's support networks may be hugely devastated by what has occurred and may themselves require outside professional support. The cause of these deaths could include accidents (on the road, in the workplace or though recreation), suicide, homicide, terrorist acts and war. A child does not have to witness an event or even know the person who has died to be traumatised by it. In recent times we see children traumatised by the media coverage of terrorist attacks in Europe and gangland killings closer to home.

Trickey (2018) states that common reactions in children who have experienced a traumatic loss might be:

- Memories or images of the event popping up unexpectedly in their thoughts
- Nightmares
- Feeling as if the event is occurring again
- Drawing or playing out the event
- Not wanting to talk or think about the event
- Avoiding anything that might remind them of the event
- Getting angry or upset easily
- Poor concentration
- Inability to sleep
- Being jumpy and on-guard
- Being more clingy with significant adults
- Physical complaints such as headaches or stomach aches
- Regression in toileting or feeding
- Problems at school

Family Context

There is a popular myth that children are resilient and bounce back easily. In truth this is not always the case. Many children are growing up with insecure attachments, which can affect their coping when death arises in their family unit. The Child Bereavement Study (Worden, 1996) highlights the fact that the coping style of a surviving parent in the family has a significant impact on how a child will grieve. Open communication about the death by trusted adults, an acknowledgement of a child's feelings and a space to be heard are essential to a child's processing of their loss. Such engagement can help develop attitudes that promote resilience including hope (Stokes, 2009). Within a family a child can become 'a forgotten mourner' (Packman et al., 2006; Horsley & Patterson, 2006; Wender, 2012) as adults around them do not understand the child's need to grieve or are unavailable to them due to the intensity of their own grief. For some families, traumatic bereavement comes on top of pre-existing stressors including poverty, financial struggles, mental health or addiction issues that are already challenging the family (Penny & Stubbs, 2014; Stephens et al., 2014; Harper et al, 2011; Stebbins & Bartouney, 2007). Children can become disenfranchised by their own silence, sometimes, within blended families and where there has been a history of abuse or addiction in the family. Bereaved children often protect the adults around them by not expressing their feelings or sharing what is difficult for them after a loss.

> *"Bereaved children often protect the adults around them by not expressing their feelings or sharing what is difficult for them after a loss."*

If the adults who support these children can encourage the development of an understanding of the loss, promote normal coping mechanisms and provide relatively stable environments, then the child can develop resilience that will help them through their bereavement (ICBN, 2017). These adults need to know that children grieve differently than they do. Unlike adults who may take a very long time to process their grief, children's grief is often described like 'splashing in puddles'. It is intermittent, intense and overwhelming when it occurs. However, a child can return to normal activities relatively quickly if a new distraction occurs.

Grief in childhood is not a once-off event but may arise many times throughout their development. Where a parent has died children will renegotiate their relationships with both their surviving and deceased parent (Christ, 2000). For a bereaved sibling it may take many years to grieve their loss and the secondary losses of role, position in the family and even loss of their parents while they grieve their deceased child. The consequence of childhood loss is carried from childhood to adulthood. Children meet the loss of a parent again at milestone times such as graduations, weddings births and anniversaries (Schonfeld et al., 2016).

> *"The consequence of childhood loss is carried from childhood to adulthood."*

This highlights the need for public awareness and community education for those supporting bereaved children through traumatic loss. With accurate information on children's grief they can come to understand how children grieve, the factors that influence that grief, what red flag symptoms they need to monitor that will require professional support and how to become comfortable in communicating with a bereaved child at a time of traumatic loss.

When Grief Becomes Complicated For Children and Young Adults

There is now a growing body of research on the depth and breadth of complications for children who are grieving. Dyregrov and Dyregrov (2012) acknowledge that a proportion of children can experience problems in grieving following parental or sibling loss. Ackerman and Statham's (2014) review gives a range of 15% of bereaved children being highly vulnerable while up to 40% of the children in families seeking help from bereavement services may have clinical level symptoms.

Stikkelbroek et al. (2016) review literature which shows up to 25% of adolescents may develop some degree of mental health problem following a close family loss. Rosenberg et al. (2015) report increases in anxiety, depression and the use of illicit substances among teenagers in the year post bereavement. Furthermore, Foster et al. (2012) record findings of reports of personal changes (including personality, school work, goals/life perspective, activities and interests) in 69% of their study population as well as changes in relationships with family and peers in 47% of their study population.

Professionals working with and assessing bereaved children identify the intensity and duration of grief reactions, together with the degree of disruption or functional impairment, as the main characteristics of problem grieving (Dyregrov & Dyregrov, 2013).

The Long-Term Consequences of Childhood Bereavement

Recent population studies have begun to show long-term mental health and physical health deficits in cohorts of bereaved children. Li et al. (2014) followed cohorts of people bereaved of a parent in childhood (at age 6 months up to 18 years) and compared mortality rates with the non-bereaved population. Controlling for gender and socio-economic factors, the researchers found a 50% increased mortality for this parentally bereaved group. Hollingshaus and Smith (2015) also established a long-term mortality risk following early parental death. These associations may vary in strength by the cause of a parent's death (e.g. natural or sudden/accidental). Guldin et al. (2015) found an increased long-term risk of suicide in children who had lost a parent during childhood, particularly before the age of 6 years. This identification of immediate, medium-term and long-term effects on children and young people of the loss of a family member, especially if due to traumatic loss, indicates that it is critical that the needs of bereaved Irish children are identified and addressed as early as possible after the death event in order to prevent long-term trauma.

What Can Help?

If routines can be kept as normal as possible for children it will provide a sense of security and safety in the middle of family trauma. It is good to help children understand what has happened. Children need honest explanations of what has happened in language that is appropriate for their age. This can give them a sense of control and prevents them 'fantasising' what has occurred. This can reduce a child's fear and anxiety and give a child a sense of control at the time of traumatic loss. This allows children to realise that what happened was not their fault. Children of a certain age often think that something they said, thought or did caused a death to occur. A leaflet entitled *Talking to children about traumatic death* (Irish Hospice Foundation, n.d.) gives an explanation as to how to address these conversations. Trickey (2012) uses cartoon images and metaphor to explain trauma to children which can simplify these conversations.

The Irish Childhood Bereavement Network's Vision of Support

The Irish Childhood Bereavement Network (ICBN) was established in 2012 by a group of professionals and parents following an examination of the findings of a 2010 Irish audit of bereavement services for children (Carroll, 2010) which replicated the UK study by Rolls and Payne (2003). The Irish audit identified a disparate range of one-to-one and group services, a feeling of isolation among practitioners, a lack of standardised training on children's grief (embedded in original professional education or provided through unspecified continuous professional development offerings) and an *ad hoc* approach to funding with more than half (53%) relying on grants and a further third relying on donations. Jones et al. (2015) and Carroll (2010) outlined the

need for services to demonstrate greater flexibility and to develop more inter-agency working. There was also a stated need for greater awareness within communities about the impact bereavement can have on children and how they can be supported. Following consultation with the Childhood Bereavement Network UK, a feasibility study was conducted and the ICBN was set up with core funding from the statutory Child and Family agency and the Irish Hospice Foundation where the ICBN is housed.

The network set out to:

- **Support** professionals to deliver high quality and accessible bereavement support.
- **Signpost** families and carers to a directory of bereavement support services.
- **Inform** the general public regarding issues involved in childhood loss.
- **Advocate** for bereaved children, young people and those supporting them.
- **Generate** new ideas and approaches to improving bereavement support for children.

The Irish Childhood Bereavement Pyramid

With the above in mind, a subgroup of the network developed The Irish Childhood Bereavement Pyramid as shown in Figure 1. below.

The framework shown in the pyramid looks at the child within their family context in light of their developmental stage and the time since the death occurred. Three different facets of concern to adults supporting a bereaved child or young person were identified and form the central elements of the pyramid, as follows:

1. The **child's needs.**
2. The **supports and services** that are appropriate to address these needs.
3. The **knowledge and competencies** required by those individuals who set out to provide information, support, counselling and psychotherapy to children and young people who experience bereavement.

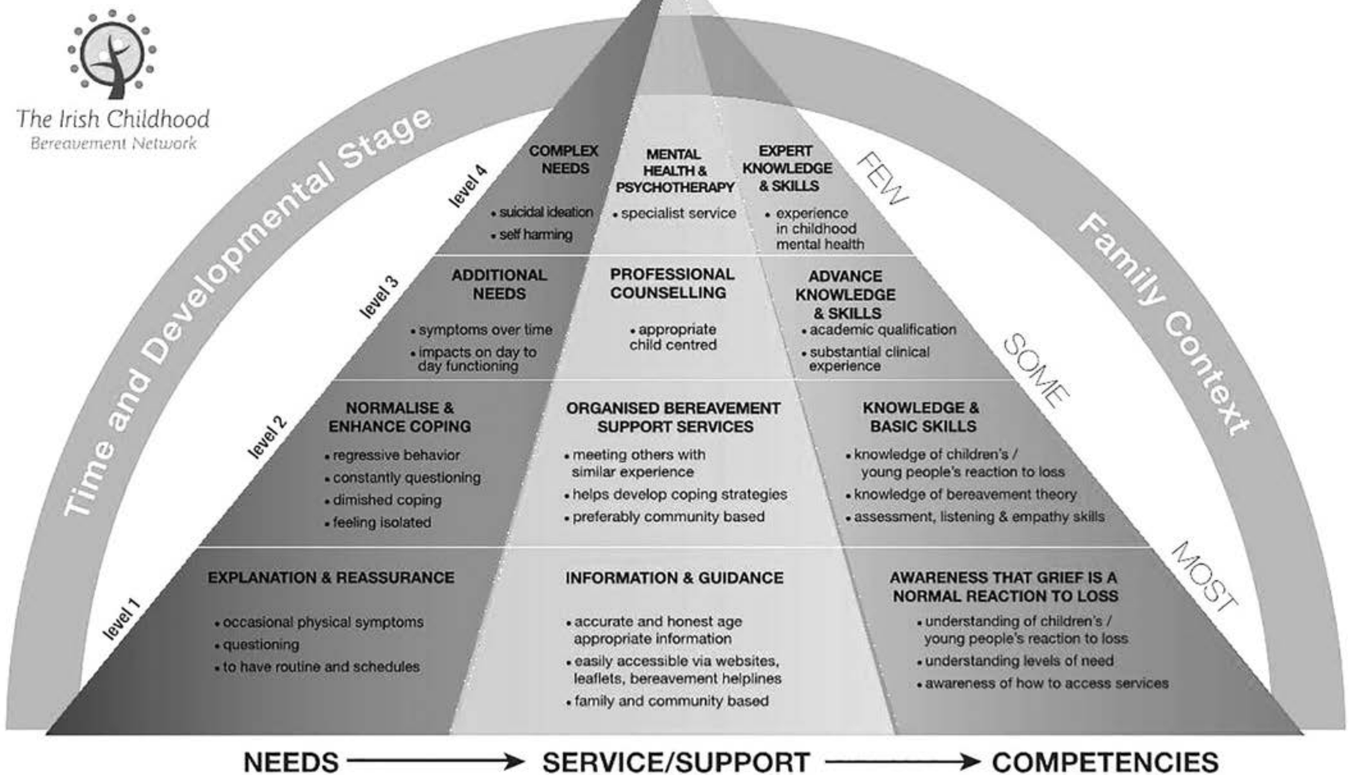


Figure 1. The Irish Childhood Bereavement Pyramid

Figure 1. illustrates the needs that apply to **most** children (Level 1), those that apply to **some** children (Level 2 and 3) and those that apply to **few** children (Level 4). If we consider the complex needs of children who have been traumatically bereaved, we can see that their needs would be met at **Level 3 and 4** of the pyramid.

Level 3 – Additional Needs

- Help with grief reactions that are interfering with day-to-day engagement – marked changed behaviour/personality – anxiety, withdrawal, isolation, aggression and anger.
- Help with deaths that may be surrounded with secrecy or stigma.
- Help to cope with conflicting emotions, with guilt, confusion, blame and relief.
- Extra help, for themselves and for their families, to understand emotional and behavioural experiences of children with learning difficulties who are bereaved.

Level 4 Complex Needs

At **Level 4** children have more **Complex needs** which include:

- Help with grief reactions and responses that are presenting as acute and require an immediate professional intervention – self-harm, suicidal ideation, depression.
- Help with pre-existing mental health issues such as anxiety/depression.
- Help with – persistent distress and preoccupation with circumstances of death.

The framework also illustrates the services that a child dealing with traumatic bereavement requires:

At **Level 3** this would be **professional counselling**, which includes:

- Appropriate child-centred counselling.
- Tailored for children with specific risk factors and/or who are experiencing difficulties relating to grief.
- May be individual or group-based approaches.

At **Level 4 Psychotherapy and Mental Health Services** includes:

- Specialist service with core psychotherapeutic/ intervention protocol aiming to ameliorate complicated grief.
- May include services which focus on symptoms of trauma.
- May involve therapeutic work with the family.

The framework illustrates the **competencies** required for supporting bereaved children at Levels 3 and 4:

Advanced knowledge and skills including:

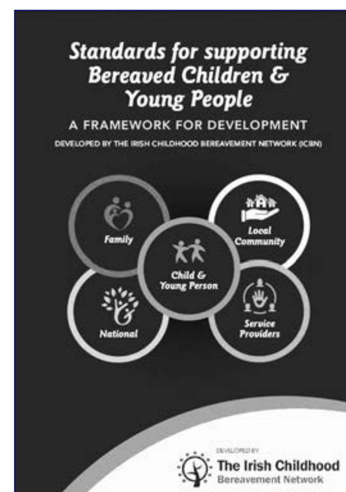
- Academic qualification
- Substantial clinical experience in working with bereaved children

Level 4 requires **Expert knowledge and skills**

- Experience in Childhood mental health

The pyramid highlights to families the most suitable style of service for their child's needs and prevents inappropriate referrals being made to Level 1 or Level 2 services, which lack the competencies required to deal with traumatic bereavement in children.

In November 2017, the Ombudsman for Children Dr Niall Muldoon launched the *Standards for supporting Bereaved Children and Young People: A Framework for Development* (ICBN, 2017).



This document sets out a way forward for the promotion of the child and young person's voice in Irish society in order that their needs may be appropriately recognised and supported when they are bereaved. The document sets a gold star target for five standards that embrace the bereaved child or young person, the family, the local community, service providers and nationally. It includes the rationale for each standard, the criteria that would demonstrate that the standard has been met and what this would mean for the bereaved child or young person, with examples of evidence of achievement. This document, which is available on the ICBN website www.childhoodbereavement.ie, is presently being disseminated. We accept that the coming years will present challenges to implement these standards and consider that as individuals, families, communities and as a country, we are at the beginning of a process.

ICBN holds a policy vision that, in the future, the impact of bereavement on children is integrated into a range

of national policies, that the economic and social consequences of bereavement are acknowledged, priority is given to reducing their negative impact on a bereaved child and their family, and that national research on childhood bereavement is promoted. through an agreed research agenda – including population level research. Furthermore, ICBN seeks national approaches that are built upon a principle of collaboration, local collaborative structures that are resourced and promoted accordingly, that national education and training programmes for professionals include education on bereavement and childhood bereavement, and, finally, that a national framework for the provision of support for bereaved children is developed and adopted to underpin decisions about resources and developments from statutory bodies.

ICBN continues to advocate on behalf of bereaved children and young people in Ireland. The Network also has a goal thatwhen parents and teachers ask how they can talk to children about terror attacks they will be directed to the best possible resources from international and national experts in the field so that they – the natural support network – of a bereaved child may feel empowered to support with confidence and competence in the years ahead.

For further information or resources Log on to our website at www.childhoodbereavement.ie or email maura.keating@hospicefoundation.ie

References

- Akerman, R. & Statham, J. (2014). Childhood bereavement: a rapid literature review. London: Childhood Wellbeing Research Centre. http://www.cwrc.ac.uk/news/documents/ Revised_Childhood_Bereavement_review_2014a.pdf.
- Barnard, P., Morland, I. & Nagy, J. (1999) Children, Bereavement and Trauma: Nurturing Resilience. Jessica Kingsley, London.
- Carroll, B. (2010). Survey of childhood bereavement services in Ireland. Unpublished thesis, Dublin: RCSI/Irish Hospice Foundation.
- Christ, G. (2000). Healing children's grief; surviving a parent's death from cancer, Oxford University Press, Oxford.
- Crenshaw, D.A. & Lee, J. (2010). The disenfranchised grief of children in Boyd Webb, N. (2010). Helping bereaved children, (3rd ed.) Gilford Press, London.
- Dyregrov, A. (2017). How parents and teachers talk to children about terror attacks? https://krisepsyk.no/in-english/articles/terror-media-and-children/
- Dyregov, A. & Dyregov, K. (2012). Complicated grief in children In Stroebe, M., Schut, H., van den Bout, J & Boelen, P (eds) Complicated grief: scientific foundations for health care professionals (p68-81) Routledge, London.
- Dyregov, A. & Dyregov, K. (2013). Complicated grief in children – the perspectives of experienced professionals Omega 67(3) 291-303.
- Foster, T.L., Gilmer, M.J., Vannatta, K., Barrera, M., Davies, B., Dietrich, M.S., Fairclough, D. & Gerhardt, C. (2012). Changes in Siblings After the Death of a Child From Cancer, Cancer Nursing, Vol. 35, No. 5, 247-354.
- Guldin, M.B., Li, J., Pederson H.S., Obel, C., Agerbo, E., Gissler, M., Cnattingius S., Olsen, J. & Vestergaard, M. (2015). Incidence of suicide among persons who had a parent who died during their childhood: a population-based cohort study, JAMA Psychiatry 12, 1227-1234.
- Harper, M., O'Connor, R., Dickson, A. & O'Carroll, R. (2011). Mothers continuing bonds and ambivalence to personal mortality after the death of their child: An interpretative phenomenological analysis, *Psychology Health & Medicine*, 16, 2, 203-214.
- Hollinghaus, M.S. & Smith, K. (2015). Life and death in the family: early parental death, parental remarriage and offspring suicide risk in adulthood, *Social Science and Medicine* (131) 181-189.
- Horsley, H. & Patterson, T. (2006). The effects of a parent guidance intervention on communication among adolescents who have experienced the sudden death of a sibling, *The American Journal of Family Therapy.* 34,2, 119-137.
- Irish Childhood Bereavement Network (2014). The Irish Childhood Bereavement Care Pyramid: a guide to support for bereaved children and young people. ICBN, Dublin. Available from: http://www.childhoodbereavement.ie/pyramid.
- Irish Childhood Bereavement Network (2017). *Standards for supporting Bereaved Children and Young People: A Framework for Development* .ICBN, Dublin.
- Irish Hospice Foundation (n.d.) *Talking to children about traumatic death.*
- Jones, A.M., Deane, C. & Keegan, O. (2015). The development of a framework to support bereaved children and young people: the Irish Childhood Bereavement Care Pyramid, *Bereavement Care*, Vol. 34 (2) 43-51.
- Li, J., Vestergaard, M., Cnattingius, S., Gissler, M., Bech, B.H., et al. (2014). Mortality after Parental Death in Childhood: A Nationwide Cohort Study from Three Nordic Countries. PLoS Med 11(7): e1001679. doi:10.1371/journal.pmed.1001679
- Packman, W., Horsley, H., Davies, B. and Kramer, R. (2006) Sibling Bereavement and Continuing Bonds, *Death studies*, 30, 9, 817-841.
- Penny, A., Stubbs, D. (2014). Bereavement in childhood – What do we know in 2014. Childhood Bereavement Network, UK.
- Rolls, L., Payne, S.A. (2003). Childhood bereavement services: a survey of UK provision. Palliative Medicine 17 423.
- Rolls, L., Payne, S.A. (2007). Children and young people's experience of UK childhood bereavement services. Mortality 12 (3) 281-303.
- Rosenberg, A.R., Postier, A., Osenga, K. Kriecbergs, U., Neville, B., Dussel, V. and Wolfe, J. (2015) Long-term Psycho-social outcomes among Bereaved Siblings of Children With Cancer, *Journal of Pain and Symptom Management,* Vol.49 No. 1.
- Schonfeld, D.J., Demaria, T., AAP Committee on psychological aspects of child and family health, disaster preparedness advisory council (2016). Supporting the grieving child and family, *Pediatrics* 138(3) e20162147.
- Stebbins J. & Bartouney, T. (2007). Summary report – beyond the death of a child. Australia: Compassionate Friends. Available from: http://www.compassionatefriendsvictoria.org.au/ reports/FINAL%20TCF%20Summary%20Report.19Jul07.pdf [Accessed 14 January 2015].
- Stephen, A., Macduff, C., Petrie, D.J. et al (2014). The economic cost of bereavement in Scotland. Death Studies 39(3) 151-157.
- Stikkelbroek, Y., Bodden, D., Reitz, E., Vollebergh, W. and van Baar, A. (2016) Mental health of adolescents before and after the death of a parent or sibling, *European Child Adolescent Psychiatry* 25: 49-59.
- Stokes J.A. (2009). Resilience and bereaved children. *Bereavement Care* 28(1) 9-17.
- Trickey, D. (2012). Explaining the Rationale for trauma-Focused Work: Why It's Good To Talk https://www.annafreud.org/media/4898/07c-david-trickey-handout-it-is-good-to-talk.pdf
- Trickey, D. (2016). After the Event: Supporting children after a frightening event. https://childbereavementuk.org/wp-content/uploads/2016/05/2-3-After-the-event-supporting-children-after-a-frightening-event.pdf.
- Trickey, D. (2018). Traumatic Events: How Children and Young People React, And How Adults Can Respond https://www.huffingtonpost.co.uk/david-trickey/traumatic-events-how-chil_b_14330466.html.
- Wender, E. & The Committee on Psychosocial Aspects of child and family health (2012). Pediatrics,130, 1164-1169.
- Worden, W. (1996). Children and grief – when a parent dies. New York: Guildford Press.

Intergenerational trauma: The cycle of negative caregiving

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Introduction

Sometimes the traumatic experiences of the one generation live on to affect the generation that follows. In particular, early childhood trauma can lead to an increased risk of less than optimal parenting practices and attitudes. It is hard to feel empathy and acceptance towards your own children if this was lacking in your own childhood; thus emotional dysfunction in the parent can be reflected in the emotional development of their child. Parents with a history of being maltreated have an increased risk of depression, PTSD or borderline personality disorder, substance abuse, self-harm, alcohol and drug misuse, anxiety disorders and post-natal psychosis, all of which will have an impact on parenting behaviour unless addressed.

It is normal for any parent to feel fear, self-doubt and tension after the birth of a baby but for those adults exposed to toxic stress in their own childhood, coping with situations that evoke these feelings can be a struggle. Our stress response is programmed early in childhood and this can be a factor in parenting styles crossing

generations. Furthermore, many parents raise their children in the same physical and social environment as they were brought up in and many risk factors outside of the family, such as poverty and overcrowding housing, will affect the caregiving relationship. It is important to make the point, however, that research shows that two thirds of parents who were themselves abused during childhood do not go on to harm their children in any way – there are many 'natural' protective factors. However, that still leaves a lot of vulnerable adults and children who, without help, might well remain trapped in the cycle of intergenerational trauma.

Intervention

Working with a family when a baby has just arrived means one has access to a lot of flexible systems – the baby's and parents' brains, the family structure and the normal dynamics of development – but to intervene successfully it is important to have an idea of the processes that are involved. Understanding counteracts the impulse to judge, which is essential as, when a vulnerable family feels judged, it becomes difficult for them to trust the help that might be on offer. The early years workforce is in a privileged position to engage with parents who may have great difficulties creating consistent, sensitive and appropriately responsive relationships with their babies because they did not have these experiences in their own childhood. The foundations on which the caregiving of these parents has been built are both shaky and dangerous, and they need skilled support to create reciprocal and repairing interaction with their children and the secure attachment that is crucial to create optimal brain development in the child. By helping parents to connect with their babies, you help them disconnect from their own negative and violent childhood.

At first it may seem surprising that the trauma of one generation can be so closely re-enacted by the next, where there seems to be little connection between the two. However, there are a number of psychological and neurological pathways on which extreme events can travel through time. The psychological is to do with a subjective sense of identity while the neurological is more bound up with basic survival responses in the face of perceived threat. Where there is a particular behaviour adapting to events and this is retained, we are looking at a natural process that has a purpose. As with so many 'problems' that children present with, what is today labelled as undesirable or unfortunate may have once had a productive purpose in our evolutionary adaption. For our ancestors, for example, there would have been a time when being relaxed and laid back was not going to get you to reproductive age – better to get mean than get munched, better to reproduce as soon as possible if life may be short. A child or adult who rapidly developed the best possible traits to cope with dangerous or stressful situations, and then was able to pass this on to their offspring, was insuring the best possible chance of genetic survival.

There are many psychological mechanisms behind the intergenerational repetition of certain patterns of behaviour or, to be more precise, of personality traits. We all have a tendency to see in another person aspects of ourselves that we would rather not address. This process of unconscious projection is happening when we hear parents say that their child is just like some traumatising figure from their past. This type of projection changes the way we see someone, altering our attitudes and behaviour towards them and colouring our expectations and judgements. An infant, especially in the preverbal period of maximum dependency, will be acutely sensitive to this unconscious script and may become the child that their parents are imagining. A particularly negative example of projection is the baby who gets linked to a past abuser – 'He's just like…' – or where normal behaviour is misinterpreted – 'She's crying because she hates me.' Unless help is forthcoming, the baby becomes a frustrated and aggressive child, thus confirming the parent's initial viewpoint and locking the pair into an almost unbreakable cycle of conflict.

A child who has been frightened by a parent may show similar scary behaviour when he or she becomes a parent. How many times do we hear parents say they want to do things differently from their own mum or dad and then admit they are being just the same?

Both negative and positive traits are passed on to the next generation by the process of identification. A frightened child, say where there is violence in the household, will identify with the aggressor, both to deny their own fear and vulnerability and to gain safety through the approval that they imagine will come from copying such behaviour. There is also the more normal process of turning passive into active, where a child who has been on the receiving end of something unpleasant will later play out being the one in control. This lends itself to experimentation and mastery which, when combined with identifying with the aggressor and denying how frightening it was to be helpless, can produce a personality who unconsciously seeks revenge by one day re-enacting the behaviour, enraged by their own child's distress and vulnerability.

> *"By helping parents to connect with their babies, you help them disconnect from their own negative and violent childhood."*

Attachment Theory

In attachment theory, Bowlby (1969) re-used the concept of 'internal working models' to describe how our early relationships become internalised as a model of expectation about ourselves, others, and the relationships that we have with them. The internal working model is an unconscious process that guides all interpersonal behaviour, especially in intimate relationships, and the internal working model of attachment provides the template for the internal working model of caregiving. If violence or neglect was an accepted feature of the former then it may reappear again in the latter.

Attachment research has demonstrated a certain, but not invariable, continuity between the attachment representations, or styles, of the parent and the attachment behaviour of their infant. Warmer 'autonomous' parents tend to have secure children; distancing 'dismissive' caregiving leads to avoidant infants; enmeshed 'preoccupied' parents cause resistant or ambivalent behaviour; and dysregulated 'unresolved' parenting leads to disorganised attachment. Each category of adult attachment indicates a different quality of sensitivity, internal regulation, responsiveness and attunement to the baby's emotional signals, a matter of emotional availability. Unfortunately the most persistent pattern is the last one.

The internal working model of children who have experienced disorganised and frightening (which includes unavailable and unpredictable) caregiving includes low self-esteem, negative expectations of intimate relationships and the need to control, all of which will one day bias how they interpret and react to their child's behaviour. Unless something happens to make them question what they do, they will repeat the way they were parented. This 'software' is largely installed in the first two years of life, when the right cerebral hemisphere is in its phase of maximum growth and neuroplasticity is at a peak (here the circuitry for attachment, stress responses, emotional regulation and self-control are largely located).

Reflective Function

The concept of reflective function, the proficiency to treat others as psychological beings, to perceive and interpret behaviour as having a basis in 'invisible' factors such as feelings, attitudes and beliefs, is important here, and has been shown to be central to creating secure attachment in the developing child. Reflective function helps us put thought between experience and action, and links with the capacity for emotional regulation and resilience. Having this capacity means generational continuity of parenting is more often positive than not.

Maltreatment and fear disintegrate the mind, seriously compromising the basis for reflective function. When children who have been maltreated become parents they frequently show (in the Adult Attachment Interview) lapses in reasoning and quality of discourse when discussing their traumatic experiences. Mothers with a background of abuse and neglect tend to have children with disorganised attachment, and one of the ways in which this may be mediated is by distorted or absent reflective function specific to issues of trauma. Not only may maltreatment be unconsciously repeated, but, when stressed, the mother's attention may lapse and she might seem to withdraw from the infant, or even fear the infant, with maternal withdrawal being one of the strongest predictors of disorganised attachment and later psychopathology. The child's distress has reverberated with her own and triggered a response more appropriate to the then rather than the now. Such parents struggle to respond appropriately to their child's attachment needs and when children feel deserted or alarmed by someone who is meant to protect them, it frequently creates disorganised attachment.

Biological Processes

Mixed up with the psychological processes are the biological routes whereby a parent's experiences can influence their child's behaviour and even sometimes that of their grandchild. Early events can alter an infant's neurobiology and predispose them to certain behaviours in the future. The first 1001 days after conception, when neuroplasticity is at its maximum, are critical for the development of the brain. This especially applies to the right hemisphere where the main circuitry for self-control, emotional responsiveness, attachment and emotional-regulation are located. The child's experiences of parenting will be reflected in the structure of their brain. It is modifications to the normal stress responses that are most concerning, as over or under stress reactivity will invariably manifest in a parenting context – rage or dissociation. The experience of toxic stress associated with trauma, especially but not only in the first few years of life, can cause long lasting changes on both a neurological and genetic level. Stress rearranges both the way the children interpret the world and their genome, giving the latter a bias towards survival traits. Early adverse experiences are associated with a heightened impulsive responsiveness to negative stimuli, emotional lability and compromised executive functioning. None of these are advantages for parenting.

> *“Early events can alter an infant's neurobiology and predispose them to certain behaviours in the future.”*

Any form of intervention for a traumatised child, or an adult who cannot shake off responses that once were means of survival, must begin with creating safety within a relationship.

How Interventions Can Help

The older the child becomes, the harder it can be to re-wire certain areas of the brain. This means that without intervention a child who has experienced abuse or neglect as an infant will unwittingly continue with patterns of responses that are engraved in the neural networks and biochemistry of the mind, even if conditions change. However, relationship-based interventions such as (but certainly not limited to) psychotherapy have the capacity to take advantage of the continuing neural plasticity of the social organ that is the infant's brain. It takes a thought-out relationship to connect with another's emotional brain in a way that promotes healing rather than continues threat. Any form of intervention for a traumatised child, or an adult who cannot shake off responses that once were means of survival, must begin with creating safety within a relationship. Realistically, this will not occur quickly, and should take neurological factors into account, as should any other therapeutic intervention for that matter. The peak of neural plasticity occurs in infancy, natural adaptability on all levels is on the side of change, so it is clear that working to prevent maltreatment at as early a stage as possible is both kinder and more cost-effective in the long term.

Multidisciplinary specialised infant mental health early intervention teams are directly tasked to enable parents create the best possible relationship that they can with their infants, and services are offered from pregnancy up until the child's second birthday. But it is far better for help to be on offer at a more universal level and this is the huge strength of children's centres. There will always be a crucial role for midwives and health visitors in offering direct assistance and in referring on to other resources when necessary. Perinatal services are vital too, working with the mental health of the adult rather than the caregiving relationship. In addition, social policies that reduce the strain on families are important in breaking the negative cycle of parenting, for instance in reducing the impact of poverty, providing resources for early intervention services and improving educational opportunities beginning in nursery (play not instruction).

We now know how the generational repetition of parenting behaviours has multiple causality, the same processes can lead to a positive or negative outcome and the variability depends on experience. Those who work in an early years setting are in an advantageous position to intervene, an exciting responsibility. Just ask, 'How do you want your grandchildren to be treated?'

Reference

- Bowlby, J. (1969). *Attachment. Attachment and loss: Vol. 1. Loss.* New York: Basic Books.

Resources

- For evidence for the intergenerational transmission of parenting in a UK sample see: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4668327/
- A range of information on the long-term effects of early maltreatment on the developing brain of the infant, and much more besides, is available on: http://developingchild.harvard.edu
- For details of a network of services dedicated to breaking the inter-generational cycle of stressed parent-baby relationships see: http://www.pipuk.org.uk/home
- And for a Nobel Prize economist's research on the long-term savings that stem from early intervention see: https://heckmanequation.org
- A short paper on the opportunity to help parents and babies offered by the enhanced neuroplasticity of a baby and new parent can be downloaded at: http://ascend.aspeninstitute.org/pages/two-open-windows-infant-and-parent-neurobiologic-change
- Epigenetics and the influence of pre-birth experiences are beautifully described on: http://www.beginbeforebirth.org
- More information on epigenetics is on: https://www.whatisepigenetics.com/fundamentals/ and http://www2.le.ac.uk/projects/vgec/schoolscolleges/epigenetics_ethics/Introduction
- The Adverse Childhood Experiences (ACEs) Study carries detailed information about the outcomes of abusive experiences in childhood: https://www.cdc.gov/violenceprevention/acestudy/
- For further details of what we have learnt from attachment research see: http://www.psychology.sunysb.edu/attachment/index_legacy.html and http://www.child-encyclopedia.com/attachment/according-experts
- Three very useful sites for information about the early years and infant mental health are:
  http://www.imhpromotion.ca
  https://www.zerotothree.org
  http://www.aimh.org.uk

Separated Children and Trauma: Irish Law, Policy and Practice

Samantha Arnold, EMN Ireland, Economic and Social Research Institute, and Trinity College Dublin, and Sarah Groarke, EMN Ireland, Economic and Social Research Institute

Introduction

The United Nations (UN) Refugee Agency (UNHCR) reported that children accounted for 51 per cent of the refugee population in 2016 (UNHCR, 2017). UNHCR (2014) observed that separated children who arrive to Europe have to cope with uncertainty regarding: the family they left behind or from whom they were separated; the legality of their future residence; and discrimination or hostility in the host country. The Committee on the Rights of the Child (Committee), the body that monitors the implementation of the UN Convention on the Rights of the Child 1989 (CRC), suggests that separated children and unaccompanied minors[1] are a particularly vulnerable cohort of children forcibly displaced and on the move. More recent research also focusses on their resilience, or ability to overcome difficult experiences and thrive in host countries (e.g. Kholi, 2006; Ní Raghallaigh & Gilligan, 2010). While many separated children are resilient, studies have shown that refugee and asylum-seeking children are ten times more likely to experience post-traumatic stress disorder compared to their non-refugee peers. Fazel et al. (2012) found that prolonged absence of a parental figure further increases vulnerability of separated children to mental health problems.

> *“While many separated children are resilient, studies have shown that refugee and asylum-seeking children are ten times more likely to experience post-traumatic stress disorder compared to their non-refugee peers.”*

In accordance with the CRC, refugee and asylum-seeking children deprived of their family shall enjoy the same *special* protection and assistance as all other children in a given State (Articles 20, 22). Additionally, the CRC provides that all States must ‘promote physical and psychological recovery and social reintegration’ of children who have experience of exploitation, abuse, harm, or armed conflict (Article 39). The Committee (2005) reiterates States’ responsibilities to ensure access to appropriate services for children who are separated from families and have experienced loss, trauma, disruption and violence, to enjoy the CRC rights to the highest attainable standard of health, and to provide facilities for the treatment of illness and rehabilitation of health (arts. 23, 24 and 39).

European Union law also provides for special protection and safeguarding of separated children and unaccompanied minors in recognition of (*inter alia*) their vulnerability to harm, exploitation and trauma. *Directive 2013/33/EU of the European Parliament and of the Council of 26 June 2013 laying down standards for the reception of applicants for international protection (recast)* (Reception Directive) requires EU Member States to ensure adequate care arrangements, representation and access to appropriate services that facilitate physical and psychological recovery.

Ireland, within their rights as set out in the Treaty on the Functioning of the European Union, did not originally opt in to the Reception Directive(s).[2] However, in November 2017 the Government announced that it intends to do so, a decision which may have the potential to benefit children seeking international protection in Ireland. This article is therefore timely as it looks at the potential framework under the Directive alongside discussions on the current practice.

This article sets out the EU legal framework for the protection of unaccompanied minors specifically in relation to recovery from trauma. We then look at law, policy and practice in Ireland. Due to limitations on the length of the article, we chose to focus on two key provisions in the Reception Directive: care and rehabilitation services for child victims.

Overview of the Main Trends Regarding Separated Children in Ireland

UNHCR estimated that 750,000 applications for asylum were lodged by unaccompanied or separated children worldwide in 2016. In the same year, a total of 63,245 applications from unaccompanied minors were submitted in EU Member States, 57 per cent of which were lodged in Germany (35,935). Some 35 applications were submitted in Ireland, ranking 21st out of the 29 Member States (and Norway) which received applications from unaccompanied minors in 2016.[3]

1 Separated children are defined as children under 18 years of age, outside their country of origin and separated from both parents, or their previous legal, or customary primary caregiver (SCEP, 2009). Unaccompanied minors are defined as a minor who arrives on the territory of the Member States unaccompanied by an adult responsible for him or her whether by law or by the practice of the Member State concerned, and for as long as he or she is not effectively taken into the care of such a person; it includes a minor who is left unaccompanied after he or she has entered the territory of the Member States (Reception Directive). This paper uses the term separated children as it is the term used by the Child and Family Agency, Tusla, the public body with responsibility for their care.

2 Council Directive 2003/9/EC of 27 January 2003 laying down minimum standards for the reception of asylum seekers.

3 Eurostat.

The Child and Family Agency, Tusla's Social Work Team for Separated Children Seeking Asylum (SWTSCSA), the team that is responsible for the care of the majority of separated children in Ireland, reported receiving 126 separated children referrals, 82 of whom were taken into their care, in 2016.[4]

In 2017, the number of asylum applications in the EU considered to be unaccompanied minors decreased by 50 percent to 31,800. Ireland also saw a decrease in applications lodged on behalf of unaccompanied minors to 30 in 2017. However, referrals to the SWTSCSA increased in 2017; precise data on the increase is not yet available. The increase in referrals is partly due to Ireland's participation in the EU relocation scheme and the Calais Special Project (both schemes are discussed below).

Care and Continuity of Care

Article 24(2) of the Reception Directive states that EU Member States must provide appropriate residential placements for separated children, including: with adult relatives, with a foster family, in accommodation centres with special provisions for minors, or other suitable accommodation for minors.

In Ireland, section 14 of the International Protection Act 2015 (the 2015 Act) provides that Tusla is responsible for providing for the care of separated children in line with childcare legislation. Tusla's specific duties in respect of separated children are not set out in legislation or guidelines, however Tusla provides care in practice based on an 'equity of care' principle, according to which separated children receive the same level of care as other children in State care up to the age of 18. Each separated child is assigned a social worker and placed in foster care, supported lodgings or residential units (Quinn, Joyce and Gusciute, 2014).

The legal status of the separated child does not significantly impact upon the level of care a child under the age of 18 enjoys. However, status greatly impacts upon continuity of care for separated young people preparing to turn 18. There is no specific immigration status for separated children in Ireland and access to legal status can often depend on the avenue through which a separated child arrives in the State.

The majority of separated children referred to Tusla arrive in Ireland spontaneously,[5] with most referrals in 2016 comprising of children from Zimbabwe, Nigeria, Afghanistan, Albania, Somalia and the Democratic Republic of Congo (Arnold & Ní Raghallaigh, 2017). Most separated children arriving spontaneously eventually apply for international protection as a minor or later as an adult.

Under the 2015 Act, Tusla is responsible for deciding whether to apply for asylum on behalf of separated children in its care. However separated children who make an asylum application rarely receive a decision before they reach the age of 18. This is in large part due to the fact that social workers often delay the making of an application for international protection on behalf of separated children until they are close to the age of majority (Quinn, Joyce & Gusciute, 2014; Mannion, 2016; Arnold & Ní Raghallaigh, 2017).

The delay in obtaining a legal status may lead to variation in the level of access to services such as medical care and education, particularly when the child reaches adulthood (Quinn, Joyce &Gusciute, 2014; Mannion, 2016; Sirriyeh & Ní Raghallaigh, 2018). Aged-out minors are transferred from care to Direct Provision reception centres for adult asylum-seekers which restricts access to aftercare supports to which they may have otherwise been entitled had their status been addressed as a child (Ní Raghallaigh & Thornton, 2017). In addition, separated children who do not receive a decision on their application for international protection before turning 18, or 'aged-out minors', will no longer be entitled to apply for family reunification with their parents and minor siblings under the 2015 Act should they receive international protection status as an adult.

Since 2016, separated children have also arrived in Ireland under Government-led programmes. In September 2015, the Government established the Irish Refugee Protection Programme (IRPP) to admit up to 4,000 persons to Ireland in response to the increase in people seeking asylum in Europe. The IRPP gives special priority to separated children and commits to putting in place special arrangements to support their needs. Some 14 separated children from Syria and Iraq were subsequently relocated from Greece to Ireland in line with the EU relocation scheme. A further 41 separated children from Afghanistan, Eritrea, South Sudan and Syria were admitted to Ireland from the former migrant camp in Calais under the Calais Special Project. In contrast to those arriving spontaneously, separated children arriving from Calais are granted programme refugee status on arrival, which does not require the child to go through the international protection process and spend protracted

4 Those not taken into care may have been reunited with family or determined to be over the age of 18, for example.

5 Separated children are said to arrive spontaneously when they present at a land/sea border or airport by their own means or with the assistance of an adult who is not their primary carer, outside of government-led programmes for admitting asylum-seekers or refugees to Ireland.

periods in uncertainty about their legal status.[6]. With international protection or programme refugee status a separated child is immediately entitled to seek and enter employment, access education and training and social welfare benefits in the same manner as Irish citizens. They are also entitled to apply for family reunification with parents and siblings under the age of 18 within one year of being granted international protection or programme refugee status under the 2015 Act.

Recovery from Trauma

Research published in 2010 in Ireland found that separated children's exposure to traumatic situations of war, persecution and loss of family places them at risk of developing mental illness, including depression, post-traumatic stress or anxiety disorders (Abunimah & Blower, 2010). Since then, studies with separated children who have arrived spontaneously in Ireland have found that accessing the international protection process, and the delays therein, including the possibility of being transferred to Direct Provision accommodation/ deported on turning 18, is a significant source of anxiety and stress for separated children (Ní Raghallaigh, 2013; Smyth, Shannon & Dolan, 2015; Mannion, 2016). The lack of status may therefore further exacerbate the trauma caused by experiences prior to arrival, particularly when the child is ageing out of care.

> *"...separated children's exposure to traumatic situations of war, persecution and loss of family places them at risk of developing mental illness, including depression, post-traumatic stress or anxiety disorders."*

Article 23(4) of the Reception Directive places an obligation on Member States to ensure access to rehabilitation services specifically for minors who have experience of 'abuse, neglect, exploitation, torture or cruel, inhuman and degrading treatment, or who have suffered from armed conflicts'. In addition, Article 23(4) requires Member States to ensure appropriate mental health care is developed and qualified counselling is provided when needed.

In Ireland, Tusla carries out a multi-disciplinary intake assessment of each separated child's needs, including a medical examination and referral to specialist services where necessary. All separated children are entitled to a medical card, which provides for access to specialised services for victims of torture, sexual violence of other conflict-related trauma. However, such services are not widely available. Spirasi, an NGO providing rehabilitation services for asylum-seekers, refugees and migrants who are victims of torture and severe trauma, is the only national provider of such services in Ireland. While separated children may avail of services provided by Spirasi, Spirasi is limited in its ability to provide for all individuals referred to its service due to resource constraints (Spirasi, 2017). As the service is based in Dublin, separated children who may need specialised services but have been placed in care outside the Dublin area may be further restricted in accessing appropriate services. The lack of continuity of care for those turning 18 may also impact upon their access to or continuation of mental health and other psychosocial supports accessed during time spent in care, in particular where separated children are transferred to Direct Provision centres outside the Dublin area.

Spirasi (2017) has expressed concern at the lack of specialised rehabilitative services and therapeutic support specifically for children and adolescents in Ireland. The lack of specialised services has been the focus of UN criticism, with the Committee against Torture (2017) most recently stating that Ireland must ensure all refugees who have been tortured have access to country-wide rehabilitation services. Stakeholders have highlighted the need for comprehensive mental health screening, access to mental health services and psychosocial referrals, particularly for separated children on arrival in Ireland (Abunimah and Blower, 2010; Arnold and Sarsfield Collins, 2011; Royal College of Physicians of Ireland, 2016). The Committee on the Rights of the Child (2016) has recommended that Ireland strengthen supports, including psychological assistance, rehabilitation, and social reintegration, to address the trauma faced by children who have been exposed to armed conflict.

Conclusions

Care for separated children in Ireland is among the best in Europe. In line with the 'equity of care' principle they receive the same care as any other child under the age of 18 in Ireland.

Separated children are more likely to experience depression, post-traumatic stress disorder and other mental health problems compared to their non-refugee/ asylum seeker counterparts. In Ireland, equitable care allows separated children to access a host of health and mental health services available to all children in the country. In addition, Dublin-based Spirasi provides

6 Parliamentary Question 14 February 2017 [7044/17], oireachtasdebates.oireachtas.ie.

tailored support for young people who have experienced trauma. Spirasi is, however, dependent on public and private funds and therefore the continuation of projects which target children into the future is not guaranteed. In accordance with the Reception Directive, rehabilitation services, i.e. appropriate mental health care and counselling provided by qualified practitioners, must be available to minors who have experience of abuse, neglect, exploitation, etc. Ireland has signalled that it will soon opt in to the Directive and, in order to fulfil this obligation, it may be necessary to establish specialised services within mainstream health institutions and/or increase funding to services like Spirasi that already have expertise.

The child's legal status may further impact upon the continuity of rehabilitation services. Due to systemic and other delays, the majority of separated young people receive a decision on their applications after they turn 18. As children approach 18, they start to worry about the potential for a negative decision, return to their country of origin or a transfer to a Direct Provision centre which might be some distance from the schools they attended, their foster families and their social and other support networks. A lack of a durable solution as to status and a lack of continuity as regards care and social networks may affect separated children's feelings of stability. It is recommended therefore that resolving separated children's legal status before 18 forms part of a holistic plan to treat and rehabilitate those who have experience of trauma.

Having a resolution of their legal status before 18 also allows separated children to apply for family reunification, which would aid their recovery as research shows children separated from their family are more likely to experience mental health difficulties when compared to their *accompanied* refugee/asylum seeker counterparts.

These challenges disproportionately affect spontaneously arriving separated children who often wait years for a decision on their application for protection/residence permission.

EMN Ireland is the Irish National Contact Point of the European Migration Network and is part of the Economic and Social Research Institute (ESRI).

For more information see www.emn.ie

References

- Abunimah, A. & Blower, S. (2010). 'The Circumstances and Needs of Separated Children Seeking Asylum in Ireland', *Child Care in Practice,* Vol. 16, No. 2, pp. 129-146.
- Arnold, S. & Ní Raghallaigh, M. (2017). 'Unaccompanied Minors in Ireland: Current Law, Policy and Practice', *Social Work and Society,* Vol. 15, No.
- Arnold, S. & Sarsfield Collins, L. (2011). *Closing a Protection Gap: National Report 2010 – 2011,* Dublin: Irish Refugee Council.
- Kohli, R. (2006a). The comfort of strangers: social work practice with unaccompanied asylum seeking children and young people in the UK. *Child and Family Social Work,* 11, 1-10.
- Fazel, M., Wheeler, J. & Danesh, J. (2005). 'Prevalence of Serious Mental Disorder in 7000 Refugees Resettled in Western Countries: A Systematic Review', The Lancet, vol. 365, no. 9467, 9 April 2005, pp. 1309–14.
- Fazel, M., Reed, R., Panter-Brick, C. & Stein, A. (2012). 'Mental Health of Displaced and Refugee Children Resettled in High-income Countries: Risk and Protection Factors', The Lancet, vol. 379, no. 9812, 21–27 January 2012, pp. 266–82.
- Mannion, K. (2016). *Child Migration Matters: Children and Young People's Experience of Migration*, Dublin: Immigrant Council of Ireland.
- Ní Raghallaigh, M. (2013). *Foster care and supported lodgings for separated asylum seeking young people in Ireland: the views of young people, carers and stakeholders,* Dublin: Barnardos & HSE.
- Ní Raghallaigh, M. & Gilligan, R. (2010). Active survival in the lives of unaccompanied minors: coping strategies, resilience, and the relevance of religion. *Child and Family Social Work* 15 (2), 226-237.
- Ní Raghallaigh, M. & Thornton, L. (2017). 'Vulnerable Childhood, Vulnerable Adulthood: Direct Provision as Aftercare for Aged-Out Separated Children Seeking Asylum in Ireland', *Critical Social Policy,* Vol. 37, No. 3, pp. 386-404.
- Quinn, E., Joyce, C. & Gusciute, E. (2014). *Policies and Practices on Unaccompanied Minors in Ireland.* European Migration Network, Dublin: Economic and Social Research Institute.
- Separated Children in Europe Programme (SCEP) (2009). *Statement of Good Practice* (4th edition). Copenhagen: Save the Children.
- Sirriyeh, A. & Ní Raghallaigh, M. (2018). 'Foster care, recognition and transitions to adulthood for unaccompanied asylum seeking young people in England and Ireland', *Children and Youth Services Review.*
- Smyth, B., Shannon, M. & Dolan, P. (2015). 'Transcending borders: Social support and resilience, the case of separated children', *Transnational Social Review*, Vol. 5, No. 3, pp.274-295.
- Spirasi (2017). *61st Session of the UN Committee Against Torture: Spirasi's Submission on Ireland,* available at www.ohchr.org.
- UN Committee against Torture (2017). *Concluding observations on the second periodic report of Ireland, CAT/C/IRL/CO/2.*
- UN Committee on the Rights of the Child (2016). *Concluding observations on the combined third and fourth periodic reports of Ireland, CRC/C/IRL/CO/3-4.*
- UNHCR (2017). *Global Trends: Forced Displacement in 2016,* Geneva: UNHCR.
- UNHCR (2014). *The Heart of the Matter: Assessing Credibility when Children Apply for Asylum in the European Union,* Brussels: UNHCR.

The Challenging Real Experiences of Children who are Refugees

Imelda Graham

Since May 2016 Imelda Graham, current Chairperson of the National Childhood Network, has worked in a volunteer capacity with the children of refugees in Lesvos in Greece. This work involved developing a kindergarten in an independent refugee camp, Lesvos Solidarity camp at Pikpa. This has evolved into a forest school, Mikros Dounias, where refugee and Greek children play and work together. The camp also still has the original kindergarten, catering mainly for children over six.

Children who are or have been refugees are among the most marginalised children in the world at this time. These children have been dispossessed and are experiencing things that no child should experience. This can include endless transitions, grief for loss of their homeland and previous lives, grief for loss of many family members, loss of their rights under the United Nations Convention on the Rights of the Child, uncertainty and stress.

Refugee children have the odds stacked against them in their daily lives with language barriers, cultural changes and differences, some with disabilities and little support, and communal living if they are in a refugee camp, Direct Provision or in another group residence.

For young children, these experiences may be the only life that they have known. Some have lost siblings while others have been witness to torture, murder and the violence of war, many live with adults who are severely traumatised themselves. The responses of these younger children vary. When a child reaches a more secure environment with their family, there will be the child who is coping, the child who is struggling but improving, and the child who is in need of professional support.

For early years educators working with children who are refugees, the theme of well-being in Aistear, the Early Childhood Curriculum Framework in Ireland, is of crucial importance. The emotional state of some of the children, the hyper-arousal and perpetual fight or flight state of being, means that focusing on work and learning can be a challenge. It is important to recognise this and provide suitable support tailored to individual needs. It is also helpful to remember that children who appear to be improving may have periods of regression, either due to family circumstances or to bad memories surfacing. Vigilance and understanding based on knowledge of the child and the family is vital on the part of the sensitive educator. Key worker systems help in this regard.

For educators who are unfamiliar with the needs of children who have been refugees, it can help to look at some real-life examples drawn from others' experience of working in a refugee camp. Each child has his or her own back story, and when particular difficult circumstances are known, educators can respond appropriately. For example, one young boy we worked with in the refugee camp in Lesvos was continually on the look-out for the well-being of his siblings, and at the slightest provocation would launch into a physical attack, in quite an agitated manner. In sessions, we constantly reassured him that we would address anything that affected his siblings so that he was free to continue with his own work and play, and just be a child.

Another little boy, a couple of years younger than the group of boys with whom he wished to play, was being excluded. On observing this over a period of time, it was apparent that he had poor social skills, a quick temper, difficult family circumstances and also that he spoke a different language, Farsi, from most of the other boys

in the camp, who spoke Arabic. Multiple strategies were employed with him, including individual support where possible and modelling that his work had equal importance to that of others, ensuring that others did not harm it, and then helping him to display the same understanding in turn. One of the damaging tactics that he used when rejected included stone throwing. A colleague from the Middle East spoke of how this may have been quite normal there, and he may have learned this behaviour when younger. His back story and his family circumstances were very difficult, but using consistent warm responses and guidance paid dividends. He was particularly fond of the story *Jack and The Beanstalk*, so using Fe Fi Fo Fum as a reminder for him helped him in a fun way (Fe = no rock throwing, Fi = no kicking, Fo = no hurting the babies and toddlers while Fum = no spitting).

While life may still be difficult when children move into a stable environment, using the Aistear framework, which can offer many means of expression as well as varied equipment and resources, produces some wonderful play moments and visible improvement in concentration, self-regulation and focus in direct work in the refugee camp. One child we worked with, who has dyspraxia, was offered many choices to help him with his coordination and with his social skills – big Lego blocks were bought which he particularly enjoyed working with.

The most popular play opportunities are those that are open-ended, and enable individual expression and learning. These are painting, playdough and junk art as well as chubby paint brushes, and large chalks and crayons to accommodate all abilities and ages. These all offer the multiple means of expression and representation that the children seem to need. For example, the fine motor skills of many children who are refugees are very weak, possibly as they have had limited opportunity while in transition to develop these. The development of fine motor skills can be supported by providing children with a variety of resources such as the obvious ones for cutting and threading, and little art stickers, which need a lot of coordination.

Being in a stable, safe environment is a great benefit to children. To establish a sense of calm in sessions, bring story and book time forward to the beginning of the sessions, along with calming nursery rhymes. Working in this way with one seven-year-old girl caused her to make massive strides in calming and settling down, interacting well and taking turns. She took part in the children's choir and drama work, and was less aggressive and disruptive. Her previous experiences, which gave her nightmares, included running from three homes which were burning down around her. After a year of coming to our setting one of her parents was diagnosed with a serious illness.

Her behaviour quickly reverted to the way it had been in her early days in the camp: destructive, angry and aggressive. She was emotionally flooded, and acting out where she had felt safe, with educators who could hold these emotions with her and help her to calm and repair.

Awareness, sensitivity, acceptance and a consistent routine based on meeting the child's emotional needs are crucial tools in supporting children with these experiences. By placing an emphasis on using open-ended materials and resources, children can work through their feelings in their own way. The educators' knowledge and experience will help them in planning for each individual child and identifying when a child's trauma requires further therapeutic support.

Trauma Smart:
Healing Communities through Trauma Informed Care

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Introduction

> *I went to school to learn to teach young children. You know, writing their name, using scissors, saying please and thank you, sharing with friends. I wasn't prepared for the level of frustration, anger, and sadness in my students. It was overwhelming, and I was so tired every day.*
>
> Head Start Teacher

Students and teachers bring their life experiences into the classroom every day. Too often, children are exposed to traumatic events, such as abuse, bullying, witnessing violence and separation from parents due to incarceration and deportation. Understanding how traumatic events may impact students' emotions and behaviours, and creating an environment for all students to feel safe to learn, underlies a growing movement towards establishing trauma-informed schools.

Research has clearly shown that trauma can have a significant impact on behaviour and performance in the classroom (NCTSNSC, 2008). Children who have experienced complex trauma often have difficulty regulating their emotions and may demonstrate 'fight, flight or freeze' responses. Without proper training and skills, caring adults may negatively impact children when responding to undesired behaviours.

This article presents lessons learned from the Trauma Smart® (TS) model. TS is designed to support pre-kindergarten and elementary age children in the US, and the adults who care for them, with hands-on, practical tools and effective strategies used in the places where kids learn every day. TS goals include:

- Teaching school staff and parents about the life-long effects of trauma and the importance of teaching healthy resiliency skills.
- Teaching and supporting parents and school personnel in how to help children learn to express their emotions in a healthy way that prepares them for social and academic success.
- Guiding educational organisations to develop trauma-informed, resilient cultures that inspire teachers, school staff, parents and students to thrive.

The Trauma Smart® Model

Crittenton Children's Center is a psychiatric hospital for children and adolescents in Kansas City, MO, USA. As part of a community mental health prevention programme, Crittenton provided therapy and mental health services to Head Start agencies and schools in the Kansas City area for over 20 years. While therapy was helpful for individual children, Crittenton staff perceived something more profound happening at the school and community level that need to be addressed if children were to heal from the impact of trauma.

During a three-year period, one Head Start Community experienced over 30 deaths of children, parents and staff. At the same time, Crittenton therapists knew about other traumatic events school staff and families were experiencing; such as incarceration, separation from parents, abuse, neglect, substance abuse and mental illness. The challenge these chronic and pervasive traumatic experiences created was apparent in increasingly difficult behaviours exhibited by students. Crittenton could not stop bad things from happening, but therapists were inspired to find systemic, multi-generational, real-life solutions that would assist communities in healing.

Trauma Smart (TS) was founded on evidence-based interventions recognised by the National Child Traumatic Stress Network to be effective in helping children and adult caregivers to effectively address the negative impact of violence and trauma. It was initially implemented in three Head Start programmes that included 15 locations in urban areas. Today, TS is practised in urban, suburban and rural locations across the United States. A full description of the model as initially implemented is available (Holmes, Levy, Smith, Pinne & Neese, 2015).

Trauma Smart®: A Transformational Approach

TS intends to create a culture shift within a school community through common language, concepts, and practices that over time result in fully trauma-informed organisations. Integrating education, mental health and overall child well-being into one model, the five pillars of Trauma Smart include:

1. A Trauma Informed Care (TIC) Leadership Team
2. Staff Training: Staff Resilience and Skill Building
3. Coaching: Mastery of Classroom Strategies
4. Smart Connections Caregiver Workshops: Parent Engagement and Skill Building
5. Individualised therapeutic intervention: Enhanced Response for Children with High Needs

More detail about each of these five pillars follow.

The Trauma Informed Care (TIC) Team

The TS consultant works with members of a dedicated team of school staff to plan for sustaining the TS model in the school community long after initial implementation with Crittenton ends. The TIC team is composed of decision makers, teachers, family service workers and other staff who are committed to assisting their peers, supervisees, children and families in implementing TS and becoming more trauma informed.

The goal of TS is to create a philosophical shift within a school community about how to respond to children and adults who may have experienced trauma. Rather than ask 'what is wrong with this child?' adults learn to ask 'what might have happened to this child?' Adults then learn to identify the need the behaviour expresses and help the child get their need met through healthy response. The TIC team is essential for setting specific goals for the school community as a whole and then in supporting staff as they learn to make the shift.

Staff Training: Staff Resilience and Skill Building

School staff, including teachers, administrators, mental health providers, bus drivers, kitchen staff and others, receive 20 hours of training in foundational knowledge and skill building to respond effectively to others. Training occurs in 5 to 10 sessions over the course of the school year.

Trauma Smart training is grounded in Kinniburg and Blaustein's Attachment, Self-regulation and Competency (ARC) Framework for fostering resiliency. Children who have experienced trauma often exhibit deficits in their ability to attach in healthy ways to adults and peers and to regulate their emotion and energy so they are able to be successful in interactions and gain competency in the skills needed for success in school and life.

Training is highly interactive and staff leave each lesson with ideas, skills and tools they can begin to implement immediately.

TS recognises that caregivers' capacity to effectively manage their own emotions and behaviours is crucial to their ability to guide children through difficult times. Helping stressed children is challenging work. Caregivers who are unable to control their own feelings of frustration and anger are at risk of negatively impacting the child, themselves and others.

TS educates staff members about secondary trauma and equips them with self-care strategies easily used in and outside of the classroom. As one teacher trained in TS observed:

> *Making sure we were communicating with each other throughout the day about our energy and feelings was helpful not only for our bonding – for making us a strong team – but also insured that we had a strong foundation for dealing with some of the more challenging behaviours. Trauma Smart gave us the language to talk about our stress, how we were feeling, and the impact that had on our ability to be there for our students.*

Coaching: mastery of classroom strategies

Each school community selects staff members to coach others between training sessions. Coaches reinforce the application of lessons learned in training sessions by observing the classroom, modeling concepts and skills, and supporting teachers to incorporate effective strategies. Coaches receive specialised training.

TS trains coaches within the school to help teachers transfer the lessons learned in training to practice in the classroom. The case of Mrs. Smith and her student 'Cara' illustrates TS classroom coaching.

Cara pinched Mrs. Smith whenever she walked by. Mrs. Smith found herself avoiding Cara because her pinches hurt! The Trauma Smart coach helped Mrs. Smith reframe this aggravating behaviour by considering what need Cara might be expressing. They hypothesised that perhaps Cara was trying to make a connection with Mrs. Smith and this was the only way she knew how. The coach encouraged Mrs. Smith to find other ways to connect with Cara. Mrs. Smith taught Cara to give a high five instead of pinching. Now, every time Mrs. Smith walks by Cara she smiles, makes eye contact and puts out her hand for a high five. Cara beams and high fives her right back.

Coaching provides opportunities for teachers to discuss, practise and receive feedback. While the primary intent of coaching is to help teachers create a more sensitive classroom overall, coaching support also validates the very normal feelings (e.g. frustration, uncertainty) that adults often experience in their work with children exhibiting diverse emotional challenges.

Smart Connections® Caregiver Workshops: Parent Engagement and Skill Building

Parents and other caregivers are educated about trauma's impact and given opportunities to improve their skills to more effectively teach their children and themselves how to be more resilient. School staff receive specialised training to present Smart Connections curriculum to parents and other caregivers.

Similar to training provided to staff, parents and caregivers receive education, modeling and opportunities for guided practice. For example, as part of the training module, 'Routines and Rituals', parents are asked to reflect on their own morning routine and what happens with their bodies, emotions, and energy levels when the routine is disrupted (e.g. when one oversleeps). In reflecting on their own experiences, participants are reminded that routines decrease anxiety and increase feelings of safety. Parents are encouraged to explore ideas for daily routines around homework, mealtime and bedtime. Training parents and caregivers ensures that children experience consistency across home and school environments and extends the supportive, trauma-informed culture into the broader community.

Charity's mother, Elise, has been in jail for two months. Charity is living with her grandmother Nan until her mother comes home. Charity's teacher noted that the little girl was easily frustrated and angry at school. Nan shared with Charity's teacher that Charity is not sleeping well and often falls asleep late in front of the TV. When Nan tries to move Charity into her bed, she wakes and cries for her mother. Nan attended Trauma Smart workshops and learned to create a bedtime routine that helped Charity ease her anxiety. After dinner, Charity snuggled with her grandmother and watched a show on TV. After a warm bath, Charity and Nan share a book and some quiet conversation in bed. Within the week, Charity was looking forward to her evening time with her grandmother. She got more rest and was able to handle frustrations at school the next day.

Individualised therapeutic intervention: enhanced response for children with high needs

When adults learn skills to assist children who have experienced trauma, the need to remove those children from the classroom for therapy or other services decreases. However, some children will benefit from intensive one to one intervention.

TS data indicates that 92% of children referred to TS therapists experienced at least one traumatic incident, 79% experienced two or more events, and 69% had three or more incidents (Boulden, 2015, p. 3). Most frequently experienced events included separation from parents (59%), family member incarcerated (53%) and having someone in the home abusing drugs or alcohol (42%) (ibid). For these children, more intensive intervention, often focused on helping children change their thinking and beliefs about themselves, is provided by TS clinicians or community mental health providers.

Evan's teacher says, 'Evan was so defeated. When his dad left, it seemed like he blamed himself. His therapist helped Evan identify what he was really feeling and then talked to his mom and to me about it. She also taught him ways to express his feelings so that others would know what he needs. He has started laughing again!'

Results are Promising

TS tracks a variety of evidence based outcomes to determine the effectiveness of the intervention.

Classroom Climate: Based on results from the Classroom Assessment Scoring System (CLASS) between 2008 and 2013, classroom environments showed statistically significant improvement with Trauma Smart implementation.

Individual Therapeutic Intervention: Data collected on the Achenbach Child Behaviour Checklist and Teacher Report Form suggests significant changes in teacher reports of attention problems as well as all externalising problems (Boulden, 2015, p.6) in children referred for trauma sensitive therapy.

School-wide philosophical shift: In 2016, Trauma Smart implemented the Attitudes Related to Trauma Informed

Care (ARTIC) scale. Early results show statistically significant improvement in the way teachers view behaviour and the impact of trauma.

Since implementing TS this year, we have reduced the staff in the behaviour management classroom because the incoming preschoolers from a Trauma Smart school have little to no reported behaviour concerns.
Behaviour Management Classroom Teacher

Lessons Learned From Trauma Smart Schools

- **Trauma happens everywhere.** Given national rates of exposure, it is highly likely there are a significant number of children within a given school dealing with the effects of trauma. Trauma is an issue for all communities and no one is immune to exposure. Promoting trauma-informed approaches like Trauma Smart helps traumatised children heal and all children benefit from an environment focused on building resiliency skills necessary for academic and life success.
- **Everyone can learn to respond.** Sustaining a trauma-informed culture requires the engagement and buy-in of the entire school. Training for all staff members is needed for true transformation. Training needs to focus on clear and practical applications that can be used in a variety of settings – classroom, home, and community.
- **Classrooms are key.** Ongoing training, regular support and reinforcement of the concepts and skills learned is needed. Coaching opportunities can ensure lessons are translated into practice and offer support for dealing with challenging behaviours.
- **Caring for children who have experienced trauma is hard.** Strategies should include resources for teachers, caregivers and other adults involved with children. Self-care is essential to helping others.
- **Schools and districts need support too.** Society often turns to schools when children's needs are identified. Many of the expectations for schools are applied without additional resources. Given what is known about the impact of trauma on learning, development and long-term well-being, policy makers and funders should consider what supports, including funding, are needed for schools and districts to shift to more trauma informed environments.

Developing Skills that Benefit for a Lifetime

When young children and their families learn about the impact of trauma and what they can do about it, they develop the skills needed to be resilient no matter what adversity comes their way. These skills can truly change the trajectory of the life of the child and the family.

Schools committed to becoming trauma-informed can benefit from practical, comprehensive approaches that include training, coaching and therapeutic intervention. Trauma Smart data show benefits to providing teachers, children and their families with practical skills they can easily integrate into their school, home, and community life. Trauma-informed teachers and other caregivers can help all children build resilience by identifying their feelings, teaching them to regulate their emotions, and building their competencies to respond to future adversities in healthy, effective ways. This approach also helps ensure that adults do not inadvertently 're-traumatise' children who may still be struggling with the effects of their experiences. With the high prevalence of children exposed to traumatic events, part of the promise of the TS model is creating trauma informed schools that can benefit all children and help them develop healthy coping skills essential to learning and life success.

One teacher noted the following:

Trauma Smart helped me to look at [my students and myself] differently. To know that it isn't about me. If I can help the children feel safe with me and help them regulate themselves, they will be ready and able to participate in all of the things I have to teach.

More information is available at www.traumasmart.org.

References

- Blaustein, M., & Kinniburgh, K. (2010). Treating traumatic stress in children and adolescents: How to foster resilience through attachment, self-regulation, and competency. New York: The Guilford Press.
- Boulden, W.T. (2015, June). *Crittenton Trauma Smart replication 2014-2015 evaluation report.* Kansas City, MO: Resource Development Institute.
- Holmes, C., Levy, M., Smith, A., Pinne, S., & Neese, P. (2015). A model for creating a supportive trauma-informed culture for children in preschool settings. *Journal of Child and Family Studies*, 24(6), 1650-1659. doi: 10.1007/s10826-014-9968-6. http://www.ncbi.nlm.nih.gov/pubmed/25972726
- National Child Traumatic Stress Network Schools Committee (NCTSNSC). (October 2008). *Child trauma toolkit for educators.* Los Angeles, CA & Durhan, NC: National Center for Child Traumatic Stress.
- Trauma-informed schools. (2017, April 7). Retrieved from http://www.countyhealthrankings.org/policies/trauma-informed-schools
- Verbitsky-Savitz, N., Hargreaves, M.B., Penoyer, S., Morales, N., Coffee-Borden, B. &Whitesell, E. (2016). *Preventing and Mitigating the Effects of ACEs by Building Community Capacity and Resilience: APPI Cross-Site Evaluation Findings.* Washington, DC: Mathematica Policy Research. Available at: https://www.mathematica-mpr.com/our-publications-and-findings/projects/community-based-family-support-networks-to-reduce-adverse-childhood-experience

Children with Kindled Stress Responses

A Self-Regulation vs. Self-Control Lens

Susan Hopkins, Executive Director and Stuart Shanker, CEO, The MEHRIT Centre, Canada

Ewan and his mum arrived in a flurry, late yet again for circle time and the morning routines. Mum's elevated stress level was easy to pick up. You could almost hear her racing heart and feel her growing frustration as she tried to get her son's hoodie off and shoes changed to indoor shoes. Ewan wasn't cooperating and within a minute the coaxing turned in to under-the-breath threats of no tablet tonight and the ominous, 'Get over here, now, before I call your dad to come down here.' The threatened consequence prompted the very opposite of the compliance that mum was targeting. Everything escalated quickly. The next thing I knew Ewan was hitting his mum in the arm with a loud, "No, no, NO!"

Within seconds, early childhood educator (ECA) Rosa came down the hall with a hand extended, 'Come my boy, come let's go see the other kids. They'll be glad you're here.' Down the hallway Ewan barrelled without a moment's thought, mum sighing with audible relief, and I garnered a snapshot of just how depleted mum was in that moment. It wasn't hard to imagine that this scenario played out over and over again and extended well beyond morning drop-off time. Mum was exhausted: depleted, defeated, and seemed very alone. She was out the door as quickly as she could manage, which was literally seconds later.

The early childhood centre's manager Kate told me a few minutes later in her office that she was very worried about four-year-old Ewan. I learned from Kate that Ewan would 'flip' into defiance and aggression in a heartbeat. He had good moments but there were multiple emotional meltdowns every day. The early childhood educators (ECEs) were constantly intervening to protect the other children from being caught in an angry outburst. They also tried gently to support Ewan, modelling and mentoring him through the incidents as best they could manage. Ewan had hurt some of the children at the centre, sometimes by accident but often times it appeared to be on purpose. He had also bitten several of the ECEs. They'd all but given up on trying to get him to go to take a nap with other children. When Ewan decided he wasn't going to do something, he made sure you knew it.

Ewan had been coming to the centre since he was six months old and everyone sensed that his home life was chaotic. Ewan and his mum were away from the community when he was two for a few weeks. The rumour in the community was that the family was staying in a women's shelter, but no one really knew for sure. They did know that mum always seemed anxious and the tears would come easily. Sometimes she could be very harsh with her words and she often stormed away. The next day she'd return with Ewan and it was always as if nothing had happened.

This was Ewan's last year at the centre. Next year Ewan would be off to his first year of formal schooling and Kate wasn't sure he was ready for them or that they would have the patience and compassion to support Ewan's needs. Kate cared deeply about this child, that was evident, but she was also at a loss as to how to support Ewan so that he could develop the self-regulation she thought he was

desperately lacking. She wondered if they were helping him when they lovingly welcomed him in their arms after he'd been unkind to other children. And she wondered if they were teaching him that it was okay to lash out, like he had with his mum that morning, each time they redirected his attention and moved on from an incident. Sure, they talked about all the issues later by looking for those magical windows for connection and learning, but was that the right thing to do or was that adding to the misbehaviour they were seeing?

> *'None of us are at our best when we're tired or stressed out, especially kids. In fact, much of what we see as "misbehaviour" in kids is actaully "stress behaviour" – the result of being over-stressed, unaware of it and unaware of what to do about it'*
>
> www.self-reg.ca

Kate was right: Ewan was struggling with self-regulation. But what do we mean by this term? Google 'self-regulation' and you will find many different definitions, and most will have something to do with applying self-control to manage one's behaviour, emotion, learning, and moods. Are self-control and self-regulation the same thing?

Clearly Ewan was struggling with self-control. Mum's coaxing to get his shoes changed didn't foster the necessary self-control to arrive at compliance any more than the threat of taking away his tablet. The incidents that the centre was experiencing each day with Ewan were further examples of Ewan's problem with self-control. Kate was rightly worried about what this would mean for his next year in school. If Ewan couldn't manage his own behaviour now and it was causing him so many problems with peers and adults alike, what would that mean for his first year at school?

Ewan wouldn't grow that sought after willpower and self-control by being placed on the time out chair or scolded until he learned better and took accountability. He might adapt to a well-implemented behaviour management strategy and do better, or he might just do worse, a lot worse. Why? The problem isn't self-control, it's self-regulation and Self-Reg could help.

Self-Reg is a framework, developed by Dr Stuart Shanker, to help children acquire strategies for dealing with stress that enable them to stay calm, socially engaged, and able to learn. Self-Reg is a valuable and accessible tool for children, youth, and adults as well as people who care about and work with them.

The term self-regulation was introduced to describe how we respond to being over-stressed. Some children become hyper-aroused and some become hypo-aroused. In the former state, the child may try to restore "homeostatic balance" by moving around a lot, soliciting attention, even by provoking confrontations. In the latter state, the child may try to flee from the stress, shut down interactions, numb the emotions they find stressful. Both of these kinds of responses are said to be maladaptive insofar as they impede development.

> *'It is essential that we do not confuse self-regulation with self-control. Self-control is about trying to inhibit impulses; self-regulation is about reducing the incidence and intensity of impulses in the first place. Self-regulation is what makes self-control possible, and in most cases, unnecessary.'*
>
> Dr Stuart Shanker

You can't solve a self-regulation problem by working on self-control. When your underlying brain-body systems are regulated, in other words within the acceptable range for maintaining homeostasis, then you can easily access and choose to exercise self-control – if, that is, this is still necessary. You can't just conjure up the willpower to persevere and do better when your "limbic alarm" – the brain's threat detector – has been triggered. And children who have – experienced trauma have an alarm that is very easily triggered.

Ewan certainly couldn't simply decide to be nicer to his mum at morning drop-off and then have that be the end of the behaviour outbursts. He arrived in an overstressed state, mirroring and exacerbating his mum's state. In all likelihood, Ewan spends a lot of his time in a brain-body state that leaves him hyper-vigilant against threats in the physical, emotional, cognitive, social and prosocial domains, and likely with an internal stress storm that quickly depletes his energy and resources to deal with stress.

This story of a kindled stress response and a lack of internal resources to manage the related tension and energy needs applies as much to Ewan's mum as it does to Ewan, Kate, the ECEs, the other children at the centre. There are three Self-Reg principles to always bear in mind when working with a child like Ewan:

- There is no such a thing as a bad child.
- There is no such thing as a child who can't learn how to self-regulate.
- There is no such thing as a trajectory that can't be changed.

The key to realising these guiding principles is to understand the effects of trauma. A good way to understand this is to think about what happens when your body gets really cold. The brain starts trying to 'turn up the heat' in order to prevent hypothermia. First,

you start to shiver. A small system in the limbic system sends a signal to the muscles to start vibrating in order to generate heat. Your heart rate and blood pressure and even your breathing rate go up for this purpose. But all this burns a lot of energy. So the brain turns off some body functions in order to keep going. All that matters is to keep you warm enough to protect the brain from getting damaged by the cold. Things like digestion, blood flow to your fingers and toes, and even parts of the brain that we use to pay attention, make decisions and control impulses are all slowed down in order to conserve energy.

Whatever the trauma, whether social, emotional, psychological or physical – including the experiences of survivors of war, natural disaster, poverty – the effect on the brain is similar. The brain adapts to protect itself from the stress that trauma produces. Certain parts of the brain are placed on high alert, while other parts become much less active. This has a significant impact on a child's emotions, their ability to stay calm, pay attention, be less impulsive and form healthy relationships. Even fairly ordinary events, like going to a supermarket or sitting in a classroom, can be very hard for a child that has experienced the effects of trauma.

> *"The brain adapts to protect itself from the stress that trauma produces."*

When children are in the heightened stress state produced by trauma, they often:

- Seem to be sad a lot of the time, or don't demonstrate any emotion at all
- Develop a hair-trigger (easily disrupted) response to stress, like a car alarm that goes off when a leaf lands on it
- See neutral facial expressions and even friendly remarks as threats
- Have problems regulating strong negative emotions – not just anger, but also fear, sadness, loneliness and shame
- Demonstrate a significant increase in impulsivity and distractibility
- Have trouble anticipating consequences and evaluating risk
- Are prone to withdrawal or aggression
- Don't seem to feel empathy or have a sense of right and wrong.

The first and most important step for dealing with these behaviours is to recognise that they do NOT mean that the child lacks self-control or is trying to be disobedient or isn't capable of feeling empathy. Such problems are not the result of choice, self-centredness or self-indulgence, but because the child is burning so much energy dealing with the effects of trauma on the brain that there isn't enough left over to regulate thoughts, emotions and actions. So you need to learn how to distinguish between *misbehaviour* and *stress-behaviour*, i.e., see these behaviours as signs that the stress levels on this child are too high and need to be reduced.

There are five key strategies for helping children suffering from the effects of trauma:

1. Provide the greatest possible feeling of safety and security, in daycare or at school as well as in the home
2. Support them in becoming aware of and able to how they are feeling
3. Encourage them to become "stress detectives", able to identify and reduce the things they find stressful
4. Help them learn and become aware of what it feels like to be calm, what it feels like when they are starting to become over-stressed
5. Turn meltdowns or when they are agitated into learning experiences, so they can begin to learn how to *self*-regulate.

We now know that children who have experienced trauma undergo neurobiological changes that render them more susceptible to distorted perceptions of safety and threat, and more susceptible to having a stress response to non-threatening as well as threatening stimuli. By helping them learn how to manage the stresses in their lives so as to balance their energy and tension, we can reduce the hyper- or hypo-arousal that is interfering with their emotional, social, cognitive, and prosocial development. We can reposition them on a trajectory that leads to long-term wellbeing.

By the same token, we also know that children can display similar behaviours even though they have not experienced trauma. Their core needs are the same as the child who has experienced trauma: to feel safe and secure. Indeed, it goes without saying that all children have this need. But this need may be a little more critical for some children, and perhaps a little harder to meet. Yet it can always be met: provided we recognise the signs of stress overload – in ourselves as much as in the children in our care – and know how to self-regulate and help children learn the same.

For more information visit https://self-reg.ca/

Useful Resources on Trauma

All resources on the reference list are available from Barnardos Library and Information Service.
Please email resources@barnardos.ie for more details.

Archer, C., Drury, C. & Hills, J. (eds.). (2015). *Healing the hidden hurts: Transforming attachment and trauma theory into effective practice with families, children and adults.* London: Jessica Kingsley Publishers 2015.

Baldwin, D. (2018). What new counselors need to know about adverse childhood experiences. *Counseling Today, 60(8), 10-12.*

Barr, D. A. (2018). When trauma hinders learning. *Phi Delta Kappan, 99(6), 39-44.*

Bath, H. (2017). The trouble with trauma. *Scottish Journal of Residential Child Care, 16(1), 1-12.*

Bunston, W. (2017). *Helping babies and children aged 0-6 to heal after family violence: A practical guide to infant- and child-led work.* London: Jessica Kingsley Publishers.

Burke Harris, N. (2018). *The deepest well: Healing the long-term effects of childhood adversity.* London: Bluebird.

Golding, Kim S. (2014). *Using stories to build bridges with traumatized children: Creative ideas for therapy, life story work, direct work and parenting.* London: Jessica Kingsley Publishers.

Chara, Kathleen A. (2004). *A safe place for Caleb: An interactive book for kids, teens, and adults with issues of attachment, grief and loss, or early trauma.* London: Jessica Kingsley Publishers.

D'Amico, D. (2017).*101 mindful arts-based activities to get children and adolescents talking.* London: Jessica Kingsley Publishers.

De Thierry, B. (2017). *The simple guide to child trauma: What it is and how to help.* London: Jessica Kingsley Publishers.

Lamb, C. (2017). Practical strategies for working with traumatised children from refugee backgrounds in early childhood settings. *Educating Young Children: Learning & Teaching In The Early Childhood Years, 23(3), 20-23.*

Levenson, J. (2017). Trauma-informed social work practice. *Social Work, 62(2), 105-113.*

McElvaney, R. (2015). *Finding the words: Talking children through the tough times.* Dublin: Dufour Editions.

Najavits, L.M. (2017). *Recovery from trauma, addiction, or both: Strategies for finding your best self.* New York: Guildford Press.

Ogden, P., Fisher, J., Del Hierro, D. & Del Hierro, A. (2015). *Sensorimotor psychotherapy: Interventions for trauma and attachment.* London; New York; W.W. Norton & Company.

Osofsky, J. D. (Ed) (2007). *Young children and trauma: Intervention and treatment.* New York: Guilford Press.

Pughe, B. & Philpot, T. (2008). *Living alongside a child's recovery: Therapeutic parenting with traumatized children.* London: Jessica Kingsley Publishers.

Racco, A.; Vis, J.A. (2015). Evidence based trauma treatment for children and youth. *Child & Adolescent Social Work Journal, 32(2), 121-129.*

Rose, R. (Ed) (2017). *Innovative therapeutic life story work: Developing trauma-informed practice for working with children, adolescents, and young adults.* London: Jessica Kingsley Publishers.

Rose, R. (2012). *Life story therapy with traumatized children: A model for practice.* London: Jessica Kingsley Publishers.

Rymaszewska, J. (2006). *Reaching the vulnerable child: Therapy with traumatized children.* London: Jessica Kingsley Publishers.

St Thomas, B. & Johnson, P. (2007). *Empowering children through art and expression: Culturally sensitive ways of healing trauma and grief.* London: Jessica Kingsley Publishers.

Sanderson, C. (2013). *Counselling skills for working with trauma: Healing from child sexual abuse, sexual violence and domestic abuse.* London: Jessica Kingsley Publishers.

Souers, K. (2017). Responding with care to students facing trauma. *Educational Leadership, 75(4), 32-36.*

Thomas, B. (2016). *More creative coping skills for children: Activities, games, stories and handouts to help children self-regulate.* London: Jessica Kingsley Publishers.

Thompson, S. (2018). Child care in disasters: Why it's best to prepare for the worst. *Exchange, 240, 68-70.*

Tomlinson, P. & Philpot, T. (2008). *A child's journey to recovery: Assessment and planning with traumatized children.* London: Jessica Kingsley Publishers.

Treisman, K, (2017). *A therapeutic treasurebox for working with children and adolescents with developmental trauma: Creative techniques and activities.* London: Jessica Kingsley Publishers.

Van der Kolk, B.A. (2015). *The body keeps the score: Mind, brain and body in the transformation of trauma.* London: Penguin Books.

Wamser-Nanney, R., Scheeringa, M.S., Weems, C. F.(2016). Early treatment response in children and adolescents receiving CBT for trauma. *Journal of Pediatric Psychology, 41(1), 128-137.*