Working with Relational and Developmental Trauma in Children and Adolescents

DR KAREN TREISMAN

ROUTLEDGE

Working with Relational and Developmental Trauma in Children and Adolescents

Working with Relational and Developmental Trauma in Children and Adolescents focuses on the multilayered complex and dynamic area of trauma, loss and disrupted attachment on babies, children, adolescents and the systems around them. The book explores the impact of relational and developmental trauma and toxic stress on children's bodies, brains, relationships, behaviours, cognitions, and emotions.

The book draws on a range of theoretical perspectives through reflective exercises, rich case studies, practical applications and therapeutic strategies. With chapters on wider organisational and systemic dynamics, strengths-based practices and the intergenerational transmission of relational trauma, Dr Karen Treisman provides a holistic view of the pervasive nature and impact of working with trauma.

Working with Relational and Developmental Trauma in Children and Adolescents will be of interest to professionals working with children and families in the community, in-patient, school, residential, and court-based settings, including clinical psychologists, psychiatrists, social workers, teachers, and students.

Dr Karen Treisman is a Highly Specialist Clinical Psychologist who has worked in the NHS and children's services for ten years. She has also worked cross-culturally in Africa and Asia, with groups ranging from former child soldiers to survivors of the Rwandan Genocide. Karen has extensive experience in the areas of trauma, parenting, and attachment, and works clinically using a range of therapeutic approaches with families, children and young people. She is the director of Safe Hands and Thinking Minds Psychological Services (www.safehandsthinkingminds.co.uk), and is an external consultant and trainer to Barnardos, PAC-UK, Hope for Families, Grandparents Plus, and the Fostering Network. Karen has worked in several Looked after Children teams and within the National Implementation Service for evidence-based interventions at the Maudsley Hospital. She currently works as Clinical Lead in a court assessment and intensive parenting intervention team in Islington.

Praise for *Working with Relational and Developmental Trauma in Children and Adolescents*

Dr Karen Treisman has written a most comprehensive book for preparing clinicians to work with the complexities of treating children and adolescents who have experienced developmental trauma. The challenges of providing such treatment are great on many levels and Dr Treisman addresses them all, from understanding and assessment to providing the most appropriate therapies for these young people and their caregivers. Not stopping there, Dr Treisman also informs us of the need to provide sensitive interventions within systems such as social services, education, and residential care that may themselves become traumatized through the challenges of caring for these very troubled children and youth. An important contribution to the field for both experienced clinicians and those just entering it.

—Daniel Hughes, Clinical Psychologist, developer of Dyadic Developmental Psychotherapy, author of *Building the Bonds of Attachment, 2nd edition* (2006), and *Attachment-Focused Family Therapy Workbook* (2011)

An exceptional book by an expert clinician! This volume articulately delivers the essentials of trauma intervention with children and adolescents whose case histories are both complex and compelling. It emphasizes the importance of applying neurobiology-informed and brain-wise approaches, providing practitioners with a solid grounding in current best practices and trauma assessment through a highly accessible and readable format. All mental health professionals will find valuable resources, richly illustrated case examples, and pragmatic strategies to immediately apply in their work with youth that will expand their clinical repertoires in work with relational and developmental trauma.

—Cathy Malchiodi, PhD, LPCC, LPAT, ATR-BC, REAT—Founder/Director, Trauma-Informed Practices and Expressive Arts Therapy Institute

This book is a wonderful resource for practitioners who work with children who have experienced relational and developmental trauma. The book includes a comprehensive overview of the impact of trauma on children, as well as assessment and treatment options. Dr Treisman also covers working with traumatized children in settings such as schools and residential care. Practical activities and reflective exercises are woven throughout the text to help the reader gain further insight into the material. This is an invaluable resource and a welcome addition to the trauma literature.

—Liana Lowenstein, MSW, author of *Cory Helps Kids Cope with Sexual Abuse*

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To my family and friends – my treasure chest of relational riches,
and to the amazing inspiring families, children, and colleagues
I have been honoured to work with and learn from.

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Chapter 1

Relational and developmental trauma

The impact of complex trauma on children's sense of selves, relationships, and development

Introduction

This chapter will first explore within the context of relational and developmental trauma the types of traumas and losses which children have experienced, as well as the interplaying factors which need to be considered. This will be followed by discussing the differences between a Post-Traumatic Stress Disorder (PTSD) framework, and a relational and developmental trauma one; and subsequently the terms "relational trauma" and "developmental trauma" will be expanded on, followed by reflections on some of their wider implications. Case examples, reflective exercises, and metaphors will be interwoven throughout. This chapter sets the scene for the subsequent chapters, which will be centred around the impact of relational and developmental trauma on children's bodies, brains, attachments/relationships, emotions, senses, identity, behaviours, and cognitions. In later chapters, these areas will be applied to some specialist subgroups and contexts within this population such as when working with unaccompanied asylum-seeking young people who offend, or when intervening with children who have experienced relational and developmental trauma within settings such as schools and residential homes.

Children who have experienced relational and developmental trauma often have lived through a matrix of multiple, overlapping, and co-occurring traumas, losses, and stressors (Table 1.1 offers some examples of relational and developmental trauma). Within the literature, these experiences are often referred to as chronic, cumulative, and/or multiple traumas. In many cases, these traumas and/or disrupted attachments have begun during the vitally important in-utero period. Although traumas can take place within intra-familial, extra-familial, institutional, or street-stranger contexts/relationships, this book holds a firmer focus on the intra and extra-familial experiences.

Interplaying factors

Before going on to discuss what relational and developmental trauma is, and what some of the implications of these experiences are, we need to be mindful that these children are a heterogeneous group of unique individuals, and that trauma

Table 1.1 Types of relational and developmental trauma experiences

Type of abuse and/or stressor:	*Case examples:*
Neglect (also referred to as invisible trauma, absent presence, relational poverty, and the faceless mother) is the persistent failure to meet a child's basic physical, medical, educational, and/or psychological needs.	*Physical and nutritional neglect:* 4-year-old Lindsey was sent into nursery school each day with the same soiled underwear on. She was also found emptying bins seemingly scouring for food, and in the snowy winter was sent to school without a jacket. *Environmental neglect:* on inspection of 18-month-old Devon's room, rat droppings and empty beer bottles were found, and the walls smeared with faeces. *Medical neglect:* Terry had rotting teeth and an untreated skin condition. *Supervisory neglect:* Nadia, aged 4, was left in charge of watching her 3-month-old baby brother. She also was expected to make him his dinner and to give him a bath. *Developmental neglect:* 10-month-old Felisha was left in her cot for hours, having little to no interaction. Tami was withheld from school by her mother for 6 months, as she felt she needed Tami to help her at home. *Emotional and moral neglect:* Damian, aged 6, was encouraged by his mother to steal food from the local shop. Kovi had been excited all day to tell his mum that he had been made class prefect. Upon arriving, he bounced into the living room to share his news. Rose momentarily turned her head, looked blankly with little change to her facial expression, and in silence continued to text on her phone.
Sexual abuse may include sexual touching, assault, exploitation, rape, sodomy, exposure to sexual activities by others, grooming, taking or showing indecent images of children, encouraging a child into pornography or prostitution.	As part of a gang initiation, Talia, aged 14, was made to perform oral sex on a line-up of five men. At age 4, Jay's parents entertained him by putting porn on the TV. Sam, aged 8, was promised she could go horse riding on the weekend if she "made her step-dad feel good". 9-year-old Angel was made to strip by her babysitter.
Physical abuse may involve hitting, shaking, kicking, stabbing, throwing, poisoning, burning, scalding, drowning, suffocating, or otherwise causing physical harm to a child. This also includes when an adult	3-year-old Anthony drew on the living room wall and as a punishment was burned several times with a cigarette. 6-year-old Clara didn't listen to her uncle and consequently was made to stand on the snow barefoot.

Type of abuse and/or stressor:	*Case examples:*
fabricates the symptoms of, or deliberately induces illness in, a child.	2-year-old Adam was reluctant to have a bath. His mother pulled him up the stairs and pushed him into a scalding bath.
Emotional abuse includes overt rejecting, isolating, degrading, criticising, terrorising, insulting, shunning, coercive control, exploiting, and denying emotional responsiveness and/or punishing a child's attempts to interact with the environment.	6-year-old Lennox was frequently told she was "a waste of space, good for nothing, and better-off dead".
	2-year-old Graham was humiliated and shamed every time he wet the bed.
	12-year-old Tara was sent pictures and suggestions of ways to commit suicide via her cousin.
	7-year-old Maisie was singled out as the black sheep of the family, and treated in a starkly different and negative way to her siblings.
Violence (i.e. domestic, community, and/or school violence).	5-year-old Angelo heard screams outside his window. When he looked outside he could see another boy being kicked and spat on. He quickly hid behind his curtains when he saw a knife being taken out.
	3-year-old Mike watched his mum being pulled by her hair into the bedroom, and later emerge with a black eye and scratch down her neck.
	11-year-old Carly reported being scared to go to school, as the day before she had been pushed against the lockers and been threatened to be raped.

does not occur within a vacuum; it is influenced by multiple systemic, relational, and contextual elements. Therefore, the impact and consequences of the traumas listed in Table 1.1 are likely to be on a continuum, and shaped by a number of interplaying factors including:

1 The child's temperament and unique attributes, including biological and genetic factors
2 Previous life events and stressors
3 The severity and nature of the traumas
4 The frequency and duration of the traumas
5 The relationship with the person who carried out the abuse
6 The response of others around the abuse e.g. how it was managed and whether it was believed/validated
7 The sense-meaning-making and attributions made about the traumas
8 The age and stage of the developing child
9 The presence and/or absence of protective factors
10 The cultural and contextual relevance of the traumas

These variables are crucial in further understanding, assessing, and intervening with this client group. Additionally, the majority of relational and developmental trauma experiences tend to involve interwoven types of abuse, which can make clear differentiation challenging. For example, it is uncommon for physical abuse to occur without some form of emotional abuse. Furthermore, the extent and nature of relational trauma is not always clear cut or simple to disentangle, as the child would have experienced a range of relationships, both through being exposed to an extended network of adults, and/or through the varying parenting styles of their primary caregivers.

These trauma experiences have generally occurred whilst the child is still developing, has a weakly formed cognitive framework, and is often preverbal. Moreover, these experiences are often characterised by a lack of the fundamental relational protective shield which children need, and instead the trauma may occur at the hands of the very person who is supposed to offer them comfort and safety. The experiences described in Table 1.1 are beneficially considered within a multilayered lens of attachment and trauma, whilst taking into account the wider context which may include:

1 The potential difficulties of having a parent with mental health difficulties, a learning disability diagnosis, and/or using substances.
2 The type of milieu, family scripts, emotional world, and parenting models the child has been shaped in.
3 The intergenerational transmission of trauma and attachment styles; including unresolved trauma and "ghosts of the past" (Fraiberg et al., 1975).
4 The environmental, socio-political, and economic context.

Some of these complexities are captured in the following case:

Post the Rwandan Genocide, June had been raised in an institution. She had experienced multiple childhood traumas and losses. In her late teens, June began experiencing hallucinations and delusions, and shortly after arriving in the UK, she was diagnosed with paranoid schizophrenia and PTSD. June was homeless and drinking significant amounts of alcohol when she became pregnant with Sienna. Sienna's father was in prison for assault and robbery.

When well, June was able to offer a level of responsive, playful, and sensitive parenting to Sienna. However, when unwell, the situation significantly differed. The cramped household was chaotic and heaving with items ranging from newspaper cut-outs, to medication lying around, whilst the fridge remained empty, and the electricity unpaid. At these times, June struggled to move out of her own mind, and was preoccupied by intrusive thoughts and images. She expressed few positive emotions and interactions towards Sienna, and presented with a short fuse. For example, she regularly misread social situations and attributed hostility in others' faces and actions. There was one occasion where June was arrested in front of Sienna for shouting racial abuse at their neighbours, and another when she was observed labelling Sienna a "dirty slut" and attributing her wetting to being purposeful and a plot against her.

Box 1.1 uses the metaphors of shark-infested waters and desolate islands to bring to life the lived experience of abuse and neglect as described in Table 1.1. See Figures 1.1 and 1.2.

Figure 1.1 Shark-infested waters.

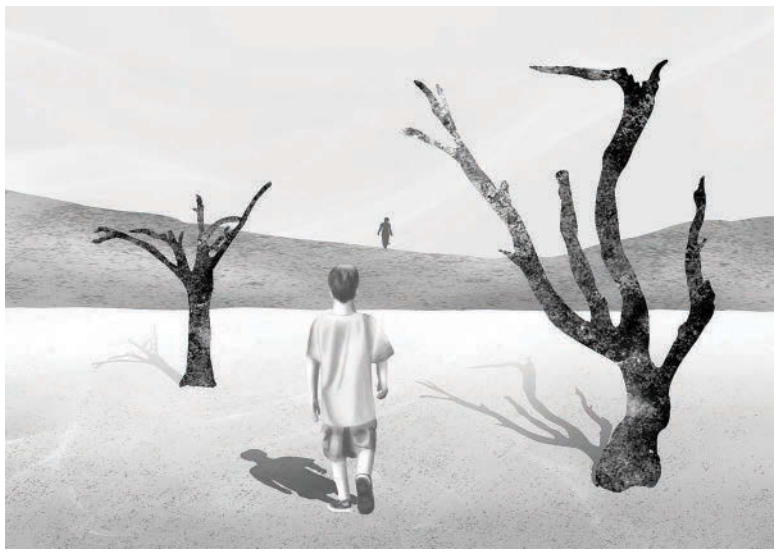

Figure 1.2 Desolate island.

1.1 Reflective exercises: metaphors of relational and developmental trauma

*Two metaphors which resonate for me when thinking about relational and developmental trauma and loss are **shark-infested waters** (e.g. abuse/frightening parenting) and **desolate islands** (e.g. neglect/relational poverty). The following build on these concepts, however it is acknowledged that metaphors fit differently with different people. If these don't work for you, can you think of others that do?*

Shark-infested waters:

Imagine swimming or being on the edge of shark-infested waters. Put yourself in the shoes of a child who is surrounded, trapped, and powerless by these big, fast, and unpredictable sharks. Waiting, anticipating, expecting and/or fearing being attacked. Feeling frightened, under threat, outnumbered, and on edge. Visualise each brush of seaweed, lurking shadow, or ripple in the water sending your body and mind into overdrive.

When in shark-infested waters what do you/can you do? a) swim away, b) punch the shark or wrestle it, c) stay incredibly still, or d) pretend to be a feared shark yourself? What if you don't have the physical strength or knowledge to know how to fight or swim away from the sharks?

How would it change your responses and meaning-making if the sharks were sometimes friendly or even turned out to be dolphins? What would it be like to be taken out of the shark-infested waters and subsequently put in a swimming pool (e.g. foster care)? What if you were then returned to the shark-infested waters? What would be your source of comfort, anchor, or lifeboat?

Desolate island:

Some children who experience neglect and relational poverty might feel like they are stuck or stranded on a lonely, dry, empty, and desolate island. A place where one feels disconnected, disengaged, and invisible. The lack of water and nourishment can be likened to being starved of relational riches and interpersonal treasures. Neglect, although often sidelined compared to physical or sexual abuse, should be forefronted due to its powerful far-reaching impact on developing children.

What would you do to survive on a desolate island? How long would you look for hidden treasures or buried food? How would you learn new skills without people teaching or encouraging you on your journey? What might it be like to go from a desolate island into shark-infested waters, and back again? What might it feel like if your island was suddenly re-inhabited with new people, or through an arduous journey, you are taken to a more populated island?

The labyrinth of the care system

Another layer of complexity is for those children who have been removed and placed in the foster care system. Although they may experience a plethora of

positive changes, for some, their waters may still look and feel shark-infested; and new lurking shadows, tides, and sharks may have appeared. For these children, their points of reference and anchors are no longer visible, and the new waters may feel and be unfamiliar. Similarly, once a child's desolate island is re-habitated with new people, or through an arduous journey they are taken to a more populated island; this too can feel alien, hostile, and overwhelming. These children are placed amongst the complex labyrinth of the care system with new dilemmas, blind spots, turns, and twists to navigate – often under a wave of uncertainty and disorientation. "Why can't I go home?", "What is a 'forever' family?", "What will I eat?", "Can I take my dog?", "Is it because I was naughty?", "Is this because I told my teacher what daddy did?", "How will my mummy know I'm ok and who will look after her?", "What about school?"

Stacking-up on the experiences described in Table 1.1, these children also need to contend with a range of additional issues around social care and multiple professional involvement, family contact arrangements, potentially being separated from their siblings, and the widespread stigma of being in care.

These children may also experience multiple placement/school moves. Studies on placement instability and disruptions have shown that there are increased links with low self-esteem, poor self-worth, low mood, and behavioural, social, and emotional difficulties. Moreover, these children have limited opportunities for forming secure attachments to their carers, or long-lasting meaningful relationships (Leathers, 2006; Eggertsen, 2008). Most likely they also missed out on key early opportunities to learn, and be curious about themselves, which can further contribute to having an incoherent life narrative and a fragmented sense of identity and belonging. Illustrative examples follow:

Cindy shared how she had gone to school and unbeknown to her, her carer had given an unplanned notice. On arrival "home", her social worker was waiting for her. Her belongings had been hurriedly packed in black bags.

Khloe was adopted with her younger sister and placed in her "forever family". However, a few months later the placement broke down, and Khloe was placed back into foster care, whilst her sister stayed with the adoptive mother. She subsequently experienced seven placement moves, with the system designed to protect children like Khloe being responsible for new abuses. With each move, Khloe's sense of safety was squashed, her defences reinforced, and her trauma jacket more firmly buttoned-up. With each transition, Khloe was faced with multiple emotional, relational, physical, and symbolic losses; ranging from losing material cherished possessions, to meaningful relationships, to her sense of familiarity. Khloe likened herself to "rubbish which needed to be disposed of". See Box 1.2 for further reflection on placement moves.

1.2 Practical activity and reflection: moving placements

1 Put yourself in a child's shoes when moving to a new "home" with new "parents" where everything is different and unfamiliar – from the smells, tastes, "language", sounds, to rules, parenting styles, people, school, and surroundings. Children have to navigate these new environments from scratch, whilst often looking at themselves, others, and the world through a relational and developmental trauma prism (shark-infested waters and desolate islands). They generally make these moves on their own, without their relational anchor. *What might that feel like? What impact might this have on your life narrative, sense of belonging, identity, beliefs, and expectations? What do the words "home" and "mother/father" mean to you?* (Write a list or visually represent this i.e. with a collage.)

2 Building on bringing the above changes to life, let's use *mealtimes* as an example. In your childhood home: *Did you know that there would be enough food? What were the meal times, routines, rules, and rituals? What type/variety/size of food was served? What utensils were available? Where did you sit? What noises were in the background? Who was with you? What happened if you wanted more food? What happened if you didn't eat your food? What was the overall mealtime atmosphere like? How were your mealtimes different to your friends' mealtimes?* Now imagine the other insurmountable changes e.g. rules, routines, environment, bedtime, play times, parenting styles, etc. For many children they have to do this over and over and over again.

Following reading the remainder of this chapter and Chapters 2–3, revisit the above questions.

Relational and developmental trauma: a wider frame than the post-traumatic stress disorder (PTSD) classification

Having explored some of the experiences that children who have faced relational and developmental trauma have lived through, the following sections will discuss why a broader attachment and trauma framework is being advocated for, what the author means by the terms *relational and developmental trauma*, and the subsequent impact these can have on children. For clarity, these terms will be briefly described separately, but in real-world practice they are intrinsically interwoven.

Within clinical and school settings, children who have experienced relational and developmental trauma often present with an alphabet soup of diagnoses (e.g. ADHD, ODD, RAD, ASD etc.). It is beyond the remit of this book to discuss each diagnostic category in detail; therefore the one which will be discussed more fully is PTSD.

The author takes the position that whilst the diagnostic classification of PTSD and the associated evidence-base can be incredibly useful, valid, and important, it often doesn't fully do justice to the complexity, co-morbidity, atypical, and multi-faceted nature of what we see in real-world clinical settings where children have

experienced relational and developmental trauma. This view is echoed by a body of professionals who continue to advocate for the inclusion of Developmental Trauma Disorder as a new diagnostic category, or for a revision of existing categories within the PTSD classification (Van der Kolk, 2005). This is based around notions that PTSD was initially conceptualised in the Western world from an adult perspective, and was mainly focused on single-event traumas and/or veteran studies.

Therefore, it is posited that these understandings do not take into account the chronic, multiple, and cumulative nature of attachment and relational trauma from a child development perspective. For example, there are several unique characteristics of trauma that occur during a child's critical sensitive developmental trajectory, which are not fully considered in the PTSD inclusion criteria. These include: complex disruptions in affect and physiological regulation, changes in attachment patterns, interferences in developmental competencies, and feelings such as ineffectiveness, shame, and self-blame (Cook et al., 2005). Furthermore, researchers suggest that many stressful childhood experiences are not included in the PTSD Criterion A (exposure to traumatic event), such as caregiver separation, verbal abuse, bullying, chronic sibling discord, multiple placement moves, and living with a caregiver with mental health difficulties (D'Andrea et al., 2012).

Thus, PTSD does not encompass the complex relational changes, impact of trauma, and layering of difficulties including considering fundamental factors such as caregiver involvement, and/or response to the trauma. Moreover, in its very name, "P"TSD is positioned around a time frame of "post", which does not adequately capture children whose trauma remains ongoing, and/or started during the in-utero period.

As demonstrated above, children who have experienced relational and developmental trauma often are "misdiagnosed" or alternatively do not meet the criteria for a PTSD diagnosis but might still require services. Therefore, this book advocates for considering and respecting existing diagnostic criteria, whilst attending to the wider relational and developmental trauma framework. This broadening framework aims to see the whole child and context rather than just the diagnosis. This is in line with the notion that one can't understand a tree by looking at just one of its branches. This is also with the hope that broader systemic and context-informed trauma/attachment-sensitive approaches can reach a wider remit, and strengthen preventative, early intervention, and proactive approaches.

Having explored why relational and developmental trauma may be more suitable terms for these children, these terms will be expanded on below and throughout this book.

Developmental trauma

The term *developmental trauma* is referred to for a number of reasons. During childhood, the brain develops, grows, and organises at an incredible rate; with a baby's soft-wired brain being like a sponge, constantly absorbing new experiences and being shaped by its environment. Therefore, when trauma and shock occur during this critical sensitive window, it is likely to have an impact on the child's neurological, social, emotional, sensorial, physiological, moral, and cognitive

developmental trajectory (Perry, 2009). For example, we know that children who have experienced relational and developmental trauma are more likely to have sensory-integration difficulties (Chapter 3), cognitive and executive function difficulties (Chapter 9), and to struggle with emotional regulation (Chapter 2).

Therefore, it is integral to keep a developmental trauma focus when working with these children. The following sections and Box 1.3 will explore the components of developmental trauma further; including the neurobiology of attachment, and the child's social and emotional age, versus their chronological age. These are expanded on in Chapters 2–3 and 9.

Social, emotional, developmental age vs. chronological age

Taking into account Table 1.1, these children would not have had the experience of a safe relational anchor, and are likely to have had to invest more energy into their survival (Reptilian brain), rather than being able to be in their learning/thinking brain (the neocortex which controls higher level processes such as logic and reasoning), and to be able to fully master age-appropriate competencies. In essence, fear restricts and safety expands learning and relationships. *For example, if a child's laser focus is on avoiding getting hurt, how can they absorb and master the skill of effective eye contact, or learning how to empathise?*

Therefore, due to these developmental vulnerabilities, the child's social, emotional, and developmental age may differ to their chronological age. *Imagine a house with fragile foundations or soggy cement. How could it be built, extended, and decorated without attending to the basic foundational structures? What lights have been left-on, switched-off, or not been wired* (Box 1.3)? Some key skills, such as problem-solving or sharing, might not have had the opportunities and care they needed to fully develop – like a wilting flower or an uprooted tree. These different ages and stages might be highlighted further when children fall through timeholes (Hobday, 2001), are catapulted back to difficult past experiences and memories, and/or are in a time of heightened arousal, emotional charge, and perceived threat. The following examples capture these changing ages/stages.

Eighteen-year-old-girl Lola who had a complex relational trauma history, came running out of her room in a frenzied way with her body language and demeanour appearing "childlike". In a panicked manner, she wagged her finger, which had a tiny papercut from an envelope, under my eyes, waiting eagerly for a response. In that moment, I felt like I was interacting with a much younger child, and intuitively engaged with her by showing lots of care through my facial expressions, words, and body. I suggested magic fairy dust and a special plaster. She delighted in this moment, and asked what type of plasters I had, and bounced up and down in anticipation. It seemed that once she had absorbed this moment, and had had her needs met, she swiftly puffed her chest out, pouted her lips, and proudly declared she was ready for a cigarette whilst strolling off to join her peers.

During a school observation of 13-year-old Cory who had recently been placed in care, I watched as he was "playfully" teased. His facial expression looked distraught; and he quickly ran to the corner of the locker room, hid under the coats in a curled-up position, sucked his thumb, and rocked back and forth.

On the other end of the spectrum, there can be children who have been forced too early into their development and into being "grown-ups"; and/or have been exposed to experiences of an adult nature; and therefore have learned to be over-independent and self-reliant. These children might have learned that closeness and intimacy can lead to danger, rejection, and vulnerability; and therefore that they can only rely on themselves. Additionally, they might have been in a reversed role position, where they were caring for a family member, or had been positioned as their caregiver's confidante. *This was captured during a home assessment of 4-year-old Jenny who insisted on trying to bathe and make dinner for her younger sister, and would actively decline support from her foster carer, Clare. This self-reliance was echoed by Jenny choosing to play alone for several hours. Clare also shared how the previous day when Jenny had fallen over and hurt herself, she had not shown any emotional reaction, and instead had shielded herself away from having her cut attended to.*

These presentations often prove tricky, particularly when there is a rapid oscillation from one need (emotional, social, and developmental) to the next, such as that demonstrated in Lola's case. This requires the receiving adult to engage in intricate dances to stay in rhythm with the ever-changing child. This can have significant implications for therapists and caregivers alike around making thoughtful developmentally-informed assessments which will inform later goals, aims, decisions, and expectations. *For example, if 4-year-old Jenny said "You're evil and I hate you" would you say it back to her? Or would Lola be ready to live in independent-living accommodation?* This said, it is important to keep in mind some of the cultural and societal differences in conceptualisations and expectations of childhood and ages/stages. For example, the Aka tribe in Africa learn to throw spears and use axes by the age of 10 months (Rogoff, 2003), whereas in some groups within Bali, babies are seen as wise reincarnated ancestors.

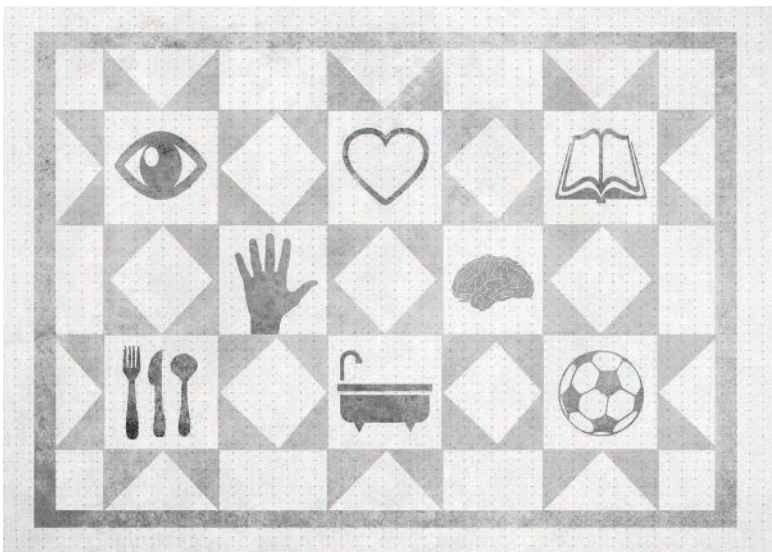

Figure 1.3 Parenting Patchwork.

1.3 Practical activity and reflective exercise: Parenting Patchwork

1 Draw or make (could use paper shapes, materials, post-it notes, magazine pictures) a patchwork quilt representing child development for a 0–2-year-old baby: *a Parenting Patchwork*. Fill each unique patchwork square with a crucial developmental need/skill/experience. The following are a few examples of these developmental needs/skills/experiences:

Physical (e.g. shelter, food, sleep, safe touch/being held, comforted, eye contact, tone of voice, warmth, movement, fresh air, personal hygiene)

Relationship (e.g. emotionally expressive, warm, attuned, reflective, nurturing, loving, sensitive, playful, affectionate, attentive, responsive, co-regulating, safe, reciprocal, protective, sense of belonging)

Cognitive (e.g. sensory stimulation, vocalisations, rhythm, communication, play, imagination, reading, teaching)

Structure and supervision (e.g. predictability, consistency, rules, routines, limit-setting, boundaries, protection, and safety)

2 Think about a particular child. Consider their chronology, lived experiences, and early history. Keep in mind that a child's sense of self can be wrapped up with their parent's Parenting Patchwork. Take away, halve, layer, cut, or black out the relevant squares. Reflect on the following questions:

What does their Parenting Patchwork look like? What type of Parenting Patchwork did they have wrapped around them? What does this say about their fabric of self? Which squares have been firmly sewn in and are rich in detail? Which are missing or loosely connected? What is the golden thread stopping the patchwork becoming unravelled? What imbalances/gaps are there, and what might these represent? How might/do these show themselves in the child? What might it be like to parent/work with this child?

Who contributed to sewing their Parenting Patchwork (e.g. extended family, teachers, professionals etc.)? What story and history is behind each square? How would they need to be filled, thickened, or connected together?

3 Children's needs continually develop as they grow. For example, a baby requires different parenting styles than an adolescent. *How would their Parenting Patchwork look if we carried on expanding it for the other age groups, such as 3–6 or 7–10 years old?*
4 *How would this be similar or different to your own parenting patchwork?*

Neurobiology of attachment

When relational trauma occurs within a child's developmental pathway it crucially influences their interpersonal neurobiology. Although still an ever-evolving area, especially with new emerging findings on epigenetics, neuroscientists have

demonstrated that the brain is an experience-use-dependent live organ. In essence, this means that the brain is shaped, influenced, and sculpted in response to interpersonal experiences. Like a muscle, the brain can and needs to be trained, exercised, and strengthened in different ways.

Therefore, early experiences can positively or negatively shape the solidness or fragility of the brain's architecture (Shonkoff and Garner, 2012). For example, babies are born with a surplus of cells, but it is the parenting and environment which actively supports these connections, like in a game of connect the numbers. This is even more poignant due to childhood being a critical sensitive period for rapid brain development. Interestingly, a newborn's brain, bar their brain stem (Fight, Flight, Freeze), is very primitive and underdeveloped; it is designed for continued growth of its higher functions through touch, movement, and relational interaction. The more these brain connections are reinforced and experienced; the more likely they are to become hard-wired, fortified, and enfolding into the brain. In essence, states can become traits (Perry and Pollard, 1998).

Thus, carer-to-child, eye-to-eye, mind-to-mind, heart-to-heart, and skin-to-skin experiences (sensory, motor, emotional, social, physical, and cognitive) all support the building of fundamental brain connections and neuronal architecture; whether this be gently rocking a baby, to mutual joyful moments, through to singing songs. These relational experiences serve to develop vital functions for the child including: increased executive function capacities, cognitive abilities, self-regulation skills, enhanced curiosity, self-agency, impulse control, self-monitoring, and anxiety management (Schore, 2001; Gunnar and Donzella, 2002). Studies also show that meaningful-connected relationships including positive attunement, affect coordination, and biobehavioural synchrony help to form later attachments, regulate the brain's stress, the infant's nervous system, and the maturation of neuronal systems (Feldman, 2012). Similarly, nurturing "parenting" experiences releases bonding chemicals such as oxytocin, opioids, prolactin, and gamma-aminobutyric leading to a range of positive effects (Sunderland, 2007).

This demonstrates the importance of child–carer interactions on the brain's architecture and function, and highlights some of the implications for children who experienced relational and developmental trauma, and toxic levels of stress. For these children, their synaptic connections are underused, and therefore are likely to be eliminated through the process of pruning. This process was described by Hebb (1949) "Cells that fire together wire together; cells that fire out of sync, lose their link". Chapter 3 discusses in-depth the brain and body-based implications of trauma and disrupted attachment.

Relational and attachment-related trauma

Having explored why the term "developmental trauma" is used, the following sections will discuss why the term and the concept of *relational trauma* is used when considering how best to understand and support these children. It is helpful to hold onto the notion that whilst this predominantly refers to person-to-person

relationships; the concept of relational trauma seems to fit into a much wider context. This whole book in essence talks about relationships – relationships to one's body, mind, society, and thoughts; and relationships across subsystems (individual, family, community). Similarly, relationships are so much more than just a bubble around the "mother–baby", they are comprised of a huge web of relationships; including multigenerational legacies and ghosts/angels of the past (Fraiberg et al., 1975; Lieberman et al., 2005).

The term *relational trauma* or *attachment-related trauma* refers to children who have experienced trauma within the context of their relationships; often interfamilial, or within their caregiver relationship. These are qualitatively different to single-event traumas, such as a car accident or natural disasters. The importance of a relational perspective is crystallised as we are all social beings born vulnerable, defenceless, and entirely reliant on the relationships and communities around us; most notably on the primary caregiver dyad. Moreover, babies are primed for social exchanges and affective interactions.

These early relationships and interactions are paramount in providing the organising framework and representational models for a child's future relationships, from their "cradle to grave" (Bowlby, 1969, p. 208). Their developing worldview, sense of self, personality, and understanding of others, is grounded and moulded through these foundational relationships. For example, caregivers support babies/children to progressively understand their own inner life, whilst building a model and map as to how it feels to be with another person, and how others usually act and react in social encounters. Thus, children learn about and see themselves through other people's eyes, like a corridor of mirrored faces (Figure 1.4).

Figure 1.4 Corridor of mirrored faces.

Through these experiences, children develop internal working models (IWM), core beliefs, and life scripts. However, mentionable is how the term "working" emphasises the dynamic and functional aspects of these representations. These belief systems and relational templates are embedded and often internalised, even more so, when a child functions in their limbic system and/or survival mode, they have limited access to be in their thinking brain, which leaves less opportunity for assimilation of belief systems, and therefore their beliefs and relational templates often become more rigid and entrenched. These can be further imprinted through repetitive and/or cyclical experiences, such as through multiple trauma experiences or "unhealthy" relationships (Box 1.4). Positively or negatively, they can be like powerful songs replaying over and over again, or a camera being stuck on a zoomed-in shot.

These beliefs and interpretative lenses colour, and at times permeate, the way children will understand themselves, their worth in relationships, and others' motivations (Pearlman, 2003). In essence, they form "*me, you, and we*" maps and scripts which become generalised and are key in guiding a child's identity, meaning-making, expectations, self-esteem, self-concept, behavioural responses, relational models, and attachment patterns. This is significant as these form the foundations for so much of what will follow throughout their lives. Within a secure attachment and positive relational experience, children are able to use their caregiver as a secure base from which they can explore, learn, and develop. They can use this person, particularly at times of perceived threat or fear arousal, as a safe haven, platform, and anchor for receiving support, warmth, and protection. For example, if a child gets enveloped in the relational treasures of love, trust, empathy, and kindness, they are more likely to feel expecting, deserving, accepting of these feelings/qualities, and be more able to express them themselves. They are also more likely to be self-compassionate, have a positive self-image and self-esteem, as well as increased likelihood of eliciting positive interactions with others. These affirming relational experiences also provide the child with a strengthened emotional immune system, a safe psychological home, and an internalised sense of security from which the building blocks of safety, trust, social competency, theory of mind, empathy, pro-social orientation, and conflict resolution skills can grow. *Interestingly, another area to highlight is the impact on children's relational world in a time where technology is so dominant.*

However, on the other side of the spectrum, there are those children who have had inconsistent access to relational treasures, with their baseline of relational interactions tipping towards the negative side of the scale. Within relational and developmental trauma (Table 1.1), and invalidating contexts, relationships, parenting models, and emotional milieus are often characterised by hostility, power, threat, pain, fear, intrusiveness, withdrawal, disconnection, and/or disengagement. These complex notions of danger, vulnerability, and powerlessness can be confusingly equated and tied to concepts such as love, trust, and intimacy; and relational scripts further blurred through double-binding, emotionally bribing, and conflicting messages; such as "I love you but I hurt you" or "Your body

responded so you must have liked it", or "If you touch me down there, then you can have that PlayStation game".

Therefore, for these children, they have had no guarantee that others will be there or respond appropriately to them at times of need; their foundations tend to be insecure and fragile. Thus, these children don't develop coherent models and mental representations of their own and others' psychological make-up, and are more likely to have formed negative IWMs and core belief systems, and an insecure attachment style. See Table 1.2 for common core beliefs in the context of relational trauma.

Table 1.2 Common core beliefs for children who have experienced relational and developmental trauma

I'm unlovable/unwanted	Others don't love me	The world is dangerous
I'm unsafe/vulnerable	Others are dangerous/bad	The world is abusive
I'm nothing/worthless/ useless	Others are abusive	The world is hurtful
I'm not worth protecting	Others are hurtful	The world is unpredictable
I'm powerless	Others are unpredictable/ inconsistent	The world is rejecting
I'm invisible/forgettable	Others are unreliable	The world is hostile
I'm a mistake	Others are untrustworthy	The world is exploitative
I deserve to be hurt	Others reject me	The world doesn't protect me
I'm damaged/defective	Others abandon me	The world is unjust/unfair
I'm bad	Others forget me	The world is cruel
I'm ugly	Others come and go	The world is meaningless
I'm dirty/disgusting	Others put their needs first	The world is full of e.g. manipulative, mean, abusive, selfish people.
I'm hopeless/helpless	Others are exploitative	
I'm inadequate/ incompetent/ stupid	Others are controlling	
I'm empty	Others are self-serving/ selfish	
I'm a loser/failure	Others don't protect me	
I'm alone	Other people manipulate me	

1.4 Reflective exercise: core beliefs and scripts

Drawing on Table 1.2, take a moment to put yourself in a child's shoes. *How would seeing yourself as, for example, "vulnerable", others as "hurtful", and the world as "dangerous" impact on the way you would "do" relationships and interact with others? What about through the prism of "I'm nothing and worthless," others are "self-serving and rejecting", and the world is "unfair"?*

These belief systems make children more vulnerable to cognitive errors, such as all-or-nothing thinking ("I'm stupid so there is no point trying"), mental filtering (only paying attention to certain evidence, in this case, negative information), and self-labelling ("I'm a loser"). The following sections will discuss some of the potential implications of these beliefs.

The impact of relational trauma

Children who have experienced relational trauma have often been under-socialised and starved of rich relationships, which can lead to an array of possible implications. Mentionable is that attachment and relational patterns are on a continuum which children can move along. They are not fixed or set; and can be influenced by multiple contextual, individual, and situational factors. Similarly, understanding the influence of relationships is further complicated by the very nature of relationships, meaning there are multiple relational patterns interacting and being triggered (see Box 1.6).

Children may have learned to see others as a threat, as opposed to as a form of comfort. Unlike small spaces or spiders, children's main phobia in life may be centred on relationships and/or of being parented. The notion of trusting an adult can feel as scary and unrealistic as doing synchronized swimming or aqua aerobics in shark-infested waters. Children may not have learned about safe relational boundaries and healthy ways of doing and/or being in relationships. This poses a host of difficulties as relationships and interpersonal skills are the cornerstone of multiple spheres of life, from making eye contact, to asking for a cup of water, to getting a haircut, to making friends, to learning how to share, to empathising etc.

In order to survive in these shark-infested waters, and/or on desolate islands, children most likely would have had to develop survival skills and powerful defence mechanisms to protect themselves from further pain and loss. Their baseline for trusting their gut instinct, assessing safety and/or danger, in all probability has been skewed and challenged. These can show themselves in a range of different ways; including the child becoming testing and/or defended to either bring about the relational loss they fear, or to create emotional distance. An example of how relational trauma can impact on a child's relational maps, and how these can show themselves in behavioural patterns, is captured in Box 1.5.

The literature discusses how children who have experienced complex trauma are more likely to have difficulties understanding others' feelings, behaviours, and intentions, and struggle at grasping social norms and codes of conduct. This has been echoed in studies showing that this subgroup of children are more likely to have poorer social judgement, lower levels of empathy, difficulties in perspective-taking, and poorer interpersonal social reading (Burack et al., 2006). This speaks to some of the commonly reported difficulties within this population, such as social rejection, unusual social behaviour, defensive conflictual aggressive relationships, indiscriminate friendships, intense relationships, mistrusting relationships, poor relational choices, social withdrawal, and poor stranger danger (DePrince et al., 2008). These are built on further in Chapter 2.

Having discussed the fundamental influence of relationships on children's overall development, this book advocates that when working with children who have experienced relational trauma; relationships need to be at the epicentre of

any assessment, formulation, and intervention, whilst attending to their developmental stage and needs. These children have experienced trauma within the context of their relationships, and therefore need to be shown and re-taught how to "do and be in" healthy relationships. Their surrounding relationships need to be the anchor of change; and to provide children with new experiences of "getting to know people differently". This second chance secure base can support them in revising, refining, and re-evaluating their relationship templates and assumptions.

1.5 Case study: 9-year-old Tristan

In-utero, Tristan was marinated in terror (DV) and exposed to a range of toxins. Within the womb, he was soaked in a high-cortisol environment. Assessments described Katie's parenting style as oscillating from "intrusive, insensitive, and hostile", to being "preoccupied and unavailable". It was also observed that Tristan's signals for interaction were often "rejected and dismissed". He was also imprinted with negative messages from a young age ("he's naughty, he sucks the life out of me like an evil vampire"). Following several intensive early interventions, Tristan was removed and placed into a kinship-care placement with his maternal grandmother. Unfortunately, she was unable to care for him and her parenting was described as "not good enough". Following three temporarily short-term foster placements, an adoptive placement was found for Tristan. His "forever family" consisted of a same-sex female couple, an older adopted brother, and a dog.

Tristan had learned and expected that his connection to others would lead to rejection and pain, and that relationships were short-lived, disposable, and fragile. Therefore he had concluded that it was more dangerous to invest in relationships than to disengage from them. Tristan had a persistent negative sense of self, a high sense of defectiveness, self-hate, and shame (e.g. "I'm a mistake, I'm unlovable"). These deeply embedded beliefs followed him around like a tattooed suit. His adoptive parents reported how at times Tristan would "actively" push them away through comments such as "I hate you" and "I want to live on my own". Tristan's hitting, biting, throwing items, and hostility also served to keep his parents at both an emotional and physical distance.

They shared how Tristan was incredibly self-reliant, and would avoid at all costs showing that he "needed" them. They felt that Tristan was waiting for the day when they would "give him back", and constantly seemed to expect and anticipate negative and critical responses from them. They reported how even a gentle request to tidy his bedroom was misread as an attack, and he would become lost in rage or say statements like "I might as well pack my bags", or "Nothing I do is ever going to be right". It was like he had a large magnet constantly powered-up ready to draw-in negative confirming comments. Tristan's relationship with rejection also resurfaced when he received negative feedback at school. He equated "not being a good enough student", with previous experiences of "not being a good enough son/person".

His adoptive parents also described how he was "a joy" with strangers, but with them "so disconnected and disengaged, like a lodger". He seemed to have created defensive walls to ward off the shame and to protect himself. This, in turn, made them feel rejected, empty, and not good enough, which resulted in them leaving

Tristan to get on with it, withdrawing emotionally, or getting angry. Unintentionally, these responses further imprinted Tristan's beliefs of "I'm unlovable" and "others are rejecting me"; which reinforced and perpetuated unhelpful relational cycles, and pushed Tristan further into his defences, and away from opportunities where he would be able to re-evaluate his relational scripts.

1.6 Practical activities and reflection: our relationships

Something that we all have experiences of are relationships. These inevitably colour the way we see ourselves, others, and the world, and have an impact on us professionally and personally. These filter into multiple aspects from our hotspots, relational patterns, to our values. Reflecting on these seems like an integral part of the role, whether this be through formal tools, such as the Adult Attachment Interview, or through genograms, supervision, and self-discovery.

1 *Who were your most* important relationships *when you were aged 0–5, 6–10, 11–15, 16–20, and so forth? How have these changed?*
2 *What three words would you use to* describe your early relationship *with your caregiver/s? How do you think these descriptors colour your way of viewing yourself, others, and the world? Do these qualities show themselves in your relationships?*
3 *What* qualities *do you avoid/look for/bring into relationships?* (Consider similarities and differences within different relationships e.g. friends/parents/clients/colleagues). *How did you learn these relational skills?* Making a collage representing "You and Your relationships" can be a creative way of doing this, or Margot Sunderland's book "Draw on your relationships" has a range of relationship-based activities.
4 Think of a positive relational experience. W*hat words, thoughts, feelings, and physical sensations accompany this memory?* Now do the same with a negative relational experience.
5 Make, draw, or design some *masks*. *Which mask captures how you see yourself? Which captures how you think others see you? What captures how you would like others to see you?* Reflect on some of the functions and patterns of the different masks. *What are some of the advantages and disadvantages of them? What allows you to show someone a particular mask; what makes you disguise others?*

How similarly or differently might your clients answer these questions?

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Chapter 2

The impact of relational and developmental trauma on emotional and behavioural dysregulation

Introduction

This chapter will expand on the previous chapter, and discuss the foundations of *emotional development*, and the significance of *emotional regulation* within the context of relational and developmental trauma. Subsequently, practical ideas and direct-working strategies for "feelings-work" will be identified. Lastly, *behavioural dysregulation* will be explored, with common presentations described, and recommended behaviour-focused questions detailed. Reflective exercises and case studies will be interwoven throughout. This chapter forms the roots for many of the subsequent chapters.

The foundations of emotional regulation

I recently had the pleasure of observing Megan interact with her baby, Carly. Carly cried and wriggled around seemingly signalling to her mum that she was uncomfortable and distressed. Megan was tuned into Carly and sensitively responded. She gently rocked, swayed, and patted Carly, whilst attending to her physical needs (i.e. checking her nappy was dry, her temperature was ok, and reflecting on when her last feed was). She spoke out loud in a calm, containing, and curious way, until it was noticeable that Carly had restored her arousal homeostasis and emotional equilibrium. Later in the day, Carly became excited when Megan sang "twinkle twinkle little star". The energy and fun level was as if they were at the peak of a rollercoaster. Megan marvelled in Carly's delight, and responded to this with exaggerated positive facial expressions, and a heightened tone of voice. She also attributed meaning and intention to Carly's emotional state, "Wow yes I can see you're very excited", and subsequently repeated the action by singing again. After a few minutes of singing, Megan skilfully attuned to Carly's cues of being overstimulated; so slowly changed the pace, tone, and her positioning.

These beautiful communication loops and loving emotional exchanges between Carly and Megan give a small flavour of how important these early relational interactions are in supporting a child's ability in reading, signalling, identifying, understanding, and expressing their emotions. As described in more detail

in Chapter 1, Carly uses and needs Megan's psychological and emotional availability as a mirror, a regulator, and as an anchor to the outside world. Through the mind and facial expressions of Megan, Carly is constantly discovering and developing her sense of self, self–other separateness, and information about herself, others, and the world. In the context of this sensitive, scaffolding, and meaningful relationship, Carly is also learning how to modulate, regulate, and tolerate frustration, anger, disappointment, and stress. These moment-to-moment serve and return interactions fill children's emotional tanks and treasure chests with positive relational experiences and memories, and provide them with a secure base and strong platform from which to explore, play, and learn. These positive co-regulation exchanges, parental mind-mindedness, sensitivity, and emotional availability contribute to interpersonal competence and resilience in multiple domains (Perkins et al., 2012) including secure attachment styles. This is even more so as childhood is not only a critical sensitive period but also a window of enrichment.

Emotional regulation in the context of relational and developmental trauma

Having touched upon the wealth of positive effects influenced by these parent–child interactions, let us consider the children who have had incongruent mirroring and absent-minded parenting, with very few emotionally-rich experiences. These children's emotional tanks have not been filled and carefully handled in the same way as Carly's.

Imagine the same scenarios above, but this time:

a *Megan is misattuned and instead attributes Carly's crying as a personal attack, and as communication that she hates and is purposely trying to upset her.*
b *When Carly cries, Megan's thinking brain goes offline, and she too becomes dysregulated, leaving Carly flooded in a storm of her own emotions, and together their arousal mutually escalates in an emotional cascade.*
c *As Megan herself is enjoying the singing and is in a good mood, she continues loudly close to Carly's face, unaware of Carly's distress and overstimulation.*
d *As Carly playfully signals (smiles, pointing, kicking her legs), she goes unresponded to without interaction or reciprocity.*

Within the context of relational and developmental trauma (Chapter 1), many children would not have had their relationship ruptures and mismatches (we all have some) repaired. Children are likely to have had their experiences chronically misattuned to, or misattributed by dysregulated caregivers, who have their own difficulties with self-regulating their affective states and levels of arousal, and struggle to step back from their own affective experience, and to reflect on their child's internal experiences.

Several of these children would not have experienced their feelings being noticed, labelled, and/or responded to. They might have learned that their feelings were not tolerable, important, or acceptable.

For example,

> *Dani's parents became increasingly upset and distanced when she expressed anger in any form, so she concluded that anger was an emotion which could not be acknowledged or expressed. Instead, Dani developed a false self, and buried her authentic self under protective layers of smiles and "everything being wonderful".*

Additionally, some children would have been positioned as an extension of their caregiver, or learned that others' feelings took precedence over their own, or that they were not given the space to be a separate person with their own mind (e.g. mind-mindedness) (Figure 2.1). Examples follow:

> *Caitlyn avoided telling her mum about being bullied for fear that her mum's own fragility would be evoked, and she would push her further into depression.*
>
> *Following Luke's parents' frictional divorce, his mother assumed that he felt the same anger towards his father as she did. She was unable to see that their relationship and Luke's feelings towards his father might be separate or different to her own.*
>
> *Six-month-old Matthew was playing happily with his trains, when his father swiftly took the trains away, and pushed the drum towards Matthew whilst sharing how Matthew was going to be a world famous drummer and needed to practice. When Matthew became distressed and reaching for the train, his father seemed preoccupied with his own desires and needs, and responded by playing the drum louder.*

Figure 2.1 Keeping one's child in mind, and being able to view them as a separate individual with their own mind, thoughts, feelings, desires, and wishes.

Moreover, some children might have had to find ways to survive in shark-infested waters, or to navigate their way through desolate islands (Chapter 1) by hiding, dissociating, bottling up, avoiding, and/or shutting out their feelings. For some of these children, due to enduring relational poverty and absence of emotion, it is likely that their stress regulation systems will become chronically supressed (Chapter 3). Examples follow:

> *Nelson excitedly performed a puppet show, his father responded by staring blankly with absent eyes, uttering a few monotone sounds, and shifting his head towards the TV.*
>
> *Christina herself had not been played with as a child, and had been under-socialised and relationally starved. When 3-month-old Morgan was born, she met her basic needs in a "robotic" manner, with her face and mood remaining flat in affect and unresponsive. Morgan would signal to Christina that she wanted to play/interact but quickly learned that those cues were not responded to, and so would turn her head away, lose herself in her own world, or go to sleep.*
>
> *Daphne smiled, laughed, and seemed unaffected, whilst baby Zoe was crying and distressed.*
>
> *Penelope's fun was restricted as she was regularly told to be quiet or stay still by her mother, for fear of provoking her father's violence.*

Other children have had to amplify their emotions and "become sharks" to get their needs met and/or noticed. In certain cases, they would have been shown that their feelings were linked to terrifying responses. For example,

> *Following falling over, Zach was burned by a cigarette for interrupting his parents' TV show and for "being a cry baby". On another occasion, despite walking on eggshells in an attempt to avoid "shark attacks", Zach accidently spilt Ribena on the floor, and was subsequently made to lick it dry, and to go without food for the remainder of the day*.

In the absence of a secure regulating caregiving system, and in the presence of complex trauma, children like Zach are vulnerable to living in a dysregulated state of arousal where they are soaked and trapped in toxic stress, and exposed to a pendulum of rapid high-intensity swings of emotions, through to flat disconnected responses. Due to these experiences, they are likely to have regularly triggered Fight, Flight, and Freeze (FFF) responses with few coping strategies available to them (fear with no solution) (Chapter 3). Bowlby (1980) described this phenomenon by stating that the child either shrinks from the world, or does battle with it.

These negative relational experiences are likely to have a whole host of consequences for the developing child's social, emotional, cognitive, and behavioural world. For example, children have often missed out on a thinking adult, such as Megan, who supported them in co-regulating their emotions, and connected with them in a meaningful way. *Without co-regulating, how can you self-regulate?*

They have not had the opportunities needed, from a safe adult, to notice, modulate, tolerate, or recover from extreme affect states, and to develop their capacity to integrate the bottom-up influences of emotions, with the top-down control of thoughts (Lilas and Turnball, 2009). *Think about the steps and support that children ordinarily need to sleep in their own room, recover from a nightmare, or calm down after their favourite toy goes missing.* Box 2.1 offers reflections around our own experience of developing and expressing emotions.

Therefore, these children often have a smaller window of tolerance (Siegel, 1999) and a sensitive defence system. They often present with a poor ability to self-regulate, process, and modulate affect and sensory stimuli (Koomar, 2009). This means they have a lower-threshold for high-intensity emotions; and are often slower to return to what often is a heightened baseline. Their defence systems can be like constantly beeping burglar alarms, meaning that a small drop of an emotion to them can feel like a drowning all-consuming sea. These complications are further exacerbated by associated executive function and cognitive difficulties, such as struggling to problem-solve, control impulse, or filter information (Chapters 3 and 9).

In addition, if relational trauma occurs when children are still developing, this means they often have little cognitive framework, or past buffering experiences to anchor onto, and are yet to master some of the key skills and competencies. Streeck-Fischer and van der Kolk (2000) discuss how children who have experienced complex trauma often lack the "internal maps to guide them" and therefore "act instead of plan" (p. 905). Therefore, children can be driven by these pouring, cascading out emotions which can show themselves through a variety of behaviours (Table 2.1).

Building a wider picture of the impact of relational and developmental trauma on children's emotional and social worlds, research has shown that these children tend to struggle with differentiating facial expressions, and are more likely to interpret events and faces as being negative, angry, and threatening; and subsequently have stronger emotional reactions to them (Perlman et al., 2008). This is sometimes referred to as hostile attribution bias (Chapter 12). Within this, children who have experienced complex trauma are also more likely to have difficulty with their reflective function (RF) capacities, cognitive flexibility, perspective-taking, ability to empathise and read emotional cues (e.g. connect with what goes on inside others' minds) (Cozolino, 2006).

This is hugely significant as these mentalisation and regulation skills are the cornerstone for guiding the child's relationships, their own ability to mentalise, sustain and form attachments, develop empathy, and to learn how to manage impulses and daily stressors (Grienenberger et al., 2005). These skills are also interlinked with behavioural responses. For example, in order to empathise, which is an aspect of RF, one needs to be able to cognitively perceive and decode another's emotional state; then to emotionally feel and connect with their emotional state, and then to behaviourally take an action (Decety and Jackson, 2006). Additionally, RF goes one step further by referring to the capacity to be able to make inferences about mental states (i.e. being able to think about what they are feeling and its potential effects).

2.1 Practical activity and reflective exercise: emotions

Draw a circle, and inside the circle represent through colour, shape, and size, *how much your* primary caregiver *gave to you the* core emotions *of sadness, fear, joy, anger, shame, and curiosity. What is interesting/surprising about this? How does this have an influence on your* current relationship *with sadness, fear, joy, anger, shame, and curiosity?*

When you experienced ... (anger, sadness, fear, shame) as a child, how did you calm or comfort yourself? How did or didn't your parents support you with these feelings? When you experienced ... (joy, excitement, curiosity) as a child, how was this responded to/fostered/encouraged by your parents? How similar or different is this now in your adult relationships?

Strategies for supporting children who have experienced relational and developmental trauma to identify, label, express, and regulate their feelings

From a practical perspective, in order to address some of the aforementioned pockets of difficulties, interventions, and interactions ideally will focus on supporting children and caregivers to be able to recognise, name, express, label, and regulate their feelings, as opposed to getting lost in a sea of emotions. Through strengthening children's/caregivers' ability to develop richer ways of describing emotion and modulating the duration, rhythm, and intensity of them, it is hoped that this will have a plethora of positive effects, including widening their window of arousal tolerance, and guiding children out of their limbic system, and back into their thinking brain.

Furthermore, this aims to increase the child's experience of meaningfully connected interactions, to fill up their emotional tank and treasure chest with new re-appraising positive experiences, and to rebalance the negative tipping scale. These strategies support children to learn that their feelings can be safe, and builds on the premise that the more we support children to have words to express themselves and to make sense of their experiences, the less likely they are to come out through tricky behaviours. These feelings foundations often need to be laid before the more complex talking and sense-making therapies can begin – children need to learn to crawl before they can run!

The following strategies offer the reader some practical creative and multi-sensory "feelings work" ideas to use with children either directly or indirectly via their key adults. These are not prescriptive or exhaustive, and should be interwoven with other existing tools. Their suitability and appropriateness need to be carefully considered, whilst tailoring them for the unique child, provider, and context. It is also acknowledged that these ideas form a sliver of one block of the feelings foundations; and some of the other blocks should be buffered through rich moment-to-moment relational interactions, like those captured by Megan and Carly and discussed throughout this book; an overarching embodiment of an emotionally aware relationship/environment, and/or through emotional literacy programs such as the Alert program, Roots of Empathy, SNAP, and Early HeartSmarts.

Role models and everyday naming of feelings

Children learn how to self-soothe, recognise, and manage their feelings through the people surrounding them. Therefore, the "thinking" adults play a pivotal role in verbally and nonverbally modelling, coaching, and scaffolding how to identify, express, and respond to high-intensity arousal and a range of feelings. They should endeavour, where appropriate, to openly name the feelings in the child, themselves, and in others. For example, *how do we respond when a child's favourite toy breaks, or in a frustrating situation (e.g. traffic), or when managing difficult feelings (bad day at work)? How openly are feelings named and acknowledged?* Everyday opportunities should be used to identify and discuss feelings. This might be in day-to-day interactions, on the TV, in a book/song/comic strip, or when playing. For example, "Wow Peppa pig has a big smile on her face she looks so excited" or "Lizzie the lizard is feeling sick, what shall we do to make her feel better?" or "If I were in your shoes, I might feel …", or "Why do you think the rabbit is looking sad?"

Keeping in mind that children who have experienced relational and developmental trauma tend to mind-read more or misinterpret emotional cues, it can be helpful to visually show the thinking and/or regulating process, such as taking in a purposeful deep breath, actively shaking out the tension, putting a finger to one's forehead, commenting on the thinking cogs moving, or the thinking clock ticking. Children should have desired skills such as showing kindness and empathy modelled by their surrounding adults (e.g. showing concern when a neighbour is unwell, volunteering at a soup kitchen, or offering an elderly person a seat on the train). These qualities are positively linked to prosocial tendencies (Masten et al., 2011).

Self-reflection and self-care

When working/living with children who have experienced complex trauma, it is inevitable that a range of strong feelings will be evoked. Sometimes the child's feelings are so overwhelming and unbearable that they are projected and pushed into those around them. Those around the child can become the containers of difficult feelings, which can lead to a variety of consequences and tricky dynamics. Therefore, it is important to reflect and be aware of our own emotional reactions, triggers, and hotspots, and to practice self-care and self-reflection (Chapters 6 and 8).

Getting to know the whole child

The more you really get to know a child, the more you can support them in identifying and learning about themselves and their feeling states (even more so in a new placement), similarly to a mother who learns to decode and decipher the different types of her baby's cries and signals. For example, *what makes them feel scared/happy/angry and how do they communicate this emotion through their body, face, words, or behaviours?* This can be increasingly difficult with children who have experienced complex trauma as they often have their protective guard dogs and trauma jacket on, so we need to look underneath the surface to see the hidden child and to hear their unexpressed needs. This crystallises the significance of looking beyond words, and attending to our own and others' unspoken communication, affect, and body language.

Creative and playful ways to expand on children's understanding and emotion expression

1. Making *biscuits or pizzas* with different facial expressions on them.
2. Making a *feelings of the day board* or a *feelings dictionary* such as E is for embarrassed.
3. Taking *feeling photographs* or using magazines to make their own *feelings collage/scrapbook*, e.g. of positive body language or sad faces.
4. *Face painting* or *designing masks, plates, balloons, playdough mats, or puppets* with different facial expressions.
5. Making a *quiz or using sentence completion tasks* with questions like, "Think of a time when you felt …", "I'm happiest when …", or "What is a feeling with 3 letters?"
6. Making a *feelings container* (bag, box, or jar) filled with *feelings cards*. Subsequently taking turns to pick a card to *describe it, act it out, or draw it.*
7. Getting children to practice *faces in the mirror* or *play follow the leader with facial expressions.*
8. Drawing a *blank head with speech marks* where the child can label different thoughts and feelings, or an even more interactive of doing this exercise is by using *a sculpture of a head or a swimming hat* to physically label the different feelings.
9. Making a *poster of different types of feelings* and letting the child put *stickers, buttons, or pebbles* by which ones they feel, and to what extent they feel them.
10. Making feelings *jewellery and badges* using different beads and decoration.
11. For those who are more *physical*, they can *run* to different places in the room representing different feelings, design a *feelings obstacles course*, *throw* sticky hands at a *feelings board*, *choreograph a feelings dance*, *drum* different *feeling rhythms*, write different feelings on the *spots in a game of twister,* or make a *feelings hopscotch*.

These ideas can be used as standalone activities, or usefully interwoven into the child's daily world. For example, when they tell you a story where they felt excited, you can connect it to their *feelings dictionary or a feelings face*. *Journaling, art, music, magazines, film, and dance* can be useful adaptations with older children. Complementing these ideas, there are amazing resources available which enhance and stimulate playful ways of talking about feelings, such as *feeling flashcards, balls, dolls, books, monsters, magnets, games (online and board), and stamps.*

All feelings are accepted

Show the child emotionally, cognitively, and physically that it is normal and safe to experience a range of feelings, and that these can be tolerated, borne witness to, and accepted in a containing way. This includes highlighting the difference between thoughts, feelings, and behaviours; as well as the usefulness of an emotion, such as how anger can help one fight for what they believe in, or for protection.

It can be very exposing for children to share their feelings, especially if they have not had positive experiences of doing this previously, so it is important to validate how difficult this can be, and to actively show that you are pleased that they came to/trusted you. Try to really listen and hear, and avoid telling them how they should feel – their feeling is their feeling, and they are entitled to feel it. *Put yourself in their shoes, how does it feel when someone tells you how you should feel, or dismisses how you are feeling?*

Mixed feelings

The child should be supported in noticing the experience of having mixed feelings. This is particularly significant for children who may have coped by separating/splitting/oscillating

feelings; or been immersed in all-or-nothing, black-or-white ways of thinking. This can be through verbal statements such as, "I can imagine you are very excited for starting school, but also a bit worried about …", and through practical activities which explore blended feelings, such as designing/drawing children's feelings rainbow, bag, puzzle, pie, or patchwork, or through mixing paints, cooking with various ingredients, making a kaleidoscope, designing inside/outside masks, or using layers of coloured sand. Where appropriate, the above ideas can be extended to talking about different parts of one's identity. For example, "It was so nice to see your caring part when you helped your sister with her homework", or "let's practice exercising your … part".

Practicing

Role playing scenarios/skills such as "Making new friends" or "Asking for help" through using puppets, masks, or dolls can be helpful. These can be incorporated into games like Charades or Pictionary, or explored through writing a story, poem, rap, or comic strip about the scenario.

Externalising and metaphors

Children should be supported in getting a stronger sense of what a feeling state is (Name it to Tame it). For example, children might like to name, describe, or externalise the feeling. Such as for worry, likening it to a worry worm, a worry cloud, jiggling jelly, or a spinning wheel; or anger, as a volcano, wave, tornado, lightning, or bubbling water. This can lead to child-friendly conversations around how you can cool the volcano down, not let water bubble over, surf the angry wave, or calm down the whirling tornado. Child-friendly weather or colour terms can also be useful, such as thunder or red for anger, and sun and yellow for happiness. Others may benefit from talking about different feelings in a sensory way, for example, using sandpaper for sad times, a rock for hard times, and fluffy material for calming times.

Body links

Where possible, support the child in making links between their feelings and their bodily sensations. This is especially important given the relationship between trauma and the body (Chapter 3). For example, "I wonder if you are feeling butterflies in your tummy", "I have noticed that your hands are tensing and you're breathing fast", or "Sometimes when I'm scared, my heart beats like a runaway train". Some children might want to make a visual representation (draw, sculpt, write) of these feelings. For example, cut out or draw the butterflies, and write a worry on each one, and let them fly away. Others might find body-mapping exercises helpful (Chapter 3).

Monitoring arousal levels

Adults need to be vigilant and responsive to the child's arousal level – both when they are under or over-aroused; and support them in increasing their awareness and monitoring of these processes. This can be through using scales and metaphors, such as a "feelings thermometer, volcano, engine, ladder", "a traffic-light system" or "a pot of bubbling feelings". The child can then be supported in learning how to recognise these patterns, to chart where on the scale they are/were, how intense the feeling was (big, small, medium), what helped bring them to a different feeling state, and what being in a different feeling state felt like. Day-to-day examples can help bring these to life, such as down-regulating at bedtime.

Adults may need to be the child's memory bank, and support them in creating links and consequential thinking between events, behaviours, and feelings, e.g. "Do you remember when …", or "When you felt … then …", or "What would happen if …". Using the head-heart-hand concept can be a child-friendly way of discussing these connections, as can be physically making a paper-chain or playing dominos.

Once children are more aware of what is happening and what feelings they are experiencing, particularly in times of emotionally charged situations, grounding and coping strategies can be introduced. Regulation skills should be practised and evaluated within a safe relationship and then transformed into a plan (coping card, hand of options, or a choice wheel) to maintain the child's arousal equilibrium, and to reduce the intensity and duration of future dysregulation. These might include relaxation exercises, a sensory box, safe place imagery, verbal affirmations, scent/smell box, and distraction techniques.

Behavioural dysregulation

Having discussed some of the ways emotions interface with behaviours, and the impact of trauma on one's relationship and overall development (Chapter 1), some of the common behavioural patterns seen in children who have experienced relational and development trauma will now be presented (Table 2.1). These behaviours span across multiple domains, and are often the catalyst for a referral to services. Although they are presented in Table 2.1 as separate categories, they often are overlapping, such as a child may present as verbally aggressive, physically aggressive, impulsive, and engage in antisocial behaviours.

Table 2.1 Common types and examples of behaviours seen within the relational and developmental trauma child population

Type of behaviour	*Example/s of how this behaviour may be shown*
Sleep difficulties (e.g. nightmares/ night terrors/excessive sleeping/difficulty falling, and/or staying asleep)	*Lilly would try her hardest to stay awake as she feared someone would come into her room to hurt her. She shared how when she fell asleep, she would have nightmares and physical sensations of the abuse she endured. She slept with the lights on, music playing, and a bell tied to her door handle, as a warning signal should anyone try to enter.*
Food difficulties (e.g. under-eating/over-eating/selective eating/ storing and/or foraging for food)	*Kieran would forage in his neighbour's dustbins, searching for scraps of food to feed him and his baby brother.*
	During mealtimes, Jamelia would have intrusive images and distressing sensations around her mouth. These were associated with forced oral sex. In turn, she would avoid food, and was worryingly underweight.
	Eating was the only way Naomi felt she could fill the void inside her.
Anti-social behaviour such as "lying", "stealing" (taking items), cruelty to animals, fire-setting, and property damage	*Nancy inaccurately told the whole class she was pregnant, and the following week that her foster carer had cancer.*
	Amelia repeatedly took money from her foster carer's wallet.
	Brian repeatedly strangled and poked the family dog's eyes.
	Scott key scratched and spray painted his neighbour's car.

Type of behaviour	*Example/s of how this behaviour may be shown*
Outbursts, physical aggression, and rage	*Tatiana physically threw chairs at her grandmother.*
	Duncan screamed, shouted, and punched walls, and occasionally his mother.
	Delia banged her dolls against the walls, put them in prison, pulled their heads off, and poked holes into their eyes.
Verbal aggression	*Ryan screamed and swore at his teacher, and made abusive threatening comments such as "I'm going to rape you".*
	Celia regularly told her adoptive mother that she was fat and ugly.
Non-cooperative behaviour	*Hayley took up to 2 hours getting ready for school. She would refuse to get out of bed, shout no, hide her clothes, lock the door, and hide the car keys.*
Hyperactive behaviour	*Kyle jumped up and down, running from wall to wall, wriggling around his seat, and touching everything in sight.*
	Sally appeared constantly on the go and would often run into the road without looking.
Hypervigilance	*Denise seemed to constantly scan the environment, and would flinch and be hypersensitive if there were any unexpected movements or external cues, such as a door opening or a car horn beeping. She would notice even the smallest changes such as a missing Lego piece.*
Controlling behaviours	*Dylan refused to play games unless he was in charge. He would clearly direct his mother what to do, and if she altered slightly, he would throw the game everywhere.*
	Liam threatened with allegations, such as "If you don't do … then I'll tell the social worker you hurt me".
Rejecting behaviours	*Carol physically pushed her kinship carer away each time she went to kiss her.*
	Leo told his grandmother that she was better off dead.
Regressive behaviours	*When Billie transitioned from primary to secondary school, she needed additional help with previously mastered tasks, such as getting dressed and being fed.*
	At age 10 after a traumatic re-triggering incident, Joey began speaking in a "baby" voice, crawling, and requesting to be in nappies.
Soiling and/or wetting	*19-year-old Jake missed out on an overseas college trip because he feared that he would wet the bed.*
	When Lydia saw a man with a dark brown beard, she would stand frozen on the spot and wet her knickers.
	Callum smeared his faeces along the dining room walls and on the hallway mirror.
Overfamiliar behaviour and/or behaviour of a sexual nature	*Lara showed little discrimination in her friendliness, and would walk off with any stranger who showed her some interest.*
	4-year-old Rose opened her legs and asked her teachers if they wanted to touch her.

(Continued)

Type of behaviour	*Example/s of how this behaviour may be shown*
Overly-compliant behaviours	*11-year-old Carol appeared scared to disagree or have a different opinion to her adoptive mother. She would often reply with whatever you want and unquestionably follow directions.*
Anxious behaviours	*Shimon engaged in rigid, ritualised, and repetitive behaviours, such as needing his clothes put on 3 times in a particular order, tapping the door knob 3 times before leaving etc.*
	8-year-old Olivia followed her mother everywhere, and became distressed even when she left for a few moments.
	Lydia avoided going to the park and to other children's parties for fear of seeing someone with a beard.
Withdrawn and/or dissociative behaviours	*Judith shut herself in her room for days.*
	Steve disengaged from conversations and answered each question with, "I don't know, I don't care" or a shoulder shrug.
	During times of high arousal such as Christmas, Mel appeared emotionally flat and had an absence of reaction.
	Pippa stared at her foster carers in a vacant trance-like state, with "hollow" eyes.
	Ivan appeared to float-off during conversation and needed his name called several times before returning.
Risky, self-stimulating, self-destructive, self-medicating, and self-soothing behaviours (e.g. self-injurious behaviour, self-harming, risky sexual behaviour, running-away, and using substances)	*Cathy was made to have unprotected sex with several men as part of a gang initiation.*
	Violet was reported to the police as going missing 6 nights in a row.
	Sacha used a razor to cut her thighs and when a sharp item was not available would drink cleaning products.
	Alfie drank 2 bottles of vodka before climbing on the roof and sitting with his legs dangling over the edge.
	5-year-old Eric banged his head against the radiator.

The behaviours in Table 2.1 are on a continuum, and often show themselves in multiple ways to varying degrees, in diverse contexts, with different people. Moreover the "age" and associated expectations will hold some bearing. For example, *a 3-year-old taking sweets from a supermarket would be viewed differently compared to the same behaviour being displayed by a 15-year-old.* Likewise, the impact of the behaviour and how stressful the behaviour is perceived to be are crucial. An example follows:

> *Sophie and Ted had longed for the time when they could take their child to the park or join their friends on a family day out. When Natalia was finally placed with them for adoption, this felt like a real possibility. Unfortunately, Natalia had difficulty interacting with other children, and there had been numerous incidents of her biting, scratching, and pinching them. Sophie and Ted found themselves increasingly uninvited to social occasions and distanced from their treasured social circles. They felt judged, ostracised, and*

criticised. This led to a vicious cycle, as Ted and Sophie's attention, preoccupation, and energy became focused on Natalia's behaviour, and the consequences of these behaviours had been magnified due to others' responses. This enhanced focus left less room for fun and parental satisfaction, which subsequently increased Natalia's misbehaviour, in turn increasing their sense of feeling like failures, and so forth. This also was wrapped up with the huge task of mourning for the parenting experience they had dreamed of.

Mentionable is that, as a society and in clinical settings, we tend to focus on the acting out of *externalised* behaviours (e.g. aggression or disruptiveness), rather than on the *internalised behaviours* (e.g. where a feeling is directed inwards, such as depression or withdrawal). These children, like the silenced phenomenon of *neglect*, can go under the radar. This is problematic as it misses valuable early intervention opportunities, and the system can mirror children's earlier experiences of neglect once again by remaining invisible and overlooked. Therefore, the balance needs to be shifted and we need to also see the absence of behaviour as a form of communication.

Moreover, behaviours can provide us with clues as to what is happening for the child and within their inner world. For example, *Chantel described how frustrated, hopeless, and stuck she felt with her key child in the residential home. She felt like giving up and blamed herself for being unskilled to effect change. These difficult, strongly triggered feelings seemed to be giving a window into how Giles might have been feeling (e.g. frustrated, hopeless, stuck) and into some of his*

Figure 2.2 Behaviour as communication. Inside/outside masks.

relational patterns. This captures how behaviours can be usefully seen as serving a function, responding to a trigger and/or as forms of communication, stories, and maps (see Chapter 9 and Boxes 2.2 and 2.3).

Striking is that behaviours are powerful, they can get under people's skin, and can trigger a range of difficult feelings. For example, *consider a foster carer whose foster child refuses to eat. Now bring into the mix the foster carer's:*

a *History of having an eating disorder,*
b *Belief that food is the vehicle for giving love, and*
c *Being raised in a war-torn country where food was limited.*

These behaviours will be conceptualised, interpreted, and responded to differently, depending on the lens through which they are viewed. These behaviours can also preoccupy people and define the child (master identity), *"She's a liar, and she never tells the truth"*. Therefore, behaviours can conceal the child's unexpressed need, and throw us off from the core; we may only be seeing the defences, and the opening sentence of the story. Rather than the camera staying in zoom mode, we need to widen the frame, and see the behaviour amongst a landscape of other relational, emotional, cognitive, historical, and systemic factors. Behaviours in Table 2.1 should be carefully reflected on within a broader context. Additional non-listed, but related concerns, such as executive function difficulties (Chapter 9), sensory-processing difficulties (Chapter 3), sense of self, and low self-esteem should be considered. The following section offers some behaviour-specific questions (see Chapter 5 for a more in-depth assessment framework). These are followed by Box 2.2 which illustrates the technique of deciphering the behaviour and viewing it as communication by using the example of "lying"; and then a case study is presented in Box 2.3. Additional questions around *"behaviour as communication"* are found in Chapter 9.

? *Behaviour Kaleidoscope*

1 *What is the behaviour? What does it look like? Can you give an example of when it happened?* It is important to use specific descriptions, which clearly define the behaviour, rather than "he's naughty" or "she doesn't sleep well".
2 *How does this behaviour look in relation to other children of their age?*
3 *When did the behaviour start, and how frequently does the behaviour occur? Why might the behaviour have started at that time?*
4 *Where does the behaviour occur? Are there differences depending on the context?*
5 *What other variables impact the behaviour? Are there particular patterns of behaviour?* It can be helpful to track, map out, chart, and/or diarise the behaviour's patterns.
6 *What triggers, hotspots, variables* (e.g. environmental, sensory, autobiographical, physical, cognitive, relational, emotional, situational) *make the presenting difficulty bigger, smaller, absent, present etc.? What happens in these times when the behaviour is absent or less?* (see trigger section in Chapter 9).

7 *What is the impact of the behaviour on the child and those around them?* For example on their: self-care, self-presentation, sleep, eating, mood, school life, relationships, learning, hobbies, daily living skills, and self-esteem. *What is the presenting difficulty making trickier or stopping the child/caregivers from doing?*
8 *What different interpretations and feelings does the behaviour evoke in different people? What clue does the way we feel, when at the receiving end of this behaviour, give us into the child's feelings?*
9 *What do we think the behaviour is communicating? What functions is it serving? What is the story behind the behaviour and underneath the surface?*
10 *What is the child's sense-making, meaning-making, attributions, explanations about the behaviour? How are these similar or different to other surrounding people's conceptualisations of the behaviour? How stressful and/or manageable is the behaviour to the child and/or team around the child (TAC)?*
11 *What strategies/interventions have been tried already? What responses/reactions from others has the child had when showing the behaviour?*
12 *What skills are needed to modify the behaviour?* (e.g. think about the child's parenting patchwork, developmental stages, EF skills).

If there are multiple concerning behaviours, this process may need to be done several times; however also consider if there are any linking threads and themes between the behaviours.

2.2 Behaviour as communication e.g. "lying"

"Lying" is often a behaviour that can be difficult to understand, tolerate, and manage. A child who frequently shows this behaviour can be defined as "a liar", "attention-seeker", and "fake". "Lying" can be helpfully reframed as *"stretching the truth"* or as *"difficulty distinguishing fantasy from reality". Does this different choice of wording change the meaning and/or feelings for you, and if so, how?*

"Lying" can really get under people's skin, particularly those who have been brought up with strong morals about honesty and truth-telling, therefore it can evoke a strong emotional connection. *What is your relationship to "lying"?* Each behaviour can be made sense of in multiple ways, which is why knowing the uniqueness of the child is crucial. The following is merely intended to illustrate how helpful it can be to *look beyond just a behaviour, and to see it as a communication*, and in some cases, as a clue to *what is happening in the child's inner world.*

Just the process of stopping, thinking, and reflecting can have a ripple effect on one's responses and conceptualisation of the child/behaviour.

Some possibilities for why children who have experienced relational and developmental trauma might stretch the truth:

- Relational and developmental trauma impacts a child's social and moral learning and therefore they may have a weakly formed conscience, theory of mind, and ability to mentalise. Additionally, stretching the truth is a normative stage of child development, which may have been impinged by developmental

(*continued*)

trauma. Moreover, children may have not yet developed the cognitive skills needed to fully grasp concepts such as cause-and-effect. Furthermore, many children have witnessed stretching the truth as the norm. Therefore, through social learning and poor role modelling this way of communicating has been reinforced, and at times encouraged. *Cammie explained how her parents would make her practice what to say and not to say to the social worker. Depending on her "performance" she was rewarded or punished.*

- Abuse is often characterised by secrecy and deception. Therefore, this way of relating can become normalised and internalised. Children may feel that the truth results in dire consequences e.g. post-disclosure of abuse, they were removed, not believed, and/or were blamed, for example, *"If you tell, your dog will be killed"*, *"This needs to be our special secret or the police will take you away"*. They also may stretch the truth in order to cover their tracks. *Liza shared how if she was "caught in a lie", she was made to swallow washing-up liquid.*
- Children may have learned that adults are unsafe and abusive; therefore "lying" can be a survival strategy to keep others at a distance (physically and emotionally). Whereas others may try and gain control to counteract feelings of powerlessness. Equally, sharing the truth means trusting someone, which, for many of these children, is an unfamiliar/dangerous concept. To be "truly seen" can feel terrifying, therefore children may buffer themselves with their "protective" trauma jacket. Similarly, this fits with the notion, "if they don't know the real me, they can't hurt me".
- Children may stretch the truth in an attempt to draw adults closer, to gain a response such as empathy, or to gain much needed attention/reward.
- Some children may attempt to create a conflict, "Better the devil you know", or "How far can I push until they hurt me?"
- Children may be testing to see if they are being listened to/noticed.
- Some may stretch the truth to build themselves up in their or others' eyes. Their fantasy world (protective dissociation) may be more desirable and safer than their reality.

2.3 Case study and practice

Ethan had stacked-up experiences of "anger" modelled to him in unhealthy ways, through witnessing DV from his father to his mother, and being the recipient of harsh parental discipline. These expressions of rage and dysregulation started from the womb, which was essentially a warzone. Ethan's mother was so often frozen in fear and preoccupied with her own survival that she was unable to provide Ethan with the safety, stimulation, and positive interaction that he needed. Ethan's father also placed blame on him for taking away his wife's attention and "draining" him physically and financially. At age six, Ethan witnessed his father stab his mother repeatedly, which resulted in her death, and his father's imprisonment. Ethan was subsequently placed in foster care, and was moved to four different placements.

At age twelve, Ethan would often respond to others with a "tornado of rage", shouting and being physically aggressive. He was described as having an "extremely

short-fuse and enjoying arguing". Ethan was frequently in trouble with the police, and had been excluded from two schools. Although difficult to decipher and see past the power of these spiky defences, it seemed that Ethan responded in this way when he felt threatened and/or vulnerable. Due to past unsafe dysregulated experiences, Ethan's baseline of danger and safety seemed skewed. He would see neediness and vulnerability in others and attack, because he couldn't bear it in himself. For Ethan, being "mad rather than sad", and "feared rather than fearful", was preferable to feeling vulnerable and hurt. He had learned that being in control made more sense than having meaningful connective relationships. The ongoing warfare in his mind was reflected outwardly in his conflict with others; and his rage seemed to be playing the role of guard dogs with spiked chains, which successfully kept others at bay, and made Ethan feel alive, potent, and strong. This protected him against painful feelings of helplessness, powerlessness, and sadness.

Impact on Ethan:

What gaps are there in the above information?
What impact might the above experiences have had on Ethan's …

1. *beliefs about himself, others, and the world e.g. "I am…", "others are…", "the world is…" (including his sense of self, self-esteem, and self-efficacy);*
2. *social and peer skills/relational and attachment styles and scripts. What might he think/have learned about relationships?*
3. *physical health, and his relationship to his body and his sensory world (Chapter 3);*
4. *social, emotional, and developmental age;*
5. *cognitive and learning abilities/ school experience (Chapter 9); and*
6. *emotional and behavioural dysregulation (e.g. ways of communicating, regulating, tolerating, and managing difficult feelings).*

How can we avoid amplifying "the tornado" and not become engaged in mutually escalating arousal (e.g. meeting anger with anger)? How can we slow "the tornado" down, reduce its intensity, or rise above it?

How can we be Ethan's external brain and co-regulator and bring him out of his limbic system into his thinking brain? How can we see Ethan as a hurt child, and the underlying emotions beyond the behaviours?

What skills does Ethan need to be taught in order to be able to express himself in a healthier way? How can we offer Ethan different experiences of being in meaningful connected relationships?

What strengths, skills, and resiliencies does Ethan have which can be acknowledged and built on (Chapter 4)?

Impact on you:

What parts of Ethan's life-story struck and made an impression on you*? What feelings/ thoughts/physical sensations did reading Ethan's lived experience have on* you*?*

What impact might working with Ethan have on you *as a professional? What might it be like to* parent *Ethan?*

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Chapter 3

The relationship between trauma, the body, and the brain

A body-based and sensory approach to relational and developmental trauma

Complex trauma can significantly imprint on children's developmental trajectories (Chapters 1–2) and on fundamental connective and integration processes. This includes the disintegration of the mind from the body, left from the right brain hemispheres, top from the bottom processes, internal from the external, psyche from the soma, and physical from the emotional experience. Therefore, there can be several sensorimotor and body-based consequences of trauma, which will be discussed in more detail throughout this chapter.

With the above in mind, this chapter will focus on the impact of relational and developmental trauma on children's brains and bodies. There are snippets of brain science peppered throughout this book, however it did not seem right to not have an additional section on brain science and body-based considerations, given the importance of the mind–body links. Therefore, some of the key brain science ideas will be presented, including the influence of maternal stress and substance abuse on the developing foetus. Additionally, some of the cautions of interpreting brain studies will be discussed, followed by a consideration of the ways in which the body is affected by complex trauma and chronic toxic stress. This will include exploring how body-based difficulties can show themselves in children, and discussing some body-based and sensory therapeutic models and practical tools. Before proceeding, it is important to clarify that I am not an expert in the field of brain science, and it is beyond the scope of this book to address the complexity of the brain in depth, nor is it necessary as a therapist to know the ins and outs. Instead, I have drawn on some of the key elements, which I find are useful to hold in mind as a clinician when supporting children and their systems who have experienced relational and developmental trauma.

Some key findings on the impact of maternal stress, maternal substance abuse, and complex trauma on the developing brain

Foetus programming and foetus memory

Studies have demonstrated how the neural connectivity between the brainstem, limbic, and cortical brain regions undergo rapid development during pregnancy.

Therefore, significant events, such as domestic violence (DV), maternal stress, malnutrition, and substance abuse during the prenatal period can revise the connectivity between these regions, to prepare the foetus for the future environment (prenatal programming). Research has also repeatedly demonstrated the occurrence of foetal memory and foetal learning through smells, sounds, and tastes during pregnancy. For example, one experiment exposed foetuses regularly to a television theme tune; once the babies were born and were played the same theme tune, they showed physiological changes, such as decreased heart rate (Hepper, 1991). This highlights the importance of the prenatal period, and positions the womb as the baby's first classroom and introduction to their world.

Maternal substance abuse

Several studies have shown the negative cognitive, emotional, and behavioural consequences on the developing child of in-utero drug, alcohol, and nicotine use. Significant is that research shows that women are more likely to be poly-drug users; meaning that there is a higher likelihood that children have been exposed to the impact of multiple substances, each with their own unique properties and effects. Mentionable is that there is overwhelming evidence on the negative influences of nicotine on the developing baby, however often in services nicotine is given less priority than other substances.

Taking alcohol as an example, there is a large body of evidence on the relationship between exposure to *alcohol prenatally*, and later cognitive and executive function (EF) difficulties, including in selective inhibition, verbal and nonverbal fluency, arousal, attention, hyperactivity, problem-solving, planning, and working memory (Green et al., 2009; Rasmussen and Bisanz, 2009) (some of the implications of poor EF are discussed in Chapter 9). Moreover, within this population, there are increased observations of self-regulation difficulties, and the ability to manage internal, sensory, emotional, behavioural, and bodily states (Chapter 2). These children also have a higher likelihood of having Fetal Alcohol Spectrum Disorders (FASD). FASD is the umbrella term for the whole spectrum of those who may be affected by fetal alcohol exposure, such as Alcohol-Related Neurodevelopmental Defects (ARND), and at the more severe end, Fetal Alcohol Syndrome (FAS). There are numerous variations of how alcohol exposure can show itself, and these are influenced by a range of factors, including the developmental timing of the exposure, and the mother's and foetus's metabolism systems. Importantly, experts believe FASD remain hugely under- and misdiagnosed in the child mental health, attachment, and trauma populations.

Whereas, in babies *prenatally exposed to cocaine* there were higher incidences of amniotic sac ruptures and placentas separating from uteruses (Addis et al., 2001). Additionally, Singer et al. (2008) used the Brazelton Neonatal Assessment Scale, and found that babies exposed to cocaine in-utero showed more difficulties in sensory asymmetry, orientation, habituation, regulation, autonomic stability, reflexes, muscle tone, motor performance, irritability, and alertness. Likewise, longitudinal studies of prenatally cocaine-exposed 4 to 7 year olds were found to

perform below standard norms on sustained and selective attention tests (Bandstra et al., 2010); and Bennett et al. (2007) found that boys aged 10 with histories of prenatal cocaine exposure were more likely to display high-risk traits; including aggression, hyperactivity, and disregard for safety (see Ira Chasnoff's Mystery of Risk book for a review of the impact of various substances on developing children).

Maternal stress

Pregnancy has commonly been characterised as a time for increased rumination and worry; even more so in the context of other life stressors, such as health complications, financial/accommodation considerations, and being known to social services. These challenges can be compounded by other factors such as being a teenage parent, having a child with additional health/learning needs, and having limited or unsafe support systems. Moreover, pregnant women have been found to be at particularly high risk for exposure to DV (Kendall-Tackett, 2007), and for experiencing mental health difficulties, such as anxiety and depression. For example, higher rates of PTSD have been found for women who experienced childhood trauma, previous pregnancy loss, or when pregnancy has been as a result of sexual assault.

With this in mind, studies have demonstrated that foetuses can respond to maternal stress, and that maternal mood, including elevated cortisol levels, can cross the placenta (Sarkar et al., 2006; Monk et al., 2012). This is in line with the "foetal-origins hypothesis" (Kinsella and Monk, 2009), which argues that stress directly affects foetal development. For example, pregnant women who were present at the September 11 attacks, who later showed PTSD symptoms, had babies who also had altered stress responses and elevated cortisol levels (Yehuda et al., 2005); and Field et al. (2006) found that babies born to mothers categorised as being depressed and withdrawn displayed flattened moods, and had lower dopamine and serotonin levels.

Furthermore, longitudinal research has shown that maternal stress is associated with negative affect, poorer motor and cognitive development, behavioural problems, problem-solving difficulties, and increased anxiety disorders in children (Talge et al., 2007; Lazinski et al., 2008). Examples of maternal toxic stress follow:

Mary, a 20-year-old Sudanese woman was raped, and subsequently fell pregnant with twins. During her pregnancy, her village was attacked and burned to the ground. In essence her twins were trapped and soaked in a war-torn conflict-ridden womb (Figure 3.1). She was also rejected from the community, due to stigma around being an unmarried pregnant woman.

Jayla broke-up with her boyfriend, and due to missed rent payments was evicted. This resulted in her living on the streets. At her first antenatal check, she received the diagnosis of being HIV-positive.

Leah came to the attention of services after being repeatedly kicked in her pregnant stomach and gagged after declining her boyfriend's sexual advances.

Figure 3.1 The womb as a warzone.

Mentionable, but beyond the remit of this book are the epigenetic studies. For example, studies have shown that changes in gene expression can occur in response to environmental factors (i.e. trauma and stress), and that these can be transmitted intergenerationally; leaving children with a gene expression that has been uniquely influenced by their parent's experiences. This has been demonstrated in a variety of contexts including during the Dutch famine (Lumey et al., 1995), and in the offspring of holocaust survivors (Kellerman, 2013). These studies uncover a whole new arena of possibilities around not just how gene sequences can be passed from parents to children, but also around how and why gene expression and regulation can vary from parent to child.

Brain development

During the critical sensitive periods including the in-utero stage, the brain develops and organises at an incredible growth rate. The brain is experience-dependent, and so it is like a sponge or muscle, constantly absorbing new experiences, and being shaped by interactions/relationships and its surrounding environment (see the neurobiology of attachment section in Chapter 1). As one would expect, developmental competencies build up over time, and are reliant upon previous stages. This fits with the way the brain develops, as it is a hierarchical system and organises itself from the bottom-up and inside out, like Lego building blocks; starting from the least complex (the brainstem, also known as the Survival/Reptilian brain) to the most complex areas (the Limbic system/Emotional brain), and then the cortex, (known as the Learning/Thinking brain).

Whilst all of these areas are significantly integrated and interconnected, they each mediate distinct functions. Like in a house, there are lots of different rooms each serving their own function but fundamentally they are still interlinked. For example, the lower structurally simpler areas mediate basic regulatory functions, such as breathing, heart rate, and the fight, flight, freeze response (FFF); whereas the highest structures mediate the more complex functions, such as logic and reasoning. Importantly, children who feel unsafe and fearful, like those who have experienced relational and development trauma, spend more time in the lower building blocks of the brain, making this survival part highly-activated and the other parts under-utilised.

Due to children's developing brains being at periods of heightened neural plasticity, this makes them particularly sensitive to the effects of trauma and stress. This fits with the idea that systems are often most adaptable during their building stage. Therefore, complex trauma has been shown to impact a child's psychobiology at multiple levels, from neurohormonal to neuroanatomical (Teicher et al., 2012). These biologically embedded changes can affect several developmental processes, such as synaptic overproduction, pruning, and myelination (Glaser, 2000) (Chapter 1). This is often referred to by the catchy phrases "If you don't use it you lose it", and "you have to fire it to wire it". Although these findings need to be interpreted with caution, this includes, in some cases, affecting the architecture, structure, and function of the developing brain. Most consistently evidenced in the child trauma literature is the effect on the ventromedial, orbitofrontal-limbic regions, and the networks of affect control (e.g. the sensory-integration, emotional-regulation, and decision-making/reward-processing functions). There is also emerging evidence for discrepancies in the lateral fronto-striatal and parieto-temporal regions, which mediate a range of functions including EF (e.g. inhibition, attention, and working memory).

Interestingly, there have also been studies documenting decreased cerebral volumes (Schore, 2009; Teicher et al., 2012), larger lateral ventricles, and frontal lobe cerebrospinal fluid volumes (Carrion et al., 2009), and an over-activity of the amygdala (Tottenham et al., 2010). This is poignant as the amygdala plays an important role in fear conditioning, FFF responses, and assigning emotional significance to stimuli. Moreover, changes have been found in the corpus callosum (CC) volume and white matter integrity (Jackowski et al., 2008), which is significant, as the CC is a main connection point, like a bridge, between the left and right cerebral hemispheres, and is key in facilitating inter-hemispheric communication for both emotion and higher cognitive abilities.

Window of tolerance and regulatory abilities

Having discussed some of the structural and functional changes in the brain, this section will now explore some of the possible regulatory effects of intense and unregulated toxic stress and trauma (Chapter 1–2). Studies have shown that trauma and stress experiences can impact cortisol levels and key regulatory processes (Heim et al., 2008; Thayer and Lane, 2009; Cicchetti et al., 2010). These include the executive systems for emotion and information-processing, the reward/motivation systems (e.g. dopamine), the sympathetic

nervous system (i.e. FFF, maintaining homeostasis, and regulation of several of the body's functions, such as temperature), the serotonin system (i.e. regulating functions including mood, sleep, appetite, bowel function, and weight), and the distress-tolerance system, such as the limbic-hypothalamic-pituitary-adrenal (HPA-axis). These have significant implications, for example, the HPA-axis plays a fundamental role in the response to external and internal stimuli, including psychological stressors; abnormalities in the HPA-axis, such as over-activity, have been linked to a range of difficulties including panic disorder, and anorexia; and under-activity to conditions such as depression and chronic fatigue (Juruena et al., 2004).

In addition to social learning and attachment theories, this sheds some light on why children exposed to abuse and neglect often demonstrate changes in the way in which they regulate their stress systems, with their systems either being chronically-elevated and up-regulated, or chronically-suppressed and under-regulated (Gunnar and Fisher, 2006). This can also extend to difficulties alternating or transitioning smoothly from one arousal state to another, for example, moving from playtime to a structured lesson, or from being alert to needing to down-regulate in order to be able to sleep.

In the context of relational and developmental trauma, children without the presence of a safe regulating adult have often been left in an overwhelming sea of emotional, sensorial, and physiological waves. Therefore, remaining in persistent fear states, their FFF responses (Reptilian and Survival brain), and rage/fear systems have often been continually overused, like a well-exercised muscle. This offers some explanation as to why these children can have sensitive defence systems (overly-sensitised), be hyper-vigilant, and be preoccupied with detecting and surviving threats. The world around them often feels too loud, too big, or too bright. They can experience regular hijacking of their limbic systems (e.g. emotions and drives), and one drop of emotion can feel like a vast ocean, which overrides their inhibitory systems. This also sheds some light as to why these children often can be more easily triggered, have a lower window of tolerance (Siegel, 2012), and out-of-sync emotional equilibrium (Chapters 1–2).

This is illustrated by the following examples.

Tilly seemed constantly in a state of high-arousal. She would scan the therapy room for any signs of danger. With each squeak of a chair, or tap on the door, she zoomed-in like looking through the lens of a threat-trained camera.

Simon, aged 9, would have extreme physical outbursts lasting for up to two hours. His adoptive parents described having to "walk on eggshells", as Simon could go from "0–100 in milliseconds". In order to survive he had developed a highly attuned antenna for danger. This meant he often misread incoming cues (i.e. a neutral face) as a threat. He appeared on guard, and with a "small" trigger such as a stare, or the sound of the toilet flushing, could be catapulted into a primitive "over-reactive" state.

Paula flinched every time her carer reached for the remote control, in fear that she was going to hit her.

A parked car's alarm went off outside the school. All of the children became unsettled, but were easily brought back to the task. Samantha remained on edge and distracted for the remainder of the day.

Children, like Simon, lived in sensory disintegration and spent more time in survival mode (lower building blocks). This often is at the expense of being able to use, master, and develop age-appropriate competencies, and higher-level brain functions (e.g. planning, problem-solving, and reasoning). This is echoed in studies showing increased EF and cognitive difficulties amongst this population (Chapter 9), such as struggling to attend, memorise, problem-solve, filter information, and analyse useful information from past experience. EF skills importantly have been linked to self-regulation (Ayduk et al., 2000).

On the other hand, some children have learned to protect themselves by psychologically "running away" (dissociating), blocking out their feelings, cutting off their mind from their body, and/or numbing themselves. Their systems are likely to have become chronically suppressed and down-regulated. This is echoed in studies of chronic neglect, showing increased dorsal vagal tones, diminished brain activity, and decreased heart rates (Marshall and Fox, 2004; Schore, 2009). Siegel (2012) describes how dissociation involves a "Disruption in the integration of memory, identity, perception, and consciousness processes" (p. 360); and that dissociation challenges neural integration, and can create a fragmentation of the self. This is captured in the following examples:

Julie (mother) became extremely dysregulated. She began screaming, punching walls, and threatening the professionals. Everyone was shaken-up and noticeably distressed. However, markedly, throughout the incident, Julie's 3-year-old daughter played in the corner with her dolls, seeming completely un-phased, non-reactive, and disconnected.

Mara discussed in a matter-of-fact manner the sexual abuse she had endured within a paedophile ring. She showed no emotional response.

Sean was taken by his foster carers to a theme park. They described how he walked around at a slow pace, expressionless, and flat in affect.

Joyce was shown a distressing video clip and asked to attend to her emotional and physical feelings. When asked about these, she said "I don't know, I felt nothing".

Implications

These findings widen the picture as to some of the complex presentations and associated difficulties we see in children who have experienced relational and developmental trauma; and crystallises the importance of thoughtfully integrating these theories and cross-disciplinary perspectives (i.e. attachment, trauma,

sensory-integration, and traumatic brain injury) into psycho-education, training, screening, assessment, formulation, and intervention processes. They also have wider implications such as in areas of public health and campaigning, for early-intervention programmes (i.e. with pregnant mothers), and for babies who are removed at or soon after birth, but still had a difficult in-utero period.

Interpreting brain science with caution

The ever-growing climate on brain-based and neurodevelopmental findings has positively taken understandings of the impact of relational and developmental trauma to a new level, and has opened the trauma and attachment community to an array of innovative therapeutic approaches. It certainly has played a large role in helping me to formulate some of the complexities within clinical cases, and has been a useful component when supporting schools and the overarching therapeutic re-parenting process (Chapter 6). However, it seems important to acknowledge that brain science is still a rapidly growing area, with many findings being in their infancy, or remaining unknown. Therefore, the outcomes presented, both in professional and public arenas, can be easily misinterpreted, skewed, or misrepresented. This is particularly worrying, when definitive cause and effect claims are made, when caregivers feel paralysed and hopeless by the findings (e.g. "Their brain is damaged, so there's nothing we can do"), or when the brain science elements are so magnified that other individual differences, contextual, and systemic factors are neglected.

Throughout the maltreatment literature, it is recognised that findings are often conflicting and contradictory, with studies varying in their reliability, consistency, and validity properties. Compounding this is that many studies have small sample sizes, limiting their statistical power; lack a control group and longitudinal outcomes; and focus on a particular brain function, rather than on a whole-brain approach. This is further complicated by the majority of studies investigating children who have experienced "trauma", but are unable to define or determine what type of trauma. This is due to a range of factors including:

1 The umbrella term of "maltreatment" being used.
2 The complexities associated with co-morbid diagnoses such as PTSD, depression, and ADHD, including some participants already being on medications.
3 The unknown or undisclosed effects of exposure to toxins during the in-utero period, and/or life events, such as sexual abuse.

Therefore, identifying what is unique to a particular type of trauma, and the different ways which these might impact the neurobiology, is challenging to conclude. Additionally is that many studies research specific groups, such as those institutionalised in Romanian orphanages, therefore questioning the transferability and generalisation of these findings to other "trauma" groups. These complexities echo the complexity of the client group; therefore it is essential to take a critical lens, and to interpret findings with caution.

Furthermore, in everyday life, we often cannot accurately test out these theories, as we generally do not have access to the complicated brain-scanning equipment needed. We also know that, whilst there are useful commonly occurring brain-based hypotheses, there are also huge individual differences, and levels of vulnerabilities/sensitivities to both positive and negative experiences (Belsky et al., 2007). Therefore, we need to consider the possible

damage caused, whilst balancing this with protective factors and the potential for growth (Chapter 4).

It is certainly not my intention to suggest that every child who has experienced trauma has significant brain difficulties as a result, but rather, to raise it as an important area in the whole-child approach. Therefore, the possible brain effects should be assessed and tentatively hypothesised, whilst considering other interplaying factors within a wider biopsychosocial framework (Chapters 1–2). For the interested reader, Table 3.1 lists some professionals who have written extensively on the impact of trauma on the brain and body.

Table 3.1 Recommended further reading on brain science and body-based approaches

Allan Schore	Daniel Siegel	Joseph LeDoux	Pat Ogden
Stephen Porges	Babette Rothschild	Susan Aposhyan	Peter Levine
Jaak Panksepp	Louis Cozalino	Bruce Perry	Antonia Damasio
Bessel van der kolk	Alan Fogel	Robert Scaer	Martin Teicher

Trauma on the body

Why is the body so important?

Having discussed some of the potential brain-based consequences of relational and developmental trauma, the following sections will consider some of the ways in which the body is affected by trauma, and how these concepts can be interwoven into real-life applications when living with or supporting these children.

Physical and emotional container

The body itself is fundamental in all stages of life, from conception, to being contained within the womb, to travelling with us throughout every life stage and experience. It is physically visible to the outside world, and acts as an actual physical container, and as a vehicle of expression and communication (e.g. scars, bruises, injuries, and malnourishment). It can also be an emotional container. *Think about where and what happens in your body when watching/witnessing something powerful, loving, emotive, or sickening.* This notion of trauma permeating through layers and really getting under one's skin has been aptly described as the "body keeping the score" (van der Kolk, 2014) or "the body remembering" (Rothschild, 2000).

Trauma-related body sensations

Research has shown that when trauma or highly-charged emotional experiences occur, they are often encoded and embedded in the limbic system, and in the right brain as sensory, somatic, and emotional memories (van der Kolk, 2014). Therefore, due to these information-processing systems, trauma often shows itself in vivid images, fragments, and sensations which are unintegrated, unprocessed, and lack a verbal narrative/context (e.g. nightmares, flashbacks). This can make

verbal declarative and autobiographical memory, and the ability to put internal experience into words, more difficult – even more so for children who are often pre-verbal at the time of the trauma, and who naturally function more in the right brain hemisphere (feeling and sensing hemisphere). Consequently, trauma is more likely to be embedded in the body, and to be re-experienced or re-lived through bodily sensations. In essence, the body may remember what the mind wants to forget. This may result in increased sensitisation to subtle affective and sensory reminders of the traumatic event, which may easily set off false alarms (Fisher, 2006). This is demonstrated in the following examples:

As a child, Stephanie had been repeatedly sexually abused by her uncle. Subsequently, at 16 years old, she had been raped as part of a gang-initiation, and became pregnant. During the pregnancy, her past body memories and sensations from the abuse were re-retriggered. She described feeling that her body was once again being taken over and controlled. She also feared that her baby could really see the "damage and dirt deep within her".

Olivia's 2-year-old son, Duncan, had begun pulling her hair as a way to gain her attention. One day, Olivia was taken by surprise and responded by hitting Duncan across the face. She was stunned by her actions, but later when debriefing, made the connection that as a child her neighbour when abusing her, would pull her down and restrict her by her hair. This unprocessed memory had been triggered through the physical sensation of having her hair pulled.

Dan visited a college with the hopes of enrolling in a mechanics course, when he got stuck in the lift, and had a panic attack. He later described that the feeling of being trapped and having to bang on the doors, had taken him back in a time-machine to memories where he had been physically abused, and locked for hours in a tiny laundry cupboard. As he was retelling this story, he curled up into a ball, making himself small, hidden, and protected. I imagine a similar pose to how his body had responded all those years ago.

Some of these physical consequences can be palatable and can evoke body-based sensations in others. For example,

Eva described having her legs bound. In that moment, I too felt glued to the seat with numbed legs.

Similarly, when Tyler entered the room, I often felt suffocated and more aware of my asthma. He later disclosed that as physical punishment for difficult behaviour, he used to have a bag tied over his head, until he passed out from a lack of oxygen.

Learning about one's sensory world in the context of a regulated adult

Children learn endless skills through the introduction and development of their sensory world (Parenting Patchwork, Box 1.3). *Just consider the intricacies that go into supporting a baby's development of their body and senses. From the soft furry clothes they wear, to attending messy play classes, to the careful selection of food types, to potty training, to bath time, to supporting a baby's hunger-arousal system etc.* Whereas for children who have experienced relational and developmental trauma, they have often missed out on many fundamental sensory experiences; they are more likely to have been exposed to multiple dysregulated adults, and to have had a sensory world which oscillated from being under- to over-flooded. Children may also have been exposed to their caregiver's unusual sensory experiences, that is, when using substances, or during a psychotic episode.

Examples follow:

> *Malcolm at 3 days old was fed chips and coca cola; whereas Jayme was left alone in a bare cot in soiled nappies for several hours; and Leo hours after being born, was presented at a crowded, smoke-filled, loud house party, where he was swung, squeezed, and spun around by multiple people.*

Children, like Leo, generally would not have had a caregiver who was consistent, attuned, and sensitive to their needs (Chapters 1–2 and 6), or who taught them how to successfully co-regulate. Therefore, it is unsurprising that we see high levels of self-regulation, sensory-processing, sensory-sensitivity, and sensory-integration difficulties within this population.

Too little or too much touching

Moreover, relational and developmental trauma directly affects the body, whether this is from too much, or too little touching. In the context of trauma, children's bodies are often used, neglected, violated, or injured. These experiences are compounded by conflicting messages being given around image, physicality, and sexuality, for example, "You got wet so you must have liked it". This is captured by the following examples:

> *Sophie would be left for hours in her pram with no touch or comfort.*
> *Troy would be violently beaten when he wet the bed.*
> *Cathy would avoid showering, in the hope that her body odour would deter her stepfather from touching her.*

Physical health

Another area which highlights the importance of the body in the context of trauma, and has vast public health implications, are the widely recognised negative effects of stress and trauma on one's physical health. Starting from the in-utero experience,

the foetal immune system has been found to be particularly vulnerable to disruptions caused by environmental factors, such as toxins, malnutrition, poor prenatal care, and maternal stress. These can also lead to problems in foetal development, blood flow, placental size, brain growth, premature birth, low birth weight; and can pose a risk for their cognitive development (Belkacemi et al., 2010). Examples follow:

Sue had a long history of uncontrolled diabetes, and throughout pregnancy struggled to comply with her treatment plan.

Fiona, reported not wanting to get "fat" and so continued to restrict her food intake.

Janice found being examined extremely intrusive and re-triggering of early sexual abuse. Consequently, she did not attend any antenatal checks.

These effects can continue throughout the lifespan, as links between a range of physical health and autoimmune disorders and childhood abuse and neglect have been repeatedly shown in longitudinal research such as the Adverse Childhood Experiences (ACE) studies (Dube et al., 2009).

Table 3.2 details some of the body-based and sensory associated presentations within the relational and developmental trauma population.

Table 3.2 Body-based and sensory associated presentations within the relational and developmental trauma population

- Re-experiencing traumatic events through multi-sensory experiences e.g. sounds, smells, bodily-sensations, intrusions, nightmares, and flashbacks.
- Eating disorders and/or eating-related difficulties.
- Sleep-related difficulties.
- Wetting and/or soiling.
- Hyperactive behaviours.
- Self-harming behaviours.
- Risky sexual behaviour.
- Poor self-care.
- Compulsive rituals.
- Sensorimotor developmental difficulties such as problems with fine motor skills, coordination, and balance.
- Sensory-processing difficulties, such as struggling to filter out irrelevant stimuli, lacking regulatory control, becoming easily overwhelmed/distracted.
- Identity and image difficulties (e.g. sexual and body) including body dysmorphic disorder.
- Conversion disorder/pain disorder.
- Increased medical/physical health difficulties.
- Rashes and allergies.
- Psychosomatic symptoms/medically-unexplained symptoms e.g. digestive problems, headaches, chronic fatigue.
- Physical aggression.
- Fixation, preoccupation, and over-attention to physical sensations.
- Difficulties separating, differentiating, and/or connecting with one's own or others' bodies.
- Decreased awareness or dissociation from sensations, emotions, and bodily states.
- Feeling one's body is being intruded on, or invaded.
- Hypersensitivity to physical contact.

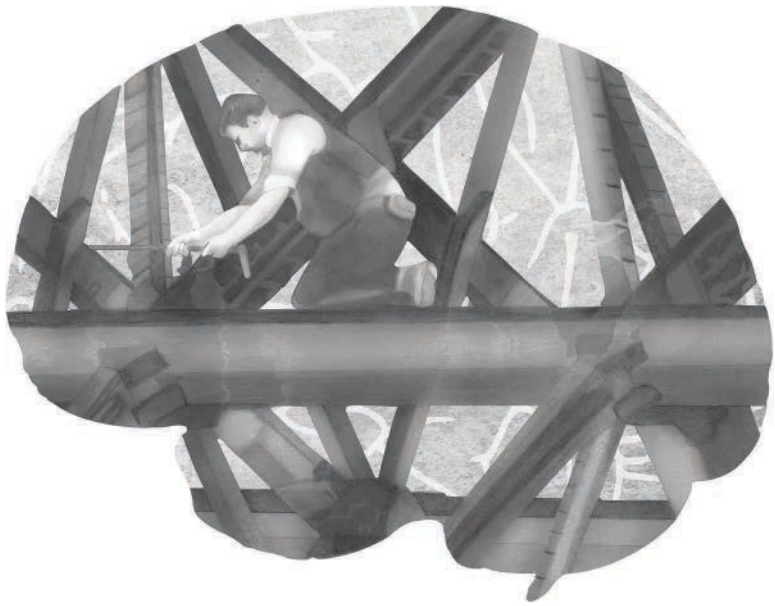

Figure 3.2 A whole brain approach. Left and right brain connection and communication.

Sensory and body-based approaches and implications

Taking the above clinical presentations into account, these call for a wider approach than isolated talking therapies, and one which prioritises reintegrating and reconnecting the mind with the body, the left with the right brain, and the internal with the external experience (Figure 3.2). Children's physical and sensory states often need to be addressed before interventions targeting higher-cortical processes (e.g. cognitive appraisal) can occur (Ogden and Fisher, 2014). Therefore, other body-based and somatic means of expression and communication, which engage the non-verbal, metaphorical, symbolic, primal, sensory, motor, and right-brained processes, should be employed and attended to.

Interventions should also target a child's ability to tune in, tolerate, and sustain connection to internal states/feelings/sensations, as well as finding strategies to regulate these. This is in line with evidence-based trauma and attachment interventions, which detail safety, grounding, and self-regulation as paramount components. It is also important to find multi-sensory ways for the child to communicate their inner experience and somatic narratives. These approaches support children to think with their bodies, and to increase their body intelligence.

A body and brain-informed approach also advocates for integrating sensory profiles, neuropsychological, and cognitive assessments into assessment and treatment packages. This advocates for widening the lens to consider surrounding environments. After all, we would not expect a child in a wheelchair to access

school without the necessary permanent provisions in place. *How can we make environments more attachment and trauma-sensitive?* (Chapters 8–9, 11) *How can we provide children with more enriched and engaged environments? How can we consider behavioural difficulties and presenting triggers from a multi-sensory perspective?*

The following sections will discuss some of the existing body-based and sensory therapeutic interventions; these should not be discounted from other trauma and attachment-informed interventions (Chapter 7) which ideally would be interwoven. Subsequently, some practical sensory and body-based tools will be offered which can be integrated into everyday life.

Body-based and sensory therapy models

Sensorimotor Psychotherapy (SP) (Ogden and Fisher, 2014) is an approach developed to address specifically the resolution of the somatic symptoms of unresolved trauma. SP is designed to address the cognitive-emotional aspects, and the bodily and autonomic symptoms of traumatic stress and attachment-related disorders. There is a strong emphasis on the client attending and observing how their body responds to experiences that have been organised or encoded. SP works from the "bottom up" by attending to the client's body and incorporates ideas drawn from Psychodynamic Psychotherapy, Mindfulness, Gestalt Therapy, Cognitive-Behavioural treatments, and the Hakomi method of Body Psychotherapy. SP is a somatic body-based approach, which can be integrated into other traditional interventions.

Sensory Motor Arousal Regulation Treatment (SMART) (Warner and Koomar, 2009). SMART embeds sensory-integration and sensory-motor strategies within trauma, emotional, behavioural, and relational dysregulation frameworks. SMART's goals are to expand the repertoire of regulating and nurturing experiences for children and their caregivers, and to facilitate integrated trauma-processing. Therapists learn an array of sensory-motor strategies (e.g. using weighted blankets, balance beams, and balls) to facilitate improved regulation and attunement.

Sensory Attachment Intervention (SAI) was developed by Ireland-based occupational therapist, Eadoin Bhreathnach, for children who have experienced relational and developmental trauma (2008). SAI combines attachment and sensory-processing theories, and primarily focuses on the modulation and regulation of body senses and arousal states, including FFF. SAI also attends to the co-regulating process between carer and child, and works to identify their arousal triggers, responses to stress, and reflective function skills. SAI uses observation, video footage, and a range of sensory-based equipment (e.g. swings, cushions, and tunnels) and also considers sensory-based daily activities, such as bathing and mealtimes. The developer also has designed a group intervention, underpinned by these principles, called the *Just Right State*.

Neurocognitive Habilitation is a group treatment approach designed for the caregivers of children prenatally exposed to alcohol. It integrates techniques and interventions used in therapy for traumatic brain injury (Dykeman, 2003) with components of the *Alert Program* (Williams and Shellenberger, 1996), and uses a combination of tools to address self-regulation, sensory-processing, and EF difficulties.

Eye Movement Desensitisation and Reprocessing (EMDR) is a well-evidenced form of psychotherapy delivered by an EMDR qualified therapist; designed to reduce trauma-related stress, anxiety, and depression symptoms. EMDR has elements of other therapeutic approaches, including Psychodynamic, Cognitive-Behavioural, Interpersonal, Experiential, and Body-centred therapies. EMDR addresses symptoms by processing components of negative memories and associating them with more adaptive behaviours, emotions, and information. EMDR consists of an eight-phased approach including: *1) history-taking, 2) preparation, 3) assessment, 4) desensitisation, 5) installation, 6) body scan, 7) closure, and 8) re-evaluation.* One of the key elements of EMDR is dual bilateral stimulation, which is in line with a whole-brain approach. For example, a client is asked to think about difficult memories, triggers, and emotions, whilst simultaneously focusing on the therapist's moving finger, or another form of bilateral stimuli, such as tapping. With this particular client group, there are specific EMDR adaptations for relational and attachment difficulties (books by: Laurel Parnell, Joan Lovett, Ana Gomez, and Debra Wesselmann).

Yoga-based therapy: Although in the early stages of developing a robust evidence-base in the treatment of children who have experienced relational and developmental trauma. There are several emerging positive findings on the use of trauma-sensitive yoga (Emerson and Hopper, 2011); including stress reduction, improved mind–body connection, increased self-awareness, and increased ability to self-regulate. These extend to concepts built on further in *Mindfulness.*

Neurofeedback training (NF) is a computer-based interface that uses sensors placed on specific areas of the scalp to provide the brain with instantaneous feedback on frequencies in the EEG (Brainwave). Frequencies are selected to be rewarded or inhibited first on assessment, and then on response and ongoing assessment. In essence it is a learning technology that enables a person to alter their brain waves. NF is growing rapidly with the widest acceptance for applications for ADHD, depression, and PTSD. There are some interesting findings emerging around its use with children who have experienced developmental trauma; particularly for those with emotional-regulation and impulse control difficulties (see Seburn Fisher's book on NF in the treatment of developmental trauma).

Creative and expressive therapies include using art, clay, puppets, masks, drama, sand, music, writing, narratives, dance, and movement. Positively, creative means often employ more developmentally-appropriate media, and rely less on language or cognitive ability. Therefore, they can offer creative, child-friendly, and imaginative ways of processing experiences; whilst focusing on integrating and connecting the different systems. Additionally, using creative means can provide a contrary

non-threatening playful experience to that associated with traumas; therefore facilitating distance, desensitisation, and enhancing one's sense of control and mastery.

The possibilities of using expressive arts are endless and can vary hugely from a course of art therapy delivered by a qualified arts psychotherapist, to using the arts in a therapeutic way, to explaining a CBT concept through using creative means. Examples of using creative means are peppered throughout this book; however, clinicians including *Ditty Dokter, Cathy Malchiodi, Margot Sunderland, Liana Lowenstein, Sue Jennings, Lois Carey, and David Crenshaw* have wonderful ideas and examples of using the arts with children who have experienced trauma.

Sensory and body-based tools and components

Having detailed some of the approaches for addressing body and sensory aspects of trauma, the following section will explore some of the components and tools within these interventions for bringing them alive, either in a therapy, or in everyday parenting/school context. These fit with the notion of the importance of parenting the child's brain. As with all strategies these need to be implemented safely, sensitively, and reflectively; and be mindful of the unique child and their needs.

Psychoeducation

Psychoeducation can be especially important, this can include finding accessible ways to explain the previously stated body and brain concepts to the TAC. Also, psychoeducation might be needed for specific difficulties, such as for a child who is struggling with bodily boundaries or unsafe touching.

Five-year-old Cora was overfamiliar with strangers, showed some behaviour of a sexual nature, and was vulnerable to being exploited. Therefore, some protective behaviour work, including psychoeducation around safe and unsafe touching, and the difference between public and private parts was carried out. This included exploring with her parents what this behaviour was communicating and what were some of the underlying functions/messages (Chapter 2). *We (myself and adoptive parents) used a combination of role plays, psychodrama, social stories, and body games to embed these ideas.*

Cora also was supported in making a range of collages and photo-books using magazines and her own digital camera to explore different types of bodies, touch, and expressions. She was a fan of KitKat chocolate bars, and so we used this to give a concrete way of measuring safe distance with strangers (e.g. by staying two KitKat bars away). She also liked the idea of having her own safe space bubble, so we expanded creatively on this concept. Cora's foster carers also gave her lots of positive experiences of being safely touched, such as through face-painting, plaiting her hair, and baking.

Making mind–body links

Children/TAC should be supported in making links between their feelings, thoughts, and bodily sensations (head, hand, and heart connections); and to listen and understand their bodies' messages. For example, through responses such as, "Where do you

Figure 3.3 My heart is beating like a runaway train.

feel … in your body", or "I wonder if you're feeling butterflies in your tummy", or "I've noticed that your hands are tensing", or "Sometimes when I'm scared, my heart beats like a runaway train" (Figure 3.3). Some children might want to make a visual representation (e.g. sculpt, painting) of these feelings. *For example, Ella described having worry worms in her tummy, and so we drew and made worry worms; and found creative ways to discuss these, such as through Narrative Therapy techniques, and by having a worry-worm eating monster*.

Body-mapping (Figure 3.4) can also be a great way to start exploring children's relationships with their bodies. Where appropriate, you can draw around the child's body, or vice versa. Alternatively, a readymade body cut-out or a doll can be used. There are endless avenues of using body-mapping including: *Where do you feel the feelings of … in your body? Which bits are e.g. tense/hot*? *How do we look after … part? Put a sticker where you feel …? What shape/colour/size in … feeling in your chest?* These can be pictorially/physically represented (e.g. by drawing a brick on their chest or by placing a miniature drum figurine to symbolise their beating heart).

Figure 3.4 Body-map and my feeling body.

Similarly, it can be useful for children to learn to express and explore their feelings in a body-based way, such as through a *feelings obstacles,* a *feelings dance*, or *drumming* different feeling rhythms (Chapter 2 discusses more feeling-work ideas). In a safe therapy context, I have found it helpful to incorporate physical movements, such as when a child says they feel stuck, to get them to physically move until they feel unstuck, or for a child who says they wished they had been able to run away from the abuse, to get them to act-out the running-away motion.

Triggers

It is important to really get to know the child and to identify their likes, dislikes, and multi-sensory triggers (e.g. environmental, sensory, autobiographical, physical, cognitive, relational, emotional, and situational – see Chapter 9). *For example, what makes them up or down regulate? What makes them feel e.g. scared, and how does this show itself on their*

face, or in their bodies, words, and behaviours? By identifying triggers, this can make it more manageable to find ways to reduce them, and to subsequently increase feelings of safety.

Self-regulation

See Chapter 2 for strategies on "feelings work" and supporting self-regulation. Building on these, it can be useful to support children in monitoring their feelings and arousal states, for example, through keeping a thoughts, feelings, and body sensations diary, or using computer games and apps like HeartMath and StressEraser. In order for children to find ways to self-manage feelings, they need to first be aware of what these feelings are, and be given opportunities to co-regulate.

Moreover, some body-based and sensory regulation strategies might include: blowing bubbles/feathers, using a weighted blanket, crawling, tapping, butterfly hugs, lighting a scented candle, boiling cinnamon, spraying perfume, soaking in a lavender bubble bath, moisturising hands, stroking a fluffy toy, colouring, seeking comfort in a womb-like tunnel, or using a sensory box. Child-friendly relaxation and breathing exercises can also be excellent additions, for example, going from being a tall giraffe to a tiny mouse; or walking with feet as heavy as bricks to floating as lightly as a cloud.

Furthermore, drumming, clapping, and other similar activities can be helpful as they are repetitive, sequential, physical, and rhythmic. These will differ depending on whether one is trying to support a child to up, down, or alternate their arousal states.

Games to support regulation and connection with one's body

Games, such as musical chairs, row row row the boat, pat-a-cake, this little piggy, heads shoulders knees and toes, Hokey Pokey, and follow the leader, can be playful ways for children to connect with their body, and of teaching key developmental skills. For example, a game of dead lions, alongside other strategies, over time, can support a child in learning about switching gears, adjusting to different arousal levels, developing impulse control skills, and learning about responding to instructions. In addition, braingym and cognitive games, such as eye spy, crosscrawl, or brain buttons can be useful. See Box 3.1 for some exercises to connect to your own relationship with your body.

Self-care

Adults need to show and role-model to children that their bodies are important and need care. This might be through sleeping routines, exercise, taking pride in one's appearance, healthy eating, and pampering activities (e.g. painting nails, putting on moisturiser, or having a spa day). This can also be supported by caregivers paying special attention to any hurts, for example, by taking 3 big breaths, blowing 3 kisses and 3 puffs of magic dust, putting-on cream and a special plaster.

Physical activity

Engaging in body-based activities has shown to have a wealth of multilayered positive physical, social, and emotional effects and supports children to explore their body's parameters and sensations. Having travelled extensively, I have been amazed and fascinated in the way that other cultures integrate and make the mind–body links, for example, through

capoeira in Brazil, Thai boxing in Thailand, mediation and tai chi in China, drumming in Africa, and yoga in India. *How can we integrate more body-based and physical activities into children's lives?* Lots of parents and professionals report noticing the brilliant influence on their children of engaging in physical activities, such as messy play, horse riding, swimming, cycling, or simply being in nature; or of incorporating a component, such as mindfulness or drumming into their daily routines.

3.1 Reflective and practice exercises: connecting with one's body

When intervening how much attention do you give to body and brain-based aspects?

It can be helpful to think about feelings, events, and situations at a cognitive, emotional, and body level. For example, think about a *positive relational experience*. *What are the associated thoughts, emotions, perceptions, movements, and body sensations?* Now think about the above elements, but using a *negative relational experience*. What did you notice? You can build on this further by making your own body-map as described above.

When you think of feeling safe *and being in a* safe place*, where and how do you feel it in your* body*? How is this similar or difficult to when you think of feeling in danger and being in a* dangerous situation*?*

Reflect on your relationship with your body. *When has it supported you/protected you/let you down/hurt you?* Write/draw next to the different body parts *what you do to care for that part* e.g. exercises for legs, moisturiser for skin.

What are your sensory likes and dislikes? What helps you to up- or down-regulate? Try the Sensory-Motor Preference Checklist for Adults (Williams and Shellenberger, 1996).

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Chapter 4

Strength, resilience, and hope-based practices

Introduction

So often within clinical practice and day-to-day life, I'm struck by how much people have lived through and survived. *Where and how do people find this strength and survivorship? Why do some people seem to "do better" than others? Why do some children function so well despite awful experiences? What factors facilitate or hinder these processes, and how can we build on these? How can these "qualities" be measured? What can we learn from this phenomenon?*

Having worked professionally with people who have been affected by extreme trauma such as former child soldiers and survivors of complex interfamilial trauma; and personally having grandparents who survived the Holocaust, parents raised in apartheid South Africa, and a mother with progressive multiple sclerosis, I am continually amazed and inspired by the stories of strength, human spirit, resilience, hope, and survivorship. This is an area that has continued to fascinate and drive me, and often amongst the difficult parts of the work is the inspirational hope-coated glue which has kept me focused and committed. Although this topic is presented as a separate chapter, a thread of strengths and resiliency has been woven throughout the entirety of this book.

Often in the world of relational and developmental trauma, there is an overwhelming emphasis on problem-saturated discourses and deficits. Even this book mirrors this by having several chapters dedicated to the negative consequences of complex trauma. However, it feels so important to balance this heavily stacked scale with the huge wealth of strengths, skills, and resiliencies that these children and the systems around them present with. In many cases and by its very nature, trauma has become the central focus in their lives and already holds so much meaning and weight. We need to work at an individual, familial, and societal level in order to see the whole person, not just the problem or the trauma, and to aim for children to do more than just survive, and instead to thrive.

The strengths-based field is vast and comprised of multiple interlinking, overlapping, but arguably unique terms including: resilience, hardiness, reserve capacity, survivorship, bouncing back, fighting spirit, positivity, strength, optimism, positive coping styles, and protective factors. Within this chapter, rather

than focusing on the different definitions, professional debates, and the minutiae around these conceptual mazes, I intend to discuss some shared threads, ideas, and considerations on how to bring some of these concepts into action within the real world. Some key points and academic developments will be presented, followed by some interventions and implications, and to conclude, a demonstration of how one of these areas, in this case self-esteem, might be practically fostered.

Table 4.1 draws from multiple sources to present some of the common components of "resilience" and known protective factors for children who have experienced relational and developmental trauma. These can be extremely helpful in informing assessments and interventions for a child and the systems around them. We know that resilience has multiple positive implications including increased trust in relationships, ability to mentalise and regulate affect, and a higher capacity for moral reasoning.

Table 4.1 Protective factors and components of resilience

- Secure attachment experience and/or availability of a stable, sensitive, caring relationship.
- Positive family climate.
- Good cognitive ability including executive function and problem-solving skills.
- Cognitive flexibility (ability to reframe, assimilate, and appraise traumatic experiences and worldviews).
- Good self-regulation skills and tolerance of negative affect.
- Positive coping style and skills.
- Positive self-esteem, self-image, self-regard, and self-worth.
- Positive core beliefs and internal working model.
- Good interpersonal, communication, and relational skills.
- Positive social support networks, peer acceptance, and friendships.
- Attachment to pro-social institutions such as school.
- Involvement in positive activities (e.g. social action and hobbies).
- Ability to navigate multiple contexts.
- Self-efficacy, internal locus of control, mastery, personal power, and autonomy.
- Sense of purpose, value, and meaning.
- Sense of faith, hope, and spirituality.
- Sense of identity, cohesion, connectedness, and belonging (community, personal, spiritual, religious, political, social, and cultural).
- Culturally sensitive ways of processing trauma, loss, and identity change.
- Positive community environment (e.g. safe, clean, cohesive, and availability and accessibility of a wide range of resources).

Luthar and Cicchetti, 2000; Olsson et al., 2003; Gilligan, 2008; Glover, 2009; Daniel, 2010.

Resilience in relation

Historically, resilience was positioned as an individual trait, however, recent developments have moved towards viewing resilience as a dynamic interactive process, comprising of a matrix of interweaving contextual factors (Masten and

Powell, 2003). This posits that resilience is multifaceted and can span several domains including internal, external, personal, social, and structural spheres. These new understandings recognise that a child's strengths and skills can change, grow, and shape throughout their lifetime, and that these can be influenced by a range of factors, such as the environment and life stressors. This also suggests that resilience is not an all-or-nothing state, a child may be deemed as resilient in one area, and less so in another, and these might show themselves differently in different contexts. *An example is 9-year-old Mark, who thrived academically and achieved excellent grades, however had pockets of difficulties with his emotional and social skills*. Further crystallising the complexity of this area is that a person's response to adversity can be influenced by the different attributions and meaning-making around them. *For example, a child who has experienced sexual abuse, and seemingly is functioning very well, could be seen by some as being a "fighter and strong", by others as "being in denial and/or dissociating", and others as showing a "false-self"*.

Another layer, which is beneficially considered within the resilience field, is around wider community approaches and collective resilience, for example, during tragedies such as the worldwide terrorist attacks, the tsunamis, earthquakes, and floods. At these times, there are frequently reported acts of psychological unity, mutual support, and community cohesion. This gives weight to treasured proverbs such as, "A single stick breaks, but a bunch of sticks stays strong". There are also several international examples which illustrate the diverse ways societies conceptualise and respond to adversity – for instance, the communal healing practices as seen in South Africa's Truth and Reconciliation trials or the Gacaca Trials which took place post the Rwandan Genocide. These are areas which require further attention, especially given the current context of climate change, economic crises, and acts of terrorism. This suggests a broadening of the resilience framework, and gives way to some wider intervention possibilities, as well as highlighting the magnitude of cultural and contextual factors. It also poses the questions: *Does individual resilience relate to collective resilience and vice versa? If so, how?* and, *How, when we are working with individual children who have experienced relational and developmental trauma, can we also intervene on a wider societal level?*

Resilience strengths-based perspectives

Experience-dependent brain

Previous chapters have discussed the potential negative brain-based consequences of toxic stress and of experiencing relational and developmental trauma (Chapters 1–3). However, on the other side of the coin, it is also possible for the brain and its neural pathways to be positively shaped, re-wired, sculpted, and changed through rewarding life experiences and rich relational interactions (Glaser, 2000). The brain is an experience-dependent developing live organ, and

promisingly, has the capacity to give birth to new neurons (neurogenesis). The brain is at its most plastic during the critical sensitive periods of childhood which means that the window for brain organisation and reorganisation is even wider and more open to new possibilities (Lupien et al., 2009). We often see the negatively impacted brain scans of a child who has experienced trauma; however we don't see the many children whose brains do not, or only, have minimal changes.

Additionally, in previous chapters the impact of toxic stress on the developing child has been discussed, but encouragingly, we also know that through nurturing "parenting" experiences, bonding and "feel good" chemicals such as oxytocin, opioids, prolactin, endorphins, vasopressin, and gamma-aminobutyric can be released (Goleman, 2006; Sunderland, 2007). This is supported further by studies which have shown that positive stimulation by a caregiver can trigger the production of the corticotrophin releasing factor by the infant's hypothalamus, which in turn stimulates the production of the rewarding biochemical dopamine (Cozolino, 2006).

These positive relational experiences, and a caregiver having a secure-autonomous state of mind (Pace et al., 2012), can promisingly support children to revise, refine, and re-evaluate their belief systems, schemas, and relational maps (Chapters 1 and 6). This is seen time and time again when children who have experienced relational and developmental trauma progress into making and sustaining healthy relationships. The potential for positive adaptation is also demonstrated in wider-scale research, such as the Romanian orphan's outcome studies (Rutter, 2000) and the Bucharest Early Intervention Project (Parker and Nelson, 2005). These positive shifts are also echoed in studies which show how some adults who had difficult early experiences had moved from having an anxious and/or disorganised attachment style to an earned or learned secure attachment style (Steele and Steele, 2008; Saunders et al., 2011). Similarly amongst late-adopted children, follow-up studies showed subtle but important changes in their mental representations of their attachment figures (Hodges et al., 2005; Beijersbergen et al., 2012).

These findings crystallise the importance of working with the systems around the child to find ways of creating reparative experiences and a second chance secure base. It advocates for positioning relationships as the agent and anchor of change; and one which symbolises a safe psychological home. This also provides hope and possibilities that change can be seen and influenced through developmentally appropriate brain-based interventions, positive opportunities, and therapeutic re-parenting.

Posttraumatic growth and adversity-activated development

Within the psychology world, the phenomena of people's positive adaptation and growth following trauma has often been referred to as posttraumatic growth (PTG) (Tedeschi and Calhoun, 2004), adversarial growth (Joseph and Linley, 2005), and adversity-activated development (AAD) (Papadopoulos, 2007). Although

predominantly studied on the adult population, these concepts are palpable when we see children's renewed drive and appreciation for life and their relationships, their reconnected sense of meaning and purpose, and increased compassion and empathy for others. These concepts bring to life the notion that trauma experiences can be shifted and can positively reframe one's self-views, "I'm strong", "I'm a fighter", and "I'm resilient". These discourses are reinforced by societal sayings such as, "What doesn't kill you makes you stronger" and through publicly celebrating people who have overcome adversities such as South African anti-apartheid politician Nelson Mandela who, following 27 years as a political prisoner, became the first black President of South Africa; political leader and human rights activist Aung Sang Li; and neurologist and psychiatrist Victor Frankl, who survived the holocaust and wrote about his experiences of finding meaning and purpose within the traumas he had faced. This continues to raise questions: *Why do some people experience PTG and AAD more than others, and how can we increase the occurrence and impact of PTG and AAD?*

Supporting resilience at an individual and collective level

The potential interventions and ways forward are so vast that this chapter cannot do justice to the multiple possibilities, however some key avenues will be highlighted to provide a flavour of how we can bring some of the above theories into action. Interestingly, these are hugely influenced by time factors. For example, we could look at preventing risk and putting early intervention, population-focused measures into place, or at ways to break a chain of negative events, or retrospectively once adversity has already occurred. Wider community-based measures will be presented before going on to consider some of the individual approaches. Ideally, community and individual approaches would be interwoven.

Community and societal level

Early intervention and preventative measures

If we look at Table 4.1 and consider what can be put in place to stack the positive scale with protective and resiliency factors, the majority of the components are linked to the foundational early years of developing children. This is not to say that there are not numerous other supportive options and windows for change opportunities at later stages, but rather to advocate first for a population, societal, and community focus, which places emphasis on breaking generational cycles, and responding at an earlier, more preventative level. Arguably, this in turn would have significant social, financial, and health ripple effects on later functioning, well-being, mental and physical health, educational attainment, and involvement with the criminal justice system. The following questions expand this thinking using the example of intervening earlier (i.e. during pregnancy). The importance for early-intervention during pregnancy is discussed in Chapters 1–3.

Population-focused resilience – narrowing the gap and intervening earlier

1 *How can universal antenatal screening be improved and expanded on?*
2 *What preventative interventions can be put in place (e.g. at school, at-risk women, during the in-utero and postnatal periods)?*
3 *How can these encourage and incorporate fathers' roles?*
4 *How can maternal nutrition, DV, mental health difficulties, substance misuse, and access to medical care be prioritised and proactively intervened with?*
5 *How can we identify, assess, and support women during their pregnancy to bond with their baby, and to adjust and transition to their new motherhood role?*
6 *How can we develop parental capacity to keep their baby in mind, and to learn how to attend to their baby's internal experiences?*
7 *How can we support parents to effectively parent their baby's brain, and to appreciate their role and influence in their baby's overall development?*
8 *How can we weave and make shifts towards a more trauma and attachment-informed system which envelopes pregnant women and new mothers?*
9 *How can we work with the government, economists, researchers, and the media to quantify, publicise, and campaign for the importance of early interventions, and about the gravitas of the in-utero period, including brain science findings?*
10 *How can these ideas be effectively communicated through training, information, publications, and popular media?*
11 *How can we work more effectively with midwives, health visitors, paediatricians, GPs, child centres, nursery schools, and child minders to enhance the quality of care?*

Community connectedness

Building on the protective factors described in Table 4.1, we know that social bonding, community cohesion, and social connectedness are linked to positive coping and resilience (Gilligan, 2008). These notions are tangible in times of joint celebration, such as during the Olympics or the Queen's jubilee. *What can we do to foster this? What can we learn and action from cohesive communities and best-practices locally and internationally?* This needs creative individualised thinking, however some ideas might include community projects and activities such as: public murals, artwork, shared gardens, naming street competitions, choirs, plays, street parties, and/or local fairs. Sometimes, something as simple as getting to know the local shop keeper and bus driver can support children in feeling more engaged in their community. Moreover, it can be valuable to support children in fostering prosocial tendencies and empathy for others, such as through volunteering at a local soup kitchen, helping out at an animal shelter, and/or fundraising for a particular cause.

Environment

Given the overwhelming amount of data suggesting the importance of contextual and systemic factors, we need to look beyond the individual, and bring environments into the frame. In the United Kingdom, we make some provisions and environmental

changes for wheelchair users, or for those who are hearing-impaired. *So what can we do to make environments/systems more trauma and attachment-informed/more trauma and attachment-aware* (Chapters 3, 6, 8–9)? After all, the number of children this would benefit is on a huge scale, given the epidemic proportions of childhood trauma.

Individual strengths-based approaches

Building skills

Table 4.1 details an array of skills and experiences, such as positive self-regulation, executive function skills, and problem-solving skills, which are likely to positively impact on children's overall well-being. Therefore, we need to draw on a range of interdisciplinary approaches to teach and build on these crucial areas. Some strategies addressing these areas are discussed throughout this book; however, to follow some real-world ideas on how to expand on one of these skills, *self-esteem* is presented.

Strengths-based framework

A clinician might be working in a strengths-based way, however it is integral to consider how this conceptual framework can be applied to the powerful systemic and organisational layers. It is easy to fall into a world of hopelessness, frustration, and negative labels, particularly given the powerful feelings evoked and emotional contagion when working with trauma. When things feel problem-saturated, it is important to shift the scale. It can be like going to the Christmas sales and having to sift through a lot of items until you find a gem, or similarly like looking for hidden treasure on a vast beach. Prominent psychologist, Daniel Hughes, advises clinicians to find something positive that you like about each person and hook onto it.

The following questions aimed at teams and/or clinicians offer some suggestions for reflecting and shaping organisational and systemic framings of children/families. Examples of common labels are used, such as ADHD, but the concepts described can be applied to a range of presenting difficulties. These are expanded on in Box 4.1.

1 *How helpful is it to label someone as "damaged"? Would you describe someone as saying "she's cancer", or "he's HIV", so why would we say "he's ADHD"?*
2 *What is the hazard of discourses such as, "it's hopeless" or "he's always nasty"? How are these labels going to colour the child's self-perception and others' perceptions of them? How will these impact subsequent responses and interventions?*
3 *What is the balance of strength and hope-based discussions within team meetings and reports? What about this balance with regards to psychometric measures employed, evaluation tools used, and assessments made?*
4 *Is it acknowledged, reflected on, and addressed when there are problem-statured dominant discourses in the team/supervision? How are strengths and resiliencies noticed, magnified, and celebrated?*

Positive reframes can be beneficial in re-storying and reframing behaviours. For example, instead of saying "He's lazy and doesn't try", one might say "He must be exhausted with trying", or instead of "She refuses to sit still", one might say "She seems to be overstimulated", and instead of "He's hyperactive", one might say "He's energetic and spirited", instead of "attention-seeking", one might say "attachment-seeking or attention needing" etc.

Therapeutic models

Many different therapeutic models and clinicians hold a strengths-based framework, however some specific therapies particularly lend themselves to this stance. These include Solution-Focused Therapy (de Shazer, 2005), Narrative Therapy (NT) (White, 2007), and Motivational Interviewing (Miller and Rollnick, 2012). These therapies position children as having the potential to change, and work within a hope-filled motivational climate. The therapist's role is to facilitate identification and reconnection to the child's already possessed skills, positive qualities, and strengths. They look for and learn from previous solutions and skills, and take a strengths-based rather than a deficit-based model, focusing on what the child can do, as opposed to what they cannot do. They also keep a firm future-oriented focus, and view the absence of a skill as an opportunity and possibility, rather than as a problem. This magnification of the positive lens is also echoed in a range of video interaction and parent–child therapies (Chapter 7) which focus on zoning-in on the positive aspects of the parent–child relationship, rather than the difficulties within it.

Measures

In addition to strengths checklists, qualitative and observational data, there is a huge array of available psychometric measures which are used across the globe to measure children's resilience and strengths. There are also several specific sub-domain measures available, such as those measuring self-esteem and positive self-concept, or those specifically related to family resilience, which are not detailed below. The following is a small selection of the existing child-focused resilience and strengths measures:

> *Youth Resiliency: Assessing Developmental Strengths (Donnon and Hammond, 2007), the Resiliency Attitudes and Skills Profile (Hurtes and Allen, 2001), the Child and Youth Resilience Measure (Ungar et al., 2008), the Resilience Scale for Adolescents (Hjemdal et al., 2006), the Resiliency Scales for Children and Adolescents (Prince-Embury, 2008), the Behavioural and Emotional Rating Scale (Epstein and Sharma, 1998), the Strength and Difficulties Questionnaire (Goodman, 1997), and the Child and Adolescent Strengths Assessment Scale (Lyons et al., 2000).*

4.1 Practical activity and reflection: team around the Child (TAC) and building on strengths

Think about a child you are supporting/living with and consider the following:

Part 1: *What skills, strengths, successes, and positive qualities of theirs have you been struck by/inspired by/impressed by? If you were stuck on a desert island with them, what skills and qualities would you appreciate in them, and be thankful for? What do you enjoy/like about them? What have been some of your most precious memories/times with them?*

What has and is going well for them? What protective and resilience factors (Table 4.1) *did/do they have? What can they do? What patches did they have in their parenting patchwork* (Chapter 1)*? What steps have been achieved? What distance has already been travelled? What challenges, obstacles, and adversities have they overcome? What skills did they use to survive the desert island or the shark-infested waters* (Chapter 1)*?*

How has knowing them made an impression on you? What will you take forward from what you have learned from them?

What are your hopes and dreams for them? How can these be recognised, acknowledged, noticed, celebrated, and built-on in person, meetings, reports, assessments? How aware is the child that you see them in this way? How can you share these discoveries with them and others?

The above responses and reflections can be powerfully documented for the recipient in a therapeutic take-back practice letter/card/recording.

Part 2: *What hobbies and activities do they engage, enjoy, and excel in? What makes them sparkle/get excited/feel proud/feel confident? What things make them feel good about themselves? How can these be recognised, acknowledged, noticed, and built-on?*

Who does the child view as supportive to them (social, peer, professional, spiritual, cultural, etc.)*? What ways can you strengthen, foster, build, and utilise these relationships?* Some children enjoy having a reminder of all the things their TAC like/notice/admire/enjoy about them, including their strengths, resiliencies, skills, uniqueness, and qualities. These could be communicated and celebrated through a list, poster, card, collage, letter, film, or recorded message.

Does the child have a clear sense of who is around their safety net and who are their life cheerleaders and TAC (real, imagined, role models)? This can be visually displayed through drawing/making a safety net or a genogram; or the different support people creatively presented such as in layers of coloured sand or as multiple beads on a necklace.

How can we creatively seek and be proactive in forming additional links with a wider positive support network? This might be through forums such as: new activities, buddy systems, support groups, social clubs, and internet forums.

Part 3: Reflect on your own role: *What skills do you bring to the children you work with/live with? What would they or the people who know you best say these are? Where did you learn these skills? Who was key in modelling/teaching them? Can you share a story/example of when you used this skill? How can these be further recognised, noticed, and built-on?* (Chapter 8).

Bringing the above concepts alive – using *self-esteem* as an example

Having explored various strengths-based approaches and components of resilience, I will now use self-esteem as an example of how we can practically build and nurture a strengths-based skill. These can be adapted for a range of client/professional groups and age ranges. These ideas are by no means an exhaustive or prescriptive list, and are intended as possible avenues which then need to reflect on the uniqueness of the child and their systems. The suitability, timing, delivery method, and appropriateness need to be carefully considered on a case-by-case basis. The strategies and factors previously mentioned will not be re-discussed, however are recommended as complementary ideas.

Why self-esteem?

Children who have experienced relational and developmental trauma are more likely to have been exposed to harsh and repeated forms of verbal abuse including criticism, humiliation, and negative attributions. In many cases their opportunities of being appreciated and cherished would have been limited. Therefore, it is commonly reported that these children have a negative sense of self, internal working model, self-esteem, self-efficacy, and self-worth (Chapters 1–2). These are likely to make children more vulnerable to cognitive errors, such as all-or-nothing thinking ("I'm stupid so there is no point trying"), mental filtering (only paying attention to certain evidence, in this case negative information), and self-labelling ("I'm a loser"). Consequently, they are more likely to disqualify the positive incoming information, and hold onto the negative information as if it were true, like a negativity magnet. Moreover, it is widely posited that positive self-esteem is highly correlated with resilience and range of other well-being factors, including some of those presented in Table 4.1.

Strategies for building on children's self-esteem

1. The TAC should model and teach verbally and non-verbally self-esteem, pride, and self-confidence. This might include self-care practices such as through pampering, little treats, and looking after yourself; and self-statements such as "I'm really proud of myself today because …"
2. Be mindful of the importance of the language and words used, and as much as possible keeping a strengths-based, praise-filled, and positive approach. This can be further achieved by finding ways to notice, celebrate, praise, and expand on the child's

positive skills, strengths, talents, qualities, and attributes (Box 4.1). This might be through verbal praise or non-verbal communication, such as giving a thumbs-up, or positive facial expressions, or through concrete ways of celebrating. Examples include: reward charts, treats, praise boards, positive work portfolios, strengths cards, celebration walls, newspaper headline success stories, certificates, displaying art work, and naming a star. These can be magnified through creative means, such as if a child is brave they can be likened to a lion or a shield; or if they have a great idea they can be given an engraved light bulb or a FROG (**F**or **R**ecognition **o**f **G**rowth). Subsequent activities can build on these concepts. Examples follow:

Alice made and drew a lion shield, and subsequently was told stories about lions and bravery. She also made a lion and bravery collage, and each time she showed bravery and courage was reminded, "Wow the lion is in full force today" or "That sounds a bit scary, we might need some help from your lion part" (Figure 4.1).

Figure 4.1 Lion shield and protective knight.

Joan identified that when her foster child Jasmine was kind, she had a "Heart of gold" and she wished that she saw this side more often. We made a life-size drawing of Jasmine which had gold hearts added to it each time this part showed itself. Joan also gave Jasmine "kindness points" in a reward jar, and spoke about using "helping hands and kind words". They practised these skills through playing a game about adventures in the "kindness kingdom". Jasmine was also awarded a heart-shaped certificate after achieving a certain amount of "kindness points", and Joan made a heart-shaped poster which was decorated with all the things she loved and appreciated about Jasmine. Jasmine was supported in adding to these.

3 Reflect and notice with the child on the positives and on what is going well. For example, they can:

- Keep a "positive me" or "sparkle moments" diary.
- Identify some positive self-mottos and affirmations.
- Write or draw a list of their various strengths.
- Write a story or make a collage on a topic such as "I am, I can, I have" (Grotberg, 1993), "I am proud of …", or "What inspires me is …"
- Use strengths-identifying games such as a feelings ball, self-esteem Jenga, self-esteem bingo, and strengths dominos.
- Decorate a T-shirt or doodle bear with fabric pens or badges of all the positive things they feel about themselves on the front, and all the positive things the TAC have identified on the back.
- Make a positive quality list using a name acronym, for example for Kate, K-kind, A-affectionate, T-trustworthy, E-enthusiastic.
- Make a feel-good personalised soothing sensory box.
- Make or decorate "strengths" jewellery. For example, they can decorate plain/wood jewellery with a collage of positive words, or make a necklace/bracelet with each bead representing e.g. different strengths/skills/supportive people.
- Make a Tree of Life (Ncazelo, 2007; Chapter 10).
- Draw a self-esteem mandala (a circle with smaller patterns inside them). The word mandala comes from Sanskrit origins meaning "circle" and "wholeness". See Curry and Kasser (2005) for a description of making self-esteem mandalas.

4 Broaden, cultivate, and build on their positive emotions, memories, and experiences (Fredrickson, 2001). Use these relational treasures and experiences to stack the positive side of their scale, and to power their positive magnet. Show the child that you value them as an individual and really get to know them. This can be extended through active means, such as an "All about me" or "My life story" book. These can be symbolically, verbally, and/or creatively added to their positive treasure chest. Try and spend time doing enjoyable activities together and communicate verbally and non-verbally how much you look forward, value, and enjoy this time.

5 Reflect on times when children have overcome something, been brave, strong, felt confident, been successful, and felt proud. *What does this mean and say about them? What did they learn about themselves? How did others respond to them at this time? What supported them in getting through these times? Where did they learn that skill from (e.g. being brave)?* They can write a list, story, draw a picture, or make a sculpture of all of their achievements. Metaphors can be useful embedding tools, such as climbing over a mountain, as can stories or films which convey these messages.

6 Find age-appropriate activities which a child enjoys and is good at. Even better if these are confidence-boosting experiences where they get a sense of achievement such as drama, circus skills, mountain climbing, and zip-lining (individual-dependent).
7 Find ways to show the child that they can effect change and that their opinion is important. This can vary from day-to-day things, like asking what they would like for dinner, or getting them to teach you something that they know about, to larger involvement, such as fundraising, social action, and/or youth-led projects. This can filter down to showing the child that you trust them by giving them some responsibility.
8 Where possible show them that they are important and that you have actively kept them in mind (e.g. having daily check-ins, remembering things that they said to you, noticing when they are absent etc.). This might extend into supporting them to feel like they belong, through things like having an allocated seat at the table, to making a name sign for their door, to designing a family crest.
9 Have discussions around "*What confidence looks like, sounds like, says, and does*". This can be linked to different body language on the TV, in magazines, and/or through roleplaying body positions, and day-to-day scenarios. They can also create a metaphor or character through NT externalisation techniques to capture "self-esteem" and find ways to weave this into their discoveries of themselves (Chapter 9). Some children might like to imagine that the character is there with them, helping, and cheering them on.
10 *Who are the child's heroes/ inspirers/role models?* Building and connecting with role models can have an extremely positive influence. This might be through a mentor, other people who have had similar experiences, or those who have experienced adversity. Examples include, although will hold different meanings for the individual: Nelson Mandela, Malala Yousafzai, Victor Frankl, Helen Keller, Oprah Winfrey, Katie Piper, Louis Zamperini, J.K. Rowling, Stephen Hawking, and Bethany Hamilton. *What can they learn from ... about life? What strengths and skills can they draw, learn, build-on from ...? What strengths and skills might they have which are similar to ...? What advice might ... give them? What and how did ... overcome adversity? How does ... show confidence?* For younger children this can be extended to superhero and magical power conversations.
11 Some children draw inspiration from poems, quotes, films, books, music, and plays. *How can we introduce them to more of these ideas, and support them in finding and connecting with the meaning, value, and purpose of their lives?*
12 The TAC need to hold on and convey hope and a better future. *How do children look through your positive hopeful lens? What part of themselves are they not seeing?* (Optical illusions or masks can be helpful aides here). It also can be useful to create a future-oriented approach. *What do they see their future-self to be? How would they like to be, feel, think, act, believe, and achieve?* They might want to write a letter from their future to their current self, make a time capsule, or draw a then-and-now picture. This can be supported by asking the solution-focused miracle question (de Shazer, 2005) and having discussions about their dreams, aspirations, goals, and hopes. Complementary props include wands, genies, fortune-teller balls, or dreamcatchers.
13 Many children will have repeatedly experienced negativity and criticism about themselves which would have contributed to their negative sense of self. In the context of a safe relationship, it can be powerful to think who or what are these downers and drainers. These can be thought about creatively through using a range of metaphors such as: a ball and chain, straightjacket, spiked fence, backpack full of bricks etc.

Some children, where appropriate, might want to identify and write down some of these thoughts, for example, "You're stupid", and "You'll never amount to anything"; and actually do or imagine getting rid of them. This might be through putting them in a bottle and watching them float away, inside a rising balloon, in a rubbish bag, on a piece of paper that is then burned, ripped up, or buried. Others may want to write words on a tissue, and watch them fade away in water, or be flushed down the toilet. Some might like to write the words on sand or an etch-a-sketch and then have the power to remove them. It can be helpful to reflect with the child about how much stronger and bigger they are, than the words on the paper.

14 In line with the above, children might find using imagery re-scripting techniques helpful. This is where a negative mental image is transformed into a more benign image, for example, imagining the person who said the hurtful comments with a funny face/a small head, on mute, or in black and white. Moreover, some children may want to imagine or design a protective shield, bulletproof jacket, guardian angel, or magic blanket, which can protect them from the hurtful comments.

15 For some, it can be useful to explore the negative self-statements in a more cognitive-behavioural way. *What evidence is there for and against the statement, "I'm stupid"? Is there a kinder alternative way of thinking about yourself than "I'm stupid"? What would you say to your best friend who says "I'm stupid"? What hazards are there of holding onto the thought "I'm stupid"?*

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Chapter 5

Multilayered psychological assessments of relational and developmental trauma

The previous chapters have described the pivotal nature of relationships and their interface with a child's development, as well as some of the multilayered complexity of relational and developmental trauma on children and the systems around them. The Complex Trauma Workgroup of the National Child Traumatic Stress Network (Cook et al., 2005) identified eight dimensions which are impacted by complex trauma: 1) Attachment/relational, 2) Affective, 3) Biological/brain, 4) Somatic/ body, 5) Behavioural, 6) Dissociation, 7) Cognitive, and 8) Self-concept. Within each dimension, there are various interconnected areas, such as blame, shame, self-hate, negative attributions, changes in self-perceptions, and meaning-making. These domains, alongside other best-practice assessment guidelines, will form the basis of assessment areas in this chapter.

It is beyond the remit of this book to present a cookbook of how to carry out assessments, and this jars with the overall premise of the book that each child is unique within a unique context assessed by a unique clinician, and that relational and developmental trauma is a multifarious area; however, some key assessment considerations, questions, practical tools, and measures will be highlighted.

Type, purpose, and goals of the assessment

First, upon the initial request, it is important to clarify the type, rationale, purpose, and goals of the assessment. This is likely to be influenced by a range of factors including the service context, logistical setup, resources available, and the assessor's professional and personal lens. Within this population, the assessment type can significantly vary (e.g. risk, court, parenting, therapeutic, sibling together-or-apart, neuropsychological, diagnostic assessments etc.), and the referrer questions may differ considerably from, "Is a particular type of therapy suitable?" to "What is the impact of the parenting they received on their emotional wellbeing?" to "How can we support them during a placement transition?", and may range from being an informal corridor conversation, to a formal court letter of instruction.

This chapter will discuss the assessment process from a *therapeutic angle*, however, the points covered may well lend themselves to a wide range of other assessment types. As an assessor you are often the first point of contact for a child

and their family, and may represent a host of hopes, worries, and expectations to them, therefore one should aim to make the *assessment a positive experience, and a therapeutic process in itself.*

Assessment factors to be mindful of

Multi-sourced, multi-contextual, and multi-method assessment

Due to the complexity of relational and developmental trauma, it is optimal to conduct multi-sourced and multi-method assessments, which have been triangulated across people, methods, and contexts. This is likely to include qualitative (interviews, observations, discussions, and self-report questionnaires) and quantitative information (psychometric and standardised measures). High-quality assessments should combine the extant literature, best-practice, and evidence-based information around the particular assessment area, for example, the impact of neglect on a child's emotional well-being. In an ideal scenario, a multi-disciplinary team would contribute to the assessment, drawing on a range of perspectives and theories implicated in relational and developmental trauma, such as mental health, physical health, sensory-processing, and speech and language (SALT). Assessments are further optimised when children/families are seen over a period of time, in a range of different contexts and situations, with varying times, people, places, and activities.

Team around the Child/Family/Worker (TAC/F/W)

The web of people and systems around the child is likely to be extensive (e.g. "family", health/education/social care/legal professionals and people in their wider community). It is important to pull together the numerous multi-disciplinary threads and information sources (e.g. meetings, reports, assessments, and chronologies). Assessors should also be mindful of members who are not in attendance, such as fathers not living in the household, bereaved, and/or imprisoned members. The TAC/F/W can be usefully captured by having a visual representation such as through using a genogram, ecomap, or service-web. These visual maps can highlight who is in the child's networks, and identify their varying roles, responsibilities, and relationships; and equally where the gaps may lie. These can also provide valuable data around the occurring systemic and organisational dynamics (Chapter 8).

Within the TAC there may be different goals and aims, which will need to be disentangled, and the hierarchy and prioritisation of the needs considered. *For example, Harry expressed some interest in having support to improve his sleep; whereas his social worker felt strongly that the priority should be around cannabis reduction, whilst his teacher was particularly concerned about his "attitude".* These personal and professional constructions and conceptualisations, including the assessors, can significantly colour and frame the assessment. *What is the*

child's goals? What are their feelings, thoughts, fears, hopes, and expectations about the assessment/therapy? How do these fit with the TACs? Within this, the differing themes, stressors, expectations, emotions, and motivations which apply to different "parenting" subgroups (i.e. adopters, foster carers, kinship carers, and residential workers) need to be considered.

A vital part of the decision-making assessment process is around weighing-up the advantages and disadvantages of seeing the child directly, and if so, where, when, how, and who with? These members, such as the foster carer, may be the focus of the intervention, may play a supporting role, or may be working alongside the therapist as the main therapeutic agent of change. In many cases, a child can be effectively supported indirectly, through buffering their personal and professional team.

> *Six-year-old Bradley had experienced extreme unpredictability and inconsistency in his early years, was reportedly having difficulties in transitioning and managing changes. Concerns were compounded by Bradley's placement breaking-down and subsequently needing new home and school placements. Therefore, the assessment undertaken indicated that instead of introducing another change and new person in the form of one-to-one therapy, the most helpful intervention at that time was around supporting Bradley's TAC (e.g. foster carers and both schools), to optimally support him.*

Evolving formulations

A therapy assessment and formulation should not be a time-limited or confined snapshot, but rather should be dynamic and ongoing, allowing for snippets of conflicting, contradictory, novel data, and revisions to emerge. This includes being mindful of blocks such as confirmation bias. As with all assessments/interventions, assessors should be reflective and sensitive to their role and their use of self within the assessment, such as considering their own responses, biases, values, prejudices, and ideologies, and how these may influence the assessment process, content, and conclusions.

In addition, children who have experienced relational trauma often respond better to a less formal more gradual process. This allows for more space to build rapport, engagement, and establish safety. This also is in line with optimising a child's/families' engagement with the assessment, in terms of getting them involved and them having a sense of mastery over it.

A small drop in the ocean

Often before we meet a child we have read and heard quite a lot of information about them. It is important to bear in mind that what we see and know is only a small grain of sand from their "desolate island", or "a small puddle of water from their shark-infested sea" (Chapter 1). There can be chunks of information unknown or missing. Moreover, we can read a statement such as "house in a state of disarray",

and might have some photographic evidence, however this does not translate the affect and lived experience of actually being reared in that house. *Imagine if someone came into your house, researched your life, reviewed key events, and then wrote a summary; would this feel like it accurately captured you and your life?* Equally, the information received can often be problem-saturated, and might not reflect the wealth of the children's/families' strengths, skills, and resiliencies (Chapter 4).

Barriers to information-gathering

There are a host of factors which may influence and block the amount, type, and accuracy of information we receive. The following factors may refer to the child, carer, and/or the system:

1. Cognitive abilities/stage (e.g. being pre-verbal).
2. The presence of dissociation, fear, guilt, self-blame, ambivalence, and shame. (*It took Tsahra close to a year to disclose that she had been repeatedly raped by her uncle. This was so wrapped-up in cultural fears around it being a sin, strongly embedded beliefs about family loyalty, and self-stigma that she was now "Dirty and spoiled"*).
3. Their protective/survival functions and defences being up. (*Facing the buried anger Claudio felt towards his father was too painful and terrifying. Instead, in a form of protective dissociation, he hung onto his father as perfect and idealised him*).
4. Low self-confidence and self-efficacy. (*Sylvie felt that no one would believe her, or that in some way she asked for it, so instead kept to herself*).
5. The mistrust, secrecy, and silence often intertwined with abuse.
6. The impact of trauma on memories such as incoherent disjointed life narratives and fragmented entangled emotionally laden memories.

Transparency

Gaining the child's understanding as to why they are there, and being transparent about the assessment purpose, practicalities, process, and role is crucial. This might be through discussing the "Elephant in the room", having myth-busting conversations (e.g. "All therapists want you to do is cry", or "Therapists can read your mind"), and encouraging curious questioning, for example, "If I was in your shoes I might …" or "Some children tell me they worry about …" There should also be clear messages that you are there to listen to them, and that what they say is really important.

Child-friendly

The therapist needs to be sensitive to the child's social, emotional, and developmental age, as well as the pace and amount that they can tolerate. The communication style will need to be adapted, depending on the child's understanding,

preferences, learning methods, cognitive level, and English language abilities. This should be echoed in the room set-up, the materials made available, and the use of child-friendly language/metaphors (e.g. butterflies in your tummy, thoughts whirling around like a tumble-dryer), and interactive playful props such as brain puzzles, feelings cards, or worry monsters. They should know that there is a clear beginning, middle, and end, which can be aided by having a child-friendly clock and countdown conversations.

Therapists need to be ready to be flexible and think on their feet to engage with a range of presentations; from a child darting out of the room, to them sitting in silence, to frantically throwing items, to talking extremely openly about difficult past experiences.

Figure 5.1 Widening the assessment lens.

Assessment domains

Table 5.1 discusses a variety of areas to consider when assessing a child/family who has experienced relational and developmental trauma. These will vary depending on the child's age and on the assessment goals. Appropriateness and usefulness of the questions, including how best to frame, deliver, and measure them, should be considered. They are by no means an exhaustive or prescriptive list, and the majority of areas overlap and are interwoven.

Some areas might need to be expanded and magnified, whereas others might not be relevant for the child/family in question; like a camera, capturing as much of the backdrop as possible with a wide angle lens, as compared to a zoomed-in shot (Figure 5.1). For example, if we were assessing for suitability for a particular intervention, such as Eye Movement Desensitisation Reprocessing therapy, the questions would lend themselves to that structure. Additionally, some questions might be kept in mind as part of a working hypothesis, but not asked, or others sought through previous information gathering. Ideally an assessor will work systematically to build a wider picture, connect the dots, and form some sort of coherent narrative. This can be usefully captured in a conceptual map which visually represents the integrated framework.

A thorough assessment acknowledges that parenting and behaviour do not occur within a vacuum, and therefore will develop a formulation based on an interplay of the multiple factors. Table 5.1 holds the dual lens of attachment and trauma within a wider frame of mental health and child development. The majority of the assessment areas are described in more detail throughout this book.

Table 5.1 Assessment areas and questions to consider

Assessing area	*Example questions*	*Additional considerations*
In-utero and post-natal	*Did the mother have antenatal care and what support systems and services were available/used?* *How was the pregnancy?* *Were there stressors, traumas, losses, accidents, injuries, and/or violence during the pregnancy?* *Did the mother smoke, drink alcohol, take medications, and/or use substances during the pregnancy?* *Was the pregnancy planned?* *What were the parent's feelings, thoughts, reactions, and responses about the pregnancy/baby?* *What was the mother's prenatal attachment like to the baby?* For example, cognitive attachment (e.g. the ability to conceptualise the foetus as a person, or be able to	If not a first time mother, there may be important questions about past pregnancies, motherhood, termination, and/or miscarriage experiences. The following may be helpful supporting measures: *The Pregnancy Interview, Parent Development Interview, Parental Reflective Functioning Questionnaire, This is My Baby Interview, Maternal Attachment Inventory, Maternal Fetal Attachment Scale, Maternal Antenatal Attachment Scale, Prenatal Attachment Inventory, Paternal Fetal Attachment Scale, Postpartum Bonding Questionnaire, and Mother-Infant Bonding Scale.*

(*Continued*)

Assessing area	*Example questions*	*Additional considerations*
	differentiate them from themselves), emotional attachment (e.g. an empathic affectionate bond), attachment behaviours (e.g. responding and interacting with the foetus), and self-care practices (e.g. maintaining good health).	
	How was the labour and delivery? Were there any complications or concerns? (e.g. baby's growth, weight, oxygen supply).	
	What was the nature and quality of the mother–baby relationship following arrival?	
Developmental trajectory	*Did the child meet their developmental milestones?*	Refer to the Parenting Patchwork exercise in Chapter 1.
	Were/are there any developmental delays/learning disabilities/difficulties or pre-existing medical conditions?	
	What core experiences and skills did they miss out on?	
	What are their emotional, social, and developmental needs? How will these change as they develop?	
Family factors	*Who is in their family?*	A Genogram or Ecomap can be beneficial tools.
	What do we know about the family experiences of trauma, genetic factors, life stressors, conflictual relationships, attachment relationships, mental and physical health diagnoses, learning disability diagnoses, criminal activity, and use of substances? What impact might these have had on the child?	The term "family" should be thought of in a broader sense. Sibling and extended family relationships should be considered.
	What is the quality and nature of the family's support system?	
	What is the family's structure and organisation (i.e. subsystems, cohesion, hierarchies, boundaries, and roles)?	
	What are the family patterns of communication, conflict-resolution, decision-making, help-seeking, and problem-solving?	
	What are the shared family models, beliefs, values, stories, and inter/multigenerational legacies?	
	What are the families' strengths, skills, protective factors, and resiliencies?	

Assessing area	*Example questions*	*Additional considerations*
Parenting experience	*Who were their primary carers?* *What does the parent/parenting experience mean to the child?* *What was the home atmosphere like?* *What parenting styles/models/quality/relational templates/behavioural management did they receive?* *Have these been shaped or changed over time? If so, how?* *How did the parenting meet the different developmental stages of the changing child?*	These questions should be informed by parenting measures, rich descriptions, specific examples, and observations of parent–child interactions. (Chapters 1–3 and 6). Observations should include a variety of tasks and settings which allow for children's attachment systems to be activated and for live examples of managing high-intensity arousal, separation, and co-construction to be seen. Observations may include: a) stressful times of day such as mealtimes or the morning routine; b) watching the family build a Lego structure together, or play a game together; c) naming the family rules or each member's likes and dislikes; d) seeing the child's responses when separated from and reunited with their primary caregiver, or when approached by a stranger. Children's representations may be sought in numerous ways, such as drawing a picture of their family, making a family sculpture, sentence-completion tasks, or telling a story.
Relationships	*Who are/were the key relationships in the child's life?* *What are the different types of relationships the child has? What relational losses and relational riches have they experienced?* *What are their patterns of relating to others? What have they learned about "doing and being in" relationships?* *How are their interpersonal and social skills?*	Consider "family", professional, and peer relationships.

(*Continued*)

Assessing area	*Example questions*	*Additional considerations*
Service history and relationship to professional support	*What is the child/ families' relationship to services/professionals?* *What services have been involved? What other interventions/assessments have taken place, and how were these experienced and responded to?*	This might be supported by drawing their service journey, map, or chronology. It can be useful to explore their conceptualisations/beliefs/ hopes/ worries/expectations about e.g. "therapy". Where appropriate, this might include questions around capacity, motivation, and readiness to change.
Placement history	If the child was or is placed in care. *What was the reason they were removed? What has/was their placement history been?* *What separations, losses, and transitions have they experienced? How have they managed and responded to these?* *What has their relationships with their caregivers been? What was the quality of the placement/s?* *What was their understanding of the placement/s and of being in care?* *Have they experienced multiple placements? If so, why, and how were these managed?* *What are their contact arrangements?*	Chronologies and life-story books can be helpful here.
Traumas and losses	*What age was the child when the traumas occurred?* *What was the nature/frequency/ severity/ duration of the traumas?* *How did the traumas come to light? What was the child's and others' responses to the traumas?* *What was the child's relationship to the person/people who carried out the traumas? What are their feelings (positive and negative) towards them?* *What consequences were there of the traumas and losses?* *What were the child's/families' understanding, sense-making, attributions, and meaning-making about the traumas?* *What might the child's core beliefs, internal working models, and sense of self be?*	These questions take into account the eight domains proposed to be affected by complex trauma (Cook et al., 2005). These are discussed in more detail in Chapters 1–3.

Assessing area	*Example questions*	*Additional considerations*
	What was the child's experience of shame and blame?	
	What have they learned about emotional and behavioural arousal/regulation?	
	How have they learned to manage stress, frustration, impulses, feeling out of control, and transitions?	
	What is their ability to trust or to feel safe?	
	What is the child's relationship like with their body and sensory world?	
Presenting difficulties and subsequent impact	Define the presenting difficulty. *What is it and what does it look like? Can you give an example of when it happened?*	It can be helpful to visually map, chart, diarise and/or track the behaviour.
	When did the presenting difficulty start and how long has it been occurring for? How frequently does it occur?	Scaling questions can also be useful here.
	When does it occur and not occur?	See Chapters 2 and 9.
	What patterns, triggers, hotspots, variables (environmental, sensory, autobiographical, physical, cognitive, relational, emotional, situational) *make the presenting difficulty bigger, smaller, absent, present etc.?*	
	What is the impact of the difficulty on the child and those around them? (e.g. self-care, self-presentation, sleep, eating, mood, school life, relationships, learning, hobbies, daily-living skills, self-esteem etc.)	
	How stressful is the difficulty to the child and to their TAC? What is the difficulty making trickier or stopping the child/ caregivers from doing?	
	What is the child's sense-making, meaning-making, attributions, explanations about the difficulty? How do these fit with their TAC views?	
	What might the difficulty be communicating, what story is it telling? What function might it be serving?	
	What responses has the difficulty received? What interventions/messages/ strategies have been put in place to address the difficulty?	

(*Continued*)

Assessing area	*Example questions*	*Additional considerations*
Education and recreation	*How is the child doing in school?* (socially, academically, behaviourally, emotionally).	Chapter 9
	How are their cognitive and executive function skills?	
	How are their play, peer, and social skills? (including relationships with teachers).	
	Have they had any additional input; such as one-to-one support, neuropsychological assessment, speech and language, and/or behavioural support?	
	What extracurricular activities/interests do they have?	
Strengths, positive qualities, and protective factors	*What are/were the protective factors?*	Chapter 4
	What has and is going well? What positive steps forward have they already made?	
	What adversities have they survived?	
	What are their strengths, skills, resiliencies, protective factors, positive qualities, coping strategies, and interests?	
	What motivates them? What makes them light up and feel good?	
	What are their hopes, dreams, and ambitions?	
Risk and safety	*What areas of risk, child protection, and safety need to be taken into account and assessed?* (e.g. suicidal ideation/self-harm/self-neglect/ social withdrawal/non-compliance with medication/going missing/criminal activity/antisocial behaviour/violence/ sexual exploitation/substance abuse/ behaviour of a sexual nature).	These areas may differ if categorised into sections of parental, child, and social risk factors; and separated as historical or current risk factors (Static vs. dynamic).
	What safety plans and risk assessments are in place? How are these working and being monitored?	
Contextual factors	*What are the important systemic, contextual, and organisational dynamics?* e.g. cultural, financial, social, political, familial, gender, religion, and organisational factors.	An example follows: *Jala reported to her teacher that she was having nightmares. Her teacher interpreted these as distressing and referred Jala to a therapist. Jala made sense of these nightmares differently; she saw them as reflecting her spiritual status whereby her*

Assessing area	*Example questions*	*Additional considerations*
		ancestors were conveying powerful messages to her. Jala also shared that she had experienced female genital mutilation (FGM). This coincided with a new governmental focus on FGM; coupled with the therapist having a specialist interest in FGM. Jala required an interpreter. She also practised Islam, a key part of her identity. Jala's immigration status was being reviewed, and she was living in temporary housing. *How would these wider factors impact and colour the assessment and responses?*

Assessing measures

Before going on to describe some of the practical assessment tools, we shall turn to some of the available psychometric measures and tools there are to support relational and developmental trauma assessments (Table 5.2). The amount of available measures is endless and tends to vary depending on the child, clinician, and service; so these are simply intended to provide a flavour. Measures need to be interpreted with caution, and should follow the relevant manuals and respective guidelines. Each measure will have different strengths and limitations including its biases, level of reliability, consistency, and validity. Measures should not be used to bypass thinking, and are best used in combination with other information-gathering methods, such as observation and interviews.

The purpose of a measure can differ from being designed as a screening tool, to being a measure of therapeutic change, and the expertise, length of time, and training needed to administer and interpret them varies significantly. Additionally, some tools may measure the domain intended, such as self-efficacy, but may not have been normed for a particular age bracket, a UK context, or for a specific population, such as children in foster care; or are based on western models, notions, and values. Therefore, clinicians should be mindful of cultural, language, and contextual factors; and their suitability and appropriateness considered.

The following measures are based on some common areas which might be valuable to assess. Due to space and focus, this list does not include specific areas which could be investigated further by a wealth of available measures, such as domains of emotional regulation, self-concept, and sensory integration. In addition, clinicians may also use specific mental health measures, such as anxiety inventories or depression questionnaires to guide their assessment. Similarly, with regards to the listed parenting measures, these do not detail specific domains of parenting, such as parenting belief systems, perceptions of parenthood, parenting satisfaction, parenting styles, and marital/partner relationship quality.

Note: It is particularly helpful to try out these measures yourself and familiarise yourself with them before administering them to clients.

Table 5.2 Assessment measures for children and adolescents

Domain	*Measure name and age*
General overview (behavioural focus)	Children's Global Assessment Scale (Shaffer et al., 1983) – ages 4 –16 years.
	DAWBA (Goodman et al., 2000) ages 5–17 years.
	The Behaviour Assessment System for Children (Reynolds et al., 2004).
	The Achenbach System of Empirically Based Assessment includes an integrated set of rating forms for children age 1.5 years through to adulthood (Achenbach, 2009).
	Vineland adaptive behaviour scales (Sparrow et al., 2005). Different age range versions available.
Child developmental milestones and profiles	Infant-Toddler Social and Emotional Assessment (ITSEA and BITSEA) (Carter and Briggs-Gowan, 2005) ages 1–3 years.
	The Bayley Scales of Infant Development (Bayley, 2006) 1–42 months.
	Ages and Stages Questionnaires (Squires et al., 2002) – Different versions available ranging from 6–60 months.
	The Communication and Symbolic Behaviour Scales Developmental Profile (Wetherby and Prizant, 2001) ages 6–24 months.
Cognitive neuropsychological measures	Wechsler Preschool and Primary Scale of Intelligence (WPSSI) (Wechsler, 1967).
	Wechsler Intelligence Scale for Children (WISC) (Wechsler, 2014).
	The developmental NEuroPSYchological Assessment (NEPSY) (Korkman et al., 1998).
	The Kaufman assessment battery for children (Kaufman, A. S., and Kaufman, N. L., 2004).
	Particular domains of cognitive functioning, for example, executive functioning may need to be investigated further by specific measures.
Trauma and PTSD measures	Clinician-administered PTSD Scale (Nader et al., 1996) – ages 8–18 years.
	Children's PTSD Inventory (Saigh et al., 2000) – ages 6–18 years.
	UCLA Trauma Reminders Inventory (Steinberg et al., 2013) – 7–12 years and an adolescent version available.
	Child PTSD Symptom Scale (Foa et al., 2001) – ages 8–18 years.
	Trauma Symptom Checklist for Children (Briere, 2005). Different age versions available.

Domain	*Measure name and age*
	PTSD Semi-Structured Interview and Observation Record for Infants and Young Children (Sheeringa et al., 1994) ages 0–7 years.
	Children's Impact of Traumatic Events Scale (Wolfe et al., 1991) ages 8–16 years.
	Structured Interview for Disorders of Extreme Stress (SIDES) –adolescent version (Pelcovitz et al., 1997) – ages 12–18 years.
	The Angie/Andy Cartoon Trauma Scale (Praver et al., 2000) – ages 6–12 years.
Dissociation measures	Child Dissociative Checklist (Putnam et al., 1993) – ages 5–12 years.
	The child dissociative experience scale (Stolbach, 1997).
	Children's Perceptual Alterations Scale (Evers-Szostak and Sanders, 1992) – ages 8–12 years.
	Adolescent Dissociative Experiences Scale (Armstrong et al., 2007) – ages 11–18 years.
Attachment measures	Strange Situation (Ainsworth at el., 1978) – 11–24 months. Adapted versions available.
	Separation anxiety tests (various versions available).
	CARE-Index Infancy and CARE-Index toddler (Crittenden, 2004).
	Assessment-Q Set (Waters, 1995) – 11 months to 5 years.
	Narrative Story Stems (various formats available).
	The Attachment Doll Play Interview for Pre-schoolers (Oppenheim, 1997).
	School-aged assessment of attachment (Crittenden et al., 2010) 6–13 years.
	Attachment Interview for Childhood and Adolescence (Ammaniti et al., 2000) – 10–16 years.
	The Child Attachment Interview (Target et al, 2003). Approx. 8–13 years.
Parenting, parent–child relationship, and family atmosphere measures	Adult Attachment Interview (George et al., 1985). Adapted and modified versions available.
	Working Model of the Child Interview (Zeanah and Benoit, 1995).
	Parent Development Interview (Slade et al., 2004).
	Caregiving Interview (George and Solomon, 2008).
	The Adult-Adolescent Parenting Inventory (Bavolek and Keene, 2001).

(*Continued*)

Domain	*Measure name and age*
	The Parenting Role Interview (Bilfulco et al., 2008).
	The Insightfulness Assessment (Oppenheim et al., 2004).
	This is My Baby (Bates and Dozier, 1998).
	Parental Reflective Functioning questionnaire (Luyten et al., 2009).
	Mayer-Salovey-Caruso Emotional Intelligence Test (2000).
	Emotional Availability Scales (Biringen, 2008).
	The Difficulties in Emotional Regulation Scale (Gratz and Roemer, 2004).
	Parent–Child Relationship Inventory (Gerard, 1994).
	Parent–Infant Relationship Global Assessment (Zero to Three, 2005).
	Parent–Infant Relational Assessment Tool (PIRAT) (Broughton, 2010).
	NCAST–Parent–Child Interaction and Teaching Scales (Mischenko et al., 2004).
	Marschak Interaction Method (Marschak, 1960).
	Parenting Stress Index (Abidin, 1995).
	The Parenting Daily Hassles Scale (Crinic and Greenberg, 1990).
	Parenting Sense of Competence (Johnston and Mash, 1989).
	Maternal Self-Efficacy Scale (Teti and Gelfand, 1991).
	Family Environment Scale (Moos, R., and Moos, B, 1983).
	Family Relationship Index (Holahan and Moos, 1983).
	Family Activity Scale (Smith, 1985).
	Family Adaptability and Cohesion Scale (Olson et al., 1985).
	Home Observation for Measurement of the Environment (Caldwell and Bradley, 1984).

Practical assessment tools

These ideas are intended as suggestions to aid the assessment process and to gain a more in-depth understanding of the child and of their inner world and representations. Their suitability must be taken into account for the individual child and situation. Moreover, the length of time for the assessment will have a large bearing on the choice of tool (assessments can vary from an hour to several months). These techniques need to be delivered within a playful, flexible, safe, transparent, and warm relationship. The overall environment, as

Figure 5.2 Practical assessment tools (a genie puppet, therapeutic sentence completion cards, a miniature genogram, feelings stamps, and feelings monsters).

well as the assessor's verbal, non-verbal, and sensory communication, is important. The therapist will need to be mindful of both the session content and process (e.g. attention to their presentation, affect, behaviour, speech, cognitions, insight, items selected, words used, emerging themes, positioning/body language, and orientation).

a Spend time getting to know the child. This might be through "All About Me" quizzes, books, collages, or stories. The questions will vary depending on the child but may include: "What is your favourite food?" to "What makes you feel excited?" to "Describe yourself in three words". This can be tailored to a child's interest. For example, if the child likes Dora the Explorer, you may ask why and what they like about Dora, and then go on to ask questions such as, "What is in (child's name) the explorer's world?" or "If Dora met you, what would you tell her about yourself?"

b Children can be encouraged to introduce themselves by drawing the story, meaning, and feelings of their name.

c Free playing and drawing can be helpful from an observational and building rapport perspective, and can provide valuable information. For example, is the child's play compulsive/chaotic/repetitive/of an adult nature? Free-playing can also create opportunities for the child to gain some mastery, and to become familiar with the space. Optimally, they should have a range of resources available (these will vary depending on age and theoretical approach) which they can use to express an array of feelings and themes (e.g. angel wings, a skeleton, and coffin to represent death). This might include puppets, masks, play doh, dressing-up kit, drawing equipment, board games, a medical kit, a doll house, puzzles, Lego, magnets, string, cellotape, and miniatures. Useful follow-up questions can map onto their play, for example a child who

is playing with animals might be asked, "If you could be an animal which one would you most/least want to be and why?", or a child drawn to the Spiderman figure might be asked, "If you could be a superhero, what powers would you have and why?"

d A shared activity such as co-creating a picture, story, or building something together like a Lego structure can be useful. The squiggle exercise (Winnicott, 1968) can be a fun way to engage with a child; this is where the therapist draws a squiggle, and the child adds to it, and so on. Using play-doh to complete the picture can be even more interactive.

e Playful resources can be extremely useful for exploring feelings in a non-talking dominated way. These might include: feelings themed balls, stamps, cards, dice, monsters, stickers, and quizzes. In addition, games such as Connect-4, pick-up sticks, or Jenga can be used therapeutically by asking a question after each turn (Figure 5.2).

f A box/bag/bottle/jar of feelings – this can be a useful way of exploring feelings. Ask the child to draw, using shapes, colours, and sizes, their different feelings. Alternatively, you can make or have a physical bag/bottle which the child can place the feelings items/words in.

g Other children might like to express their feelings through placing feeling stickers on a doll, or on a life-sized body cut-out (Chapter 3), or drawing or making all of their different feelings as pieces of a pie/puzzle, beads on a necklace, or squares on a patchwork quilt. Alternatively, you can draw a head and ask the child to complete the blank speech marks or do some sentence-completion tasks (e.g. "I feel happy when …", "I wish my family would …"). Chapter 2 offers additional feeling-work ideas.

h The solution-focused miracle question (de Shazer, 1985) can be a great way to explore a child's wishes and goals. This can be enhanced by using props such as genie puppets, wishing wells, or magic wands.

i Creating a family sculpt, genogram, or Eco map can be a fantastic way of identifying family patterns and relationships. Using miniatures, stickers, playdoh, and/or buttons can make this a more engaging process. It can also be useful to get the child to place their "worst enemy" or "person they don't like", as this can support them in putting distance between them, and making space for expressing negative feelings.

j Creating a visual timeline, such as on a road or path, can be beneficial. Children may want to assign different symbols to represent different times, such as the sun and rain. Others might find making a paper chain or a comic strip a valuable way of discussing a chain of events.

k Directive exercises include asking the child to draw/make/sculpt/create/collage/use a sand tray/with puppets/with miniatures:

   i A self-portrait.
   ii Their family.
   iii Their, for example, "stomach-ache", "worries" or "anger".
   iv Their hero or fantasy world.
   v Inside/outside masks, or dual self-portraits (folded paper), representing how they think others see them, and how they see themselves.
   vi Their own garden, house, tree, world, safe place, or under the sea life.

As a clinician, in a safe context, it can be helpful to try out some of the above on yourself *or with a trusted other before trying them with a young person.*

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Chapter 6

Therapeutic re-parenting those who have experienced relational and developmental trauma and loss

Who does the term "therapeutic re-parenting" refer to?

This chapter will first discuss the importance of therapeutically re-parenting (also known as attachment-facilitating parenting) a child who has experienced relational and developmental trauma; then the qualities and components of therapeutic re-parenting will be explored, followed by some practical implications for the Team around the Family/Worker (TAF/W) to support the therapeutic re-parenting process.

Although this chapter writes predominantly with a foster carer, kinship carer, or adoptive parent in mind, these concepts and qualities have relevance and applicability to a range of other subgroups, including residential workers, social workers, family support workers, birth parents, teachers, therapists etc. To capture these variations, the terms "carer", "caregiver", and "parent" are used interchangeably. However, it is acknowledged that it is not helpful nor accurate to lump all types of "parents" (e.g. adoptive, foster, kinship) together in one category, as they are a widely diverse heterogeneous group of individuals, each with their own unique needs, journeys, and motivations. It is also important to recognise that the task of parenting is dynamic, does not take place in a vacuum, and is influenced and shaped by wider systems, cultures, and contexts.

Why do children who have experienced relational and developmental trauma need therapeutic re-parenting?

Children who have experienced relational and developmental trauma often present with multiple complexities, which require highly skilled resilient well-supported carers (see Chapters 1–4 for more in-depth discussion). Within this, the potential for change and new possibilities is far greater in a 24-hour relationship that takes place over a longer time span in multiple contexts, where there are thousands of everyday moment-to-moment learning opportunities available.

Many of these children have missed out on being taught and having solidified multiple fundamental developmental and life skills (see Parenting Patchwork exercise in Chapter 1). They are also more likely to have been soaked in negative relational patterns and interactions, with parenting experiences characterised by

Figure 6.1 Safe containing hands.

emotional unavailability, incongruent mirroring, and dyadic dysregulation, meaning that access to relational riches or relational anchors was limited (Chapters 1–3). Therefore, these children need more than love, they need environments and relationships which are going to provide them with a reparative second chance secure base and safe haven, and ones which strengthen their parenting patchwork (Figure 6.1). They need the scaffolding and active parenting, which is going to support them to feel safe and to develop much needed skills. For example, a child cannot learn to self-regulate their emotions before they have learned the skills needed through co-regulating their emotions (Chapters 2–3).

In order to address the previous unrepaired ruptures and relational poverty, the therapeutic re-parenting experience needs to be emotionally, physically, developmentally, and socially enriched and enhanced. This should aim to provide children with the capacity to revise, refine, and re-evaluate their previous relationship templates and relational trauma, through new positive relational experiences. Moreover, positive parenting styles, maternal sensitivity, and parental secure attachment styles are linked with better child and placement outcomes, such as fewer externalising behavioural difficulties, less placement breakdowns, and increased positive parent–child relations (Kaniuk et al., 2004; Simmel et al., 2007). Therapeutic re-parenting experiences will support the child towards developing a learned/earned secure attachment style (Saunders et al., 2011), which has multiple positive implications on their emotional attunement, reflective function (RF), social cognitions, emotional intelligence, and interpersonal competence.

Additionally, previous chapters have discussed the potential negative brain-based consequences of experiencing relational and developmental trauma and toxic stress. However, on the other side of the coin, it is also possible for the brain and its neural pathways to be positively shaped, re-wired, sculpted, and changed through life experiences and relational interactions (Glaser, 2000). The brain is an experience-dependent developing live organ, and promisingly is at its most plastic and flexible during the critical sensitive periods of childhood; therefore the window for brain organisation and reorganisation is even wider and more open to new possibilities (Lupien et al., 2009). Children are born with a surplus of cells but it is the parenting and environment, like in draw by numbers games, which connects and strengthens these links. Positive experiences can give birth to new neurons (neurogenesis) and bring different parts of the brain online.

Encouragingly, we also know that through nurturing bonding "parenting" experiences, positive "feel good" chemicals such as oxytocin, opioids, prolactin, endorphins, vasopressin, and gamma-aminobutyric can be released (Goleman, 2006; Sunderland, 2007). This is supported further by studies that have shown that positive stimulation by a caregiver can trigger the production of the corticotrophin releasing factor by the infant's hypothalamus, which in turn stimulates the production of the rewarding biochemical dopamine (Cozolino, 2002). This gives weight to the idea that carers can support positive architectural, structural, and functional changes in the brain, which emphasises the importance of the child–carer relationship being at the epicentre and vehicle of change for any intervention.

Figure 6.2 Parenting Orchestral Choir.

Therapeutically re-parenting a child: the parenting orchestral choir

The task of parenting a child is huge and demanding, let alone a hurt child who has experienced relational and developmental trauma. Therapeutic re-parenting involves massive amounts of time, skill, and energy. These parents often have to juggle multiple balls, some of which are heavier, quicker, and slipperier than usual; some are even camouflaged. This juggling is often done in an arena of people watching, judging, assessing, and of being in the spotlight (i.e. social workers, family members, therapists). In order to manage these competing balls, therapeutic re-parents have to employ various different roles and skills (e.g. being the child's external brain, teacher, safe hands, advocate, nurturer, and co-regulator). These multiple roles are even more multifaceted given the changing expectations and context of certain "parents" in the United Kingdom, such as foster carers being expected to be a hybrid of both a professional and a parent. These parenting roles and skills can be likened to the complexity of an orchestral choir – *a parenting orchestral choir* (Figure 6.2).

Like with parenting, musicians have generally been guided and taught along their musical journey; and their skills have been refined and practiced repeatedly over time. Each instrument requires different skills, timing, physical strength, care, and maintenance. The successful coming together as a choir requires structure, order, and organisation. This might need to evolve depending on newcomers, people departing, change of venues etc. *Imagine a choir playing relentlessly for hours on end with little or no re-energising time, or a guitar being played for years without having its strings changed or tuned.*

The instruments are reliant on the person behind them, and the performance is influenced by multiple factors (e.g. the audience, the conductor, the environment, and their neighbouring players). Similarly, the love and enjoyment of the musicians will have an impact on their feelings towards being part of the choir, as will the energy of the audience and fellow musicians. The music can affect and be interpreted differently by varying people.

There can be times of absolute musical union, and others when it is all out-of-sync. Sometimes they play together as a team, and others it's dependent on a soloist, or on the conductor. The music's pace, volume, tone, and feelings can be changed and shaped. When the music isn't sounding quite right, then thought, experience, problem-solving, and gut-instinct are needed to consider how to improve the performance, and what is needed to be added, taken away, or tweaked. See Box 6.1 to continue building on this metaphor. Specific qualities and skills which make-up a therapeutic re-parent will be discussed in the following sections.

What qualities does a therapeutic parent and system need?

The following sections will discuss some of the components, qualities, and desirables which constitute therapeutic and attachment-facilitating parenting. Like in a well-coordinated choir, many of these ingredients are interlinked, and can complement or conflict with each other. These qualities are on a continuum, and are

significantly influenced by individual, contextual, and situational factors. They have wider implications for support services, such as around recruitment, assessment, training, and matching of carers; as well as for the therapeutic support packages offered. Many of these concepts and strategies are built on throughout this book.

6.1 Reflective practice: Parenting Orchestral Choir

Think about your own experience of being parented and/or when you are parenting. *What did/does your parenting orchestra look/sound/feel like? What skills, roles, and qualities are needed to play effectively in your choir? What did or does it feel like when it's in unison or when it's out-of-sync? What changes, influences, or factors make or made its performance better or worse?*

When parenting a child who has experienced relational and developmental trauma, how might the choir feel or be different?

Consider how these different roles (child's external brain, teacher, safe hands, advocate, nurturer, and co-regulator) *relate to therapeutically re-parenting a child. What skills do these roles require, and what skills do they teach children?*

Team Around the Family (TAF)

In order to be able to therapeutically re-parent effectively, it is crucial to be able to work with and alongside others, and to have a high level of interpersonal and relational skills. This includes an openness and flexibility to practice "different" parenting styles, for example, using different strategies to "traditional parenting" or ones that were successful with other children. Therapeutic re-parenting is also optimised when one has an overall positive relationship to seeking/accepting "help" and communicating collaboratively with the TAC (e.g. clinicians, schools, and social workers). Due to the permeating nature of trauma, it is important to work towards the TAC being well connected and coordinated. Building on the choir metaphor, *imagine what a muddle it would be if half the choir sung Amazing Grace and the other half sung Oh Happy Days? Or if all members swayed to the left and one member swayed to the right? Or if the soloist began singing and the backing singers and music did not?*

There are often multiple people in the melting pot, so it is integral to consider the web of systemic and organisational dynamics that may be at play, such as fragmentation, scapegoating, projection, and splitting (Chapter 8). Examples follow:

> *Leon's early experiences of his warring parents became mirrored in his foster mother's conflictual relationship with social services. This resulted in her feeling ostracised, blamed, and positioned as the problem, and Leon once again feeling uncontained and caught in the middle.*

Kylie and Chris adopted a child who had been significantly neglected. This was echoed in the surrounding services, as they too started feeling forgotten, dismissed, and neglected.

This TAF framework extends to the importance of the caregiver/s having a robust active support system. Emphasised further as a consistent finding in the literature is the increased sense of isolation felt by carers, and conversely, the buffering protective factor a positive support system can create. This is brought to life by the African proverbs – "It takes a village to raise a child", and "Sticks in a bundle cannot be broken".

Commitment, motivation, and dedication

Therapeutic re-parents will need high levels of commitment, energy, time, motivation, and dedication to their role, themselves, the child, and the system. Studies have shown that when children do not have caregivers who are committed and motivated to care for them, they are at increased risk for negative self-perceptions, problem behaviours, and placement breakdowns (Redding et al., 2000; Ackerman and Dozier, 2005; Lindhiem and Dozier, 2007). Parents will also need a sense of intentional purpose, mastery, and self-efficacy in their ability to positively contribute to their child's progress. Oyserman et al. (2004) found that parents who feel efficacious are less stressed and overwhelmed by parenting tasks, and are more likely to be warmer, nurturing, and less punitive in their behaviour management.

Being trauma and attachment-informed

Enhanced-parenting includes an increased awareness, sensitivity, and knowledge around the multilayered impact of *developmental and relational trauma and loss* on the child, on themselves, and on the surrounding systems (Chapters 1–3, 8, 9). Moreover, therapeutic re-parenting includes an acceptance and understanding that the child has had significant relational trauma, and therefore the primary need is on relational repair (break–reconnect). This includes the therapist/parent and child working through difficult conflicting times and mismatching feelings (relational ruptures) to ensure that there is relational repair. This should be worked towards through moment-to-moment meaningful interactions, which provide children with the opportunities for experiencing connected relationships (e.g. being the child's external brain, to teacher, to safe hands, to advocate, to nurturer, to co-regulator). In addition to the everyday interactions, this also might be through engaging in indirect work, and/or parent–child therapies, such as Dyadic Developmental Psychotherapy or Theraplay (Chapter 7). This positions caregivers as children's greatest tool and anchor for change. Out of respect and acknowledgement of the mammoth parenting task, they will need to be part of a sophisticated and/or well-supported orchestral choir.

Safe haven and secure base

The home environment/person needs to provide children with a physical and psychological secure-base. This place/person should be internalised as an inner

sense of felt safety. A place/person where the child feels like they belong and are held and contained; and that they have someone to turn to in difficult times, and to celebrate with in joyous times. This place/person may need to be their anchor, safety net, or lifeboat in stormy weather, choppy seas, changing landscapes, and overwhelming waves of emotional, sensorial, and physiological dysregulation. Additional strategies to practically promote safety are detailed in Chapter 9.

Warm, playful, and nurturing

Throughout the literature, being able to express warmth, affection, and love has been associated with closer parent–child relationships (Zeanah et al., 2011). Many children previously would have experienced power and control-based interactions, therefore they need reparative relationships which are kind, authentic, warm, nurturing, and affectionate. Nurturing parenting may show itself in many forms ranging from holding, feeding, tickling, laughing, pampering, to paying special attention to any hurts. Examples follow:

> *Each time Andrea hurt herself, Janice would give her a getting-better ritual, which included 3 big breaths, 3 kisses, 3 puffs of magic dust, some healing cream, and a special plaster.*
>
> *Brendan found touch and intimacy difficult and re-triggering, so instead we made him a blanket of love, and a doodle-bear filled with loving messages.*

Similarly, the ability to be humorous, playful, fun, and child-centred is key for diffusing power battles, pushing on parents and children's reward buttons, and increasing positive parent–child interactions. This can be anything from: making a treasure hunt, to going on a camping adventure in the garden, to having a race to the bus stop, to playing eye spy in the car, to making faces with their food, to playing supermarket sweep.

Getting to know the whole child

Carers should aim to see, accept, tolerate, and appreciate all of the child's different parts, like the different layers of Russian dolls or pieces in a puzzle. This is particularly important given that many of these children have low self-esteem and a toxic sense of shame, self-loathing, and humiliation (e.g. "I'm a mistake" and "I'm unlovable") (Chapter 1), and because many children would have not had opportunities to identify, build, and celebrate their identities and life stories. Within this, carers should take a deep interest in their child, and recognise and celebrate their uniqueness (Chapter 4). For example, what drives them, makes them sparkle, makes them happy, sad, and fearful; and how do they show these feelings? (Chapter 2).

Caregivers need to find ways to get to know, communicate, spend time, and connect with children as valued individuals. This might include things like

making an "All About Me" book or a "Katie's World" quiz, collage, or box. In essence, the more the caregiver knows the child, the more they will be able to effectively tailor and assess the suggested strategies. This is also significant as many children would have been suffocated by problem-saturated discourses, forgotten, neglected, not kept in one's mind, or not seen as a separate person with their own thoughts and feelings (Chapters 1–2).

Developmentally-sequenced parenting

Therapeutic re-parents will require knowledge around child development, and an enhanced awareness of the potential impact which trauma and disrupted attachments can have on developmental stages and competencies (Chapters 1–3). This will include understanding the child's social, developmental, and emotional age versus their chronological age. This will need to take into account their parenting patchwork (Chapter 1) and consider what skills need to be filled in before the child can master future steps, and which ones need more guidance and supervision. This includes from the very start services being appropriately transparent about the child's needs and background. This allows for preparation and adjustment of expectations, and avoids carers feeling blindfolded, unprepared, forced, and/or tricked (e.g. *"They told me he had typical tantrums, I had no idea of the rage and two-hour long outbursts I'd face" or "I especially chose to adopt an older child and now I have a 4 year old who socially and emotionally is like a baby!"*).

Understanding the differing ages and stages has important implications for ensuring that expectations are developmentally appropriate, and that caregivers can interact and support their child accordingly (Chapter 1–2). This includes identifying areas, where in the context of a safe relationship the child needs to do the co-learning and co-regulating before they can progress to being able to self-learn and self-regulate. For example, *if a 3 year old said "You're a bitch", would you say it back? Or if a 15 year old presented with the emotional and social age of a 9 year old, would you feel comfortable with them travelling alone to school on the train, or would there need to be skills and steps they learned and were taught first? Would we expect children who had been living in desolate islands (Chapter 1) to easily go from that starkness into the sensory overload of Disneyland?*

Taking the above into consideration, it is important that caregivers understand that it is likely that these children require a stepped approach, one that appreciates that there are multiple footprints on a long journey, and that children have had to put up certain barriers and protective strategies for good reasons. Like with a young baby, a parent expects the steps to be slow and difficult, and they marvel at each new milestone, whether it be a gurgle or a smile. Therefore, steps and goals need to be ***SMART*** (***S****pecific,* ***M****easureable,* ***A****chievable,* ***R****ealistic,* ***T****imely*) in order to maximise the child's opportunities to succeed, have a sense of achievement, and to eventually master the desired skill. *For example, if a parent says their goal is for the child "to be happy" or "to behave well", how can this be defined and made into a* ***SMART*** *goal?*

These goals/expectations need to consider the changing needs and stages of developing children, and the snakes and ladders nature and tricky tightrope-walking which this can require. For example, the parenting skills required for a baby are different to that of a toddler and that of an adolescent. Steps taken and distance travelled need to be punctuated, noticed, and celebrated (Chapter 4). Moreover, goals may differ significantly, depending on whose goals, wishes, worries, and hopes they are. They may also require mourning a loss (Chapter 2). Examples follow:

> *Elizabeth (adoptive mother) longed for a child who would need, embrace, and be affectionate with her, but instead was faced with a child who was rejecting, distant, and overly self-reliant.*
>
> *Niall's main connective tool was playing sports, however he was confronted with a foster child who had significant motor delays.*
>
> *Barbara dreamed of having a child who achieved great academic success, however she had to resolve that Billie needed to go to a specialist school with little emphasis on academia.*

Whole-brain-approach

Taking into account the sensory and body-based impact and disintegration of relational and developmental trauma (Chapter 3), it is vital that therapeutic re-parents are able to promote a whole-brain, head, hand, and heart approach. This multifaceted sensory approach contributes to making integral connections between the mind and body, hemispheres and functions of the brain, internal and external experience, and thoughts, feelings, and physical sensations. This also allows for consideration of the child's age/stage, different learning styles, and possible cognitive difficulties, which are more common with these children (Chapters 3 and 9).

Caregivers can bring concepts, rules, feelings, and desired behaviours alive by communicating verbally and non-verbally using an array of senses; such as kinaesthetic (role plays, games, physical movement, cooking), auditory (discussions, music, stories), and visual (worksheets, diagrams, pictures) means.

> *For example, when explaining the concept of a safe place to a child, one might embed this through a range of creative ways including: a) drawing the safe place, b) making a sculpture, collage, or sandtray representation of the safe place, c) writing a song, poem, story, or rap about the safe place, d) recording the story of the safe place, e) choosing a smell or cooking a meal associated with the safe place, and f) physically moving and role playing entering and being in the safe place.*

This multi-sensory approach also extends to therapeutic re-parents needing to consider the whole environment and the child's sensory world. *Can the child have a calm corner or weighted blanket to help them regulate when feeling unsafe?*

Can they have a safety tour to show them which safety procedures are in place to protect them? Can their access to green space and water-based environments be increased? (see Chapters 3 and 9).

Skill development and behavioural management

Through a process of assessment, getting to know the child, and being a detective, caregivers will need to identify which skills the child needs to be taught. Subsequently, creative problem-solving, perspective-taking, and multi-sensory approaches can be introduced to work on these in a stepped-SMART way. *This might range from a skill, such as impulse control, which can be supported through various means (e.g. playing musical statues, dead lions, computer games, and breathing exercises), through to specific behaviours such as learning to speak using "kind words".* These are likely to go hand in hand with praise, incentive, and reward techniques. Interestingly, Spratt et al. (2007) investigated factors associated with parenting stress in children with medical, developmental, and behavioural problems and found that behavioural problems were the strongest predictor of parenting stress. Similarly, within foster care, the severity of problem behaviour has been associated with increased placement breakdown (Oosterman et al., 2007). This crystallises the importance of behaviour reduction, and for therapeutic re-parents, in line with authoritative parenting practices, to have practical strategies and managing behaviour plans in place.

These ideally should be delivered in an empathetic way, which holds attachment and trauma in mind (e.g. maintaining the relational focus and repair in mind), whilst focusing on SMART goals and natural/logical consequences. These behavioural strategies need to go hand in hand with the other frameworks discussed, including *behaviour as communication*, *whole-brain approaches*, *developmentally-sequenced parenting*, and *strengths-based approaches*. Daniel Hughes uses a wonderful acronym "Connection before correction" to capture this. This is one of the philosophies he discusses in his **PACE** (**P**layfulness, **A**cceptance, **C**uriosity, and **E**mpathy) parenting model (Chapter 7).

Parents need to believe in the strategies or the underlying rationale for them, and feel confident and efficacious in consistently implementing them. Therefore, behavioural strategies need to take into account potential barriers to implementing or delivering them safely on both ends of the spectrum, including parents' own parenting experiences and rearing values (e.g. *"He's been through too much, I can't say no", "My dad was militant and I hated him, so I don't want to be anything like that" "I was hit when I misbehaved, and it didn't do me any harm"*).

Strengths and hope

Carers should provide children will high levels of hope, future-oriented thinking, and praise. "I will believe in you, even if you don't believe in yourself." Opportunities for their success and cultivating their positive affect, strengths, and

resiliencies should be optimised. These sparkle moments, mutual joy, and positive connections are fundamental for both parents and children to experience reciprocal meaningfully connected relationships, and to fill up their, and their children's, treasure chests with positive relational experiences and memories. The fuller this treasure chest is, the more it can be anchored onto when feeling depleted. This also aims to power up the child and carer's positive magnets, and push their reward system buttons. Caregivers need to identify and magnify what keeps them going and what parenting rewards they receive. This is especially useful when in problem-saturated and/or crisis situations (Chapter 4).

Safe hands and thinking minds

Caregivers ideally will be sensitive, empathetic, curious, engaged, and available. They will communicate in a transparent way; and be able to be in touch with a range of feelings and arousal states. A therapeutic parent will need high levels of reflective function (RF) and mind-mindedness, both of which enable them to parent mindfully (i.e. keep the child's mind-in-mind) (Siegel and Hartzell, 2003). This means that they will be able see their child as a separate differentiated person with their own thoughts, feelings, and mind, and will try to understand the mental states that underlie their behaviours, therefore enabling them to respond to their child's emotions and needs in a reflective manner (Slade, 2006) (see the *behaviour as communication* section). In essence, the more reflective the carer is about their child's mental state/inner world, the more the child feels understood. The more understood the child feels, the more understanding they will have of their own and others' minds, and in turn the more able they will be in understanding, controlling, and regulating behavioural, emotional, and physical arousal.

Emotional regulation

With the above in mind, caregivers need to be able to support children to develop richer ways of recognising, naming, expressing, labelling, and regulating their feelings, as opposed to being overwhelmed by an intense avalanche of emotions (Chapter 2). These regulatory skills teach and model healthy stress management and effective coping strategies.

Similarly, emotional regulation extends to carers, as it is important for them to stay grounded, regulated, and to operate in their thinking brains as much as possible (Chapter 3). This ensures that they are parenting mindfully and being the child's much needed role model, co-regulator, and external brain. Therefore, although easier said than done, efforts need to be made to avoid mutually escalating arousal or meeting, for example, anger with anger. This crystallises the importance of self-care and stress management, building on the parenting orchestral metaphor, instruments need to be maintained and tuned, and singers need to look after their voice and health. Strategies for prioritising self-care for professionals are detailed in Chapter 8 but can be usefully adapted for carers.

Behaviour as communication

Therapeutic re-parents need to be able to use their RF and detective skills to recognise, deconstruct, and respond to the emotional needs underlying their child's behaviours and/or defences. Support forums such as therapeutic consultation can assist this by helping to slow down the process, press pause, or slowly replay a situation that feels like it is on a fast-paced emotionally driven downward spiral. Ideally, carers should view the behaviour in context, see the child behind the behaviour, and try to decipher what function the behaviour is serving and what the behaviour is communicating (ways of doing this are discussed in Chapters 2 and 9). This supports carers gaining a window into the child's inner world and keeping the child's mind-in-mind.

An example follows:

> *Twelve-year-old Leslie had been in multiple placements and had experienced significant relational trauma. Her behaviour of slamming doors, spitting, and telling her foster carers to leave her alone gave the message "Stay away I don't need or like you". She seemed to have planted mines and concrete barriers in the ground, to protect herself from being hurt. Positively, once her carers were able to see and feel the links between Leslie's past and her present way of relating, and recognise her underlying fear of being parented and hurt, they were able to shift their conceptualisation, meaning-making, and attribution of the behaviours. Instead, they re-interpreted them as a possible way for saying, "I'm scared to let you close, you'll just let me down or send me away, so it's safer to keep you away." This also supported them to reconnect to their goal of providing her with reparative meaningfully connected relationships, and helped foster carers, Todd and Andrea, to distinguish some of the countertransference processes, and in turn depersonalise the behaviours and take some of the emotion out. This enabled them to see the behaviours as learned and protective strategies, rather than as personal attacks.*
>
> *By reframing the difficulties, and using Narrative Therapy techniques to see the problem as the problem, rather than locating it in Leslie (Chapter 10), they were able to gain some distance from e.g. "the spitting" and to think creatively how to problem-solve together against "the spitting". Consultation supported the carers to connect the dots, recognise patterns, and to make sense of the negative reinforcing cycles that were occurring and being perpetuated. For example, them staying away or getting angry was not providing Leslie with an opportunity to challenge her entrenched belief systems/relational patterns. Instead they were finding themselves playing out the reciprocal role of Leslie's transference, e.g. her angry parents. Once Todd and Andrea were able to connect with Leslie in a different way, they were more able to think about what she could do, what journey they had travelled, and what strengths and resiliencies were present (Chapter 4). This helped to refuel their emotional tanks, and to trigger their parenting reward systems.*

Unresolved trauma and parenting a hurt child

Being those safe hands and thinking minds can be challenging when supporting children who bring with them complex trauma and immensely powerful feelings. These feelings, at times, are likely to push and trigger surrounding people's buttons. Past experiences and relational patterns inevitably are brought into relationships; and subsequently impact our responses and associated feelings – even more so when these remain unresolved and unprocessed. When caregiver's hotspots are pushed, they can become dysregulated, re-triggered, preoccupied, and/or absorbed in their own trauma and loss experiences. In these moments, when lost in a sea of emotions, or having fallen through a timehole (Hobday, 2001), caregivers understandably may struggle to read, connect, and respond appropriately to their children's emotional states. This can be a significant block to being able to parent mindfully. This is extremely important in terms of its implications for assessment, recruitment, and matching of carers; as well as the support packages that should be offered. The importance of the caregiver's state of mind, level of maternal sensitivity, and their ability to be emotionally available is highlighted further, as studies have found that the attachment classification of a caregiver has a profound effect on the attachment classification of the child (Dozier et al., 2001). Examples follow:

> *Kayden's rejecting and distancing behaviour towards her adoptive father, Jay, triggered his own long relationship with rejection. When Kayden shouted at Jay "You're disgusting, I don't love you", and refused his invitations, "I don't want to go to the cinema with you, I'd prefer to eat poo", for him, it was like looking through a corridor of past mirrors. Once again, he was haunted by his ghosts from the past (Fraiberg et al., 1975), and felt the rawness of his own experiences of feeling "unlovable" and "not good enough" from his critical mother. His feelings of being "a failure" as a father were echoed and entangled with his feelings of being a failure as a son.*
>
> *Julie, when faced with her 4-year-old son Kai's rage, would see her ex-partner's anger during a DV incident, rather than the hurt little boy standing in front of her. This re-surfaced feelings of powerlessness and helplessness. In order to manage these terrifying feelings, she had learned to emotionally distance herself, and position Kai as a threat, "Just like his father".*
>
> *Cate was described by her health visitor as barely able to look at her baby. Each time he cried, she physically recoiled. Being in touch with his distress was too painful and triggered her own vulnerability.*
>
> *Naomi reported how 2-month-old Damien was out to get her. She described his behaviour as being "evil and malicious".*

Research strongly suggests that the processing and integration of childhood experiences is an integral variable in a parent's ability to be a safe haven to their children (Cozolino, 2002, p. 206). Therefore, assessment of (e.g. using the adult

attachment interview, parent development interview, Chapter 5) and work around these areas seems vital in order to successfully therapeutically re-parent these children. Support forums such as reflective practice, carer consultation, therapy, or training can help parents in recognising which patterns are being evoked, triggered, sucking them in like quicksand, or overwhelming them like an avalanche. Returning to the shark-infested waters metaphor (Chapter 1), *How can one avoid becoming one of the sharks, but equally not drowning in the fear, whilst learning about which waters scare them, and who are/were their sharks?*

These support forums can also address other difficult areas, like foster carer disenfranchised grief/stress when a baby is adopted, or a placement breaks down (Buehler et al., 2003; Hebert et al., 2013). These are crucial as the significance of these losses is often not acknowledged or socially validated.

Moreover, these support packages should identify ways to stay regulated, empathetic, manage high levels of affect, and regain emotional equilibrium, rather than getting hooked-into or engaging in mutually escalating arousal patterns. Parenting support needs to acknowledge the emotional, physical, social, financial, spiritual, and cognitive impact of parenting a hurt child, and validate their lived and felt experiences (see Chapter 8 on self-care). *Imagine what it's like to be left black and blue by your 5-year-old child whom you are pouring your everything into? Or a child who bites you when you go to kiss them goodnight? Or to be excluded from birthday parties due to your child's behaviour?*

This space should provide caregivers with non-judgemental, normalising, and affirming opportunities to speak about the good, the bad, and the ugly (e.g. not liking the child, wanting to give-up, fearing the child might become a criminal, difficult feelings towards their birth parents or about the child's dual loyalty to them). This models the model, that is, not brushing spiky bits under the carpet, and accepting all parts.

6.2 Practical activity and reflection

Firstly, please refer to Box 8.3 in Chapter 8 entitled "Self-care, empathy, and hot-spots" for related reflective exercises.

Then, having read the above, please consider the following questions:

What is the difference between parenting and therapeutically re-parenting?

How are these differences perceived, conceptualised, accepted, within your organisation, within the media, within public opinion? How much is the mammoth task of re-parenting a hurt child acknowledged, respected, considered?

How are the aforementioned qualities and skills assessed? Built-on? Supported? Integrated into preparation groups and intervention models?

Support services and styles to support therapeutic re-parenting

Taking the epic task, additional stressors, challenges, and powerful feelings evoked when parenting a hurt child into account, systems need to be put in place to support the TAF/TAW. This also respects and appreciates the crucial expertise and skills that carers bring into the mix, and positions them as being at the top of the hierarchy, and as fundamental to the TAC. This is even more important as carers often describe feeling powerless and voiceless amongst the complex labyrinth of the care system.

These parenting support systems can be structured in many different forms and combinations including: consultation, reflective practice, indirect work, workshops, training, therapeutic interventions, and groups. They may be face-to-face, through the internet, or on the telephone; and their frequency ranging from several times a week, to as-and-when, and from being professional to peer-led.

Within these support mechanisms, the model should be modelled. For example, if services are trying to support carers to create whole-brain approaches and account for language, cognitive, and learning differences, this should be modelled and reflected within the service delivery. This might include using multi-sensory communicative tools to embed the learning (e.g. jargon-free language, video clips, pictures, role plays, stories, art, live examples, and experiential exercises). There should also be opportunities for caregivers to be able to practice and reflect on the emotions evoked and evaluate the techniques employed across multiple contexts over a period of time.

Studies which evaluated the needs of adoptive parents and foster carers have shown that services were most valued when they were deemed as responsive, available, and appreciative of the pressures faced, and offered long-term support (Atkinson and Gonet, 2007). Having supported a range of therapeutic parents in different capacities, I have found this longer lifespan approach invaluable. This way of working is hugely determined by funding and service specifications, however I have found it a privilege when able to walk alongside caregivers' snakes and ladders journeys. This maps onto the changing nature of parenting and children, for example, for a parent to have someone to go to when their child transitions to a new school, or when the child starts asking tricky questions, or when contending with the complexities of adolescence. I often liken this to a parenting rubix cube – once you move and solve one dilemma, another arises.

Early intervention

In addition to having crisis services, support offered to families should also prioritise early intervention and preventative practice. *How much easier is it to intervene when a behaviour is in its early stages, or to anticipate the likelihood of it occurring, rather than once it is entrenched and has already escalated? What*

advantages are there in identifying a carer's triggers and hotspots before a child is matched/placed?

This aims to lower retention rates, increase satisfaction, increase the early identification of difficulties, improve relationships with services, and decrease associated difficulties, such as vicarious trauma, foster carer stress, and compassionate fatigue (Chapter 8). An early intervention approach can consider what emotional dynamite might be triggered, what qualities might be needed to best support the child, and what needs to be actioned to be able to fill both the child's and the carer's emotional tanks.

Modelling the model

As discussed previously, support mechanisms offered to carers should model the model i.e. be nurturing, empathetic, validating, and reflective. This supports the notion that the way services are delivered, and the way parents are received (e.g. feeling contained and in safe hands), sets the tone, and has an influence on what carers take home to their children. This said, clinicians generally see families at a time of crisis/emotional distress, and when powerful dynamics are alive. The pervasiveness of trauma and relational patterns, coupled with the occurrence of these powerful emotions, can impact on one's ability to empathise, stay connected, and to think mindfully. Like parents, clinicians' thinking can also become stuck, fragmented, in survival mode, blocked, and/or overwhelmed (Chapter 8). In these moments it feels so important to consider the question, *how can we hold the hope and see progress as possible when the situation feels so problem-saturated and hopeless?* and *how can we share and spread this hope to the families whom are living the situation?* An example follows:

> *Tara, a single foster carer, who had been caring for 15-year-old Lena for 5 years, presented as being "angry, critical, and negative". Tara described Lena as being, "hopeless, manipulative, and bad". In that moment, I found myself battling with feeling those same feelings about Tara and her parenting, "How could she say that? What happened to her empathy? No wonder Lena is struggling". Whereas, on other occasions, I found myself identifying with Tara's negative feelings about Lena "Her behaviour is extreme, I can't see it changing, what's the point". It was in these moments that to reconnect with Tara, and to be able to offer her a space where she was contained, so that she could do the same for Lena, it was integral to re-anchor onto Tara's underlying hurt at feeling chronically rejected and disconnected from Lena. I needed to see the defences and protective strategies that Tara had learned to put up (i.e. becoming shut off and emotionally disconnected). These had been her coping strategies to ward off the extreme feelings of emotional fatigue, pain, and hopelessness.*
>
> *After years of investment, energy, and sacrifice, and with the original drive of making a difference to a child's life, Tara was left feeling ostracised by her*

social support network, judged by the wider professional system, labelled as "a failure", and attacked in her own home. She was emotionally full up and overwhelmed by the feelings that Lena could not communicate or process. It was important to keep hold of the journey which Tara had lived through, rather than get preoccupied with the snapshot I was seeing which represented Tara at her most challenged time. Although disguised, this included reconnecting with Tara's underlying positive intentions for Lena.

This highlights the importance of having a containing reflective space, such as supervision, and one which anchors onto the qualities which are being advocated for the child receiving, such as being sensitive, non-judging, and having the ability to tolerate a range of emotions. This accentuates the significance of organisational and systemic dynamics, as well as the complex emotions and pervasive multilayered nature of trauma.

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Chapter 7

Therapeutic models, approaches, and ingredients for children and their families who have experienced relational and developmental trauma

Introduction

This chapter highlights some of the existing therapy models recommended for use when working with children who have experienced relational and developmental trauma, and then goes on to consider some of the common ingredients between the models.

As with most areas of complexity, there is no magic bullet or all encompassing "how to" guide for working with children and families who have experienced relational and developmental trauma. With changing evidence bases and contemporary dilemmas, it feels like real-world applications, for these children require approaches to be within a broader continuum of interventions, which are based on a wider knowledge-base. Intervening in a creative, flexible, and dynamic way increases the likelihood of matching the multilayered range of symptoms and presentations. This acknowledges and embraces that one-size-doesn't-fit-all, and that different approaches will resonate differently for varying individuals/contexts, at different times. The appropriateness of the chosen therapy will be influenced by an array of variables, including co-morbidities, cognitive abilities, learning styles, the client/families relationship to "help", and risks. Examples follow:

> *Although it was felt that family therapy was needed to support Grant and his mother's relationship until the ongoing danger was addressed and they both felt physically and psychologically safe to be in the room together, an alternative plan needed to be sought.*
>
> *Until Candice could be supported to reach a "healthy weight" and some of the anorexia-related risks reduced, it would not have been possible, safe, or as effective to primarily address her relational patterns and early trauma experiences.*
>
> *Kingsley had attentional, information-processing, and verbal comprehension difficulties. This meant a purist form of talking therapy would not be appropriate to optimise his engagement and to consider his learning style and cognitive abilities.*

Similarly, wider factors play an important role, including service restrictions (e.g. a maximum of 15 sessions, economic policies, no clinicians trained in particular models, firm inclusion/exclusion criteria etc.), politically charged agendas (e.g. in the UK initiatives such as troubled families and IAPT), and therapist factors (e.g. attachment style, personal values, and theoretical positioning). Therefore, therapies need to be adapted, tailored, and meaningfully delivered accordingly.

In real-world settings, therapy choice and delivery may significantly vary. For example, clinicians may work purely in one modality, may deliver a synthesis of approaches, or they may interweave, embed, or layer new knowledge into their "standard" approaches. Alternatively, they may intervene using a particular model, but draw on a wealth of others to inform their formulation; or they might select certain approaches at different stages of the intervention, depending on the hierarchy and prioritisation of needs. These eclectic ways of working are illustrated in the following examples:

Twelve-year-old Antonia had been placed in foster care after witnessing her mother kill her father. Her mother was subsequently imprisoned. Antonia presented with panic attacks around leaving the house, which significantly impacted on her school attendance and ability to engage in meaningful activities. Following assessment, Antonia initially was offered a course of Cognitive Behavioural Therapy for panic attacks, alongside some grounding and sensory regulation techniques. Once Antonia was able to attend school, and being led by her own pace, some grief and trauma work was carried out around her father's death, the loss of her mother, and the mourning of her lost childhood. Concurrently, her carers were offered support around how to support Antonia, as well as processing some of their own feelings towards her birth parents. At a later date, Antonia and her carers worked on their relationship through Dyadic Developmental Psychotherapy.

Ashley, a recently adopted 6-year-old boy, was engaging in, alongside his adoptive parents, a course of Theraplay. Throughout these sessions, it became clear that Ashley was having difficulty self-regulating, and had some sensory processing difficulties. Therefore, other body and sensory-based approaches were used to enhance the work being done in Theraplay, such as those demonstrated in Sensory Attachment Intervention and Sensorimotor Psychotherapy (Chapter 3).

Fifteen-year-old Jordan presented with an incoherent life narrative and a fragmented sense of self. Although the overall intervention and therapeutic process was formulated and informed by psychodynamic thinking, a therapeutic expressive arts and life-story approach was offered. This aimed to provide her with creative, concrete, and safe ways to explore complex feelings and wider areas of her life. The approach was buffered by incorporating elements of Narrative Therapy, Testimonial Psychotherapy, and Narrative Exposure Therapy (Chapter 10).

Seven-year-old Jude had witnessed several incidents of DV between his mother and stepfather. He was processing some of these feelings through art and

play-based mediums (e.g. puppets, masks, sandtray, and clay). He engaged well and significant improvements were made, however he remained stuck on and distressed by one specific traumatic memory. This memory was repeatedly played out in his play and in his nightmares. To address this particular memory, Eye Movement Desensitisation Reprocessing was successfully employed.

Variations

The therapies which will be discussed in the following sections are by no means an exhaustive list of approaches, but rather intended to provide a flavour of some of the more commonly used interventions within the relational and developmental trauma community. These therapies differ on multiple layers, including on their intended frequency, aims (e.g. symptom reduction vs. increased parent–child interactions), theoretical underpinnings (e.g. psychodynamic vs. cognitive behavioural), and the amount of training, qualifications, time, and resources they require to be effectively delivered. They also may vary in their constellation and formatting.

For example, *over a two-year period, the multidisciplinary team offered Javon twice-weekly intensive direct-working sessions, and his mother the same with a separate therapist. The pair were also seen together in weekly joint sessions by a pairing of therapists.*

Simone, however, was never seen by a therapist, but her surrounding system, including her teacher, social worker, and caregivers, were offered training, reflective practice, and consultation sessions, over a time-limited, 12-week programme.

In addition, the therapy approaches for the target population tends to vary, ranging from early intervention, all the way through to crisis intervention, or from being aimed at "everyday parenting", to a specifically designed remit, for example, for foster carers looking after under threes who have experienced neglect. Therefore, the applicability to a particular client needs to be carefully considered. For example, an intervention designed for foster carers may not lend itself to an intervention for adoptive parents; or an approach based on western notions of therapy may not be optimally transferred without adaptations for those from different cultural backgrounds.

It is important to highlight that any of the discussed interventions should be informed by a thorough assessment (Chapter 5), professional development, existing professional guidelines, and high-quality supervision. In the same vein, the effectiveness and suitability of the intervention should be monitored and evaluated within a critical and reflective lens. Whilst the majority of these interventions take an overarching attachment and trauma framework, it is also critical to not divorce or disregard other diagnoses, presenting difficulties, and "gold-standard" approaches.

Evidence base

The discussed approaches also differ significantly in their stage of development and existing evidence base – ranging from being highly-researched and standardised, to being evidence informed, clinically informed, and newly evolving. Mentionable is that some approaches and professional backgrounds lend themselves better to rigorous evaluation than others, which understandably colours the output.

It is beyond the scope of this book to describe each approach and its associated evidence base in detail; rather it is intended to offer the reader a wide platform of approaches from and with which to continue their discovery. For many of the approaches, evidence is emerging at such a rapid pace that the most up-to-date source of information is best sought through published journal articles. This said, the importance of researching, evaluating, selecting, and subsequently successfully implementing approaches is strongly advocated (Box 7.1).

7.1 Taking a critical stance when evaluating the evidence base

What are the aims, goals, and rationale for the approach/study? Who is undertaking and reporting the study?

What are the inclusion and exclusion criteria/sampling biases? How do these map onto the complexity, co-morbidity, and multifaceted nature of the client group?

What is the sample size? Was there a control group?

What was measured, and how robust (e.g. valid, reliable, consistent) were the measurements, analysis, and study design? How was model adherence and fidelity measured? How significant are the claims which have been made? Are the study's assumptions, aims, and limitations described?

Have the follow-up and longitudinal effects been examined?

What other existing evidence is there to support or conflict with the findings? How do the findings/recommendations inform real-world application?

Therapy approaches for children and families who have experienced relational and developmental trauma

A plethora of literature is available regarding well-researched psychological approaches in working with people who have experienced trauma, such as ***Trauma-Focused Cognitive Behavioural Therapy (TF-CBT)*** and ***Eye Movement Desensitisation Reprocessing Therapy (EMDR)*** (see Chapter 3). Therefore, this section will briefly introduce TF-CBT; however will focus on the less-represented approaches.

Trauma-Focused Cognitive Behavioural Therapy (TF-CBT) is an evidence-based manualised treatment recommended by the National Institute for Clinical Excellence, the World Health Organisation, and the American Psychiatric Association. TF-CBT is based on the Ehlers and Clark (2000) CBT model for PTSD. Suitable adaptations for use with young people have been extensively documented. The specific components of TF-CBT are summarised by the acronym **PRACTICE**: **P**sycho-education, **R**elaxation and stress-management skills, **A**ffective expression and modulation, **C**ognitive coping, **T**rauma narration, **I**n vivo mastery of trauma reminders, **C**onjoint child–parent sessions, and **E**nhancing future safety (Cohen et al., 2012).

In addition to traditional CBT, third wave therapies including ***Mindfulness, Compassion-Focused Therapy*** (Gilbert, 2010), and ***Acceptance and Commitment Therapy*** (Hayes and Smith, 2005) have been used creatively with this client population. Also, ***Dialectical Behavioural Therapy (DBT)*** (Miller et al., 2007) has shown to be useful for intervening with complex adolescents (i.e. self-harm, self-regulation difficulties, poor impulse control). DBT combines strategies of CBT with Eastern mindfulness practices, and predominantly focuses on four areas including: 1) mindfulness skills, 2) distress-tolerance skills, 3) emotion-regulation skills and 4) interpersonal effectiveness skills.

The Attachment and Biobehavioral Catch-up (ABC) intervention was developed by Mary Dozier to help caregivers re-interpret children's behavioural signals in order to provide predictable, responsive, and nurturing care; and to be able to engage in synchronous carer–child interactions. ABC was designed to target the behavioural and biological dysregulation and attachment security of young foster, adopted, and at-risk children who had experienced maltreatment. Although there are variations, in general, ABC sessions are implemented by "parent coaches" who provide one-hour in-home parent training-based sessions over a period of 10 weeks. ABC is a manualised intervention that also incorporates video-feedback, homework, and the "parent coach's" use of "In-the-Moment" comments that target the caregiver behaviours of nurturance, following the lead, delight, and non-frightening behaviors, and overriding one's own history.

Video Interaction Guidance (VIG) is an intervention which focuses on building increased parental sensitivity, attunement, positive relationships, and effective communication through filming and coaching feedback sessions. Adult–child interactions are filmed and then carefully edited to produce a short film, which focuses on the positive relational interactions. The family and therapist review the microanalysis of successful moments, particularly those when the adult has responded (verbally and non-verbally) in an attuned way to the child's action. Subsequently, they reflect collaboratively on what they are doing that is contributing towards the achievement of their goals, celebrate the success, and then make further goals for change. These reflections include an analysis of the behaviour and exploration of the associated feelings, thoughts, wishes, and intentions. There are various adaptations of using video-feedback including: ***Video-feedback Intervention to promote Positive Parenting and Sensitive Discipline (VIPP-SD)*** *and* ***SPIN Video Interaction Guidance.***

Attachment, Self-Regulation, and Competency (ARC) is a conceptual framework and offers guiding principles developed by Margaret Blaustein and Kristine Kinniburgh of the Trauma Center at Justice Resource Institute in Massachusetts. ARC was designed for young people from early childhood to adolescence, and their caregiving systems, who had experienced multiple traumas. It is grounded in trauma, attachment, and child development theories. It attends to the social, systemic, and contextual frameworks, and has been implemented in a variety of contexts (e.g. inpatient, residential, group, and community). ARC recognises that one-size does-not-fit-all and encourages a creative, flexible, and individually tailored approach. It draws on a range of therapeutic procedures, including

strengths-based psychoeducation, relationship strengthening, parent training, sensory and body-based strategies, social skills training, CBT strategies, and psychodynamic techniques. It focuses on three core domains, comprising: building secure **Attachments**, enhancing **Self-Regulation** capacities, and increasing **Competencies** across several domains. Each domain consists of several building blocks, which contain a range of "menu-like" activities. For example, under the *competency* domain, the building blocks include *developmental tasks, executive functions, self-development, and trauma integration*.

Dyadic Developmental Psychotherapy (DDP) was developed by Daniel Hughes (2011) as a way of supporting children and their families, affected by the impact of trauma, neglect, and loss. DDP sessions usually involve the therapist working with the carer and child together (e.g. the carers having an active presence). DDP is based on the premise that children's development is dependent upon, and highly influenced by, the nature of the parent–child relationship. Therefore, through the carer–child relationships and interactions, DDP facilitates repeated experiences of attachment security, emotional expression, trust, comfort, safety seeking, co-regulating, and responsive and sensitive caregiving, and reduces shame experiences. DDP supports the parent using the attitude of **P**layfulness, **L**ove, **A**cceptance, **C**uriosity, and **E**mpathy **(PLACE)** and affective–reflective dialogues to be attuned to the child's subjective experience, make sense of those experiences, and communicate them back to them (in DDP, referred to as follow-lead-follow). The **PACE/PLACE** attitude is modelled and embodied by the DDP therapist.

Parent-Infant Psychotherapy (PIP) is a targeted dyadic or triadic psychodynamic intervention that works with parent/s and infant together with the aim of improving the parent–infant relationship and promoting optimal infant attachment and development. PIP focuses on establishing a therapeutic alliance with the parent, in order to identify unconscious patterns of relating, in terms of the parent's own experiences of being parented, their ghosts of the past, and their internal working models. PIP aims to help the parent to recognise the way in which their current interactions are shaped by past experiences, and to support the parent in observing and finding different ways to relate to their baby, therefore enabling them to respond to them more freely and sensitively.

Child–Parent Psychotherapy (CPP) (Lieberman and Van Horn, 2008) is a manualised intervention for children aged 0–5 who have experienced at least one traumatic event (e.g. DV) and as a result are experiencing behaviour, attachment, and/or mental health difficulties. CPP's primary goal is to support and strengthen the relationship between a child and their caregiver as a vehicle for restoring the child's sense of safety and attachment, thereby improving the child's cognitive, behavioural, and social functioning. In CPP, the caregiver and child are guided to create a joint narrative of the traumatic event, and to identify and address traumatic triggers, which generate dysregulated behaviours and affect. CPP also examines how the trauma and the caregivers' relational history affect the caregiver–child relationship, and the child's developmental trajectory, and also focuses on how contextual factors (e.g. socio-economic stressors) may affect this relationship.

Mentalisation-based Treatment (MBT) is a form of psychodynamic psychotherapy, developed and manualised by Fonagy et al. (2006). MBT was initially designed for individuals diagnosed with borderline personality disorder (BPD); however the "mentalising stance" has since been extended to support a range of clients, including children (MBT-C), families (MBT-F), foster carers (MBT-fostering), and adolescents (MBT-A and AMBIT). The concept of mentalisation builds on the idea that being able to think about one's own thoughts and feelings is necessary to understand, control, and regulate behavioural, emotional, and physical arousal; and that the ability to understand other minds rests on the experience of having been understood as an individual *with* a mind.

Mentalisation interventions have also been adapted with a focus on parenting, such as *Minding the Baby* (Sadler et al., 2006), *Mindful Parenting*, and *New Beginnings* programmes. These aim to improve the parent's reflective functioning to hold in mind physically, emotionally, and developmentally their child's mind; and to increase their capacity to make sense of the child as being a separate differentiated person, with their own thoughts and feelings. This approach also involves modelling reflectiveness, facilitating curiosity, and eliciting affects, with the overall aims of improving sensitive caregiving, secure attachment, and the child's mentalisation abilities.

Theraplay (Booth and Jernberg, 2010) is an intensive short-term treatment model for children and their parents; it focuses on enhancing parent–child attachment and is based in attachment theory, developmental psychology, and educational practices. Theraplay interactions focus on four essential qualities found in parent–child relationships: *Structure, Engagement, Nurture, and Challenge*. Activities are introduced which promote self-esteem, playfulness, fun, and nurturing touch. Examples of these include: feeding each other, making a tower of hands, and blanket swings. Theraplay is primarily used with younger children, however there are some positive examples of its use with adolescents. It has been used with a range of populations including adoptive, foster, and at-risk families as the main modality, or interwoven with other approaches.

Child-Relationship Enhancement Family Therapy, also known as ***Filial therapy (Ft)***, was initially developed by Bernard Guerney. There are numerous forms of Ft, however a widely accepted definition is that Ft is a hybrid of child-centred play therapy in which primary caregivers engage in play therapy with their own child (Landreth and Bratton, 2005). The aim of Ft is to address the child's difficulties within the context of the parent–child relationship by teaching parents techniques to facilitate weekly play sessions with their children, which subsequently effect changes in the parent–child interactions. These skills include *tracking, focused-listening, reflecting feelings, and therapeutic limit setting*. Within a context of unconditional acceptance and positive regard, children are free to talk and play-out issues of their choosing, with minimal direction from adults. Ft uses a psycho-educational strengths-based model, and positions carers as therapeutic change agents for their children (VanFleet and Guerney, 2003). Ft has been used in varying short- and long-term formats delivered to families and groups.

The Parent–Child Game (PCG) was originally developed in the United States by Forehand and McMahon (2003) and was adapted for use in the United Kingdom by Sue Jenner. PCG was designed for children aged from 18 months to 8 years with longstanding behavioural difficulties, and is underpinned by social learning and attachment theories. PCG focuses on reducing challenging behaviours, as well as fostering improved attachment through strengthening the parent–child relationship. It involves two components: *The Child Game and The Parent Game*. The Child Game focuses on helping parents to develop their child-centred behaviours within the context of 10-minute guided coached play sessions, in which the therapist remains behind a screen and communicates directly with the parent through an earpiece. The Parent Game then focuses on helping the parent to use child-directive strategies, which focus on increasing positive behaviour and reducing undesirable behaviour. PCG takes a positive and collaborative stance where parents are able to observe and reflect upon their own parenting behaviours through live skill coaching and video feedback. Home practice is also given to support parents in implementing these skills at home.

Many of the same principles as PCG are used in ***Parent-Child-Interaction-Therapy***. PCIT includes two sequential phases. Goals of the first phase, the *Child-Directed Interaction*, are to improve the quality of the parent–child relationship, and strengthen the parent's ability to attend to and reinforce positive child behaviour. Parents learn to "follow the child's lead" in one-to-one play, to provide positive attention, and to actively ignore minor misbehaviours. Parents are taught to use **PRIDE** skills (**P**raise, **R**eflection, **I**mitation, **D**escription, and **Enjoyment**) to reinforce positive child behaviours. Parents also learn to avoid intrusive or leading behaviours. In the second phase of PCIT, the *Parent-Directed Interaction*, parents learn to give effective instructions and to follow through with consistent consequences, including praise for compliance, and timeout for noncompliance.

Therapeutic Life-Story Work (TLSW) or ***Life-Story Therapy*** focuses on processing loss and trauma experiences and facilitating continuity in identity. Children who have experienced relational and developmental trauma (Chapters 1–2) often have fragmented disjointed sense of selves and incoherent life narratives. TLSW goes deeper than factual information and the book itself, and offers opportunities to construct, integrate, share stories, co-create, process, record, meaning-make, and reflect on their life-stories, and a range of difficult feelings, thoughts, and sensations. Through this process, children can grow to understand themselves and make links between their past, present, and future, in the context of a safe relationship that bears witness to their lived experiences, similarly to that in Testimonial Psychotherapy (Chapter 10). This enhances their sense of control, gives them a voice, and supports them in taking an active part in their journey. Within this process, difficult feelings can be externalised into a concrete tangible form, returned to, and reworked on, and the book itself can act as a transitional object which holds and contains anxieties.

TLSW can take multiple forms including as a book, a box, a DVD, a sculpture, or online. I have found using multi-media enhances the process, such as the

inclusion of mirrors, materials, and sensory aids. There are various frameworks/guides available in supporting TLSW including books by Rees (2009), Wrench et al. (2013), and Rose and Philpot (2012). TLSW can be a modality in itself, or used as a vehicle to interweave other approaches.

Narrative and stories*:** Other approaches which utilise the power of storying and narratives include: ***Narrative Therapy, ***Narrative Exposure Therapy***, and ***Testimonial Psychotherapy*** (discussed in Chapter 10). Also worth mentioning are ***Bibliotherapy***, which involves the reading of specific texts with the purpose of "healing"; ***Attachment Narrative Therapy*** (Dallos and Vetere, 2009), which incorporates systemic, narrative (stories and meanings), and attachment theories; and ***Family Attachment Narrative Therapy*** (May, 2005), which is where therapists train carers to create narratives/stories (*claiming, developmental, trauma, and successful child*) which increase feelings of security, address issues in the child's history, and support the child to reach new understandings about their life experiences.

The following books explore the power of narratives and storytelling: 1) *Parenting with Stories: Creating a Foundation of Attachment for Parenting your Child, 2) Connecting with Kids Through Stories: Using Narratives to Facilitate Attachment in Adopted Children, 3) Using Stories to Build Bridges with Traumatized Children: Creative Ideas for Therapy, Life Story Work, Direct Work, and Parenting, and 4) Using Story Telling as a Therapeutic Tool with Children.*

Creative and expressive therapies include using art, clay, puppets, masks, drama, sand, music, writing, narratives, dance, and movement. These creative means often employ more playful, child-friendly, and developmentally appropriate media, and rely less on language or cognitive ability. They also can provide a contrary, non-threatening experience to that associated with traumas, thus facilitating distance, desensitisation, and enhancing one's sense of control and mastery. Therefore, they can offer different ways of processing experiences, and support the integration of the left with the right hemispheres of the brain, the internal with the external experience, and the mind with the body.

The possibilities of using expressive arts are endless and can vary hugely from a course of art therapy delivered by a qualified arts psychotherapist, using the arts in a therapeutic way, to explaining a CBT concept through using creative means. Examples of using creative means are peppered throughout this book. However, clinicians *Ditty Dokter, Cathy Malchiodi, Margot Sunderland, Liana Lowenstein, Sue Jennings, Lois Carey, and David Crenshaw* have wonderful examples of using the arts with children who have experienced trauma.

Groups*:** In addition to many of the aforementioned approaches being adaptable to group formats, there is also a range of group interventions available for this client group. These are by no means an exhaustive list: ***Nurturing attachments (Golding, 2013), ***Managing Behaviour with Attachment in Mind***, ***Circle of Security*** (Powell et al., 2013), ***Mellow Bumps/Mellow Babies*** (Puckering et al., 2010), ***Child–Parent Relationship Therapy*** (Landreth and Bratton, 2005), and ***Fostering Changes*** (Bachmann et al., 2011).

Grief, bereavement, and loss approaches are not discussed here, however as a body of interventions they can lend themselves well to working with relational loss.

Body and sensory-based approaches These body and brain-based interventions are crucial in the support of relational and developmental trauma. Please see Chapter 3 for detailed discussion of the available interventions including: *Sensorimotor Psychotherapy, Sensory Motor Arousal Regulation Treatment, Sensory Attachment Intervention, Yoga-Based Therapy, EMDR, and Neurofeedback Training*.

Strengths-based approaches *such as Narrative Therapy, Solution-Focused Therapy, and Motivational Interviewing are discussed in Chapter 4.*

Additional trauma approaches *such as Testimonial Psychotherapy, Narrative Therapy, and Narrative Exposure Therapy are discussed in Chapter 10.*

Common ingredients of interventions for addressing relational and developmental trauma – The Therapy Tree

The landscape of trauma and attachment therapies, like the client group itself, can be conflicting, confusing, and complex; therefore keeping the above approaches in mind, I have drawn out some of the golden interlinking threads amongst the varying therapy models, using the metaphor of a *Therapy Tree*. This is in keeping with the notion that although delivered and conceptualised differently, many of the underlying ingredients of therapy models are similar, with shared aims and goals. The following *branches* are often connected and intertwined, and are in line with taking a stepped and phased approach to trauma and attachment intervention. These stages and steps are not linear, definitive, or straightforward, and like in changing seasons and nature, they go through ebbs and flows.

The landscape (overarching framework and wider context)

In keeping with the therapy tree metaphor, key intervention ingredients to be considered and incorporated include the importance of not only knowing the individual branches, but also widening the frame and knowing the whole tree, and on a broader level, the surrounding environment (e.g. the weather, the changing seasons, the landscape, the soil, the neighbouring trees, and the air). Within the context of relational and developmental trauma, these include as follows:

1. *The wider systems approach* takes into account that children are embedded within families, who live in communities, which exist within wider societal systems, and that all parts of the system are interrelated, meaning that one part cannot be fully understood in isolation from the rest. Therefore, the interactions and synergies between these systems and the interplaying influence of factors (e.g. familial, economic, cultural, social, political, and organisational) need to be considered.
2. *A developmentally-sensitive and sequenced framework* keeps a strong grounding in child development (culturally sensitive) and prioritises the child's age, stage, competencies, and developmental needs, and the possible influence

that the traumas and disrupted attachment have had on their developmental trajectory (Chapters 1–3).

3 *The attachment, relational, and trauma framework* (Chapters 1–3) positions relational repair and positive carer–child interactions as key in the context of relational trauma, and therefore uses relationships as anchors and agents for change. This also considers the multilayered impact that trauma can have on a child's attachment/relationships, emotions, bodies, brains, behaviours, cognitions, and self-concept/sense of self.
4 *A risk and behavioural approach* considers the function, role, and impact of behaviours and associated risks, as well as focusing on reducing symptomatic behaviours and increasing safety.
5 *A strengths, hope, and resiliency-based* framework (Chapter 4) includes engendering hope for the child's future, and noticing and magnifying their various strengths, skills, positive qualities, and protective factors.

The Tree Trunk therapeutic relationship

Amongst all of these frameworks/landscapes, when intervening, priority also needs to be placed on the overarching *therapeutic relationship – the Tree Trunk*. Throughout qualitative and quantitative studies, the therapeutic relationship, the belief the therapist has in their approach, and the therapist's expectations of improvement are positioned as central components for positive therapy outcomes.

Within the context of relational and developmental trauma, this relational anchor extends to the carer–child relationships, which is why the vast majority of aforementioned approaches prioritise the role and inclusion of caregivers. These therapeutic relationships model and provide the child/families with a different way of doing and being in relationships. They also aim to offer children a second chance secure base and a reliable attachment experience from which they can have reparative reciprocal relational experiences. Elements of the therapeutic relationship are interspersed throughout this book, and are expanded further in *Chapter 6* on therapeutic re-parenting.

Branch of Psychoeducation

This psychoeducational branch involves providing the child and/or family with child-friendly knowledge, metaphors, and frameworks for understanding the therapy process, the trauma, your professional role, the nature of their difficulties, and particular psychological concepts such as the difference between thoughts, feelings, sensations, and actions. An example follows:

> *I was explaining to an adoptive parent about her son's executive function (EF) difficulties. In order to embed this learning and bring the concept alive, I used a brain sculpture, a brain puzzle, brain labels on a swimming cap, and a YouTube clip on EF. We also did experiential exercises, where she made a cup of tea or played a game like snap, and we then broke down the skills/instructions that this took.*

Branch of Safety and Stabilisation

The therapeutic milieu and relationship needs to provide children and families with a physically and psychologically secure base where they feel held, noticed, and contained. Ideally, like in therapeutic re-parenting relationships, this "place" can be internalised as an inner sense of felt safety. The therapy may take the form of a safety net or lifeboat, in times of stormy seas, changing landscapes, and overwhelming waves of emotional and physiological dysregulation. Although this is more of an embodiment and felt sense, some strategies for creating safety are described in Chapters 6 and 9–10.

Branch of Processing and Integration

The majority of aforementioned therapies aim in some way towards meaning- and sense-making, creating coherence across experience; processing and interweaving experiences and feelings using emotion, body, somatosensory, and bilateral information-processing mechanisms. This generally includes learning words, telling the story of the trauma, and/or re-scripting, re-appraising, and re-evaluating schemas; and then finding ways to identify, express, integrate, and regulate a range of feelings and emotional charges (Chapter 2). *For example, when processing a recurring nightmare, a variety of ways might be used to process and integrate the nightmare. This might range from externalising the nightmare using NT ideas; to drawing/sculpting the nightmare; to using imagery re-scripting or re-living techniques; to physically getting the child to run away or unstick themselves; or to using EMDR techniques to process the distressing memory.*

Future-oriented and Reconnecting Branch

The future-oriented branch supports the child/family to reconnect with a positive self-image of themselves, harness enhanced motivation, hope, and self-efficacy, and to find ways of reconnecting with their relationships and wider world. This branch includes planning ahead, anticipating potential obstacles, and having a thoughtful reparative ending.

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Chapter 8

Working within traumatised systems and amongst complex organisational dynamics

Creating a team around the worker and a positive self-care culture

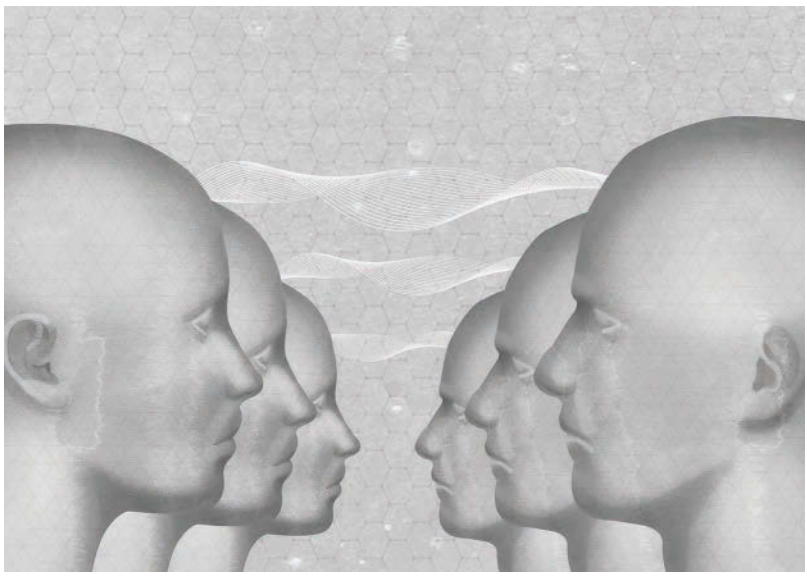

Figure 8.1 Collective brains within live systems.

Introduction

Throughout this book, multiple areas relating to relational and developmental trauma have been discussed. Each chapter has emphasised the importance of contextual factors. Therefore, it seems integral to consider the wider systemic and organisational dynamics of working with people affected by trauma. This chapter's intention is not to offer detailed insights into organisational psychology, as this in itself is such a vast complex area, but rather to offer some key ideas around how trauma can permeate organisations (e.g. the NHS and children's services) and vice versa; and to consider some practical applications for working within organisations with a self-care and stress management lens. Experts in the field often describe organisations as being live systems with a collective brain (Bloom

and Farragher, 2013) (Figure 8.1). This captures how an organisation, such as social services, can be like a sponge, with trauma and loss both seeping out and being absorbed in. Complex feelings evoked by trauma can be contagious, and the ripple effects can be felt throughout the system's multiple layers.

Similarly, the organisation can grow, develop, change, and mean very different things, to different people, at different times. Within this "live system", interesting parallels and dynamics which emerge within group processes and intergroup relations can be explored. For example, a live organisation like its members can have its own emotional climate and collective state. It too can be vulnerable, happy, sad, stressed, confused, angry, helpless etc. Britton (1994, pp. 79–80) uses a theatre metaphor to discuss how the family dynamics can move through the audience, "The cast changes, but the plot remains the same". This can also be applied to organisational dynamics. Illustrative examples follow:

> Symptoms may present, permeate, and travel through multiple layers of the system. *For example, Edith (mother) presented with symptoms of depression, her child with low mood, their social worker as hopeless and depleted, and the overarching organisation as deflated, with a collective sense of helplessness.*
>
> *The fragmented warring nature of the Evans family became echoed in the warring and fragmented assessing team. Powerful divides occurred amongst usually united team members, and they found themselves playing out the reciprocal role of the child's transference e.g. the angry parents.*
>
> *Noah, who was living in a residential home, had experienced significant neglect within his birth family, and presented with an insecure avoidant attachment style. He internalised his difficulties, and often seemed to fade into the background. In handover meetings, the children were discussed in detail, and yet on numerous occasions the meeting would end and the team would discover that they had forgotten to discuss Noah. As a team, they were mirroring what had happened to him in his birth family; they were struggling to keep him in mind.*
>
> *Leah was repeatedly told and shown that she was unlovable by her parents. This "repelling bubble" seemed to be replayed through the system which labelled Leah as unlikable and located several difficulties within her.*
>
> *Taylor presented with beliefs which included, "I'm bad, unlovable, and a failure"; these were then reflected in her carer reporting similar thoughts about her role and herself, and consequently the therapist also felt "I'm ineffective and I'm helpless to change things".*
>
> *Talia was allocated a new case and upon reading graphic details of neglect said "It's not that bad, I've seen worse". Her threshold had become so high and due to a range of reasons she had become desensitised and hardened to the work.*
>
> *David had become so emotionally full and consumed by the work such that he defended against these difficult feelings by making fun of the clients, distancing himself emotionally from them, and widening the "them and us" gap.*

These strong feelings, as captured by the above examples, will inevitably have an influence on the worker's feelings, responses, conceptualisations, and actions of the case. These processes are interactive, dynamic, can be moved and triggered in multiple directions. The impact of these feelings can be even greater when they resurface unresolved issues and old wounds. *For example, a client put in a complaint about Janelle's practice. This left her feeling like she was not a good enough practitioner, which echoed past stories around her mum positioning her as not a good enough daughter.*

To protect oneself from these powerful feelings, people can respond in multiple ways, including shutting down, emotionally withdrawing, splitting (them and us), and putting their walls up. This is exacerbated when working with trauma in a traumatised system.

> *One social worker felt so overwhelmed with the hostility that a birth mother displayed and by the pain the child was facing, that she managed these feelings by emotionally withdrawing. This crushed her ability to empathise with the mother's trauma of having her child removed, and to see the vulnerable person behind the rage defences. Instead, she positioned the mother in very black and white and negative terms.*

Organisational survival responses and belief systems

Throughout this book, there is much discussion around a child or parent being in Fight, Flight, Freeze (FFF) mode, and utilising survival and self-protective strategies (Chapters 1–3). These responses can also be considered in relation to organisations.

How does your organisation show its survival FFF response? What does this look like? Can you think of examples of these FFF modes? This is crucial, as similarly with the secure base that children need, without workers feeling and sensing trust and safety within the organisation or the supervisory relationship, productivity and effectiveness is eroded. *How well can you perform, think, flourish under unsafe, unsupportive, or unthinking situations?*

In the same vein, Chapters 1 and 2 discussed the power and influences of children's core beliefs, schemas, and internal working models. *What are your organisation's values and assumptions? What is its belief system and its world view?*

Mirrored family dynamics

Additionally to being "live" systems, organisations and teams have also been referred to and their dynamics likened to a family group. Like families, there are unique systems and coalitions within them. For example, effective leadership is essential for effective teamwork, which parallels the pivotal role which effective parenting plays within a family. Similarly, when an embedded manager leaves a

team, this can trigger feelings of abandonment within its members, even more so if a team member has had a previous relationship with abandonment. Building on this, leaders, like parents, are commonly positioned in polar ways, for example, all knowing, or impotent; idealised, or denigrated. Also, the majority of long-standing organisations have an organisational memory, in some cases organisational historical trauma, or are made up of members who have come from different organisational families.

The different roles, functions, patterns, expectations, belief systems, values, and patterns which people occupy within their families can emerge, particularly in a group structure and team-setting (Box 8.1).

8.1 Reflective exercise: role within family and groups

What was your experience and role within your primary group (family of origin)? How and why did/do you play these roles? How has this impacted your role in teams and groups in the past? Have these roles changed over time?

What roles do you currently hold within your team? What other roles within your team do you align with or find trickier? Do certain team members represent roles in other areas of your life and relational experiences?

Why is understanding the impact of working in a traumatised system important?

We know that the children and families who are at the heart of the interventions need containing safe hands, thinking minds, and reparative relationships in response to the relational and developmental trauma which they have experienced. However, a traumatised system supporting a traumatised family further compounds the trauma, and it creates a triple deprivation (Emanuel, 2002). Therefore, ensuring a reflective nurturing workforce filled with positive role models, co-regulators, and thinking minds inevitably provides the space and relationships which children and families need. See Box 8.2 for further resources on working towards this.

Throughout the book, we have discussed the disintegration and disconnection that can occur as a result of trauma – whether this is the left from the right brain, the mind from the body, or the internal from the external experience. Similarly, an organisation can also be disintegrated and disconnected; therefore attention needs to be paid to ensure it is as coordinated and connected as possible. It is like a husky-led sleigh, if one dog sits down and refuses to move or decides to go in a different direction, it has a huge impact on the functioning of the overall sleigh. This is aptly captured by Aristotle, "The whole is greater than the sum of its parts".

In addition, we know that working with complex trauma (Chapters 1–3) can evoke hugely powerful feelings (Maslach, 2003; Rothschild, 2006), and studies have shown that professionals working within these areas are more vulnerable to experiencing

secondary trauma (st) (Stamm, 1999), vicarious trauma (vt) (McCann and Pearlman, 1990), compassionate fatigue (cf) (Figley, 1995), and staff burnout. Rather than grappling with the conceptual maze and definitional complexities of these concepts, I will instead look at the interface between them, and some of the real-life implications of their occurrence. In essence, st, vt, and cf can lead to higher levels of staff dissatisfaction, turnover, sickness, and levels of stress (Bride et al., 2007; Sprang et al., 2011). With high staff turnover, the continuity of relationships for children and their families is further compromised, which challenges the very core of stable relationship-based practice. Moreover, the presence of st, vt, and cf are likely to permeate into various areas of the professional's spiritual, physical, emotional, and cognitive life, and impact on their ability to do their job to the best of their ability. A growing body of literature describes how stress impacts on one's judgement, and the ability to effectively perform tasks (Baginsky, 2013). Similarly, to the trauma responses of the children we are discussing, professionals also when stressed can function in survival mode which can move them away from their thinking brain (Chapters 1–3). The effects of st, vt, and cf are far reaching but may include a loss of interest, weakened empathy, anxiety, low mood, withdrawal, anger, hopelessness, detachment, reliving symptoms such as nightmares and flashbacks, and physical responses such as headaches and heart palpitations.

As a result of the work, clinicians often experience shifts in the way they perceive themselves, others, and the world. These responses can show themselves in different ways, ranging from seemingly lacking empathy, shutting off (dissociating), and objectifying clients, to having over-involved unrealistic levels of responsibility and accountability. The latter can send a clinician's rescue-valency into overdrive. For others, connecting with their client's vulnerability and helplessness can lead to an erosion of self-esteem and decreased sense of professional efficacy (Dane, 2000). Examples of this from a caregiver perspective are discussed in Chapter 6.

In the following sections, some of the reasons why professionals are more susceptible to st, cf, and vt will be discussed, as well as offering strategies for improving effective teams, organisational culture, and more specifically self-care and stress management. For more detailed symptom summaries, multiple st, vt, and cf checklists and measures are widely available. Some of these are referred to in Box 8.2.

Why are caring professionals more susceptible to experiencing st, vt, cf, and staff burnout?

The following states some of the reasons why this is the case, however this is by no means an exhaustive list.

1 Professionals who go into the caring profession are more likely to have a rescue valency which can be tricky to manage when this is challenged. This can create lots of conflicting situations, such as going in wanting to support and keep families together, and then being responsible for removing a child; or knowing that a child would benefit from long-term therapy, but the service only allowing for six sessions, or taking a child for contact, even though they see the negative post-contact fallout. This can also extend to having to function

in limbo or uncertainty, such as the many shades involved in whether a parent is "good enough", or if a child is "safe".

2 Working with complex trauma inevitably evokes powerful feelings and often triggers professionals' own hotspots and vulnerabilities. Therefore, unresolved losses and traumas such as abandonment, injustice, vulnerability, and helplessness may resurface. Moreover, professionals are often the containers for these difficult feelings, and in order to be effective, they need to show and feel empathy. However, connecting in this way can open one up to facing parts of human nature and society which are painful, difficult, and often avoided.
3 Often professionals working within this field have heavy trauma-dominated caseloads, which means that they are having daily trauma exposure with little recovery time or respite. These experiences get stacked up and accumulate, and are exacerbated further if cases feel unsolvable, in crisis, or stuck.
4 Organisations are increasingly driven by performance indicators, financial implications, and paperwork/policies; this can neglect accounting for and acknowledgement of the complex nature of the work, and lose sight of the child, the underlying motivation for being in the caring profession, and the human costs. Working in a system where a practitioner does not feel valued or appreciated, and where the overarching vision or purpose of work becomes diluted, can make one more vulnerable to consequences such as cf (e.g. crisis-driven, reactive, shaming). These conflicts are compounded by wider systemic issues such as public opinion, the media (naming, shaming, and blaming), and changing political agendas. For example, the UK National Health Service and children's services feel like a constant amphitheatre for judgement and controversy.

8.2 Self-reflection: organisational culture, measures, and resources

Trauma-informed organisations:

What impact does working within a trauma context have on you, on the team, and on the organisation? How does this show itself? Is the impact acknowledged and responded to within your team/organisation? How is change dealt with, how are decisions made, conflicts resolved, and emotions managed within your organisation? How open is your organisation to learning, reflecting, and analysing situations?

Organisational culture:

What is the weather, climate, and culture like in your workplace? What qualities/mood/characteristics/patterns does your organisation have? How do you feel this compares or contrasts to previous work settings? What makes these shift or shape? What is the organisational glue which holds it together and what is the quicksand which pulls it under and keeps it stuck?

(*Continued*)

Psychometric measures:

There is a range of organisational culture, professional quality of life, and group environment scales available. Please see the following resource for a detailed review of these: Scott et al., (2007) *Instruments for the Exploration of Organisational Culture.* Working Paper.

Available at http://www.scothub.org/culture/instruments.html.

There is also a plethora of other measures on organisational emotional intelligence, effective leadership, and different personality and working styles, such as the commonly used Myer-Briggs Type Indicator.

Useful websites on organisational cultures include:

http://www.wellbeingwizard.com
http://www.resorgs.org.nz
http://traumastewardship.com
http://www.chadwickcenter.org
http://www.sanctuaryweb.com

Creating, building, and maintaining effective teams within a relational and developmental trauma context

The following elements offer some suggestions for creating, maintaining, and building effective teams, particularly when working within a system focused on addressing relational and developmental trauma. These are generalised notions, as it is acknowledged that each team and organisation is unique depending on its context, culture, and an array of other factors. In essence, each aspect such as effective leadership could be a whole book in itself, and therefore this chapter offers some components to consider as a starting point. In later sections, more specific strategies will be presented in relation to improving professional's self-care and stress management, which would ideally be married with the following sections. The overall aim is to reduce the likelihood of st, vt, cf, dissatisfaction, and burnout, and to improve one's well-being, self-care, staff retention, and work satisfaction. After all, in order for clients to be fed and nourished by professionals, professionals need to be fed and nourished themselves.

First, *leadership* needs to be effective, similarly to parents being the head of the household. In order for professionals to be able to create a containing relationship and supportive environment for their clients, and to be those fundamental safe hands and thinking minds, they need to feel the same from their leaders. The leaders need to *model the model*. In addition, the team needs to have clearly defined individual and collective *roles, accountability, responsibilities, goals, expectations, and purpose*, so that they can successfully complete tasks. This should be echoed in a *child-centred mission statement*, *shared vision, ethos, and philosophy*, all of which the team buys into, and is committed to achieving. Furthermore, the team needs to have clear *structures, assessments, and plans* in place. This is in keeping with a preventive and early intervention focus. The notion is that it is easier to prevent fires than to put them out.

In addition, there should be an emphasis on creating a *trusting, safe, cohesive, open, and honest* environment. This extends to the way *conflict* is addressed, rather than dismissing, ignoring, scapegoating conflict, or reinforcing the culture of a silencing or silenced organisation. A healthy organization seems to view conflict as an opportunity for creative problem-solving, lessons learnt, and growth. Equally, an effective team, like in families, should have open and effective opportunities for both *bottom-up and top-down communication*. It is essential that all members are *valued, feel listened to, and are seen.* The hazards of an overly *hierarchical authoritarian structure* have been demonstrated in the majority of serious case reviews, where a consistent finding is that someone regarded as "low down the chain" was not listened to, such as a trainee. This should include *meaningful feedback loops and communication flow systems*. This way, like the husky sleigh, the team is working together to ensure *connectedness and coordination*. Once again this would model effective problem-solving, communication styles, and conflict resolution to the children and families.

Building on this notion is having a culture that is mindful; and that acknowledges, reflects, names, and thinks critically about the *complexity and impact of trauma* on its workers and subsequently finds ways to support them. This is more likely to be effective than a quick knee-jerk reaction following a crisis. Along this line, *forums, reflective practice, emotionally-informed thinking spaces, regular high-quality supervision, team meetings, appraisals, best-practice discussions, and/or debrief processes* should be put in place to reflect on difficult situations and evoked emotions. Importantly, high-quality supervision has been consistently linked to increased retention and satisfaction rates (Nissly et al., 2005), and the lack of supervision has frequently been reported as one of the reasons for workers leaving or feeling dissatisfied.

Within the umbrella of acknowledging the impact of the work, organisations working within this field should strive to be *more attachment and trauma-sensitive and aware* (Chapters 6 and 9), and these frameworks should be an integral part of the daily decisions, integrated into all aspects of the organisation, ranging from paperwork, to recruitment, to inductions, to supervision, and in appraisals. Examples of best-practice would include staff receiving high-quality trauma and attachment training with an emphasis on the potential impact of the work such as cf and vt, and with the organisation having *champions* around self-care and stress management, and robust policies which support these. This would also include a culture of continuous development through a range of opportunities such as *training, attendance at conferences, subscriptions to relevant journals, and membership to specialist interest groups*.

In addition, organisations need to continue to *grow, develop,* and to be informed by *best practise, emerging evidence base, and the wealth of skills* that its members bring. The importance of this is crystallised further by the rapidly changing health and social care contexts, ranging from changing governments and new legal frameworks, to "new" areas such as the expansion of social media, the introduction of the Adoption Support Fund, International Crises, or the increase of Special Guardianship Orders. Change is inevitable, however it should include staff in a meaningful thoughtful way, and be done in a stepped approach, which acknowledges that new beginnings also represent losses and endings.

On a smaller but important note, *professionals' caseloads*, where possible, should be considered. Ideally, this would offer some diversity and range, and also take into account the professionals' own attributes, experiences, hotspots, and interests. Moreover, the team's *physical workspace* needs to be optimised. In the current climate where hot-desking and portable working is increasing, this is becoming more challenging. However, practicalities such as allocated desks, working equipment, and the provision of refreshments have been found to make a difference, as does having a culture that acknowledges the importance of breaks. Equally, having access to *well-being opportunities* such as bicycles, a gym, tai chi, massage, drumming, mindfulness, and yoga may also be beneficial.

Built on further in the following section and introduced in Chapter 4 is the importance of creating a *strengths-based mutually supportive team atmosphere*, where members feel valued and noticed. Attempts should be made to create a *Team around the Worker (TAW)* environment which triggers members' reward systems and refuels their emotional tanks. Some concrete ways of celebrating teams and boosting morale include:

1 Having a positive celebration team wall or wishing well.
2 Designing certificates/awards such as an engraved light bulb for a great idea, or a model **FROG** (**F**or **R**ecognition **o**f **G**rowth).
3 Naming a star or planting a team tree.
4 Making a work shield, team mural, or crest.
5 Having regular productive, nurturing, and energising team meetings.
6 Having team away days.
7 Celebrating events such as birthdays, people leaving, and Christmas.
8 Using the Team of Life tool, adapted from the Tree of Life (Chapter 10).

Having discussed some of the overarching team strategies, the following section will describe more specific strategies for improving *self-care and stress management.*

The progress, effectiveness, and success of these strategies should be *evaluated and monitored*, with an underpinning focus of improving and providing high-quality services to the children and their families, and being a desirable place for staff to work.

Self-care and stress management

As previously discussed, when working with children who have experienced relational and developmental trauma and loss, our own triggers, hotspots, and vulnerabilities can be pushed and exposed. We are often the containers for their difficult and intolerable feelings, and our coping resources, buffers, and protective factors can be weakened, making our ability to think and respond effectively more challenging.

To address the relational trauma we need relational repair. Our ability to make healthy relationships, even amongst complex and sometimes hostile contexts, is one

of our greatest tools. Therefore, our self-care and stress management is paramount to enabling this relational process. This is in line with the advice when on board a plane around putting on your own oxygen mask and life jacket before tending to your child's. We need to teach and model self-care and stress management to the families we support. We can't expect families to exercise self-care if we don't prioritise and model it ourselves. Too often, self-care is bolted onto programs/interventions, rather than a core component and integrated into all interactions.

Box 8.3 describes some reflective exercises and questions around self-care These aspects will inform the strategies presented in the following section.

If we keep filling their glass with water or their bowl with fruit, who and how is ours going to get replenished? What can we offer if our water or fruit is depleted?

8.3 Practical activity and reflection exercise: self-care, empathy, and hotspots

Blocks and barriers:

Why is self-care so important? What are some of the hazards of cumulative stacked-up stress?

How did/does it feel to care for yourself? Do you experience any guilt over taking time to care for yourself? What blocks and barriers are there for you taking this time? (Write down or draw your responses.)

Multifaceted identity:

What makes you uniquely you? What lens do you like to be seen through? What are your different layers of identity? Which layers are really important to you? What is the meaning and story behind each layer? You might like to draw, make a list, or a collage of these different layers. *How are these different layers used/acknowledged/built-on/pushed aside? If they were in a pie chart, which layer would be a large chunk or a little sliver? How have these changed?*

Hotspots and triggers:

Is there a particular behaviour/difficulty/theme/person within work that is worrying and/or distressing you? Let's take food refusal as an example for something which really gets under your skin. *What is your relationship with food or the deprivation of it? What does the refusal of food and significant weight loss mean to you? What issues does it stir up in you? What ideas/values/beliefs hotspots do you have that are being evoked/triggered challenged by the food refusal?*

Identify and reflect on your own triggers, hotspots, and vulnerabilities, and try to apply the above questions to that particular issue. This may shed some light as to why we may be reacting the way we are. *How can you reduce/notice/manage these? How can you find ways to stay regulated and grounded when a hotspot is pushed?*

(*Continued*)

Empathy:

How do you show empathy to your colleagues/clients? What makes it easier or trickier to show empathy? How do you know when your empathy levels are depleted? What are the hazards of weakened empathy?

How does this impact your thinking and decision-making? What helps you reconnect with feelings of empathy? Where and how did you learn those reconnecting and empathising skills?

Reflect on an experience where you felt deeply empathised with and vice versa. *How did this leave you feeling emotionally, cognitively, and physically?*

Some self-care measures include:

The *Professional Quality of Life Scale* (Stamm, 2009). This measures positive and negative effects experienced by those who choose to help others experiencing trauma. It is made up of three subscales: CS, CF, and burnout.

The *Areas of Work Life Scale* which measures person–job match or congruence in six areas of work life: workload, control, reward, community, values, and fairness (Leiter and Maslach, 2000).

Maslach Burnout Inventory-General Survey (MBI-GS) which measures burnout.

Coping Strategies Inventory (Bober et al., 2006) which measures beliefs and behaviours regarding coping amongst trauma counsellors.

Strategies for improving self-care and stress management

Below are some strategies to support professionals to look after and care for themselves. These build on Box 8.3, are by no means an extensive or rigid list, and are just intended as ideas. They are based on the premise that working and supporting children who have experienced relational and developmental trauma and loss, and the systems around them, inevitably evokes a range of multilayered conflicting and complex feelings. Although written with professionals in mind, these can and should be modelled and filtered through to parents, foster carers, children etc. I have used these strategies in a range of settings from social services, to prisons, to residential homes, and in refugee camps in Africa. Careful selection and thought around the timing, the delivery, and how to suitably tailor them is strongly recommended.

Self-care plan

Reflect/write down/draw/make a collage about *what feeds you? What helps you to feel happy/calm/at your best/relaxed/re-charged? What makes you feel vice versa?* Everyone is different but some common activities include: exercise, sleep, physical activity, socialising, pamper activities, music, TV, reading, cooking/baking, comedy, creative means such as art, gardening, and being in nature. Others find introducing relaxing and re-focusing

activities helpful, such as mindfulness, breathing techniques, imagery exercises, relaxation techniques, tai chi, yoga, and using a sensory calming box.

Make a *self-care plan or pledge*, detailing how you can increase and build-on these things – start small but give yourself permission and time to try at least one of these things on a daily basis. Monitor and evaluate the effectiveness of this activity – *What does it feel like during and after? Does it make a difference, and if so what difference does it make?* This can be something as small as eating your lunch away from your desk, and instead in the park.

Personal and professional team of support

Who are your role models, inspirers, feeders, and life cheerleaders? How can you utilise and expand on these? How can you draw on their positivity, strength, and encouragement? How can you drink them in and internalise them? How can you see yourself through their eyes? This might include a range of forums from clinical, management, and peer supervision structures through to spiritual/religious support, family, and friends. It can be helpful to have a visual way of representing these supportive people; such as beads on a necklace, buttons in a jar, or layers of coloured sand. Others might like to draw a support genogram or their people safety net. Some people find it helpful to have photos on their desk, or to keep meaningful letters/cards close by. Relationships should be reciprocal*: What more can you do to support others in your system or to show your appreciation to them?*

Professional development

Be as informed as possible. Seek out, be proactive, and advocate for continuing professional development opportunities through training, workshops, conferences, seminars, accessing journals, relevant books, specialist interest groups, peer support, reflective practice groups, and clinical supervision. Find safe nurturing spaces and like-minded people who recognise the complexity of the work that you do.

Motivation and satisfaction

Remind yourself why you do what you do. *What motivated you in the first place? What parts do you enjoy and get satisfaction from? What parts are you learning from? Which elements do you feel valued in? Which do you feel you make a difference in? What parts are you proud of? Which would you miss if you were no longer doing the work that you do?*

Strengths-based reflection

Following a tricky day/situation, after having a space to debrief and reflect, *remind yourself of other times you have been through a difficult situation which has been/felt worse and how it improved? What skills, strengths, resiliencies, and positive qualities did you use to get through those times? How can you build and reconnect with these?* Revisit these positive times verbally, "Remember the time when …",

and find ways to hold onto the positive times e.g. keeping thank you cards from clients. You can set yourself a challenge of finding at least three positive things in a day – things within yourself, things within your young person, things in the world, things within your relationships. It can also be helpful to use positive self-talk, positive self-mottos, or to draw on inspirational quotes or affirmations.

Strengths-based take-back practice letter

Sometimes I find writing take-back practice letters (informed by Narrative Therapy techniques) to a colleague/parent/child a helpful way of taking a strengths-based appreciative perspective (Chapter 4). Some example questions follow:

> *What skills, strengths, successes, and positive qualities of theirs do you appreciate and have been struck by/inspired by/impressed by? What do you enjoy/like about them? What have been some of your most precious memories/times with them? If you were stuck on a desolate island with them, which of their skills and qualities would you appreciate and be thankful for? What skills did they use to survive the desolate island or the shark-infested waters (Chapter 1)?*
>
> *What has and is going well for them? What protective and resilience factors (Chapter 4) did/do they have? What can they do? What patches did they have in their parenting patchwork (Chapter 1)? What steps have been achieved? What distance has already been travelled? What challenges, obstacles and adversities have they overcome?*
>
> *How has knowing them made an impression on you? What will you take forward from what you have learned from them? What are your hopes and dreams for them? How can these be recognised, acknowledged, noticed, celebrated, and built on in person, meetings, reports, assessments? How aware is the child/colleagues that you see them in this way? How can you share these discoveries with them and others?*

Diaries

Keeping a diary can be useful in expressing difficult feelings, but also for keeping note of all the changes and achievements that have been made. You can even have a separate sparkle moment book/bank of positive memories book. This could be extended to a team wall of pride or art gallery of celebrations/successes.

Magic carpet position and imagery re-scripting

If particular work situations are troubling, it can be useful to take a magic carpet position. *What does it look like when I step back or look at the situation from a different perspective? What advice would I give to a friend/colleague in the same situation? Will this be worrying me in a week, a month, a year?* It can be helpful to reflect on the common thinking traps from a Cognitive Behavioural

framework. *Am I overgeneralising? Catastrophising? Using all-or-nothing thinking? Filtering? Mind reading? Am I being dominated by emotional thinking? Are these thoughts supporting me to move forward or holding me back?*

These can be reflected on creatively through using a range of metaphors such as: a ball and chain, straightjacket, spiked fence, a backpack full of bricks etc. Some people, where appropriate, might want to identify and write down some of these thoughts, for example, "I'm not good enough", and actually do or imagine getting rid of them. This might be through putting them in a bottle or a balloon and watching them float away, in a rubbish bag, or on a piece of paper that is then burned, ripped-up, or buried. Others may want to write words on a tissue and watch them fade away in water, or be flushed down the toilet. In line with the above, imagery re-scripting techniques can be beneficial. This is where negative mental images are transformed into more benign images, for example, imagining the person who said the hurtful comments with a funny face/small head, on mute, or in black and white. Moreover, some people may want to imagine or design a protective shield, bulletproof jacket, guardian angel, or magic blanket which can protect them from the hurtful comments.

Safe place

It is important to get some time away from your desk/computer. If you can't get physical time out, take an imaginary break. Imagine yourself in a safe/happy place. Try and connect with all the senses – *What does it feel, sound, look, and smell like?* Some people find it useful to have a physical object or visual representation that reminds them of this place, like a photo key ring or a poster.

De-roling and debriefing

Cognitively de-role and debrief after a difficult visit/day. Take off your ID badge, put a boundary around the amount of time you speak about work outside of work, remind yourself that tomorrow is a new day, and/or write a list of things which are worrying you or tasks for the next day and lock them in a drawer until the next day.

SMART goals

It's important to take breaks and to be boundaried with your time – know your limitations. *Which way is the work/life balance scale stacked?* Try and prioritise which tasks are of highest importance. *Which tasks can be achieved (Think SMART goals, for example; are your expectations realistic and manageable)? Which can you make a difference with? Which need to be put aside for a bit or shared with others? What can wait and what needs to be done now? Which can be broken down into smaller steps? How can you pick your battles wisely and make decisions when you're not feeling too overwhelmed? Is there a different system of organisation and time management that you could employ?*

Positive social action

When working in areas of social injustice it can be beneficial to find ways to express your views in a positive, meaningful way, for example, social action, position paper, fundraisers, letters, donations, marches, and protests.

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Chapter 9

Attachment and trauma within an educational context

Making schools more trauma and attachment-sensitive

Education is an integral part of children's development and an area that requires special attention, nurturing, and support, particularly when addressing the complexities of children who have experienced relational and developmental trauma. This chapter discusses how educational provisions, staff, and classrooms can become more attachment and trauma informed and sensitive on an organisational, schoolwide, and individualised level. Key themes will be explored and some practical strategies offered. However, first some of the reasons *why school is so important, and equally why it might be more challenging for children who have experienced relational and developmental trauma*, will be presented. These map onto the additional complexities described in more detail in Chapters 1–4. The terms *children* and *students* are used to provide some uniformity, however, it is suggested that the themes and strategies discussed have relevance and validity for young people and learners of varying ages, who are being educated in multiple settings ranging from school, to college, to pupil referral units. Moreover, many of the concepts and suggested strategies can be applied to other settings such as residential homes and therapeutic re-parenting homes.

Why is school so important, and equally why might school be more challenging for children who have experienced relational and developmental trauma?

Educational provisions are such unique multifaceted systems with their own subcultures; however a few common strengths and areas of difficulty will be presented in the following sections.

Risk and protective factors

Within national statistics and the extant literature base, children who have experienced relational and developmental trauma have been found to have increased absenteeism, difficulties with school adjustment, and lower education achievement. Furthermore, amongst this population, there are higher occurrences of educational statements, truancy rates, and exclusion incidents (Social Exclusion Unit,

2003). These children require careful attention, particularly given that school can contribute to multiple protective factors including academic achievement, intelligence, buffering teacher–child relationships, and an overall positive school experience (Riley, 2010).

Moreover, children spend a considerable amount of time in school, and therefore school's role and possibilities for effective change, and introducing children to a wider world of opportunities and perspectives, can be huge. It is also hoped that amongst a context of "feeling different" and having experienced a higher incidence of school moves, school can provide these children with a sense of future-thinking, normality, universality, community, and belonging. This is even more important given that many of these children have been marinated in a sense of hopelessness and helplessness (Chapter 1) which inevitably impacts on their confidence, self-esteem, motivation, and self-efficacy, for example, *"I'll never amount to anything, I'm stupid, so what's the point?", "I've been excluded seven times, so how's this gonna be any different?"*

Behavioural/emotional dysregulation and cognitive difficulties

Children who have experienced relational and developmental trauma are more likely to struggle with noticing, modulating, and regulating their emotions and behaviours (Chapters 1–3). Research demonstrates that these children have a poorer performance on tests of emotional understanding and theory of mind (Pears and Fisher, 2005), and are more likely to have difficulty with their reflective function capacities and their ability to mentalise, which can lead to cognitive inflexibility and difficulty with keeping themselves, and others, in mind (Cozolino, 2006). Evidence also shows that emotions drive cognitive learning. This suggests that, in order to generate optimal learning and reduce disciplinary incidents, children's affective minds need to be engaged (Immordino-Yang and Damasio, 2007).

These behavioural and emotional regulation difficulties show themselves in a range of ways, however commonly reported ones within the school setting include: low self-control, impulsiveness, preoccupation with threats, responding negatively to novel situations, flashbacks/intrusions, raised anxiety levels, poor cooperation, poor motivation, outbursts, difficulties with peers and with navigating the classroom environment (Morrison et al., 2010; Cadima et al., 2015). Importantly, poor emotional regulation can also have behavioural ramifications, and has been linked to higher rates of expulsion and exclusion (Gilliam and Shahar, 2006). For example, *if a child is struggling to think of the cause-and-effect of hitting other children, or is overwhelmed by impulses to act on their frustration of another child laughing at them, this can result in regulation difficulties, such as aggression and outbursts.* These, alongside other interplaying individual and contextual factors, need to be identified and interwoven into the child's learning plan.

Emotional and behavioural dysregulation can be exacerbated by *speech and language/developmental/sensory/cognitive/executive function (EF) difficulties*,

which are more common in the relational and developmental trauma population. These have multilayered implications for children's learning and life skills (Spann et al., 2012; Loman et al., 2013). Some examples of EF difficulties include struggling with planning, organising, completing tasks, goal setting, anticipating consequences, orientation, spatial awareness, initiating, attending, memorising, processing information, concentrating, exerting self-control, switching focus, managing impulse-control, utilising cognitive flexibility, problem-solving, abstract thinking, reasoning, making inferences, and understanding object permanency (Pollak et al., 2010; Samuelson et al., 2010). *How might some of these EF difficulties show themselves in a school-setting? How might these be misinterpreted if attributed to, for example, "defiance" rather than a processing difficulty?* One example follows and is expanded on in Box 9.1.

> *Schoolteachers reported feeling increasingly stuck and frustrated with Perry's behaviour and "slow" progress. Some of their concerns included: he repeatedly forgot to bring in necessary items such as his sports kit or pencil case; he struggled to attend, switch focus, and concentrate, and would be easily distracted or become out-of-sync by the ticking clock or the light shining in from the window. They also shared that he found it difficult to make sense of abstract concepts, and that this was echoed in his difficulty retaining information, and completing work on time. They also described how Perry would wriggle around in his seat, shout out in class, and ask to go to the toilet several times an hour.*

Some strategies to support EF difficulties within the classroom are detailed at the end of this Chapter, and in Chapters 3 and 7.

Relational skills

Positively, school hosts a range of opportunities for social and relational skills which require complex conflict resolution and problem-solving abilities. School also provides access to "thinking role models" which gives children multiple live examples of positive child–adult relationships. However, the experience of relational trauma can mean that "doing and being in relationships", reading social cues, and functioning in social situations can be challenging (Chapters 1–2). These changes can manifest in a variety of ways ranging from difficulties initiating and sustaining friendships, bullying or being bullied, exhibiting controlling behaviours, social withdrawal, to difficulty with particular social skills, such as sharing/turn-taking.

This is further compounded by the very nature of school requiring children to relinquish control and to instinctively trust that teachers are safe adults. For children who have experienced relational trauma, often at the hands of trusted adults, this can be extremely difficult, almost like facing a phobia. For many, this can feel counterintuitive, and can go against their previously developed and important survival strategies, relational templates, and defence mechanisms (Chapters 1–3).

At the same time, school requires children to share adult support/attention with multiple others, whilst spending long periods of time away from their attachment figure. This can also trigger their attachment needs or attachment-related trauma, for example, they may be contending with questions, such as: "Will my carer still be at home?" "Will they forget about me?" "Will they be ok without me?" Examples follow:

> *Ten-year-old Amber was described as, "Clingy, attention-seeking, and disruptive". The teachers shared how she would regularly shout out in class, and often follow the teacher around the room. Through a thorough assessment, it emerged that Amber had previously been starved of adult attention, and had been significantly neglected. She had learned various survival strategies for being kept in the minds of others; her shouting out was her way of communicating "Don't forget me, please remember me".*
>
> *Five-year-old Dylan had experienced unavailable/absent parenting. He had learned to conceal, internalise, and/or deny his emotions* (Chapters 1–2). *Within the classroom this showed itself as Dylan being overly self-reliant and compliant. He avoided teacher support, seemingly from fear of being rejected or ignored. This, in turn, made him fall under the radar and appear "invisible", and once again mirrored his early experiences of being forgotten and neglected. This reinforced Dylan's insecure avoidant-attachment style and his expectations of being ignored, invisible, and unimportant.*

Structure, transitions, and survival mode

Schools are highly structured systems, generally characterised by predictability, codes of conduct, rules, and routine. Managing and negotiating these requires crucial developmental skills such as impulse control, memory, "felt safety", and prosocial tendencies. These can be particularly challenging for children who have had developmental and relational trauma (Chapters 1–3), poor parental supervision, few boundaries/limits implemented, and/or have experienced negative role-modelling and educational scripts around adhering to social norms and rules.

School can also be demanding, as it requires children to be able to negotiate multiple transitions and unpredictable situations. These can be mammoth tasks for those who have experienced traumatic endings, chronic feelings of powerlessness, and situations of unpredictability. This may be further impeded by children functioning in survival FFF mode (hyper-aroused, hyper-vigilant, cut-off) (Chapters 1–3).

How might a child react differently to being disciplined by a teacher if they are hyper-aroused and in fight mode, as opposed to when they are in flight mode and disconnected? How well would you do if you were asked to sit an exam or comment on a discussion point whilst in the midst of a battlefield?

Figure 9.1 Trauma jacket, which travels with child.

Due to earlier trauma and disrupted attachment experiences and negative internal working models (IWM), children will often see themselves, others, and their world through their trauma and insecure attachment mirror (Chapter 1). This is likely to decrease their feelings of safety, and increase their sense of danger, "I'm vulnerable", "Others are dangerous", and "The world is unsafe". Therefore, although they may currently be in a "safe" school environment, this does not mean that they feel and believe that they are safe. Their trauma jacket (Figure 9.1) is likely to have travelled with them and be firmly buttoned-up; and so we often see children's strongly developed defences/FFF at play within the school context.

Chronological vs. social and emotional age

Children who have experienced relational and developmental trauma often respond in line with their social and emotional age as opposed to their chronological age, particularly in times of perceived threat or dysregulation. Some children may have underdeveloped developmental skills and still have some loose patches needing to be sown into their parenting patchwork (Chapter 1). This can pose challenges as to where teachers should set goals, and how to pitch their expectations and interventions. Examples follow:

> *Seven-year-old Evan was initially expected to play independently at break time, but in times of feeling dysregulated such as in the playground, he responded more like a 4 year old and required a higher level of supervision and structure.*
>
> *Nine-year-old Nyla needed to be taught skills such as making and sustaining friends before she felt comfortable and able to stay sitting next to her fellow students.*

Sensory triggers

Building on the above factors around safety, survival (FFF), and the impact of trauma on one's developmental trajectory, it is crucial to consider the environmental and physical context, especially as these children are more likely to have a lower window of tolerance, a finely tuned danger antenna, and be more easily dysregulated and triggered (Chapters 1–3). Schools can be an attack on the senses, and host a playground of multi-sensory unpredictable triggers, which can leave the child feeling out of control, unsafe, and overwhelmed. *Would we expect a child to synchronize swim or do aqua aerobics in shark-infested waters?*

Therefore these are key in considering why school may be more difficult, why behaviours or changes in mood may occur; in finding ways to reduce their occurrence and impact, and to increase the child's ability to recognise, tolerate, and manage them. These triggers can be across multiple spheres as presented by Table 9.1. *What others can you think of?*

Table 9.1 School-related triggers

Type of trigger	*School-related examples*
Sensory (Auditory, olfactory, tactile, gustatory, visual)	*The feeling of being trapped amongst crowds of people in the corridors*
	Doors slamming and bells ringing
	A teacher's raised voice echoing the angry voices of one's parents during a DV incident
	A teacher's perfume reminiscent of an "abuser's" perfume (smell is an extremely powerful sense which is often neglected when considering triggers)
	Being at the back of the food queue wondering whether there will be enough food left to eat
Relational and/or emotional	*A peer declining an invite to play, triggering past feelings of rejection*
	A teacher leaving to have a baby (feelings of abandonment, rejection, envy, loss)
	Struggling with a task, which triggers their toxic sense of shame and reinforces their negative IWM, "I'm stupid", "I'm ineffective"
	A teacher's support being focused on another student, triggering feelings of being ignored, and/or fears of being forgotten
	An unpredictable situation or sudden change, such as having a substitute teacher, or a fight breaking out in class, triggering feelings of being out of control, powerless, unsafe
Autobiographical	*Family tree assignments*
	A "Bring in your dad" day or mother's day
	Sex education classes or having to change in communal areas
	The baby Jesus story in the nativity play
	Snow (it snowed the day they were removed from their birth parents)

A whole-school approach

Having demonstrated the importance, and some of the challenges, of school for children who have experienced relational and developmental trauma, this chapter will go on to advocate for all educational provisions to be more trauma and attachment-informed and sensitive. On a wider governmental and societal level, this should be worked towards in a range of ways including being integrated into teacher-training programmes, creating mandatory attachment and trauma training, making attachment and trauma sensitivity part of the assessment criteria for inspecting bodies, and increasing access to specialist attachment and trauma supervision and consultancy.

The rationale behind thinking on a wider school attachment and trauma-informed approach, rather than simply focusing on individuals, is to aim towards achieving a bottom-up and top-down cultural shift within the whole organisation and system. A whole-school approach will have a far wider reach, rather than locating certain "problem" children. It will extend to those who fall under the radar, or are not identified as "high-risk children"; and prioritise emotional well-being for all children. It places emphasis on schools working towards being a second chance secure base, safe haven, and metaphoric "brick mother" (Henri Rey). It is intended that this framework will have a subsequent ripple effect at multiple layers including for teachers, parents, and the community.

The following suggestions of how to move towards becoming a more trauma and attachment-sensitive school are intended as tools and thinking aides, rather than a prescriptive way of following or structuring things. These strategies are built on in boxes 9.1 and 9.2. Each school is unique and has its own culture, history, philosophy, identity, values, norms, and rules, and therefore will need to think creatively and strategically about how to take these concepts forward, whilst keeping in line with their school ethos. These concepts are built on more widely in Chapters 6, 8, and 11.

- As in any organisation, the *leadership* of a school (e.g. governors, head teacher and senior team, commissioners, inspecting bodies) is paramount to the domino effect on its members. Leaders need to be on board in order to create a secure base for their teachers, which in turn will have a ripple effect on the parents and students. *How can children be held by safe hands and within thinking minds if the people delivering the services themselves are not held in the same way? How can an issue, such as bullying, be addressed if the staff group bullies or feels bullied?*
- Schools need to recognise and understand the *impact and consequences* that trauma and disrupted attachment has on children, and on their learning and overall school experience, and how crucial a *role* school can play in addressing these difficulties (Chapter 1–3), whilst being mindful that an attachment and trauma perspective does *not divorce itself from other important factors* such as mental health and learning disabilities. This requires the ability to hold multiple perspectives in mind, and to know when to zoom the camera in and when to pan out to scan the whole landscape.
- *Organisational dynamics* and the *system-wide impact of trauma* need to be recognised and attended to. This will include mirroring, splitting, and projection processes. Schools also need to acknowledge the difficult nature of the work, such as vulnerability to compassion fatigue and secondary trauma, and to provide strategies around

self-care and stress management. This may include considering teachers' own attachment style, relational templates, and hotspots, which are likely to be triggered when working in the context of trauma and loss (Chapters 6 and 8).

- Schools need to *"buy in" to the rationale, importance, value and benefits* (short and long-term) of becoming more trauma and attachment-informed; and this *shared vision* and philosophy should be reflected in the *mission statement*. Within this, schools need to acknowledge the widespread relevance of being more attachment and trauma-informed for *overall well-being*, rather than positioning the need within a small handful of children. Commitment to these principles will need to be driven by *champions and motivators*. These champions will need to create space for *challenges and barriers* to be voiced and creatively problem-solved. This is likely to include concerns such as, "We're not therapists, this isn't our job and we aren't qualified to do it", "there aren't that many children who need this", and "there's no time".
- Schools will need to put some *structures* in place around becoming more attachment and trauma-informed. These may include steering groups, training, supervision, consultation, debrief meetings, best-practice reviews, conferences, and reflective practice groups. The idea is that the concepts will *be embedded and interwoven into daily school life.* This is optimised by schools having an attachment and trauma thread running through *all spheres* (e.g. recruitment, induction, supervisory, and disciplinary procedures).
- Schools should explicitly and implicitly convey the message of, *"We want you here, and you are important to us"*. Schools also will need to develop a *commonly agreed language* which aims to avoid negative stereotyping labels and problem-saturated talk. This attachment and trauma-informed vocabulary and strategy should be reflected in the *whole spectrum of documents* from policies, to letters, school rules, and behavioural contracts. For example, this might include reciprocal behavioural contracts, where the school details their promises and agreement to the child, and vice versa (e.g. "We promise to …", "we will ensure …"). Within this, the consequences need to be logical, fair, clear, and predictable, and communicated in line with the whole-brain approach (Chapters 3 and 6) using multi-sensory methods. For example, *in what way can the school rules and consequences be clearly communicated and embedded using role plays, photos, videos, props, and pictures?*
- Schools need to recognise that *relationships are the anchor* on which children learn, flourish, and make behavioural changes, and therefore a relational approach is integral. This should include a central focus being placed on building, engaging, and maintaining student–teacher relationships. This should also include creative, individualised, and "out of the chair" strategies. On a wider relational level, community spirit, belongingness, school bonding, and pro-social behaviour need to be actively supported.
- Schools should focus on taking a *strengths-based approach* (see Chapter 4 for more in-depth strengths-based discussions and strategies). This will include focusing on what children can do instead of what they can't, and on building their strengths, skills, resiliencies, and positive qualities. This approach will also view target areas as opportunities, skills, and possibilities to learn, rather than as deficits. Schools should envision and hold the hope for their children, and believe in a better future for them. Under the strengths-based umbrella, schools should place emphasis on praise, incentives, and rewards, and find ways to verbally and non-verbally affirm their students. This may be through a range of strategies such as reward charts, positive letters home, displaying work, making success books, having a praise pod, keeping a "positive me" journal, and creating a wall of success.
- The *school milieu* should be nurturing, warm, and empathetic, and positioned as a reparative safe space. This should be reflected in daily interactions being used as

shaping, learning, and non-punitive experiences, led by "thinking" positive role models. *Behaviour management* should be done with *attachment in mind*, and power struggles actively avoided. Once the child is able to access their thinking brain, there should be opportunities for them to problem-solve, consider alternatives, and to set **SMART** goals (**S**pecific, **M**easurable, **A**chievable, **R**ealistic, and **T**imely). Schools should actively work towards avoiding shaming and triggering experiences, and optimising opportunities for success.

- Schools will need to put a range of *practical measures* in place to echo the trauma/attachment-informed ethos such as: having designated places for emotional regulation and safety, changing seating arrangements, labelling classroom areas, and decluttering spaces.

9.1 Practical activity and reflection

Imagine a "typical" class task. *What EF/social/emotional/sensory skills might this require? What might happen if some of these skills were less accessible?*

Considering all of the above factors, *what ways do schools provide "safe havens and secure bases" for children? When might they not be "safe havens and secure bases"?*

9.2 Practical activity and reflection

How trauma and attachment-informed is your school or the school you are consulting to? How does your school manage transitions? How does your school conceptualise and manage "difficult" behaviour? What "safe spaces" are there? How are children described and spoken about (e.g. labels, power of language)?

What are some of the barriers/challenges/advantages to moving further towards being a trauma attachment-informed school?

What is needed to move forward in implementing the above?

Preparation, planning, and assessment

Moving from a school-wide approach, it is essential to think about individual planning and assessment. The more a school knows about a particular child, the more it can plan, prepare, and put in place preventative strategies and measures to support them. This will also serve as a platform for whatever areas require focus, monitoring, and development. The most effective discipline and management strategy is prevention and early intervention. Therefore, careful planning should support preventing, rather than putting out fires. The assessment process should ideally start before the child attends the school, and should include multi-source data and information gathering from the Team around the Child/Family (TAC/F). See Box 9.3 for some suggested assessment areas, and Chapter 5 for a more in-depth discussion

of assessment. These should be alongside any existing assessment processes, and will need to be reviewed. These can also be complemented further by using Kim Golding's (2012) book *Observing Children with Attachment Difficulties in School: A Tool for Identifying and Supporting Emotional and Social Difficulties*.

This assessment process can helpfully feed into having an "All About Me" or pen portrait of the child to optimise communication, consistency, and transparency.

9.3 School Assessment Questions

1. *What reports/assessments are in existence or need to be requested?* (e.g. previous schools, nurseries, health visitors, therapists, nurses, youth workers, GPs, virtual school, SALT, paediatricians, social workers etc.). *What are the main learning points, gaps, and actions to be taken from these reports? What has worked well and what has been more difficult? What needs to be circulated/kept in mind/clarified?*
2. A framework of coordinated care is integral in order to communicate, liaise, and work effectively with the complex wider system around the child/family. *Who is the "TAC"?* (a visual web of support or ecomap can be helpful here). *Who needs to be included? What role does each person play? Do members have an understanding of each other's roles? What does each person mean to the child? Who is frontline and who is behind the scenes? How will the TAC work together/communicate?* (too many people can be overwhelming, confusing, and lead to organisational splits, and poor communication). *What are the team's visions/understandings/goals for the child? How do these fit with the child's self-goals?*
3. *What has the child's experience of relational and developmental trauma/loss been?* (a visual representation of this may be helpful, e.g. a genogram, map, graph, or timeline). Remember to include the in-utero period (e.g. DV/substance abuse/malnutrition).
4. *What developmental milestones/experiences did they miss out on, or are likely to have gaps in?* (consider their Parenting Patchwork, Chapter 1). *Is there an observed difference in their social and emotional age vs. their chronological age? How do these differences show themselves?*
5. *What are the child's triggers, hotspots, and vulnerabilities? What increases their feelings of safety, and decreases their feelings of danger?* (think on multi-sensory and multi-perspective levels).
6. *What do we know about their core beliefs, relational templates, and their IWM? How do they see themselves, others, and the world? What are their patterns of behaviour and ways of relating to others, e.g. how do they respond to discipline/change/separation/social situations?* (Chapters 1–2)
7. *What are their strengths, skills, interests, and positive qualities? How can you utilise and build-on these?* (Chapter 4)
8. *What school/systemic changes can be implemented to support them and the TAC?*
9. *What are the targeted areas to work on? Are these* ***SMART*** *goals? Who will support, implement, and monitor these? How will they be measured and evaluated?* (consider reliable and validated psychometric measures). *Are there barriers to achieving these? What plans need to be put in place for these to be addressed?*

Approaches and ways of conceptualising behaviour

Some of the above school-wide approaches will now be described in more detail.

Attachment and trauma-sensitive TAC

Having discussed the school-wide approach, and in keeping with relationships being at the epicentre of any intervention, it is important to think carefully about staff–child interactions. A relational framework proposes that children will be more able to learn, explore, be curious, and develop in a context characterised by safety, security, predictability, consistency, and containment. The TAC should therefore be small, but very present in the child's school experience. This said, behind the scenes they will be embedded within the wider Team around the Worker (TAW) and will require support, reflective time, training, supervision, and consultation (Bomber, 2007).

To develop and master these skills, educational professionals need to be aware and reflective of their own emotions, responses, and hotspots. This can sometimes be referred to as teacher sensitivity, teacher empathy, and teacher reflective function. The underlying principle is that the student can explore his/her mind through the mind of the educator (Riley, 2010). This supports the premise that educational professionals need to actively show, coach, and model co-regulation to the child, before they can progress to self-regulation. This will include being their role model, co-regulator, external brain, interpreter, cheerleader and advocate (Chapter 6), in order to support them in finding healthy ways of coping, problem-solving, communicating, and managing difficult feelings, and to move from their survival brain to their thinking brain (Chapter 3).

This team/person should really value and get to know the whole child (e.g. likes, dislikes, strengths, hotspots, triggers, relational patterns, communication styles, cues, etc.). They will endeavour to keep the child in mind, and to respond with high levels of empathy, warmth, and sensitivity. They will set the emotional tone and aim to be their safe hands and circle of security, which will include decreasing triggers and perceived threats, and increasing experiences for them to feel safe, particularly in times of high arousal and/or dysregulation. They will use many of the strategies described in Chapter 6 and find ways to repair any relational ruptures. They will be used as a relational anchor for change and skill development and will take a strengths-based approach, seeing the best in the child, and keeping an emphasis on their unique exceptions, positive choices, and overall development. They will find creative and individualised ways of engaging and supporting the child. Examples follow:

> *Five-year-old Zoe was struggling to ask teachers for support due to a suffocating fear of being rejected or ignored. Zoe loved Peppa Pig. So amongst other strategies, we used a Peppa Pig puppet to role play and ask for support. We watched Peppa Pig clips and discussed who or what could support Peppa in feeling able to ask for help. We made Peppa Pig-themed support cards to give to the teacher, and a Peppa-themed celebration chart which rewarded Zoe each time she attempted and/or managed to ask for support.*

Seven-year-old Dante regularly had outbursts in both the classroom and at lunchtime. Through a process of really getting alongside Dante, using the aforementioned frameworks, and together with the support of attachment-informed consultation sessions, his teaching assistant was able to find several strategies that were effective in reducing incidents and increasing positive moments. Some of these included: having a personalised sensory box; starting the morning with drumming sessions; having a zen-zone filled with items such as weighted blankets and bubbles; using picture checklists; and having outdoor brain breaks.

Safety

Naturally, school procedures need to be put in place to ensure that safety remains paramount; this will include *clear guidelines and shared agreements* around key issues such as *confidentiality and boundaries*. Nonetheless, it is hoped that these management strategies will still be implemented with *attachment in mind.* Children who have experienced relational and developmental trauma often are crippled by fear and feel unsafe physically, socially psychologically and cognitively (Chapters 1–3). In order for them to be able to learn and explore, they need to *feel and believe that they are safe* and to not be in a state of dysregulation; therefore *multi-levelled safety* should be prioritised. Education professionals need to actively *talk about safety*, and *have a place of safety* for the child to go to. Ideally this should be twofold, an *actual place of safety and an imaginary place of safety*.

Places of safety should be easily accessible and provide children with a sense of calm and containment. Some schools will have an allocated place such as a sensory room, whilst others will have something like a special tent, a thinking corner, or a Zen zone. It can be nice to have children name or decorate their own space. *One child aptly named his safe space "Cloud corner", whilst another who used hers to re-ground chose "Tree time".* Equipment varies but may include: weighted blankets, cushions, water items, bubble machines, rocking chairs, massaging items, sensory boxes, stress balls, beanbags, and soothing music. Children may need a *way of communicating* when they need their safe place. This might include a traffic light system, a movement, or an exit card. Others may not have the ability to recognise when they are dysregulated, so their *TAC* will need to support them around this. As with all new strategies, when in a thinking place, children should have a few turns at *practicing and role playing* how and when to use the safe space.

Additionally, the child should know who their *safe person* is, and how they can gain access to them. This should be discussed several times and represented visually. Building on these concepts, it is helpful to provide children with a *school safety tour* (Bomber, 2011). For example, they can be shown how the alarm system works, CCTV cameras, the security man etc. They may need this tour several times. Similar tours may be needed to address specific concerns, such as in the playground.

Safety is also conveyed through the day being *highly structured, predictable, and consistent*. Like in settings tailored for children on the autistic spectrum or with

additional learning needs, *clear routines, rituals, and rules are important, and can be helpfully aided by visual timetables, visual checklists, communication boards, daily charts and activity boards*. Often these are used in primary schools, but less frequent in secondary schools. It is important to remember that children often require approaches targeted to their *emotional and social age, rather than their chronological age*.

Mastery

Providing children with a *safe sense of control* can be beneficial particularly when they have had earlier experiences of feeling powerless and helpless. This supports them in having opportunities to be *facilitators of change*. This might range from choosing which colour to write on the board with, selecting a name for the class pet, to being given a class prefect role. These responsibilities need to be considered carefully on a case-by-case basis, as they can be overwhelming.

Behaviour as communication

Education professionals should be supported to deconstruct the behaviour/s they are presented with, and to reflect on what the behaviour is communicating. Box 9.4 and Chapter 2 expand on the concept of *behaviour as communication*. This deciphering technique is key in:

a Being able to think of an appropriate response and intervention.
b Really getting to know the child behind the behaviour.
c Decreasing the likelihood of interpreting the behaviour as personal, rather than as a learned survival strategy.
d Decreasing opportunities for the child to become negatively labelled.

For example, when faced with rage outbursts, in addition to the necessary strategies and safety procedures, it is vital to consider what defence mechanism/walls we are seeing. *What is underneath the rage*? *What are the hidden emotions that are harder to* (See Box 9.4)? An example follows:

> *During a puppet-based session, Noel, a child who had been excluded from three schools for "extremely aggressive behaviour", chose a hedgehog to describe himself and shared, "Hamlet the Hedgehog is prickly on the outside, but soft and gooey on the inside". He then used a crocodile to show how he had learned to "snap his big teeth to keep the meanies away".*

These children may find it difficult to express themselves and to relate to others, and therefore need adults to be like detectives and/or interpreters to discover and decipher the various messages that are being given, or sometimes thrown at them (Chapter 2). Often teachers or caregivers will respond to this concept of behaviour as communication by expressing concerns such as, "So we should just let them

get away with it?", or "I don't care why they are doing it, regardless it isn't ok to …". These are all understandable concerns and this way of thinking can appear counterintuitive, however this in no way is advocating for a pity approach or brushing over difficult behaviours. Rather, that the response can be done, albeit extremely difficult, in an empathetic way, and one which encourages learning and reflection, as opposed to pushing children deeper into their survival strategies. Daniel Hughes, psychologist and founder of Dyadic Developmental Psychotherapy, captures this concept by coining the phrase "Connection before correction". *For example, if a child shouts at a teacher, rather than saying, "Don't shout, it is extremely rude, be quiet", a teacher calmly might say, "I can see you really want to be heard and I want to listen but I need you to speak".*

9.4 Practical activity and reflection: behaviour as communication

1 Think about a child who is presenting with a behaviour you would like to understand in more depth (Chapter 2). *What function/meaning/purpose is the behaviour having for the child/for their relationships? What is the meaning of the behaviour? What might the child be communicating and why? What is the story behind the behaviour and underneath the surface?* If we think about a painting, we often only see the "finished" product, *but what are all the different colours, layers, techniques within? What different interpretations and feelings does it evoke in different people? What clue does the way we feel, when at the receiving end of this behaviour, give us into the child's feelings?*
2 *How does knowing a bit more about what the behaviour is communicating shape your feelings/thoughts about the child and the behaviour? How does the behaviour change when viewed from a different angle? How might this impact on your way of responding and supporting the behavioural change?*
3 *Is there a particular behaviour/difficulty that really pushes your buttons or gets under your skin? What is your relationship to that difficulty? What values are being challenged by the presenting behaviour? What is being triggered in you?*

Creating a new lens

It can be easy to fall into the trap of labelling, stereotyping, or placing a child into a box. These labels are powerful and can stick throughout a child's journey. Some common loaded terms include: "Trouble-maker", "naughty", "defiant", "lazy", "bad", "hopeless", "bad blood", and "damaged". These are often married with definitive terms such as "always" and "never". These labels can be hazardous for a number of reasons, they can:

1 Lead to self-fulfilling prophecies.
2 Contribute and reinforce a child's sense of hopelessness, negative self-esteem, and IWMs.

3 Affect staff's responses, expectations, and management styles, which in turn can create a vicious cycle.
4 Place blame on the child, as opposed to thinking about the context and other variables.
5 Define a child purely by their behaviour.
6 Impede hope and block ideas to move forward.

In addition to consciously considering our choice of words and creating a shared language, some ways in which we can address the above is through:

1 Narrative Therapy techniques (Chapters 4, 7, and 10), such as identifying the unique exceptions, and externalising and noticing the less told parts of one's identities, rather than just the behaviour or trickier parts.
2 Finding ways to positively reframe the behaviour, for example, instead of "hyperactive" one might say "energetic" or "spirited", or instead of "easily distracted", one might say "easily fascinated", or instead of "attention-seeking", one might say "attachment-seeking or attention-needing".
3 Re-claiming the balance and shifting the focus onto the child's positive strengths, skills, qualities, and resiliencies (Chapter 4). The more we look for the positives and take stock of what the child can do, the more we will appreciate them, notice them, and find an "in" which hooks onto the child's uniqueness.

Emotional, social, and behavioural regulation

As previously discussed and in Chapters 1–2, schools need to put support mechanisms in place to enhance the child's ability to notice, focus on, monitor, tolerate, and sustain a connection to their internal states. This will include learning what feelings are, how to communicate feelings in a safe way, and how to reduce the escalation and intensity of emotions (Chapter 2). This also has direct links to behaviour, *if a child does not understand or recognise their emotions, how can they control or shift them?* For example, *if a child shows their distress through throwing items, how can we acknowledge their feelings and ensure that they feel heard and are able to communicate their distress, without needing to do this through the throwing behaviour?*

Interventions that build on one's emotional intelligence, reflective capacity, and emotional regulation can take many forms. These strategies can be delivered on a one-to-one basis, in a group format, or to a whole classroom. It is important to keep in mind that emotional sensitivity is most effective when interwoven into moment-to-moment daily interactions (Chapters 2 and 6), it does not need to take the structure of a formalised lesson plan or set intervention. This said, there are hundreds of emotional literacy curriculums and interventions in existence, some of these include: *Creating A Peaceful School Learning Environment, Roots of Empathy, Promoting Alternative Thinking Strategies, Second Step, RULER approach, 4Rs, and MindUP*. Other schools have focused on finding creative ways to create *calmer classrooms* through interventions such as *school-based mindfulness or*

yoga programs. Other best-practice examples include integrating *regulating and brain-break activities into daily routines,* such as using calming music, drumming sessions, or green space time.

Transitions

An example of transitions will be used to demonstrate some of the previously discussed concepts being brought to life. For children who have experienced relational and developmental trauma, the skill of managing transitions is commonly reported as difficult. These can vary from transitioning from one task to another, through to moving from primary to secondary school. Ideally, transitions should be minimised, planned for, and linked to the associated trigger. These will vary depending on the uniqueness of the individual and context, however some strategies are as follows:

- Noticing, acknowledging, and naming what constitutes a transition for that child, and providing them with opportunities to express the associated feelings, hopes, fears, and expectations. This might include a safe trusted person using resources such as a wand, genie, quiz, head with speech marks, or collage (Chapter 2).
- Planning, preparing, and anticipating any transitions, where possible keeping as many things the same and unchanged, allowing for adjustment time, taking a bite-sized approach, and facilitating opportunities to have some choice and mastery.
- Decreasing the uncertainty by explicitly talking about and showing on visual timetables and checklists what will happen before, during, and after the transition.
- Reflecting on lessons learned from what made previous transitions go well, and what factors contributed to them being more difficult.
- Finding ways to show the child that they are kept in mind, for example, by having a daily check-in time, "invisible string", "magic glue", transitional objects, and/or "memory bank cards".
- In advance, formalising and teaching transition skills by having clear systems in place, such as a traffic light system, movement cards, a drum sequence, music playing, switching the lights on and off, or using visual timers (e.g. stop watches or sand timers).
- Using transition-focused photo books, moving calendars, social stories, comic strip conversations, and communication books.
- Practicing and role playing transitions and scenarios, with complimenting humour, playfulness, rewards, praise, and distraction techniques.
- Ensuring the child has their toolbox of self-regulation techniques to hand during the transition (e.g. safe person, down-regulating, comforting smell/scent item, sensory box, transitional object etc.).
- Facilitating graded visits, tours, and handovers, with ideally the child seeing their carer and school engaged in dialogue and being partners.
- Finding ways for the child to get involved and taking some ownership, such as taking photos of their new school/journey, decorating their new notebook, and/or making an "All About Me" book.

These strategies might be incorporated with other techniques to address a specific concern. This would be dependent on the individual child, and on what areas of development were highlighted by the assessment. For example, *Lily was struggling with some of her* ***social***

***skills, including initiating friendships and sharing toys**. To support her, alongside having an attachment and trauma-friendly team, and using a strengths-based framework, some other strategies were put in place. These included: introducing her to a buddy, engaging her in circle time and a nurturing group, and practicing these skills through role plays, conversation starter cards, and sharing games.*

*Devon had pockets of difficulties with his **executive functions**. Alongside the above strategies, and support from an educational psychologist, the TAC introduced a range of support mechanisms including having brain breaks, using cognitive and brain-gym exercises/games (e.g. Spot the difference, Snap, I went to the shops and bought, and Crosscrawl), and ensuring that information was communicated using multi-sensory means (e.g. props, pictures, and films). Devon also was supported in having checklists, visual organisers, and fidget toys. The delivery of information was aided through being highlighted/underlined, and broken down into bite-sized SMART goals. Moreover, to assist Devon in making links and connections, paper chains, dominos, social stories, and ladder images were used to support him in developing these skills.*

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Chapter 10

Reflecting on the experiences and working effectively with unaccompanied asylum-seeking young people

Setting the scene

Unaccompanied asylum-seeking young people (UASYP) have been deemed as one of the most marginalised and vulnerable groups within the UK. Their needs are multifaceted and multidimensional and may cover the entire human spectrum. With this in mind and within the current context of globalisation, migration, and international interconnectedness, it seems crucial to consider the support offered to UASYP.

This chapter will use the terms "unaccompanied asylum-seeking young person" and "unaccompanied refugee young person" as opposed to the term "refugee" or "asylum-seeker". This choice of wording is intentional, as it conveys the message that each child is unique within a unique context, and that their legal status does not define who they are or become their master identity. UASYP are an extremely heterogeneous diverse group of individuals.

Although this chapter will focus on UASYP within the clinical context, it is acknowledged that it will reflect a sub-population of the wider group. Human suffering does not necessarily fit or need to be dissected in a medical, diagnostic, or pathological way (Papadopoulos, 2007).

Legal definition and legislation

The United Nations High Commissioner for Refugees (1994, p. 121) defines UASYP as: "Those who are separated from both parents and are not being cared for by an adult who, by law or custom, has responsibility to do so." UASYP share three key components: being younger than 18 years old, entering a country seeking asylum, and being separated from their caregivers. The United Nations Convention on the Rights of the Child (2005) states that host countries have a responsibility to afford these children the same protection as any other child permanently or temporarily deprived of their family environment.

In the current UK political, social, and economic climate, only a minority of children post-18 are likely to be granted refugee status and indefinite leave to remain. The legislation can create an ongoing state of insecurity and instability, with UASYP living in legal limbo (Luebben, 2003), with the ever-present threat of being repatriated (Sourander, 2003), whilst contending with a myriad of

psychosocial challenges. This uncertainty is exacerbated by frequent amendments to legal requirements, which can prove a daunting and confusing maze to navigate.

Considerations and complexities for UASYP

Within UK service provisions, UASYP are generally supported within wider "children in care" services. Whilst many of the previous chapters on relational and developmental trauma are applicable to working with UASYP, there are additional multilayered complexities which will now be considered. This said, it is essential to emphasise that many UASYP have also experienced relational and developmental trauma and whilst this chapter focuses on their pre, during, and post-migration experience, it is integral that when assessing and intervening, the areas discussed in Chapters 1–4 are carefully interwoven.

Multilayered

Mentionable is that UASYP often present with little-to-no background information. Therefore, clinicians are invariably left with a sense of uncertainty and unanswered questions, which mirror the incoherent fragmented narrative which many UASYP describe. This can also be echoed in the additional need for paperwork chasing, in-depth assessments, and the work requiring a multi-pronged approach (e.g. housing, immigration, medical concerns, age assessments, and schooling).

Relational loss

Many UASYP have been uprooted from everything they know, and often have been separated from their nuclear and extended family in traumatic fragmented ways. Therefore, they are likely to have experienced numerous ruptured attachments and relational losses. Many UASYP report having little to no contact with their family, and for some, their families' well-being and safety remains unknown. This "not knowing" can be exacerbated through daily reminders and triggers, such as through media reports. *One young boy captured this powerfully; "Every time the TV says four bodies found, I instantly think it's my family, I have this picture of them just lying there in bits".* For others, they may have experienced traumatic bereavements with limited time or space to process them so they remain unresolved. Examples follow:

> *Cyrus described how his last memory of his mother had been watching her being brutally raped and beaten to death. He shared "Now's the first time I'm talking about it, I've just been running, I cut my head-off from thinking about it".*
>
> *Whereas Safia felt she had "lost" the opportunity to honour and connect to her father. She longed for the faraway acacia tree where he had been buried and which held so many of their shared memories.*

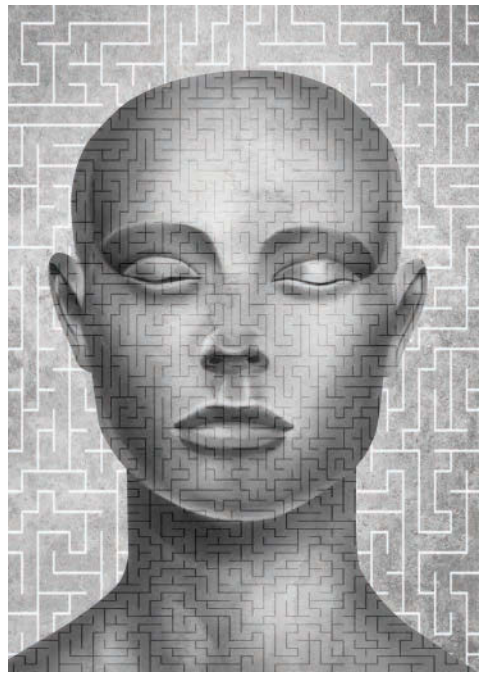

Figure 10.1 Internal and external mazes.

Losses, identity confusion, and navigating complex mazes

UASYP often have to contend with unimaginable changes and insurmountable losses, which are associated with being in a new country and "home". In this case, "home" represents so much more than a physical building. UASYP have to face complex language, social, and cultural barriers, which can permeate into every sphere of their life and identity. They also need to master and make sense of the intricacies of cultural, social, political, gender, relational, and moral norms, values, beliefs, rules, and expectations (Figure 10.1). Within the literature-base, this is sometimes referred to as: cultural bereavement, cultural nostalgia, or acculturation stress.

Furthermore, *imagine being in a country where you do not speak or understand the language.* Metaphorically and/or factually this might represent the loss of voice or of being heard; which can lead to increased oppression and stigmatisation (Lynn and Lea, 2003). Language barriers can contribute to feelings of isolation, disconnection, disorientation, and being misunderstood/different. In the same vein, UASYP are likely to experience difficulties with navigating the complex Western health, social, and educational systems which often rely on specialist local knowledge (Warr, 2010), and may appear unfamiliar and alien, such as; registering with a "GP", meeting with a "social worker", attending "therapy" or being placed in "foster care". Despite best efforts, this may be exacerbated by the

majority of people having limited knowledge about the impact of trauma, being a UASYP, their country of origin, and culture. Within this, so often culture is whittled down to its bare bones and oversimplified or stereotyped, rather than appreciating the wider framework with all of its different interweaving layers and threads.

The above complexities sound overwhelming, let alone whilst being "stateless" and managing the instability and uncertainty of their immigration status. These children have to cope without having access to their previously relied on support systems, communities, buffers, and safety nets. This includes lessened opportunities for parental guidance, role modelling, shared history, and receiving wisdom from their elders. Additionally, although expectations, roles, and conceptualisations of adolescence can vary significantly across cultures, the majority of these young people are contending with the developmental tasks and hormonal, physical, emotional, social, cognitive, and identity changes of adolescence, with the additional task of navigating their ethnic identity, and making sense of how the cultures mix, complement, or conflict with each other. Moreover, many UASYP have had to be independent and self-reliant; which for some may have seemed rushed, and equally can be conflicting with situations they find themselves in, such as being parented within foster care (See boxes 10.1, 10.2, and 10.3).

Furthermore, UASYP often must contend with their own or others' pressure and expectations that they are the "lucky one" and should be grateful and relieved. This can be linked with feelings of survivor guilt and self blame, and also restrict their capacity to feel that it is ok to experience a range of difficult emotions. *One young person shared, "I watched as they dragged my father away, I ask myself why didn't I make him see that we were more important than politics; he was a special man, and here I am, failing in school, and sitting with you complaining, how is that fair?".*

Discrimination and stigma

The host country is often not the trouble-free haven one might have expected, been promised, or hoped for. UASYP may experience social and political oppression and be left competing with a range of different stressors, including experiences of racism, hostility, discrimination, and stigma, for example through negative media portrayals, where UASYP are often represented as being exploitative and draining of services, and positioned as scapegoats and responsible for society's ills (Leudar et al., 2008; Innes, 2010) (Figure 10.2). Reviews of media coverage around UASYP have shown that headlines have been dominated by derogatory and sensationalist language, including terms such as: "bogus asylum-seekers", "fake", "illegal", "lazy", "asylum-rapist", and "spongers". Misleading statistics and referencing are also used to feed into these negative discourses (Smart et al., 2007).

These are likely to contribute to a disbelieving and suspicious culture and leave UASYP feeling criminalised, judged, unwelcomed, and blamed. *A client shared, "When I was in history class, the teacher said terrorism, and everyone stared at me, it was like a stone in my heart",* another young person described, *"They screamed at me to go back to where I came from. I wish I'd that choice".*

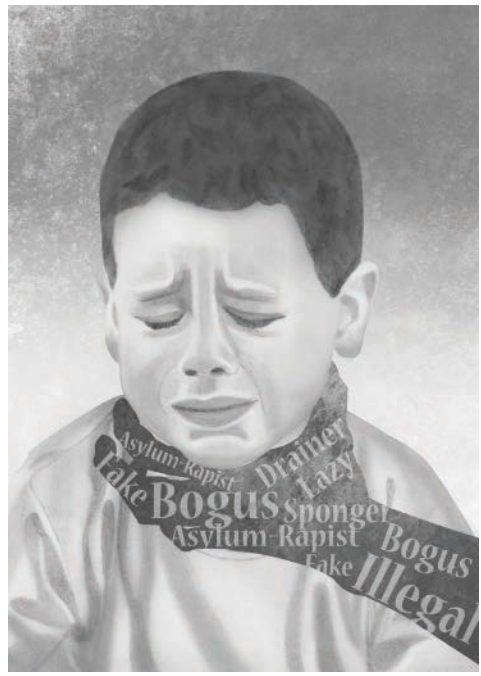

Figure 10.2 The power of language and labels.

Importantly, this needs to be balanced with the many best-practice examples where UASYP report feeling welcomed, celebrated, and embraced; and in situations where the media has acted as a powerful communication and connective tool.

Physical health

Another layer of intricacy is that UASYP are more likely to have physical health complications and/or untreated medical conditions, which in turn can have psychological and neurological implications. These are far-reaching but may include: head injuries, HIV/AIDS, hepatitis, tuberculosis, syphilis, vitamin deficiencies, STIs, intestinal parasites, malnourishment, and dehydration. Furthermore, UASYP may have experienced physical consequences from experiences of torture, rape, and female genital mutilation (FGM).

Pre-flight experiences

Table 10.1 lists some of the losses and traumas which UASYP may have lived through prior to arriving in the host country (Thomas et al., 2004). These are often referred to as the pre-flight or pre-migration experiences. These include the direct,

indirect, and witnessing of traumas. Noteworthy is that there is huge diversity in the lived experiences, and whilst this chapter focuses on the more extreme end, and those represented in a clinical context, it is acknowledged that not all UASYP have experienced the traumas listed below. The impact of these traumas is likely to be on a continuum and influenced by a number of interplaying factors which have significance for understanding, assessing, and/or intervening with UASYP. Some of these factors include:

1 The child's temperament and unique attributes including genetic factors.
2 Previous life events and stressors.
3 The severity and nature of the traumas.
4 The frequency and duration of the traumas.
5 The relationship with the person who carried out the abuse.
6 The response of others around the abuse, for example, how it was managed and whether it was believed/validated.
7 The sense-meaning-making and attributions made about the traumas.
8 The age and stage of the developing child.
9 The presence and/or absence of protective factors.
10 The cultural and contextual relevance of the traumas.

Table 10.1 Pre-flight experiences

Physical and/or sexual violence and torture
Persecution due to one's ethnicity, gender, political opinion, nationality, religion, sexuality, or membership of a particular social group
Arrest, entrapment, and/or imprisonment
Persecution of loved ones (including being killed, executed, tortured, kidnapped, imprisoned, detained, and deported) and separation from them (ruptured attachments, grief, and relational loss)
Honour-based violence/forced marriage/FGM
Physical destruction of home and community
Forced recruitment, trafficking, and slavery (child soldiers, child labour/drug-trafficking, prostitution, domestic slavery)
Homelessness/living in hiding/living in cramped spaces
Poverty – lack of food, water, and shelter. Limited access to medical and educational provisions
Genocide/war/terrorism (including bombings/shootings/political instability/forced ideologies/a fear-based society/no "safe haven")
Experiences of multigenerational and intergenerational loss and trauma, and historical hostility

10.1 Practical activity and reflection: identity exploration

Write, draw, make a collage, and/or sculpt the different parts of your identity. *If you were to design yourself an identity shield, what would be on it? What are the stories and meaning behind each facet of your shield? What is your relationship with that part? What or who influenced that part to develop? How did it come to be important to you?*

Now consider that part was taken away, destroyed, not acknowledged, no longer visible. *How would that feel emotionally, physically, and cognitively? What would you miss? What would that do to your overall sense of self?*

The journey itself

Often I'm struck by children reporting that some of their most distressing experiences took place during their journey to the host country. The following statement shared by a 16-year-old boy captures this: *"The nightmares ... they sometimes are about the prison room and ... the footsteps ... but to be honest they usually are about coming here. I lie awake at night and it haunts me. The journey was like a never-ending horror movie"*. Again, it is acknowledged that some young people arrive in a planned safe manner, but for others their journey is characterised by further trauma as described below:

- Separation from their loved ones en-route and/or violence, rape, and financial/sexual exploitation. *Maryam described, "He told me he'd get me safely on the boat, but once there he gave an ultimatum, either do sex things or have no food. He told me if I didn't, he would tell them I was illegal."*
- Long arduous journeys often with multiple stops and complications, such as being interrogated by authorities and being in poor conditions (lack of water and food, cramped into small spaces, or having to hide). Many UASYP have described contemplating daunting questions such as: "How long will the journey be? Will I actually arrive/survive? Where will I arrive to? And what will it be like?" Ezekiel shared, *"After my father's execution, the only light at the end of the tunnel was knowing I'd be safe in Canada with my aunt; I can't explain what went through my head when I arrived in this place called England; I had no one there and no idea what to do."*
- Many UASYP's journey includes time spent living on the streets, staying in refugee camps and/or detention centres, all of which host a range of additional complications.
- UASYP often report the pressures of being told what to say or not say to secure their safety and/or to avoid deportation. This can create a culture of secrecy, mistrust, guardedness, and further exacerbate the conspiracy of silence.

10.2 Practical activity and reflection: walk a day in their shoes

When reading lists, it can be easy to scan through the words, tick-boxes, and lose the gravitas of the situation. *Look back at the list of experiences and try to imagine how you might see the world from their eyes. What might that feel like?*

To bring to life some of the above, it can be helpful to read autobiographies, watch movies or youtube clips from the perspective of an UASYP. For example, for *child soldiers,* there are many relevant movies including*; Johnny Mad Dog, War Witch, Invisible Children, the Silent Army, Beasts of No Nation, and Aquel No Era Yo.*

Some books include: *War Child, A Long Way Gone, Child Soldier, and A Girl Soldier.*

10.3 Practical activity and reflection: invisible suitcase

Imagine that imminent danger has broken out! You have to go NOW; it is a matter of life and death.

How are you feeling (emotionally and physically)? What are you thinking? What things of value do you have to leave behind? What cognitive, emotional, social, geographical, physical, and losses are in your invisible suitcase? Who have you left behind?

When distressed, what usually helps you to cope/to calm down/to feel better/to move on? Are those things/people/strategies still there?

You now arrive in a foreign country, with an incomprehensive language, without a map, guidebook, compass, phone, or travel companions. *How are you feeling? What struggles are you facing?*

De-constructing diagnostic categories

Now that some of the multidimensional lived experiences of UASYP have been discussed, the potential consequences this may have on their emotional well-being will be presented.

First, it is important to recognise that one-size-does-not-fit-all. Whilst some common presentations will be discussed, this is within a clinical lens, and I'm mindful of not pathologising distress by labelling it as a "disorder" or emphasising the relationship with the time in which the trauma occurred, for example, "post" (Chapter 1). Clinicians have become increasingly critical of the universal applicability of a narrowly biomedical model, based on Northern notions of trauma (Summerfield, 2004; Papadopoulos, 2007; Quosh and Gergen, 2008). This is not to deny that trauma can be usefully conceptualised in biological and psychological terms, but that an overemphasis on symptomology can result in the divorce of the mind from the body, the individual from the community, and the community from the environment. It is essential to consider the cultural, historical, familial, and

individual meaning to the symptoms that are shaped by a range of factors, including history and culture. For example, nightmares are designated as a symptom of Post-traumatic Stress Disorder (PTSD), yet whether they are reported will depend on whether an individual/society regards them as problematic. In some cultures, nightmares are viewed as conveying ancestors' messages, and/or as indicators of the person's spiritual status.

Similarly, there are wider considerations around the individual lens versus the collective frame. *For example, the role of social recognition and community response can have a significant impact on the well-being of an individual – such as whether a former child soldier is positioned as a victim of war, a perpetrator, or framed in another culturally relevant way.*

Psychological consequences

Each individual requires a tailor-made approach and holistic assessment, and it is acknowledged that emotions and distress in diverse cultures can be expressed in different ways; however, some common presentations which clinicians see when working with UASYP will be highlighted. Many are interlinked and form an interactional matrix; as with any child it is essential to decipher the meaning and sense-making of their experiences and to take into account the developmental, social, emotional, and contextual factors. This is not an exhaustive list and will aim to capture areas not covered in the previous sections:

- Unresolved and unprocessed anger. This may be targeted towards self, others, and/or the injustice of their circumstances. *Mohammad was so furious about his mother's tragic death, but had been unable to process these feelings. Instead, he directed his anger towards the legal system, and towards day-to-day stressors, such as pocket money. Once his legal situation was resolved, and his pocket money approved, Mohammad was left facing the rawness of his feelings about his mother's death.*
- UASYP understandably may have some difficulties with trusting, allowing closeness and intimacy, and seeking/accepting help, following experiences of relational trauma. This can be reinforced by children having to have been self-reliant or pushed into pseudo-independence. Many UASYP would have experienced a change of their life scripts, core beliefs, and assumptions, which has significant implications for their thoughts, feelings, and behaviours (Chapter 1), for example, *"I'm vulnerable", "Others are dangerous and abusive" and "The world is hostile and unsafe".*
- UASYP may have high levels of avoidance of distressing memories, feelings, and situations. They may appear withdrawn, disconnected, and dissociated. Referrers often describe "bottling things up or seeming hollow". This can be reinforced by some cultures having a more dominant discourse of avoidance. This avoidance can also show itself through self-medicating (e.g. drugs and/or alcohol), or being drawn to risk-taking activities, such as joining gangs and engaging in aggressive behaviour (Chapter 12).

- UASYP may experience disturbed sleep, including the occurrence of nightmares, flashbacks, night terrors, intrusions, and/or bed-wetting.
- UASYP may show difficulties in their executive and cognitive functions including with their attention, memory, concentration, sensory perception, and interpretation of visuospatial stimuli (Chapter 9).
- UASYP may present with a sense of hopelessness, helplessness, and powerlessness. These feelings can be coupled with low self-esteem, low self-efficacy, self-stigmatisation, and internalised sense of shame. Others may present with low mood, suicidal ideation, and self-harming behaviours (Bean et al., 2007).
- UASYP may experience ongoing fear, hyper-arousal, hyper-vigilance, suspiciousness, guardedness, and panic. *Louie entered my therapy room and immediately scanned for potential dangers and an escape route. He sat by the edge with his hood pulled over his head, as if creating a physical barrier between us, whilst darting a fearful look at my pen, later asking if I would be sharing it with his lawyer.*
- UASYP often present with somatising or medically unexplained symptoms, such as headaches and stomach aches (Bäänheilm and Ekblad, 2000). This is married to a whole multitude of factors, such as the mind–body connection, and the way pain is communicated, conceptualised, and responded to in different cultures.

School considerations

Understanding the impact of trauma on one's learning and ways of making schools more trauma-informed are explored in Chapter 9. Therefore, with Chapter 9 detailing careful school-based findings and strategies, this section will primarily focus on some of the additional considerations for this target population.

Interestingly, there are some promising interventions, which focus on in-school therapeutic approaches for UASYP (see Tyrer and Fazel, 2014 for a systematic review). These approaches mainly advocate for school-based interventions as they view school as a normalising, safe, and non-stigmatising environment which can enhance early intervention, integration, and accessibility. Interestingly, this creates some dilemmas for schools as they may only have one or a small number of children who fit the programme's inclusion criteria, and therefore may have limited resources due to the unidentified need. Equally, many UASYP are age assessed at the 16–17.5-year-old mark, which generally means they attend alternative provisions, such as ESOL courses or colleges which are usually less set up to provide such group interventions.

In line with often having limited background information, it is key to consider the child's prior educational experience – *What styles of learning have they been familiar with or do they find most helpful? What is their understanding of the school structures and rules? What are their and their families' stories/beliefs/*

values/expectations around education? Did they have significant gaps/absences in their school trajectory? Are there any known additional learning and developmental needs? On the extreme end, some children may not have had access to education, and may be illiterate or not know some of the basics, such as how to hold a pen or use a calculator.

Education can mean a number of different things. For some, education is a significant protective factor and one of the driving forces behind their resettlement. It can represent a better future and serve as an opportunity to make loved ones proud; however for others, there can be a sense of meaninglessness in the context of other survival needs. Many children achieve well and dream of attending university like their peers, however without leave to remain this may not be possible, and can prohibit thoughts to the future. *"What's the point I might be sent back anyway?"* or *"How can I pay attention to Geography, when tomorrow I'm in court?"*

Moreover, as previously discussed, the presence of language and cultural barriers/differences can have significant implications. This was highlighted by a UASYP who had been sex-trafficked, *"I sit in class and look at the other girls and I think; you're sweet, you're innocent, you worry about boys and makeup; then I think me? I wish I could worry about that! I'm dirty, I was used as a toy, how can I click with them? They know nothing about where I've come from and what I've done – they're just little girls!"*

Other trauma-related difficulties (e.g. dissociation, re-experiencing symptoms, and hyper-vigilance) can also significantly affect UASYP's ability to think coherently, concentrate, attend, and memorise, filter, and process information (Chapter 9). *Imagine being asked to do a maths sum whilst in your mind you are still in a warzone; or having to focus on the teacher's question when every bell or shifting movement takes you back to the sound of machetes raiding your village.*

Resilience, hope, protective factors, and survivorship

This chapter has presented many of the potential negative consequences of being a UASYP, and therefore it is essential to balance these with the resilience and protective factors of being active survivors. In alignment with this, vulnerability-focused research and interventions have been criticised for constructing tragic, spoiled identities and softening UASYP's strengths (Kohli, 2007). However, there are also hazards of automatically positioning UASYP as inherently resilient. Therefore, it is advised to consider both the child's pockets of difficulties and their resiliency factors. Formulations should employ a wide range of approaches, however a central component of all should be identifying and building on existing skills, strengths, positive qualities, and protective factors. In the literature, this growth, the positive changes, and development have been referred to as adversity-activated development (Papadopoulos, 2007), or posttraumatic growth (Tedeschi

and Calhoun, 2004), or adversarial growth (Joseph and Linley, 2005). See Chapter 4 on strengths-based approaches.

The following sections will take a more therapeutic focus, and will discuss in more detail some of the *barriers of engaging in therapy*, some practical strategies for *working with interpreters*, some of the *common ingredients in working therapeutically* with UASYP, some available *therapeutic models* for this client group, then followed by a *case study*.

Barriers of accessing and engaging in therapy

In order to improve accessibility and engagement of therapy to UASYP, it is vital to work alongside the Team around the Child (TAC). For example, if the TAC holds apprehensions about therapy, then the preparatory conversations or encouragement to engage will not take place, or will be under a negative lens. I often have potential referrers make comments such as, *"He won't benefit because he doesn't speak English",* or *"She has nightmares but so do all refugees"*. Therefore, using a variety of means (multi-sensory, individual, and wider-community) to dispel myths, name the elephant in the room, voice common fears, preconceptions, misrepresentations and gently challenge negative discourses, is key to overcoming engagement obstacles. This should include finding ways to normalise some of these apprehensions, and of creating a safe place to explore them, for example, "If I was in your shoes, I might be feeling …", "Some other children have said they felt … is that similar or different for you?", "I wonder what you were thinking a psychologist was …". To improve engagement, services might need to be delivered in more flexible, "out-of-the-chair", culturally sensitive, and creative ways.

The following captures some of the barriers to engagement which are helpfully kept in mind when working with UASYP:

- In some cases, due to negative past experiences; there can be a difficulty in trusting, letting someone in, or allowing oneself to be supported. There can be fears about being interrogated, not believed, and/or judged. Moreover, UASYP may have varying negative scripts, discourses, and narratives around mental health, emotional expression, and therapy, alongside not understanding relevant concepts (e.g. "psychologist"). These can lead to all sorts of misrepresentations and fears: *What might be done to me and what is expected of me? What will they do with the information? Is it linked to my immigration claim? How can it work with an interpreter? How can talking help? Will she think I'm mad? Does she just want me to cry? She's never been to Sudan, so how can she understand?*
- There also can be concerns about how their spiritual, religious, and cultural beliefs and rituals may be judged and/or misinterpreted. These belief systems are crucial as they will impact in part on how they see their world, make sense of what has happened to them, and be used to

support them in moving forward. For example, illness representations/sex/emotions can be conceptualised differently across cultures, such as ill health can be seen in different cultures as being: a) possessed by ancestral spirits, b) an imbalance between yin and yang or between Vata, Pitta, and Kapha, c) a failure to be in harmony with nature or with the evil eye, and/or d) as punishment for sins.

- UASYP are often preoccupied with other significant areas and are in survival mode, therefore, therapy can feel untimely and less important. Several children have reported that they do not feel deserving of therapy, as they feel others are worse off than they. Moreover, many UASYP speak to their concern of "opening a can of worms" and then going to the point of no return. They may be in a place where they are functioning well by keeping their defences up or blocking some intolerable feelings. Therefore the notion of letting this protective wall down can feel overwhelming and threatening.

10.4 Reflection: critical thinking about our own positioning

Western models of psychological therapy are largely embedded within European and North American cultural values, such as the emphasis on individualism and self-disclosure.

What are your own ethnocentric, political, historical, and theoretical biases/experiences/motives/assumptions/positions?

What do you bring to the therapeutic space? What lens do you view the world through? What focus or response might a different therapist looking from a different lens or coming from a different class/race/gender/age etc. bring or take?

How can we work towards taking "a position of curiosity", and one which respects clients as "experts of their own experiences"?

Is there a role we should or could play within wider-related areas such as the media? In what ways could we contribute to improving social engagement, community cohesiveness, and challenge misperceptions about UASYP?

Working with interpreters

Working effectively and safely within a therapeutic environment with interpreters can be a complex area, requiring reflective negotiation and navigation. The presence of an interpreter creates an additional physical and emotional relationship to work with, a triadic dynamic. Often the requirement of an interpreter is viewed as a barrier and negative intrusion, however there are also numerous benefits where the interpreter is a valued part of the therapy. I have had the good fortune of several such experiences, where the interpreter has contributed greatly, and reported satisfaction in their own personal and

professional development. These interpreters seemed invested in the therapeutic process, actively showing their presence through empathy, respect, and containment.

The following suggestions provide some guidance as to how to optimise the interpreter experience, however the author acknowledges that some of these ideas are based on working in the culturally diverse setting of London, where there is lots of choice available, and that these recommendations may not be feasible in certain contexts. It is hoped that regardless, these ideas will be a springboard for creative thinking around working therapeutically with interpreters (Farooq and Fear, 2003; Tribe and Raval, 2003).

1 Allow additional session time to build rapport with the interpreter, to slow the session's pace down, and to factor in debriefing time.
2 Communicate, clarify, and check the understanding of roles, boundaries, confidentiality, and expectations of each other and of the therapy (e.g. verbal and written agreements). This will include discussions around the importance of translating as close to word-for-word as possible, rather than amending the information. Be mindful of the use of jargon and phrases; and try to use succinct clear sentences.
3 Use the same carefully selected interpreter for the intervention's entirety. There should be clear messages about the significance of their reliability and consistency.
4 Where appropriate, draw on their cultural knowledge and expertise.
5 Encourage eye contact between the therapist and the client, this can be optimised by sitting in a triangle position. Be attuned to non-verbal forms of communication.
6 Preferably the first person narrative should be used when translating, for example, "I had a nightmare".
7 Create forums and a safe space where the interpreter can ask for repetition/clarification or a change of pace. The interpreter should also have opportunities to reflect on the experience, as should the client on the interpreter experience.
8 Interpreters should be qualified professionals, as opposed to friends or family. Where possible, the interpreter should not be used for other non-therapeutic appointments in order to preserve the therapeutic relationship and to avoid blurred boundaries.
9 Engstrom et al. (2010) pointed out that interpreters often have similar trauma experiences to the clients they interpret for. This shared history can help to build rapport, but also may create some over-identification, and/or resurface some of the interpreters' own trauma experiences. This places them at an increased risk for experiencing vicarious and secondary trauma. Therefore, it is important to consider their self-care, supervision processes, debriefing opportunities, and training requirements.

Moreover, clinicians should be mindful that the interpreter's characteristics will have an impact on the overall interactions. Some clients might have a clear preference over who they would feel more comfortable with. *For example, Martina, who had been sexually abused, stated she would only feel comfortable with a female interpreter; whereas Gloria, who had been gang-raped by a particular tribe, was clear that she would not feel safe with a person who identified themselves as being from that tribe.* There are varying opinions about the selection of an interpreter; some might argue that having a positive experience with, for example, a male interpreter could be reparative and re-scripting, whereas others may feel that this could re-traumatise the client and/or not allow them to feel safe. There are no hard and fast rules, but rather my intention is to raise awareness so that clinicians can make informed decisions.

The impact of trauma work

The therapeutic process of working with UASYP who have experienced trauma is often an intense, connected, and emotional relationship. Effective intervention requires the therapist to be actively engaged in empathising with the client's lived experience. Despite training and guidelines, the nature of the work often results in the therapist being affected by the distress. Therefore, helping professionals are at greater risk of being affected by vicarious trauma (VT) (McCann and Pearlman, 1990), secondary traumatic stress (STS), and compassionate fatigue (CF) (Figley, 1995) (see Chapter 8 for more detailed discussion).

Conversely, working with trauma can be incredibly rewarding, as one can experience an enhanced sense of self, meaning, growth, and spirituality; an appreciation for their own situation and fortunes; and can foster feelings of resilience, faith, and hope. Clinicians have reported an increased awareness of people's amazing capacity for survivorship and strength, and huge satisfaction in observing and being part of the growing process (Tedeschi and Calhoun, 2004). Noteworthy is that the impact of working with trauma refers to the whole system including school, social workers, caregivers etc. Therefore, stress management and self-care should be an enhanced lens throughout any intervention (Chapters 6 and 8).

Elements of the therapeutic process

Now that the scene has been set and common presentations explored, some of the available therapeutic interventions will be discussed. Before that, it is important to acknowledge that there are numerous common ingredients in each model, and therefore the following aims to highlight some of the key elements that I feel are valuable regardless of the approach applied (Table 10.2). It is acknowledged that these will differ according to the therapist's style, lens, and experiences; and need to be tailored to the individual.

Table 10.2 Top tips for working with UASYP

To focus on forming a containing, consistent, predictable, safe, and trusting therapeutic relationship with an emphasis around individualised engagement and rapport-building. The therapeutic relationship is often intensified when working with UASYP due to the lack of parental guidance and support systems; and UASYP may experience a metaphorical home within the therapeutic relationship.
To ensure that the client is offered accessible psychoeducation and clear explanations about the therapy, the presenting difficulty, the professional role, and the interpreter.
To be transparent and led by the young person's pace and goals, and to create opportunities for choice and mastery, with the aim of counteracting feelings of powerlessness and helplessness. This will include being mindful of not recreating earlier experiences of being disempowered, silenced and/or positioned as a "helpless passive victim".
To take a position of curiosity and to respect the client as a unique valued individual and as an expert of their own experience.
To take a non-neutral approach when addressing human rights violations; and to keep in mind the wider systemic, organisational, and contextual factors.
To focus on the individual's sense-making, and to support the reintegration of systems between past and present, internal and external, and thoughts, feelings, and actions. This may include integrating or supporting non-verbal and body-based interventions such as tai chi, yoga, art, music, and dance (Chapter 3).
To build on the client's resiliencies, strengths, skills, hope, and future-oriented thinking. To support the client in discovering and/or reconnecting with the meaning and purpose within their life (Chapter 4).
To work with and strengthen the TAC; and to support access to meaningful activity/ education/employment.
To be a reflective, critical, and reflexive clinician.
To be mindful of the impact of working with trauma on the whole system, and to prioritise self-care.
To be open and encouraging of client feedback.

Psychological interventions

A plethora of literature is available regarding well-researched psychological approaches in working with children who have experienced trauma, such as Trauma-focused Cognitive Behavioural Therapy (TF-CBT) and Eye Movement Desensitisation Reprocessing Therapy (EMDR) (Shapiro, 2001). Therefore, these will not be discussed here but are acknowledged to be important evidence-based approaches (Chapter 7). Instead, this chapter will focus on the less represented approaches. This will include *Narrative Therapy, cultural genograms, Testimonial Psychotherapy, Narrative Exposure Therapy, creative and expressive therapies, grief and bereavement work, and Mindfulness practices.*

This is by no means an exhaustive summary, and does not aim to offer a comprehensive review of the extant evidence base; rather, it is hoped that some of the breadth of options demonstrates the wide range of approaches available, which can be creatively and eclectically employed and interweaved into existing multimodal therapies. A thorough assessment and formulation is needed to ascertain

the appropriateness of the type and time of all interventions. Cultural relevance, applicability, and effectiveness with UASYP need to be considered. The following vary in the training required, the amount of sessions needed, and the theoretical underpinnings.

Meditation, yoga, body and spiritual-based healing practices

Although relatively new in relation to UASYP, emerging studies and anecdotal reports indicate promising results for utilising meditation, yoga, and spiritual-based healing practices as the main treatment modality or as a buffering component. Furthermore, there is increased interest in the use of Mindfulness-Based Cognitive Therapy (MBCT), a therapy that incorporates traditional CBT methods with mindfulness and meditation techniques, mainly rooted in Buddhism. In addition, thinking creatively about the mind–body connection is advocated throughout the trauma literature (Chapter 3). During my travels, I have been struck by the amazing power and cultural relevance of certain meaningful activities. These have ranged from capoeira in Brazil, to drumming in Tanzania, to tai chi in China, to meditation in India. It is important to think how we can integrate these approaches into daily practices, or alternatively how to work with local non-clinical providers to make these more accessible.

Narrative Therapy (NT)

NT is rooted in social constructionism; it rejects the idea of a universal truth and favours multiple realities and perspectives. NT seeks to be a transparent, collaborative, non-blaming approach, which centres people as the experts in their own lives. It views problems as separate from people, and assumes that people have many skills, competencies, beliefs, and values that will assist them to reduce the influence of problems in their lives, and reconnect them with their own sense of personal agency.

Children often present with negative self-perceptions, labels, problem-saturated stories, and negative dominant discourses, such as, "I'm bad and dirty". These can be internalised and can contribute to children self-stigmatising, self-blaming, or feeling stuck in a learned helplessness position. Furthermore, this may lead to the "problem" becoming the child's way of defining themselves, their master identity, "I've always been depressed" and "I am hopeless". These discourses can be generated and/or reinforced by the wider systems and contexts around the children, for example, "He's always bad" and "She's damaged". Therefore, a central goal of NT is to support children to deconstruct and challenge these dominant narratives in order to re-author their lives and develop therapeutic solutions to problems (White, 2004). NT advocates for not seeing the problem as intrinsic to the person, therefore supporting the UASYP to externalise the problem, and to see that *they* are not the problem; *the problem* is the problem (White, 2004).

Various techniques are employed to support the UASYP in re authoring their life, including *externalising* tools. UASYP are supported to label or personify problems, to allow them to be seen as separate entities. For example, a child who presents as wetting the bed may be supported in making the bedwetting into a character.

 *What is it called? Look like? Sound like? Say? Do?* Then various therapeutic avenues could be followed (examples of names children have chosen are used)

 *How did they manage to outsmart "sneaky wee"? How much bigger or stronger are they than "dripping Derek"? What skills and strengths did they use to conquer "Lucy liquid"? Who would they rather have in charge of their life, "Penelope Pee" or them? What is it like to share their life with "Raging River"? What plans does the "worry waterfall" have on their life? What is "the trickling terror" stopping them from doing?* Some UASYP may want to write a story about the character, or make, mould, or sculpt it. They then may want to lock it away, tear it up, shout at it, bury it, burn it, jump on it, squash it, imagine it with a funny costume on etc.

Other NT techniques include identifying and reflecting on *unique outcomes or exceptions* (e.g. times when they have overcome a particular problem, or when the problem was less noticeable or stressful). Some examples of unique exception questions include: *Since last week, was there a time that the "Anger" could have got the best of you but you didn't let it? Where and with whom is the "Anger" least likely to appear? How did you manage to not let the "Anger" turn to violence?*

NT also focuses on *thickening children's stories* and guiding them to *reconnect with their strengths, sense of agency, and values*. NT focuses on *mapping the problem's influence* on the child's life, and on their *relationship to the problem*, and to finding a skill which can contribute to the solution.

 Some questions which illustrate this are: *How is "the fear" affecting your life? When the voice of "the fear" is less strong, what will you be doing that you're not doing now? How is "the cloud" attempting to prevent you from enjoying the self-confidence you were able to acknowledge before the trauma? What plans does the "jittery jelly" have for your life? How do you think you came to think "I'm strong"? What is the history of thinking "I'm strong"? Was there anyone in particular that introduced you to this way of being strong?*

NT also takes the stance that people respond to trauma, and that these responses say something about what the person values, was preserving and protecting.

 *What is this anger you feel a testimony to? What is it you hold precious that has been violated? What kind of life have you been fighting for? When you say you're giving up, what were you keeping holding of until this point?*

Remembering conversations can be particularly powerful for UASYP who may be grieving or yearning for a loved one. See Box 10.5 for examples of these.

"Take-back" practices, therapeutic letters, or conversations are based on the assumption that therapy is a two-way reciprocal process, and that the relationship with the child has an impact and influence on the therapist. See Chapter 4 for ideas of what can be put into a take-back practice letter.

Tree of Life (ToL) technique: This NT tool originally was developed in 2007 by Ncazelo Ncube, a Zimbabwean psychologist, for children who had been orphaned by HIV/AIDS, however it has since been extended to working with numerous age groups and in wide-reaching areas. The ToL enables people to strengthen their relationships with their own history, their culture, and significant relationships.

In this technique, children use a tree as a metaphor to discuss their lives. Often these representations are in pictorial form. People can express their ideas in whichever way they choose including using objects, pictures, paints, collage, sculpture, etc.

- *Roots* (These represent where they come from, family life, family name, stories/songs from their past, and ancestry).
- *Ground* (This represents their present and everyday activities/hobbies).
- *Trunk* (This represents their strengths, resiliencies, positive qualities, and skills).
- *Branches* (These represent their hopes, wishes, goals, and dreams).
- *Leaves* (These represent important people in their lives – real, imagined, dead, inspirational, or pets).
- *Fruits* (These represent the physical, psychological, and social gifts which they have been given).

When the ToL is carried out amongst a group; the next stage involves members displaying all of their trees together, and in doing so they create a *forest of trees*, a community. This can support people in feeling part of something, and of being listened to; then the group may choose to reflect on what appears on others' trees that they have been struck by. The group also discusses the storms and dangers faced by trees; and can use this as a metaphor for thinking of ways of weathering their own storms. The ToL process is usually completed with a certificate and ceremony celebration.

Since development, the ToL has been extended and creatively applied in a range of contexts, for example, through using a football pitch metaphor with former child soldiers (Denborough, 2008), to a Kite of Life, focusing on moving people from intergenerational conflict to intergenerational alliance (Denborough, 2008). Other NT tools which may be useful for UASYP but are not detailed here include *Outsider Witness Groups, Maps of History* (Denborough, 2008), and *Songs of Sustenance* (Denborough, 2008).

10.5 Practical activities: narrative therapy

Exercise 1 – History of a skill: Please describe a value, belief, or skill that gets you through difficult times.

Share a story of a time when this value, belief, or skill made a difference to you or to others. Share the history/relationship of this skill, value, or belief. *How did you learn this? Who did you learn it from? Who would be the least surprised to hear you talking about this? Is this linked to any groups or communities which you are a part of?*

Exercise 2 – Tree of Life (ToL): Create your own ToL (optimally in pairs or groups). This may be over a period of time. *What have you learned and noticed? What have you been struck and surprised by?*

Exercise 3 – Remembering conversations: In pairs try and have and reflect on the below conversation.

Can you remember a person who you felt understood and appreciated by? What was it that they brought to your life? What is it that they helped you with? What did they see that others missed? If ... was sitting here, what do you think they would say they appreciated/enjoyed about you? How did they influence what you felt about yourself? What do you think it meant to them to be connected to you? How might their life have been different for knowing you? How might the way you saw them, and the way you were when you were with them, have contributed to how they saw themselves? How are they still able to be present, in varying forms, in your life?

Cultural Genograms

Cultural Genograms have similar aims to those described above. A genogram is a pictorial representation of a multigenerational family tree that goes beyond factual detail by attending to themes, relational dynamics, and psychological factors. The clinician uses a position of curiosity to discover more about the child, and to support them in retelling their story. A cultural genogram facilitates exploration of life themes, whilst attending to and mapping out areas of historical, geographical, and cultural processes and identity which have occurred in the family lifecycle. This can be a sensitive way to explore areas of difference and similarities, such as religion, gender, and race, as well as an opportunity to explore children's representations, multigenerational legacies, and cultural conceptualisations. Cultural genograms also identify patterns, including those around shame, pride, acceptance, rejection, historical hostility, and transmission of trauma; and can be key in understanding how the UASYP position themselves within their socio-political context; for example, *Lyla explained how in her culture rape was viewed in blaming and ostracising ways; and was conceptualised using terms such as "dirty and sinful". Therefore, these deeply embedded societal beliefs were contributing to her feelings of self-blame; and formed a central part of the intervention.*

Cultural Genograms can be interwoven into various therapy approaches and complement other tools, such as eco-maps, timelines, and/or therapeutic life-story books. There are endless avenues that can be explored, however here is a flavour of the type of questions which can be included:

What hardships did your grandmother experience and what was her sense-making around these? How was mental health viewed by …? What role does gender play within the family? What religious rituals or beliefs did you grow up with? What or who influenced the development of these beliefs? What collective traumas and losses has … experienced? How have family values changed over time? How is … understood in your culture? What emotions are valued or avoided in …?

10.6 Practical exercise: cultural genogram

Cultural genograms are powerful exercises for therapists to personally use to enhance their understanding of their own influences, connections, and patterns (e.g. cultural, historical, geographical, political, spiritual, religious, socio-economic, and gender factors).Take some time, with a trusted partner, to create your own cultural genogram.

Following the process, reflect on what the experience was like. What did you learn/take from the process? What parts were more difficult/surprising/enlightening?

Testimonial Psychotherapy (TP)

TP gives weight to the importance of bearing witness to the atrocities faced and to support young people in having their voices heard. Building on their sense of agency is vital in counteracting feelings of powerlessness, helplessness, and self-blame. TP places weight on justice and incorporates a socio-political/social action stance, as well as embracing the storytelling culture of some communities. TP enables the child to gain some distance from the event, and to focus on different aspects of their story (e.g. the courage that led to their survival). Testimonials allow the retelling of events to a therapist who documents the narrative, and through an interactive process produces a written testimony that acknowledges the experiences and provides documentation for political/personal purposes. The child has control over the creation of the document, and whether to keep it to themselves or disseminate it (e.g. to amnesty). TP has been extended to consider incorporating ending ceremonies/rituals which may include local customs and leaders (e.g. monks and village chiefs) to provide a form of community recognition and reconnection (Agger et al., 2009; Lustig et al., 2004).

Narrative Exposure Therapy (NET)

NET (Schauer et al., 2011) is a fairly well researched standardised short-term approach that was initially developed for the treatment of PTSD within a refugee camp context for those affected by organised violence. NET is based on CBT principles and builds on the theory of the dual representation of traumatic memories, and makes a distinction between hot memories (i.e. emotions) and

cold memories (i.e. facts). The therapist explores the emotions, cognitions, sensory information, and physiological responses associated with the traumas. Some reliving techniques are used whilst the child narrates their story – processing, integrating, and meaning-making their experiences in the course of their life. In NET, the client constructs a chronological narrative of their life with a focus on the traumatic experiences. This lifeline is often carried out using stones, flowers, candles, sticks, rope, and ribbon to represent a range of feelings and wishes for their future. At the end of treatment the recorded autobiography may be used for human rights advocacy, in line with TP principles.

Creative and expressive therapies

Trauma can impact the regulation of one's self and body; therefore expressive therapies can support the integration of physical and emotional, left-to-right brain, and internal to external processes. Therefore, other means of expression and communication which engage the non-verbal, metaphorical, symbolic, primal, sensory, motor, and right-brained processes can be beneficial when working with children who have experienced trauma (Chapter 3).

Additionally, using creative means encourages UASYP to be active participants in the therapeutic process, and may resonate more with those from backgrounds where the arts are culturally important means of expression. Creative therapies also often employ more developmentally appropriate media, and rely less on language or cognitive ability. These creative interventions include using art, clay, puppets, masks, storytelling, drama, sand, music, creative writing, dance and movement. The possibilities are endless and using expressive arts can vary hugely from a course of art therapy delivered by a qualified arts psychotherapist, using the arts in a therapeutic way, to explaining a CBT concept through creative means.

Examples of using creative means are described throughout this book, and in the below case study. However, clinicians including *Ditty Dokter, Cathy Malchiodi, Margot Sunderland, Liana Lowenstein, Sue Jennings, Lois Carey, and David Crenshaw* have wonderful examples of using the arts within a trauma context.

Bereavement and grief work

As previously explored, UASYP have experienced multiple losses and therefore a focus on these may be needed. Some of these losses may be tangible, whereas others conceptual. Moreover, with some clients, alongside the grief is a host of complex factors that need to be integrated. *Nigel's father had been murdered for his political involvement. To preserve his very treasured relationship with his father, whom he titled his hero, he had shut off and denied the feelings of anger and resentment towards him for what he deemed as choosing politics over his family. This anger was being directed towards himself and being communicated in self-harming ways. Part of the work was making sense of these conflicting feelings and finding a way to reconnect with his father.*

It is important to be mindful that ideas about death, afterlife, and goodbye rituals differ. They may include beliefs about spirits, ghosts of the past, and cleansing rituals. Therefore, interventions need to consider culturally sensitive ways of processing the losses. Due to the extensive losses, separations, and endings UASYP are likely to have experienced, therapists should be aware of the potential significance of the ending of therapy, and what this might represent and trigger for them.

Some grief-based techniques include:

- Writing a letter to lost loved ones, and/or using the Gestalt empty-chair technique.
- Creating a memory box/candle/quilt.
- Releasing a balloon or a message in a bottle.
- Planting a tree/naming a star.
- Creating a remembrance mural/shrine/canvas/collage.
- Carrying-out cultural rituals and ceremonies, which may include linking with spiritual/cultural leaders.
- Having remembering conversations and creating a ToL.
- Reading and writing stories/poems/songs/prayers around loss.
- Making a self-portrait and reflecting on all the different aspects of one's loved one, which they possess within them. This can be extended to thinking about ways to continue to hold people in their heart and in their head, like Simba holds Mufasa in the Lion King.

Team Around the Child (TAC)

It is easy to focus on the individual, especially when UASYP often present "alone" to services, but it is imperative to consider the wider contextual, organisational, and systemic factors. The UASYP needs a connected wraparound team, which interweaves their wider systems such as school, legal professionals, and foster carers. It can be useful, when there is a web of systems, to carry out an organisational genogram or ecomap. Some UASYP find it useful to have a visual representation of who is holding up their safety net or who are their life cheerleaders. For some, keeping in mind the associated precautions, traditional healers, and spiritual figures are helpfully included as part of the TAC. Moreover, different cultures have different concepts of family, roles, and responsibilities; and these should be considered. Furthermore, even though family members are not physically present, it does not mean that they are not psychologically and symbolically present.

Case study and putting into practice various therapeutic approaches

Background history, presentation, and reason for referral

Fifteen-year-old David arrived in the UK from the Democratic Republic of Congo (DRC). David experienced numerous traumas in his pre-migration experience, including watching his mother being raped and subsequently killed by a rebel group, being separated from his

younger siblings, and himself being brutally beaten in a village attack. Despite being raised in a war-torn environment, a significant protective factor was that David described positive childhood experiences. David's father was unknown to him, and he had been raised by his mother and three maternal aunts. As the eldest child, and without a father figure, David played an active role in supporting his siblings and seemed to take great pride in being a positive role model. David's mother was Rwandan, and David described how this had been a source of village hostility and had resulted in the family being treated differently. This feeling of being ostracised was later replicated with certain situations in the UK.

Following his mother's murder, David had been traumatically separated from his siblings, and their whereabouts remained unknown. David had travelled from the DRC to Kenya, and subsequently through various means, arrived in London. David described his journey as extremely traumatic, characterised by living in a refugee camp, and then sleeping rough in two European countries. David did not speak English, and chose to use a French-speaking interpreter.

David had been referred due to experiencing medically unexplained headaches and stomach aches. He also reported regular nightmares and general sleep difficulties. Although David reported enjoying school, having made friends, and settled in well, he increasingly found it difficult to concentrate in class. This was evident in his limited progress of acquiring the English language. David explained that in the DRC he had been one of the top students and that these difficulties were unfamiliar to him.

David was described by his teachers as being "likeable and resilient", but seeming to be "in his own bubble". The team also described that David would sometimes draw pictures with violent and distressing content, and that they felt overwhelmed and ill-equipped to know how to best support him.

Initially, David presented as flat in affect, withdrawn, and disconnected. He made no eye contact and sat with his head stooped low. He chose to sit right by the exit and dressed in three layers of clothes even though it was during the summer months. I was struck by him functioning in "flight" mode, and how he seemingly was swaddling himself with protective layers. David answered questions in a monosyllabic way, and described his mood with restricted emotional vocabulary. He stated some fleeting suicidal ideation but with no intent or plan. Positively, he was able to show hope in his future.

The following sections aim to give a flavour of the intervention, whilst referring to some of the strategies used; which will most likely have some applicability to other UASYP. The assessment process and measures used are not detailed here.

Engagement stage

Time was taken to explore what David's expectations, goals, hopes, and fears were. There were detailed discussions around David's understanding of trauma, therapy, and psychologists, with a central focus being around building a rapport and engaging David – i.e. What football team did he support? Who was his favourite musician? This seemed integral as David was initially guarded. These sessions actively sought feedback and gathered David's ideas for ways of conducting the sessions and moving forward.

Safety stage

A range of tools was introduced to increase David's sense of self and ability to self-regulate. These included grounding and relaxation exercises. David was supported in connecting with his safe place; and used his artistic talents to design a safe place poster which he kept

proudly above his bed. David also designed a portable keyring version. Moreover, attempts were made to build on David's numerous skills, strengths, and resiliencies (Chapter 4). For example, David was a lover of music; so we linked him in with a music group, supported him to find an inspirational song which was then recorded and the words written down, and assisted him in writing his own experience-focused songs.

In the same vein, David was inspired by Nelson Mandela, so we reflected on how he could draw on some of Nelson's strengths. What Nelson might think and enjoy about David? What challenges Nelson had faced and how he had overcome them? Who, like Nelson, could David inspire? What quotes of Nelson's could David use as positive messages? David also engaged in our peer-mentoring programme, which seemed to offer him a sense of purpose and a way to reconnect with the positive role model position he had once treasured with his siblings.

Grief

David chose to work on some of his grief experiences first, as he reported feeling increasingly preoccupied with the loss of his siblings. Some practical steps were taken to support David in beginning the Red Cross family tracing process. Additionally, there were many conversations around the losses David had experienced and the feelings this had evoked. David was supported in finding meaningful activities to support him in his losses. For example, he spoke about his fondest memories of playing in the sand with his siblings and hiding in the trees; so we made a memory jar and keyring filled with different coloured sand to represent each family member. This symbolically represented David being able to carry these family members with him wherever he went. David also chose to have a ceremony where, with the TAC, he planted a memory tree.

Difficulties sleeping and nightmares

David was having difficulties falling asleep and was having repeated nightmares. A range of sleep and nightmare-specific strategies was used, however some of David's preferred technique's included using fabric pens to decorate his pillow case with positive images/messages, getting his TAC to record positive safety messages on his phone, and having an electronic fish by his bed so that he did not feel alone, as he found the silence overwhelming. David also was supported in externalising the nightmares; he chose the name "spiked arms" which he processed through a range of techniques including drawing them, sculpting them, and designing a music piece which captured the associated feelings.

ToL

A large piece of work was around carrying out a ToL with David. This was a very powerful exercise and allowed David to explore a range of areas including around his identity, self-esteem, coping strategies, resiliencies, and values. David also really connected to the metaphor of storms and trees, so these became a continual thread, which we integrated and drew on throughout the therapy. At the end, he requested his tree to be framed.

Trauma-Focused CBT

David identified some specific intrusive images and thoughts (e.g. "I am weak") which he found distressing. These were explored and processed using CBT techniques such as

cognitive restructuring and imagery rehearsal. Re-living was not deemed necessary in the context of other strategies, nor was work around avoidance.

Weathering the storms

David experienced ongoing stressors during the course of therapy, which were worked through. Some time was spent on recognising his triggers, identifying the emotions evoked, utilising problem-solving strategies, and reflecting on the lessons learned.

Ending

The therapy process was carried out over a 22-month period. Research regarding UASYP emphasises the need for long-term support to help them maintain their well-being over the course of emerging difficult events (Chase et al., 2008). Sessions were gradually decreased from weekly to monthly. David organically came to a place where he felt ready to end the sessions. We reflected at great length on the mixed feelings provoked by endings, and about his previous ending experiences. We collaborated on what a reparative ending might look like and what it might mean. We reflected on the journey and lessons learned, and considered what strategies/skills he would use should he face challenges in the future. David chose to share his ToL with his TAC in a celebration ceremony, where he also buried a time capsule, and I read a take-back practice letter (Chapter 4) to him. The interpreter played a valued part of these ceremonies.

Outcomes (acknowledging the other support avenues and time passed)

At the time of discharge, David reported a significant reduction in the occurrence of headaches and stomach aches. He described having only one nightmare in the 6 months prior to discharge, and a significant decrease in intrusive images. He rated his mood at 7/10 (10 being the best), and reported no longer having fleeting suicidal ideation.

He made significant improvement in his language acquisition, and school reported positive changes in his concentration levels. They also described him as more present and engaged. He showed open confident body language, excellent eye contact, and used a lot of humour. He was able to label and express a range of feelings, including understanding their link to what was happening in his body. He also was able to identify his triggers, and successfully put into place self-regulating activities.

He actively began seeking his family through the British Red Cross, and continued to find ways to grieve and honour them. His engagement in recreational activities increased, and he continued to be an active mentor for other UASYP. Fortunately, following a traumatic ordeal and amazing efforts by his TAC, David was granted leave to remain. He hopes to go to university and work for the United Nations.

David kindly agreed for me to share a translated excerpt from his ending letter; this I feel describes the process far more powerfully than I could:

> *Thank your being on this journey which sometimes felt impossible and hopeless. When I felt like I was stuck in quick sand or trapped behind a huge rock, you helped me find ways to get unstuck. Sometimes by literally pulling me out! When the storms*

hit, you helped me weather through or to at least take shelter for a little while. When I felt lost, you gave me something which felt like a compass. When I ran or leaped ahead too fast, you helped me slow down, take a breath, and to see the footprints I had already travelled. When it felt never-ending and pointless you helped me take one step at a time, and to appreciate that it is all a journey, as opposed to there being a final destination. And with all this said, you made me feel and believe that I was the discoverer of my own journey. Thanks for being in my heart and in my head.

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Chapter 11

Children's residential homes

A relational and developmental trauma perspective

Introduction

This chapter considers some of the needs, challenges, and interventions for working therapeutically within children's residential homes, occupied by Looked after Children (LAC). Residential homes should be an important focus under the relational and developmental trauma umbrella, as although they tend to represent only a small proportion of the UK's LAC population, they often care for the most vulnerable, complex, risky, and marginalised children. The term residential children's home is broad and encompasses many different types of homes, and multiple variations within them. Furthermore, residential care serves different functions depending on the local borough and service needs. Adding to this complexity are the unique subcultures and group climates which are found within each home. Table 11.1 illustrates some of the varying residential home categories.

Within the UK, there has been a changing context around children's residential care, including an overall reduction of using residential homes as placement choices, which seems to coincide with changes in government policy, economic considerations, and increased quality assurance measures. Moreover, currently there is a principal government agenda to keep children within their birth families, or if this is not possible, in a family-like environment, for example, fostering. There have also been shifts in professional and public perceptions of residential care including increased stigma, scrutiny, and negative media representation (Box 11.1). This is echoed in dominant discourses around there being high levels of abuse, low levels of quality care, and being positioned as "The end of the road", "Only for the hopeless ones", the "Last stop before prison", or the "Worst case scenario".

This chapter will first discuss who the children are who are placed within residential homes, followed by exploring some of the unique components of residential settings; then it will consider some of the common threads of moving residential homes to become more trauma and attachment-informed, followed by some existing context-specific therapeutic approaches presented, and lastly a case study with accompanying reflective questions.

Table 11.1 Types of children's residential homes within the UK

Funded by and responsible to	Local authority/private sector/voluntary sector
Other characteristic differences	Inclusion and exclusion criteria for referrals
	Mixed vs. single sex unit
	Staff ratio and size
	Staff factors (skills, experience, qualification, demographics)
	Number of children
	Length of admission
	Staffing rotas and shift patterns
	Team structure (e.g. key workers, senior clinicians)
	Security level
	Management and leadership structure
	Geographical location
	Links with other service provisions (e.g. CAMHS, youth offending teams, social care) and community resources
	Monitoring, inspection, and governing procedures
	Level of family involvement and systemic working
	Level of therapeutic input (e.g. no access to therapy/therapeutic community/therapeutic milieu/in-house therapy provisions/ external specialist input/access to local mental health services/a specific model of therapy underpinning the home's philosophy)
Child factors	Age, gender, ethnicity
	Reason for referral
	Presenting difficulties
	Health, mental health, sensory, and learning disability diagnoses
	Family background and placement history
	Risk and safety factors
	School attendance
	Contact with birth families and family involvement
	Legal status

11.1 Reflective exercise: narratives and images around residential homes

What images/stories/labels/feelings come to mind when thinking about residential homes? Where do these narratives and images come from, and what are these linked to? How would these impact your way of conceptualising/approaching/responding to staff working in, or children living in, a residential home?

How might these discourses and messages make the children who are placed within a residential home feel? (e.g. sense of hope, internalised stigmatisation, self-esteem etc.)

How might these influence the feelings of residential workers around an "outsider" (e.g. a psychologist) coming into the home? (e.g. implied criticism)

Who are the children placed within residential homes?

Children placed within residential homes, particularly on a long-term basis, often represent a complex subgroup of the LAC population. Their needs span the entire biopsychosocial spectrum, and they are more likely to have had extensive service-involvement histories; and experienced fragmented care journeys fraught with losses and traumas (Chapters 1–3). From an intergenerational and systemic perspective, studies investigating the parents of children placed within residential homes have shown an increased occurrence of mental health difficulties; complex trauma histories, themselves having been in the care system; and engagement in high-risk behaviours, such as substance abuse, criminal involvement, and violence (Baker et al., 2006; Griffith et al., 2009).

Moreover, children within residential homes tend to have a higher proportion of trauma and neglect histories (Briggs et al., 2012), and often present with an alphabet soup of clinical diagnoses and "labels". Berridge et al. (2012) found that half of the children in their study of 16 residential homes had special educational needs, mental health needs six times the rate of the wider population, and presented with significant behaviour problems, including offending behaviour. These children often have had significantly more placement and school moves; which are linked to a host of risk factors, including low educational attainment and poor school attendance (Berridge et al., 2012).

Amongst residential homes, there is also an increased occurrence of risky behaviours, such as going missing, misusing substances, and engaging in unsafe sex practices (Dale et al., 2007). Furthermore, there continues to be concerns around the relationship between being placed in a care home and being more vulnerable to being groomed, engaging in gang activity, and/or being sexually exploited (Brodie et al., 2011). This myriad of factors is further layered with complexity due to the majority of these young people contending with developmental tasks, and the hormonal, physical, emotional, social, cognitive, and identity changes of adolescence (Chapter 12).

This said, the above focuses on the negative side of the scale, and by no means wishes to dismiss the resiliency (Chapter 4) of many of the children placed within homes, and the wealth of positive child outcomes which have been evidenced. The aforementioned multilayered complexities support the notion of moving residential homes to be more attachment and trauma-informed (Chapters 8–9).

What makes residential homes unique?

Taking the above into account, some unique components of residential settings, which distinguish them from other contexts, will now be explored. This said, it is once again acknowledged that each home is a live system within itself, with a unique subculture and group climate. Therefore these areas should be considered

under the umbrella of the multifaceted impact of relational and developmental trauma which has been discussed in Chapters 1–4.

Unpredictable environments

Residential homes can be ever-changing and unpredictable environments and hugely impacted by the emotional tone of the children and of the staff. Emotional contagion can quickly filter through the corridors of the home, and they can oscillate from being quiet, settled, and/or empty, to being extremely fast-paced and chaotic. Environmentally, they can host a playground of triggers, and at times be an attack on the senses, for example, shouting, doors slamming, doorbells ringing, cupboards shutting, music blaring, cigarette smoke looming etc. (Chapters 2–3 and 9).

Depending on the shift, staff often have to juggle multiple competing demands. For example, they may have to report a young person as missing to the police, whilst another insists that they need their pocket money NOW, whilst the phone is ringing endlessly, and in the midst of all of this, the long-awaited TV repair man arrives. This can all be happening simultaneously, whilst other service-factors are at play; such as being short-staffed, having a discharge report to finalise, and a school parents evening to attend. These juggling balls can be slipperier and trickier when a staff member is in the dark, for example they receive an emergency admission, but have no choice over the suitability of the referral, no time to prepare themselves or the other residents, and have little background/risk information of the incoming child.

These changes and unpredictability are further mirrored amongst the backdrop of continual organisational/governmental change and expectations, which is problematic as we know these children need containment, safety, structure, routine, and predictability. This also gives weight to ensuring that support is put in place around triggers, emotional regulation, sensory-processing, and ways to increase feelings of safety and decrease feelings of danger (Chapters 2–3, 6, and 9).

Living within a group

Children are placed within a group-based living environment full of other young people, with their own complex, and at times competing needs. This is a unique system in itself, and poses a whole host of additional considerations, including around group dynamics, intergroup relations, sibling relationships, and family processes.

Think about the research recommendations and decision-making that usually goes into matching and placing children in foster care (e.g. gender, age, wishes, attachment strategy etc.), and then reflect on how this would be different or similar when placing a child in a residential home.

Imagine placing six high-need foster children who have experienced significant relational and developmental trauma, and most likely have colliding and conflicting attachment patterns and relational styles, together in one house, with a staff team of "parents", who also have their own unique needs and histories.

Some relational patterns I have observed within these settings include: 1) hierarchical and battle of wills behaviours, 2) negative peer culture/role-modelling, 3) groupthink behaviours, 4) "unhealthy" in-house relationships, and 5) comparisons between residents and resident–worker interactions.

This said, residential homes can also provide a range of positive relational opportunities; including development of interpersonal and peer skills, a sense of belonging, mutual support, and camaraderie.

Multiple caregivers

From a practical point of view, simply managing to communicate key information to multiple staff members, and pulling together the pieces held by several people, can prove challenging. For example, even deciding what discipline should be actioned for a child who has skipped school, or what activity to do on Halloween, can become a complex decision-making process. Even for a two-parent household, creating a consistent caregiving plan is tricky enough, let alone when it is amongst a group of multiple "parents" (Box 11.2) amid a wider web of people and systems (e.g. school, police, youth offending teams etc.). Adding to this mix is when there are changes in the staff team and/or within the residents, which once again requires a whole re-structuring of the "family" and group.

Building on the above, staff teams comprise of multiple individuals with varying values, expectations, norms, philosophies, goals, assumptions, and motivations. These add additional layers of complexity, as they can be conflicting and/or contradictory to each other. These inevitably filter into different sense-making, attributions, and conceptualisations around the role, which range from how to interpret a child's behaviours to what the purpose of the home is (e.g. *"It's the same as foster care"*, *"It's like a step down from prison or a secure unit"*, *"It's to get the naughty kids off the streets"* etc.), to what being a residential worker means (e.g. *"Am I a corporate parent, a therapeutic agent of change, or a behavioural management officer"?*) to different behavioural management and parent-rearing views (e.g. *"These children need to learn right from wrong"*, *"All they need is love"*, *"Being hit never did me any harm"*).

The various contents of these complex melting pots are thickened by residential workers often having their own trauma and/or care histories (Esaki and Larkin, 2013). These alongside the systemic dynamics and impact of working within a trauma-driven system such as becoming emotionally full up, experiencing vicarious trauma, compassionate fatigue, and burnout can lead to unhelpful mirroring, countertransference, re-enactments, splitting, projections (Chapter 8), and/or

being pulled into challenging family roles, such as being the "warring parents", "The neglectful parent" or the "punitive parent". An example follows:

Becca (a residential home worker) had been repeatedly threatened by a young person, she felt targeted and on edge which made her retreat to survival mode. Without this being attended to, this created blocked care, and crushed her ability to empathise with him, and the hidden hurt child beneath the attacking behaviours. Like him, she now felt unsafe, vulnerable, and alone. Mixed in was Becca's own hotspots and ghosts of the past, as this boy reminded her of the stories she had been told of her father, who remained in prison since her fourth birthday.

Therefore, having a reflective critical stance and awareness of the powerful processes and dynamics at play is crucial, as well as having a shared vision with clear role definitions and purpose.

External relationships

Residential homes depending on their links with the community and other existing services can often feel quite disconnected from the outside world. When inside them, they can feel like they are functioning very separately, and viewed differently to other options, such as foster care. Examples of this include residential workers not being invited to attend carer training; or a social worker's frequency of visits decreasing once they are placed in a residential home; or families being excluded from important decision-making processes. Some reflective questions follow:

What is it like to have a friend sleeping over or visiting when you are in a residential home? What needs to be in place for this to be permitted? What are other children's parents' thoughts around them visiting a residential home? Who attends school parents evenings or football matches?

What is the home's relationship like with the child's family? How involved are they? Within the residential home, how much time is spent, and how much expertise is there in building family relationships?

How embedded in the community is the residential home? How is the child's sense of belonging and interconnectedness strengthened? What is the child's world beyond the residential home and how is this supported?

An office within a home, or a home within an office

A residential home in its very nature is an unusual set-up, in that the staff's work space is physically within the children's home space, and vice versa. This creates some dilemmas around boundaries and privacy, which are key areas for children with trauma histories (Bebout, 2001) (Box 11.2). Activities that are usually reserved for "home mode" such as cooking, cleaning, watching TV, and sleeping in a residential home are part of the daily work routines. Moreover, staff may be exposed to difficult events such as being threatened, assaulted, or an allegation made, whilst having to remain professional, and return to a place where they feel unsafe, time and time again.

11.2 Reflective practice exercise: home vs. office and multiple "parents"

What does "home" mean to you? What does "home" feel and look like? What makes "home" different to other places?

Imagine someone else's office being located in your home? Envision your home full of health and safety posters, or having your room checked every hour and your whereabouts ticked off on a form? Visualise business meetings taking place in your lounge? Your fridge filled with other people's food? Inspectors assessing your home?

Visualise living in a home with sometimes up to 15 "parents"? What might that feel/look like?

Imagine you went for a sleepover on a Saturday night, and did not return until the Monday morning. You were reported to the police as missing. This is the fifth incident of going *missing* that month; your placement future is in jeopardy. You return to four members of staff, and have another four coming on shift in a few hours.

What responses might you get? What might you hope for/be fearful of/expect? What differing staff values/conceptualisations/attributions/expectations/beliefs might there be around going missing? How might these complement or conflict with each other?

Figure 11.1 Residential home as a brick mother.

Attachment and trauma sensitive and informed

There are several components and threads involved in how to move towards making organisations/environments like residential homes more attachment and trauma sensitive and informed. This said, rather than repeating chunks of information covered elsewhere, I refer the reader to Chapter 9, which goes into detail as to how to make schools more trauma and attachment-sensitive and aware, and offers individual and system-wide strategies and reflections around these.

These concepts with some creativity and transferability can be helpfully applied and adapted to residential home settings. For example, when discussing ways to increase *mastery in school*, this could be applied to residential homes by ensuring that residential workers find ways to *value each child as a unique individual*, and involving them as *"experts of experience" in their care*, by having opportunities for them to be *facilitators of change*. This might range from *choosing how to decorate the living room, to chairing in-house meetings, to supporting the inspecting process, to sitting on recruitment panels, to designing brochures about the home.* Similarly, another example of adapting Chapter 9's strategies to residential homes might be having *sensory calming boxes in each child's room, and creating a Zen zone or calm corner within the home.* Moreover, as discussed in Chapter 9, the consideration of forming an *attachment friendly team/person* can also be applied to the qualities needed, and the decision-making around the careful selection of key workers, the matching process, and co-working relationships. Chapter 6 and Chapter 8 also enhance this thinking around making organisations more attachment and trauma-informed, so should be referred to.

Ideally, approaches tailored to residential homes should endeavour to create an organisational cultural shift which filters down into various levels, and embeds attachment and trauma frameworks into the whole system. This widened lens strives to enrich the overall environment, which in turn supports both the children and the staff. Given the complexity and diversity of residential homes, it is likely that a range of interventions drawing on multiple theories and a broader knowledge-base are needed for maximum effect, with the clinician/team employing a flexible, creative, strengths-based, and out of the chair approach, and who are aware of child development, the subculture, and the system-wide dynamics at play (Box 11.4).

In line with an attachment and trauma framework (Chapter 9), this needs to position relational repair and positive carer–child interactions as key in the context of relational trauma; and place residential staff as therapeutic agents and anchors of change who can provide the children with much needed safe hands, thinking minds, and positive role models within the context of a second chance secure base, safe haven, and positive "Brick Mother" (Henri Rey) (Chapters 6–9) (Figure 11.1).

Positively, the window and opportunity for change is huge, given the 24-hour living environment with endless moment-to-moment learning and shaping opportunities available, and developmentally with adolescence being a time of significant reorganisation and brain growth.

11.3 Practical activity and reflection: trauma and attachment informed

Having read and reflected on Chapters 6, 8, and 9, consider the following questions with relation to making residential homes more attachment and trauma informed.

What ways do residential homes provide "safe havens and secure bases" for children? When might they not be "safe havens and secure bases"?

How trauma and attachment informed is your residential home/or the residential you are consulting to? How does your residential home manage transitions? How does your residential home conceptualise and manage "difficult" behaviour? What "safe spaces" are there? What are the behavioural management plans, do these keep attachment and trauma in mind? How are young people described and spoken about (e.g. labels, power of language)?

What are some of the barriers/challenges/advantages to moving further towards being a trauma attachment-informed residential home?

What is needed to move forward in implementing the above?

Frameworks and models

There is a real dearth in the literature around effective evidence-based interventions within residential home settings, even more so within a UK context. Whilst there are some excellent examples of best-practice and some promising findings, the majority of these are in their early stages of evolution and implementation, and require more rigorous, longitudinal, and larger-scale evaluation. These gaps seem to reflect the complexity of residential homes and the children placed within them. In addition, certain factors and research limitations further complicate the process of establishing an effective evidence-base. These include:

- Their subcultures, group climates, and the huge diversity of the staff-groups, the environments, the management, and the geographical locations, further including the extensive organisational/systemic dynamics and differences.
- Variations within the target population and their multilayered needs, including high occurrence of co-morbidity, varying amounts of family involvement, different admission lengths, and a wide range of ages, presenting difficulties, and cognitive abilities.
- Diversity of the goals of the interventions. For example, is the intervention aimed at the individual, group, family, home, staff, and/or management level?
- The unpredictable and changing nature of residential homes.
- The lack of accurate baseline and/or validated standardised measures.
- The lack of children's voices/wishes driving the interventions.

The following sections detail some of the frameworks that have been used positively in residential homes. The suitability and adaptability of these models will vary from home-to-home, and by the quality of how they are delivered and monitored. Due to the vast variations, cultural and contextual differences need to be carefully considered when applying a model or transferring findings to a particular home. The majority of these approaches are reliant on practitioners continuing to use all of their other existing tools, skills, and experiences; rather than throwing them out of the window. This includes keeping in mind that the interventions which have been evidenced and recommended for children who have experienced relational and developmental trauma should still be offered and made available to those living within residential homes (Chapters 3 and 7 describe these interventions ranging from Dyadic Developmental Psychotherapy, Dialectical Behavioural Therapy, to Sensory Attachment Intervention).

As the following models are fast developing and constantly evolving, the research-base will not be stated here, as the most accurate source of information will be from journals, websites, and the model developers.

***Sanctuary Model* (Bloom and Yanosy, 2008)**. This model represents a trauma-informed whole system approach for creating or shifting an organisational culture. It was initially developed within the context of an acute inpatient psychiatric setting, and draws predominantly from both the trauma and the therapeutic community literature. Sanctuary has been implemented and modified in a range of settings including multiple residential homes. The Sanctuary model focuses on embedding seven elements within organisations, including a culture of: 1) *nonviolence*, 2) *emotional intelligence*, 3) *inquiry and social learning*, 4) *shared governance*, 5) *open communication*, 6) *social responsibility*, and 7) *growth and change*. Sanctuary uses the acronym S.E.L.F to guide its therapeutic approaches: *Safety* (attaining safety in self, relationships, and environment); *Emotional management* (identifying and modulating affect in response to memories, persons, events); *Loss* (feeling grief and dealing with personal losses), and *Future* (trying out new roles/ways of relating, ensuring personal safety and to help others). Within the model, these concepts are incorporated into different elements of running a home, such as community meetings and safety plans.

Attachment, Regulation, and Competency (ARC) (Blaustein and Kinniburgh, 2010) is a conceptual framework and offers guiding principles for children who have experienced multiple traumas, from early childhood to adolescence, and their caregiving systems. ARC is grounded in trauma, attachment, and child development theories. It attends to the social, systemic, and contextual frameworks; and has been implemented in a variety of contexts (e.g. inpatient, residential, group, community). ARC recognises that one-size-does-not-fit-all and encourages a creative, flexible, and individually-tailored approach. It draws on a range of therapeutic procedures including strengths-based psychoeducation, relationship strengthening, parent-training, sensory and body-based strategies, social skills training, CBT strategies, and psychodynamic techniques. It focuses on three core domains, which include: building secure attachments, enhancing self-regulation capacities, and increasing competencies across several domains. Each domain consists of several

building blocks, which contain a range of "menu-like" activities. For example, under the *competency* domain, the building blocks include: *developmental tasks, executive functions, self-development, and trauma integration*.

Children and Residential Experiences (CARE) (Holden, 2009) originated in the United States in 2005; it is informed by a range of research and best-practice approaches including Parent Child Interaction Therapy (Chapter 7). It is a competency-based curriculum to support residential care staff to establish practices that aim to improve outcomes for children. CARE focuses on two core areas. The first is *organisational*, and focuses on improving leadership and organisational support for change. The second focuses on *enhancing consistency* within and across team members in how they think about, and respond to, the needs of the children. The six guiding principles are as follows: *1) Developmentally-focused, 2) family-involved, 3) relationship-based, 4) competence-centred, 5) trauma-informed, and 6) ecologically-oriented environment.*

RESuLT is a UK-developed research-informed training programme, which is delivered to whole teams of Residential Child Care Workers (RCCWs) on a home-by-home basis. RESuLT includes direct teaching on social learning theory and neuroscience, and also focuses on the development of enhancing self-reflective practice. RESuLT is delivered over 10 weeks in three-hour blocks to the whole residential home team using multiple training methods. RESuLT aims to promote partnership working across Child and Adolescent Mental Health Services (CAMHS) and the children's home sector, through joint delivery of the training from children's home managers and CAMHS staff. The broad aims of the training are: 1) to enhance the shared practice language for the work carried out by RCCWs, 2) to rehearse practical strategies for promoting consistency with the young people they care for, and 3) to embed intervention methods for promoting positive learning and relational skill development in the group-living environment.

Having discussed some of the overarching frameworks which are useful to bear in mind when working in or supporting a residential home, a case study will now be presented, followed by some key questions to consider.

Case study: Nathan, a 15-year-old boy

Linda herself had been in and out of the foster care system, including within a residential home. At age 18 she fell pregnant (unplanned) with baby Nathan. During her pregnancy she was admitted to hospital twice for sustaining injuries believed to have been caused through domestic violence (DV) from Nathan's father. Linda's blood tests also showed high levels of alcohol and cocaine. From birth, Nathan was placed on the at-risk register with a support package offered, including a period of time in a mother–baby unit for a parenting assessment.

By the age of four, significant concerns had been raised, and it was decided that Nathan be placed in foster care. These concerns included: 1) Six DV household incidents; 2) bruises seen on Nathan's arms on three occasions; 3) Nathan showing indiscriminate friendliness to strangers, and rarely seeking comfort from his mother; 4) observations of Nathan having soiled nappies and limited access to age-appropriate toys; and 5) playgroup reporting that

Nathan appeared unkempt and hungry, and had been pushing and pinching the other children. Further investigation concluded that Linda's alcohol and drug-intake had increased, and that Nathan had often been left home alone or unsupervised with a range of neighbours. Suspicions had been raised querying sexual abuse, as one of these neighbours was a known sex offender, however this was not evidenced.

Nathan was subsequently placed with a single foster carer in her 60s where he remained for 2 years. She requested for Nathan to remain with her permanently. However, social services felt that due to her age and a range of other factors she could not care for him on a long-term basis; and therefore he was moved. In later retelling of his experience, Nathan had described this move as "hell".

Following this, Nathan was moved to a different part of England to a foster family with three of their own birth children. Nathan remained with them for 5 years. There were periods of him being settled, but there were also concerns raised from the social worker that Nathan was treated differently to the birth children, and often described in negative terms. Nathan also struggled with his attention and concentration at school, and was reportedly drawn to the "naughty" children. The placement broke down following a series of incidents where Nathan was described as going from "0 to 100" culminating in hitting the family dog or throwing around the furniture.

Once again, Nathan was moved to another foster family. They put a lot of strategies in place and made some positive progress. They also magnified Nathan's strengths and supported him in following his desire to pursue mechanics and boxing. The family reported loving Nathan and feeling very bonded with him, despite there still being several outburst incidents, and occasions of him shoplifting and going missing. The foster carers described Nathan as "a bottler". They said that he would often shrug his shoulders, or say "I don't know". They described him as being "all-or-nothing", one minute saying "I don't care" and the next trashing his room.

Unfortunately, despite this being an overall positive placement and the family wanting to support Nathan, there was a traumatic family bereavement, and other extenuating circumstances which resulted in the placement ending quickly.

Due to multiple placement breakdowns, Nathan's age, and several concerns around his behaviour, Nathan was referred to a long-term children's home.

Mentionable is that Linda maintained supervised contact throughout Nathan's life, despite this being characterised by unpredictability. She subsequently had two other children who were placed for adoption. Nathan never met them, but had letterbox contact.

Questions

(Draw on this Chapter and Chapters 1–4)

i *What gaps are there in the information? The above is a snapshot, what else might be in the full-length film?*

ii *What impact might the above experiences have had on Nathan's*
- *Beliefs about himself, others, and the world, for example, "I am …", "Others are …", "The world is …", including his sense of self, self-esteem, and self-efficacy?*
- *Social and peer skills/relational and attachment styles – what might he think/have learned about relationships?*

- *Physical health, relationship to his body, relationship to his sensory world?*
- *Emotional, developmental, and social age? (How might these jar with governmental policies around 18 being classed as an adult and transition time point?)*
- *Cognitive and learning abilities/school experience?*
- *Behaviours/way of communicating, regulating, and managing difficult feelings?*

iii *How does formulating in this way support/change/strengthen your thinking about Nathan and his needs?*

iv *How might these areas/difficulties show themselves in a residential home-setting?*

v *When reading the above, what parts of Nathan's life-story struck and made an impression on you? What impact/feelings/physical sensations did reading Nathan's lived experience have on you?*

vi *What impact might working with Nathan have on you as a professional?*

vii *How might we engage and build a rapport with Nathan? What might the key areas of focus/goals be for working with Nathan? What qualities from Chapter 6 might need to be applied? What strategies or therapeutic approaches (Chapters 2–3, 6–7, 9–10) might benefit Nathan?*

viii *What strengths, skills, and resiliencies does he have which can be acknowledged and built on?*

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Chapter 12

Gang activity, antisocial, and youth offending behaviour

An attachment and trauma framework

Introduction

Throughout the literature there are multiple blurred definitions around what constitutes a gang, a group, antisocial and offending behaviour. Within this chapter, it is not my intention to navigate through these theoretical labyrinths, but rather to consider within an attachment and trauma framework some of the themes, issues, and interventions which may be applicable to children who are identified as being, or vulnerable to being, in a gang; those presenting with anti-social behaviour; and/or those who have been sentenced for an offence. Whilst for simplicity, terms such as gangs and young offenders will be used, the author acknowledges that each young person is unique within a unique context, and by no means wishes to imply homogeneity. Furthermore, the rigorous evidence base for working with this client group, although growing, is small, and often based on young males within an American and/or South African context. Although these findings can be usefully transferred, these cultural and contextual differences need to be considered with caution.

Beyond the behaviours

These young people are often negatively depicted by services, society, and the media (Box 12.1). Therefore, this chapter intends to move away from labels and stereotypes, and to instead think about presenting behaviours within a context, and to see the children behind the behaviours. This does not advocate for minimising risk, excusing behaviour, or downplaying actions, but rather focusing on how we can incorporate more trauma and attachment thinking into the responses and services they receive. This comes hand-in-hand with advocating for a more linked-up approach. I am continually amazed at how interventions and services targeting young offenders, externalising behaviour, and gangs place little emphasis on the interplaying influences of trauma and attachment; whereas adoption and Looked after Children (LAC) services, often supporting the same client groups, are dominated by these theories. This poses the question as to how these frameworks can be integrated, in order to draw on the best of both worlds and on best-practice.

12.1 Practical activity and reflection: Labels, stereotypes, and wider public messages

What emotions, labels, images, and attributions do you think of and feel in association with the words "gangs", "antisocial behaviour", or "young offenders"?

What do you think are some of the underlying reasons why a child may be part of a gang, engage in antisocial behaviour, or end up in an offending unit?

Do these reasons/understandings/perspectives differ if considering the above for a child, an adolescent, or an adult?

What feelings and thoughts might you have when hearing about a 4-year-old boy who has been physically abused and neglected? What happens to these thoughts/feelings when you hear about that same boy aged 17 who has just been arrested for a school stabbing?

What discourses and perceptions might there be around a girl who is dressed in revealing clothing? How might receiving different information about this girl adjust those perceptions, worries, conceptualisations (i.e. she was abused, she was 8 years old, she has had sex with 30 men, she was 19 years old, she was raped, she was a politician's daughter, she was an A student etc.)?*

How can these notions be used to further consider the power of language and storying? (Chapters 4, 8, and 10).

In what ways could we contribute to improving social engagement, community cohesiveness, and challenging these misperceptions? Is there a role we should or could play within wider-related areas such as the media and the arts?

Widening the focus to incorporate young women and group-think theories

Before proceeding to some of the reasons why there are strong links between relational and developmental trauma and antisocial behaviour, it seems important to widen the frame to incorporate young women. Mentionable is that adolescent girls have remained relatively unrepresented in the gang and youth offending literature; however they are increasingly being seen within services. Research suggests that young women involved in gang-related and/or youth-offending behaviours have disproportionate histories of victimisation and sexual abuse. They have also been highlighted as vulnerable to being multiply oppressed and to being sexually exploited (Grekul and LaRoque, 2011; Berelowitz et al., 2013). For example, several young women have reported being coerced into joining gangs through peer pressure, intimidated, being "beat in", or sexually groomed (Beckett and Warrington, 2015).

Chia shared how she was made to do a "naked dance" for 23 men, and subsequently forced to perform oral sex on all of them. She later told me how she had been promised to be kept safe and protected if she kept on being "a good girl".

Yasmina disclosed how she had been made to be a "honey trap" to lure a young boy into a house to be attacked. Months later, she was raped by that boy's brother as punishment for her part in his attack.

Powerfully, this world can also be seductive and appealing. Several young women have revealed how being in these relationships can have advantages and hooks. These include ensuring their safety, making them feel untouchable, raising their status, and getting them material possessions. *Tina told me how she preferred to be "tough and a bi*ch to ensure that no one else would ever hurt her again".*

Group behaviour

Group behaviour, group dynamics, and social psychology are such vast areas and are beyond the remit of this chapter, but are still important to acknowledge. Being part of a group brings about numerous complex dynamics, including re-enactments from earlier experiences of one's primary group (family), diffusion of responsibility, feeling invisible, and in-group/out-group splits (them and us). Importantly, group-thinking processes can rely on a collective brain, which may shutdown individual-thinking processes. *When exploring Lincoln's actions around an attack of a younger boy, he justified it due to higher loyalty to his older brother, it serving a worthy cause in establishing respect, and by dehumanising the boy as a "Grass who asked for it". He also minimised the outcome saying, "It wasn't that bad, we've all been there. Thanks to me at least he'll have a story to tell".*

Relational and developmental trauma and its links to gang-related, antisocial, and offending behaviour

Positive parenting experiences and having a secure attachment style have been found to be primary protective factors against the development of violent and antisocial patterns of cognition and behaviour (Levy and Orlans, 2000). Moreover, it has been posited that positive internalised parental representations provide children with a secure base for cognitive development, and the development of social cognition and social competence (Baron, 2003). On the other hand, insecure and disorganised attachment styles, like those within a relational and developmental trauma context (Chapters 1–3), have been strongly associated with the development of peer aggression, externalising, and offending behaviours (Fearon et al., 2010; Bohlin et al., 2012).

Adding weight to why an attachment and trauma framework is applicable when formulating and intervening with these clients and their surrounding systems is that there have been numerous cross-sectional, cross-cultural, and longitudinal studies carried out over several decades which have demonstrated considerable evidence of associations between witnessing domestic violence (DV), experiencing childhood abuse, trauma, and neglect, with high-risk, antisocial, externalising, and/or offending behavior (Kitzmann et al., 2003; D'Andrea et al., 2012). Studies have also shown that children who become involved in the justice system

tend to have experienced multiple types of trauma and polyvictimisation (Abram et al., 2004). Moreover, although a small proportion of the overall LAC population, statistics show offending rates for LAC are twice that of the general community. This is echoed in a disproportionate amount of care leavers being overrepresented in the prison population (Social Exclusion Unit, 2002; HM Inspectorate of Prisons, 2009). Some of the possible reasons for these are as follows:

Low Self-esteem and Negative Internal Working Models (IWMs)

For children who have had to survive and be shaped in harsh, invalidating, and unsafe environments, their relationships, parenting models, and emotional milieus have often been characterised by power, trauma, threat, pain, fear, and/or disconnection (Chapters 1–2). Concepts such as intimacy, trust, love, and dependency may have become equated with notions of danger, control, and vulnerability. These relationships inevitably impact on the developing child's core beliefs, life scripts, worldview, sense of self, organising frameworks, and representational models for their future relationships. These colour and at times permeate the way children will understand themselves, their worth in relationships, and others' motivations.

George's childhood (not neglecting the positive elements) had been characterised by violence. He regularly watched his father hurt his mother (Pina), which on many occasions resulted in her shutting herself alone in her bedroom for several days. At other times, her pain was directed at George, and she would repeatedly kick and punch him; with each cry the force intensifying. When George misbehaved, he was often told "You're just like your father", which was reinforced by other family members pointing out "You're cut from the same cloth". When George was aged five, his father was arrested for Grievous Bodily Harm. Visits were infrequent as he was moved several times for violent incidents within the prison. During this time, Pina's outbursts increased, and due to unpaid rent they were evicted. Although this is a snapshot, and offers just one facet of George's lived experience, it makes sense as to some of his deeply-held beliefs, "I'm unlovable and alone", and "Others are abusive and unpredictable". This was also echoed in his fatalistic world views, "The world has disregarded me, so I'm going to disregard the world". This was further reinforced by the systems around George sharing these negative discourses, for example, "He has no morals", "Nothing phases him", "He'll end up in prison", "He has bad blood", "He's unteachable".

These beliefs and scripts can further contribute to a child, like George, having low self-expectations, self-esteem, and poor self-efficacy, which in turn can lead to self-fulfilling prophecies such as believing that they won't amount to anything, or concluding that there is no point trying. This is significant as low self-esteem has been shown to have a strong relationship with antisocial behaviour and aggression (Donnellan et al., 2005).

Additionally, without strong early foundations (e.g. secure attachment), positive relational anchors or relational treasures (Chapters 1–2); children are more likely to have a fragile sense of self, and to be swayed or influenced by others. This may include engaging in unsafe and/or exploitative relationships. They are also less likely to have that strong inner voice of a positive internalised "parent" which helps to guide their moral compass and decision-making processes. For example, "*What would my mum think if I got arrested?"*, *"How would I feel if that was my little sister?"*, and *"How will I explain myself to my dad?"* For children who lack those relational anchors and safe havens, literature has shown that they may feel that being in a gang and/or group provides a sense of family, belonging, and of being embraced, accepted, respected, and protected (Cross Government Report, 2011). *Jordan captured this through his statements, "They are the only ones who get me" and "They always have my back".*

12.2 Reflective questions: core beliefs, relational templates, and internalised parent (Draw on ideas discussed in Chapters 1–3)

For a child drawn to gang-related activity or engaging in offending behaviour, what core beliefs might they have about themselves, others, and the world? What have they learned about doing and being in relationships? How might these have been reinforced and embedded through their life experiences?

Where did your moral compass/internalised parent come from? How did this develop? Can you think of an example when this guided you?

Reflective function (RF) and mentalising

Building on the above, parental mind-mindedness and emotional availability is of chief importance for children's development of self and interpersonal competence (Chapters 1–3 and 6). For those who have experienced relational and developmental trauma, their caregivers, due to a range of factors (i.e. interpersonal trauma, mental health difficulties, and drug dependency), may have been absent-minded, shut-off, or unable to parent-mindfully. Therefore they would have been shaped and enveloped in relationships characterised by limited RF, emotional unavailability, incongruent mirroring, chronic misattunement, and dyadic dysregulation. See Chapters 1–2 for extensive examples.

Taryn tripped-up and was told "Get-up you pathetic little creature". She was subsequently hit over the head for being "clumsy".

Nahla was sent home from nursery school with tonsillitis. She was left unsupervised with no antibiotics or comfort.

Ben told his mother that he was sad after coming last in the school race. His mother smiled, rolled her eyes, and said, "Snap out of it, it's not a big deal, you obviously didn't try hard enough".

Pablo was asked about his 3-year-old son's personality, likes, and dislikes. He answered "He's the same as all little kids". With prompting he responded, "I guess he likes to play".

Therefore, these children have not had the same opportunities as others to be able to develop key emotional, relational, and developmental skills (e.g. empathy, kindness, and perspective-taking). This is exacerbated by functioning in survival FFF mode (Chapter 3). Several studies of children who have experienced complex trauma have shown differences in their empathy, cause-and-effect thinking, conflict resolution, prosocial orientation, RF capacities, cognitive flexibility, perspective-taking, theory of mind, ability to read emotional cues, and mentalisation skills. This is significant, as these skills form the cornerstone of interpersonal relational skills and guide emotional, social, and behavioural responses; including regulating emotions, managing impulses and stressors, sustaining and forming attachments, engaging in prosocial behaviours, and developing the understanding of internal states and others' intentions (i.e. empathy) (Fonagy et al., 2002; Tucker et al., 2005; Eisenberg et al., 2006).

For example, being able to understand, accept, and express empathy requires multiple skills; one needs to be able to *cognitively* perceive and decode another's emotional state, then to *emotionally* feel and connect with their emotional state, and then to *behaviourally* take an action (Decety and Jackson, 2006). The lack of these skills can shed some light as to why some children may engage in risky or aggressive behaviours; and this is echoed in studies of young offenders who show significant deficits in their capacity for mentalisation (Moller et al., 2014).

Consider what the consequences might be for Gavin who struggles to perspective-take. What about for Callum who never learned how to effectively regulate his emotions? During a "typical tantrum", Callum would either be laughed at or hit, and later would see anger modelled by his father through drinking alcohol, and/or hitting his mother. If a child has not been taught these skills, how do we expect them to be able to respect legal and societal rules and considerations?

Emotional regulation and window of tolerance

These children have often not had the opportunities to learn healthy ways of expressing themselves, managing high arousal, and tolerating a range of emotions (Chapters 2–3); and so can present with a poor ability to self-regulate, process, and modulate affect and sensory stimuli (Warner and Koomar, 2009). Therefore, we often see these children showing changes in the way in which they regulate their stress systems, with their systems either being chronically elevated, over-expressed and up-regulated, or chronically suppressed, under-expressed, and under-regulated (e.g. shutting off, blocking out, or dissociating) (Gunnar and

Fisher, 2006). Bowlby (1980) described this phenomenon by stating that the child either shrinks from the world or does battle with it.

Children are often left without the presence of a safe regulating adult in an overwhelming sea of emotional, sensorial, and physiological waves (Chapters 1–3). This means they are likely to have been left in highly-activated fear and rage systems with few coping strategies available to them (persistent fear and with no solution). This results in them forming a sensitive defence system as their FFF responses (Reptilian and survival brain) have been overused, like an overly-exercised muscle or a constantly triggered burglar alarm. This offers an explanation as to why these children often have a preoccupation with detecting and surviving threats, and are more easily triggered. This also gives weight as to why some children who have experienced complex trauma can become over-sensitised, hypervigilant to threat, have a lower window of tolerance (Siegel, 1999), and an out-of-sync emotional equilibrium (Chapters 1–3). In essence, they have a lower threshold for high-intensity emotions, and are slower to return to what is often a heightened baseline. Therefore, a small drop of an emotion can feel to them like a drowning all-consuming sea (Chapter 3). Interestingly, studies have shown that children exposed to family violence show a similar pattern of activity in their brains as shown in soldiers who have been exposed to combat. Examples follow but are built on in Chapter 3.

Daniel had been so hurt and had felt so ignored that he survived through cutting himself off from his feelings. He depersonalised and switched-off from others' pain. In a victim statement, the lady Daniel had hurt had reported him as "Being dead behind the eyes". Daniel found connecting with others' vulnerability too painful, and re-triggering of his own vulnerability, so responded by going into fight mode, or by finding other ways, such as taking drugs to forget the past and get rid of intolerable feelings.

Cameron, aged 12, would have extreme physical outbursts lasting for up to two hours. His foster carers described him as "Jekyll and Hyde", and how they had to "walk on eggshells", to avoid a fiery rage. Due to earlier experiences of violence, abuse, unpredictability, and feeling utterly powerless, Cameron had developed a highly-attuned antenna for danger. This meant he often misread incoming cues (i.e. a neutral face) as threats, and with "small" triggers such as a stare or the sound of the doorbell, could be catapulted into a primitive "over-reactive" state.

Moreover, difficulties with regulating one's emotions have been linked to problems with low self-control (i.e. being impulsive, reactive, defensive, emotionally charged, taking risks, having a low tolerance for frustration, and being short-sighted). These children often lack the "internal maps to guide them", are driven by cascading out emotions, and "act instead of plan" (Streeck-Fischer and van der Kolk, 2000, p. 905). This is key as low self-control has been evidenced as a risk factor of offending behaviour (Mullin and Hinshaw, 2007; Wikström and Svensson, 2010), and linked with poor choices to social dilemmas and poor long-term planning skills (Fisher et al., 2008). These are likely to be exacerbated within the

context of an absent/negative internalised parent, hierarchical boundaries having been violated, and associated cognitive difficulties (e.g. difficulties with problem-solving, cause and effect thinking, and attention) (Chapters 3 and 9).

Hostile Attribution Bias

Research has also shown that children who have experienced complex trauma tend to struggle with differentiating facial experiences, and are more likely to interpret events and faces as being angry and threatening, and subsequently have stronger emotional reactions to negative facial expressions (Perlman et al., 2008). This is sometimes referred to as Hostile Attribution Bias, where a person will assume that another person has an intention to harm/wrong them, meaning that "normal/benign" behaviours can be perceived as hostile or aggressive. These difficulties can be intensified by emotional regulation and cognitive difficulties. *When accompanying Fiona to college, she was accidently pushed by an elderly man due to the busy rush hour streets. Fiona attributed this to being deliberate and attacking, and therefore responded as such*. These face and mind-reading difficulties have been echoed in studies of offenders' emotional responses, including demonstrating their increased struggle in recognising fear on others' faces (Munoz, 2009).

Social Learning Theory

Familial inter- and multigenerational criminality and gang membership are thought to be significant variables which push children into gang culture (Miller, 2001). For some, it is strongly weaved into their family fabric, and they have been reared in situations where violence and anger was the common language or observed way of managing things. They most probably had limited access to positive role models, demonstrations of positive conflict resolution or problem-solving skills, and modelling of prosocial behaviours/codes of conduct. Often they would have been exposed to antisocial behaviour and unhealthy messages, which may have been reinforced or rewarded. These can be powerfully influenced by dominant discourses, including those around masculinity, what being strong looks like, and, the dangers of showing weakness etc. Whilst reading the following examples consider: *What would these children learn about feelings, behaviours, and rules?*

Jonah came home from school and shared a story of another boy pushing him, his father responded by pushing him against a wall and saying, "Next time you fight back you weak little girl". The next day, Jonah's brother reported getting into a fight and winning, their father beamed with pride and gave him a high-five.

Jessica's mother was disconnected and emotionally unavailable. The only way Jessica could get attention was when she upped the ante, and magnified her behaviour, i.e. throwing items, smashing doors, and screaming.

Manny's father David got a verbal police warning for getting into a physical altercation in a pub. Later that night, when Manny and he walked home, David spotted a police car, which he keyed.

Mason watched from the back seat of the car, his dad stealing an 83-year-old lady's handbag. Later, Mason witnessed his dad retelling and celebrating the day's success with a group of friends.

Within this, many of these children would have been raised with a lack of boundaries and parental supervision, limit-setting, and monitoring. The discipline they received often would have been inconsistent, disproportionate, of a harsh nature, or given from a dysregulated caregiver. For example:

Harry hit his brother repeatedly with a frying pan, his mother said nothing and looked away, whereas the next day, Harry by accident spilled some milk, which resulted in his mother violently beating him with a chair.

Maia went uncorrected by her uncle after shouting racial abuse at a bus driver, and instead was given permission to go that night to a friend's party.

Social ties

As shown, many of these children would have experienced weakened social bond, social ties, social integration, and would have been exposed to wider factors, such as community violence. Taking school as an example (Chapter 9), there is an increased amount of truancy, heightened school exclusion, and higher rates of school disengagement within this population. According to the theory of age-graded informal social control (Sampson and Laub, 2005), the occurrence of these weakened social ties is linked to increased crime rates. For instance, being in a gang may serve functions which children perceive to be unattainable or lacking in other societal means or within their own families (i.e. money, status, attention, respect, etc.). Within this, research has shown a relationship between social-disadvantage/socio-economic status, and higher crime rates and externalising behaviours. These are not direct cause and effect claims, and need to be considered within the complex interrelationship of various individual and community factors.

Adolescence

Adding to the complexity is that the majority of young people this chapter refers to fall within the adolescent developmental stages, which comes with its own unique set of challenges (important to be mindful of cultural differences of "adolescence" and the impact of complex trauma on children's developmental trajectory). The "normal" adolescent brain experiences fluctuations in numerous chemicals, including dopamine (the "feel good" hormone and reward-trigger) and serotonin (helps to control impulsive behaviour). Additionally, adolescents primarily work from the limbic system (emotionally driven) as opposed to their cortex (thinking brain) (Chapter 3); and have a decrease in activity in the amygdala (involved in the avoidance response to danger or threat). These structural and functional changes can make registering negative outcomes seem less aversive or threatening to adolescents, and can make adolescents more prone to risky behaviours, impulsivity, engaging in experimentation, novelty-seeking, and highly-stimulating experiences (Romer et al., 2010).

These are further compounded with other stages of adolescence, such as an increased need to identify, belong, and fit in with peers, exploration of their identity and sexuality, and separation from their parents as they become more autonomous, and transition to adulthood. These alongside other factors offer some explanation as to why adolescence is a time of increased risk (e.g. sexual exploitation, grooming, self-harm, eating disorders, misusing substances etc.). Mentionable here are the modern dilemmas which vulnerable children face who live in a world consumed by social media. Examples follow:

Troy was found posting "how to hang yourself" links onto other children's Facebook pages.

Jayla was pressured into posting naked pictures of herself, and later had a sex video put up on YouTube as retaliation for breaking up with her boyfriend.

Tyrese boasted about the number of hits he had received from viewers liking his video of a street fight.

With this said, whilst adolescence is a period of increased risk, it also promisingly represents an important window of opportunity, as it is a critical sensitive period for change and brain re-organisation (Wekerle et al., 2007) (Chapters 3 and 5).

Community and early intervention approaches

Having considered some of the reasons for a more attachment and trauma-informed approach, this chapter will now go on to explore some of the obstacles within the system, and then some of the available community, early intervention, and individual therapy approaches. These however should be viewed within the context of other therapeutic approaches available to children who have experienced relational and developmental trauma (Chapter 7). Lastly, some practical tools and therapy stages will be demonstrated through a case study.

Obstacles within the system

Intervening with children who present with antisocial behaviour and/or offending behaviour is further complicated by a range of systemic and organisational factors. *As you read the following points, consider how they fit with your or your organisation's views. What might some of the hazards of these factors be?*

- A predominant focus on risk, behaviour, and reduction of offending. These areas are of course important, but may be neglectful of other fundamental factors such as trauma and attachment. This tunnel vision can shut down feelings of empathy and narrow the processes needed to unpick what behaviours are communicating (Chapters 2 and 9), and to see the child behind the behaviours.
- A societal (varies amongst cultures) assumption that adolescents are more resilient, should know better, are more able to make their own informed choices, and are more able to protect themselves than younger children.

- The legal/service systems often not fitting with therapeutic perspectives. For example, viewing 18 years old as the child cut-off and transition to adulthood. This jars with well-evidenced theories of the impact of trauma and disrupted attachments on children's development (Chapters 1–3) and often leaves children falling through the gap, or having unmet needs. This also is one of the reasons I have intentionally referred to this client group as "children" throughout this chapter.
- By the time these children have reached their adolescence, they often have had longer histories of service involvement; are more likely to have trickier relationships to "help", more deeply embedded difficulties, and an alphabet soup of diagnoses (e.g. Oppositional Defiant Disorder, ADHD, Conduct Disorder, and Antisocial Personality Disorder). There may also be higher incidences of multi-factorial difficulties including alcohol/drug-use, mental health, and social difficulties (e.g. housing, placement breakdown, and schooling). Therefore, these require multi-factorial responses, and highlight the importance of proactively addressing disengagement and service accessibility.
- With some exceptions, the majority of interventions targeted to this client group were initially designed for either a child or adult population, and then applied to adolescents, which raises questions of transferability and applicability to the unique challenges and needs of adolescents.

Early intervention

Criminal and/or antisocial behaviour is generally a result of synergistic interactions amongst factors. Therefore, interventions need to look at both reducing risk factors and at improving positive factors on an individual, family, and wider community level (Chapter 4). This includes intervening at different time points across the spectrum. Preventive, proactive, and early intervention approaches aim to catch things early, reduce escalation, and build on protective factors, for example, by making schools more attachment and trauma-informed (Chapter 9) by increasing resiliency, community bonding, and emotional well-being programmes, by improving neighbourhood environments, by supporting at-risk pregnant women, and by embedding a therapeutic re-parenting culture into wider systems (Chapters 4 and 6).

This might include intervening at significant transition times or turning points, like during high-risk pregnancies, school moves, for those with high-rates of school truancy, and/or at their first service contact (e.g. incidence of petty crime/first time arrested). These could be extended by increasing national support, training, and interventions specifically designed around adolescence and "parenting adolescents".

Linked-up services

These children need a Team around the Child, Family, Worker (TAC/F/W) wraparound service which includes being embedded in safeguarding communities and

for the TAC/F/W (e.g. family, police, youth workers, CAMHS, schools, children's services, and youth justice), to work together as a multi-agency team, delivering coordinated support packages.

This also will enable the system to form a web of support and safety net around the child, whilst tracking, communicating, and having an overview of the local criminal/vulnerable children activity and landscape. This also allows for ideas and resources to be pooled, the organisational dynamics to be considered (e.g. reducing the likelihood of splitting), and a reduction of the likelihood of missing gaps or repeating work.

Interventions

Given the complexity and multi-factorial nature of this client group, it seems crucial to draw on a more integrated, multi-pronged, cross-disciplinary approach which interweaves a range of theories and perspectives.

How can we draw on expertise in risk management, behavioural approaches, theories around offending behaviour, and experience with the youth justice system, whilst still considering theories of trauma, mentalisation, emotional regulation, neuroscience, body-based, sensory integration, strengths-based and attachment approaches and perspectives?

An array of these holistic approaches is detailed in Chapters 3, 7, and 10, therefore will not be discussed here. However, worth mentioning are some common approaches/frameworks for this client group which include:

- *Adolescent Mentalisation-Based Integrative Therapy*
- *Cognitive Behavioural Therapy and Dialectical Behavioural Therapy*
- *Schema-Focused Therapy*
- *Narrative Therapy*
- *Motivational Interviewing and Solution-Focused Therapy*
- *Multi-Systemic Therapy*

An eclectic approach will be discussed in the following case study. This will highlight some of the main areas of the intervention, and try to name some of the practical tools employed. As with all cases, it is advocated for a multilayered assessment (Chapter 5) to be carried out, which looks beyond the behaviours and takes into account 1) an attachment, relational, and trauma framework, 2) wider familial, societal, and systemic context, 3) the child's chronological, social, and emotional age, 4) life experiences which may have impacted their developmental trajectory, 5) their strengths and protective factors; and 6) other compounding factors, such as in-utero exposure, EF, learning disabilities, speech and language, and sensory-processing difficulties.

Figure 12.1 Trapped and attacked internally and externally.

A snapshot case study

Fourteen-year-old Chris repeatedly got into arguments at home, on the streets, and at school. He had been moved from placement to placement (Chapter 1), with each one breaking-down due to violent, aggressive, and dysregulated incidents (e.g. biting his foster carer's ear and throwing a chair through a window). One would only have to make an undesirable utter, or a quick look, to catapult Chris into fight mode (Chapters 1–3).

Chris's world seemed to be like a combat zone, everyday filled with new threats. Like a soldier, he constantly seemed to be anticipating an attack and was ready for action, but in his case he lacked the control, training, or safe base of a soldier. The relational and developmental trauma from his childhood (details not described here) seemed to continually play out, like a war in his head, and this was outwardly reflected in his ongoing conflict with others. When in these throws of rage, he seemed addicted to the adrenaline buzz, a mode he had been habituated in as a child.

Exerting control and fear in others seemed to be his way of trying to counteract past feelings of powerlessness and helplessness. This fitted with his life mottos of "Better to hurt than be hurt, and better to be feared than to be fearful". He had become the shark to survive the shark-infested waters (Chapter 1). For those around Chris, it became increasingly difficult to connect with the little boy behind the aggressive behaviours. He had sadly learned that the best way to protect himself and keep himself safe (e.g. running away, getting into fights, avoiding conversations by putting on headphones when adults were talking to him etc.) was to keep others at a distance, put up spiked walls, and wrap himself in heavy armour.

TAC

Not described here but importantly a large part of the work involved working effectively and collaboratively with the TAC. This included at multiple levels from information-sharing and risk-planning, to further understanding Chris's behaviours as communication, to reflecting on and processing some of the difficult feelings evoked and values challenged by supporting Chris. Examples of working with the system to become more attachment and trauma aware are described in Chapters 6–9.

Individual sessions

The intervention was underpinned by attachment and trauma principles, with the frameworks described in Chapters 1–4 being drawn on. In order to connect with Chris, maintain empathy, respect and see past his survival strategies, and to give him a different experience of being held in mind within a safe relationship, the therapeutic re-parenting qualities explored in Chapter 6 were employed.

Engagement

Chris understandably presented with a complex and mistrusting relationship to help. This meant that *establishing rapport and building trust* through the *therapeutic relationship* (Chapters 6–7) was particularly important. This also meant that many of the sessions took place out of the therapy room (street therapy) talking about topics which Chris enjoyed and found safe to discuss (e.g. racing, play station, and graphic design). Ample time was spent *myth busting* and exploring Chris's *hopes, worries, expectations, and negative perceptions* about psychologists.

To avoid past feelings of powerlessness, and Chris feeling that things were being done *to* him as opposed to *with* him, he was very much in the *driving seat*, steering the pace and content of the session; he was also encouraged to give

honest *feedback*. This was echoed in ensuring that I was actively "thinking-out-loud" and being as transparent as possible. *Motivational Interviewing and Solution-Focused* questions, alongside creative means and metaphors (e.g. a time machine and race track), were used to establish his *goals and ownership* of the therapy process.

Sessions considered Chris's learning style/preference, which magnified the importance of using a *range of mediums and communication techniques* including visual prompts, art, music, videos, and worksheets.

Grounding and regulation

Chris was supported in connecting with a *safe place*. Within sessions, he painted this using spray paint onto a large canvas, and also wrote a safe place rap which he recorded onto his mobile. A range of other *regulating exercises* such as *positive self-talk, a sensory box, and muscle tension and relaxation techniques* were introduced, reviewed, and practiced. These were then visually incorporated into several laminated copies of a *safety plan, a coping card, and due to Chris's love of computer games and TV, into Chris's remote control of strategies*.

Triggers

Using a range of physical and creative means, Chris was able to identify his *multisensory* including *body-based* triggers (Chapters 3 and 9).

He was encouraged to think, reflect, and record about, *What happened when these occurred, what they looked like, what their impact was, what his relationship to them was, and how he could reduce and take control over them.*

Strengths and externalising conversations

Different techniques were used to identify, acknowledge, and build-on Chris's strengths (Chapter 4). These included:

1. Making an "I am proud" collage.
2. Engaging in meaningful strength-building activities, such as joining a music group, and getting work experience with a tattoo artist.
3. Sculpting of all of the different parts of himself.

To complement these, a range of *Narrative Therapy Techniques* (Chapters 4, 7, and 10) was used, particularly *externalising conversations*. Chris was supported

in naming and creating/drawing/sculpting a character for the rage/violence. He named this "*The lava*", as it "was hot, quick, dangerous, and in a weird way beautiful".

Questions on "The lava" included:

> ? *When did "The lava" first appear in your life? Was "The lava" around in your family? What purpose did "The lava" serve for you back then? In what ways did "The lava" help you?*
>
> *How does "The lava" affect you and your life now? What does "The lava" stop you from doing/getting? What's "The lava's" cleverest trick or superpower?*
>
> *If "The lava" were to pack his bags and leave, what would you miss about him? What have you learned from him that can be useful in your life? Have you ever managed to deal with a conflict in a different way, without "The lava"? If so, how?*

These discussions were extended further through making links and identifying Chris's *protective/survival strategies, relational scripts, and core beliefs* (Chapters 1–3). These were explored further through *metaphors* such as the *spiked walls and combat zone* discussed earlier; and linked to *psychoeducation* around trauma, anger, FFF, Hostile Attribution Bias, window of tolerance etc. Throughout, these factors and lived experiences were discussed within *a wider societal and community context* (e.g. community violence, financial hardship); as well as exploring the influences of *stereotyping and pejorative language*.

Problem-solving and identifying links

Chris was supported to *differentiate thoughts, feelings, and actions*, and in order to deconstruct the various steps and chain of events was encouraged to *stop, think, plan, and reflect* on frictional situations/life stressors.

Some questions included:

> ? *What emotional needs were you expressing through your behaviour? What other ways might there be? What were the negative consequences of that situation?*
>
> *What could you do more if you were in charge of your emotions? If you had a time machine, what would you have done differently?*
>
> *How would you like someone to respond to you in a conflict? How do you know you're being listened to and heard? Can you recall an example of when this happened, what did it feel like emotionally, cognitively, physically? What might have to change for you to be able to listen and be heard?*

We subsequently *role played* different scenarios, made *paper chains* to illustrate the sequence of events, drew *comic-strip* conversations, and used *sentence completion* tasks, *speech bubble* exercises, and *domino* games to expand on these ideas.

> *Questions around role models, popular media, and inspirational figures were also incorporated such as, "Who do you know who was good at resolving conflict?", "If … met you, how would you like them to be able to describe you?" This also informed an added component of linking Chris in with a local reformed gang leader who ran a series of community projects.*

"Feelings work" exercises from Chapter 2 were used, as well as some *social accountability and restorative justice-type questions*. Chris was encouraged through mentalisation ideas to see himself from the outside, and others from the inside.

Future-thinking

A thread running through the whole intervention was holding the hope and envisioning and believing a different future for Chris. This was interwoven with a gradual reflective ending, which was enhanced through making a therapy blueprint, writing a take-back practice letter (Chapter 4), and making a past, present, and future painting.

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