Foundational theories and knowledge Trauma Practice Paper

1. Introduction

The purpose of this practice paper is to provide Department for Child Protection (DCP) case workers with a comprehensive understanding of trauma as a foundational theory of quality child protection practice. Particular attention is given to early childhood experiences and how trauma can shape the brain and affect functioning across the lifespan.

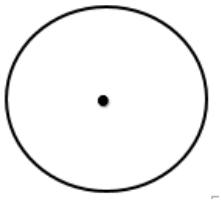
This practice paper should be read in conjunction with the Trauma Lens Practice Paper which focuses on understanding the impact of trauma on families, caregivers and staff. This practice paper uses the language 'caregiver' to refer to parents, carers and any other adult caregiver.

2. Trauma defined

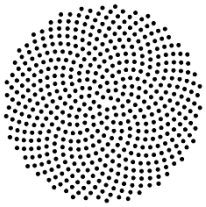
Trauma refers to the harm caused by experiencing an event or situation that overwhelms a person's capacity to cope. The experience of trauma can produce psychological and physiological effects, caused by the heightened stress experienced when encountering threats to physical and/or emotional safety. These threats can be real or perceived, meaning that just the expectation of harm can be traumatic if the experience overwhelms the person's capacity to cope. People can also experience trauma when the harm or threat of harm is directed towards someone else.

There are several types of trauma and many of the children, young people and families who come into contact with the child protection system will have experienced multiple types.

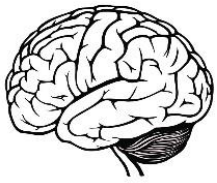
2.1 Types of trauma



Simple (or single incident) trauma involves exposure to a single traumatic event. Typically, this traumatic event does not occur within the context of a significant relationship, meaning the trauma was not caused by someone the person has a close relationship with, such as a family member. Examples of simple traumas include serious car accidents or nearly drowning.



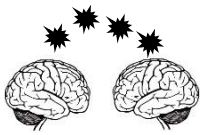
Complex trauma involves exposure to multiple traumatic events or prolonged exposure to a chronically harmful environment. Complex trauma occurs within the context of a significant relationship, for example when a child is harmed by their caregiver or when a woman is subjected to domestic and family violence by her partner. Physical abuse, sexual abuse, chronic and severe neglect and emotional abuse (including exposure to domestic and family violence, serious caregiver mental health difficulties or problematic alcohol and other drug use) can result in complex trauma.



Developmental trauma involves exposure to traumatic events during critical stages of development in early childhood. Developmental trauma can have significant effects on development across all domains, including cognitive, physical, emotional and social development, language progression and adaptive functioning. These effects can be exacerbated if the trauma occurs within the context of a caregiving or significant relationship. Developmental trauma can also be complex trauma.

Intergenerational trauma involves the transmission of trauma from older generations to younger generations. This can occur when trauma remains unresolved and continues to adversely affect a person's functioning into adulthood, including their mental health and parenting practices, which then affects other people around them including their children. Children and young people can experience intergenerational trauma by witnessing the maladaptive behaviour of older generations who have been affected by trauma and being parented by people who have experienced trauma.

Intergenerational trauma as a result of the Stolen Generations, colonisation and institutionalisation has significant implications for Aboriginal children and young people, families and communities. Many Aboriginal families continue to feel the impact of pain and grief associated with loss of family connections, a sense of identity, traditions, cultural knowledge, language, connection to land and spirituality. The ongoing impacts on Aboriginal people and families are reflective of intergenerational trauma and many Aboriginal communities have a collective sense of suffering due to current and historical trauma. Despite the impact of these experiences, many Aboriginal people and families have significant resilience and do not present with difficulties associated with intergenerational trauma. This highlights the importance of recognising that impacts of trauma are not the same for all Aboriginal people and the strengths that exist for individual people, families and communities. Please refer to the Aboriginal and Torres Strait Islander Child Placement Principle Practice Paper and the Family Led Decision Making for Aboriginal Families Framework for more information.



Vicarious trauma involves indirect exposure to a traumatic event or events that overwhelm a person's capacity to cope and/or causes a detrimental change in the way the person views the world. A caregiver becoming overwhelmed by distress or fear when listening to a child in their care talk about trauma they experienced or a case worker becoming distressed by a victim's experiences by domestic and family violence are examples of vicarious trauma. Symptoms of vicarious trauma can mirror symptoms of direct trauma. Vicarious trauma is different to compassion fatigue, which is the experience of emotional exhaustion that results from frequent caring for/about others in distress.

3. The impact of trauma

Trauma can have both neurological and psychosocial impacts. Neurological impacts include cognitive and developmental delays, memory problems and changes to brain functioning that cause physiological difficulties (such as a heightened startle response, sleep disturbance, and/or a sense of restlessness or anxiety that results in repetitive or unintentional movements). Psychosocial impacts include emotional and behavioural difficulties, interpersonal and social problems, intrusive thoughts or memories, mental health difficulties and in severe cases, personality disturbances. The development of maladaptive coping

strategies, such as alcohol and other drug use or self-harming behaviours, is also common following trauma. The experience of trauma has also been associated with a range of health concerns, including physical injuries and chronic health conditions.

Trauma can have both short- and long-term effects. Common short-term impacts may include recovery from physical injuries that resulted from the trauma, sleep disturbance, intrusive thoughts or memories of the traumatic event, confusion, a heightened startle response and feelings of anxiety or fatigue. Where a person's coping strategies are overwhelmed or ineffective, impacts can be experienced in the longer term and may impact on attachment and other significant relationships, parenting, mental health, developmental progress (for children and young people) or cognitive functioning.

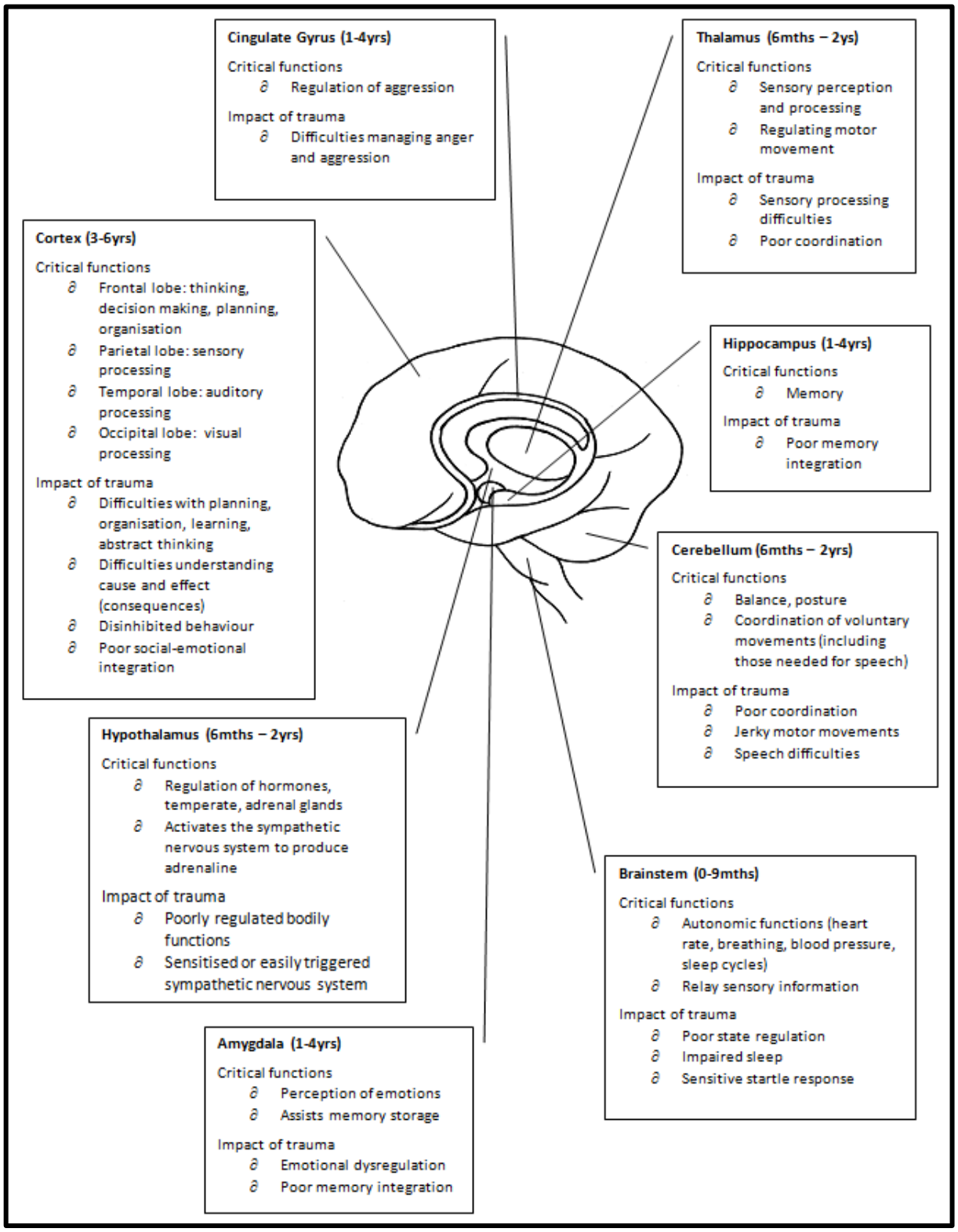
The severity of impacts of trauma can be influenced by many factors, including the age at which the trauma occurred, the chronicity and severity of the trauma and whether or not the trauma occurred in the context of what should be a safe relationship. The presence or absence of protective factors is also important, such as a nurturing family environment, consistent primary caregivers and associated healthy attachment relationships, strong connections to community and culture, stable housing and access to health care and support services. The availability and immediacy of therapeutic support, provided either by professional services or trauma-informed caregivers, can also moderate the impact of trauma. It is also important to note that people can respond to trauma experiences in different ways which may mean that people who have experienced similar events will not necessarily respond in the same way (including siblings).

Trauma and the brain

Infants and young children are highly vulnerable to the adverse effects of trauma. Because their brains are rapidly growing and being shaped by their experiences, exposure to trauma can significantly influence the development of an infant or young child's brain. Also, because infants and young children are entirely dependent on their caregivers for survival, they are incredibly vulnerable to complex trauma if harm occurs within the context of what should be a safe relationship. Infants and young children in critical stages of brain development are particularly vulnerable to neurological and psychosocial changes which reflect the trauma to which they have been exposed.

Children and young people's brains develop sequentially from the lower, more primitive areas of the brain responsible for our basic regulatory functions and survival to the higher, more complex and advanced areas of the brain responsible for executive functions such as thinking, planning, organising and problem solving. Each area of the brain has a critical period for development, which is the time when that area of the brain is more receptive (or vulnerable) to experiences and undergoes rapid development. Because the brain develops in a sequential and hierarchical way, disruptions to the development of lower areas of the brain can affect the developmental potential of higher areas of the brain and may inhibit the overall growth of a child or young person's brain. While the brain can continue to grow and develop into adulthood, the neural connections that develop during critical periods and which are shaped by our experiences can be more difficult to change or 'override' with new experiences as we age.

The following diagram offers an overview of the sequential development of the brain and how trauma at different ages can affect development.



NB The ages in the diagram above refer to the sensitive period of development of that area of the brain

Trauma and perception of threat

Trauma not only affects the way the brain develops, it also changes how it responds to perceived threats. When feeling calm and safe, people are able to access the more complex structures of the brain that are responsible for planning, organisation, problem solving and reasoning. People's sense of time is extended and they are able to think about the future with clarity and consideration. When in this state people are able to respond, rather than react, to their environment. Conversely, when in a state of fear, people become reactive and rely on automatic behaviours as the more primitive areas of the brain that are responsible for survival become more active. This is known as a 'fight/flight/freeze/fawn' response. Fight and flight responses (which include arguing or becoming aggressive and leaving or avoiding a situation respectively) are considered hyper-arousal strategies. Freeze responses include ceasing to respond (or even dissociating) in an attempt to reduce the likelihood of further targeting or escalation and fawn responses (more often seen in response to chronic trauma) include attempts to placate perpetrators of trauma are considered hypo-arousal strategies. When in the 'fight/flight/freeze/fawn' state, sense of time becomes contracted with a focus on the immediate future as it relates to safety.

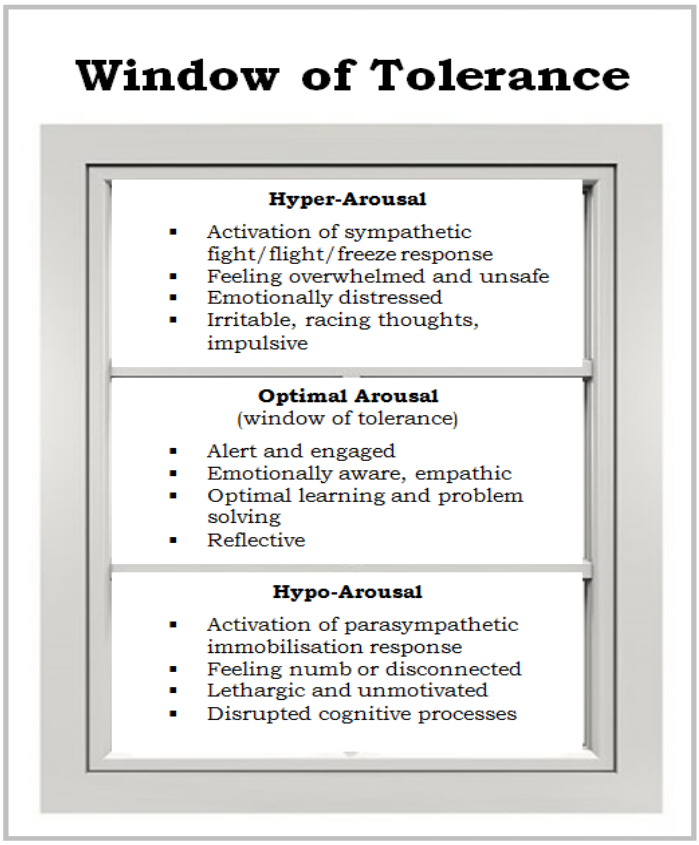
On a physiological level, when a person perceives danger, the amygdala sends out a distress signal to the hypothalamus (control centre), which then activates the sympathetic nervous system to respond to the threat, and all resources (cognitive and physical) are re-directed for this purpose. When the danger has passed, the hypothalamus activates the parasympathetic nervous system to help the person calm down and return to a state of homeostasis (balance within the body).

The amygdala helps to store memories of events and emotions to assist with recognising and responding to similar events in the future. People who have not experienced trauma will usually only move into 'survival' mode (fight/flight/freeze/fawn) when real danger presents itself and can quickly return to calm when the danger passes. However, exposure to chronic stress or trauma can result in a person moving into survival mode more quickly or easily, and can interfere with their ability to return to a state of calm. Put another way, with chronic exposure to trauma comes an increased and ongoing activation of the amygdala, which then becomes highly sensitised to signs of threat in the environment. When the amygdala is constantly activated by fear it can begin to associate non-harmful events, people and places with fear. The hippocampus (responsible for memory) is also affected, which interferes with the ability to discriminate between contexts, and can lead to perceiving threats where none are present.

Children and young people who have experienced developmental and/or complex trauma and whose sympathetic nervous system (stress system) is constantly activated can become 'stuck' in heightened states of arousal and fear, leading them to become hyper-vigilant to threats and preoccupied with ensuring their safety. As a result, any changes in the child or young person's environment can be perceived as threatening which can evoke a 'fight/flight/freeze/fawn' response. Children and young people who experience this level of arousal and fear can also experience developmental consequences as they are often so preoccupied with their immediate safety that they are less able to be engaged in their environment. They can struggle to play, concentrate, develop attachment relationships, relate to others and learn which has detrimental effects on their broader development (refer to the Child and adolescent development Practice Paper and Attachment Practice Paper for more information).

Window of Tolerance

Another way of understanding the impact of trauma is by looking at the "Window of Tolerance"[1] model. The Window of Tolerance refers to the amount of stress (arousal) that a person can manage before becoming overwhelmed. When people are functioning within their window of tolerance, they are calm and alert without being anxious. They can also think clearly, respond rationally, learn accurately, perceive and respond to other people's social cues, and regulate their emotions. However, when overly aroused, overwhelmed or highly stressed, people can move outside of their window of tolerance. Once outside their window of tolerance, people can experience fear and their brains and bodies move into survival mode. Refer to Window of Tolerance diagram below.



People who have had developmentally and culturally enriched childhoods and few experiences of trauma tend to have a large window of tolerance. When they experience stress or distress, they can generally manage those feelings without becoming overwhelmed most of the time. Conversely, people who have experienced developmental, complex or intergenerational trauma may have a narrow window of tolerance, such that minor stressors can exceed their capacity to cope and may overwhelm them.

[1] The "window of tolerance" was coined by Daniel Siegel in his book "Mindsight".

Internal working models

Internal working models are the templates or beliefs developed about oneself, relationships and the world. The development of an internal working model is a significant developmental task for children and young people. Children and young people's internal working models are strongly affected by their attachment relationships (see the Attachment Practice Paper) and their experiences of trauma. That is, infants and children's experiences of their attachment figures and of trauma impact on how they see themselves, how they understand relationships and how they perceive the world in general.

Children and young people who are raised in safe, nurturing, enriching and culturally strong environments are more likely to develop healthy internal working models. Their experiences lead them to view themselves as lovable, competent, worthwhile, valued and safe, and to develop a strong sense of identity and belonging. Their positive relationships with their attachment figures will lead them to see relationships as safe, consistently available, nurturing and responsive. Their positive experiences in their caregiving environments assist them to see the world as safe, rewarding and enjoyable. Conversely, children and young people who experience complex, developmental or intergenerational trauma may be more likely to develop unhealthy internal working models. Their negative and traumatic experiences lead them to view themselves as unlovable, unwanted, incapable, unsafe and devalued, and not have a sense of belonging. Poor quality or traumatic experiences within relationships will mean that they may understand relationships to be unsafe, unresponsive, unavailable or inconsistent, and incapable of meeting their needs. Children with negative experiences in their caregiving environments will form the view that the world is unsafe, unrewarding, dangerous and frightening. The longer a child experiences abusive or poor quality caregiving, the stronger their negative beliefs about themselves, relationships and the world are likely to be. This means that negative internal working models will persist even when children or young people are placed in safe, nurturing and responsive care environments. It may take many, many positive experiences and considerable time for a child or young person's internal working model to become more positive.

Children and young people tend to behave in ways that reflect their internal working models. If a child or young person believes themselves to be bad, they may behave in ways that are consistent with that belief. For example, they may behave aggressively, become argumentative, steal, lie and/or engage in anti-social behaviour. If a child or young person believes that relationships are not safe or reliable, then they may try to keep others at a distance, reject others' attempts to care for them, or behave violently to prevent others from getting close to them. If a child or young person believes that the world is dangerous, they may either withdraw from the world in an attempt to stay safe or connect with others who are more powerful (and often dangerous) in an attempt to keep themselves protected. This must be considered when making assessments about children and young people's safety (refer to the DCP Assessment framework for staff).

Children and young people who have unhealthy internal working models of themselves and relationships are also more vulnerable to exploitation and seeking connections with and validation from others in unsafe ways. These children and young people are also more susceptible to experiencing mental health difficulties and developing maladaptive behaviours, such as alcohol or other drug use or self-harm, due to the poor views they have of themselves and their inability to seek assistance and care from others to help with their overwhelming negative feelings. Refer to the Supporting children and young people in care with high risk and complex behaviour Practice Paper.

Memories

Memories of traumatic events can also adversely affect a child or young person's functioning. Memories can be stored in multiple ways in the brain and body. Implicit memories are non-verbal memories that are often created from physical and sensory experiences. These memories are believed to be stored in the lower areas of the brain (brainstem, diencephalon, cerebellum and limbic system). Implicit memories can include memories of how things are done, or 'procedural memory', such as riding a bike, and are often recalled unconsciously. For example, the sound of a particular song might bring back fond memories of a certain family member or event. Explicit memories are those that people are consciously aware of. Explicit memories involve semantic memory (memories of facts), episodic memory (memories of what has happened) and narrative memory (memories of one's sense of self and time). Explicit memories do not tend to develop until after 12 months of age, as they require certain brain structures (such as the language centres) to be somewhat developed before explicit memories can be stored.

Childhood memories are predominately stored in the limbic system and are therefore mostly implicit and subconscious and have a strong emotional component. When those memories are triggered, children and young people can often experience all the emotions associated with the memory but may not have the language to describe or make sense of what they are experiencing or remembering. This can leave children and young people feeling confused about the source of their fear. For example, if a traumatic memory is triggered by hearing a teacher raise their voice in the classroom, the child or young person may not have the ability to differentiate between the traumatic memory of being verbally abused by a caregiver and what is occurring in the classroom resulting in both events become entangled in the traumatic response. Children and young people experiencing these reactions can then have immense difficulty understanding the cause of their emotions and responses potentially leading to further distress. Children and young people who experience trauma also develop explicit memories but some of these memories may have been created during times of distress and fear when the brain is operating more from lower regions necessary for survival and therefore even explicit memories can be fragmented and lack a cohesive narrative about what occurred. This can make it difficult for children and young people to make sense of what has happened to them.

It is also understood that memories that have a sensory component (touch, smell, sounds or sights) can be re-experienced with the same intensity as they were experienced at the time of the traumatic event. This means that when a child or young person's traumatic memories are triggered, they can be flooded by the feelings that they experienced at the time of the original traumatic event.

4. Healing from trauma

It is critical that healing from trauma is actively supported. Healing from trauma requires safety to be established, for further trauma to be avoided and for reparative experiences to be offered. Healing from trauma also requires strengths to be identified (refer to the Strengths based practice – Practice Paper for further information) and the importance of cultural connections being recognised.

Carers play an integral role in the process of healing from trauma by providing children and young people with repeated experiences that challenge unhealthy or negative internal working models. These experiences include providing safe, stable, predictable, attuned and nurturing environments and relationships. It is important to note that some children and young people in care can find their experiences of quality care uncomfortable as it is not consistent with their unhealthy internal working model and is therefore often experienced as very confusing. Persistence is key to helping the child or young person accept that their carers are trustworthy and will consistently provide them with a positive caregiving environment. In addition, caregivers must focus their attention on what is happening 'under

the surface' for children and young people (rather than solely focusing on their behaviour) so that they are responding to their underlying need. Refer to Iceberg Model: A trauma-informed approach to understanding and managing traumatised children and young people's behaviour for more information.

It is important for practitioners to understand that caring for children and young people in a way that supports healing from trauma can be both rewarding but also extremely demanding. It is essential that carers are supported through a care team approach and are provided with responsive support from the DCP case worker and kinship or agency support worker in line with the Statement of Commitment (refer to Support the placement in the Supporting children and young people in care chapter of the Manual of Practice).

At times, children and young people (and their carers) will require a therapeutic intervention to assist them to shift their negative internal working model to a more positive sense of themselves, relationships and the world. Please also refer to Identify and respond to the psychological and emotional needs of the child or young person in the Supporting children and young people in care chapter of the Manual of Practice for more information about therapeutic interventions or consult with DCP Psychological Services.

In addition to obtaining such an intervention, DCP case workers can undertake life story work. Life story work is a process through which the child or young person makes sense of their experiences and their history, which includes their experiences of trauma, disconnection, rejection, grief loss and poor attachment relationships, and helps them to form a coherent and more positive life narrative. Life story work can help the child or young person to develop an alternative story about themselves which supports the development of a more positive internal working model and a sense of belonging within their care environment (see Support the development of the child or young person's identity in the Supporting children and young people in care chapter of the Manual of Practice and the Life story work and Aboriginal life story work Practice Paper for guidance in relation to life story work).

When working with Aboriginal children, young people, their families and carers it is important to consider cultural safety and a holistic approach to healing. Consideration should include connection with their culture, family, kin and community as well as return to Country trips. In consultation with the Principal Aboriginal Consultant, consideration should be given to use of traditional cultural practices, including Ngangkaris (Aboriginal traditional healers) and bush medicine. Additional resources can be found on the Healing Foundation website in relation to Aboriginal intergenerational healing.

Refer to the Trauma lens Practice Paper for further information about healing from trauma. For more information on understanding and responding to behaviour of children and young people that have experienced trauma refer to the Iceberg Model and for information on responding to disclosures from children and young people refer to the Safeguarding children and young people Practice Paper.

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