Trauma-informed practice

FOR CHILDREN AGED 0-11

From theory to practice

Québec

EDITORIAL

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"THESE CHILDREN WILL, FOR THE MOST PART, HAVE A HEAVY LOAD TO CARRY. LET'S MAKE SURE THAT BEST PRACTICES HELP THEM COPE WITH THIS BURDEN FOR WHICH THEY'RE NOT RESPONSIBLE."

Sylvain Palardy, Child Psychiatrist

PRINCIPLES OF TRAUMA-INFORMED PRACTICE IN YOUTH PROTECTION

• Recognize the high prevalence of traumatic experiences among individuals receiving services.

• Demonstrate a thorough understanding of the neurological, psychological and social impacts of trauma and violence on the individual **(Jennings, 2004)**.

• Assume that clients have a life story marked by adversity, requiring "universal precautions" to be taken when creating trauma-informed care systems (Hodas, 2005).

• Recognize that some of the practices used may aggravate a client's trauma.

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Why be concerned by the notion of trauma?

Maltreatment leaves its mark

Although childhood is often associated with a carefree attitude, fun, innocence and love, the life trajectory of many children has been marked by violence and fear. Each year in Quebec, the DYP reports that an average of **18,000 children** between the ages of 0 and 12 are placed under its care. Despite it seeming obvious that children who have been abused can develop after-effects, it appears that the notion of trauma is still not adequately employed to describe the impact of such abuse.

However, the systematic assessment of traumatic experiences and sequelae, beyond the reason for reporting, is not a routine practice in child welfare centres *(Greeson et al., 2011).*

While it was once thought that children had a certain invulnerability to traumatic events because they were too young and immature to realize the nature of these events, or even to remember them (Osofsky, 2004), we now know that the opposite is true. Due to their age, they are most vulnerable to these extreme situations that pose a serious risk to their physical and psychological integrity. **(Milot et al., 2013)**

Maltreatment is associated with the emergence of various psychological sequelae in children who are victims of it *(Paolucci et al., 2001)*. These difficulties may persist into adulthood *(Briere and Elliott, 2003)*. Research shows that some child victims of abuse are particularly at risk of developing mental health problems, including post-traumatic stress disorder. The concepts of trauma, post-traumatic stress disorder and complex trauma are particularly useful in developing a better understanding of the potential consequences of maltreatment and conducting interventions with children and their families.

If only the tip of the iceberg is seen, these marks may persist and become more pronounced.

Research has confirmed that the emotional and behavioural disorders manifested by children placed in foster care may represent symptoms associated with cumulative traumatic life experiences **(Cook et al., 2005)**

> ***A house that is not repaired, or only partially repaired, will be shaken by the wind, is at risk of collapsing later, or may be completely destroyed by another hurricane.***

Many young people placed in foster care have experienced various forms of abuse without necessarily reporting them to authorities, therefore much of the baggage carried by these children remains invisible. In addition, young people placed in foster care have more frequently experienced multiple traumas rather than an isolated traumatic event. Unfortunately, there have been few longitudinal studies that document the long-term effects of childhood trauma. However, some studies demonstrate that children with traumatic sequelae are at greater risk of:

- developing mental health problems
- having a poorer prognosis
- being more difficult to treat
- living on the margins of society as adults and relying on social services, resulting in huge costs to society
- having multiple risk factors related to many of the leading causes of death in adults

Caregivers and the intervention community need to understand the notion of trauma in order to:

- identify as early as possible the children most at risk of developing sequelae that will affect their developmental trajectory;
- support those who work with these children in order to avoid placement moves;
- avoid interventions that aggravate the condition of traumatized children and potentially cause institutional trauma, which would add to the relational wounds already suffered;
- provide resources and services that foster resilience.

Closing the youth protection file for children who have developed traumatic sequelae or are at high risk of developing them does not mean that these children have received the necessary services to treat such after-effects and resume a more harmonious developmental path.

Basic concepts and theoretical framework

TRAUMA: WHAT EXACTLY ARE WE TALKING ABOUT?

Terminology and definitions

Several terms can be used to describe the reality of children who have been exposed to maltreatment in their living environment, are monitored in youth protection centres, and are at risk of developing or have developed sequelae. Caregivers may hear the following:

- Developmental trauma
- Psychological trauma
- Complex trauma
- Post-traumatic stress disorder, etc.

The word "trauma" is derived from the Greek term meaning "wound." In medicine, the notion of trauma is used when the body is attacked and damaged by a force so powerful that its natural defences are unable to defend it and cope with the injury without medical help. Freud was the first to talk about psychic trauma as an analogy to physical injury.

Beyond the conceptual angle, we want these children at high risk of developing sequelae due to maltreatment and adverse living conditions to be identified and to have this reality taken into account in the services offered to them. **For all recommended tools, we will be using the term "trauma."** However, in this reference document, two terms will be presented:

- **Post-traumatic stress disorder** from the latest version of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5), published in 2013
- **Complex trauma** from the work of several researchers whose aim is to accurately describe the reality of children and adolescents exposed to interpersonal and chronic trauma, whether or not they have symptoms corresponding to post-traumatic stress disorder

Post-traumatic stress disorder

In the DSM-5, post-traumatic stress disorder (PTSD) is divided into two categories:

1. "Posttraumatic stress disorder in adults, adolescents, and children older than 6 years"
2. "Posttraumatic stress disorder in children 6 years and younger"

Post-traumatic stress disorder as a diagnosis emerged in the 1980s in the wake of the return of Vietnam War veterans and was incorporated into the DSM-3.

For a person to develop PTSD, he or she must have experienced, witnessed or faced one or more distressing events. These can be situations in which people could have died, been very seriously injured or threatened. It could be a variety of repeated exposures: violence; sexual assault or inappropriate sexual experiences for the child, with or without violence or injury; physical abuse; exposure to domestic violence, etc. It could also

be exposure to a unique event (e.g., accident, natural disaster, etc.), a direct event (e.g., being on the scene of a terrorist attack) or an indirect event (e.g., seeing images of the attack on television and having a loved one involved in the incident). It should be noted that witnessing an event solely through electronic media, television, movies or pictures is insufficient (according to DSM-5 criteria). For post-traumatic stress disorder in children aged 6 or younger, it is specified that traumatic exposure as a witness or being exposed indirectly mostly concerns situations that affect the child's parent or caregiver.

Some diagnostic criteria have been modified in the DSM-5 version. For example, a child may have heard his or her parent talk about "the war" or another traumatic event and how the event affected a loved one. This could lead the child to develop PTSD.

The symptoms of PTSD may appear following a traumatic event or take some time to develop, sometimes even several years.

In the DSM-4, the exposed person had to be able to recount the traumatic event. There is less emphasis on this criterion in the DSM-5.

The essential characteristic of PTSD is the development of specific symptoms following exposure to an extremely traumatic stressor. This diagnosis describes four families of symptoms:

1. **Intrusion symptoms** associated with the traumatic event, appearing after the traumatic event, such as the following:

- Involuntary, intrusive re-experiencing of the distress-causing event through thoughts, images, perceptions or memories that recall it. For children, the memories may arise during play without necessarily appearing to cause distress.
- Repetitive dreams or nightmares related to the event or, for children, frightening dreams without recognizable content.
- Dissociative reactions (e.g., flashbacks) in which individuals feel or act as if the event is happening again. This can go as far as completely losing touch with what is really going on around them. For children, this can be experienced through the re-enactment of a traumatic event using games or drawings.
- The impression that the event can happen again, when an internal or external cue symbolizes an aspect of it, creating intense or prolonged psychological distress.
- Marked physiological reactions to internal or external cues symbolizing an aspect of the event.

2. **Symptoms of avoidance of stimuli** associated with the event which begin after exposure and are characterized by:

- efforts to avoid memories, thoughts, feelings or conversations associated with the trauma.
- efforts to avoid external reminders such as activities, places, people or situations that recall the event.

3. **Altered cognitions** and mood associated with the traumatic event beginning or worsening after exposure and characterized by:

- an inability to remember.
- persistent and exaggerated negative beliefs and expectations of the self, others, and even the world. For example, individuals may believe that the future is no longer promising for them.
- distorted cognitions about the causes or consequences of the event, leading the individuals to blame themselves or others
- a persistent negative emotional state (e.g., fear, anger, shame, guilt, etc.)
- markedly diminished interest or participation in activities. Individuals may stop doing activities that they used to enjoy.
- feelings of detachment or estrangement when interacting with others.
- a persistent inability to experience positive emotions.

4. Marked alteration in arousal and reactivity (neurovegetative symptoms) beginning or worsening following exposure and characterized by:

- irritability and temper tantrums expressed as verbal or physical aggression toward objects or people
- reckless or self-destructive behaviour
- hyperarousal, alertness and hypervigilance
- an exaggerated startle response
- problems with concentration
- sleep disturbances such as difficulty falling asleep, or staying awake after nighttime sleep is interrupted

For a diagnosis of PTSD **in children 6 years or younger**, fewer criteria are required, particularly in the categories of avoidance and altered cognitions and mood. Regressive behaviour (e.g., loss of language, resumption of bedwetting, thumb-sucking, wanting to sleep with parents, etc.) may also be present. It is also mentioned that in situations of severe and chronic events such as childhood abuse, individuals may also experience difficulties in emotional regulation and maintaining stable interpersonal relationships.

> ***According to putnam (2003), the idea of childhood abuse is not a diagnosis, but a life experience.***

Post-traumatic stress disorder may appear with or without dissociative symptoms such as the following:

- **Depersonalization:** Persistent or recurrent experiences of feeling detached from one's body, being an outside observer of one's body or thoughts as if in a dream, or feeling a sense of unreality of the body or self. Individuals may feel as if time is standing still or moving in slow motion.

- **Derealization:** Persistent or recurrent experiences of individuals that the world around them is unreal, distant or distorted

---

"Dissociation is an experience in which individuals become cognitively and emotionally disconnected from their environment. Dissociation is not a feeling, but rather an automatic reaction to an overwhelming feeling. It is a protective reaction by which individuals escape from suffering or an intense emotion they deem intolerable. Dissociation is most often a reaction to fear, anxiety, or very strong non-specific anxiety."

(Cloitre et al., 2014)

Several disorders are often associated with PTSD:

- Anxiety disorder
- Oppositional defiant disorder
- Mood disorder
- Attention-deficit/hyperactivity disorder
- Reactive attachment disorder
- Disinhibited social engagement disorder
- Substance abuse (for older children)

Individuals with a diagnosis of PTSD are 80% more likely to have symptoms that match those of at least one other disorder listed above.

Complex trauma

For some researchers, post-traumatic stress disorder (PTSD) does not adequately describe the reality of certain children receiving care in clinics and who exhibit a wider range of symptoms that are the result of exposure to multiple situations of abuse *(Brière and Spinazzola, 2005; Herman, 1992)*.

The concept of complex trauma was first introduced in the 1990s.

The National Child Traumatic Stress Network (NCTSN) proposed the adoption of a new diagnosis: developmental trauma or complex trauma. Research has shown that trauma that occurs early in life and is prolonged,

in addition to having an interpersonal component, can have an impact on psychological health and cause a range of developmental sequelae that goes beyond the symptomatology described by PTSD.

"On the one hand, al though there is consensus on the traumatic nature of maltreatment, most maltreated children do not meet the criteria for PTSD. On the other hand, many maltreated children are labelled with a multitude of other mental health diagnoses, including oppositional defiant disorder, attention-deficit/hyperactivity disorder, reactive attachment disorder, depression and conduct disorder. Traumatic symptoms as usually defined in the DSM then appear either inappropriate or camouflaged by the intensity and diversity of other difficulties. Therefore, for many researchers and clinicians, PTSD is an incomplete diagnosis that serves children poorly."

(Milot et al., 2013)

The notion of complex trauma is very useful in describing the profile of many children referred to youth centres. Complex trauma avoids compartmentalizing the different symptoms that can be explained by maltreatment: difficulties with attachment, impact on self-esteem, and difficulties with behaviour and affect regulation. The notion of complex trauma involves not only exposure to traumatic events, but also a failure of the protective function of the parent. Many of the symptoms developed by children can be interpreted as having an adaptive function to the abusive experience by allowing them to cope with distress or reassure themselves, but they can become problematic in the process of adaptation.

The notion of complex trauma is intended to recognize that behind many types of behaviour that appear problematic or dysfunctional, there may be fear or adaptive behaviour related to the intense and repeated stress experienced.

Being alert to chronic neglect

The cumulative effects of chronic neglect can be underestimated. It can sometimes be easier to associate the term "trauma" with abuse than with neglect, which does not create the same sense of urgency. There are still few studies on the relationship between neglect and traumatic symptoms. It is recognized that neglect can have serious effects on a child. For some, situations of neglect do not pose as severe a threat to physical integrity as physical or sexual abuse. However, several authors *(e.g., Debellis, 2005)* suggest that situations that threaten psychological integrity can also be traumatic. In addition, various studies have observed that children who experience neglect are frequently exposed to other forms of victimization *(Dessureault et al., 2008; Mennen et al., 2010)*.

> ***"But this baggage is also an accumulation of adverse and traumatic life events that precipitated the involvement of child welfare services."***
>
> **(Cook et al., 2005)**

Which children are at risk of developing traumatic sequelae?

1. Children exposed to potentially traumatic situations

To describe the reality of a child experiencing potentially traumatic situations, the following question needs to be answered: what is a traumatic event? The answer may seem simple, but it could be summarized this way: anything that could be traumatizing for a person is traumatizing. It is fairly easy to agree on certain types of events that are likely to cause trauma, such as a terrorist attack, a plane crash, an armed assault or a natural disaster. It is also recognized today that **maltreatment during childhood is a traumatic experience that may be reflected in all of a child's spheres of development** *(Blaustein et al., 2010; D'Andrea et al., 2012)*.

> *"Coping" is the set of cognitive, (e.g., assessment of a stressful situation, evaluation of one's resources, search for information, etc.), **emotional** (e.g., expression or repression of fear, anger, distress, etc.) **and behavioural** (e.g., problem-solving, help-seeking, etc.) **efforts aimed at tolerating, avoiding or minimizing the harmful effect of stress** on personal well-being and maintaining physical and psychological balance.*
>
> **(Lazarus and Folkman, 1984)**

However, it is important to recognize that there is a subjective aspect associated with a person's own experience of being traumatized by an event or being "only" stressed by it. Each person has individual characteristics that influence how he or she will cope with life events. Trauma occurs when a person is overwhelmed by an event or situation that exceeds his or her coping skills or strategies.

The definition of trauma implies that an individual senses a risk to his or her physical or psychological integrity. For example, due to its vulnerability and high dependence on the adults responsible for its care, a baby who is neglected or left alone without response may experience intense stress, extreme helplessness, and even distress that can be experienced in a traumatic manner. This is especially true if the baby experiences this repeatedly.

2. Children with characteristics of greater vulnerability

It is also important to distinguish whether a person has been exposed to a single event, has experienced a form of abuse that is continuous or repeated over time, or has been exposed to different forms of abuse that occurred early and then continued over a long period of time. It is also important to consider whether the person who provides much of the child's care (usually the parent) is the abuser or witnesses the abuse and fails to protect the child. These factors may increase the risk of the child developing post-traumatic sequelae.

Assessing the risk of a child developing sequelae following exposure to potentially traumatic situations is not a simple endeavour. Each child is unique and has personal characteristics that may constitute risk factors or, conversely, protective factors. Similarly, the child's environment brings aggravating or protective factors, as well.

Why are children particularly vulnerable to trauma?

Some children have a combination of risk factors that make them even more likely to develop traumatic sequelae. Some factors are present even before the child is conceived, others occur during pregnancy, and others occur after birth. They may be related to the child, the parents or the environment.

As developing beings, children are particularly vulnerable to trauma. Their developmental trajectory depends on a multitude of factors that are related to not only their own characteristics, but also those of their environment. The environment is the complex set of exterior influences upon which children depend for their survival. Of all species, human children depend on their environment, and by extension, their parents, for the longest time in order to ensure their survival, grow up well, and develop on a variety of levels. The first few years of life are decisive for a child's development, especially for the development of the brain. Children are particularly vulnerable to stressful situations and danger. They have limited resources (in relation to their physical, cognitive and emotional development) to cope. For example, their regulatory skills are emerging and they depend on the availability of a caring adult to protect them.

What is complex with younger children is that the limits of language mean that they will not be able to put into words what they are feeling. Beyond this difficulty to put feelings into words, there is also the dependent nature of the relationship between children and their parents which makes it particularly difficult to denounce inappropriate situations. In addition, these young children do not usually attend daycare and are therefore less likely to be identified before they reach school age. Further, some abusive experiences occur so early that language has not yet developed, making them difficult to mentalize (i.e., not accessible to memories nor integrated into emotions or cognitions). Sometimes, these memories are only present in body memory. They will then be felt or acted upon rather than verbalized. The age at which a child is exposed to trauma is therefore one of the factors that can influence the severity of the sequelae *(Schmid et al., 2013)*. Trauma changes the way the child develops, which affects later stages of development.

"The internal or personal resources by which children can protect themselves are limited solely by their development .... What's more, the child's external resources are far more limited than those of adults." **(Cloitre et al., 2014)**

NOTE: Caregivers have long known that maltreatment causes its share of sequelae. The notion of trauma must be integrated into the knowledge base to enrich it. It should be kept in mind that it is not only actual events that cause trauma. The way in which children cope with these experiences and the reaction of those close to them will influence how the children process and integrate these experiences, depending on the abilities and resources available at the time of the events. It is not helpful to simply declare that a certain child "is traumatized." Children do not need to be given a new label, but rather to be given a fair assessment of their needs and access to the right care. The notion of trauma must be integrated into existing knowledge and practices along with permanency planning and an evaluation of the quality of their attachment relationships.

What are the developmental consequences associated with trauma?

The consequences listed for complex trauma are numerous and affect several areas of the child's functioning. They have been classified by Cook et al. *(2005)* into seven categories:

- Attachment
- Biology
- Affect regulation
- Dissociation
- Behavioural control
- Cognition
- Self-concept

Attachment

It has been shown that when children establish meaningful connections with adults who ensure their safety and protection, it is a protective factor for their development. Conversely, exposure to stressful situations involving potential danger and unpredictability without the presence of attentive, reliable adults who can provide protection and care puts the children in a situation where they must absorb intense emotions on their own. It is usually the parent who supports a child and helps the child regulate his or her physical, emotional and behavioural states. A young child does not have the internal resources to deal with distress alone.

Children exposed to trauma without the protection of a secure attachment relationship may have difficulty developing relationships with peers and accepting their dependence on the adults around them.

Biology

Childhood maltreatment, especially in the absence of caring parental responses, may lead to increased reactivity to stress. Neurobiological development follows genetic programming that can be modified by external stimuli from the environment. High levels of stimulation can act as triggers for adaptive processes that sculpt the brain differently and alter biological functioning. This can affect the immune system and have an impact on health.

> *What about when the parent is not the aggressor, but a passive witness? According to Herman (1992), passivity in the face of aggression is also hurtful to a child. The function of attachment is to guarantee a child's safety. The failure to protect could itself be a source of trauma.* **(Cloitre et al., 2014)**

During childhood, certain parts of the brain develop. These are responsible for abilities such as the following:

- Filtering sensory signals to identify important information
- Learning to detect and respond to potential threats
- Recognizing information and stimuli from the environment
- Coordinating and organizing rapid and appropriate responses
- Discriminating between, identifying and responding to internal and external stimuli

Trauma interferes with the ability to integrate this analytical potential, causing the emotional component to overwhelm and partly explaining the irrational way of reacting to stressful situations. Similarly, when the regulatory system is dysregulated, even exposure to moderate or mild stress can provoke an extreme response. The impact of trauma can lead to sensory dysregulation, meaning that a child has hyposensitive or hypersensitive responses to sensory stimuli (e.g., noises, smells, light, touch, etc.). For example, a young child may react intensely to changes in position (proprioception), be intolerant of physical contact, not react to pain caused by an injury, or seek physical sensations to feel connected to his or her body.

Affect regulation

Affect regulation is the ability to identify and express the emotions felt and modulate the response in a consistent and graded manner based on life experience.

A deficiency in the ability to regulate emotional experiences can be classified into three categories:

1. Difficulty in identifying internal emotional experiences (e.g., not knowing what one is feeling or recognizing internal arousal without being able to name it or differentiate its level)

2. Difficulty in expressing emotions (e.g., freezing up and remaining very stiff and rigid, or being explosive and unpredictable)

3. Difficulty in modulating emotional experiences (e.g., inability to calm oneself)

Traumatic experiences overwhelm children's coping skills, forcing them to cut themselves off from their emotions in order to "survive" abuse. If they are incapable of putting their emotions into words, their responses to stress may be internalized (e.g., depression, withdrawal or anxiety) or externalized (e.g., aggressiveness, hyperactivity, opposition or anger).

Dissociation

Sometimes, traumatized children resort to dissociation. According to Putnam *(1997)*, it is an inability to integrate information and experiences (i.e., thoughts, emotions, memories and self-concept) in a normal, coherent and adaptive manner. Different aspects remain fragmented, such as the following:

- Thoughts without affect
- Emotions without cognition
- Bodily sensations without consciousness
- Behaviour without consciousness

Dissociation is a defence mechanism that occurs as a result of chronic traumatic exposure and has the potential to become a disorder. Putman has identified three functions of dissociation:

1. Make behaviour automatic in circumstances that overwhelm the individual.

2. Compartmentalize memories and emotions that are too painful.

3. Allow the detachment from the self in extreme situations.

For example, traumatized children may use dissociation to psychologically escape a situation that is beyond their ability to cope. This form of escape overrides fleeing or fighting and is a very useful mechanism that the brain uses to ensure survival. But when used too often, this mechanism is not without consequences for the child's future.

Dissociation can have an impact on children's ability to truly invest themselves in their daily activities, affecting their readiness to learn and develop social relationships. As Bloom *(1999)* points out, access to a wide range of emotions is necessary to build and maintain healthy relationships with others. It is not always easy for the adults close to a child to perceive that the child is dissociating. The child may be perceived as daydreaming, detached or not paying attention. The child may be active, but is not really receptive to what is around him or her.

Behavioural regulation

Behavioural regulation is a child's ability to control his or her behaviour in a way that is appropriate for various situations. A traumatized child may have a problem with over- or under-regulation. For example, the child may be very controlling and appear overly obedient or inhibited. Similarly, the child may be unable to cope with a change in routine. Conversely, the child may be very impulsive, even explosive, and unable to cope with frustration or delays. He or she may have great difficulty calming down and thinking before acting. The difficulty a child faces in regulating his or her behaviour is closely related to the impact of the complex trauma on biology, more specifically on the physiology of stress, attachment relationships, and brain development and function.

According to Bloom *(1999)*, there is a type of repetition compulsion related to traumatic scenarios. Unconscious reactivations are interactional traps into which adults responsible for a child may fall, contributing to a degree of retraumatization. Bloom *(1999)* reminds us that Freud was one of the first to point out that certain behaviour that a person cannot refrain from perpetuating amounts to an unconscious repetition of scenarios that were experienced but are inaccessible to memories. Repetition of the behaviour somehow becomes the only way to manifest what one has experienced, given the inability to put it into words. This is how individuals continually re-enact their past, regardless of the current situation in which they find themselves.

When interacting with children, it can be difficult to understand and accept that they so often repeat behaviour that has unfortunate and negative consequences for them. It is particularly counterproductive to criticize them or hope that adding other consequences will dissuade them from engaging in such behaviour again. We will come back to this when we address the topic of intervention.

Cognition

During childhood and adolescence, children acquire certain reasoning skills necessary for optimal development, which occurs in tandem with the development of certain parts of the brain. What are called "executive functions" are essential in the ability to function independently and engage in reciprocal relationships. These functions enable individuals to do the following:

- Evaluate the meaning of more complex emotional experiences.
- Anticipate the effect of an action based on previous experience.
- Create a reference model that incorporates an understanding of other people's perspectives.
- Develop planning, problem-solving and decision-making strategies.
- Have access to a more stable and easily accessible working memory.

Traumatized children may show various delays in cognitive and language skills. They may also have difficulty managing and solving problems. These different cognitive impairments can cause academic problems.

The reality of a child functioning almost continually in survival mode mobilizes resources that should be available for learning and developmental challenges. This demonstrates the importance of providing reassurance to traumatized children during their

interventions and repeating positive experiences that nourish the development of these executive functions — circuits that have somehow been atrophied by the stress response.

Self-concept

Children form an idea of their self-worth based on how they are viewed by others. This perception of how others appraise them is even more important when it comes from the people with whom they are closest. When it is the parents who maltreat, denigrate, or fail to care for or protect, it can have a significant impact on children's assessment of their self-worth. Abuse and neglect can lead children to think of themselves as undesirable objects who do not deserve to be loved and invested in. It is often less psychologically and emotionally painful for children to blame themselves for what happens to them than to recognize that their parents are untrustworthy and dangerous. Every professional who has worked with young children is struck by this type of response. It is fascinating to see children make up every excuse imaginable to protect even the most failing parent. Feelings of shame, guilt, exaggerated responsibility and low self-esteem are common to many maltreated children.

> ***For children to be able to dream and envision some kind of future for themselves, they require a basic sense of confidence, hope and control over what happens to them.***

Attachment and neuroscience shed light on the impact of trauma

Some theoretical models can help us understand the diverse and complex impact that maltreatment and trauma can have on the developmental trajectory of children. Attachment theory and neuroscience can explain the damage that is done to the body and mind and the possible ways of coping which children may resort to when their internal and external resources are insufficient to deal with traumatic situations.

In recent years, attachment theory, originally developed by John Bowlby, has gained acceptance in clinical practice. More recent knowledge related to complex trauma not only complements attachment theory in making sense of some of the difficulties experienced by children, but also provides guidance for intervention.

Current research in neurophysiology opens the door to a wealth of knowledge that should alert caregivers and managers working in youth protection systems. It is fundamental to recognize the effects of chronic stress on human functioning, particularly for developing children, in order to adjust how intervention settings are organized and adapt intervention methods accordingly.

Attachment and trauma

The words "trauma" and "attachment" represent two independent but closely related concepts.

The links between attachment and trauma cannot be discussed without first addressing how human beings adapt to stress. The relationship between a child and the adults caring for that child is a decisive factor in proper development, since these adults act as shields to protect the child from stressors. Quality care received early in life and the establishment of a secure attachment are essential for the developmental of an optimally functioning stress response system.

Most children who have experienced neglect or maltreatment have difficulty developing a **secure** attachment to their caregiver. However, the power of attachment remains evident even in situations of abuse. Children need to remain close to their parents, as they depend on them for their survival.

One of the key concepts of attachment theory is that every child is genetically programmed to become attached to his or her caregiver. Children organize their behaviour in order to maximize their physical proximity to that person, which usually increases the likelihood of survival.

Depending on the quality of a parent's responses, children develop expectations regarding that parent. The quality of the parent's responses also influences the child's self-worth as an individual. These representations influence the quality of the attachment relationship.

Children develop a concept of the self, of others, and of themselves in a relationship from the experience of their first attachment relationship. Their sense of security, the trust they develop in others, the confidence they acquire in their ability to explore the world, the feeling of competence, and the ability to self-regulate and communicate are influenced by the quality of this attachment relationship. The world becomes a place where one can feel good or, conversely, a dangerous place where one must be constantly on guard. When the abuse comes from a person who should be taking care of and protecting them, children may come to believe that they are "bad" and that the world is a scary place.

Children who develop secure attachments expect their parents to protect, support and soothe them. They seek closeness and contact. They are also able to explore when they feel secure.

Children who develop insecure attachments expect their parents not to meet their needs. They may avoid or maximize signs of distress depending on the type of parental responses that have been given.

Children who develop disorganized attachments see their strategies collapse when they experience stress or distress. They exhibit disorganized behavioural responses, as they are confronted with an insoluble dilemma by having to seek comfort from an adult that frightens them. As a result, these children experience significant feelings of abandonment and vulnerability. They are left to cope with their distress on their own. As they grow older, some children continue to exhibit this breakdown in strategies. Others develop a disorganized/controlling attachment. Sometimes the control is manifested through maternal behaviour: children are benevolent toward their parents and may try to entertain them or cheer them up. These children are not in sync with the emotional tone shown by the parents. Control can also manifest itself in punitive behaviour: children may be denigrating, irritated or angry with the parents. These types of controlling behaviour occur in situations of distress and may exist because the parents are abdicating their role in terms of parental authority.

There are a variety of stressors that have been identified as being associated with the development of disorganized attachment and are related to the quality of care received:

- Parental maltreatment. Some studies suggest that up to 86% of maltreated children have disorganized attachment *(Cyr et al., 2010; van IJzendoorn et al., 1999)*.
- Institutionalization and lack of parental care *(Bakermans-Kranenburg et al., 2011)*
- Chaotic parental interactions, especially frightening behaviour *(Madigan et al., 2006)*
- Parental remarks that are hostile, intrusive, sexualized, etc. *(Dubois-Comtois et al., 2011)*
- Trauma (abuse) and unresolved grief in the parent *(Madigan et al., 2006; van IJzendoorn et al., 1995)*
- Mental health problems (e.g., depression) in the parent *(van IJzendoorn et al., 1995)*
- Stressful events experienced in the family environment: hospitalization of a parent, death of a close relative, etc. *(Moss et al., 2004)*
- Cumulative environmental risk factors: young age of the mother, low education level, poverty, etc. *(Cyr et al., 2010)*
- Domestic violence *(Zeanah et al., 1999)*

Therefore, there is a significant link between the presence of potentially traumatic events and the development of a disorganized style of attachment by a child.

Disorganized attachment in children is itself a recognized risk factor for various problems:

Age 1 to 7: Internalized and externalized behavioural problems *(Fearon et al., 2010; Groh et al., 2012; Madigan et al., 2012)*

Age 7 to 9: Clinical disorders (internalized/externalized) and suicidal ideation *(Dubois-Comtois et al., 2013)*

Age 12: Intense emotional stress (abnormal cortisol production curve; low emotional regulation capacity, especially in fearful situations *(Spangler et al., 2014)*

Age 18-23: Dissociative disorders *(Carlson et al., 1998)*, personality disorders (borderline) and suicidal risks *(Lyons-Ruth et al., 2013)*

Children with disorganized attachments are at greater risk for these difficulties because they are not equipped to deal with distressing or potentially traumatic situations. These experiences activate the attachment system without integrating affective information (i.e., thoughts, emotions or experiences). As a result, children develop multiple, parallel and fragmented representations of themselves. This makes them more fragile and at risk of developing dissociative states as well as more vulnerable to developing post-traumatic stress disorder if they experience other disturbing events.

According to Bloom *(1999)*, the longer-term consequences can be seen later in adolescence and adulthood in the choice of intimate partners who will be negligent, abusive and, all too often, violent. After establishing early relationships with individuals who are a source of terror, but from whom one continues to hope for comfort, these young people may be led to expect nothing other than this type of relationship in future emotional attachments.

Many of the parents referred to youth protection have themselves experienced abuse as children and have traumatic sequelae. Children in youth protection are doubly exposed:

- Their parents have different risk factors that predispose them to the development of an insecure, and sometimes disorganized, attachment.
- The children experience abuse from their parent(s) or in their family or exterior environment without being protected by the parent(s).

Parents may not have the personal resources to be caring with and receptive to their children and what they have experienced. Sometimes, for various reasons, a parent will protect the abuser rather than the child victim. In cases where trauma is experienced within the family, the situation is even more complex for the child, creating an irresolvable dilemma. For example, a person who survives a plane crash can subsequently choose to avoid the airport, but a child who is neglected or abused cannot realistically avoid his or her home or parents. The impact on a child of not being protected by his or her parents must be considered, regardless of the reasons for this neglect.

The neurophysiology of stress and the impact of maltreatment and adverse life experiences on brain development

"Research evidence suggests that persons who have experienced severe forms of stress in the first few years of life are at high risk of experiencing negative consequences not only in childhood, but also in adulthood." **(Lemelin et al., 2012)**

When human beings are confronted with a situation perceived as a threat, they are biologically programmed to protect themselves from danger. This internal defence mechanism affects all of our systems in order to promote a ***fight-or-flight*** reaction, thereby optimizing our chances of survival. In some situations, it may be useful to ***freeze***, camouflage oneself or submit momentarily. When the stress management system is activated, all available energy and resources are mobilized to deal with threats and challenges. Anything that is not immediately useful stops!

It seems that situations containing components such as a perceived lack of control, unpredictability, novelty or a risk to the ego generate a stress reaction.[1] Learning to cope with mild to moderate stress is an important part of healthy child development. When children are faced with new or threatening situations, their body reacts within seconds by increasing their heart rate, blood pressure, alertness and production of stress hormones such as cortisol. When young children's stress response systems are activated in secure relationships in which their adult caregivers provide reassurance and comfort, these physiological effects subside and return to baseline levels. The result of this repeated process is the development of a healthy stress response system.

However, if children are exposed to extreme and long-term stress and their relationships do not play a protective role for them, the result can be toxic stress that causes damage at various levels, even affecting the architecture of the brain. These experiences can alter the brain system responsible for self-management and self-regulation. Altered patterns of stress reactivity have been observed in children and adults who have been exposed to abuse or neglected by their caregivers *(Tarullo and Gunnar, 2006)*. The stress management system seems to become dysregulated, producing lasting manifestations of hypersensitivity or hyperreactivity. Toxic stress refers to frequent and intense activation of the stress management system, which is dangerous to health.

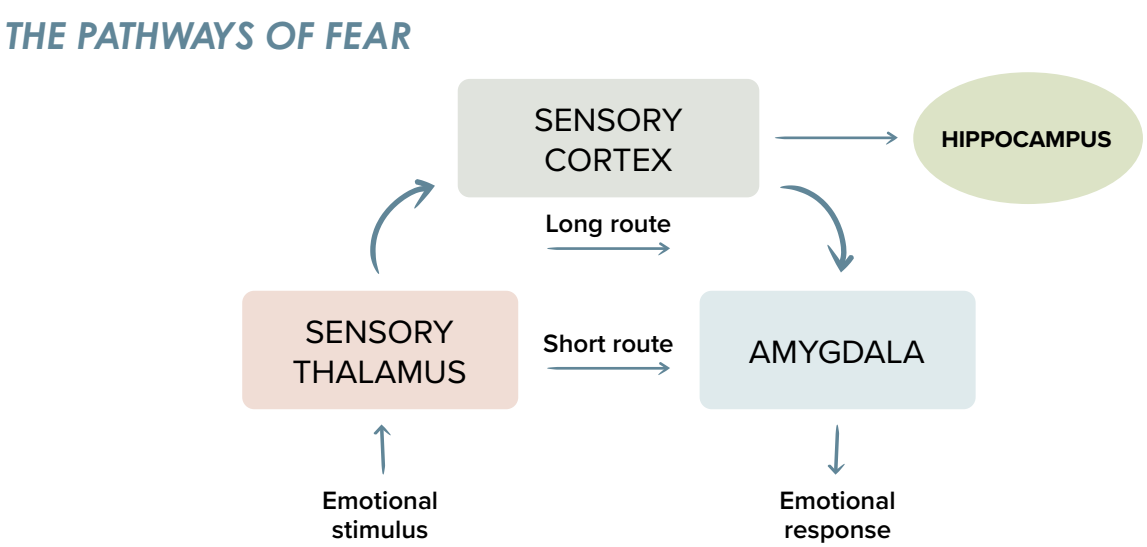
In fact, with each new experience of confrontation or danger, the fight-or-flight system is activated. The body then produces a strong response generating connections that can, with repeated instances, create a more sensitive circuit that will be triggered, even in the face of minor threats. The ability to modulate the state of alertness is affected and children may go from a state of calm to a state of high reactivity without an outside observer having perceived the slightest trigger. Children may also feel more easily threatened or provoked and respond impulsively in situations where there are no real threats. In addition, they may perceive anger or hostility in facial expressions displaying neutral emotions. Conversely, it seems that certain repeated stressful experiences can alter the normal fluctuation of cortisol, reducing the energy a child needs to get through the day and meet its challenges and causing sleepiness when the curve drops for the purpose of regeneration.

The body also produces other substances that are useful in everyday life, particularly in times of stress or threats. Chemicals such as endorphins help calm anxiety, tolerate and relieve pain, and improve mood. It seems that this system can also be altered following repeated exposure to chronic stress, leading to a form of dependence on endorphins. As a result, some people can only function by inducing states of stress, agitation or pain (e.g., self-harm), and by developing risky behaviours. In such cases, the production of endorphins becomes a way of giving oneself a form of temporary comfort.

If the fight-or-flight response is effective or individuals receive the necessary protection, the long-term negative impact is reduced. However, if these persons are unable to defend themselves or flee and are not protected because of their age, characteristics or situation, they may become extremely vulnerable and powerless in the face of the threat. They may freeze when confronted with danger and develop a form of learned helplessness while continuing to experience the impact of stress in their body. This type of paralysis in the face of danger is believed to be associated with neuro-psycho-physiological disorders and influence the strategies people adopt to cope with stress. Young children who are neglected or maltreated have abnormal cortisol production patterns, which may last even after a child has been moved to a safe and loving home. For example, babies do not have the necessary tools to flee or defend themselves, so if there is a perceived threat, they will give out signals. If they do not have a reassuring response to these signals, they may eventually stop exhibiting them. As a result, these children learn that the only way of coping with repeated danger is to freeze.

[1] See the work of Sonia Lupien on human stress: http://www.humanstress.ca/.

What happens when a human being feels fear?[2]



A child is sitting in class and hears a door slam. He tells himself that it is only the door of a neighbouring classroom and that he is not in danger. He gets back to work.

Another child is sitting in the classroom and hears the same door slam. He is startled, gets up and hits the student in front of him. The teacher does not understand what happened. The child is punished and removed from the classroom.

When people are confronted with a situation that frightens or threatens them, it occurs via a sensory stimulus (in this case, the sound of the door slamming). The **thalamus** is the essential gateway for all messages captured by the senses (sight, hearing, touch, smell and taste).

Information from this external stimulus reaches the amygdala in two different ways: by a **short route** that is quick but imprecise, directly from the thalamus, and by a **long route** that is slow but precise, passing through the cortex.

The more direct **short route** allows us to start preparing for potential danger even before we know exactly what it is. These precious fractions of a second can, in some situations, make the difference for survival. The **amygdala** is one of the structures responsible for self-protective responses such as fight or flight. It plays an important role in learning, memorizing and managing emotions. In addition, the amygdala coordinates the body's response to fear and aggression (e.g., sweaty hands, increased heart rate, muscle tension, etc.). It contains several circuits of our alarm system. The fast route from the thalamus to the amygdala takes no chances and alerts us to anything that appears to be a danger.

The stimulus will also take the **long route** from the thalamus to the **cortex** and **hippocampus**, giving access to memories and cognitions. The **hippocampus** is mainly involved in associating the stimulus with the context of the situation. The **cortex** is believed to be involved in the last phase of the confrontation with the danger, the one where after the initial automatic emotional reaction, it is necessary to react and choose the most effective action to avoid the danger. It allows for the correction or interruption of responses that prove to be inappropriate. The voluntary planning of an emotional

[2] See "The Two Pathways of Fear" in The Brain from Top to Bottom: https://thebrain.mcgill.ca/flash/i/i_04/i_04_cr/i_04_cr_peu/i_04_cr_peu.html

response suited to a situation, which higher mental structures enable, is a wonderful complement to the system of rapid and automatic responses. Connections from the prefrontal cortex to the amygdala also allow for some conscious control over anxiety. Having access to both routes is an asset and it is understandable why, from an evolutionary perspective, these two complementary pathways were able to develop.

In the example mentioned above, the child who has access to the long route can say to himself, *"It's nothing, I'm in class, I'm not in danger, it's just the door. My teacher is there for me."*

For children exposed to maltreatment, who have experienced chronic stress, the path from the stimulus to the amygdala becomes a well-used and increasingly fast road, while the long route becomes a path less and less travelled. This explains why traumatized individuals frequently move without transition from a calm state to an emotional outburst. Bloom *(1999)* explains that such individuals react as if they have lost control of the volume of the warning system and become unable to regulate their reactions according to the intensity of the threat or stressor. It can also be said that young children who have lived in an abusive environment have not had the chance to learn to develop this ability to regulate their internal states. Areas of the brain such as the hippocampus and cortex may even atrophy *(Teicher, 2000; Perry, 2001)*.

In addition, Broca's area, an area of the brain responsible for language processing, may also be reduced, making it more difficult for children to put into words what is worrying or disturbing them. Traumatic fragments may be encoded in non-verbal memory and protective responses may then be triggered unconsciously. Children who do not have the words to translate their experience into a story will record the traumatic experience in the form of powerful and pervasive images, sensations and impressions. Sandra Bloom *(1999)* talks of "wordless" experiences: children cannot talk about or even reflect on what they have experienced, but can only relive it.

It is not only the stress management system that can be affected. Exposure to maltreatment and adverse conditions in childhood can affect the brain in terms of its size, structure and function. The neuroendocrine system may also be altered and neural networks dedicated to protection against danger may be favoured to the detriment of circuits associated with learning. These effects are also associated with a decreased capacity to regulate emotions and behaviour as well as inadequate development of executive functions that enable the execution of more complex cognitive tasks such as goal selection and planning, anticipation and inhibition. They are closely linked to the management of behaviour, emotions and social skills. For example, inhibition plays a role in controlling impulsivity by allowing a young person to curb a behavioural impulse.

Fortunately, current knowledge also speaks of positive brain plasticity and the ability to create new neural networks. Early life experiences are periods of intense change in the brain. It seems that having positive and restorative experiences has an effect on the development of self-esteem and that this may ultimately be reflected in the size of certain regions of the brain, including the hippocampus. Providing children with enriched environments that offer a variety of stimuli and encourage exploratory behaviour could have a positive and possibly restorative effect. Experiences that allow children to feel in control of situations would enable them to develop adaptive stress management strategies. If children perceive that they have power over situations that generate minimal stress, it allows them to process the information, experiment with more adaptive strategies at the behavioural, emotional and cognitive levels, strengthen their self-esteem, and ultimately achieve a more harmonious brain development.

In dangerous situations, it is more useful to fight or flee than to develop plans or strategies.

Acting rather than thinking	→	***The limbic system (amygdala) rather than the hippocampus and cortex***

Assessment and intervention

According to Bloom (1999), children with sequelae related to complex trauma should not be considered as sick or bad, but rather as individuals who have been injured. This understanding profoundly changes the perspective in terms of the care to be provided and the conditions to be put in place to foster their resilience. It is rather unproductive to try to diagnose the disorders these children are experiencing. Instead, we need to focus on finding environments in which they can feel safe enough to risk learning the things they were unable to learn because they had to mobilize all their resources to protect themselves and survive.

When a caregiver or person responsible for a child on a daily basis truly understands that an injured child does not function like everyone else, that the impact of trauma has led to changes even in the structure of the brain, that the inability to trust leaves a child alone and helpless, it is easier for him or her to be empathetic. Children sometimes have very little control over their reactions and do not have access to all the tools to cope and face all the challenges that present themselves daily. A parallel can be drawn with children who have suffered multiple fractures and do not have the power, despite their best intentions, to control what is happening in their bodies. It will be necessary to protect these children long enough to set up conditions for recovery and gradual relearning. Children need to be encouraged to be active participants in their own well-being by facing challenges that will be adjusted over time.

Recommended tool:

THE NOTION OF TRAUMA	Appendix 1 – **TIP SHEET FOR CAREGIVERS**

Information gathering, assessment and screening

HOW ARE CHILDREN SCREENED FOR TRAUMATIC SEQUELAE?

Not all children who have been exposed to potentially traumatic events will develop traumatic symptoms. However, it is essential to be as aware as possible of the adverse events that have marked a child's life.

In addition, it is important to be aware of the cumulative effects of repeated, chronic abuse. Such situations, taken individually, may seem trivial or insufficient on their own to cause significant harm and may therefore escape the youth protection system. In fact, **dealing with such situations individually without treating them as part of a larger pattern may have the effect of exposing a child to what is described as cumulative harm or chronic abuse**.

By their very nature, trauma-informed interventions require caregivers to engage in a **rigorous process of information gathering during which they are willing to question their initial perceptions**. In addition, caregivers must remain curious and open to what they do not yet know or understand.

Note: It is helpful to have information on a child's traumatic experience, but it is not essential for intervention. In situations where a child has been maltreated, the trauma hypothesis must always be considered in the intervention. It is important to avoid intrusion and inquisitive attitudes, opting instead for sensitivity and respect in order to welcome additional information, should it present itself.

Proper assessment of a child requires a caregiver to:

- identify, out of a broad range of traumatic events, those to which the child has been exposed (either as a witness or victim) and determine at what age and stage of development they occurred. The type of exposure, frequency, severity, duration and source are all important factors in building a picture of the child's individual experience.

> *"... the different victimization experiences, whether they take place within the family or in the child's broader environment (e.g., school, neighbourhood, etc.), and whether they come from a parent, another adult or a peer, tend to be associated with each other in the lives of young people. These youth, who accumulate victimization experiences ... appear to be particularly affected at various levels of their development."* **(Gagné et al., 2012)**

Recommended tool:

THE NOTION OF TRAUMA	Appendix 8 – **FACTORS FOR IDENTIFYING CHILDREN AT HIGH RISK OF DEVELOPING *POST-TRAUMATIC STRESS DISORDER* (PTSD)** **A.** Trauma / History of loss

- Assess whether the caregivers (parents or substitutes) have experienced traumatic events themselves and still have sequelae.
- Learn the history of the child's placements and relocations since birth (history of relational breakdowns).
- Identify symptoms, risky behaviour, difficulties in functioning and developmental delays. According to Miller and Bromfield *(2010)*, developmental delays may be one of the key components of traumatic sequelae in addition to behavioural difficulties and problematic attachment to caregivers.

Recommended tools:

THE NOTION OF TRAUMA	Appendix 8 – **FACTORS FOR IDENTIFYING CHILDREN AT HIGH RISK OF DEVELOPING PTSD** **B.** Current traumatic stress reactions **C.** Attachment **D.** Behaviour requiring immediate stabilization **E.** Current reactions / behaviours / functioning
THE NOTION OF TRAUMA	Appendix 2 – **DOMAINS OF IMPAIRMENT IN CHILDREN EXPOSED TO COMPLEX TRAUMA**[3]

- Gather all relevant information from clinical interviews, standardized measurements and observations.
- Gather information from a variety of sources (e.g., the child, parents, extended family members, adults responsible for the child at the daycare or school, and other professionals).
- Try to understand how different events may have impacted the child's development.
- Search for factors that remind the child of the trauma and cause symptoms or problematic behaviours.
- Work with a multidisciplinary team, if possible.
- Use the information gathered from the tools while keeping in mind that there is no direct correlation between the number of items checked off and the child's risk of developing traumatic sequelae. Caregivers must use their clinical judgment to interpret the information collected. These tools allow for rigorous collection, taking into account the notion of trauma, and promote a response that is better suited to a child's needs.

[3] Cook, A., Blaustein, M., Spinazzola, J. and Van der Kolk, B. (2003). Complex trauma in children and adolescents. National Child Traumatic Stress Network.

Questioning the symptoms

Human development is a process of maturation and learning that continues at every stage of life. Research shows that children exposed to violence are at risk of developmental delays, particularly in the areas of attachment, academic success and socialization.

The symptoms observed in children are often the result of their efforts to cope and survive in certain extremely stressful or dangerous situations. These defensive coping strategies are then used in different contexts in which such children cannot adjust and may even become harmful. Some symptoms may be due to developmental delays related to a lack of stimulation or to the deleterious effect of stress on certain regions of the brain.

Signs indicating problems in young children:

- Hypertonia or hypotonia (muscle tone)
- Baby does not explore his or her body or objects
- Lack of vocalization
- Does not engage in mutual discussions
- Baby is overreactive or underreactive
- Absence of the Moro reflex[4]
- Problems with sleep or feeding
- Failure to thrive (height/weight ratio)
- Developmental delay
- Unexplained infections or fevers

Manifestations of trauma in older children:

- Nightmares and phobias illustrating fear
- Intrusive thoughts
- Alert state in which the child is agitated or tense
- Difficulty sleeping or oversleeping
- Marked distrust of others or lack of boundaries
- Rigidity and fear of change or novelty
- Impulsive behaviour
- Lack of concentration
- Unconsciously repeats the traumatic experience, causing chaos, rejection and violence
- Behavioural problems
- Difficulty in cognitive and neurological functioning
- Difficulty in social and emotional functioning, affecting relationships

Recommended tool:

THE NOTION OF TRAUMA	Appendix 3 – **POSSIBLE REACTIONS OF CHILDREN AGED ZERO TO SIX EXPOSED TO TRAUMATIC STRESS**

[4] Young infants that are doing well tend to bring their upper limbs together. During the first three months of life, the most common body posture is the fetal curl. Any extension posture during this period is either a stress posture or a posture related to a brain injury. They are tense and sometimes look like disjointed dolls.

Identifying triggers

Knowing a child's triggers

When there is good reason to believe that children have been maltreated, neglected or exposed to potentially traumatic events, and they exhibit various behaviour and symptoms that appear to be traumatic sequelae, it is necessary to examine what may trigger automatic stress reactions in them. A "trigger" is anything that causes an emotion, cognition, physiological reaction or flashback in a traumatized child and brings the child back to a previous traumatic experience. These flashbacks can occur in situations such as play (e.g., a toy car siren or toy gun sound) or a child's daily routine (e.g., having their hair brushed) and unconsciously recall a violent or abusive experience. Triggers are very personal and as varied as there are experiences and ways of dealing with them. Children may begin avoiding situations and stimuli associated with their flashback. They may react with an emotional intensity similar to that felt at the time of the trauma. Triggers can be activated by one or more of the five senses: sight, hearing, touch, smell and taste. According to Blaustein and Kinniburg *(2010)*, some triggers may be non-specific and therefore more difficult to identify. This leads adults caring for these children to become veritable "feelings detectives."

Children need to be supported and adults must search with them for what triggers certain automatic responses of fight, flight or freeze.

For example, children may react to the establishment of a routine. They may feel that there is an attempt to control them which they consider threatening. Children may also react to some form of positive reinforcement. They are usually not aware of their triggers and therefore cannot make the connection between the behaviour manifested and its corresponding triggers. This requires that the adults caring for such children perform some investigative work to help them understand what is going on. However, this work needs to be done in a respectful manner: it is useless to question a child incessantly about the situations that contributed to the activation of such triggers. The preferred approach is to be on the lookout for the moment when it happens.

Examples of triggers:

SIGHT

- Someone who resembles the adult at the source of the trauma or has similar traits or attributes (e.g., clothing, hair colour, particular gait, etc.)
- A situation that is reminiscent of abuse (e.g., verbal or physical abuse; more subtle gestures associated with anger or aggression such as wide eyes, raised eyebrows, etc.)
- An object that was used during traumatic situations
- Objects associated with a place where traumatic events occurred (e.g., bottle of alcohol, furniture, etc.)
- Any place or moment associated with the trauma (e.g., specific locations in a house, such as the bedroom, or a specific time of day or year, such as bedtime or back to school)

HEARING

- Anything that sounds like anger (e.g., yelling, blaming, banging on a table, tearing sounds, etc.)
- Anything that sounds like pain or fear (e.g., crying, whispering, screaming)
- Any sound that could have been heard and that recalls traumatic situations (e.g., police or fire truck sirens, music, car, door closing, someone's tone of voice, whistling, etc.)
- Certain words related to events (e.g., swearing, criticism, specific words used, etc.)

SMELL

- An odour associated with a person that reminds one of the trauma (e.g., tobacco, alcohol, drugs, aftershave, perfume, cologne, etc.)
- A smell that is reminiscent of a place where the trauma occurred (e.g., cooking food, wood, household products, etc.)

TOUCH

- Coming into contact with something that reminds one of the trauma (e.g., certain physical contact, someone standing too close, petting an animal, the way a person approaches, etc.)

TASTE

- Something related to the trauma (e.g., certain foods, alcohol, tobacco, etc.)

Examples of non-specific recall

Many other circumstances can be perceived by children as a threat or loss of control and can generate an automatic fight, flight or freeze response to those stressors. Here are some examples:

- Being asked to do something you do not feel capable of doing (at school or at home)
- Being refused something
- Being alone in the dark
- Feeling hungry or thirsty
- Being given a directive or instructions
- Having to wait
- Being subjected to a change or something unexpected
- Receiving positive attention
- Being bored
- Being sick
- Being in a noisy place, with many people

Decoding what triggers excessive stress responses requires careful and patient observation by the adults caring for a child. As such, it would be useful to ask the following questions and reflect on them with the child and adult caregivers:

- What are this child's triggers?
- Are the triggers known and taken into account by the child's caregivers?
- What actions need to be put in place?

Recommended tool:

THE NOTION OF TRAUMA

Appendix 4 – **PLAYING THE "FEELINGS DETECTIVE": IDENTIFYING TRIGGERS WITH CHILDREN AND WAYS TO REASSURE THEM**

Recording and sharing information

To provide effective services, the people who make up the support network (i.e., the various professionals working with the child, the parents, the foster parents, etc.) must collaborate and get organized. It is sometimes difficult for the various caregivers involved with a child to coordinate their efforts and communicate while respecting the confidentiality rights of users. One of the aspects to ponder in order to better help the child is to create a care system around the child.

Sometimes families and the people involved in the child's day-to-day life do not have enough information and are not aware of what precautions to take.

We believe that certain information (e.g., this child does not like being touched, this child is afraid of such and such an environment or such and such a person, etc.) should be able to be communicated without jeopardizing the right to confidentiality.

It is also important to convey to the child's parents that, to truly help the child, certain information needs to be grouped together. In addition, the child's triggers need to be identified and communicated to caregivers daily so that they can participate in the screening process. This will allow stakeholders to reflect together on the best strategies to put in place in order to soothe the child and help him or her feel better.

In complex situations (e.g., family history of psychiatric problems, ADHD, substance abuse, etc.), **it is important to avoid isolation**. The use of specialized clinical support must be considered. Requests must be forwarded quickly before the situation becomes irrecoverable (e.g., obligation to move a child in a crisis situation). Requested psychological assessments must be used appropriately. Such children must not only be viewed from a trauma perspective, but also treated by taking into account their past experience and genetic heritage. For example, many parents who maltreat their children or are unable to protect them have ADHD, mental health problems, or traumatic sequelae related to their own relationship history. These factors confirm the importance of working in an interdisciplinary manner with these children.

Intervention: Fostering resilience

To conduct interventions according to best practices, it is necessary to ensure that professionals are familiar with the stages of child development and understand the impact of trauma on this development. This means they will need to take a greater interest in the trauma aspect and take actions that minimize the risk of causing further negative effects. Care must be taken to avoid any actions that might be perceived by the child as adding to the trauma, and such thinking should become a daily practice in the clinical community, regardless of the person's role. The first treatment for a child experiencing traumatic sequelae is to enable the child to develop a sense of security. It is necessary to ensure that the neglect and abuse come to an end and that the child's needs are met. We must provide a physical, emotional and sensory environment that allows the child to avoid further dysregulation and promotes the acquisition, development and strengthening of self-regulation skills. It is essential to support and promote stable relationships in the child's life so that he or she can resume optimal development.

When faced with behaviour that is difficult to understand, either by the parents or the child, here are some guidelines from several sources of knowledge on trauma:

Remember that each child and family situation is unique, therefore you will need to find and implement what is appropriate for that child and family. Unfortunately, there is no foolproof method that applies to all!

- Make sure to keep in mind the possibility of traumatic sequelae as a result of the child being abused.

- Consider that the parents may be living with traumatic sequelae themselves, whether they are aware of it or not.

In such a case, keep in mind the unconscious pattern of responses activated in the brain by stress in order to better interpret the child's or parent's behaviour.

Blaustein and Kinniburgh *(2010)* outline some possible expressions of these stress responses:

FLIGHT ➡	Isolating oneself socially, avoiding others, running away
FIGHT ➡	Aggression, irritation, anger, difficulty concentrating, restlessness
FREEZE ➡	Restricting one's emotional expression, denying needs, inhibiting behaviour, being overly submissive

- Remember that traumatic stress at a young age may have affected the development of all of the person's resources and hindered the deployment of higher cognitive abilities (e.g., reasoning, self-control, problem-solving, etc.). Such individuals do not choose bad strategies on purpose; they may possibly not have been able to develop other strategies or find it difficult to learn new ones. Their stress response has become an automatic reaction as if they are **continuously** in a survival situation.

- Never lose sight of the fact that caregivers can be moved and affected by what the parents and children with whom they work have experienced and are still experiencing. It is important to remain aware of one's own feelings and to give oneself the means to self-regulate in order to provide more effective interventions. Do not hesitate to seek all available support in and around the work environment.

- When dealing with traumatized children, it is necessary to calm them and reduce their state of alertness in order to achieve meaningful discussion. As long as the perception of a threat has not been extinguished or truly diminished, these individuals find it difficult to reason or engage in dialogue.

- As much as possible, consider and anticipate what can trigger anxiety, insecurity or stress. This includes anything that can make the child or parent feel threatened.

- Be aware of the possibility of hyposensitivity or hypersensitivity which could lead children to underreact or overreact to sensory stimuli. For example, children with hypersensitivity may react strongly to innocuous physical contact, as if they have been startled. A young child who is being held may express a strong sense of discomfort at a change in posture. When such reactions are observed, the child should be warned in advance and prepared for the necessary change in position or physical contact. In these cases, do not hesitate to consult an occupational therapist.

- Ask yourself what actions should be taken, identify those that could be a source of stress for the parent or child, and try to make them as predictable as possible.

- Provide explanations, guidance and reassurance, paying attention to the verbal and non-verbal language used to communicate with the person so that the message is comforting. Caregivers must first regulate their own emotions to ensure that their message is not compromised.

When the children live with their parents

Parents who live in potentially traumatic situations need to be supported in order to properly carry out their parental duties in relation to their child's characteristics.

When children are kept in their family environment, we must try to help the parents put an end to potentially traumatic situations and be able to respond to the needs of their children, who have been rendered more vulnerable through their adverse experiences. The stakes of such interventions are high because in successful situations, it will ensure that these children will not be displaced, avoiding a relational breakdown that can be a new source of trauma.

However, as human beings, the parents often have difficulties of their own or a history of having lived through several events that have left them traumatized. For many, this past is unresolved and affects several aspects of their lives (e.g., employment, stability, interpersonal relationships, victimization, isolation, etc.). Therefore, we need to help them better understand these issues in order to encourage them to seek personal help and initiate the necessary changes.

It is important to consider that parents who are refugees or have emigrated from a country ravaged by war, an oppressive system or natural disasters may also be dealing with unresolved traumas. The experience of emigration itself, with adjustments to a new culture and value system, can also be a significant source of stress which increases the vulnerability of the family and thus the child. Consultation with and supervision by experts in cross-cultural intervention can help caregivers put the child's needs and family issues into perspective.

A factor that fosters resilience in children is when their parent engages in a rehabilitative process with them and accepts responsibility for exposing them to abuse or failing to protect them. This initiative by the parent toward the child is beneficial whether the child remains with the parent or is placed with an extended family or in a substitute environment. Often, children feel shame, guilt and responsibility for what has happened to them. Sometimes, children experience role reversal by trying to take care of their parents and may continue to feel responsible and helpless in their futile attempts to help

or change them. When a professional reassures a child that he or she is looking after the parent's condition, the child may feel relieved.

When children are kept in their family environment, despite any compromise decided, caregivers must remain alert to their behaviour or verbalizations, their reactions in the presence of their parent, and their relationship with their parent. In addition, caregivers must arrange meetings with these children without the presence of their parents to allow them to express themselves and learn about their difficulties and needs.

Recommended tool:

THE NOTION OF TRAUMA	Appendix 5 – **PARENT TIP SHEET**

When the children require placement

If a child's situation requires placement or relocation, it should always be considered that placement is a means of protecting the child and ensuring his or her safety and development. It is an intervention designed to address the "harm" to which the child is exposed. However, such placement may be perceived by the child as a new traumatic event on top of what has already been experienced. That said, some children experience placement as a relief or safe haven where they finally feel understood. It should be kept in mind that each situation is unique. The important thing is to prepare the child at all times and inform him or her of what is happening.

It should also be taken into account that placement or relocation removes children from their living environment, separating them from their parents with whom they may have developed an attachment bond if they were sufficiently present and provided them with care, despite the episodes of maltreatment. Although such an attachment may not be secure, it remains that these parents are the individuals with whom these children have bonded. In other situations, children may have failed to bond with their parents due to their excessive neglect and repeated tendency to transfer them to other guardians. Therefore, stakeholders need to think about the bonds that each child has developed and the quality of these bonds. In addition, children who undergo placement find themselves in a new environment that we, as adults, know is safe, but which they view as completely foreign. It is important for young children to be able to maintain their bearings. For example, caregivers must be aware of the olfactory cues of the parents' living environment (e.g., stuffed toys, blankets, clothing, etc.). Familiar smells can be reassuring for children who have been separated from their environment. Therefore, it is important to inform the foster home upon the child's arrival. On the other hand, in the case of children who have experienced trauma in their family environment, it is important to determine whether these cues are reassuring or not. In addition, any interventions taken should be explained to a child, along with their meaning, in an age-appropriate manner. The impact of our clinical actions on children should never be trivialized, even though we are acting for their benefit. The planning of an intervention during a placement, clinical reasoning, knowledge and soft skills are all very important, in the interests of the children.

When a child is scheduled to return to his or her parents, they must be aware that even if they make personal and environmental changes, the child will still have to develop a sense of security and trust. Therefore, these parents require counselling so that they understand the impact that traumatic experiences

have had on their child and can develop appropriate support strategies. As well, work on the relationship will be necessary to facilitate reunification.

It is important to be aware of this reality so that children are not "treated" and returned to their family environment without the necessary support being provided to their parents.

In the process of working with troubled youth, when the alternative of returning to the parents is not possible and such children are to be kept in a substitute living environment for a longer period of time, until the age of majority or they are adopted, intervention in the substitute environment is essential, especially for children who have been victimized by trauma. To avoid relocation and ensure the stability and permanence of a living environment and its new attachment figures, interventions with the foster parents and children should be as intensive as possible for at least the first three to five months of the placement. Foster parents must be made aware that this period will be more difficult, but if they are patient and persevere, they will enable the child to resume his or her development and, more specifically, regain normal brain functioning.

Traumatized children require adults who can offer them serenity, patience, security and a quality response to their needs. These same adults must be able to create a safe haven for these children: a place that will finally enable them to develop an alarm system that functions more appropriately.

In addition, when children are placed in foster care, an assessment must be made as to whether they can have contact with their parents and whether or not these encounters should be supervised. The child's needs and best interests must be considered and prioritized when arranging contact with the parents. Although the child has been maltreated by the parents (i.e., neglect, abuse, lack of protection, etc.), they remain the child's attachment figures and, as mentioned earlier, being separated from them can have a significant impact.

If contact poses a risk of triggering traumatic memories, different strategies can be considered to encourage contact in a way that meets a child's needs. Caregivers can arrange various forms of indirect contact such as letter exchanges, video contact or supervised visits. If the child's caregiver is not the person supervising the visit, youth workers who do should be informed about the child's situation, the parents' difficulties, and the child's reactions and behaviour during previous supervised visits. Supervising adults need to know where to focus their attention and ensure that the child is protected both physically and psychologically.

In some cases, children's visits with their parents may trigger traumatic memories. Sometimes, simply hearing about a parent can trigger fears in a child. For this reason, visits should be documented (before, during and after) and evaluated regularly (e.g., frequency, duration, quality of the encounter and the parent's ability to be reassuring or not). During a placement, everything must be done to make the child feel safe.

Daily intervention with a child and some guidelines for adults who care for a child on a daily basis[5]

(Foster family, rehabilitation workers)

The following guidelines are intended for both foster families and rehabilitation workers involved with these children, either in the community or a rehabilitation setting. It is important to note that regular foster families, particularly local ones, need to be supported and guided by caregivers regarding the care to be provided and the resources available in order to develop this different understanding and the intervention strategies resulting from it. The support to be offered to families is of crucial importance in the first few months of a traumatized child's arrival. Since rehabilitation workers share the daily lives of children placed in foster care, they too must become familiar with these concepts, but their basic and on-the-job training facilitates their use of this knowledge.

[5] The following content is strongly based on the ARC model.

Meeting a child's safety and attachment needs

In addition to the actions mentioned above regarding the prevention and management of stressors that can lead to problematic behaviour, adults who share a child's daily life can address his or her safety and attachment needs with the following precautions:

- Establish and maintain stable and predictable daily routines. If exceptions need to be made, the child should be notified as soon as possible and reassured with information on what will happen next. This is important even if it makes the child react, because it is an opportunity to work with the child on predictability and coping skills. It also becomes an opportunity for the child to use the adult to calm down.

- Establish rituals, traditions and familiar aspects in the child's life which can become positive cues that the child can anticipate, hope for and remember (e.g., birthdays, Halloween, holidays, etc.). For many children with a traumatic past, time is just a succession of unrelated moments.

- Before committing yourself and "promising" something to a child, make sure you are capable of carrying it out so that you do not jeopardize the trust that may begin to develop.

- When dealing with a child's disruptive behaviour, take the time to self-regulate as an adult before acting on the child's behaviour. Remember that children are sensitive to non-verbal language (i.e., the adult's body language), not just words.

Observe the child to find out to what extent the child benefits from closeness to the adult. Be aware of the level of closeness in which the child feels comfortable in the adult's presence without feeling invaded or controlled.

Supporting emotional regulation

- When children express discomfort through their words or behaviour, they need to be reassured that they are being heard, that caregivers are aware of their discomfort and that their need will be addressed, even if it cannot be done immediately. If they are told that their concerns will be dealt with in a few moments, ensure that this can be done or at least demonstrate that they have not been forgotten.

- When children exhibit disruptive or inappropriate behaviour, let them know that caregivers are aware of their situation, understand that they are not well and hope to address their need without putting them in an uncomfortable state.

- Help children become aware of the bodily sensations they experience when they are stressed, feel bad or are angry, which is often a useful first step before helping them recognize, regulate and express their emotions another way.

- Help children put their feelings and emotions into words by beginning to identify these feelings and emotions for them and then, increasingly, with them.

- Help children understand how they function in situations that generate stress for them and to relieve themselves of guilt when faced with their more problematic behaviour or failures. This does not mean relieving them of responsibility, since learning to regulate their alarm system will allow their brain to access other possibilities.

Recommended tool:

THE NOTION OF TRAUMA

Appendix 6 – **EXPLAINING THE INJURED BRAIN TO CHILDREN AND THEIR ADULT CAREGIVERS**

- Propose various fun activities to children to allow them to experience moderate stress or challenges (e.g., an activity involving physical effort) with the support of an adult in order to help them develop and practise positive strategies.

- Help children develop a sense of mastery and empowerment by not exposing them to other experiences that make them feel helpless. Offer them choices, even if limited, rather than forcing them to do something.

- Work with children to help them identify the situations when they feel particularly bad (i.e., become "feelings detectives"[6]) and which make them activate their stress response.

- Encourage experiences that enable children to practise and utilize positive expression strategies and to recognize the appropriate times or situations to do so.

- Remain vigilant when faced with children who are less noticed and more distant. They may be just as stressed or frightened as those who react by fighting or fleeing.

- Support children in their search for ways to restore internal calm and bring their energy back to a comfortable level (e.g., diaphragmatic breathing, yoga postures, etc.). Depending on their age, various methods can be chosen with them. Occupational therapy provides a multitude of sensory methods that can be used for this purpose. Sensory treatment as part of an occupational therapy follow-up can be an opportunity to provide children with another space to receive reassurance.

Promoting skill development

- Help children experiment with activities in which they can build new skills. This will enable them to gradually discover what they enjoy and whether they possess hidden talents.

- Expose children to a variety of learning situations (e.g., gross motor activities; artistic, cognitive and musical expression, etc.). Activities promoting non-verbal expression (e.g., drawing, poetry, music, etc.) can provide children with the tools to express their feelings in a constructive way.

- Encourage children's positive interests, pay attention to what they enjoy (e.g., collecting, reading, games, etc.) and encourage them to engage in these activities with others, if possible.

- Support children by raising their awareness of what they are learning. Help them explore ways of doing things which lead to success and provide them with a sense of power over their lives.

- Take advantage of every opportunity to broaden their vocabulary and knowledge, which will also help them expand their emotional range.

- Give children the opportunity to hear adults openly engage in the problem-solving process (i.e., acknowledge their own emotional reaction, calm themselves and take a step back, analyze what is happening, think about possible solutions and their consequences, make a choice, etc.).

- Teach children to practise the problem-solving process, helping them take the time to perform the various steps. Conduct such practice in peaceful surroundings, as it will be difficult to do so spontaneously in conflictual situations.

- Provide opportunities for children to make choices and decisions in non-stressful situations (i.e., work on the long route to the amygdala).

Supporting the integration of traumatic experiences

The ultimate goal of intervention is to allow children to somehow "digest" their traumatic experience and free themselves from it as much as possible in order to live more peacefully. It is important to realize that this outcome may take many more years and far more treatment than we can provide. All of the intervention strategies previously mentioned have been designed

[6] See Appendix 3.

to reduce the impact of trauma and help individuals develop the mental fortitude to be able to gradually deal with these painful aspects of their past.

It is important to understand that reaching this stage of traumatic experience integration is not strictly necessary in order to conclude that an appropriate intervention has been made. In many cases, learning to free oneself from the dark aspects of maltreatment and coming to terms with a past that cannot be changed are achievements that happen over the course of a lifetime.

- Never insist that children talk about the trauma they experienced in their family, but be prepared to be receptive if such experiences are mentioned or they appear open to such a discussion. Above all, listen without interpreting or judging. Avoid making judgments about the family, which would only exacerbate loyalty conflicts.

- If children are willing to talk about their traumatic experiences, it is important, if more than one caregiver is involved in their case, to coordinate who is best suited to support them in such a process. It is essential that any discussion of a child's traumatic past does not become another occasion for the child to be upset or hurt (see box on psychotherapy).

- Help children make sense of their past and current experiences when they are receptive to such an exercise and the situation is appropriate.

How do we know when a child is doing better?

One of the keys to intervention is measuring its effects to ensure that it is having a positive impact on a developing child. Has the child become better at playing, concentrating, participating and connecting with others? **(Miller 2007)**

Opting for psychotherapy

There are times when caregivers work with children who struggle noticeably and wish to refer these children for psychotherapy in order to relieve their suffering or that of the family. When caregivers feel helpless, they look for ways to alleviate this feeling by suggesting other types of services than what is already being provided. However, some children may not be ready to undergo therapy for a variety of reasons. A face-to-face encounter with an unfamiliar adult may be threatening. Such children may not have developed the tools to cope with the traumatic experiences they have faced. They must first build up certain strengths. Never underestimate the benefits of the care they can receive daily through the establishment of routines and rituals, the presence of a caring and reliable person who helps them recognize and express their emotions appropriately, their participation in activities that help them build more positive self-esteem, and so on. When children experience a stable environment that is truly committed to their needs, their chances of benefitting from psychotherapy are much greater.

Note: When children enter psychotherapy, attention must be paid to their status before and after the treatment in order to provide them with the support they require. Having a familiar caregiver and driver to and from the sessions facilitate the process. It is important not to initiate an intervention until the necessary conditions are in place.

Supportive intervention with an adult who cares for a child on a daily basis

(Substitute environment)

Before a child is placed in a foster home, it is imperative to properly assess the capacity of the substitute environment to care for that child and meet his or her specific needs. Whenever possible, we need to be able to recognize the attachment patterns of the foster parents to understand their relational patterns of interaction and determine how they can be helped to respond to and understand that of the child.

Foster families that receive children who have been removed from an environment marked by violence and abuse should be educated about trauma. Traumatized children have specific characteristics, including the possibility of re-experiencing the trauma (triggers) or post-traumatic symptoms, which we will often learn to detect along with the foster family. It is important to learn to detect what may trigger traumatic memories in a child (e.g., a child who was sexually abused when given a bath may react strongly simply by hearing water running from a faucet).

In addition, children are sometimes perceived as having a behavioural or oppositional defiant disorder, but in reality, they may have post-traumatic symptoms or reactions related to their attachment difficulties. It is important to keep in mind that such children will have to slowly learn to get attached to these new figures, which is not easy for them. Having good intentions, foster families are sometimes very loving and affectionate toward the children, thinking that they are helping them, but in such cases, they need to be informed of the importance of not invading the children's space and respecting their pace. The substitute environment must be able to make sense of a child's difficulties, allowing the child to be aware of previous life experiences in order to "survive" his or her problematic behaviour and emotions. A sustained intervention with the child and the substitute environment helps the foster parents better manage the emotions exhibited, while remaining receptive to the child.

It is important to do a rigorous follow-up with both the child and the foster family to see how the child is doing and consult specialized services quickly if there are signs of significant difficulties (e.g., psychologist, occupational therapist, child psychiatrist, etc.). The sooner services are put in place, the greater the chances of helping the child integrate into the family.

Caregivers

First coined in 1992, the term "compassion fatigue" was used to describe the exhaustion of nurses who respond to hospital emergencies on a daily basis. Since then, the term has been redefined and the phenomenon is known by several names (vicarious trauma or stress, secondary traumatic stress). Professionals who work in environments where social conditions are more difficult are most affected (e.g., youth protection, drug addiction, mental health, etc.). Symptoms of compassion fatigue are very similar to those of burnout. Affected caregivers tend to "bring their work home" and are no longer able to create a barrier between their work and personal lives. Gradually, stress, cynicism and irritability set in.

Caregivers may sometimes become very affected by the situations experienced by their clients. They may feel angry, powerless and discouraged which can lead to quick, impulsive decisions. They may want to conduct a massive intervention, perceiving an emergency. Conversely, they may try to cut themselves off from difficult emotions to protect themselves and then continue the intervention by minimizing what is happening and delaying their decision-making or actions. Caregivers may reach a point where they are unable to empathize with their clients.

Sometimes, caregivers minimize the magnitude of an event: "It's not the first time," "It's part of the job" (e.g., exposure to physical or verbal aggression, threats, etc.).

Caregivers sometimes feel ill-equipped to deal with certain traumatic situations because they do not consider themselves to be specialists (e.g., situations of physical or sexual abuse or mental health problems).

Caregivers who learn that a child in their caseload has experienced a traumatic situation may feel very guilty for not having seen it coming or for misjudging the risk. Insecurity may set in and they may become over-protective of the child, excessively intrude upon the family to which the child will be entrusted, or minimize the sequelae out of excessive guilt.

It is important for caregivers to take a step back before conducting an intervention and think about what is happening with a young person, even in an emergency situation, to avoid taking actions that make the situation worse or re-trigger a traumatic experience.

In addition, over the long term, it is recommended to build a support network around the family and child to avoid having everything rest on the shoulders of one caregiver.

Caregivers need to take care of themselves.

Here are some guidelines:

- Evaluate and monitor your own limitations.
- Maintain a healthy lifestyle (e.g., diet, physical activities, leisure, sleep, social life).
- Use a support network to share professional concerns (supervision, consultation, etc.).
- If needed, consult the Workplace Violence, Raise Your Awareness Self Test for Practitioners: https://violencetravail.criusmm.net/en/ or the Compassion/Satisfactory/Fatigue Self-Test for Helpers: http://www.community-networks.ca/wp-content/uploads/2015/07/Self-Assessment-Tools-Compassion-Fatigue-Feb-22-2010.pdf

Recommended tool:

THE NOTION OF TRAUMA	Appendix 7 – **SUMMARY LEAFLET**

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Trauma-informed practice

FOR CHILDREN AGED 0-11

APPENDICES

Appendix 1 – **TIP SHEET FOR CAREGIVERS**

A large proportion of young children being monitored under the *Youth Protection Act* have experienced or are at risk of experiencing traumatic situations while being extremely vulnerable, which can affect several aspects of their lives and have significant consequences on their development and security (physical and psychological). In addition to the violence experienced in the family, they are often exposed to other significant sources of stress such as poverty, which contribute to an uncertain environment.

Once in the system established for their protection, they face other stressors such as changes in their routine, relationship breakdowns, and so on. Each of the players involved, whether they are responsible for assessment, counselling, applying measures, resources, community rehabilitation or lodging, should be mindful of the sequelae left by the trauma experienced by adults and children. This knowledge is particularly useful in ensuring that the actions taken, gestures made and words spoken do not exacerbate the perception of the child or parent that an additional danger must be faced. Caregivers have a pivotal role in reducing the impact of a child's exposure to violence and traumatic events. The first step is to integrate the basic practice of routinely screening children who are at risk of developing traumatic sequelae and ensure that they and their families receive the attention and services they need. It is important to work as a team and provide the services that are required. Intervention planning must take into consideration the traumatic experiences of the parent and child and anticipate the potential stress that the caregiver's actions may cause them in order to take the necessary precautions to reduce this impact. Finally, certain caregivers may have been exposed to violent situations themselves. This must be taken into account and highlights the need for caregivers to take care of themselves in order to be truly receptive to helping others.

TO DO

1. Find out about the child's exposure to traumatic events

Tool to use:

Appendix 8 – A. Trauma / History of loss

Note: It is helpful to have information about a child's traumatic past, but it is not essential for providing support. In situations where the child has experienced maltreatment, the trauma hypothesis should always be considered in the intervention. An intrusive approach should be avoided in favour of sensitivity to encourage the child to disclose additional information.

2. How is the child doing? Is the child showing symptoms? Has a diagnosis been made?

Use the following tools:

Appendix 8 – B. Common reactions to traumatic stress
C. Attachment
D. Behaviour requiring immediate stabilization
E. Common reactions / Behaviour / Functioning

Appendix 2 – Domains of Impairment in Children Exposed to Complex Trauma

Appendix 3 – Possible Reactions of Children Aged Zero to Six Exposed to Traumatic Stress

It is important to look at the child's development and potential developmental delays by using the developmental assessment scale for children aged 0-5 or the document entitled "From Littlest to Biggest!" for older children.

3. What are the triggers? What provides comfort?

Use:

Appendix 4 – Playing the "feelings detective": Identifying triggers with children and ways to reassure them

4. Whether the intervention will take place in the original environment, a substitute environment or a rehabilitative environment, use a trauma-informed approach to adjust the support provided.

Use the following tools as needed:

Appendix 5 – Parent tip sheet

Appendix 6 – Explaining the injured brain to children and their adult caregivers

Appendix 7 – Summary leaflet

WHAT TO DO
If a child shows traumatic sequelae

Be aware of the symptoms that may be linked to one or more traumas experienced by the child to enable caregivers to identify them more clearly.

From the very first intervention, keep in mind the notion of trauma and its impact on the child to anticipate the effects of the actions to be taken to protect the child and determine strategies that reduce the stress caused to the child as much as possible (how, who, where).

Record observations (situation assessment, direction reports, follow-up of activities, etc.) on an ongoing basis so that support measures can be implemented as soon as possible by all those involved with the child (e.g., school, parents, foster family, professionals, volunteers, school bus drivers, etc.).

Ensure that this information is shared with partners and/or collaborators to promote interventions that are appropriate for the trauma experienced by the child and to avoid aggravating the child's mental state while respecting the confidentiality of user information.

Conduct a rigorous assessment of the impact of the child's placement and the resulting breakdown in contact between the child and the family (i.e., mother, father, siblings) in connection with the trauma experienced.

Similarly, document these facts in the reports to be produced in order to identify resources and/or services suited to their needs.

In the event of a placement in a substitute environment:

Prepare for the placement with the child and parent. Ensure that the move and integration are carried out as predictably and calmly as possible.

Repeatedly reassure the child that he[1] is not to blame for the placement. If possible, consider a gradual integration to give the child time to get to know the foster family.

Validate the child's emotions and answer his questions if he is capable of formulating them. If not, reassure and comfort him as much as possible. Inform him of what is coming, assure him that good people are taking care of him and that caregivers will remain in touch with him.

Find out about the child's habits, adjustment to routines, likes and dislikes so that the foster family can take them into account when welcoming the child and comfort the child as much as possible in dealing with a new and potentially stressful situation. Make sure that the child can bring along familiar objects that can comfort him. Visit the child in the environment where he resides to observe and learn how he is doing. Meet with the child and the adult taking care of him. A child living with traumatic sequelae cannot automatically establish a calm state because he lives in a protective environment. He will require thoughtful support from everyone involved before he is able to settle down and begins to be receptive.

The caregivers assigned to both the youth and the foster family work together to help the foster family understand the impact of trauma on the child's behaviour and support the child more effectively in the new challenges he will face on a daily basis. Convey the importance of both stability and predictability for the child, even if he seems indifferent.

[1] Throughout this appendix, when referring to children who have experienced trauma, the masculine gender is used for convenience only and refers to both males and females.

WHAT TO DO
If a child shows traumatic sequelae

Think of ways to help children calm down, become familiar with their new environment, and feel safe in this space before exposing them to other environments. These children, who have often not experienced a comforting routine, will learn what it means to have one. They will also learn that their new adult caregivers are there to help them through the conflicting emotions they are experiencing, that in response to their major tantrums, they will receive caring support and that ultimately these adults will try to help them put words to everything they are feeling.

Invite the foster family to observe how the child reacts to the adult caregiver's physical proximity, physical contact and displays of affection in order to quickly re-assess the intervention approach if the child shows discomfort through his or her behaviour.

With the network *(daycare, school, partners)*

Taking care to ensure the confidentiality of the child's history, inform the daycare or school from the outset about situations that are delicate for the child.

Involve these settings in careful observation in order to identify situations that may generate stressful reactions (i.e., fight, flight or freeze) in the child and to determine ways of calming the child according to his or her needs.

Special attention during supervised visits

- Refer to clear criteria for re-establishing contact between the child and his or her biological parents which take into consideration the child's state following one or more traumatic experiences.
- Refer to clear criteria for assessing the appropriateness of visits and, if they occur, the appropriateness of supervising them, taking into account the impact on the child's mental health following one or more traumatic experiences.
- Carefully observe the reactions of the parents and/or adults surrounding the traumatized child, as they may have a history of previous trauma that may be reactivated.
- Provide attentive support during supervised visits and respond quickly and calmly if the parent's attitudes arouse disturbed behaviour in the child.
- Promptly review with collaborators (resources, reviewer, etc.) the appropriateness of the visits if the child exhibits behaviour suggesting a reliving of trauma following the visits.

Appendix 2 – DOMAINS OF IMPAIRMENT IN CHILDREN EXPOSED TO COMPLEX TRAUMA[1]

1. Attachment

- ☐ Problems with boundaries
- ☐ Distrust and suspiciousness
- ☐ Social isolation
- ☐ Interpersonal difficulties
- ☐ Difficulty attuning to other people's emotional states
- ☐ Difficulty with perspective taking

2. Biology

- ☐ Sensorimotor developmental problems
- ☐ Analgesia
- ☐ Problems with coordination, balance, body tone
- ☐ Somatization
- ☐ Increased medical problems across a wide span (e.g.)
- ☐ Pelvic pain, Asthma, Skin Problems,
- ☐ Autoimmune disorders, Pseudoseizures

3. Affect regulation

- ☐ Difficulty with emotional self-regulation
- ☐ Difficulty labeling and expressing feelings
- ☐ Problems knowing and describing internal states
- ☐ Difficulty communicating wishes and needs

4. Dissociation

- ☐ Distinct alterations in states of consciousness
- ☐ Amnesia
- ☐ Depersonalization and derealization
- ☐ Two or more distinct states of consciousness
- ☐ Impaired memory for state-based events

Appendix 2 – DOMAINS OF IMPAIRMENT IN CHILDREN EXPOSED TO COMPLEX TRAUMA[1]

5. Behavioral control

- ☐ Poor modulation of impulses
- ☐ Self-destructive behavior
- ☐ Aggression toward others
- ☐ Pathological self-soothing behaviors
- ☐ Sleep disturbances Eating disorders
- ☐ Substance abuse Excessive compliance
- ☐ Oppositional behavior
- ☐ Difficulty understanding and complying with rssules
- ☐ Reenactment of trauma in behavior or play (sexual, aggressive, etc.)

6. Cognition

- ☐ Difficulties in attention regulation and executive functioning
- ☐ Lack of sustained curiosity
- ☐ Problems with processing novel information
- ☐ Problems focusing on and completing tasks
- ☐ Problems with object constancy
- ☐ Difficulty planning and anticipating
- ☐ Problems understanding responsibility
- ☐ Learning difficulties
- ☐ Problems with language development
- ☐ Problems with orientation in time and space

7. Self-concept

- ☐ Lack of a continuous, predictable sense of self
- ☐ Poor sense of separateness
- ☐ Disturbances of body image
- ☐ Low self-esteem
- ☐ Shame and guilt

[1] Cook, A., Blaustein, M., Spinazzola, J., & van der Kolk, B. (2003). Complex trauma in children and adolescents. Retrieved from https://complextrauma.org/wp-content/uploads/2019/01/Complex-Trauma-1-Joseph-Spinazzola.pdf.

Appendix 3 – POSSIBLE REACTIONS OF CHILDREN AGED ZERO TO SIX EXPOSED TO TRAUMATIC STRESS[1]

BEHAVIOR TYPE	CHILDREN AGED 0–2	CHILDREN AGED 3–6
COGNITIVE		
Demonstrate poor verbal skills	✓	
Exhibit memory problems	✓	
Have difficulties focusing or learning in school		✓
Develop learning disabilities		✓
Show poor skill development		✓
BEHAVIORAL		
Display excessive temper	✓	✓
Demand attention through both positive and negative behaviors	✓	✓
Exhibit regressive behaviors	✓	✓
Exhibit aggressive behaviors	✓	✓
Act out in social situations	✓	✓
Imitate the abusive/traumatic event		✓
Are verbally abusive		✓
Scream or cry excessively	✓	
Startle easily	✓	✓
Are unable to trust others or make friends		✓
Believe they are to blame for the traumatic experience		✓
Fear adults who remind them of the traumatic event	✓	✓
Fear being separated from parent/caregiver	✓	✓
Are anxious and fearful and avoidant		✓
Show irritability, sadness, and anxiety	✓	✓
Act withdrawn	✓	✓
Lack self-confidence		✓
PHYSIOLOGICAL		
Have a poor appetite, low weight, and/or digestive problems	✓	
Experience stomachaches and headaches		✓
Have poor sleep habits	✓	✓
Experience nightmares or sleep difficulties	✓	✓
Experience urinary accidents or exhibit other regressive behaviors		✓

[1] Zero to Six Collaborative Group, National Child Traumatic Stress Network. (2010). Early childhood trauma. Los Angeles, CA & Durham, NC: National Center for Child Traumatic Stress. Retrieved from https://www.nctsn.org/sites/default/files/resources/early_childhood_trauma.pdf.

Appendix 4 – PLAYING THE "FEELINGS DETECTIVE": IDENTIFYING TRIGGERS WITH CHILDREN AND WAYS TO REASSURE THEM[1]

What disturbs me, upsets me, angers me, makes me feel bad?

- ☐ **Hearing** screams, cries, words, sounds, etc.
- ☐ **Seeing** someone, something, a place, etc.
- ☐ **Tasting** a food, a liquid, etc.
- ☐ **Smelling** a perfume, an odour, etc.
- ☐ **Touching** something or being touched

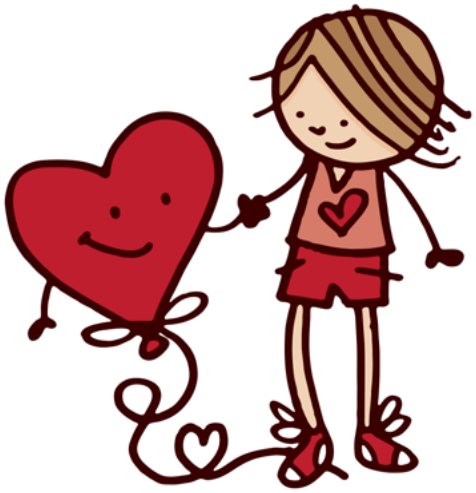
Other situations that bother me:

- ☐ Being asked to do something I don't feel capable of doing, either in class or at home
- ☐ Being refused something
- ☐ Being alone in the dark
- ☐ Being hungry or thirsty
- ☐ Being given a directive or instructions
- ☐ Having to wait
- ☐ Being subjected to a change or an unexpected situation
- ☐ Being bored
- ☐ Being in a noisy place, with many people

[1] For more information: https://psychcentral.com/lib/what-is-a-triggerTriggers.

Appendix 4 – PLAYING THE "FEELINGS DETECTIVE": IDENTIFYING TRIGGERS WITH CHILDREN AND WAYS TO REASSURE THEM[1]

What calms me down, makes me feel good?



Doing an activity: *Which one?*

Playing: *What? With whom?*

Talking: *With whom? In person? On the phone?*

Reading a story or having a story read to me: *Which one? By whom?*

Listening to music: *What kind? Favourite song?*

Others: *Plush toy, stress balls, an object, a blanket, etc.*

[1] For more information: https://psychcentral.com/lib/what-is-a-triggerTriggers.

Appendix 5 – **PARENT TIP SHEET**

While children can adapt to many situations, they still suffer when they are hit, abused, rejected or neglected. When they see or hear violence in their home or neighbourhood, they become afraid and may feel that their world is unsafe.

Each child is different, but exposure to violence can disrupt their lives and cause emotional, physical and learning difficulties as well as developmental delays, unless they get the help they need to recover and regain their confidence. Science has revealed that the brain of a child under 18 years of age develops less well when there is violence in the home.

Sometimes children react immediately to certain events, sometimes the expression of difficulties comes much later. Some children react very strongly and develop a host of problematic behaviours, while others live with the difficulties by isolating themselves. Children have their own way of reacting based on their age, their temperament and the reactions of those around them, and it varies from one child to another.

CHILDREN AGED 0–5

The reactions of young children are greatly influenced by the reactions of those who care for them. At this age, children who experience violence or traumatic situations may:

- be irritable and difficult to console
- be easily startled
- exhibit regressive behaviour (e.g., thumb sucking, bedwetting, fear of the dark, etc.)
- have frequent tantrums
- cling to you
- have wide variations in their activity level
- repeat during play or conversations what they have been through
- become passive or lose interest in playing or exploring
- become overly compliant

CHILDREN AGED 6-12

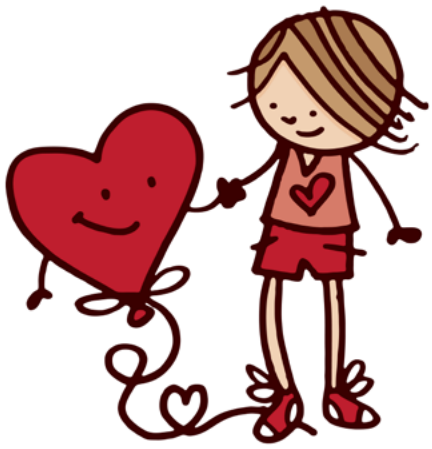
School-aged children exposed to violence or traumatic situations may have difficulties at home or school. They may:

- have difficulty concentrating
- be worried, upset or withdrawn
- cry, be sad or say alarming things
- argue with friends or adults
- isolate themselves

WHAT CAN YOU DO?

You are the most important person in your children's lives. You can help your children regain a sense of security and stability by providing a calm, predictable environment.

Some options:



- Answer your children's questions in simple language that they can understand.
- Believe your children and show them that you recognize what they have experienced.
- Tolerate your children's emotions.
- Do age-appropriate activities with your children which are good for skill development.
- Find ways to have fun and relax together.
- Help the children develop their vocabulary and teach them to identify the emotion they are feeling: angry, happy, sad, disappointed, etc.
- Establish routines and a predictable schedule. Children are reassured when they know what will happen, when and how.
- Set clear boundaries on an ongoing basis with patience.
- Show the children affection by comforting them, encouraging them and spending time with them.
- Manage your own emotions. If you are upset, take as much time as possible to calm down before talking to your children.
- Accept that your children are experiencing certain difficulties and behaving in ways that are unusual.
- Allow your children to use means to reduce their fears at bedtime (e.g., bedside radio, nightlight, reading, etc.).
- Protect your children from seeing or reading about scary situations (e.g., movies, stories, books, news, etc.).
- Take care of yourself.

Your children may need care or professional help to feel well and safe again. Do not hesitate to ask for information or consult an expert regarding your children's development.

You may need support yourself, especially if you have lived through difficult events in your childhood as well or are currently experiencing significant stress.

The Injured BRAIN

EXPLAINED TO CHILDREN AND THEIR ADULT CAREGIVERS

Québec

EDITORIAL

Carole Côté, Planning, Programming and Research Officer, Centre d'expertise sur la maltraitance, Centre de recherche et d'expertise Jeunes en difficulté, Centre intégré universitaire de santé et de services sociaux du Centre-Sud-de-l'Île-de-Montréal (CCSMTL)

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ILLUSTRATION

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This leaflet was created after watching a video in which Allison Sampson Jackson, inspired by the work of Dan Siegel and Joseph LeDoux among others, explains in a very simple way the brain and how it is affected by trauma. To make this material accessible to young children, we decided to present it in an illustrated and playful way. To access the video entitled "Explaining the Brain to Children and Adolescents," use the following link:

https://vimeo.com/109042767

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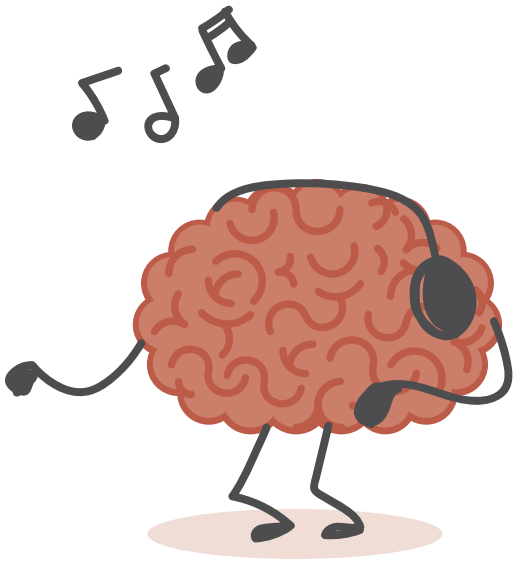
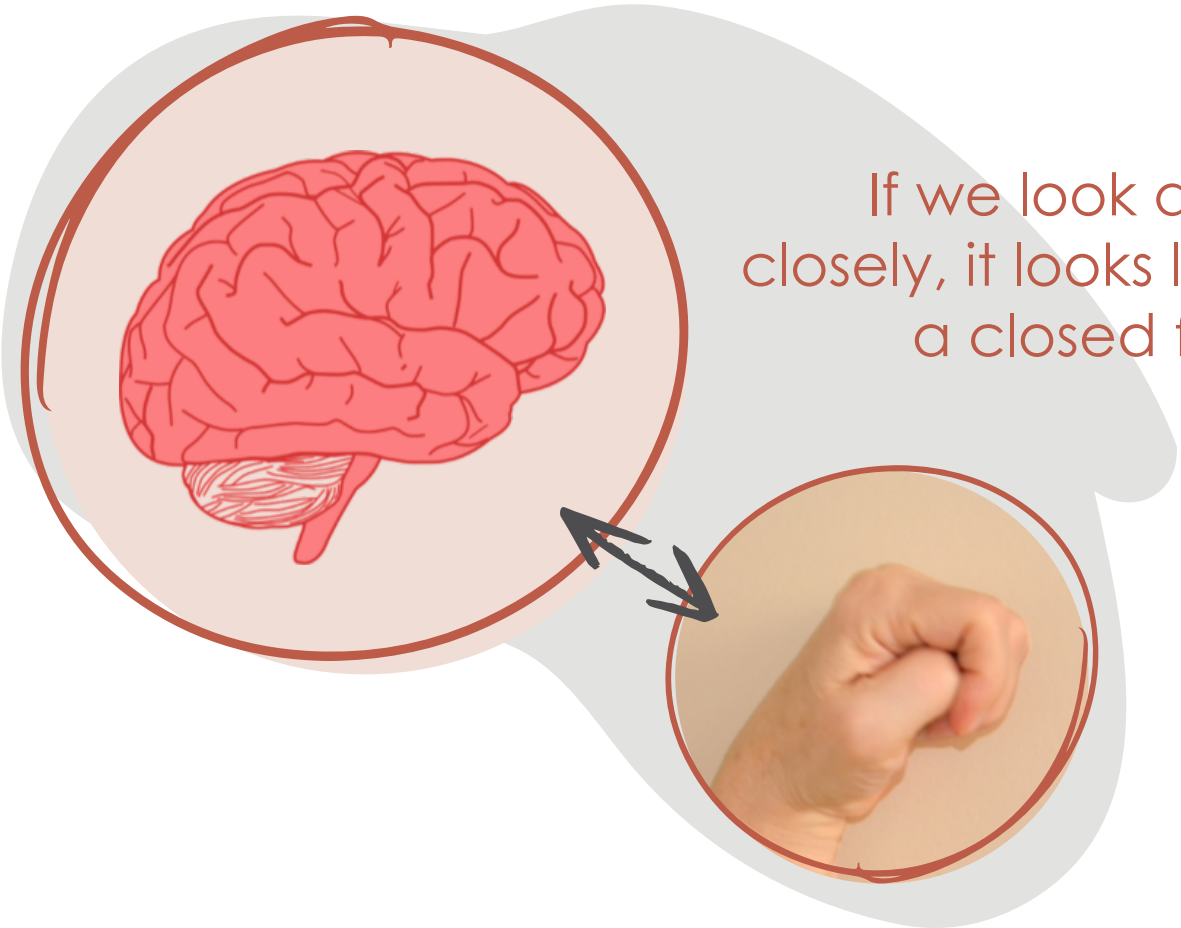
Your BRAIN is a part of your body that is not visible to others. Yet, it's this part that helps you move, communicate, think, feel emotions and perceive your environment.





If we look at it closely, it looks like a closed fist.

The part that looks like a thumb is a very important part of your brain.

It's like a watchdog that can growl and bark when it perceives a threat. It warns your body of danger so that you can protect yourself. It's like an alarm system.

The other part resembling a hand is also a very important part of your brain. It's the one that helps you think. We can call it your "wise owl."

Hoo-hoo

Most of the time, your owl and your dog live together harmoniously.

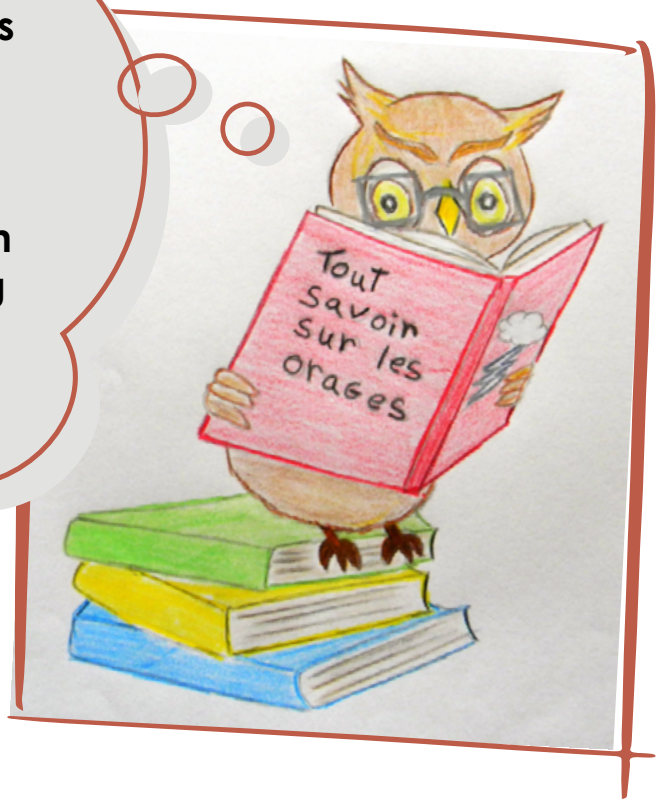
Sometimes, something happens that puts your dog on alert.

There was a loud sound of thunder and your dog was startled!

Boom!!!

Your wise owl knows a lot of things.

It explains to yourdog that it's only a thunderstorm and there's nothing to worry about in the house.



But sometimes, your owl doesn't have time to reassure your dog...

It barks so loudly that your owl flies away.

To make your owl come back, you have no choice but to calm your dog down!

You can find activities that help you calm down so that the dog stops barking: blowing bubbles, breathing calmly, playing sports, etc.

You can become a good master for your dog.
If you know it well and listen to it, you'll be able to reassure it more quickly when there's no real danger.

As soon as you feel that its fur bristles and it shows its teeth, that's when you have to act!

At first, you may need a grown-up to help you recognize that your dog is worried without your being in real danger. If your wise owl has already flown away, you'll need that adult to lend you his or hers.

Owl owned by an adult you know who comes to the rescue.

With the adult's help, you'll find ways to get your dog to calm down and your owl to come back.

Each dog is different. Do you know yours well? Do you really know how to calm it down and help your owl come back?

When he's around, your owl gives your dog good advice. They're good friends!

Help for parents or adult caregivers

Children who have experienced maltreatment and neglect and have developed traumatic sequelae have had their brain functions altered. They are very sensitive and react strongly to stress. It is important to remember that children have had to adapt and develop strategies to feel safe and have their needs met. These strategies are not always successful, but they are the ones that were available to them. When children perceive that they are in danger, their alarm system is triggered and their immediate survival reactions are put in place. These mechanisms are unconscious, therefore from the adult's point of view, there may be no reason for the child to feel threatened or experience these emotions.

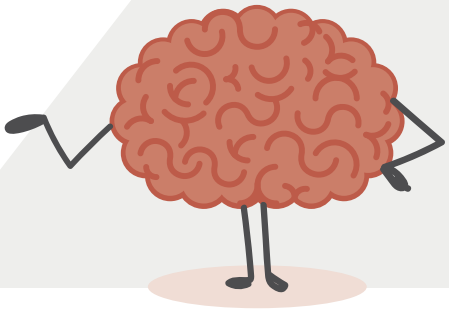
However, something in the child's past environment, which is associated with the traumatic experience, has surfaced in the present environment. This is called a "trigger." It can be a smell, a sound, a gesture, or a simple request that makes children recall the difficult events of their past. Often, the first intervention used is intended to punish the child's behaviour. We sometimes say, "Stop doing that at once." Such interventions are aimed at the wise owl. The problem is that the wise owl has flown away.

What to do first:

- Take a moment to calm yourself before conducting an intervention.
- Acknowledge what the child has experienced despite the behaviour he or she is exhibiting.
- Address the safety needs manifested by the child.
- Help the child calm down the barking dog so that the wise owl can return.

> ***Only when this is done can the child be challenged to find a solution or better behavioural strategies.***

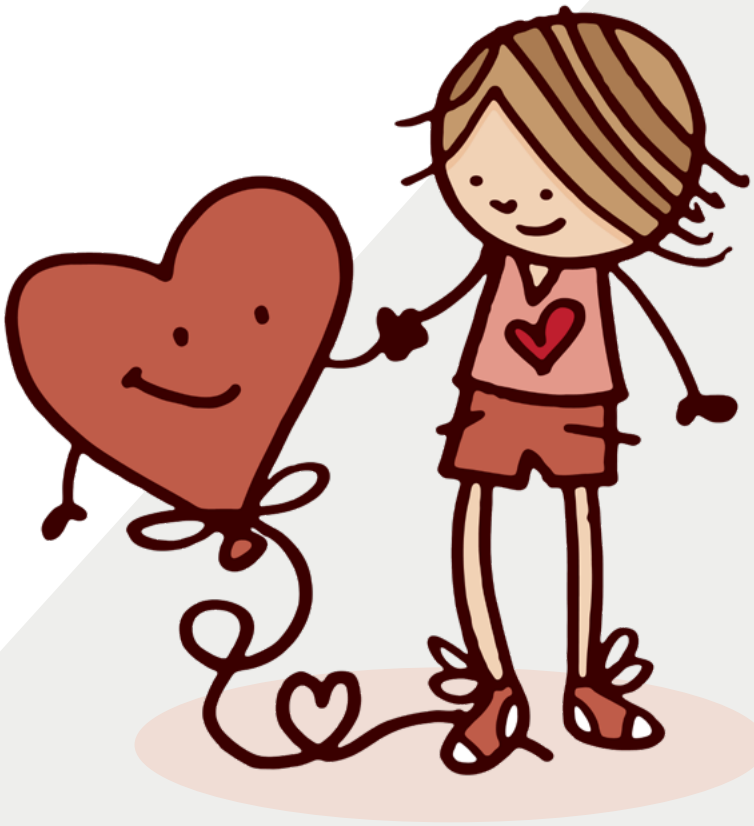
- Over time, it is important to examine what is causing the child stress and provoking a survival response. There are often patterns that repeat from time to time which, once they become known, can help us anticipate the child's reaction and provide the necessary support earlier (i.e., help the child calm the barking dog before the owl flies away).



Centre intégré
universitaire de santé
et de services sociaux
du Centre-Sud-
de-l'Île-de-Montréal

Québec

Trauma-informed INTERVENTION



Québec

OBSERVE AND UNDERSTAND

The notion of trauma: Definitions

Post-traumatic stress disorder (PTSD) emerged as a mental disorder in the United States primarily due to cumulative observations of what was happening to many veterans a few years after their return from the Vietnam War. PTSD is characterized by intrusive symptoms related to traumatic events, avoidance symptoms, altered cognition and mood, and markedly altered arousal and responsiveness. It has been subsequently recognized that different types of traumatic exposure could affect not only adults facing such extreme situations, but also children.

With the evolution of neuroscience, new knowledge about the ways in which acute stress affects the brain and entire body has provided practitioners and researchers, since the early 1990s or so, with new hypotheses for understanding the mechanisms by which maltreatment can affect a child's future: the creation of complex trauma, also known as developmental trauma. The notion of complex trauma highlights the fact that children are repeatedly exposed over a prolonged period of time to traumatic events caused by people responsible for their care and have no adults to protect them. Consequences appear in various spheres of development: attachment, biology, emotional and behavioural regulation, dissociation, cognition and identity. Although the experts who updated the DSM-5 did not agree to create a new nosological entity under this name, complex or developmental trauma retains its value in making sense of a constellation of intrapersonal and interpersonal difficulties and provides new directions for intervention. Therefore, these two notions are essential to keep in mind to provide better support.

Forms of maltreatment and their consequences

By definition, maltreatment is an action or omission that occurs in a parent-child interaction. When the person who should be providing for the child's various needs responds with neglect, physical, psychological or sexual abuse, or abandonment, with all the unpredictability that this entails, the child's entire body must adjust to survive in such a climate. The child's underdeveloped brain (which will not reach full neurological maturity until a few years after the legal age of majority) must rely on the mechanisms that the evolution of the species has provided, namely the biologically programmed stress response generated by the perception of a threat. This alert system used by even an immature brain sets in motion a series of biochemical reactions predisposing the organism to either fight, flee, or, when one or the other is impossible, make oneself as invisible as possible; in other words, freeze. The younger the children, the fewer options they have for escaping danger. Of course, they can scream, cry or get agitated in the hope that someone will come to their aid, and if not, resort to self-isolation. If the experiences that trigger the neurobiological system of stress repeat themselves without a human presence to consistently help restore calm, the reactions that follow are not without consequences on the brain and entire developing body. The accumulation and intensity of the stress experienced by the child then reaches a level deemed "toxic."

Adverse childhood experience studies conducted in the United States demonstrate significant links between so-called "adverse" childhood experiences and numerous distressing health conditions (cancers; cardiovascular, pulmonary and kidney diseases; etc.) as well as severe consequences for mental health during adulthood.

BEING TRAUMA-INFORMED

Before describing a few concepts, here is a summary of an episode in the life of Danny, 4, when he is removed from his mother's home and placed in a foster home.

He arrives at the home of Mrs. Jansen, the foster home, where three other children, aged 3 to 6, live. Shortly after his arrival, at supper time, he becomes inconsolable and refuses to eat. To soothe him, Mrs. Jansen decides to give him a bath. Danny struggles furiously and bites her to the point of drawing blood. Mrs. Jansen lets out a scream and the child curls up into a ball on the floor, trembling. Danny is sent to his room and lies down on an unfamiliar bed. He cries himself hoarse before finally falling asleep.

How can we understand why his arrival took such a turn?

Identifying traumatic experiences

When it comes to intervention for the purposes of youth protection, it must be considered that children who have been victimized by a history of maltreatment are at higher risk of developing traumatic sequelae. By focusing on what toxic stress situations the child may have experienced, the caregiver looks closely into the child's relational history. In state-imposed interventions to protect youth, it is not always easy to uncover the relational climate that may have characterized the child's early life story. Sometimes, it is possible to confirm dramatic events that occurred within the family: incidents of conflict or conjugal violence, repeated stays in the care of different people, episodes of substance abuse during which the parent leaves the child alone, etc. The "trauma lens" through which these events are viewed brings up the question of how the child was or was not protected from the tension generated. Once the child's safety and development have been declared compromised, it is not a matter of systematically investigating the facts that may have caused trauma in the child, but rather of trying to determine, throughout the intervention, what the child may have experienced, keeping in mind the sensitive stages of the child's overall development. Knowing that a child needs adults in order to learn how to regulate stress and explore the world, it is important to question how the child was supported, beyond known episodes of violence or solitude.

Identifying developmental consequences

Another way of understanding the reality experienced by a child is to observe his development. The presence of complex trauma or post-traumatic stress can be gauged by observing developmental impairment. As mentioned earlier, a traumatic experience has repercussions on the body first, impacting brain maturity throughout childhood, but in an intense and accelerated way before the age of three. Signs of hypersensitivity or hyposensitivity to sensory stimuli can be observed during this period. It is easy to understand the resulting impact on attachment, both in terms of activation and comfort, when a parent who should be encouraging, guiding and reassuring is instead threatening, indifferent or unpredictable. This makes it very difficult for children to learn to regulate their emotions if no one is there to consistently calm them down through dialogue and soothe

them physically. The same is true for the regulation of behaviour, as children cannot learn to discriminate on their own how to interact with others. They need an adult model to observe and an adult to guide, supervise and encourage them. Children's cognition is also affected, as their energy is too often diverted toward protecting themselves from stress rather than developing their ability to think using a vocabulary and explore the world around them. This compromises the development of the brain's executive functions. The construction of the child's entire identity is affected by the traumatic experience, blurring the possibility of believing in one's own value, in that of others, and in life in general. This difficult experience can lead the child to resort to dissociation, which is manifested several ways: detaching emotional aspects of events, not keeping any memories in words but retaining strong emotions, and feelings expressed in behaviour. All of these manifestations have a meaning and are in some way the child's means of survival in a frightening, indifferent or disconcerting environment.

What has been learned about Danny's experience:

His parents only lived together for the first year after he was born. They had been dating for a few months when his mother became pregnant but did not realize she was pregnant until the fifth month. Both parents used cannabis and alcohol during the pregnancy. They were both unemployed and their relationship was punctuated by arguments, sometimes violent, leading to breakups and reconciliations, until their final separation. The mother currently lives in a rundown apartment building, which is also home to drug dealers and prostitutes.

The maternal grandmother, who has significant personal difficulties of her own which prevent her from being more available to Danny, believes that Danny was sometimes left alone while the parents partied and that he probably overheard many arguments. Since the breakup with the father, the mother has had a few relationships with men who lived with her and Danny for a certain time. The grandmother knows that at least two of the men were abusive with the mother, who was often covered in bruises. The mother claims that the men never hit Danny, but only yelled at him. However, she also says that Danny is annoying and is often "cruising for a bruising." It seems that Danny was often driven by his mother to the homes of various friends and acquaintances to be looked after. These individuals often had their own problems with substance abuse.

It is reasonable to assume that Danny has experienced many tense and violent situations in which he likely feared for his mother and himself. In addition, he appears to have been left pretty much alone on a number of occasions, without a stable, loving person to attend to his needs and help him calm down. The number of intensely stressful situations to which he has been exposed, without the help of a familiar and reassuring person, seems to be quite overwhelming in his young life.

Detecting triggers

It is important to try to decipher the triggers that cause children to overreact to stress. This requires careful and patient observation on the part of the adults caring for them. A trigger is something that causes an emotion, cognition, physiological reaction or flashback in traumatized

children and brings them back to or connects them with a previous traumatic experience.

Conducting interventions with individuals whose development has been impaired remains a vast field of developing knowledge. However, the current literature allows us to identify some useful benchmarks, which will be briefly summarized.

Coming back to Danny's situation, a few details can be added to the more recent story of the intervention with him and his mother:

Danny was reported to the Director of Youth Protection (DYP) six months ago when neighbours called the police, fed up with hearing a child crying without anyone appearing to try to comfort him. The police called the DYP, and because Danny was alone and his mother was nowhere to be seen, the caregiver entrusted Danny to a transitional foster family. The child arrived at the home wearing soiled pyjamas. The mother showed up the next day and agreed to an in-home intervention in order to get her son back as well as to participate in the Jessie program. After a few weeks of intervention in his home, it was noted that the mother was missing appointments, Danny was often dirty and his weight was abnormally low. The decision was made to remove Danny from his environment, and a transitional family was identified. Shortly after this decision was made by the advisory committee, a new caregiver was assigned to his case and came to pick up Danny with an educator from the Jessie program. While Danny's bags were being packed, he saw his mother being initially furious with the caregivers, then begin crying profusely. She did not say a word to him as he left and continued crying.

So soon after leaving such an emotional climate, we can see how difficult it is for Danny to accept being fed and bathed by a foster mother, despite her very good intentions. The fact that Danny struggles so much when it comes time to take a bath raises other questions, but from the outset, his care requires getting naked in front of someone he has only known for a few hours. The emotions involved are different at four and a half years old than they would be at the age of six months! To Danny, what could be soothing is perceived as very threatening.

PROMOTING RESILIENCE AND PREVENTING NEW TRAUMATIC SITUATIONS

Establish a safe environment and restore it when it is compromised

Before children or parents can somehow "reprogram" their automatic stress responses, they will need to repeatedly experience interactions characterized by respect and kindness. This will certainly take time, provided that the interactions are conscious of the relational wounds left by the traumatic experience. This is why the issue of safety is so often mentioned as a cornerstone of complex trauma interventions. Bloom describes this safety as necessary at multiple levels: physical, psychological, social and moral. As well, Blaustein and Kinniburgh emphasize the importance of reference points provided by a routine or ritual in building this sense of safety. Such a routine can of course be created at home, in the foster family, in supervised visits or in interviews. If the climate of safety and predictability is compromised for whatever reason, it is

important to acknowledge it and take steps to restore it.

Being "trauma-informed" also means taking the necessary precautions to ensure that the actions we must take are planned so that they prevent or at least reduce the possibility that they will be experienced as new traumatic events. Any withdrawal from an environment, placement move or state-imposed action must be organized in such a way as to minimize the impact that could add to an existing trauma. Be careful to not expose the child to "institutional trauma."

Recognize the stress response pattern and take it into account during an interaction

When dealing with individuals — parents or children — who are suspected of experiencing traumatic sequelae, it is important to keep in mind the extent to which these individuals are influenced by their automatic stress response. Recall that the typical response can take three forms overall, but with a multitude of expressions: fight, flight or freeze. People who leave the room, respond angrily or become silent, without identifying exactly what caused such a reaction, could be demonstrating that the situation represents a threat of some kind. In such a state, they cannot access the higher functions of their brain (e.g., reasoning, logic, memory) and are merely trying to protect themselves. All of this happens unconsciously, but they are convinced that what they are doing is the best thing to do.

If we want to be able to talk with these people, it is useful to reassure them so that their feeling of a perceived threat diminishes. Therefore, it is to the caregivers' advantage to be aware of their own internal state for such an interaction. Self-regulation is essential if one wishes to help another person do so. Keeping in mind that it is inevitable that certain circumstances and interventions will cause stress, it will always be helpful to try to make them as predictable as possible through the use of reference points.

The brief account of Danny's intervention does not provide any insight into how the child and his mother were prepared for the placement, both before and after the decision made by the advisory committee. Looking at the behaviour manifested by Danny upon his arrival at the foster home, one recognizes more of a fight stress response, as evidenced by the resistance to eating, then the struggles and biting behaviour at bath time. How could Danny have been helped more effectively?

One possibility, during the placement move, is to have used simple language to let the child know that his caregivers understand how upsetting these events are for him and that grown-ups are responsible for his situation. Acknowledge the child's feelings while conveying the message that he is not to blame for leaving his home. It is important to reassure the child that both he and his mother will be taken care of and that they will hear from each other without fail. Ensure that this promise of news is kept so that the child can develop trust and allow himself to settle in with the family without being haunted by his mother's distress or anger.

In addition, the child should be informed as simply as possible of what is coming or what will soon be proposed in order to give the child some leeway to decide on certain things. In all these changes imposed upon the child, it is wise to give him power over certain aspects and ask him how he is accustomed to doing things.

For example, the foster mother can show Danny how to wash up properly by using less water in a tub full of bubble bath.

Promote emotional regulation

Adults who live with children on a daily basis are encouraged to observe the circumstances in which they overreact (from inhibition to disorganized action) in order to identify triggers for discomfort, uneasiness or disorganization. The child can also be asked to identify the events and situations that generate attitudes of "fight, flight or freeze." The bodily sensations felt at these moments (e.g., increased heart rate, abdominal tightness, muscle contractions, accelerated breathing, etc.) can be useful starting points before being able to access the underlying emotions.

Working together with the child afterward to find suitable ways of restoring calm is also part of the logic of complex trauma intervention, knowing that a brain in an alert state cannot think and search for solutions. It is only when the child calms down that reflection can begin. Engaging the thought process during calmer moments will not instantly eliminate automatic stress responses: here again, it is only through repetition that real alternatives can be created.

Encouraging means of expression other than speech is also a vector of intervention advocated by Bloom and by Blaustein and Kinniburgh: physical, cultural and expressive activities (e.g., mime, theatre, dancing, singing, writing, etc.) are all ways to create a potential outlet for emotions that are sometimes exceedingly difficult to mentalize.

In Danny's situation, his caregiver and the one assigned to the foster family will support Mrs. Jansen and her partner in identifying, with Danny, the circumstances that are stressful for him and make him feel unwell as well as strategies that can bring him comfort. Look for the best ways to calm him down: a stuffed animal, a rocking chair, anything that can help the child feel better.

Further, caregivers must remain attentive and show interest in how the child experiences things on a daily basis. For example, Mrs. Jansen may notice while giving Danny a bath one day that he tightly clutches a doll and submerges it in the water while saying "Bad Danny, listen to me!" Staying aware and on the lookout for certain behaviour can provide ideas for other approaches, which may allow us to establish a better connection with the child.

Provide multiple opportunities for skill development

In addition to providing opportunities for self-expression, the activities mentioned above are also opportunities to discover interests, hidden talent and work methods. The brain pathway most used by children who have experienced a toxic level of stress has somehow diverted them from the learning pathway that allows them to develop the executive functions of their brain. This is why it is important to provide a variety of opportunities to develop skills with caring adults who can act as role models. The child gaining confidence in his overall ability to learn remains an undeniable springboard for resilience. This is why the child's developmental recovery depends on the engagement of all the adults involved.

Learning problem-solving processes and effective communication are precious assets for gradually getting out of the rut in which a traumatic experience has placed a person. Having a child witness moment when an adult demonstrates a problem-solving process aloud enables the child to learn by observation that it is possible to calm down, step back, properly identify a problem, evaluate possible solutions, select one, and apply it.

There is much more to say than these few key ideas, and interested readers will find more information and full references of the works mentioned in this leaflet in the toolkit entitled "Trauma-informed practice."

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* References of the authors cited can be found in the document entitled "From Theory to Practice" in this toolkit.

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Appendix 8 – FACTORS FOR IDENTIFYING CHILDREN AT HIGH RISK OF DEVELOPING *POST-TRAUMATIC STRESS DISORDER* (PTSD)

A. Trauma / History of loss

TRAUMA TYPE	YES	SUSPECTED	NO	UNKNOWN	Age(s) experienced – Check appropriate boxes *(e.g., sexual abuse from ages 6 to 9 requires checking boxes 6, 7, 8 and 9)*																			
					1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20
Sexual abuse or assault/rape																								
Physical abuse or assault																								
Emotional abuse/psychological maltreatment																								
Neglect																								
Serious accident or illness/medical procedure																								
Witness to domestic violence																								
Victim of/witness to community violence																								
Victim of/witness to school violence																								
Natural or man-made disasters																								
Forced displacement																								
War/terrorism/political violence																								
Victim of/witness to extreme personal/interpersonal violence																								
Traumatic grief/separation (does not include placement in foster care)																								
System-induced trauma																								

Child Welfare Trauma Referral Tool (Taylor, Steinberg and Wilson, 2006)

Appendix 8 – FACTORS FOR IDENTIFYING CHILDREN AT HIGH RISK OF DEVELOPING PTSD

B. Current traumatic stress reactions

	YES	SUSPECTED	NO	UNKNOWN	Answer questions B1-B4 in reference to the CURRENT situation only **Definition** *(check "Yes" if child displays any of the descriptors below)*
1. Re-experiencing					These symptoms consist of difficulties with intrusive memories or reminders of traumatic events, including nightmares, flashbacks, intense reliving of the events, and repetitive play with themes of specific traumatic experiences. Also included is pronounced reactivity to trauma or loss reminders. These symptoms are part of the DSM-IV criteria for PTSD.
2. Avoidance					These symptoms include efforts to avoid stimuli associated with traumatic experiences. The child may avoid certain places or people, or avoid discussing the specifics of the trauma. These symptoms are part of the DSM-IV criteria for PTSD.
3. Numbing					These symptoms include numbing responses that are part of the DSM-IV criteria for PTSD. These responses were not present before the trauma. Numbing symptoms include feelings of detachment or estrangement from others, restricted range of emotion (e. g., unable to have loving feelings), feeling out of sync with others, or having a sense of a foreshortened future.
4. Arousal					These symptoms consist of difficulties with hypervigilance (i.e., an exaggerated awareness of potential dangers), difficulty concentrating, exaggerated startle reactions, difficulties falling or staying asleep, and irritability or angry outbursts. Children with these symptoms often seem distractible, impulsive and inattentive, leading to a common misdiagnosis of ADHD.

Appendix 8 – FACTORS FOR IDENTIFYING CHILDREN AT HIGH RISK OF DEVELOPING PTSD

C. Attachment

	YES	SUSPECTED	NO	UNKNOWN	**Definition** *(check "Yes" if child displays the descriptor below)*
1. Attachment difficulties					This category refers to a child's difficulty forming or maintaining relationships with significant parental or caregiver figures. It relates to the child's sense of security and trust in interacting with others. Often, children with attachment difficulties interact with new acquaintances in unusual ways. They may bond too quickly (e.g., hugging strangers and climbing on their laps) or fail to engage in appropriate ways (e.g., avoid eye contact and fail to engage in appropriate conversations/ interactions).

D. Behaviours requiring immediate stabilization

	YES	SUSPECTED	NO	UNKNOWN
1. Suicidal ideation				
2. Active substance abuse				
3. Eating disorder				
4. Serious sleep disturbance				

Appendix 8 – FACTORS FOR IDENTIFYING CHILDREN AT HIGH RISK OF DEVELOPING PTSD

E. Current reactions / behaviours / functioning

Does this interfere with child's daily functioning at home, in school or in the community?	YES	SUSPECTED	NO	UNKNOWN	**Answer questions E1-E12 in reference to the CURRENT situation only** **How to recognize problem behaviours** *(Check "Yes" if child displays any of the descriptors below)*
1. Anxiety					Anxious children often appear tense or uptight. Worries may interfere with activities and they may seek reassurance from others or be clingy. These children may be quiet, compliant and eager to please, so they may be overlooked. Anxious children may report phobias, panic symptoms and physical complaints; startle easily; or have repetitive unwanted thoughts or actions.
2. Depression					Depressed children may appear tearful/sad, show decreased interest in previous activities, have difficulty concentrating, or display irritability. They may present with depressed mood, social withdrawal, sleep disturbances, weight/eating disturbances, loss of motivation, hopelessness, verbal aggression, sullenness, grouchiness, or negativity. They may have frequent complaints of physical problems.
3. Affect dysregulation					Children with affect dysregulation may have difficulty expressing specific feelings, whether positive or negative, and may have trouble fully engaging in activities. They may have problems modulating or expressing emotions, experience intense fear or helplessness, or have difficulties regulating their sleep/wake cycle.
4. Dissociation					Children experiencing dissociation may be easily distracted or appear "spaced out." They may daydream frequently and be emotionally detached or numb. They are often forgetful and sometimes experience rapid changes in personality often associated with traumatic experiences.
5. Somatization					Somatization is characterized by recurrent physical complaints without apparent physical cause. Children may report stomach aches or headaches, or even blindness, pseudoseizures or paralysis.
6. Attention / Concentration					Children who have problems with attention, concentration and task completion often have difficulty completing school work or may have difficulty forming strong peer relationships.

E. Current reactions / behaviours / functioning

Does this interfere with child's daily functioning at home, in school or in the community?	**YES**	**SUSPECTED**	**NO**	**UNKNOWN**	**Answer questions E1-E12 in reference to the CURRENT situation only** **How to recognize problem behaviours** ***(Check "Yes" if child displays any of the descriptors below)***
7. Suicidal behaviour					This category includes both superficial and more serious actions with potentially life-threatening consequences. Examples include overdosing, slashing wrists, or deliberately crashing a car.
8. Self-harm					This is when children deliberately harm themselves. It can include cutting behaviours, punching oneself, pulling out hair or eyelashes, picking skin causing sores, burning, inhaling or overdosing on medications.
9. Regression					This occurs when children cease using previously adaptive behaviours. Children may begin wetting or soiling themselves after they had been toilet-trained, and may begin using baby talk or refusing to sleep alone even though these skills were previously mastered.
10. Impulsivity					This refers to acting or speaking without first thinking of the consequences.
11. Oppositional behaviours					These are defined as negativistic, hostile and defiant behaviours. Children may lose their temper frequently, argue with adults and refuse to comply with adult rules. They may deliberately annoy people and blame others for mistakes or misbehaviour.
12. Conduct problems					This category includes a variety of conduct problems. These children may be physically or verbally aggressive to other people or animals. Children with conduct problems may destroy property, steal, break the law, or start fires. They may run away from home or act in a sexually promiscuous or aggressive manner.

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