Department of Communities, Child Safety and Disability Services
Department of Education, Training and Employment

Calmer classrooms

A guide to working with traumatised children

3386 OCT13

Queensland Government

Acknowledgements

This resource was originally commissioned by Bernie Geary, Victorian Child Safety Commissioner in 2007 and managed by Maree Tehan, Office of the Child Safety Commissioner. It was originally written by Laurel Downey, then Manager, Practice Development and Training, Take Two, Berry Street Victoria. Laurel Downey is now in private practice.

The Victorian Commission for Children and Young People (previously the Victorian Office of the Child Safety Commissioner) has kindly given permission to the State of Queeensland (Department of Communities, Child Safety and Disability Services and Department of Education, Training and Employment) to reproduce and customise this resource for the Queensland context.

Understanding the experience of the abused and neglected child assists us to develop compassion, patience and empathy. It is a key intervention in itself.

Recovery from trauma will occur best in the context of healing relationships.

Contents

Introduction

The role of teacher, school and support systems

Both research and wisdom show us that regardless of the adversity they face, if a child can develop and maintain a positive attachment to school, and gain an enthusiasm for learning, they will do so much better in their lives. The role of teachers in the lives of traumatised children cannot be underestimated.

This booklet encourages teachers and other school personnel to forge those attachments through two key mechanisms: understanding traumatised children and developing relationship-based skills to help them.

Teachers who understand the effects of trauma on children's education, who are able to develop teaching practices to help them, and who are able to participate actively and collaboratively in the systems designed to support traumatised children will not only improve their educational outcomes but will assist in their healing and recovery.

The Queensland Child Protection Commission of Inquiry report raised that children in care are likely to have poorer educational outcomes than the general population. The Calmer Classrooms resource specifically aims to equip teachers with an understanding of the impact that trauma can cause to a child's development, learning and engagement in school and identifies strategies to assist children in care to maximise their educational potential.

Section One

Experiencing abuse and neglect leads to trauma and disturbed attachment

When trying to understand the complex worlds of children who have suffered abuse and neglect, it is most useful to integrate the theories of trauma, attachment and child development.

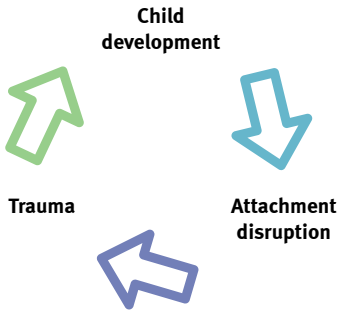

Figure 1 Trauma triangle

An integration of theories

Attachment theory helps us understand human relationship development from pre-birth onwards throughout the life span. ***Trauma theory*** helps us understand the neurobiological and psychological impact of abuse and neglect on the human individual. ***Child development theory*** helps us understand normal development and consequently development under adversity (Figure 1).

This section introduces attachment theory and trauma theory, and describes the impact of trauma on child development. It outlines how the child's general behaviour is affected and the circumstances in which recovery can occur.

Attachment and early security: building resilience

Attachment theory explains how resilience in children is built through the support of an attachment figure.

Early security

It is in the early care-giving relationship that a child grows to know love, to depend on that love and to come to the conclusion that they themselves are fundamentally good and worth loving. Without a good experience of early love, and of having someone to interact with us in an attuned way when we are infants, our brains don't develop the pathways we need to understand the social world, to understand the rules of relationships and to gain strength from the pleasure of healthy touch, healthy talk and healthy play.

Attachment theory

Normal development is expressed in play and exploratory activity in children. It requires the presence of a familiar attachment figure or figures who regulate the child's physiological arousal by providing a balance between soothing and stimulation.

By soothing the infant when this is appropriate, the caregiver not only protects them from the effects of stressful situations, but also enables the child to develop the biological framework for dealing with future stress. In this process the caregiver plays the critical role. The caregiver is the leader of the child, helping the child to know their own feeling states by giving words to their experience (oh, you look tired, what a beautiful smile, you look so happy, you're really upset now); helping the child to regulate their physical body and to know physical boundaries by holding them, touching, playing with and comforting them. Without these early experiences we grow up not recognising or understanding our emotional and physical states and consequently not able to make good decisions and judgements, not able to manage strong emotions and lacking trust in the world.

An example of this is the experience of a young child who, upon seeing the front door open wanders into the front yard, to be confronted by a large dog which rushes at them, growling and barking. A parent or caregiver hears the noise, and if competent, rushes out, shoos away the dog, picks up the child, holding tight, speaking in a calm and soothing voice, until the child is calm again. The alternative picture is the caregiver who runs out, grabs the child by the arm, smacks her bottom and drags her inside, shouting 'what were you doing out there, I told you not to go out the front door'.

Both parents have been frightened, but one acts to comfort the child while the other acts on their own raw emotions. If we don't get attuned and loving early care ourselves, we tend to act on our emotions, not being able to think or put the other's needs first.

Early security builds resilience

People become resilient and can cope better with stress in adult life if they are exposed to some stress in childhood. Children become resilient when exposed to a threat or stress in the presence of a comforting, secure adult. When children are alone and exposed to a threat or stress the child's emotional state becomes highly aroused, but also quickly returns to normal, as the fear and anxiety are alleviated by the presence of a comforting attachment figure.

Over time, as this process of exposure to stress followed by protection and comfort is repeated, the child develops an ability to rely on an internal sense of security, and resilience is built. Therefore although resilience is not inborn, the capacity to develop the attachment relationships within which resilience is built is there from the start.

Attachment, trauma and the impact on development

Chronic abuse and/or neglect in childhood affect the mind, the developing brain, the body, spirit and relationships with others. As outlined below, the attachment difficulties associated with this and subsequent trauma interfere with the child's capacity to regulate emotions and reactions. Among other things, such ***affect dysregulation*** leads to problems with controlling anger and impulses, and maintaining attention and connection.

This sub-section goes on to describe other impacts of trauma: disruption to thinking, the effects of neglect, problems in traumatised communities, and self-harm and addiction; it concludes by outlining the context in which recovery can occur and the importance of understanding the child's complex layers of experience.

Trauma theory

One definition of trauma is when something happens that is so terrible it overwhelms our ability to cope.

> 'At the moment of trauma, the victim is (made) helpless by overwhelming force … Traumatic events overwhelm the ordinary systems of care that give people a sense of control, connection, and meaning' (Herman, 1992/1997).

Trauma occurs when an event is so frightening it causes a prolonged alarm reaction, where the body is primed and pumped with chemicals and enzymes such as adrenaline and does not calm down for a long time. In any person, this creates an altered neurological state (Figure 2). The severity of this depends on a number of factors, including previous experiences of trauma and the availability of support. Children are more vulnerable to trauma than adults. Traumatic events modify an adult's state of neurological organisation but may be the primary organising experience for the child, which creates the foundation for the child's key neurological systems. For adults, traumatic experience alters their mature and organised brain, which can create difficulties; however in infants and

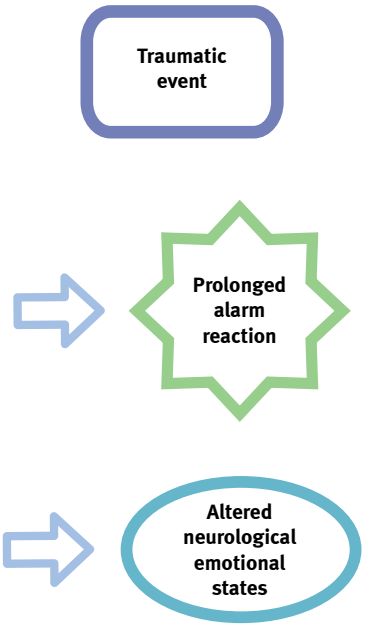

Figure 2 Trauma alters neurological states

The media pays far more attention to the one-off traumas of natural disasters, terrorist attacks or acts of random violence than it does to child abuse, even though it is known that around 80 per cent of human trauma occurs within the family setting.

children it has a detrimental impact on the developing brain (van der Kolk & McFarlane, 1996).

The media pays far more attention to the one-off traumas of natural disasters, terrorist attacks or acts of random violence than it does to child abuse, even though it is known that around 80 per cent of human trauma occurs within the family setting.

> 'The most pernicious trauma is deliberately inflicted in a relationship where the traumatized individual is dependent—at worst, in a parent-child relationship.' (Allen, 1995).

Trauma affects children differently at different ages, depending on their temperament and existing resilience factors. Chronic childhood trauma interferes with the capacity to integrate sensory, emotional and cognitive information into a cohesive whole; it sets the stage for unfocused and irrelevant responses to subsequent stress. The solutions to life's problems used by traumatised children seem unconnected and unhelpful. Yet these are all they have. Children who have suffered chronic abuse or neglect often experience developmental delays across a broad spectrum, including cognitive, language, motor and socialisation skills (van der Kolk & McFarlane, 1996). One of the key messages to emerge in recent times is that trauma affects the whole person: their mind, brain, body, spirit and relationships with others.

Indeed, van der Kolk, (2005) proposes a new mental health condition that he calls 'Development Trauma Disorder'. Children who present with this condition 'manifest in multiple ways their tendency to re-enact and replicate their trauma throughout their lives'. They do so by:

> fearful reactions, aggressive and sexual acting-out, avoidance and uncontrolled emotional reactions. Unless this tendency to repeat the trauma is recognised, the response of the environment is likely to replay the original traumatising, abusive but familiar, relationships. Because these children are prone to experience anything novel, including rules and other protective interventions, as punishments, they tend to regard teachers and therapists (and carers) who try to establish safety as perpetrators.

Impact on the brain and body

Our brains are developed to help us to respond to threat. We refer to this as the flight, fight or freeze response. When we are confronted with a dangerous or potentially dangerous situation, our brain goes on alert and makes the body ready to respond. It does this by increasing the adrenaline in our system so we can be faster and stronger. When the threat is no longer there, then our brain releases other chemicals such as cortisol to reduce the adrenaline in our bodies. This helps us to relax and to quieten down. We no longer need to fight or run so our body adjusts accordingly. This is a normal, healthy reaction in all humans and many animals.

In some situations where fighting or running is not possible, our brain may help us to freeze. In these situations our breathing may slow down and chemicals such as endorphins are released that help us to be very still or even to go numb and therefore feel less pain. When someone is traumatised by extreme or repeated events of abuse, chemical reactions in the body and brain can be switched on as if they have never been switched off.

‘Each time a [traumatised person] has a flashback or nightmare, or is merely startled by a sudden sound or movement, his heart, lungs, muscles, blood vessels, and immune system are primed to save his life—from nothing at all’ (Beaulieu, 2003).

Affect dysregulation

The capacity to regulate our emotions and reactions is built during the early years of life. This capacity is known as ‘affect regulation’. Positive affect regulation depends on an attuned attachment relationship with a well regulated caregiver. Attachment difficulties often lead to poor affect regulation, as do subsequent experiences of trauma. Poor affect regulation is known as ‘affect dysregulation’.

It is not surprising that some traumatised children have ongoing problems controlling their anger and impulses, and maintaining their attention and connection—their reduced capacity to regulate strong emotions leads them straight to reaction, with no time to think. The reactions associated with affect dysregulation are often classified as either ‘hyperarousal’, where children are reactive, hypervigilant, alarmed, prone to aggression or to flight, or ‘dissociation’, where they are disengaged, numb, compliant and inattentive. Both hyperarousal and dissociation are adaptive human responses to unresolved early attachment disruption and/or abuse experiences. Both are intensely painful and uncomfortable emotional states (Figure 3).

Dissociation can also be described thus:

> Many traumatized children, and adults who were traumatized as children, have noted that when they are under stress they can make themselves ‘disappear’. That is, they can watch what is going on from a distance while having the sense that what is occurring is not really happening to them, but to someone else. (van der Kolk, 1996b).

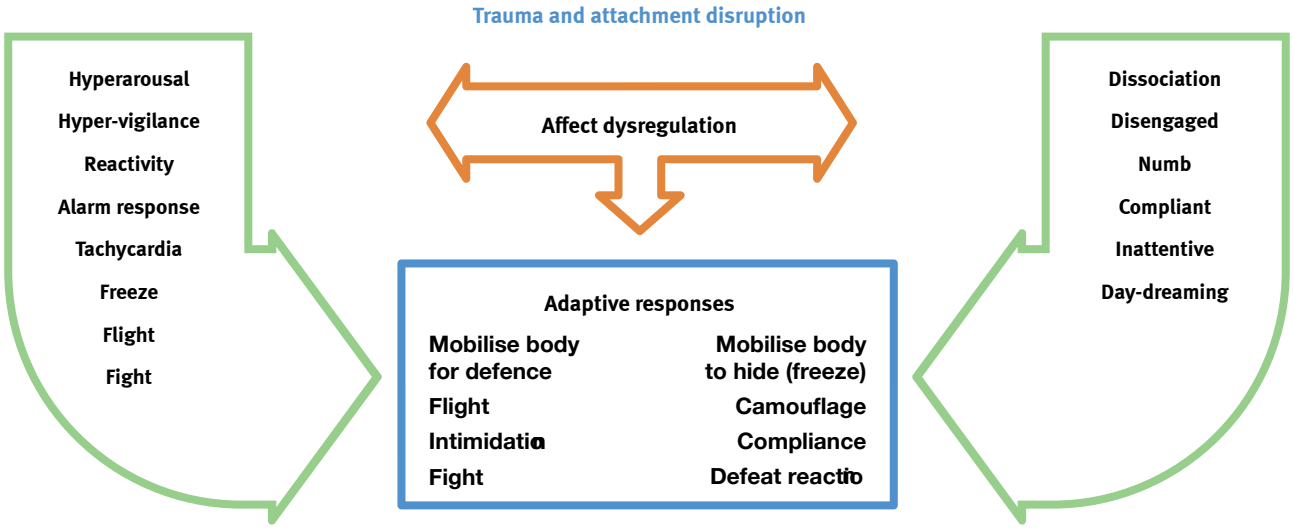

Figure 3 Trauma, attachment disruption and affect dysregulation

It is not surprising that some traumatised children have ongoing problems controlling their anger and impulses, and maintaining their attention and connection—their reduced capacity to regulate strong emotions leads them straight to reaction, with no time to think.

Neglect

The issue of neglect illustrates the need for integration of trauma and attachment theories. Each time a young child is left cold, hungry, dirty or unattended this experience triggers a fear response, which turns to terror if it goes on for long. This fear or terror will have the same effect on the brain and body of the child as abuse. The terror is also compounded by the lack of stimulation usually seen in neglect, which slows brain growth and social development. It is further compounded by the lack of an attuned attachment relationship, where the child is not getting the opportunity to understand themselves and others within a loving relationship. Neglected children are therefore compromised in many ways.

Trauma affects thinking

One of the most difficult issues for teachers and others who interact with traumatised children is the problems they have in thinking. They often seem to have very disorganised minds: they forget things, leave their clothes where they fall, leave their toys and other mess for others to clean up after them, don't seem to pay attention to things others tell them; they can seem thoughtless and uncaring due to that thoughtlessness. Consider though, that some victims of childhood abuse and neglect cope by refusing to conceive of their caregiver's thoughts, thus avoiding having to think about their caregiver's wish to harm them. They close down any thoughts that come into their minds about that harm because thinking takes them down corridors of pain. It is better if they close the door rather than go down those corridors. Eventually they have closed so many doors in their minds that they can hardly think about anything.

This process can continue to disrupt the capacity to think about their own thoughts or the thoughts of others and this leads them to operate on inaccurate assumptions of the thoughts and feelings of others (Fonagy, 1999).

To cope with relationships we all need to be able to think about what other people might be thinking. We all 'read' people. We read their faces and gestures and we make quick, often accurate, assumptions about what they might be thinking. We do this all time, checking out our assumptions with questions, looks and gestures. It is a large part of our communication with others, our ongoing inter-subjective relationships, and if we can't do it we place ourselves at a great disadvantage.

Traumatised communities

Some communities have a collective sense of suffering due to current and historical traumas such as Aboriginal communities affected by the history of removal of Aboriginal children and the dislocation from traditional lands. Members of these communities often have had significant experiences of trauma themselves, due to removal from family, disrupted attachments and abuse and neglect, which has been complicated by ongoing experiences of trauma such as domestic and community violence, racism and discrimination. Children living in these communities, while often surrounded by love, warmth and humour, may also be affected by the suffering of the community. If children in such communities are also subjected to abuse and neglect, the adults around them may not always be able to act protectively or provide support for recovery due to their own life difficulties (Figure 4).

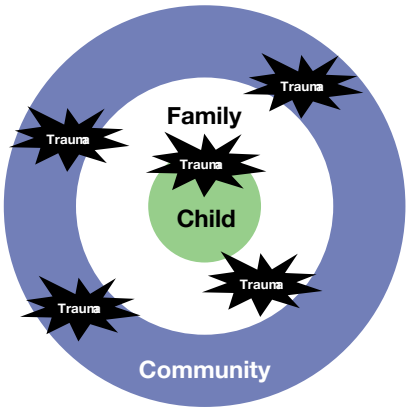

Figure 4 Trauma can affect all levels of the community

Self-harm and addiction

Self-harm can be difficult to understand, but is very common in traumatised or stressed children. The reasons for it can be different for different children. Some self-harm because they become 'addicted' to the endorphin release that accompanies traumatic stress, and will cause trauma to themselves to obtain that endorphin release. Others have developed a profound self-hatred and act that hatred out on their bodies. Some suffer from deep depression and their self-harm is closely associated with a wish to end their pain, which can become suicidality when severe. Still others self-harm to overcome the numb and alienated feelings that come from dissociation, where the self-inflicted pain is an attempt to feel something rather than feel nothing. Another group who have been abused may internalise the aggression of the abuser and then become the victims of their own aggression (Cairns, 2004).

Traumatised children often lack the capacity to regulate their own physiology, for example struggling to put themselves to sleep or having difficulties regulating appetite. As they grow older this can become even more difficult. They are very likely to self-medicate to try to get some relief and to establish some control over their own function. Drugs, alcohol, inhalants and other substances are commonly used by children and young people living with trauma. Children may also become addicted to high-stimulus activities such as computer games, dance or sexual activity, or engage in high risk behaviours such as train surfing in an attempt to regain a 'high' feeling. Some young people find criminal activities highly stimulating and attractive.

Intervention and recovery

Research indicates that the earlier intervention is applied, the greater the chance of recovery. Children who are neglected and abused in infancy stand the greatest chance of recovery if intervention occurs in the first year of life. The older the child, and the longer they have been exposed to trauma, the more difficult it is for them to recover. However, the presence of other caring adults in the child's life will build resilience, maintain hope, and provide a different template of possibility (Perry, 2006).

Recovery from trauma will not occur unless the child is safe. There is no hope for recovery from trauma if the trauma is still occurring. This involves ensuring that not only is the abuse or neglect no longer occurring, but that the child is feeling safe and secure where they are living. This does not only mean no-one is actually hurting them, it means that the adults in their lives acknowledge the hurt they have suffered, nurture them in appropriate ways, contain their difficult behaviours, and most importantly, keep them in their minds. To be happy, we all need to know that there is someone who cares about us and thinks about us, thinks about what we are doing, and how we are feeling. This is the basis of security.

Recovery from trauma will occur best in the context of healing relationships. For a child to have a positive view of him or herself reflected in the eyes of a trusted, caring adult counteracts the negative internal view he or she has and heals the terrifying experience of abuse.

> The core experiences of psychological trauma are disempowerment and disconnection from others. Recovery, therefore, is based upon the empowerment of the survivor and the creation of new connections. Recovery can take place only within the context of relationships; it cannot occur in isolation. (Herman, 1992/1997).

Recovery from trauma will not occur unless the child is safe. There is no hope for recovery from trauma if the trauma is still occurring.

Understanding the complex interplay of attachment disruption and trauma can assist us in seeing beyond disturbed behaviours.

Complex layers of experience

Children who have been abused and neglected will often have complex layers of experiences of adversity. Their infancy may have been insecure with harsh or neglectful parenting. They may not have had an attuned, loving attachment relationship in which they were reflected in their parent's gaze as lovable and delightful. From this experience they may have built an internal working model of unworthiness. This lack of a loving relationship is often compounded by traumatic experiences of abuse, such as witnessing domestic violence, being subjected to physical and emotional abuse, or being exploited by sexual abuse. Understanding the complex interplay of attachment disruption and trauma can assist us in seeing beyond the disturbed behaviours of such children and empathising with the lonely, frightened and humiliated child within.

Section Two

The impact of abuse and neglect on learning

This section explains in more detail the impact of trauma on children, focusing on the impact on their education. Three case studies are presented at the outset to provide examples of different histories of abuse and neglect. They will be referred to throughout the section to illustrate the ways in which having experienced abuse and neglect affects children at kindergarten and school.

Case studies

The following case studies are compiled from stories about the lives of children in the child protection system.[1]

Case study one: Jasmine

Jasmine, three years and ten months old, presents as a quiet, distant child who doesn't like to be cuddled and is delayed in all developmental areas. She was born to Jane and Doug and remained in their care for her first eight months. Jane has a mild intellectual disability and Doug was using heroin at that time. It is likely that both her parents were unable to identify or respond to Jasmine's physical or emotional needs, and she was also surrounded by frequent outbursts of anger and violence between her parents.

Jane took Jasmine to hospital at eight months of age stating that she couldn't get her to eat or drink. Jasmine was extremely underweight, dehydrated, listless and had extensive scarring from nappy rash. Medical examination also uncovered several old fractures to her ribs and stress fractures around one knee.

At this time she was placed in the care of her maternal grandmother, Rhonda, who has four of her own teenage children living with her. Rhonda continues to provide emotional and practical support to Jane who continues to visit the home.

Rhonda states that Jasmine responds well to her care, although she is never cuddly and does not like to maintain eye contact. Rhonda had no specialist help with Jasmine when she was placed with her.

At kindergarten Jasmine engages in some activities but is often on the outer with other children. She has poor cooperative play skills and finds sharing difficult. Her many outbursts of anger are often directed at other children, and she will spit at and bite them. At other times she is very quiet and withdrawn appearing to be 'in her own world'. She is due for cognitive testing as it is suspected she has a mild intellectual disability.

Case study two: Michael

Michael, nine years of age, is an Aboriginal boy born to Vivien and Charlie. He has two older half siblings who live with their maternal grandparents and have intermittent contact with him.

He was recently placed in the care of a family with an Aboriginal mum, Cheryl, and non-Aboriginal dad, Pete, who reside in the same town as his birth family. They have three older children, 14, 17 and 20, all living at home.

Michael has many delightful characteristics including a good sense of humour and an enjoyment of life. However at home he can be oppositional and is at times aggressive towards his carers.

Michael's current difficulties exist within a history of trans-generational trauma and abuse. He has witnessed significant family violence and has been the victim of early neglect, and ongoing physical and emotional abuse. He has had many out-of-home placements throughout his early childhood, including several periods in the care of his Auntie Faye and Uncle Bruce, and a brief number of short term foster placements. Michael has not seen his mother, Vivien, since he was five. She has bipolar disorder and this has at times gone untreated. Her whereabouts are currently unknown. It appears that Michael's father, Charlie, was very violent to Vivien, with past police reports indicating significant injuries to her body.

Michael was removed from his father's care following an assault by Charlie in which Michael sustained a fractured skull, and currently his father is not allowed to have contact with him.

Michael appears confused and anxious about his situation; he wants to be with his family and does not understand why he can't see his father. His carers believe that he has 'many feelings bottled up' inside. He often says things that indicate to them that he hates himself and blames himself for his father's assault and his family breaking up.

At school, he is easily distracted. His grades are well below average. His teacher describes him as a likeable boy, but one who 'attracts trouble'. He is liked by his peers, although his friendships appear somewhat superficial; for example, he often acts as the class clown. Michael has increasingly displayed aggressive behaviours during playtime and some children are beginning to become wary of him. Michael has a diagnosis of ADHD and is on a high dosage of medication.

1 See Appendix A for brief description of child protection.

Case study three: Danielle

Danielle, fourteen years of age, is the only child of Helen and David. Helen suffered severe post-natal depression and her relationship with David broke down when Danielle was five weeks old. Danielle experienced intermittent neglect during her first three years of life, depending on her mother's mental health and the occasional involvement of stable others, such as her grandmother Joyce.

Danielle endured much stress during her early childhood, including separations from her mother when Helen was admitted to a psychiatric hospital. She was often placed with Joyce, although she also spent time in foster care when Joyce was unable to take her. Joyce has generally been a stable influence for Danielle, and has encouraged her to learn to play guitar. On at least one occasion Danielle witnessed her mother attempting suicide. Helen has had several brief relationships with men, and one of these men sexually assaulted Danielle over a period of a year. It is suspected she has also been sexually abused by a neighbour of her grandmother's but refused to make a full disclosure about this.

Helen's most recent suicide attempt resulted in Danielle being placed with Joyce; however this broke down as Joyce could not tolerate her aggression and defiance. Joyce describes her as shifting between being highly needy and overly demanding to rejecting her, and at times displaying aggressive and violent behaviour. Joyce would like to continue caring for Danielle and hopes she will settle down enough to come back to her.

Currently Danielle is in a fostercare placement with a sole parent, Sarah, and her nineteen year old son. Danielle has phone contact with her mother and believes she will return to live with her soon. This phone contact unsettles her, although she is worse without it. The placement with Sarah is very unstable, as Danielle is very unhappy and abusive there, and it is quite likely she will be moved to a residential unit if she can't settle soon.

Danielle has many areas of strength at school. She loves music and art and she is a talented guitarist. She engages well in some classroom activities (but only on her terms). Although she is quite bright she is very behind academically and gets very upset about her difficulties. She can be very disruptive in the classroom, noisy, oppositional and at times aggressive. She upsets other students by shocking them with stories of drug use and prostitution, although it is unknown if she has engaged in these activities. She has been suspended many times and is on the verge of exclusion. She has a small group of friends who have similar difficulties, and all of whom engage in some self-harm. Recently following a conversation with her mother she cut herself severely and needed emergency room attention. All those who are involved with Danielle like and want to help her but hold fears for her future.

Impacts on academic performance and social functioning

The most recognisable impacts of abuse and neglect on education fit into two intertwining categories, outlined in the table below.

Impacts on academic performance	Impacts on social relationships
Reduced cognitive capacity	**Need for control** (causing conflict with teachers and other students)
Sleep disturbance (causing poor concentration)	**Attachment difficulties** (making attachment to school problematic)
Difficulties with memory (making learning harder)	**Poor peer relationships** (making school an unpleasant experience)
Language delays (reducing capacity for listening, understanding and expressing)	**Unstable living situation** (reducing learning, and capacity to engage with a new school)

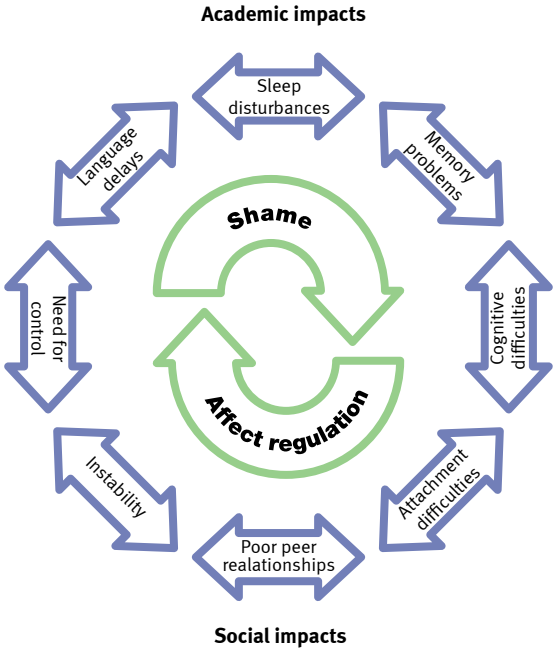

Figure 5 Academic and social impacts of trauma

These impacts are all manifested in, and intensified by, ***shame*** and ***affect dysregulation*** (see Figure 5 and page 5 for an explanation of affect dysregulation).

As mentioned, the various impacts of abuse and neglect on children's academic performance and social functioning are manifested in, and intensified by:

- affect dysregulation (seen as hyperarousal or dissociation)
- **shame** (which can produce overwhelming affect dysregulation.

These processes are explained in more detail below, using the case studies to provide examples.

Academic performance

Abuse and neglect impact on children's academic performance in various ways, including reduced cognitive capacity, sleep disturbance, memory difficulties, and language delays.

Reduced cognitive capacity

Some children with severe early neglect and/or severe traumatic experiences have cognitive delays. For optimum brain growth children need the security of early attuned relationships free from extremes of stress and trauma. Of our three case studies, Jasmine is the most obviously affected in this area. While it may be difficult to determine the cause of her delays as she has a parent with an intellectual disability, the extreme neglect she suffered in early infancy may have limited her intellectual growth. Although she was removed from her parents at eight months she did not receive the specialist infant mental health assessment and intervention which might have improved her overall functioning. Other children, like Michael, are not necessarily delayed in terms of brain growth, but often appear to have cognitive and academic delays due to hyperarousal or dissociation. Hyperarousal usually leads to attention problems, which lead to academic and cognitive difficulties as the child finds it difficult to concentrate on learning. Dissociation can lead to gaps in learning, also because of difficulty with concentration.

Sleep disturbance

Children who sleep poorly do less well at school than their rested peers. Sleep disturbance is common in abused and neglected children. Some children who have missed out on a secure early relationship will never have learnt to put themselves to sleep, never having been given the comfort and support to do so as infants. Some children who have been subjected to abuse or surrounded by frightening, violent events will not want to sleep due to fear of what might happen in the night. Other children who have been removed from home will be distressed due to this dislocation and will have trouble sleeping. Yet others will have developed internal patterns of hyperarousal, anxiety and fear that interfere with their sleeping patterns. A smaller number may use sleep as a dissociative mechanism, oversleeping to avoid the world, or falling asleep as a response to a trauma trigger in the environment.

Whatever the cause, children who are not rested will struggle in the classroom. Both Danielle and Michael have sleep problems. Michael is often woken in the night by nightmares, and will lie awake for hours, fearful and anxious. Michael is always first awake in the house, up and on the go from six am. Danielle finds it hard to fall asleep and feels unsafe at night time. She prefers to sleep late, and is irritable and sleepy in the mornings, and often late for school.

Difficulties with memory

Some traumatised children may be overwhelmed by memories of abuse, which preoccupy them and reduce their capacity to concentrate. Children with 'working memory' problems struggle to hold chunks of information in mind as they process or work on them, for example as part of mathematical processes. Danielle has frequent flashbacks of sexual abuse and can be preoccupied by these, although she rarely talks about it. Jasmine has many problems with memory and finds it hard to remember day to day events. Michael has a good general memory but struggles with working memory. He finds it hard to hold on to information while he thinks about it. His maths is very poor because of this. At times his affect dysregulation also interferes with his memory, as he cannot pay attention while he is in a hyperaroused state.

Language delays

Trauma and attachment disruption reduce the capacity to listen and retain information, to understand complex concepts and to express ideas and thoughts. Early relationships should be rich in language, including the language of emotions and relationship.

Several language areas in the brain are affected by trauma. This makes finding words for experience and translating emotions into words very difficult. While Danielle has well developed language and literacy skills, Michael has many difficulties. He has trouble with receptive language and needs information broken up into small, manageable pieces before he can complete a task. Jasmine has global language delays and is 18 months behind her peers in language development.

Social functioning

The impacts of abuse and neglect on children's social functioning include the need for control; attachment difficulties (including attachment to school); poor peer relationships; and the instability arising from frequent moving.

The impacts of abuse and neglect on children's social functioning include the need for control; attachment difficulties (including attachment to school); poor peer relationships; and the instability arising from frequent moving.

Controlling behaviours

Many traumatised children have experienced terrible and frightening abuse. They have had no control over what has happened to them, and later they may try to control their environment and the adults within those environments as a response to that earlier lack of control. This often leads to debilitating power struggles. Danielle often tries to control others in order to reduce her feelings of being out of control and to try to keep others from connecting with her, and to minimise any feelings of shame she may have. She finds connection with adults very threatening and will display aggressive and oppositional behaviours to push others away, trying to control them through making them angry or disgusted with her.

Some children find a secure attachment to school functions as an alternative to the adversity at home, particularly if they can attend the same school regardless of placement change.

Attachment difficulties

One important process young children undergo is a transfer of attachment from attachment figures to the world. School, crèche or kindergarten can be the earliest example of this, where the child who has a secure attachment at home feels secure, safe, protected and nurtured at school/crèche. Children without secure attachments at home may struggle to attach to school or kindergarten and may need sensitive assistance to do this.

Some children find a secure attachment to school functions as an alternative to the adversity at home, particularly if they can attend the same school regardless of placement change. These children can use school to sustain good relationships, increase a sense of belonging and improve self-esteem. Michael is well attached to his school, which he has attended since prep. There are other Aboriginal children attending the school and a liason officer from an Aboriginal and Torres Strait Islander community organisation who assists teachers to connect with family members. His school also has an Aboriginal and Torres Strait Islander studies program as part of the school curriculum.

Jasmine also has the capacity to attach to kinder and school as she is responding well to the support of her teachers. She is likely to qualify for additional support, which if used wisely will assist in this attachment process.

In contrast, Danielle is not well attached to school, as she has moved schools many times, perceiving herself to be an 'alien' in the school environment, different to and deviant from her peers.

Poor peer relationships

Children who struggle with relationship skills (such as attunement, and the reading of another's body language and facial expression) find it difficult to engage in mutually satisfying play with other children, because they often don't understand the usual rules of relationships such as turn taking and sharing. They find friendship difficult, and other children often react negatively to their aggression, silliness or bossy controlling behaviour. Danielle has very poor peer relationships, joining only with a small group of young people with similar problems to her own. She spends time with others but does not have real friends. Michael also has poor peer relationships, although there are times when he can spend happy and productive time with others. He tends to drive other children away, either through silly behaviour or through aggression. Jasmine finds other children very foreign and has few social or play skills.

Instability of living situation

The child who is separated from their parents due to abuse and/or neglect has to undergo a massive internal reorganisation. They have to adjust to a new living situation, with new parents or carers, new siblings and often a new school. This is a total dislocation, which, coupled with the ongoing effects of the actual abuse or neglect is a 'double whammy'. Unfortunately, in our out-of-home care[2] system some children move frequently from placement to placement, sometimes due to problems caused by the child's own difficult behaviours.

2 See Appendix A for a description of Queensland's out-of-home care service.

Moving frequently reduces the child's ability and desire to attach to the new school. Children often feel as though they stand out as the newcomer and don't have the relationship skills to make new friends and get on well with others. Of all our three case studies, instability has had the most marked effect on Danielle, interfering with her attachment to school and capacity to have meaningful friendships. This instability has also meant she has missed large sections of curriculum and is far behind her peers.

The Department of Communities, Child Safety and Disability Services and the Department of Education, Training and Employment acknowledge their shared responsibility regarding educational outcomes for children living in out-of-home care. See Appendix A for more information on the joint Education Support Plan Initiative.

Affect dysregulation: seen as hyperarousal or dissociation

As we have seen, the impact of abuse and neglect on children's academic performance and social functioning are closely associated with affect dysregulation. There are two forms in which affect dysregulation can be manifested: hyperarousal and dissociation. Children may present with either or both of these forms.

Hyperarousal often goes hand in hand with hypervigilance. Hypervigilant children will often perceive neutral stimuli as threatening. Although physiologically prepared for danger, they are in practice very poor at assessing real danger, and often put themselves in situations of risk. Attention and concentration are both severely reduced by hypervigilance, as the child is constantly on the alert for danger and not relaxed enough to listen and learn.

Affect dysregulation may also lead to dissociation. Dissociative children often do not know how they feel; seem distant, vague and unreachable; and they may become oppositional as a response to a demand for attention, contact, and closeness. They are often just not thinking, and they do not want to think.

All three children in our case studies have problems with affect dysregulation. Jasmine is often dysregulated because her infancy was marked by extreme neglect and she did not have a comforting attachment figure to help her regulate her physical and emotional being. Her affect dysregulation moves swiftly between hyperarousal—where she is oppositional and aggressive—and dissociation, where she is spaced out and disconnected. Michael becomes dysregulated as a response to many triggers. He has been severely hurt and frightened throughout his life, and memories or perceptions will throw him into a dysregulated, hyperaroused, silly or aggressive state. Danielle has been neglected, frightened and hurt, and is sometimes quite dissociative, often in response to flashbacks of memory, appearing disengaged and 'in another world' and at other times hyperaroused and aggressive, as a response to perceived insult or shame.

Children who have been abused and neglected often have intense shame responses to perceived failures or insults and to the experience of being disciplined.

Shame: can increase affect dysregulation

Children who have been abused and neglected often have intense shame responses to perceived failures or insults and to the experience of being disciplined. It is as if all the humiliation of the abuse is triggered any time they perceive themselves as failing or wrong, leaving them feeling intrinsically bad and worthless. Being overwhelmed by shame increases affect dysregulation and often leads to aggressive outbursts. Many traumatised children try very hard to control their environments so as not to feel this paralysing shame. Michael experiences extreme and paralysing shame when he can't do something or does not succeed in front of his peers. He becomes very silly or aggressive at these times. Danielle rarely speaks about her feelings of shame, but her presentation and behaviour indicate extremes of shame, particularly in relation to her sense of self-worth and feelings about her body.

> 'People who live with toxic shame feel fundamentally disgraced, intrinsically worthless, and profoundly humiliated in their own skin, just for being themselves … toxic shame arises when an individual's inner core is tormented through rejection.' (Garbarino, 1999).

Section Three

Calmer classrooms – relationship-based practices

Teachers can do much to enable traumatised children to stay in mainstream schooling. The focus here is on the relationship between teacher and child, and also on the effectiveness of teachers becoming part of a wider support team system. The crucial issues are:

- creating connection and defusing conflict
- planning for challenging incidents
- responding to Aboriginal and Torres Strait Islander children's needs
- remembering self-care for teachers
- participating in systems (such as the care team approach).

Sometimes children who have been abused and neglected create disruption and chaos in the classroom. Many will be far behind in their learning, and have problems with their peers. Some may hurt other children, try to hurt teachers, refuse to cooperate, not pay attention, have regular tantrums and generally create disharmony, while others may be silent, withdrawn, inattentive and overly compliant. Children may alternate in confusing ways between these two extremes.

The relationship-based approach

The following ideas for classroom practices are based on the development of a ***relationship between the teacher and the child***. Change for these children will come more easily if the focus is on the relationship, rather than on behaviour management strategies.

The suggestions in this section may help teachers to manage such children without excluding them from mainstream schooling. Teachers may need extra help, in terms of both time and energy in the classroom, and support and reflective space outside it. Traumatised children are challenging; however when they are responded to with patience and care can come to see school as a safe, supportive place where they can learn and grow. Most of the examples that follow have been developed for primary age children, and can be adapted for older children and adolescents.

At times it may also be useful to talk to other children in the class about the traumatised child's difficulties. The child may be causing disruption, which can be annoying for others. If other children don't have any information about this, they can make it more difficult by marginalising the traumatised child. Other children may be upset if they perceive that this child is receiving special treatment. With the agreement of parents, carers and the child, it may be useful to give some overview of the effects of trauma on children. This needs to be done sensitively and with regard to confidentiality, in cooperation with the child's therapist or case manager.

The central concept in working with these children is to be in control of the relationship without being controlling. The teacher should be the one to set the tone, rhythm and emotional quality. Not being able to control you emotionally will eventually teach the child that it is safe to trust you.

Creating connection and defusing conflict

The central concept in working with these children is to be in control of the relationship without being controlling. The teacher should be the one to set the tone, rhythm and emotional quality. Not being able to control you emotionally will eventually teach the child that it is safe to trust you.

Understanding the child

The most effective strategy a teacher has is a clear understanding of the child, their history and the reasons behind their behaviour. Many children with abuse and neglect histories are developmentally much younger than their chronological age. It has been found that teachers who manage their

behaviours with this in mind develop empathy for the child, which helps them to feel understood and valued.

Keep the child close, maintain a high level of physical presence, support and supervision, as you would for a younger child.This is relevant for adolescents as well, who may be emotionally more like toddlers than other teenagers. Keeping close may mean walking alongside to help them calm down, keeping a close presence with appropriate discussion.

Managing your own reactions

Traumatised children often try to control the emotions of the adults in their lives. This climate of aggression is much more familiar to them than calm, considerate interactions. Practices which help teachers remain calm and avoid the power battles will be most effective.

Try to avoid having the child control your emotions by making you angry or upset. Don't be hemmed in when a child attempts to control you by controlling your emotions. If you feel yourself becoming angry or feeling hurt or rejected, take a moment to reflect, calm yourself and then come back to the interaction. How you manage your own emotional arousal and regulation is vital to assisting the child and to maintaining a peaceful classroom. If you feel you are 'losing it', ask for help or get another adult to take over to give you time to regain composure.

Practices which help teachers remain calm and avoid the power battles will be most effective.

'I see you need help with'

Usually when these children are angry, they are not angry about ***a particular thing***. It is likely that something has triggered shame or other strong feelings such as fear or sadness, and they have become dysregulated. Their anger is the expression of internal affect dysregulation. If they are asked why they have misbehaved or why they are angry, often they will not know.

When you become aware of misbehaviour try saying:

> 'I see you need help with …' (stopping an activity, moving to another part of the room, cleaning up, not kicking the chair, etc).

Instead of giving warnings, help the child to comply with the request. Warnings and second chances are less helpful for these children, as they don't have the established patterns of attachment—of wanting to please adults and to establish relationships—that non-abused children use to maintain a sense of connection.

Structure and consistency

Abused and neglected children often have very little internal structure. They often do much better when they know there are consistent rules and boundaries. Regular routines in the classroom; warning the children of changes to routine; and supporting the child's anxiety when there are transitions and other changes will help the child to develop internal structure, and will assist in the development of a strong relationship with the teacher.

For example some children will struggle when they have to move from their own classroom to the art or music room, and may need close supervision and support during these transitions. This is much more difficult to manage in the secondary education system, where there are many transitions in every day. If possible set up a system for the child, so that they have structure and routine even as they move between classrooms, or enlist teachers or older, responsible students to assist the child find the right books and equipment and get to class on time.

Close supervision is often necessary for younger children in the playground, as the open space and unstructured time can exacerbate the child's difficulties. When a problem arises, address it directly and calmly, giving the child a clear direction and an outcome that is controlled by you.

'You hit Jane, so you need to sit here with me until I decide that you can play without hurting anyone.'

Some children with trauma and attachment difficulties will respond to the structure of point systems, star charts and the like. If so, use them. Many of these children will not respond well, however, as they often do not have a strong enough motivation to please the teacher.

Setting limits on unacceptable behaviour

Teachers have to set limits on unacceptable behaviours, but traumatised and attachment-disrupted children have difficulty accepting these limits, due to the intense shame evoked by discipline, and the common pattern of the child attempting to replicate familiar interactions through angry and disrespectful behaviours.

When there is a problem, try saying to the child:

'I see you aren't ready to do (the activity), …'

and ask them to sit quietly for a moment and try again. If they cannot comply use a natural consequence such as

'Since it took you longer than ten minutes to clean up the table, we have run out of time for you to have time on the computer (or other favoured activity)'.

Time in, not time out

Time out replicates the rejection these children have often experienced and reinforces the child's internal working model of self as unlovable. Instead, bring the child close to the activity undertaken by the other children and keep her by your side. If possible, speak quietly to her about how much fun she will have when she is able to be cooperative and join in with the other children. For older children, rather than send them out of the classroom ask them to come and sit with you to complete their work. Reframe their disruption as a need for your extra attention and help.

Time out replicates the rejection these children have often experienced and reinforces the child's internal working model of self as unlovable.

Connecting

Children with complex difficulties often swing between withdrawn, dissociative responses to internal affect dysregulation and hyperaroused, silly or aggressive responses. Some children will be consistently dissociative, withdrawn and spaced out but internally chaotic and anxious. They will be unlikely to take in new information, think clearly or make decisions while in this state. Children with a history of abuse and neglect who present as very compliant or withdrawn, look spaced out, or are unable to give full concentration, respond well to gentle and consistent attempts to connect with them, to bring them back to themselves.
A light touch or direct word may help when dissociation is noticed. Try to gain eye contact by asking for it (gently). Be aware that the dissociative child is missing chunks of information through inattention, and try to help them catch up. Alert parents, carers and other professionals of your concerns.

Consequences, not punishment

Consequences for unacceptable behaviour should be natural consequences, designed to repair any damage to relationships or property, rather than punishments that have no relationship to the behaviour. Where possible, consequences should have a relational element, and an educative element.

> 'When you are calm I want you to apologise to Jane for hitting her, and I would like you to help her to tidy up her table.'
>
> 'Instead of going outside at recess I want you to stay with me and we will put all the books back on the shelves that you tipped on the floor.'
>
> 'Seeing that you spent a lot of time swearing this morning, I want you to come to the library with me and we will look up some other words you might use when you are angry.'

It is often said about these children that they are 'attention seeking', and should not be rewarded for bad behaviour by having special time with a teacher or other school personnel. It is true that they are seeking attention: they are often desperate for it, having had so little positive attention in their lives. If they are seeking it, give it to them! It will not be long before they are so disillusioned with the adult world they no longer seek your attention, and they will be so much harder to connect with and to help once they have turned away.

Always follow through without argument or emotion. Natural consequences are consequences that are directly related to the misbehaviour. If there is a mess, the consequence is to clean it up, not to sit in the classroom during recess. If the child hurts another, the consequence is to apologise, or to do something nice or to help out that child, not to write fifty lines after school, Bart Simpson style.

Structure choices to remain in control

Another aspect of the child's attempt to control situations and try to get teachers engaged in power battles is oppositional behaviour: standing when asked to sit, refusing to put a hat or jacket on, keeping on doing an activity after they have been asked to stop. Engaging in these battles is fruitless and exhausting. Many people involved with traumatised children have found that offering choices, any of which get the job done, is a useful practice. Using them with humour and creativity also defuses the child's desire to fight.

> 'Do you want to wear your coat or carry it to the playground?'
>
> 'You can finish that work sitting down or standing up.'
>
> 'You can finish that work now or at recess.'
>
> 'If you don't want to put your hat on I'll have to wear it!'

You are in charge of the relationship: keep the child responding to you, not the other way round. Keep anger and frustration out of your voice; use structure without threat.

Acknowledge good decisions and choices

Traumatised children tend to receive little praise, and in fact often don't respond well to praise. They do, however, need positive reinforcement when they have done something well.

Traumatised children tend to receive little praise, and in fact often don't respond well to praise. They do, however, need positive reinforcement when they have done something well.

Try to avoid statements about internal characteristics, such as 'you are a good kid' or 'you are a kind girl', as sometimes that is too much of a contradiction for a child who believes they are not good or kind, but actually bad and unlovable. It is better to comment on actions, as the child can feel good about something they have done, rather than have to think about whether or not they are intrinsically good or bad.

'I see you made a good choice and finished your work before recess, off you go to play now.'

'That was a good decision not to fight with Con, I can see that was hard to do.'

'You did well in the playground today, good on you.'

'You were able to cooperate really well in that group and I saw you being really kind to Sarah when she hurt herself.'

Support the parents and carers

Children with neglect and abuse histories are often not living with their parents. They may be living with foster carers who are (hopefully) trying their best to provide a healing, therapeutic environment. (A small number may be living in residential care, with a number of rostered carers.) Make sure you know the carers, understand the way they are trying to help the child, and make sure you check with them if the child tells you things that seem incongruous.

Stay in close and regular communication with the carers and don't communicate through the child. Talk to carers about how you see the child in the classroom and ask them for specific ideas about what works to calm the child and gain cooperation.

For those children who are living with their parents, it is worth remembering that the parents may themselves have abuse histories. The information in this booklet may help teachers to understand them as well. These parents may have had a negative experience of school and an expectation that things will not go well. Listen to angry outbursts and acknowledge how difficult things seem to be. Try to stay calm and well regulated with angry parents, just as with angry children. If parents feel heard and respected they are more likely to work cooperatively.

Try to stay calm and well regulated with angry parents, just as with angry children. If parents feel heard and respected they are more likely to work cooperatively.

With both carers and parents, acknowledge the positive aspects of the child, and make sure they understand that you, and the school, care about the child and want the best for them. Ask the parent or carer to be a part of any problem-solving around school issues, listen to their dilemmas and difficulties, and try to include them in decisions.

Maintain your role

Remember that you are the child's teacher and that sometimes these children pull you into intense relationships with them. It is sometimes tempting (and quite normal) to imagine taking the child home to live with you, as you may think you could do a good job of parenting this child. The child may also express a wish to come and live with you. Find someone to talk to about these fantasies: it is often better for the child to have you as a competent, caring teacher, than for them to think you might be a better parent or carer than the one they have. Children move on at the end of the year, and can experience this as rejection by you if you have offered too much.

If you are interested in fostering, contact your local foster care agency.

Planning for challenging incidents

Some traumatised children will have outbursts of extreme anger and aggression. It is always better to defuse such situations before they become extreme, through the use of the teaching practices described above. However there are times when you as the teacher will have to respond to the child's extreme affect dysregulation.

At times the practices outlined above will not have been enough, or not enacted soon enough, or the child is experiencing such extremes of emotion they cannot manage themselves. For children who are prone to aggressive outbursts it is very important to have a prepared plan of action, detailing who is to do what, when and where. The plan may include calling the parents/carers to help with the child. The child should be included in this planning, so that they know what will happen and have some choice if there is an outburst.

Establish safety

The immediate safety of the child, other students, teachers and staff needs to be ensured.

When highly aroused and dysregulated, the child is not able to think clearly or to make good decisions. The child will also be terrified by their own lack of control, which heightens their emotions further. They will need help to calm down, and will not be able to respond to logical requests until they are calmer.

For further information refer to the behaviour support policies within the Department of Communities, Child Safety and Disability Services and the Department of Education, Training and Employment.

Maintain self-regulation

The best way to help the extremely dysregulated child is to remain calm and regulated yourself. Use a soothing tone to remind the child that you are helping them to keep safe by removing them to a quiet space where they can calm down. If you are frightened of the child, remove yourself and let someone else take action. Stay close to the child; keep talking; use your presence to help them calm.

If the child's outburst did frighten you, reflect on this later, as it may relate to your own experiences of trauma. Talk to someone about this so that you may be able to assist at another time.

Calm the child

The child may need the presence of a parent/carer in order to become fully calm, or may need some quiet time alone. Many children do better if someone is with them during this time, sitting quietly or talking quietly.

Depending on the severity of the event the child may take some time to calm completely and may need to go home rather than return to the classroom.

When highly aroused and dysregulated, the child is not able to think clearly or to make good decisions. The child will also be terrified by their own lack of control, which heightens their emotions further. They will need help to calm down, and will not be able to respond to logical requests until they are calmer.

Assist the child to understand what happened

The child will need time to talk through what happened, and will be better able to do this when fully calm. It is better to pursue this before enacting any necessary discipline. Comment on the child's strong feelings, and how difficult such events are for everyone. Ask the child to reflect on what was happening for them before and during the event. Children will often respond with 'I don't know'. Say to the child, 'It must hard and confusing not to know how you feel when difficult things happen."

Provide the child with a narrative you have gathered for what happened, being sure to distinguish between what you know and what others have told you. Check that the child has heard and understood, listen to their story and agree to change the narrative if there is a mistake that does not contradict your observation or what you know to be true. Do not enter into an argument with the child about what happened. Children may not tell the truth about the event, or they may blame others for their own behaviour.

Make sure the child has heard a comprehensive narrative about the event.

Consequences

Give a clear statement about the consequences. Try to make these natural and fitting for the level of aggression. If the child has broken anything they should fix it, or use their own pocket money to have it fixed, or contribute to having it fixed. If they have hurt someone, they will need to apologise and make restitution, by doing something for the person they have hurt. If school policy is to exclude the child for a period of time, this time should have a structure and a purpose that contributes to the child learning about safe behaviour.

Help the child to take responsibility

The child will often have trouble thinking about the social consequences of their behaviour, and may need help to take responsibility for the hurt they have caused and damage done. This can be a long process that will need therapeutic intervention to be complete. Encourage the child to reflect on the event, and the consequences that have arisen: for example, that other children may be frightened of them and not want to play with them. Help the child to re-integrate into the group, and help the other children to accept the child.

Speaking to other children

If other children have been involved in a challenging incident, they may need some debriefing or other attention. If a child has been hurt during a challenging incident, the child's parents will be upset and want to know what the school is doing about the traumatised child. An injured child will, of course, need prompt attention, and may need support or counselling if badly affected by the incident. The child and their parents will need to be listened to attentively and given an explanation of the traumatised child's behaviour that does not compromise confidentiality. They will also need an understanding of the school's plan to manage such incidents in the future. Parents may need several meetings to feel thoroughly heard in these issues.

Other children who have witnessed a challenging incident may need an opportunity to talk about the incident and be reassured that they will be safe in the future. A calm, reassuring and contained response by all school personnel is vital to the ongoing healthy functioning of the school.

Review the plan

After a challenging event, find some time to debrief with others involved, and then review the plan with other school personnel, support staff, parents and others, such as therapists and case managers. Did the plan work in the way it was intended? Could anything else have been done, or other support been used? Change the plan as necessary. Make sure the child knows of any changes to the plan.

Teaching Aboriginal and Torres Strait Islander children

Aboriginal and Torres Strait Islander children have specific educational needs, regardless of whether they have experienced abuse and neglect, but complicated by such experience if present.

Aboriginal and Torres Strait Islander children have the same spread of intelligence, talents and skills as non-Aboriginal and Torres Strait Islander children, but learning for Aboriginal and Torres Strait Islander children may proceed differently, due to cultural differences. Aboriginal and Torres Strait Islander people tend to teach and learn through narrative story telling, with the addition of visual cues, rather than through reading and processing materials directly. Incorporation of story telling may be a useful teaching strategy for teachers with Aboriginal and Torres Strait Islander students in their classes.

Aboriginal and Torres Strait Islander people tend to teach and learn through narrative story telling, with the addition of visual cues, rather than through reading and processing materials directly. Incorporation of story telling may be a useful teaching strategy for teachers with Aboriginal and Torres Strait Islander students in their classes.

Large numbers of Aboriginal and Torres Strait Islander children have suffered from early untreated ear infections, which may lead to hearing loss. In the classroom teachers may often notice such children not listening, or speaking very loudly.

Aboriginal and Torres Strait Islander children may also need more time to observe and absorb material. They may have difficulty letting teachers know when they don't know something or are struggling to understand, due to a sensitivity to feeling shamed. These children will not want to 'get it wrong' and so will keep quiet about finding anything difficult. Teachers need to understand and accommodate this, checking with the child that they are understanding and absorbing without them feeling shame if they are not.

Throughout Australia the curriculum should include Aboriginal and Torres Strait Islander studies, particularly traditional stories. Aboriginal and Torres Strait Islander children will feel more valued and accepted if their culture and history is part of the general learning of the classroom. The achievements of Aboriginal people in the arts, sport, politics and other areas of social life should be highlighted and celebrated, to give Aboriginal and Torres Strait Islander children a strong and positive sense of Aboriginal identity.

Aboriginal and Torres Strait Islander students will do better if others from the same culture are in their class and in their school. Invite community or family members to be part of the school experience for all Aborigianal and Torres Strait Islander children, particularly those that may be taumatised. This reduces isolation and the feeling of difference.

Abused and neglected Aboriginal and Torres Strait Islander students

Teachers should be able to recognise the signs of trauma, which may result from domestic violence, drug and alcohol or adult mental health problems at home. Knowledge of the historical trauma suffered by

Teachers need to remember to

- educate themselves about the history of Aboriginal and Torres Strait Island peoples, including the history of removal and disruption
- be sensitive to the possibility of abuse and neglect
- watch for hearing loss
- understand the child's perception of family
- acknowledge grief and loss
- form strong two-way relationship with the child's parent or carer
- where available, make use of an Aboriginal and Storres Strait Islander community organisation liaison workers to get to know families.

Aboriginal and Torres Strait Islander people will fill out the teacher's understanding of the child. Knowing about the removal of the Stolen Generations is particularly important, as this has caused intergenerational problems with attachment and appropriate child-rearing practices. Children already in the Child Protection and out-of-home care systems will present with the range of difficulties described here already, and will need similar support to other abused children. The differences lie in the complexity of the lives of Aboriginal and Torres Strait Islander families, and their communities.

It is also important for teachers to understand the child's perception of family. Their biological parents may not be the most significant adults in their lives, because in Aboriginal and Torres Strait Islander cultures child rearing is shared amongst a network of attachment figures.

It must also be remembered that early death is very common in Aboriginal and Torres Strait Islander families, and children or other family members may be in a process of grieving the loss of loved ones. Indigenous children attend many more funerals than non-Aboriginal and Torres Strait Islander children.

For further information refer to the Department of Education, Training and Employment Indigenous Partnerships Unit.

Self-care for teachers

People working with traumatised children can become worn out by the demands of such work, and can also suffer secondary traumatisation through contact with these children. Sometimes it is the painful stories of the experiences of the child that can hurt the adult working with them, and sometimes it is the child's behaviour that hurts. Working day after day with aggressive or withdrawn children who do not respond to the usual care and consideration shown by a teacher can be very wearying. Teachers can become less effective individually and collectively when this happens.

Reducing stress: the three Rs

Who takes care of the caretaker? Teachers can use the three Rs to remember three very effective strategies for taking care of themselves: ***Reflection, Regulation*** and ***Relaxation***.

Reflection

Take time to reflect on the child you are teaching, your relationship with the child, and assistance that you might need.

- Reflect on the child's behaviour. What were they doing, and why might they have been doing it? Think about the information you now have about abuse and neglect.
- Try to understand the behaviour (what is their behaviour telling me?)
- What are my thoughts/feelings, can I regulate myself?
- What were my responses in relation to the child's behaviour?
- Where is our relationship at? Is the child able to connect with me and listen, to take strength from the containment and structure I am offering?
- What assistance do I need to do this work?
- Who can I talk to about how I feel?

Learn as much as you can about caring for and working with children with trauma and attachment difficulties. Read, search the internet, share your knowledge and experiences, learn from others. Useful resources and websites are listed on page 34.

Regulation

It is important to acknowledge and regulate the feelings that teaching a child with trauma and attachment disruption evoke in you. For example, caring for these children can often trigger our own unresolved issues from the past.

Manage your own emotions and responses by:

- knowing the child might make you angry or upset, in order to recreate familiar relationship patterns
- knowing that strong emotions are contagious
- knowing what your own trigger points are and what upsets you the most
- taking time to calm yourself when you do get angry or hurt
- calling for assistance, not trying to do it all alone
- having clear plans and practices/strategies worked out in advance
- debriefing after challenging incidents so that you are clear in your mind about what happened and the intensity of your feelings can subside.

Relaxation

As important as reflection and regulation is relaxation, allowing you to renew your spirits and energy.

- Make time for yourself and your family.
- Ensure that you make time for yourself and the things you are interested in, such as hobbies, time with friends.
- Maintain a sense of humour: this can help us maintain perspective and not take things personally.
- Be patient and realistic with yourself. Traumatised children with disrupted attachments often require time to change.

Participating in systems: the case planning approach

The network of workers and carers surrounding traumatised children should have forums to meet in, and processes for reflection and collectively managing the inevitable anxieties these children arouse. Teachers and other school personnel should be open to bringing their experiences and their worries to the table at these meetings.

The forums that maintain collaboration and cooperation between parents, carers, agencies and institutions are often called ‘professionals meetings’, ‘stakeholder meetings’, or ‘case planning meetings’.

Children in out-of-home care will often have key stakeholders and professionals working together to meet the child’s needs.

When children are living in out-of-home care, the Department of Communities, Child Safety and Disability Services and the Department of Education, Training and Employment will work in partnership to improve educational outcomes and maximise educational potential.

Be patient and realistic with yourself. Traumatised children with disrupted attachments often require time to change.

Children and therapy

Many traumatised children attend therapy, either through CYMHS (Child Youth Mental Health Service), Evolve Interagency Services or a private practitioner. Therapists place a high level of importance on the teacher’s experience and perspective of the child, as the child’s experience of school is a valuable resource for the therapist in understanding and working with them. Many therapists will ask teachers to fill out questionnaires, such as the Strengths and Difficulties Questionnaire (SDQ) or a Behaviour Checklist. The child’s therapist can also be a resource for the teacher, in helping to understand the child’s history and the reasons for their responses in the classroom.

Good relationships, honest sharing of difficulties, sharing of information, respectful collaboration and commitment to attending are the key elements of effective case planning.

- Case plans focus on the changing needs of the child allows for consistency of approach. In practice this means that the child experiences consistency in their interactions with everyone in the system.
- Many decisions can be made by the key stakeholders in developing the case plan, as there is shared information about the child.
- The case planning allows for the group to think together about the child, and to process some of the difficult emotions and anxieties aroused when working with them.

The key stakeholders involved in developing and reviewing the case plan:

- supports the child's learning, development and growth, as well as their healing from trauma and disrupted attachment.
- promotes proactive rather than reactive responses to the child.
- provide an opportunity to identify positive changes in the child's life, no matter how small.
- ensure that effective coordination and information-sharing strategies have been implemented.

Sometimes the strong emotions aroused by working with these children can cause disagreements in how to manage them, or how to advocate for them. These splits in working teams can be very destructive, and ultimately bad for the child. Participation in case plans can alleviate some of these difficulties by providing a forum for discussion and collaboration.

Teachers and other school personnel have an important role in the case planning process as they have contact with the child on a day to day basis and are in a position to notice both difficulties and change as it occurs. Teachers will also benefit from the support and collaboration of case planning process.

Conclusion

As the traumatised child develops greater relationship skills and regulation capacities they will begin to take pleasure in learning and draw strength from a strong attachment bond to their school.

Schools can become—or continue as—an extremely important point of reference for children whose lives are marred by abuse and neglect. Wherever possible, when a child's placement changes, schools should try to keep the child with them. A strong attachment to their school can provide a child with stability in an otherwise unstable world: offering relationships, maintaining friendships, providing positive and enjoyable learning opportunities and ultimately building resilience and hope.

A snapshot

If we look ***behind*** the acting-out behaviour of abused and neglected children we see that many are suffering from deep, long-lasting pain.
This pain comes from:

- grief and loss
- abandonment and neglect
- physical and sexual abuse
- emotional abuse
- persistent anxiety
- fear or terror of the future
- depression and dispiritedness
- physical self-mutilation.

We see then that much of the behaviour of traumatised children is ***pain-based,*** and it is not that they ***won't*** behave like other children, but that they ***can't***.

The impact of trauma on learning

Affect dysregulation—making children hyperaroused or dissociated
Shame—which can produce overwhelming affect dysregulation
Reduced cognitive capacity—due to early deprivation and/or affect dysregulation
Difficulties with memory—making learning harder
Language delays—reducing capacity for listening, understanding and expressing
Need for control—causing conflict with teachers and other students
Attachment difficulties—making attachment to school problematic
Poor peer relationships—making school an unpleasant experience
Unstable living situation—reducing learning, and capacity to engage with a new school

Classroom practices for dealing with traumatised children

Understand the child Understanding trauma and attachment difficulties brings compassion and empathy; understanding that the child may be developmentally younger than their chronological age will guide teaching practices.
Manage your own reactions Working with traumatised children can bring strong emotions; staying calm will help the child to calm themselves.
I see you need help with ... Help children to comply with requests. Because they don't necessarily want to please adults, helping them comply will avoid power battles.
Structure and Consistency Traumatised children often have little internal structure and need firm boundaries, rules, expectations and consequences—applied with sensitivity and calm.
Time in, not time out Traumatised children experience time out as yet more rejection, increasing their feelings of shame and worthlessness; time in keeps them engaged in a relationship.
Connect Dissociative children, who are often quiet and compliant, need gentle and consistent attempts to connect with them.
Consequences, not punishment Use natural consequences that relate to the problem behaviour and are designed to repair damaged property or damaged relationships.
Structure choices to remain in control Offer choices with humour and creativity to avoid power battles; keep the child responding to you rather than allowing them to control the interaction.
Acknowledge good decisions and choices Traumatised children often don't respond well to praise, but still need positive reinforcement for doing something well: comment on the job well done rather than intrinsic characteristics.
Support parents and carers Get to know the parents or carers; keep up good communication and don't communicate through the child. Try to be understanding and compassionate: living with a child who has trauma and attachment difficulties can be very stressful.
Maintain your role Don't be tempted to move too far out of your role. These children need caring and competent teachers.

Appendix A
Child Protection and out-of-home care QLD

Queensland's child protection system

The Department of Communities, Child Safety and Disability Services ('the department') is the lead Queensland Government agency responsible for child protection. It is dedicated to protecting children and young people from harm or risk of harm when their parents cannot provide an adequate level of care or protection.

Responding effectively to the needs and wellbeing of children and young people and their families is a responsibility for the whole community. When parents are unable or unwilling to protect their children from harm, it is the role of government to work with families, the community and non-government partners to support the ongoing safety and wellbeing of these children and young people.

Wherever possible, the department works to keep families together, offering counselling and support services to help families help themselves. In situations where children need to live away from the family home for their own safety, every effort is made to place them with extended family members.

In collaboration with government and non-government partners, the department provides a diverse range of services:

- prevention and early intervention with the aim of reducing the likelihood of harm or risk of harm to children and young people
- voluntary intervention with the families of children and young people who have been harmed or are at risk of harm
- intervention in the form of child protection orders to protect children and young people who have been harmed or are at risk of harm
- provision of out-of-home care for children and young people whose parents are unable or unwilling to ensure the safety and wellbeing of their children
- provision of services that respond to the cultural, wellbeing and therapeutic needs of children and young people who have been harmed or are at risk of harm.

Primarily, the delivery of child protection services is enabled by the *Child Protection Act 1999* (the Act), which empowers the department to ensure a child or young person's immediate protection and ongoing safety and wellbeing. This involves responding to allegations of harm, providing support services to strengthen and support families to reduce the incidence of harm, and ensuring children and young people who are unable to live with their families receive stable, safe and secure out-of-home care.

Out-of-home care is utilised for a child when it is assessed that the separation of a child from their family is required to ensure the child's safety. Out-of-home care provides a safe, supportive and therapeutic environment for a child, while working towards either family reunification or an alternative permanency option. Out-of-home care may be provided during the investigation and assessment or ongoing intervention phases of child protection intervention. Out-of-home care options can include the following:

- **Kinship care** – involves children living with family or people they know, such as an aunt, grandparent or friend of the family.
- **Foster care** – if kinship care is not a suitable option, a child maybe placed with a volunteer caregiver. A foster carer is not usually known to the child and provides home-based care in their own home.
- **Licensed residential care service** – residential care services include rostered staff models and group homes, and may provide up to 24 hours a day care for children between the ages of 12-17 years. A younger child may also be placed in a licensed residential care service where they are part of a large sibling group, to keep siblings together. These placement types occur in a group setting of up to six young people.
- **Licensed supported independent living services** – this placement option is best suited to a young person aged from 15-17 years who is in the process of transitioning from care. Supported independent living services provide staff that offer external support but are not live-in carers.
- **Therapeutic residential** - this placement option is for young people unable to be placed in home-based care or other residential services, and aims to promote the development of the skills and behaviours required to transition to less intensive forms of out-of-home care.
- **Safe Houses** – is a residential service located in remote Aboriginal and Torres Strait Islander communities to provide short to medium-term care—24 hour houseparent models of care with additional rostered staff.

Children who are being placed in out-of-home care are likely to be in a state of crisis, feeling afraid and uncertain about their situation. In some cases, the length of placement is subject to change. This unknown and changing aspect of placements can be stressful for the child and their family, as well as for the carer and their family.

Education Outcomes for children in out-of-home care

A positive and successful educational experience for children in care is a key factor which contributes to future life outcomes as an adult. The engagement of children in education is recognised as a critical issue that warrants the same level of attention as other aspects of their wellbeing. The research on children in out-of-home care and education shows that education should be a priority for child protection and education professionals.

In order to meet the complex needs of children who are in out-of-home care, the department works in partnership with the Department of Education, Training and Employment (DETE) to develop Education Support Plans (ESP).

ESPs are completed for each child who is in out-of-home care and are on a custody or guardianship order to the department and enrolled at school. The plans are developed by the school in collaboration with the child or young person, their carer, child safety officer and other key people in the child or young person's life to maximise the educational potential of children in care.

The ESP identifies the individual support needs for children and young people in care to improve participation, wellbeing and academic achievement at school. The ESP includes specific educational goals, the required and available resources, strategies needed to achieve these goals, who is responsible for implementing the strategies and processes for monitoring and reviewing the plan, to maximise the child's educational outcomes.

Useful resources

Queensland Government

Department of Communities, Child Safety and Disability Services
www.communities.qld.gov.au/childsafety

Contact **Child Safety** on **13QGOV (13 74 68)**
After business hours, call the Child Safety After-Hours Service Centre on **3235 9999** or freecall **1800 177 135**.
TTY for the speech or hearing impaired (Child Safety Services) **3012 8655**

Department of Education, Training and Employment
www.education.qld.gov.au

Child Youth Mental Health Service
www.health.qld.gov.au/rch/families/cymhs.asp

Police District Communication Centres (24 hours)
Beenleigh 3807 7770 Brisbane 3364 6464
Broadbeach 5581 2900 Bundaberg 4153 9111
Cairns 4030 7000 Charleville 4654 1200
Gladstone 4971 3222 Gympie 5482 2111
Innisfail 4061 5777 Ipswich 3817 1585
Longreach 4652 7200 Mackay 4968 3444
Mareeba 4030 3300 Maroochydore 5475 2444
Maryborough 4123 8111 Mount Isa 4744 1111
Redcliffe 3283 0555 Rockhampton 4932 1500
Roma 4622 9333 Toowoomba 4631 6333
Townsville 4759 9777
Crimestoppers 1800 333 000
TTY for the speech or hearing impaired (Police)
3364 4655

Other contacts

For additional support, families can contact one of the confidential organisations below that provide a variety of services, counselling and referrals.

Parentline 1300 301 300 (8am – 10pm)
Kids Help Line 1800 55 1800 (24 hours)
Community Child Health Service
3862 2333 or 1800 177 279
Community Care Information Service
3224 4225 or 1800 637 711
Women's Infolink 1800 177 577
Men's Info Line 1800 600 636
Statewide Sexual Assault Service 1800 010 120

Many local community groups are also engaged in activities to promote a strong and supportive community. Find out which groups operate in your local area and support their activities to promote child protection.

Federal Government

MindMatters – A national mental health initiative for secondary schools
www.mindmatters.edu.au

Trauma

Child Trauma Academy
www.childtraumaacademy.com

International Society for Traumatic Stress Studies
www.istss.org

Traumatic Stress Institute/Center for Adult & Adolescent Psychotherapy
www.tsicaap.com

Glossary

Affect dysregulation Reduced capacity to regulate strong emotions, which leads to reaction with no time to think. The reactions associated with affect dysregulation are often classified as either ***hyperarousal***, where children are reactive, hypervigilant, alarmed, prone to aggression or to flight, or ***dissociation***, where they are disengaged, numb, compliant and inattentive.

Affect regulation Affect regulation, the capacity to manage and regulate feelings and body states, is developed through a secure attachment relationship in infancy. The affect regulation of the parent/caregiver is passed on to the infant through repeated interactions, where the caregiver soothes and regulates the infant when they are distressed. This eventually builds into the infant the capacity to regulate themselves.

Attachment Attachment is built through an experience of security in infancy. The attachment relationships with parents/caregivers promote feelings of protection and safety. Once the child feels safe and secure they can explore their world (learn and develop), build trusting relationships with others and feel good about themselves. Secure attachment gives a child a deep feeling of being good and lovable.

Attunement When two people are in 'emotional sync', communicating together (both verbally & nonverbally) and responding to each other in a sensitive manner.

Dissociation Form of withdrawal, in which the child cuts off from contact with others and the world—causing the child to become numb, unfeeling or unaware. It is a form of mental 'freezing' or 'absence' to avoid being overwhelmed by fear.

Empathy The ability to imagine and share what another is experiencing.

Hyperarousal When a child is in a constant state of stress showing extreme reactions and over-responsiveness to stimuli.

Hypervigilance Responding to the environment as if there is imminent danger, being hyper-alert, constantly scanning for threat.

Internal working model Develops from repeated experiences of relationship with the primary caregiver. Their IWM influences how the child sees themselves and how they will respond to future relationships. Abused and neglected children have often developed a negative internal working model. They see themselves as unlovable, expect rejection, see the world as unsafe and do not believe that relationships can be relied upon to keep them safe.

Reflection The ability to pay attention to the contents of our own mind and to think about the minds of others. This leads to the ability to understand why things happen and why people behave the way they do. Developing our reflective capacity means we can think before reacting.

Resilience A key quality that supports children to respond to adverse events or experiences. Nurture, protection and attunement give children a secure base—this secure base is the foundation for resilience.

Secure base This occurs when a child is able to feel safe and secure with a parent or carer and is therefore able to engage in confident exploration of the world. A secure base gives a child the sense that they will be cared for and protected because they are worthy of love.

Self-regulation Ability to manage, and organise our own feelings and emotions (for example calm ourselves down when stressed).

Shame A complex emotional state in which a person experiences negative feelings about the self. A feeling of inferiority, being not good enough. Shame differs from guilt in that the person feels that they are intrinsically bad whereas feelings of guilt evoke a need to make things right or repair the relationship.

Trauma Traumatisation occurs when the child's inner resources are overwhelmed by a perceived or actual external threat. An acute alarm reaction occurs, triggering a response of fight, flight or freeze. Long term damage can be done to key neurological and psychological systems. Trauma caused by abuse and neglect in childhood almost always has an impact on attachment.

References

Allen, Jon, G. (2003) Mentalizing. ***Bulletin of the Menninger Clinic***, 67(2) Spring.

Archer, Caroline & Burnell (2003), Alan (eds) ***Trauma, Attachment and Family Permanence: Fear Can Stop You Loving***, Jessica Kingsley Publishers, London.

Beaulieu D (2003) ***Eye Movement Integration Therapy: The Comprehensive Clinical Guide***, Crown House Publishing, Carmarthen.

Becker-Weidman, A. & Shell, D. (2005) ***Creating Capacity for Attachment***, Wood 'N' Barns, Oklahoma, U.S.A.

Cairns, Kate & Stanway, Chris (2004) Learning the Child: Helping Looked After Children to Learn, a good practice guide for social workers, carers and teachers, ***BAAF Adoption & Fostering***, The Russell Press (YU) Nottingham, UK.

Cassidy & Mohr, (2001) Unsolvable Fear, Trauma, and Psychopathology: Theory, Research, and Clinical Considerations Related to Disorganized Attachment Across the Life Span, ***Clinical Psychology: Science and Practice***, 8 (3), Fall.

Fonagy, Peter (1999) ***Transgenerational Consistencies of Attachment: A New Theory*** (web version: www.dspp.com/papers/fonagy2)

Garbarino, James (1999) ***Lost Boys: Why our Sons Turn Violent and How We Can Save Them***. Anchor Books, New York.

Golding, K., H. Dent, et al., Eds. (2006). ***Thinking psychologically about children who are looked after and adopted. Holding it all together: creating thinking networks***, John Wiley and Sons England.

Herman, Judith, L. & van der Kolk, Bessel, A. (1987) Traumatic Antecedents of Borderline Personality Disorder. ***Psychological Trauma***, American Psychiatry Press Inc. Washington.

Herman Judith, L., Perry, J. Christopher and van der Kolk, Bessel, A. (1989) ***Childhood Trauma in Borderline Personality Disorder*** American Journal of Psychiatry.

Herman, Judith (1992/1997) Trauma and Recovery: ***The Aftermath of Violence – From Domestic Abuse to Political Terror*** Basic Books, New York.

Hughes, Daniel A. (1997) ***Facilitating Developmental Attachment: The Road to Emotional Recovery and Behavioural Change in Foster and Adopted Children***, Rowman & Littlefield Publishers, Inc. Lanham.

Matsakis, Aphrodite (1996) ***I Can't Get Over It: A Handbook for Trauma Survivors***, 2nd ed, New Harbinger Publications Inc, Oakland.

Perry, B. (2006) ***Applying principles of neurodevelopment to clinical work with maltreated and traumatized children***, The Guilford Press New York.

Schore, Allan N. (2003a) ***Affect Dysregulation and Disorders of the Self***, W.W. Norton and Co. New York.

Schore, Allan N. (2003b) ***Affect Dysregulation and the Repair of the Self***, W.W. Norton and Co. New York.

Siegel, Daniel J. & Solomon, Marion, F. ***Healing Trauma: Attachment, Mind, Body, and Brain***, W.W. Norton & Company, New York.

Stern, Daniel (1985) ***The Interpersonal World of the Infant***. Basic Books, New York.

Take Two Practice Framework (2007), available through Berrystreet Victoria.

van der Kolk, Bessel, A. (1996a) ***Trauma and Memory***, in van der Kolk, Bessel A., McFarlane, Andrew & Weisaeth, Laars (Eds) Traumatic Stress: the effects of overwhelming Experience on Mind, Body and Society. The Guilford Press, New York.

van der Kolk, Bessel A., McFarlane, Andrew & Weisaeth, Laars (eds) (1996b), ***Traumatic Stress: the effects of overwhelming Experience on Mind, Body and Society***, The Guilford Press, New York.

van der Kolk, Bessel, A. (2005) ***Developmental Trauma Disorder***, Psychiatric Annals, May.