Trauma Informed Behaviour Support: A Practical Guide to Developing Resilient Learners

TRAUMA INFORMED BEHAVIOUR SUPPORT: A PRACTICAL GUIDE TO DEVELOPING RESILIENT LEARNERS

KAY AYRE AND GOVIND KRISHNAMOORTHY

University of Southern Queensland

Toowoomba

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ABOUT THE AUTHORS

DR KAY AYRE

Dr Kay Ayre is a lecturer in Early Childhood Studies in the School of Education at Edith Cowan University, Western Australia. She has a background in early years teaching and behaviour support. She has worked extensively with disengaged and disruptive children, their teachers and schools. Kay has a passion for helping build the capacity of teachers to develop and maintain positive, inclusive classrooms with a focus on supporting children affected by trauma who demonstrate serious, disruptive behaviour. Her research interests are in challenging behaviour of children, positive behaviour support, trauma informed practice and parent-school engagement.

Kay can be contacted by email at: k.ayre@ecu.edu.au

DR GOVIND KRISHNAMOORTHY

Dr Govind Krishnamoorthy is a clinical psychologist and lecturer in the School of Psychology and Counselling at the University of Southern Queensland, Australia. Govind's clinical practice and research focuses on improving mental health and educational outcomes for children and adolescents from marginalised backgrounds. He has worked extensively with children and families exposed to abuse and neglect in both public and private sector. Govind has collaborated extensively with schools and a number of child welfare services in implementing systems approaches for trauma informed and attachment sensitive practices.

Govind can be contacted by email at: Govind.Krishnamoorthy@usq.edu.au

ACKNOWLEDGMENTS

ACKNOWLEDGMENT FROM DR KAY AYRE

Govind, my sincere thanks for your inspiration, guidance and friendship. To all the heroes making a difference to the lives of vulnerable children and young people, this book is for you.

ACKNOWLEDGMENT FROM DR GOVIND KRISHNAMOORTHY

Thank you Kay for your wisdom, patience and generosity. Thank you to my family for their sacrifices and giving me the opportunities they never had. I dedicate this book to my two girls.

We offer special thanks to Mr Adrian Stagg and Miss Nikki Andersen and members of the Open Educational Practice community for their invaluable support.

ACKNOWLEDGMENT OF COUNTRY

The authors wish to acknowledge the Aboriginal and Torres Strait Islander peoples of this nation. We acknowledge the traditional owners of the country throughout Australia and their continuing connection to the land, culture and community. We acknowledge the traditional custodians of the lands on which we live and work, and where the book was written. We acknowledge the cultural diversity of all Aboriginal and Torres Strait Islander peoples and pay respect to Elders past, present and future. We celebrate the continuous living cultures of First Australians and acknowledge the important contributions Aboriginal and Torres Strait Islander people have and continue to make in Australian society.

FOREWORD

DAVE ZIEGLER

As I write this the planet is in the grasp of a global pandemic in which 28 million individuals have become ill and nearly one million have died. This event has changed the lives of nearly everyone in the world. By the time you read this it is my sincere hope that there are effective vaccines and ample quantities to address this catastrophe. I feel the pandemic has been able to put the focus of this book into perspective. As terrible and heartbreaking as the COVID 19 pandemic has been, the impact of trauma on the children of the world has been and continues to be much greater. However, unlike the pandemic crisis that headlines the news, children living with trauma is a hidden crisis that only catches the attention of media and world leaders periodically and that attention is sadly not sustained, and no vaccine will address this hidden crisis.

When I say that childhood trauma impacts our children far more than a viral pandemic, here are a few comparisons. The United States has 13 times the total population of Australia. The United States (US) leads the world in many areas, some we don't like to discuss such as more incarcerated individuals than any other nation, and more child abuse than any country that has data. The US does have excellent child abuse data, so we know that every year in the US around 1,700 children die of child maltreatment. However, COVID 19 so far has resulted in 60 child deaths. Any child's death is tragic, but a child in the US is 28 times more likely to die at the hands of parents and care providers than from the pandemic, and 10 times more likely to be a victim of child abuse than infected by the COVID 19 virus. Recent data has found 182 children in Australia died of maltreatment in a year. Compare that number to the child deaths in Australia from COVID 19 where no child death had been reported as I write this. Trauma often has an impact throughout the lifespan of the individual, unlike an illness in which many children recover from. You get the point, we call the pandemic a catastrophe, but child abuse and the resulting trauma and its impact on learning and the child's future is a far greater catastrophe.

For every death by abuse and maltreatment there are millions of children who survive but pay the price of the lingering impacts of the trauma of childhood throughout their life span. Statistics are cold and impersonal, but every individual is a child deserving of love, of learning and a life of wonderful possibilities. All children deserve these things, but trauma reflects the primary reason children start their lives on the wrong track and often never recover.

We have known for nearly a quarter of a century that trauma impacts the lives and learning of children. A pivotal study from the 1990s called the Adverse Childhood Experiences Study (ACES) brought the facts out in clear detail. Briefly stated, the more trauma a child experiences in early years

the greater the likelihood of a life filled with poverty, substance abuse, mental health issues, smoking, obesity, under employment, medical disease and early death. This study reflects a direct link between early trauma and some of society's most damaging dysfunctions. Seriously traumatised children start life by losing their carefree childhoods, have trouble managing emotions and behaviour, fail in school, fail in the world of work, fail in relationships and ultimately have untimely deaths due to physical illnesses brought on by a lifetime of toxic stress. Other than death, no pandemic can cause the lifelong problems caused by child maltreatment and trauma.

One of the outcomes of childhood trauma is failure in school. The serious impacts of childhood trauma in many ways are most obvious in educational settings. Trauma impacts the child's brain in ways that make academic learning challenging. Trauma can rob the child of self-regulation, managing emotions such as anxiety and fear, and can impact the child's ability to manage behaviour. This combination often results in poor attention and disruptive behaviour in the school setting. Even if these children can stay in their seat and not seriously act out, they may struggle with learning disabilities that are directly linked to trauma. When a child does poorly in academics and often poorly in peer relationships, the usual result is a lack of attendance and the eventual dropping out of school. Often "problem children" in our schools are actually survivors of early childhood trauma.

These children learn differently because of brain changes due to childhood trauma. They do not handle many experiences in a typical classroom well such as: competition, transitions, peer relationships, social skills, memory recall as well as attending to assignments and handling frustration. To learn an individual must fail many times before they master the task. Children with a history of trauma give up easily with something difficult or new and will eventually view school as a negative place to be avoided.

Although the conclusion all this information seems to lead to is certain failure, this need not be the case. If we can learn how the brain of a traumatised child functions, and we have done so, then we should be able to adjust our schools and our teaching to meet these children where they are. There are many efforts throughout the world that are searching for the best methods to help the millions of children who learn differently due to trauma. Some of the best new ideas are coming out of Australia. Unless we can face the challenge of successful instruction to children with a traumatic history, our schools will continue to have major problems with drop outs, underachievers, suspensions and expulsions and our educational systems may actually be causing further harm to the very children who deserve our best efforts to help them.

Before I comment on this book there is one more point that is critical to make. Trauma in childhood need not be a life-long sentence of loneliness and failure leading to an easy death as indicated in the ACES findings. We have ample research on resiliency that shows that past difficulties can not only be overcome with the right help, but past trauma can actually make the individual stronger. When children get the support, the encouragement, the understanding and the right environments to learn, we know that many will take advantage of the opportunity and may become more impressive adults because of what they have overcome. My own program in the United States has shown decades of success by the very children least likely to do well. It is from this experience that I have spoken out on behalf of the traumatised children who have no voice to say we can and we must do better to help these children succeed in school and develop an interest in lifelong learning.

I have followed some of the work done by Drs. Kay Ayre and Govind Krishnamoorthy over the years as well as the efforts of the University of Southern Queensland to bring trauma informed instruction into the classroom. When they asked me to write a foreword to this book I agreed for

several reasons. *Trauma Informed Behaviour Support: A Practical Guide to Developing Resilient Learners* is well written and has a tight style of getting to the point. This book will not waste your time and will outline a wide variety of factors that you need to know in your school and in your classroom. From brain development to attachment to behavioural interventions and more, it is a one-stop source of information that can inform and provide you with tools that you can use.

This book is well researched with further resources provided in every chapter. It does not try to sell you a product but offers hundreds of practical tips that can help you help the children you are responsible to teach and help achieve academic growth and success. I particularly liked the links provided in the book to other resources such as audio and video recordings that add further practical advice and suggestions. In all the complexity that is involved in trauma and in learning, I love the bottom-line suggestions you will find in this book such as the three elements of success with traumatised children: 1. Hold high expectations, 2. Reward desirable behaviour and 3. Teach by modeling. I have spent a 50-year career highlighting these foundational approaches to helping children.

In addition to the above strengths, this book takes additional steps to go beyond the educational approach and puts a spotlight on the teacher/healer. I say healer because with traumatised children you will have to invest time healing the damage to their brain to make room for the learning that will bring them success in life, not only in academics but also in relationships. Chapter six is a gem in this book. It instructs you to not only put the focus on the learner but also to focus on yourself. I have spent a career following the Latin motto "Nemo dat quod non habit" or you cannot give to someone that which you do not possess yourself. If you want to teach a struggling child patience, resilience, self-regulation, and persistence despite the difficulties, then you must possess these qualities in your contact with the child you seek to help. Take it from my experience with some of the most challenging children in our system of care. It is amazing what we can accomplish when we refuse to give up on a child.

Additionally, this book takes one more critical step. If we want to impact the world of children who have experienced trauma then we must change not only ourselves and our classroom, but we must change our schools, our organisations, and our systems of care for children. We must all speak out for these children who have no voice to bring awareness of new educational and mental health approaches to children who will become tomorrow's failed adults unless they receive our understanding and our help.

For whatever reason you have been attracted to this book, you have come to the right place. You may at times put it down and wonder if the challenge is too great, but trust me it is not. If you stay engaged with this book and with a child who has experienced trauma then you will learn new understandings, new ideas and new ways to reach the mind, the heart and the soul of young people who need our support and our love.

I often close my workshops by saying that our society has a mistaken sense of what a hero is. The heroes we too often give this label to are actors, musicians, successful athletes and celebrities in the news. However, the real heroes do their work quietly and often unnoticed. They seek only one goal and that is to help someone and change a person's life for the better. I encourage you to expand the heroic work you already do and change the lives of children by instilling in one child at a time a love of learning. Your task is important. It is possible and furthermore it is essential. Thanks for being the hero you are!

With my best wishes,

Dave Ziegler, Ph.D.
Jasper Mountain, USA

PART I.

UNDERSTAND AND EMPATHISE

Child sitting in jeans in the door by Rubberduck1951 is licensed under CC0

"Childhood neglect is the most damaging trauma. The child must not have the basic needs threatened in any way or survival will be all they think about" – Dave Ziegler

Overview and learning outcomes

Chapter one focuses on understanding the nature and impact of child maltreatment on the academic and social-emotional development of students. This chapter is organised into:

- Understanding child maltreatment, including an introduction to the nature and prevalence of child maltreatment
- Childhood trauma, and the impact of child abuse and neglect

- Trauma informed practice and implications for educators

On successful completion of this chapter, you should be able to:

- Understand types of childhood abuse and neglect and the related risk and protective factors
- Know the pervasive impact of adverse childhood experiences on the physical and emotional wellbeing of children
- Be aware of the influences on the development of post-traumatic stress reactions in children
- Identify the range of symptoms associated with complex trauma and its impact on learning
- Understand the principles of trauma informed practice in education

INTRODUCTION

Every day, children enter their classrooms bringing backpacks, pencils, paper—and their unique views of the world. Every child has their own expectations and insights, formed from experiences at home, in the community, and at school. Inclusive schools and teachers recognise and respond to the diverse needs of their students, accommodating both different styles and rates of learning and ensuring quality education to all through quality curricula, organisational arrangements, teaching strategies, resource use, and partnerships within their communities.

When children witness violence between their adult caregivers or experience abuse or neglect, they can enter the classroom believing that the world is an unpredictable and threatening place. Teachers who understand the effects of such experiences of abuse and neglect 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 these children, will not only improve educational outcomes for these children but will assist in their healing and recovery.

1.1 CHILDHOOD ADVERSITY AND MALTREATMENT

Child maltreatment refers to any non-accidental behaviour by parents, caregivers, other adults or older adolescents that are outside the norms of conduct and entail a substantial risk of causing physical or emotional harm to a child or young person. Such behaviours may be intentional or unintentional and can include acts of omission (i.e., neglect) and commission (i.e., abuse) (Bromfield, 2005; Christoffel et al., 1992).

Child maltreatment is commonly divided into five main subtypes:

- physical abuse
- emotional maltreatment
- neglect
- sexual abuse and
- exposure to family violence

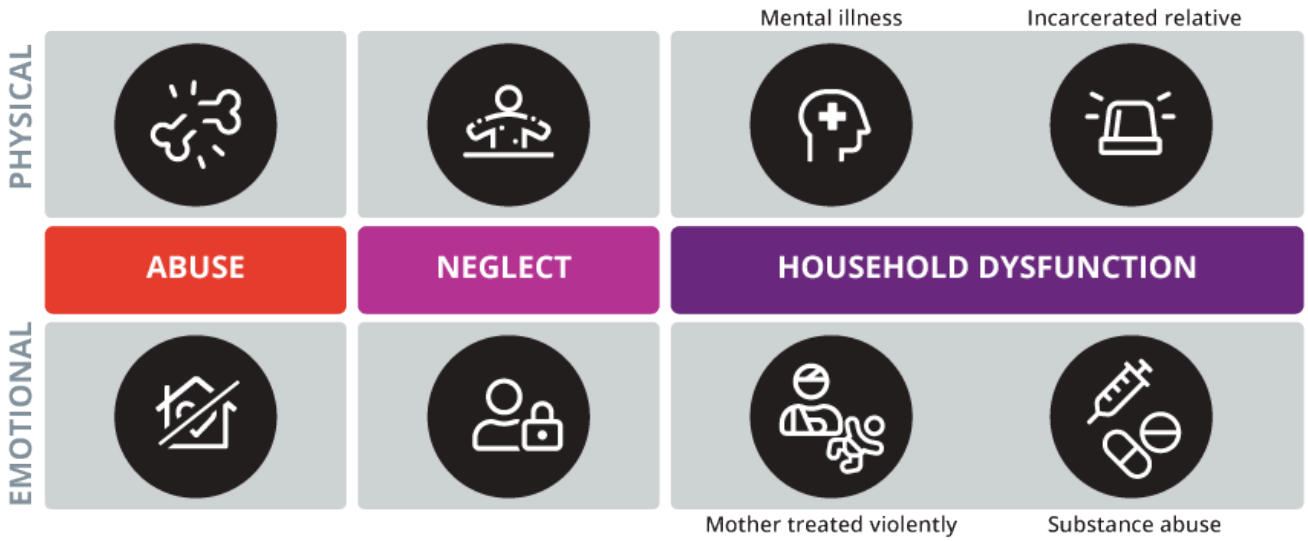

Figure 1.1 Childhood maltreatment sub-types

Although there is a broad consensus regarding the different subtypes of maltreatment, disagreement exists about exactly how to define these subtypes. In the absence of universal definitions of child abuse and neglect, different professional fields have developed their own definitions. There are medical and clinical definitions, social service definitions, legal and judicial definitions, and research definitions of child maltreatment. Each professional sector tends to emphasise the facets of maltreatment that

are most salient to their own field. For example, medical definitions highlight the physical symptoms of a child rather than the abusive or neglectful behaviours of a perpetrator, while legal and judicial definitions focus on those aspects of parental behaviour and mental health symptoms that provide the best evidence for a successful prosecution (Bromfield, 2005; Feerick, Knutson, Trickett, & Flanzer, 2006).

View

ReMOVED [12 mins 46 secs]

Watch this short video to understand the impact of child maltreatment on children in child welfare. Please note that the clip contains themes and images that may be distressing to some. Please feel free to stop watching the video if you are distressed.

A transcript and Closed Captions are also available within the video.

A number of complex issues need to be considered when trying to define a form of maltreatment. For example:

- Definitions of child maltreatment reflect cultural values and beliefs. Behaviour that is considered abusive in one culture may be considered acceptable in another (e.g., corporal punishment).
- Parental behaviour that is appropriate at one stage in a child's development may be inappropriate at another stage of development (e.g., the level of supervision needed for toddlers versus adolescents).
- The potential perpetrators of maltreatment need to be defined, so as not to inadvertently exclude particular behaviours and contexts. However, disagreement exists over whom should be included as potential perpetrators in the definitions of certain maltreatment subtypes.
- Researchers often use categorical definitions of child maltreatment (i.e., a child is either maltreated or not maltreated). However, this approach fails to acknowledge that abusive and neglectful behaviours can differ markedly in terms of severity, the frequency and duration of occurrence, and the likelihood that they will cause physical or emotional harm.
- Child maltreatment can be defined either using abusive or neglectful adult behaviours (e.g., the definition of child physical abuse would comprise parental behaviours such as hitting or shaking), or by the harm caused to the child as a result of such behaviours (e.g., child physical abuse would be indicated if the child displayed physical symptoms such as bruising or swelling).
- Although perpetrator intent to maltreat a child is often a useful indicator of child maltreatment, there are a number of instances where abuse or neglect can occur even though the perpetrator did not intend to commit it (e.g., neglectful parents may have had no intention of neglecting their children) (Bromfield, 2005; Feerick et al., 2006; US National Research Council, 1993).

Let's take a closer look at each if these major types of child maltreatment.

PHYSICAL ABUSE

Generally, child physical abuse refers to the non-accidental use of physical force against a child that results in harm to the child. However, a parent does not have to intend to physically harm their child to have physically abused them (e.g., physical punishment that results in bruising would generally be considered physical abuse). Depending on the age and the nature of the behaviour, physical force that is likely to cause physical harm to the child may also be considered abusive (e.g., a situation in which a baby is shaken but not injured would still be considered physically abusive). Physically abusive behaviours include shoving, hitting, slapping, shaking, throwing, punching, kicking biting, burning, strangling and poisoning. The fabrication or induction of an illness by a parent or carer (previously known as Munchausen syndrome by proxy) is also considered physically abusive behaviour (Bromfield, 2005; World Health Organization, 2006).

EMOTIONAL MALTREATMENT

Emotional maltreatment is also sometimes called 'emotional abuse,' 'psychological maltreatment' or 'psychological abuse'. Emotional maltreatment refers to a parent or caregiver's inappropriate verbal or symbolic acts toward a child and/or a pattern of failure over time to provide a child with adequate non-physical nurture and emotional availability. Such acts of commission or omission have a high probability of damaging a child's self-esteem or social competence (Bromfield, 2005; Garbarino, Guttman, & Seeley, 1986; World Health Organization, 2006). Emotional maltreatment can include when a caregiver or adult rejects or refuses to acknowledge the child's needs. Some children are isolated from normative social experiences, preventing them from forming friendships (Gabarino et al., 1986). Caregivers can frighten children with verbal abuse, creating a climate of fear at home. Depriving children of opportunities for learning and intellectual development, and encouraging them to engage in antisocial behaviour constitute emotional maltreatment (Gabarino et. al., 1986). It is worth noting that some researchers classify emotionally neglectful behaviours (e.g., rejecting, ignoring) as a form of neglect. This does not pose a problem, as long as researchers explicitly indicate under which maltreatment subtype they record such behaviours. There is certainly common conceptual ground between some types of emotional maltreatment and some types of neglect, which serves to illustrate that the different maltreatment subtypes are not always neatly demarcated.

NEGLECT

Neglect refers to the failure by a parent or caregiver to provide a child (where they are in a position to do so) with the conditions that are culturally accepted in a society as being essential for their physical and emotional development and wellbeing (Broadbent & Bentley, 1997; Bromfield, 2005; Scott, 2014; World Health Organization, 2006). Common forms of child neglect include a consistent lack of appropriate adult supervision and the failure to provide basic physical necessities such as clothing and food. The failure of caregivers to meet the medical needs of children, or by deliberately withholding treatment, can have fatal consequences. Similarly, caregivers can fail to support a child engaging in education or regularly attend school (Scott, 2014). Finally, children left alone for more than a reasonable period and not providing them with appropriate alternate care can have adverse consequences for the child's development (Scott, 2014).

SEXUAL ABUSE

Defining sexual abuse is a complicated task. Although some behaviours are considered sexually abusive by almost everyone (e.g., the rape of a 10-year-old child by a parent), other behaviours are much more equivocal (e.g., consensual sex between a 19-year-old and a 15- year-old) and judging whether or not they constitute abuse requires a sensitive understanding of a number of definitional issues specific to child sexual abuse. In places such as Australia where there are multiple legal definitions of child sexual abuse, a more general definition may be useful (Quadara, Nagy, Higgins, & Siegel, 2015).

The World Health Organization (WHO, 1999) defines child sexual abuse as the involvement of a child in sexual activity that he or she does not fully comprehend, is unable to give informed consent to … or that violate the laws or social taboos of society. Child sexual abuse is evidenced by this activity between a child and an adult or another child who by age or development is in a relationship of responsibility, trust or power, the activity being intended to gratify or satisfy the needs of the other person (WHO, 1999). Sexually abusive behaviours can include the fondling of genitals, masturbation, oral sex, vaginal or anal penetration by a penis, finger or any other object, fondling of breasts, voyeurism, exhibitionism and exposing the child to or involving the child in pornography (Bromfield, 2005; US National Research Council, 1993).

However, unlike the other maltreatment types, the definition of child sexual abuse varies depending on the relationship between the victim and the perpetrator. For example, any sexual behaviour between a child and a member of their family (e.g., parent, uncle) would always be considered abusive, while sexual behaviour between two adolescents may or may not be considered abusive, depending on whether the behaviour was consensual, whether any coercion was present, or whether the relationship between the two young people was equal (Ryan, 1997). Thus, there are different definitions for each class of perpetrator: adults with no familial relationship to the child, adult family members of the child, adults in a position of power or authority over the child (e.g., teacher, doctor), adolescent or child perpetrators, and adolescent or child family members.

According to Smallbone et al. (2013) there are four dimensions of child sexual abuse: relationships, contexts or settings, victim vulnerabilities and grooming strategies. These are not mutually exclusive, but are used to highlight the idea that some forms of child sexual abuse are made possible and are shaped by the relationships between victims and perpetrators, while other forms of child sexual abuse are significantly shaped by the settings and contexts in which victims and perpetrators come together. This is highlighted by the notion that sexual abuse is only possible at the convergence or interaction of two factors: the person (both victim and offender) and the situation (context or setting) (Smallbone et al., 2013). Furthermore, adult perpetrators typically target children who appear vulnerable (due to family dysfunction, social isolation, disability, etc.), and employ a range of grooming strategies to develop trust and intimacy with the child, which enables sexualisation of the relationship to occur (Salter, 1995). Any sexual behaviour between a child under the age of consent and an adult is abusive. The age of consent is 16 years in most Australian states. In Australia, consensual sexual activity between a 20-year-old and a 15-year-old is considered abusive, while in most jurisdictions the same activity between a 20-year-old and a 17-year-old is not considered abusive.

Communication technologies facilitate a range of sexually abusive behaviours and allow perpetrators to have anonymous contact with a large number of children. Forms of perpetration include grooming children in a virtual environment such as through instant messaging, accessing child exploitation material, and producing and distributing exploitation material even where there

is no sexual interest in children. Online sexual abuse behaviours are often active with perpetrators seeking out minors online, and perpetrators may move from making connections with children online to making contact offline (Quadara et al., 2015). Any sexual behaviour between a child and an adult family member is abusive. The concepts of consent, equality and coercion are inapplicable in instances of intra-familial abuse.

Sexual abuse occurs when there is any sexual behaviour between a child and an adult in a position of power or authority over them (e.g., a teacher). The age of consent laws is inapplicable in such instances due to the strong imbalance of power that exists between children and authority figures, as well as the breaching of both personal and public trust that occurs when professional boundaries are violated.

Sexual abuse occurs when there is sexual activity between a child and an adolescent or child family member that is non-consensual or coercive, or where there is an inequality of power or development between the two young people. Although consensual and non-coercive sexual behaviour between two developmentally similar family members is not considered child sexual abuse, it is considered incest, and is strongly proscribed both socially and legally in Australia.

EXPOSURE TO FAMILY VIOLENCE

Exposure to family violence has been broadly defined as "a child being present (hearing or seeing) while a parent or sibling is subjected to physical abuse, sexual abuse or psychological maltreatment, or is visually exposed to the damage caused to persons or property by a family member's violent behaviour" (Higgins, 1998, p. 104). Narrower definitions refer only to children being exposed to domestic violence between intimate partners.

Some researchers classify the witnessing of family violence as a special form of emotional maltreatment. However, a growing number of professionals regard the exposure to family violence as a unique and independent subtype of abuse (Bromfield, 2005; Higgins, 2004; James, 1994). Regardless of the classification used, research has shown that children who are exposed to domestic violence tend to experience significant disruptions in their psychosocial wellbeing, often exhibiting a similar pattern of symptoms to other abused or neglected children (Kitzmann, Gaylord, Holt, & Kenny, 2003; Tomison, 2000).

OTHER FORMS OF CHILD MALTREATMENT

As well as the five main subtypes of child maltreatment, researchers have identified others, including:

- fetal abuse (i.e., behaviours by pregnant mothers that could endanger a fetus, such as the excessive use of tobacco, alcohol or illicit drugs)
- bullying, or peer abuse
- sibling abuse
- exposure to community violence
- institutional abuse (i.e., abuse that occurs in institutions such as foster homes, group homes, voluntary organisations such as the Scouts, and child care centres)
- organised exploitation (e.g., child sex rings, child pornography, child prostitution); and
- state-sanctioned abuse (e.g., female genital mutilation in parts of Africa, and the 'Stolen Generations' in Australia) (Corby, 2006; Miller-Perrin & Perrin, 2007).

RELATIONSHIP BETWEEN DIFFERENT FORMS OF ABUSE

Although it is useful to distinguish between the different subtypes of child maltreatment in order to understand and identify them more thoroughly, it can also be slightly misleading. It is misleading if it creates the impression that there are always strong lines of demarcation between the different abuse subtypes, or that abuse subtypes usually occur in isolation. There is a growing body of evidence to suggest that maltreatment subtypes seldom occur in isolation; the majority of individuals with a history of maltreatment report exposure to two or more subtypes (Arata, Langhinrichsen-Rohling, Bowers, & O'Farrill-Swails, 2005; Higgins & McCabe, 2000; Ney, Fung, & Wickett, 1994). Additionally, some acts of violence against children involve multiple maltreatment subtypes. For example, an adult who sexually abuses a child may simultaneously hit them (i.e., physical abuse) and isolate or terrorise them (e.g., emotional abuse). Similarly, when parents subject their children to sexual or physical abuse, the emotional harm and betrayal of trust implicit in these acts need to also be thought of as a form of emotional maltreatment.

PREVALENCE OF CHILD MALTREATMENT

Prevalence refers to the proportion of a population that has experienced a phenomenon, for example the percentage of Australians aged 18 years and over in 2015 who were ever abused or neglected as a child. Incidence refers to the number of new cases occurring over a specified period of time (normally a year), for example the number of Australian children aged 0–17 years who were abused or neglected during 2015 (Mathews et al., 2016).

Australia is one of the only developed countries where there has been no methodologically rigorous, nationwide study of the prevalence or incidence of child abuse and neglect (Mathews et al., 2016) There are, however, a number of recent studies that have either measured one or two maltreatment types in detail or have superficially measured all individual maltreatment types as part of a larger study.

Physical Abuse: Six contemporary Australian studies and one systematic review (encompassing some of the same studies) have measured the prevalence of child physical abuse within relatively large community samples. Prevalence estimates ranged from 5%-18%, with the majority of studies finding rates between 5% and 10%.

Neglect: Three contemporary Australian studies have measured child neglect in community samples. Prevalence estimates of neglect ranged from 1.6% to 4%.

Emotional Maltreatment: Three Australian studies and one Australian systematic review have estimated the prevalence of emotional maltreatment. Although the studies were all conducted with relatively large community samples, their prevalence estimates were quite different, ranging from 6% (Rosenman & Rodgers, 2004) to 17% (Price-Robertson et al., 2010). This large range is likely due to differences in the wording of questions. For example, Rosenman and Rodgers (2004) defined emotional maltreatment using stronger terms (e.g., 'mental cruelty') than Price-Robertson and colleagues (e.g., "humiliated"). The best available evidence suggests that the prevalence rate for emotional maltreatment in Australia is between 9% and 14% (Chu et al., 2013; Moore et al., 2015).

Exposure to family violence: Four community-based studies have estimated the extent to which Australian children are exposed to family violence. Prevalence estimates were from self- reported exposure, and ranged from 4% to 23% of children.

Sexual maltreatment: Studies that comprehensively measured the prevalence of child sexual

maltreatment found that males had prevalence rates of 1.4-7.5% for penetrative abuse and 5.2- 12% for non-penetrative abuse, while females had prevalence rates of 4.0-12.0% for penetrative abuse and 14-26.8% for non-penetrative abuse (Price-Robertson et al., 2010

View

ReMOVED Statistics [41 secs]

Watch this short video to understand some key statistics about children who have been maltreated. Please note that the clip contains themes and images that may be distressing to some. Please feel free to stop watching the video if you are distressed.

A transcript and Closed Captions are also available within the video.

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1.2 WELFARE OF ABORIGINAL AND TORRES STRAIT ISLANDER CHILDREN

Aboriginal and Torres Strait Islander children are over-represented in child protection and out-of-home care services compared to non-Indigenous children (Titterton, 2017). The reasons for this are complex and are connected to past policies and the legacy of colonisation. Poverty, assimilation policies, intergenerational trauma and discrimination and forced child removals have all contributed to the over-representation of Aboriginal and Torres Strait Islander children in care, as have cultural differences in childrearing practices and family structure (Human Rights and Equal Opportunity Commission [HREOC], 1997; SNAICC, 2016; Titterton, 2017).

Child protection authorities are required to intervene if a child has been, is being or is at risk of significant harm. Between 1 July 2015 and 30 June 2016, the rate of substantiations of abuse, neglect or risk of harm was 43.6% – 1,000 Aboriginal and Torres Strait Islander children in Australia. This means that Aboriginal and Torres Strait Islander children were almost seven times more likely than non-Indigenous children to be the subject of substantiated reports of harm or risk of harm (Titterton, 2017).

Child protection data tell us how many Aboriginal and Torres Strait Islander children come into contact with child protection services. These data are not a measure of the actual prevalence of child abuse and neglect experienced by Aboriginal and Torres Strait Islander children, as there are several problems with these data that result in some children who:

- have been abused or neglected not being included in child protection statistics; and
- have not been abused or neglected being included in child protection statistics

In addition to these known problems with child protection data, there are several issues that contribute to the under-reporting of violence, neglect and child abuse in Aboriginal and Torres Strait Islander communities. These include:

- Fear, mistrust and loss of confidence in the police, justice system, government agencies and the media, including a belief that perpetrators of sexual or family violence will not be punished (Aboriginal Child Sexual Assault Taskforce, 2006; Anderson & Wild, 2007; Bailey, Powell, & Brubacher, 2017; Prentice, Blair, & O'Mullan, 2017; Willis, 2011).
- Fear of racism (Closing the Gap Clearinghouse, 2013).
- Fear that the child may be removed from the community (Anderson & Wild, 2007; Taylor & Putt, 2007; Titterton, 2017).
- Community silence and denial (Gordon, Hallahan, & Henry, 2002).
- Social and cultural pressure from other members of the family or community not to report

abuse or violence, the belief that reporting is a betrayal of the culture and community, and the fear of being shunned by the community (Aboriginal Child Sexual Assault Taskforce, 2006; Prentice et al., 2017; Taylor & Putt, 2007).

- A belief in the need to protect the perpetrator because of the high number of Indigenous deaths in custody (Stanley, Tomison, & Pocock, 2003).
- Fear of repercussions or retaliation from the perpetrator or their family (Stanley et al., 2003; Willis, 2011).
- Personal and cultural factors of shame, guilt and fear (Aboriginal Child Sexual Assault Taskforce, 2006; Anderson & Wild, 2007; Prentice et al., 2017; Taylor & Putt, 2007).
- Lack of understanding about what family violence and child abuse and neglect are generally, and lack of understanding about what constitutes family violence and child sexual abuse specifically (Aboriginal Child Sexual Assault Taskforce, 2006; Anderson & Wild, 2007; Prentice et al., 2017).
- High levels of violence and the subsequent normalisation of family violence (Prentice et al., 2017; Willis, 2011).
- Lack of culturally appropriate services (Prentice et al., 2017).
- Language and communication barriers, lack of knowledge about legal rights and the services available, and lack of services for victims of child sexual abuse (Anderson & Wild, 2007).
- Geographical isolation (i.e., nobody to report to, no means of reporting and minimal contact with child welfare professionals) (Gordon et al., 2002; New South Wales Ombudsman, 2012; Stanley et al., 2003).

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1.3 ETIOLOGY OF CHILDHOOD ADVERSITY AND MALTREATMENT

Etiology or aetiology refers to a branch of knowledge concerned with causes – typically of social, psychological and medical phenomenon.

There is not any single fact which causes child abuse. Abuse usually occurs in families where there is a combination of risk factors. Any effort to identify definitive causes of child abuse and neglect is complicated by the interrelatedness of factors. One model that has been used to demonstrate how factors at multiple levels intersect to increase the likelihood of child abuse and neglect is Bronfenbrenner's (1979) 'developmental-ecological' model (Horton, 2003; Irenyi, Bromfield, Beyer, & Higgins, 2006).

The developmental-ecological model has four levels:

- cultural beliefs and values (macrosystem)
- neighbourhood and community settings (exosystem)
- family environment (microsystem)
- the individual's own characteristics and developmental stage

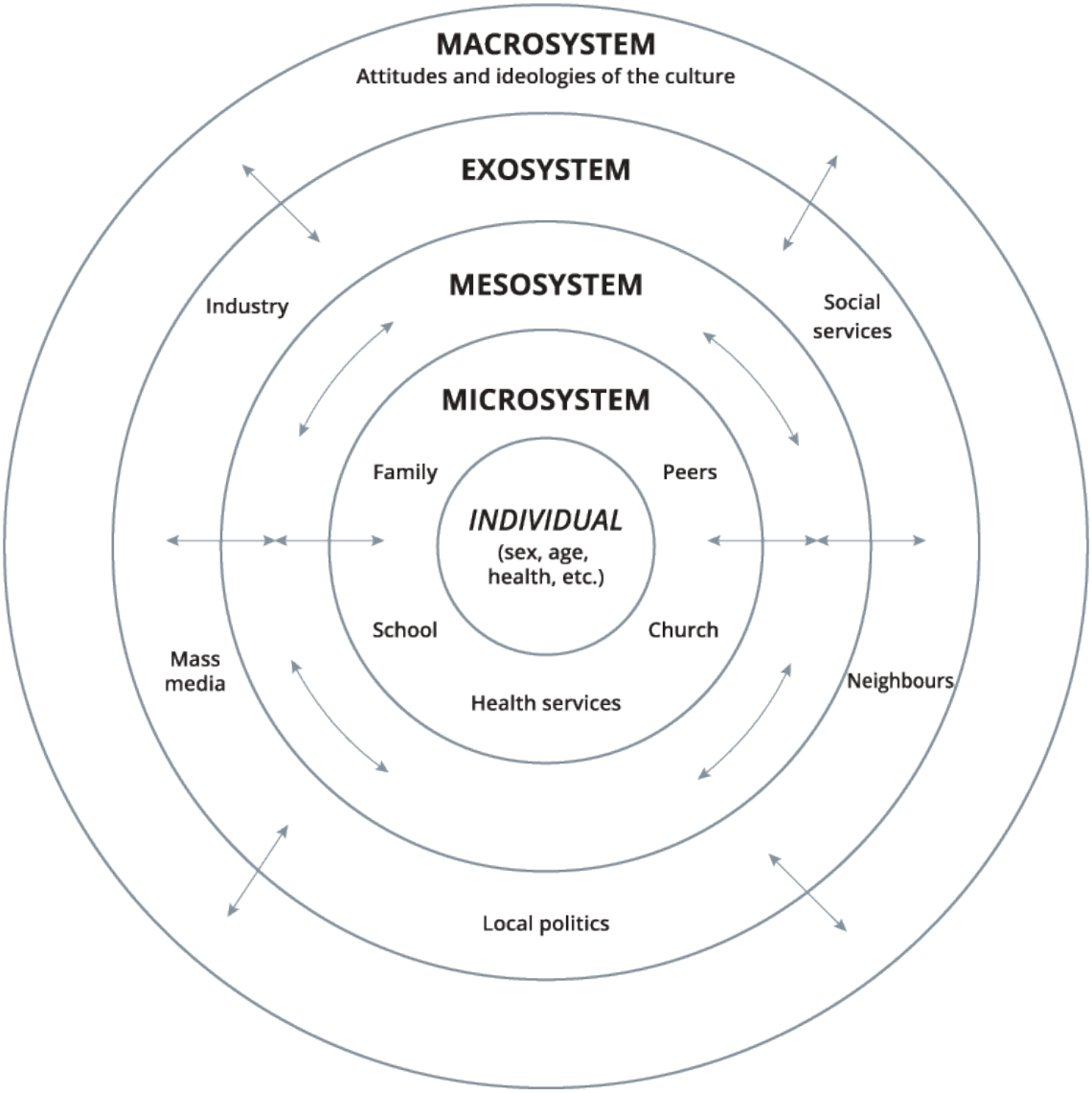

Figure 1.2: Bronfenbrenner's Ecological Theory of Development by Hchokr licensed under CC- BY-SA 3.0

International research has identified many risk factors for child abuse and neglect. It is beyond the scope of this book to provide detailed evidence of all of these risk factors or to discuss the extent to which specific risk factors relate to different forms of maltreatment. However, some of the commonly cited risk factors for child maltreatment, divided according to the ecological levels of the developmental-ecological model described above, especially relating to the macrosystem are not included as they are likely to vary significantly between societies and cultures.

Risk and protective factors can be used to develop both universal and targeted approaches to reducing child maltreatment. Universal approaches seek to reduce risk factors and promote protective factors in all families. This could include ensuring that all parents are provided with accessible information about parenting and child development. Identifying social and environmental risk factors such as low socio-economic status or neighbourhood disadvantage can inform systemic responses that seek to address the causes of disadvantage (Bromfield, Lamont, Parker, & Horsfall, 2010).

Identification of risk and protective factors can also be used to develop targeted approaches to

reducing child abuse and neglect. Families that display multiple risk factors and minimal protective factors can be identified and provided with additional services and support (Putnam-Hornstein & Needell, 2011; Wu et al., 2004). Strengths-based practice, emphasising the assets and strengths within families, is a common strategy used to build and enhance protective factors and promote quality communication and engagement with families (Bromfield et al., 2012). All children and their families exhibit both risk and protective factors to some extent. The interaction of multiple risk factors in combination with limited protective factors may increase the likelihood of child abuse and neglect. Strong protective factors in families such as supportive social networks and a good parent-child attachment, and engagement with education can build resilience in children and parents.

RISK AND PROTECTIVE FACTORS FOR CHILD MALTREATMENT

The presence of one or more risk factors, alongside a cluster of trauma indicators, may greatly increase the risk to the child's wellbeing and should flag the need for further child and family assessment.

The following risk factors can impact on children and families and the care-giving environment:

Child and family risk factors include:

- family violence, current or past
- mental health issue or disorder, current or past (including self-harm and suicide attempts)
- alcohol/substance abuse, current or past, addictive behaviours
- disability or complex medical needs e.g., intellectual or physical disability, acquired brain injury
- newborn, prematurity, low birth weight, chemically dependent, fetal alcohol syndrome, feeding/sleeping/settling difficulties, prolonged and frequent crying
- parent, partner, close relative or sibling with a history of assault, prostitution or sexual offences
- experience of inter-generational abuse and trauma
- poverty, financial hardship, unemployment
- social isolation (family, extended family, community and cultural isolation)
- lack of stimulation and learning opportunities, disengagement from school, truanting
- inattention to developmental health needs and/or poor diet
- recent refugee experience

Parent risk factors include:

- parent/carer under 20 years or under 20 years at birth of first child
- lack of willingness or ability to prioritise child's needs above own
- rejection or scapegoating of child
- harsh, inconsistent discipline, neglect or abuse
- inadequate supervision of child or emotional enmeshment

- single parenting or multiple partners
- inadequate antenatal care or alcohol/substance abuse during pregnancy

Wider factors that influence **positive outcomes** include:

- sense of belonging to home, family, community and a strong cultural identity
- pro-social peer group
- positive parental expectations, home learning environment and opportunities at major life transitions
- access to child and adult focused services e.g., health, mental health, maternal and child health, early intervention, disability, drug and alcohol, family support, family preservation, parenting education, recreational facilities and other child and family support and therapeutic services
- accessible and affordable child care and high-quality preschool programs
- inclusive community neighbourhoods
- service system's understanding of neglect and abuse

PROTECTIVE FACTORS AND RESILIENCE IN THE SCHOOL CONTEXT

So how can we as educators support children with trauma in the school context and build their resilience with our knowledge of protective factors? Taking a strengths-based focus is paramount in helping the traumatised child. This means that we use the strengths and interests of the child to provide opportunities for experiences that promote success and a sense of accomplishment. Trauma informed practice can be viewed from both a deficit perspective and a strengths perspective. If we take a deficit view of the traumatised student our focus is on the difficulties, problems and challenges and the negative impacts on development for that student. If we take a strengths-based perspective we are focussed on the student's abilities and how we can harness the positives to promote and guide the student with trauma towards successful experiences at school (Brunzell, Stokes, & Waters, 2016).

To do this we need to know what the student's strengths, interests and abilities are. What are their interests? What do they like to do? Who are trusted people in the school? What are their academic strengths? How do we find this information out? Many teachers do this through planned instructional activities and also by seizing opportunities through teachable moments. Strategies may include: classroom games, talking to the previous teacher, talking to parents or significant adults in the student's life or completing a short survey etc.

Remember that if the family environment (microsystem) of the child with trauma has been one where trauma has significantly impeded secure parental attachment, the development of the child is severely impacted. As Tobin (2016, p. 8) reminds "positive attachment to caregivers and adults acts as a protective factor to help develop self-regulatory capacities after trauma exposure".

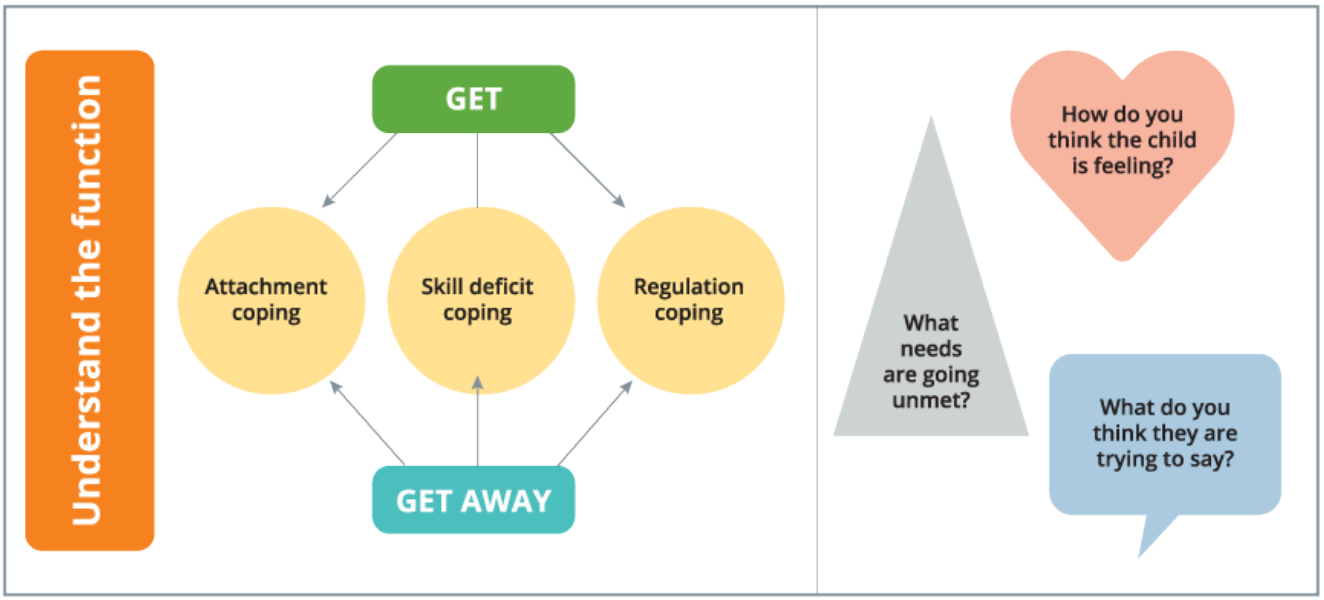

Figure 1.3: Understand the function by Govind Krishnamoorthy and Kay Ayre licensed under CC BY-SA

As teachers we should never underestimate the power of establishing strong connections and relationships. Brunzell et al. (2016, p. 67) suggests demonstrating "unconditional positive regard". Ensuring that the classroom is a place where the student with trauma (and all students) feel a strong sense of belonging, value and safety while they are encouraged to take risks and learn. We have discussed some ideas here about protective factors and how these contribute to building resilience. It is ultimately about us providing an experience of safety and success. This is where the focus needs to be.

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1.4 KEEPING STUDENTS SAFE: REPORTING CHILD PROTECTION CONCERNS

Due to their regular contact with students and families, staff in schools play a vital role in:

- identifying and responding to suspected child abuse and neglect
- helping families to access support services that may build on their strengths and address issues impacting on their parenting

The Child Protection Act 1999 (PDF) requires certain professionals, referred to as 'mandatory reporters', to make a report to Child Safety, if they form a reasonable suspicion that a child has suffered, is suffering or is at an unacceptable risk of suffering significant harm caused by physical or sexual abuse, and may not have a parent able and willing to protect them.

Mandatory reporters should also report to Child Safety a reasonable suspicion that a child is in need of protection caused by any other form of abuse or neglect. Under the *Child Protection Act 1999*, mandatory reporters are:

- teachers
- doctors
- registered nurses
- police officers with child protection responsibilities
- a person performing a child advocate function under the *Public Guardian Act 2014*
- early childhood education and care professionals, from 1 July 2017

Teachers include approved teachers under the *Education (Queensland College of Teachers) Act 2005*, employed at a school. For teachers working in public schools for the Department of Education (DoE), staff actions and decision making in relation to suspected student protection concerns are guided by departmental procedures. For staff working in other schools, departments and agencies, please check the procedures and guidelines for managing student protection concerns.

ADVERSE CHILDHOOD EXPERIENCES (ACES)

Read

Research Byte: The Story of the Adverse Childhood Experiences Study (ACEs)

Read this case study on the Adverse Childhood Experiences Study.

Read

Additional reading

The 'Child Development and Trauma' guides from the Department of Child Protection in Western Australia provide a detailed list of warning signs and risk factors linked to the impact of trauma on developmental norms.

View

The ACEs Study [6 min 37 sec]

Watch this video from the movie 'Resilience' from director James Redford – outlining the findings of the ACEs study.

A transcript and Closed Captions are also available within the video.

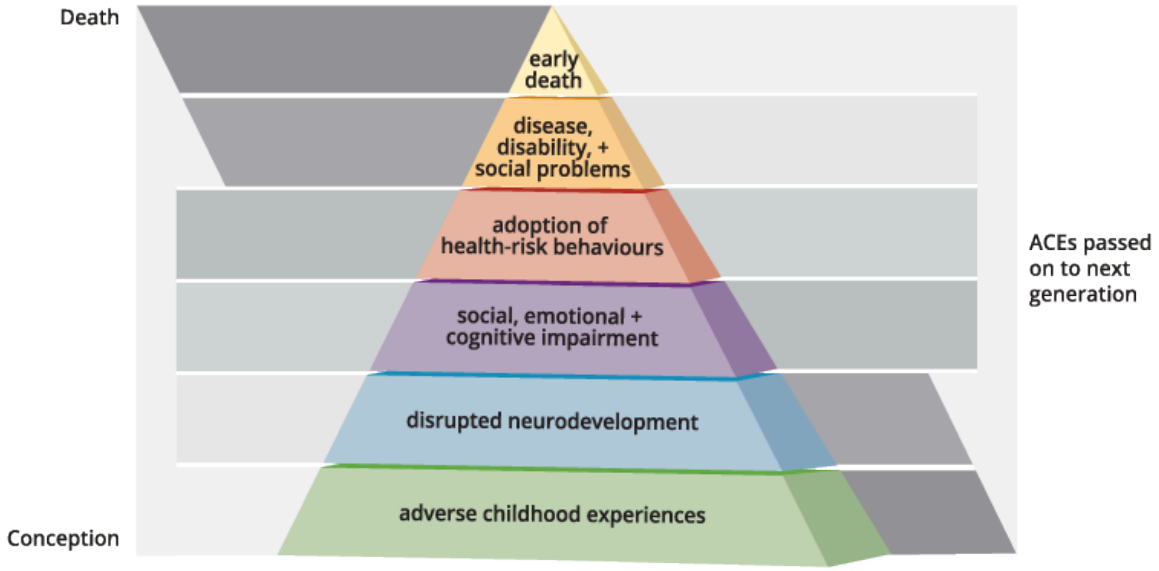

Figure 1.4: ACE Intergenerational Transmission Pyramid from conception to death, adapted from ACE Interface master Trainer Program licensed under CC-BY.

It is important to note that the ACE study participants were average Americans. 75% were white, 11% Latino, 7.5% Asian and Pacific Islander, and 5% were black. They were middle-class, middle-aged,

36% had attended college and 40% had college degrees or higher. Since they were members of Kaiser Permanente, they all had jobs and great health care. Their average age was 57.

In the last 14 years, Anda, Felitti and other researchers have published more than 60 papers in prestigious peer-reviewed journals, including the *Journal of the American Medical Association* and the *American Journal of Preventive Medicine* (Stevens, 2012). Children affected by ACEs appear in all human service systems throughout the lifespan — childhood, adolescence, and adulthood — as clients with behavioural, learning, social, criminal, and chronic health problems. "But our society has tended to treat the abuse, maltreatment, violence and chaotic experiences of our children as an oddity instead of commonplace, as the ACE study revealed," notes Anda (Stevens, 2012). "And our society believes that these experiences are adequately dealt with by emergency response systems such as child protective services, criminal justice, foster care, and alternative schools" (Stevens, 2012).

Trauma informed practices are popping up around the world in schools, prisons, mental clinics and hospitals, a few paediatric practices, crisis nurseries, local public health departments, homeless shelters, at least one hospital emergency room, substance-abuse clinics, child welfare services, youth services, domestic violence shelters, rehab centres for seniors, residential treatment centres for girls and boys, and courtrooms.

Read

Research Byte: The Dunedin Multidisciplinary Health & Development Study

Read this two case cases studies:

- The birth of the Dunedin study
- Childhood disadvantage strongly predicts costly adult life-course outcomes

Read

Additional reading

Moffitt, T. E., & Caspi, A. (1999). Findings about partner violence from the Dunedin multidisciplinary Health and development study. The National Institute of Justice.

View

The Dunedin Study [6 min 37 sec]

Watch this news story on the Dunedin study.

A transcript and Closed Captions are also available within the video.

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1.5 CHILDHOOD TRAUMA

WHAT IS TRAUMA?

Experts explain that trauma is not an event itself, but rather a response to a stressful experience in which a person's ability to cope is dramatically undermined. More than 20 years ago, Lenore Terr (1992) defined childhood trauma as the impact of external forces that "[render] the young person temporarily helpless and [break] past ordinary coping and defensive operation. . . ." Terrasi and de Galarce (2017, p. 36) suggest that complex trauma is "the cumulative effect of traumatic experiences that are repeated or prolonged over time".

Similarly, de Thierry (2017, p. 14) writes, "Trauma is an event or series of events such as abuse, maltreatment, neglect or tragedy that causes a profound experience of helplessness leading to terror". As discussed earlier, the range of potentially traumatic events in childhood is quite broad, including not only physical threat and harm but also emotional maltreatment, neglect, abandonment, and devastating loss.

Every traumatic experience is different, and each child's response depends on their coping skills and resources and on the context and circumstances in which the stressful event occurs. Whether a child develops a trauma reaction that increases in severity, becomes chronic, and is less responsive to intervention or has a reaction that is moderate, manageable, and time limited depends on several factors. These include the nature of the experience, the characteristics of the child, and the way the family, school, and community respond. For example, chronic or repetitive traumatic experiences, especially those perpetrated intentionally by a caregiver, are likely to result in a different set of symptoms than a single shocking traumatic event.

DETERMINANTS OF TRAUMA REACTIONS

Trauma results from an event, series of events, or set circumstances that is experienced by individual as physically emotionally harmful life threatening and has lasting adverse effects on the individual's functioning mental, physical, social, emotional, spiritual wellbeing. The Substance Abuse and Mental Health Services Administration (SAMHSA) provide a useful 'The Three E' framework to understand how traumatic events impact on individuals (SAMHSA, 2013).

Events: The first 'E' of the framework refers to events – this is the circumstances surrounding the actual or extreme threat of physical or psychological harm (i.e., physical violence, natural disasters etc.) or severe, life threatening neglect for a child that imperils healthy development. These events and circumstances may occur as a single occurrence or repeatedly over time.

Experience: The individual's experience of these events or circumstances helps to determine whether it circumstances helps to determine whether it experienced as traumatic for one individual

and not for another (e.g., a child removed from an abusive home experiences this differently than their sibling; one refugee may experience fleeing one's country differently from another refugee). How the individual labels, assigns meaning to, and is disrupted physically and psychologically by an event will contribute to whether or not it is experienced as traumatic. Traumatic events by their very nature set up a power differential where one entity (whether an individual, an event or a force of nature) has power over another. They elicit a profound question of "why me?" The individual's experience of these events or circumstances is shaped in the context of this powerlessness and questioning.

Feelings of humiliation, guilt, shame, betrayal, or silencing often shape the experience of the event. When someone experiences physical or sexual abuse, it is often accompanied by a sense of humiliation, which can lead the person to feel as though they are bad or dirty, leading to a sense of self-blame, shame and guilt. In cases of war or natural disasters, those who survived the traumatic event may blame themselves for surviving when others did not. Abuse by a trusted caregiver frequently gives rise to feelings of betrayal, shattering a person's trust and leaving them feeling alone. Often, abuse of children and domestic violence are accompanied by threats that lead to silencing and fear of reaching out for help. How the event is experienced may be linked to a range of factors, including the individual's cultural beliefs (e.g., the subjugation of women and the experience of domestic violence), availability of social supports (e.g., whether isolated or embedded in a supportive family or community structure) or to the developmental stage of the individual (i.e., an individual may understand and experience events differently at age five, 15 or 50).

Effects: The long-lasting adverse effects of the event are a critical component to trauma. These effects may occur immediately or may have a delayed onset. The duration of the effects can be short to long term. In some situations, the individual may not recognise the connection between the traumatic events and the effects. Examples of adverse effects include an individual's inability to cope with normal stressors, and strains of daily living; to trust and benefit from relationships; to manage cognitive processes – such as memory, attention, thinking, to regulate behaviour; or to control the expression of emotions. In addition to these visible effects, there may be an altering of one's neurobiological make-up and ongoing health and wellbeing. Advances in neuroscience and an increased understanding of the interaction of neurobiological and environmental factors have documented the effects of such threatening events.

Traumatic effects, which may range from hyper-vigilance or a constant state of arousal, to numbing or avoidance, can eventually wear a person down, physically, mentally and emotionally. Survivors of trauma also highlight the impact of these events on spiritual beliefs and the capacity to make meaning of these experiences.

Please note that the above information on the Three E's is reproduced with permission from SAMHSA Trauma and Justice Strategic Initiative (2013). SAMHSA's concept of trauma and guidance for a trauma-informed approach. https://store.samhsa.gov/system/files/sma14-4884.pdf. Additional reproduction of this information is not permitted without prior permission from SAMHSA.

CHILD DEVELOPMENT AND TRAUMA

REACTIONS

The following points give an essential perspective for using the information about childhood trauma and its impact on development across specific age groups:

- Children, even at birth, are not 'blank slates' – they are born with a certain neurological make-up and temperament. As children get older, these individual differences become greater as they are affected by their experiences and environment. This is particularly the case where the child is born either drug dependent or with fetal alcohol syndrome.
- Even young babies differ in temperament e.g., activity level, amount and intensity of crying, ability to adapt to changes, general mood, etc.
- From birth on, children play an active role in their own development and impact on others around them.
- Culture, family, home and community play an important role in children's development, as they impact on a child's experiences and opportunities. Cultural groups are likely to have particular values, priorities and practices in child rearing that will influence children's development and learning of particular skills and behaviours. The development of children from some cultural backgrounds will vary from traditional developmental norms, which usually reflect an Anglo-Western perspective.
- As children get older, it becomes increasingly difficult to list specific developmental milestones, as the achievement of many of these depends very much on the opportunities that the child has to practice them, and also, on the experiences available to the child. A child will not be able to ride a bicycle unless they have access to a bicycle.
- Development does not occur in a straight line or evenly. Development progresses in a sequential manner, although it is essential to note that while the path of development is somewhat predictable, there is variation in what is considered normal development. That is to say no two children develop in exactly the same way.
- The pace of development is more rapid in the early years than at any other time in life.
- Every area of development impacts on other areas. Developmental delays in one area will impact on the child's ability to consolidate skills and progress through to the next developmental stage.

Most experts now agree that both nature and nurture interact to influence almost every significant aspect of a child's development.

- General health affects development and behaviour. Minor illnesses will have short to medium term effects, while chronic health conditions can have long-term effects. Nutritional deficiencies will also have negative impacts on developmental progression. Specific characteristics and behaviours are indicative only. Many specific developmental characteristics should be seen as 'flags' of a child's behaviour, which may need to be looked at more closely, if a child is not meeting them. Teachers and education staff should refer to

relevant specialist assessment guides in undertaking further assessments of child and family.

The indicators of trauma listed in this guide should not become judgements about the particular child or family made in isolation from others who know the child and family well, or from other sources of information. However, they are a useful alert that a more thorough contextual assessment may be required.

There has been an explosion of knowledge in regard to the detrimental impact of neglect and child abuse trauma on the developing child, and particularly on the neurological development of infants. It is critical to have a good working knowledge of this growing evidence base so that we can be more helpful to families and child focused.

The following basic points are useful to keep in mind and to discuss with parents and young people:

- Children need stable, sensitive, loving, stimulating relationships and environments in order to reach their potential. They are particularly vulnerable to witnessing and experiencing violence, abuse and neglectful circumstances. Abuse and neglect at the hands of those who are meant to care is particularly distressing and harmful for infants, children and adolescents.
- Given that the infant's primary drive is towards attachment to a parent or caregiver, not safety, they will accommodate to the parenting style they experience. They have no choice given their age and vulnerability, and in more chronic and extreme circumstances, they will show a complex trauma response. They can eventually make meaning of their circumstances by believing that the abuse is their fault and that they are inherently bad.
- Infants, children and adults will adapt to frightening and overwhelming circumstances by the body's survival response, where the autonomic nervous system will become activated and switch on to the freeze/fight/flight response. Immediately the body is flooded with a biochemical response which includes adrenalin and cortisol, and the child feels agitated and hypervigilant. Infants may show a 'frozen watchfulness' and children and young people can dissociate and appear to be 'zoned out'.
- Prolonged exposure to these circumstances can lead to 'toxic stress' for a child which changes the child's brain development, sensitises the child to further stress, leads to heightened activity levels and affects future learning and concentration. Most importantly, it impairs the child's ability to trust and relate to others. When children are traumatised, they find it very hard to regulate behaviour and soothe or calm themselves. They often attract the description of being 'hyperactive'.

Babies are particularly attuned to their primary carer and will sense their fear and traumatic stress. This is particularly the case where family violence is present. They will become unsettled and therefore more demanding of an already overwhelmed parent. The first task of any service is to support the non-offending parent and to engage the family in safety.

- Traumatic memories are stored differently in the brain compared to everyday memories. They are encoded in vivid images and sensations and lack a verbal narrative and context. As they are unprocessed and more primitive, they are likely to flood the child or adult when triggers like smells, sights, sounds or internal or external reminders present at a later stage.
- These flashbacks can be affective, i.e., intense feelings, that are often unspeakable; or

cognitive, vivid memories or parts of memories, which seem to be actually occurring. Alcohol and drug abuse are the classic and usually most destructive attempts to numb out the pain and avoid these distressing and intrusive experiences.

- Children are particularly vulnerable to flashbacks at quiet times or at bedtimes and will often avoid both, by acting out at school and bedtimes. They can experience severe sleep disruption and intrusive nightmares which add to their 'dysregulated' behaviour, and limits their capacity at school the next day. Adolescents will often stay up all night to avoid the nightmares and sleep in the safety of the daylight.

Now that we know about the impact of the risk factors and of childhood trauma we can begin thinking functionally about the needs of these students and begin by considering the factors depicted in the triangle, heart and speech bubble shapes in the figure below.

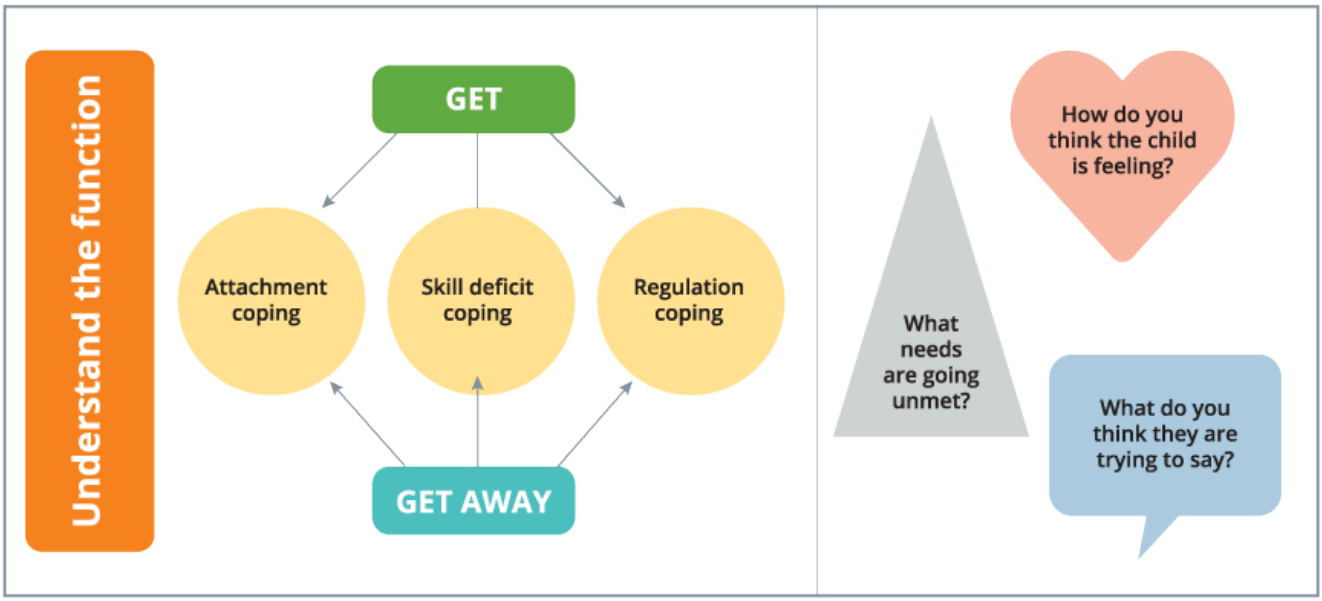

Figure 1.5 Understand the function by Govind Krishnamoorthy and Kay Ayre licensed under CC BY-SA.

The triangle represents the pyramid of needs (see Snowman et al., 2009 for Maslow's hierarchy of needs) starting with physiological needs, such as adequate food, hydration, clothing and physical health care. Examples of how this can be supported in the school environment include rest times, snack times built into learning time, water bottles on desks and available at all times throughout the day, and breakfast clubs.

The heart represents the feelings of grief linked to the losses in the child's life that may impact their academic and social functioning at school. These losses may include the death of loved ones, separation from family and friends, and traumatic grief linked to experiences of abuse. Understanding these losses and their impact on the student can inform our expectations of the student's functioning, the management of the classroom and school environment to minimise triggers and the support for the student to build trusting relationships that can help them with these complex and painful feelings.

The speech bubble shape represents the student's behaviour as communicating unmet needs and unprocessed feelings. The deprivation and abuse experienced by these children often leaves them with deficits in their skills to seek out appropriate support. Due to this, the child's misbehaviour may come

across as deliberately defiant and oppositional, when in fact, it may the result of their inability to appropriately communicate the challenges that they are facing. It is then, the job of the educators to understand the context of the child – both in and out of the school environment – to interpret the function and meaning of the misbehaviours and disengagement.

The next section will look in depth at how we can use our knowledge of childhood trauma in adapting our pedagogical practices.

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1.6 TRAUMA INFORMED PRACTICE

In the previous sections, we learned that a traumatic experience involves a threat to one's physical or emotional wellbeing, and elicits intense feelings of helplessness, terror, and lack of control (American Psychiatric Association, 2000). Traumatic experiences can significantly alter a person's perception of themselves, their environment, and the people around them. As traumatic experiences accumulate, responses become more intense and have a greater impact on functioning. Ongoing exposure to traumatic stress can impact all areas of people's lives, including biological, cognitive, and emotional functioning; social interactions, relationships and identity formation. Because people who have experienced multiple traumas do not relate to the world in the same way as those who have not had these experiences, they require services and responses that are sensitive to their experiences and needs.

Meeting the needs of trauma survivors requires that programs become 'trauma informed' (Harris & Fallot, 2001). Harris and Fallot (2001) describe a trauma informed service system as a one who's mission is altered by knowledge of trauma and the impact it has on the lives of the consumers. This means looking at all aspects of programming through a trauma lens, constantly keeping in mind how traumatic experiences impact consumers. Programs that are informed by an understanding of trauma respond best to consumer needs and avoid engaging in re-traumatising practices.

PRINCIPLES OF TRAUMA INFORMED PRACTICE

The principles of trauma informed care were identified on the basis of knowledge about trauma and its impact, findings of the Co-Occurring Disorders and Violence Project (Moses, Reed, Mazelis, & D'Ambrosio, 2003), literature on therapeutic communities (Campling, 2001), and the work of Maxine Harris and Roger Fallot (Fallot & Harris, 2002; Harris & Fallot, 2001;) and Sandra Bloom (Bloom, 2004). Principles of trauma informed practice include:

- **Understanding trauma and its impact:** understanding traumatic stress and how it impacts people and recognising that many behaviours and responses that may be seem ineffective and unhealthy in the present, represent adaptive responses to past traumatic experiences.
- **Promoting safety**: establishing a safe physical and emotional environment where basic needs are met, safety measures are in place, and provider responses are consistent, predictable, and respectful.
- **Ensuring cultural competence**: understanding how cultural context influences one's perception of and response to traumatic events and the recovery process; respecting diversity within the program, providing opportunities for students to engage in cultural rituals, and using interventions respectful of and specific to cultural backgrounds.

- **Supporting student control, choice and autonomy**: helping students regain a sense of control over their daily lives and build competencies that will strengthen their sense of autonomy; keeping consumers well-informed about all aspects of the system, outlining clear expectations, providing opportunities for students to make daily decisions and participate in the creation of personal goals, and maintaining awareness and respect for basic human rights and freedoms.
- **Sharing power and responsibility**: promoting democracy and equalisation of the power differentials across the program; sharing power and decision-making across all levels of an organisation, whether related to daily decisions or in the review and creation of policies and procedures.
- **Integrating care**: maintaining a holistic view of consumers and their process of healing and facilitating communication within and among service providers and systems.

Children listening to teacher by Emmaws4s licensed under CC0

- **Healing happens in relationships**: believing that establishing safe, authentic and positive relationships can be corrective and restorative to survivors of trauma.
- **Recovery is possible**: understanding that recovery is possible for everyone regardless of how vulnerable they may appear. Instilling hope by providing opportunities for consumer and former consumer involvement at all levels of the system, facilitating peer support, focusing on strength and resiliency, and establishing future-oriented goals.

TRAUMA INFORMED PRACTICE IN SCHOOLS

In summary, the connection between student disengagement and underachievement and trauma underscores the need for specific programming for these students. The following realities highlight the need for trauma informed practice in schools.

Trauma can impact school performance, as evidenced by:

- Lower academic achievement and grades
- Higher rate of school absences
- Increased drop-out
- More suspensions and expulsions
- Decreased reading ability
- Trauma can impair learning
- Single exposure to traumatic events may cause jumpiness, intrusive thoughts, interrupted sleep and nightmares, anger and moodiness, and/or social withdrawal—any of which can interfere with concentration and memory.

- Chronic exposure to traumatic events, especially during a child's early years, can adversely affect attention, memory, and cognition, reduce a child's ability to focus, organise, and process information, interfere with effective problem solving and/or planning. This may result in overwhelming feelings of frustration and anxiety.

Traumatised children may experience physical and emotional distress.

- Physical symptoms like headaches and stomach aches
- Poor control of emotions
- Inconsistent academic performance
- Unpredictable and/or impulsive behaviour
- Over or under-reacting to bells, physical contact, doors slamming, sirens, lighting, sudden movements
- Intense reactions to reminders of their traumatic event
- Thinking others are violating their personal space, i.e., "What are you looking at?"
- Blowing up when being corrected or told what to do by an authority figure
- Fighting when criticised or teased by others
- Resisting transition and/or change

Once schools understand the educational impacts of trauma, they can become safe, supportive environments where students make the positive connections with adults and peers they might otherwise push away, calm their emotions so they can focus and behave appropriately, and feel confident enough to advance their learning. In other words, schools can make trauma sensitivity a regular part of how the school is run. Trauma sensitivity will look different at each school. However, a shared definition of what it means to be a trauma-sensitive school can bring educators, parents, and policymakers together around a common vision. We define the core attributes of a trauma informed school to include the following:

- A shared understanding among all staff—educators, administrators, counsellors, school nurses, cafeteria workers, custodians, bus drivers, athletic coaches, advisors to extracurricular activities, and paraprofessionals—that adverse experiences in the lives of children are more common than many of us ever imagined, that trauma can impact learning, behaviour, and relationships at school, and that a 'whole school' approach to trauma sensitivity is needed.
- The school supports all children to feel safe physically, socially, emotionally, and academically. Children's traumatic responses, and the associated difficulties they can face at school, are often rooted in real or perceived threats to their safety that undermine a sense of wellbeing in fundamental ways. Therefore, the first step in helping students succeed in school, despite their traumatic experiences, is to help them feel safe—in the classroom, on the playground, in the hallway, in the cafeteria, on the bus, in the gym, on the walk to and from school. This includes not only physical safety but also social and emotional safety, as well as the sense of academic safety needed in order to take risks to advance one's learning in the classroom.

- The school addresses students' need in holistic ways, taking into account their relationships, self-regulation, academic competence, and physical and emotional wellbeing. The impacts of trauma can be pervasive and take many forms, and the way in which a child who has experienced traumatic events presents themselves may mask—rather than reveal—their difficulties. A broader more holistic lens is needed to understand the needs that underlie a child's presentation. Researchers tell us that if we bolster children in four key domains—relationships with teachers and peers; the ability to self-regulate behaviours, emotions, and attention; success in academic and non-academic areas; and physical and emotional health and well-being—we maximise their opportunities to overcome all kinds of adversity in order to succeed at school. A trauma informed school recognises the inextricable link that exists among these domains and has a structure in place that supports staff to address students' needs holistically in all four areas.

Teacher learning school by Emmaws4s is licensed under CC0.

- The school explicitly connects students to the school community and provides multiple opportunities to practice newly developing skills. The loss of a sense of safety resulting from traumatic events can cause a child to disconnect from those around him or her. Typically, children who have experienced traumatic events are looking to those at school to restore their feeling of security and to help reconnect them with the school community. Schools can meet this need if they foster a culture of acceptance and tolerance where all students are welcomed and taught to respect the needs of others. Individual support services and policies that do not pull children away from their peers and trusted adults, but rather assist children to be full members of the classroom and school community, are also essential.
- The school embraces teamwork and staff share responsibility for all students. Expecting individual educators to address trauma's challenges alone on a case-by-case basis, or to reinvent the wheel every time a new adversity presents itself, is not only inefficient, but it can cause educators to feel overwhelmed. A trauma informed school moves away from the typical paradigm in which classroom teachers have primary responsibility for their respective students to one based on shared responsibility requiring teamwork and ongoing, effective communication throughout the school. In a trauma-sensitive school, educators make the switch from asking "what can I do to fix this child?" to "what can we do as a community to support all children to help them feel safe and participate fully in our school community?" Trauma informed schools help staff—as well as those outside the school who work with staff—feel part of a strong and supportive professional community.
- Leadership and staff anticipate and adapt to the ever-changing needs of students. In a trauma informed school, educators and administrators take the time to learn about changes in the local community so that they can anticipate new challenges before they arise. They do their best to plan ahead for changes in staffing and policies that are all too common in schools.

Trauma informed schools also try to adapt to all of these challenges flexibly and proactively so that the equilibrium of the school is not disrupted by inevitable shifts and changes.

Listen

Interview with Erik Gordon on being a trauma-informed teacher [51 min 46 sec]

Listen to this interview with Erik Gordon – a science teacher from Washington, US who works at Lincoln High School.

View

How childhood trauma affects health across the lifespan [6 min 37 sec]

Watch this TED Talk by Nadine Burke Harris. A transcript and Closed Captions are also available within the video.

Reflection Questions

1. Name the five common types of child maltreatment.
2. How does child trauma impact development and learning?
3. Explain three principles of trauma informed practice.

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PART II.

OBSERVE AND REFLECT

Red haired girl standing alone by Matheus Bertelli licensed under CC0.

Overview and learning objectives

Chapter two focuses on supporting positive behaviour from a behavioural perspective. This chapter is organised into:

- Behaviourism, behaviour theory and applied behaviour analysis
- Positive behaviour support
- Thinking functionally about disruptive student behaviour
- The ABCs of behaviour – planning to intervene

- A dual perspective

On successful completion of this chapter, you should be able to:

- Understand key elements of behaviourism, behaviour theory and applied behaviour analysis
- Describe core features and principles of positive behaviour support
- Think functionally about disruptive student behaviour
- Explain the ABCs and their relationship to planning interventions
- View disruptive behaviour through a trauma lens

INTRODUCTION

Positive behaviour support is a proactive and preventative approach to reducing disruptive student behaviour. Applied to the school context it is a continuum of support and intervention that flows from least intensive strategies to most intensive strategies. The strategies employed are founded in and reflect the principles of applied behaviour analysis or a behaviourist perspective but is this alone enough for the child who has experienced trauma and is having difficulty with self-regulation? The current research says "No," (Chafouleas, Johnson, Overstreet & Santos, 2016; Dorado, Martinez, McArthur & Leibovitz, 2016; Nash, Schlosser & Scarr, 2016; Phifer & Hull, 2016). In this book, we agree, and this is demonstrated in our interdisciplinary approach of providing a blended perspective drawing from psychology and education. Behaviourist strategies are highly effective, evidenced-based strategies that achieve excellent results, for most children. Children with trauma are not most children, they are our most troubled children many of whom will need a more comprehensive approach to support their success at school that combines the best of both worlds of psychology and education.

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2.1 DISRUPTIVE STUDENT BEHAVIOUR

Read

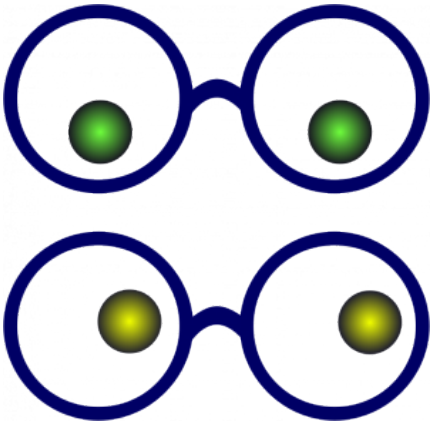
True story

The frantic phone call to the office came requesting immediate assistance in the Year one classroom. Molly was holding the class to ransom (yet again) and the teacher was in the process of evacuation. Molly had taken the box of chalk from the shelf beneath the blackboard, had turned the ceiling fans up to the highest speed, climbed onto the desk and had begun to systematically throw handfuls of chalk into the spinning blades. Chalk ricocheted around the classroom like bullets from a machine gun and chaos reigned supreme.

This year, Molly's disruptive behaviour had escalated to being serious and unsafe. I (Kay) was Deputy Principal of the junior school (Prep to Year three) at the time of this incident and it was to be one of many, many incidents involving myself and Molly that would span years, schools and behaviour centre contexts. I could never have imagined the profound impact that our long-term relationship was to have, on both of us.

Armstrong (2016) points out that the distinction often made between 'disruptive' and 'challenging behaviour' is in reference to the severity. Disruptive behaviour can be characterised by minor behaviours such as talking out of turn, calling out, and ignoring adult instruction while challenging behaviour reflects more major types of behaviours that include physical and verbal aggression, unsafe and dangerous behaviours. In this book, we use the term 'serious, disruptive behaviour' interchangeably with challenging behaviour to suggest behaviour that goes beyond what is considered ongoing, low-level disruptive behaviours.

HOW DO YOU VIEW DISRUPTIVE BEHAVIOUR?



Eyes with glasses by Sanja licensed under CC0.

Where do you lay the blame for a student's disruptive behaviour? Do you see the cause as being attributed to factors that are internal, external, both or neither? Do you attribute disruptive behaviour to the individual student and their lack of self-control and inability to make the "right choice?" (internal causes) or do you think it is because of poor parenting and other factors outside of the school space? (external causes).What part do you, the teacher, play in sustaining the disruptive behaviour? Stop and think about what it is you believe because what you believe about why disruptive behaviour occurs, determines how you manage it. Do you react in a proactive, supportive manner or in a punitive fashion? If you believe the causes of the misbehaviour are attributed to factors beyond your control (outside of school) for example, you will probably react in a more punitive manner because you believe that there is nothing you can do to change the situation so why bother?

Johansen, Little and Akin-Little (2011) studied New Zealand teachers' perceptions of the cause of disruptive behaviour at school and concluded that teachers believed the cause was attributed to external impacts such as parenting and home life. In addition, teachers believed that the disruptive student was in control of their behaviour and was making a conscious 'choice' to behave badly. Worryingly, many teachers did not believe that they had a significant role to play in influencing student behaviour and most seemed to be unaware that they were highly likely to be a contributing factor to the disruptive behaviour. In contrast, when Tillery, Varjas, Meyers and Collins (2010) conducted a small-scale study of a group of kindergarten and first grade teachers in a US mainstream school to understand their perspectives and approaches to behaviour management they found that "the teachers perceived themselves as strong influences on student behavior development and described the use of positive strategies" (Tillery et al., 2010, p. 86). These strategies included having high expectations, rewarding desirable behaviour and modelling. Keep this and your own beliefs in mind as you read on as we now explore various commonly held beliefs with regards to why some students are disruptive.

WHY ARE SOME STUDENTS DISRUPTIVE?

Westling (2010) studied both mainstream and special education teachers' views about challenging student behaviour and included the examination of beliefs about the causes of challenging behaviour. Seventy teachers participated in the study. Thirty-eight were from special education and 32 were mainstream classroom teachers working in public schools in the United States. In response to the impact of challenging student behaviour on teaching and learning, the special education teachers and the mainstream teachers listed time taken, teacher stress, reduced learning time for other students and the students demonstrating the challenging behaviour. Sadly, nearly half of the mainstream teachers also expressed that having to cope with student challenging behaviour had caused them to consider leaving the teaching profession. When responding to causes of challenging behaviour, in general the teachers believed that the challenging behaviour was due to both internal factors

(personality, the disability) and to external factors (the home). All teachers felt that student behaviour could be improved. Do you agree that behaviour is learned and can be improved?

What we believe about why challenging student behaviour occurs governs the nature of the interventions we apply. From a functional perspective, Chandler and Dahlquist (2015, p. 12) refer to commonly held beliefs about why challenging behaviour occurs such as the bad child, the disability, the bad parent, bad home situation and previous trauma or bad experiences, as 'faulty explanations'. Chandler and Dahlquist (2015) note that they are not insinuating that knowledge of original causes such as trauma are not important, but it is the current behaviour that is happening in the current situation that needs to be addressed. While the authors rightly suggest that harbouring these 'faulty explanations' does little to help resolve the situation happening in the classroom where disruptive behaviour is hindering the learning and teaching, it is important that we think functionally about difficult behaviour using a trauma lens. Acknowledging that factors such as home life or disability are those that the teacher has little if any capacity to change, they do influence the child's behaviour in the learning environment. Furthermore, the response of the teacher and the culture of the learning environment, significantly influence student expression of difficult behaviours when "trauma comes to school" (Jennings, 2019, p. 29).

From a behaviourist point of view, it is the environmental conditions (at the time the behaviour is occurring) that are maintaining the behaviour and therefore determining the relationship between the behaviour and what is happening in the environment in which the behaviour is occurring, is the focus. The primary goal is to change the behaviour. While the behaviourist is first and foremost trying to ascertain the functional relationship between behaviour and environment, they also acknowledge the role that physiological difficulties, heredity and development may play in impacting behaviour. Chandler and Dahlquist (2015) argue that the following types of explanations are unhelpful in assisting teachers to identify strategies to help manage and change the behaviour. The authors refer to these explanations as 'faulty beliefs'.

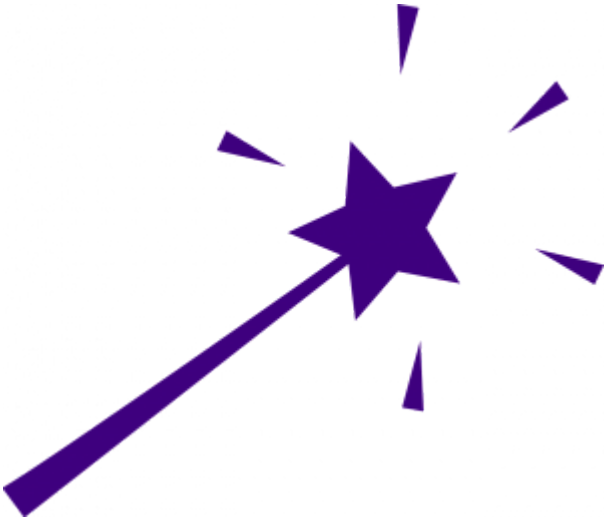
It's the child: Holding the belief that the child is innately bad and that the behaviour they demonstrate is a personal vendetta to make the teacher's life miserable is of no benefit to anyone. It probably perpetuates teacher anger and increases the likelihood of punishment being used (Chandler & Dahlquist, 2015). What strategy will be implemented to change the behaviour? Remove the student from the classroom? This strategy will always eliminate the behaviour from the classroom, if only for a short time (or maybe altogether if the student moves to another school). Is it helpful to the child? Has the child been taught an alternative way to behave?

It's the disability: From the outset, it needs to be clear that it is extremely important for a teacher to know if a child has a disability and for the teacher to learn as much as they can about the disability so that the student can be supported in the best way possible. Knowing about the disability will help us to understand the characteristics of that disability and in some cases the possible triggers for the behaviour but knowing does not tell us how to deal with the actual disruptive behaviour unfolding in front of us in the classroom. Furthermore, all children with a disability are individuals and it is dangerous to assume that all children with the same disability will behave in the same way. Disabilities do not change or go away. The disability cannot be changed so therefore if the belief is that it is the disability that is causing the disruptive behaviour then it follows that nothing can be done because the disability is what it is (Tillery et al., 2010). The behaviour is the problem! Knowing that a child has a diagnosis of Autism Spectrum Disorder (ASD) or Attention Deficit Hyperactivity Disorder (ADHD) does little to help the teacher resolve the problem. Casey and Carter (2016) suggest

that this type of thinking is similar to what came first the chicken or the egg? They give the example of the child with ADHD noting "a diagnosis such as ADHD does not cause a child to behave in any manner; rather, when a child behaves in a certain manner someone may categorise the behavior by placing a diagnosis on the child" (Casey & Carter, 2016, p. 14).

It's the parenting: Passing judgement is easy to do. Be careful here! The vast majority of parents do the best they can with the knowledge and resources they have. Teachers will often say that having met the child's parents explains all and sheds light on why the child is the way they are. And yes, it is possible there is a hint of truth in this. As Alberto and Troutman (2013, p. 3) note "it is possible that certain genetic characteristics may increase the probability of certain behavioral characteristics". Disrupted parenting in terms of the parent's ability to respond with caring, nurturing behaviour that supports their child, making them feel safe and secure, negatively impacts on the child's behaviour. For example, lack of acceptance of the child demonstrated through ongoing conflicts, drug use and criminal behaviour. That said and as critical as it is for teachers to understanding this, can a teacher influence change to this situation? The disruptive behaviour is happening at school, in the classroom or playground (or both) and needs to be dealt with in the context in which it is happening. If the same behaviour is occurring at home, then teachers need to work collaboratively with (willing) family members to help them as best they can.

It's the home life: Can a teacher change the home situation of a student? Is it helpful to blame the student's home life as awful as the living situation may be or seem to us? Living in a chaotic home with dysfunctional adults does affect behaviour (Chandler & Dahlquist, 2015). A student's behaviour is impacted by happenings that occur within the spaces and the relationships in those spaces. If a student's family life is characterised by chaos and dysfunction, then the student will most likely respond with higher levels of anxiety and negative behaviours demonstrated within the school context. While we cannot change this home situation, we can use the knowledge of it, to inform our support of the student at school. Positive interactions are the key to a student's ability to adjust their behaviour.



Magic Wand by Clker Free Vector Images used under CC0.

Teachers cannot change or erase the child's trauma history and we need to remember that not all children with trauma demonstrate 'acting out' externalised disruptive behaviours, but some do, and teachers need to know how to cope with disruptive behaviour that is occurring in the here and now of the classroom. Finding out why the child is behaving the way they are within the environment, needs to be the firm focus of observation and intervention if the disruptive behaviour is to be reduced. Teachers have little, if any control over the context beyond the classroom and school grounds, so the energy needs to be directed to factors that are within the teacher's control – the classroom and school environment and what can be changed there that will decrease the disruptive behaviour. Knowing about possible impacting factors beyond the school and classroom environment is vital and helps teachers to build a deeper understanding of the student demonstrating the disruptive behaviour. Do you need to rethink your view of causes of disruptive behaviour?

It is important to state that there is no magic wand for disruptive student behaviour. No intervention, strategy or program will work for every disruptive student, every time and indeed none are guaranteed to do so. Using quality research to build understanding and knowledge to inform careful planning and skills to implement evidenced-based strategies, is the best place to start.

Listen

Chat with Esther, Behaviour Team Leader [52 min]

Listen to this podcast and learn about multi-tiered trauma support as applied in one context in the United States. This is a long coaching session, so just listen for the first 30 minutes.

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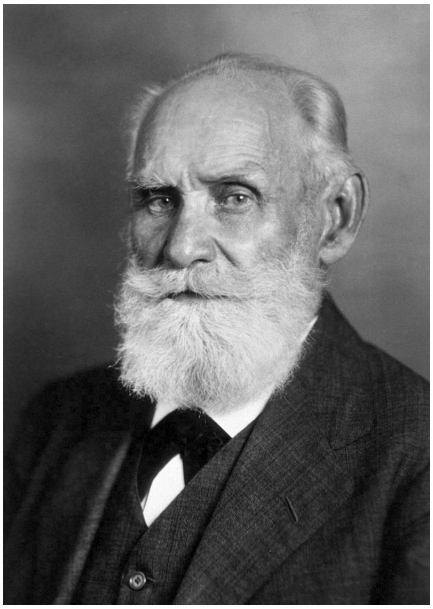
2.2 BEHAVIOURISM AND APPLIED BEHAVIOUR ANALYSIS

The use of behaviourist strategies that tend to be 'hierarchical' in nature are successful for most of the students most of the time (Nash, Schlosser, & Scarr, 2016, p. 168). Students whose behaviour is serious, disruptive and ongoing require individualised more intensive strategies of intervention. However, there is an additional layer that needs to be considered and that is the child with trauma. For the child with trauma who demonstrates difficult and challenging behaviour (and not all do), a combination of strategies from a behavioural and psychological perspective will help us to better understand them and provide the support they need, the best we can.

From a behavioural perspective, we start with the theoretical foundation of behaviour theory. From behaviour theory arose applied behaviour analysis (ABA) which is behaviour theory applied to the 'real world' context. ABA manifested in schools looks like the processes and procedures of Positive Behaviour Support (PBS) which when then implemented at a whole school level is called School-wide Positive Behaviour Support (SWPBS) or as is the case in many Australian schools, Positive Behaviour for Learning (PBL). Our focus is on behaviour theory and the behaviourist strategies associated with managing individuals challenging behaviour at the most intense end of the continuum when we think about challenging behaviour from least disruptive (for example constant pencil tapping) to most disruptive (for example aggressive and unsafe). Used together with the knowledge from the psychological perspective (for example attachment and trauma theory), we will have a deeper, more comprehensive approach to understanding and supporting children with trauma. We will now turn our attention to a detailed exploration of positive behaviour support and its theoretical foundation of behaviourism and applied behaviour analysis.

BEHAVIOURISM: A SNAPSHOT OF HISTORY

Pavlov (Ivan Petrovich Pavlov, born in Russia in 1849)



Ivan Pavlov by unknown author, used within Public Domain

Most people have heard of Pavlov and his dogs. Pavlov observed that when a bell was rung at the same time that the dogs were being fed even if there was no food present, the dogs would salivate. As a result of his experimentation, classical conditioning (sometimes called respondent conditioning) was born. Classical conditioning is when an unconditioned stimulus gets a response. Food is the unconditioned stimulus; the bell is the conditioned stimulus.

While this type of conditioning is not as common as operant conditioning (see Skinner), it is most likely demonstrated by children who have experienced trauma. They react with reflexive behaviour. For example, an unconditioned stimulus (threat of harm) and an unconditioned response (fight, flight or freeze) with a neutral stimulus (such as a person, activity or smell). A child may behave disruptively upon smelling perfume because that perfume was worn by the person who physically harmed the child. It appears to be an extreme reaction to a 'normal' situation. This concept (flight, fight or freeze response) will be fully explored throughout the book.

Thorndike (Edward Lee Thorndike born in America 1874)

Thorndike studied cats not dogs as Pavlov did. He is famous for crafting two laws. The first being the Law of Effect (Thorndike, 1905 as cited in Alberto & Troutman, 2013, p. 18) which describes positive reinforcement. That is, when behaviour produces a positive outcome and as a result this behaviour is strengthened and more likely to occur again. The second law was called the Law of Exercise. This was similar to the stimulus/response of Pavlov where a behaviour and the situation are linked.

Edward Lee Thorndike by unknown author, used within Public Domain

Watson (John Broadus Watson, born America 1878)

John Broadus Watson at Johns Hopkins c. 1908-1921 by unknown author, used within Public Domain

The term behaviourism is attributed to Watson. Watson advocated that the only real data (in psychology because he was a psychologist) was that acquired through direct observation. Watson and his colleague Raynor are well-known for their 'Little Albert' experiment where they conditioned baby Albert (11 months old and raised in a hospital) to be fearful of a white rat. It seems that unlike other experiments that baby Albert was never 'desensitised' of his fear and it was never known if his fear persisted. He died at age six from hydrocephalus.

Skinner (Burrhus Frederic Skinner, born in America in 1904)

B.F. Skinner at Harvard circa 1950 by Silly Rabbitt licensed used under CC-BY.

BF Skinner is known for operant conditioning a key concept in applied behaviour analysis and our ability to think about the function or the purpose of behaviour. For students demonstrating challenging behaviour, this means working out "What's in it for the kid?" Skinner worked with rats and pigeons and he discovered that there was a difference between classical conditioning (Pavlov's idea that behaviours are a reflex) and operant conditioning (that behaviours are voluntary and concerned with consequences). The notion of the relationship between the behaviour and the consequence of that behaviour and how the consequence affects the likelihood that a behaviour will occur again, Skinner called a contingency. Behaviour can be reinforced was another key concept of Skinner's. Reinforced means strengthened or increased. Skinner maintained that it was irresponsible not to use scientific control to shape humanbehaviour. He was a major influence behind the adaptation of experimental and clinical behaviour modification techniques to classroom settings. Behaviour modification applied to the classroom settings is known as applied behaviour analysis.

View

Use a Learning Theory: Behaviourism [3 min 24 sec]

Watch this fun clip on applying behaviourism to the classroom to help shape student behaviour and reduce disruption.

A transcript and Closed Captions are also available within the video.

APPLIED BEHAVIOUR ANALYSIS (ABA)

Up until the 1960s most behavioural research was conducted in laboratories with animals as the subjects of experiments (Landrum & McDuffie, 2008). Recognition of the possibility and value of the application of behavioural theory to problems being experienced by real people in real contexts, led to the emergence of applied behaviour analysis (ABA) (Baer, Wolf, & Risley, 1968; Landrum & McDuffie, 2008; Simonsen & Sugai, 2009). Baer, Wolf and Risley (1968) note that ABA scrutinises behaviour through observation and measurement to determine what environmental factors are maintaining the problem behaviour. The authors identified the key elements of ABA in the inaugural volume of the *Journal of Applied Behavior Analysis*. These are: applied, behavioural, analytic, technological, conceptually systematic, effective and generality. These seven key elements mean that apart from being applied, behavioural and analytic, an ABA approach to investigating behaviour is focussed upon clear descriptions, procedures, and the importance of behaviour change and the generalisation of behaviour to other settings that is ongoing (Baer, et al., 1968; Martella et al., 2012). The principles of ABA constitute the procedures and strategies used for behaviour intervention. These include direct observation of the behaviour in the setting in which it is occurring, collection and analysis of data, and identification of possible reinforcement subject to the demonstration of socially appropriate behaviour (Baer et al., 1968). ABA is about understanding and improving behaviour (Cooper et al., 2014).

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2.3 POSITIVE BEHAVIOUR SUPPORT

KEY FACTORS AND PRINCIPLES

When using a positive behaviour support (PBS) approach to addressing challenging behaviour, key factors and principles are drawn from ABA. The first principle is that behaviour is learned as a result of reinforcement. Reinforcement generally is perceived to originate in the environment rather than within the individual. If behaviour is learned, then problem behaviour can be changed through teaching and learning.

"The environment affects behaviour in predictable ways" (Scott, Anderson & Alter, 2012, p. 17).

Understanding that behaviour is the result of an interaction between it and the environment, is a key principle of a positive behaviour support approach. Within the environment some examples of influence on behaviour could be the space itself, the people in it, the expectations or the task. If a behaviour is followed by a positive or favourable outcome, then it is more likely to keep happening or occur again. Therefore, inappropriate student behaviour occurs because the consequences of the behaviour are reinforcing. To reduce the behaviour, a teacher must identify these consequences and alter them. This leads to the next important principle, behaviour can be changed.

The conditions surrounding the behaviour are changed to reduce or stop the undesirable behaviour and increase appropriate behaviour. The focus is upon determining the antecedents or events that trigger the behaviour, alter the consequences maintaining the behaviour and reinforce the desired behaviours. By scrutinising the environment, looking for patterns and influences on the behaviour, the function or purpose of the behaviour can be determined, and behaviour interventions can be developed to match the function, teach and reinforce new (replacement) behaviours.

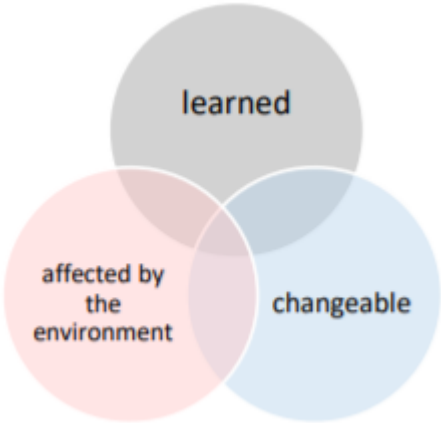

Figure 2.1 Govind Krishnamoorthy and Kay Ayre licensed under CC BY-SA.

Think back to earlier in the chapter when you considered your own beliefs regarding the causes of disruptive student behaviour. Can you see that the belief that the causes of misbehaviour lie within the student are in direct contrast to the underlying ABA belief that observable behaviour is an important source of behaviour change? From a PBS perspective, the blame for the disruptive behaviour is not levelled at

the individual, the family, the home life or the disability, rather, it is directed at the environment and what is happening there.

Considering disruptive student behaviour from the point of view of its relationship to the environment (a behaviourist view) means that the teacher is more likely to persist in trying to discover the function of the behaviour and how to change the environment to prevent, teach and reinforce the desired student behaviour. So how can teachers do this? Teachers can embrace a positive behaviour support mindset, employing ABA methods and interventions to help reduce disruptive student behaviour. Proactive and preventative, a positive behaviour support framework uses the core principles of applied behaviour analysis to promote student discipline at the whole school, small group and individual levels (Bambara, Janney, & Snell, 2015). Kincaid (2016, p. 71) states that "PBS relies on strategies that are respectful of a person's dignity and overall well-being and that are drawn primarily from behavioral, educational, and social sciences," in addition to other evidence-based procedures. Kincaid (2016, p. 71) notes that PBS may be applied at an individual level and a larger level (e.g., families, classrooms, schools, social service programs, and facilities).

There is an emphasis on proactive, preventative behaviour of staff and students through altering the environment and explicitly teaching students the behaviour expectations and any skills they may need to effectively participate and achieve their best at school. Using the principles of applied behaviour analysis, PBS expands upon these principles by providing a multi-tiered (tier one, tier two and tier three) structure that caters for all students across different degrees of support for behaviour.

View

An introduction to PBS [6 min 37 sec]

Watch this animated video which introduces the key elements of positive behaviour support.

A transcript and Closed Captions are also available within the video.

Discover

Positive Behavioural Interventions and Supports (PBIS)

Explore this website to learn more about positive behavioural interventions and supports (PBIS).

THINKING FUNCTIONALLY TO SUPPORT POSITIVE BEHAVIOUR

Thinking functionally about disruptive student behaviour is an important objective of positive behaviour support focussed on changing the conditions surrounding the behaviour to reduce or stop the undesirable behaviour and increase appropriate behaviour. Scrutinising the environment is key to determining why the behaviour is happening. Working from this perspective shifts the focus from something being wrong with the student (within the child that is not observable) to the actual

behaviour. The focus is upon determining the antecedents or events that trigger the behaviour, altering the consequences maintaining the behaviour and reinforcing the desired behaviours. Determining the function of the disruptive behaviour is at the core of any intervention developed from a behavioural perspective. From this behaviourist perspective, there are only two functions to peoples' behaviour, to **access/get** a thing, person or event or sensory stimulation (these are examples of positive reinforcement) to **avoid/escape** something, a person or event or sensory stimulation (these are examples of negative reinforcement).

Sensory regulation/sensory stimulation is often outlined in the literature as a third function of behaviour. This is just another way of explaining the functional outcomes of behaviour where sensory stimulation is viewed as a separate category of a possible function. For our purposes here, we will remain focused on the two primary functions of access and escape. "Reinforcement always increases a behaviour, but it does so in two different ways" (Scott et al., 2012, p. 24) – positively and negatively. When a student 'gets/accesses' something as a result of their behaviour this is positive reinforcement. For example, during reading time Julie pushes another child and her peers laugh, she gets peer attention. Something is added to the behaviour of pushing – peer attention, so this is positive reinforcement. When the behaviour serves the purpose to escape or avoid something, this is called negative reinforcement. If Julie was sent to 'buddy class' when she pushed the other child, and she kept pushing the other child, we would say that the pushing behaviour (that was still happening) was negatively reinforced – Julie escaped/avoided reading groups (she pushed and was sent to buddy class).

When we are thinking functionally about behaviour the process of gathering and analysing the data is to help us to determine and understand the purpose of the challenging behaviour. We want to find out the function or what is in it for the student? Behaviour is communication. It is important to remember that challenging behaviour will often serve different functions for the student depending on the context, so looking closely at the behaviour within the context in which it happens is vital. Think for a minute about your own behaviour and how it changes depending on the context. How do you behave in the context of your own home, in your car when driving, or at a sporting event? Does your 'teacher behaviour' look and sound like your 'socialising' behaviour? Behaviour is related to the particular environment in which it happens.

View

Toxic stress: a story [8 min 38 sec]

This video clip provides a snapshot of behaviour management approaches across time.

A transcript and Closed Captions are also available within the video.

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2.4 OBSERVING BEHAVIOUR

OBSERVING BEHAVIOUR = ABC

Thinking functionally about disruptive student behaviour assumes that behaviour is maintained by something in the environment where the behaviour is happening. To find out why or the function, we examine the antecedents, the behaviour and the consequences. That is, we watch or observe the behaviour directly and document the A, B and C of that disruptive behaviour.

Antecedent – what happens before the behaviour?

Behaviour – the actual behaviour that was observed

Consequence – what happens after the behaviour?

Alphabet by Geralt licensed under CC0.

Even though the sequence says A, B then C – **always start with the behaviour** which is described in observable and measurable terms. If the behaviour is not described in a manner that tells others exactly what it looks like and sounds like, it is not only difficult to accurately observe and measure but determining the appropriate intervention, is made problematic. The behaviour is the actual behaviour that was demonstrated by the student. What does the behaviour look like in observable and measurable terms? Challenging behaviour needs to be explicitly described so that a visitor to the school would be able to accurately identify the behaviour. How we define behaviour guides how we measure it. Which of the following are observable and measurable?

She knocks her book the floor and tells adults 'No!"	He is anxious	She interrupts people when they are talking by constantly tapping them	He leaves the room without permission
He pushes, punches and bites people	She daydreams a lot	He hums and calls out swear words	He lacks motivation
She is disrespectful	She hits her peers	He has ADHD	She rocks on her chair, taps her feet

The antecedent is what happened just before the behaviour did. It is sometimes called the fast trigger. While, the antecedent is often described as all the happenings within the context in which the behaviour occurs, it can be more helpful to think of the antecedent as what happens immediately before the behaviour. Other factors which also occur before the behaviour but over which the teacher often has little control, for example tiredness, hunger, fighting at home, removal from the family, are termed setting events. Awareness of these factors is important because while they are not an immediate trigger, they can significantly influence student behaviour. Some behaviourists choose to not single out the setting events from other antecedents (Umbreit, Ferro, Liaupsin, & Lane, 2007) but we will consider them separately and the antecedent recorded on the ABC form will be what happened immediately before the actual behaviour.

The consequence is what happens after the behaviour. What is it that the adults say or do? It is the consequence that will make the behaviour more or less likely to occur again. If the consequence encourages the behaviour to be repeated, it is called a reinforcer. If the consequence reduces the likelihood the behaviour will happen again, it is called a punisher. It is unfortunate that the term consequence is often used only in reference to punishment.

The table below shows the observable and measurable behaviours, highlighted in blue.

She knocks her book the floor and tells adults 'No!"	He is anxious	She interrupts people when they are talking by constantly tapping them	He leaves the room without permission
He pushes, punches and bites people	She daydreams a lot	He hums and calls out swear words	He lacks motivation
She is disrespectful	She hits her peers	He has ADHD	She rocks on her chair, taps her feet

Now that you understand the principles of a behaviourist approach and the importance of ABC for data collection, put on your trauma glasses and consider carefully the child affected by trauma. How can you apply this functional knowledge with thoughtfulness and caring consideration? You know that the child or young person is not "bad" or deliberately setting out to disrupt the learning and teaching and make your life difficult but is responding in a manner that reflects their current level of ability to cope. Their focus is on survival and they respond accordingly. They have no choice. It is up to the teacher to work out how best to guide and support the child whose trauma-driven behaviour is constantly sabotaging their ability to behave in a prosocial manner and successfully engage in learning.

Armed with knowledge about the impact of trauma on the brain, development, learning and behaviour, planning for the individual child demonstrating trauma-driven behaviour is a collaboration with many significant adults (e.g., family members, community workers, specialist personnel) to ensure all voices are heard and considered. Throughout the information and data

collection process, the teacher, other educators and staff will come to know the child well. Taking a strengths-based approach underpins this work where the focus is on the capabilities, interests and unique strengths of the child. How to nurture a sense of safety and stability within the context of a trusting relationship, is the goal.

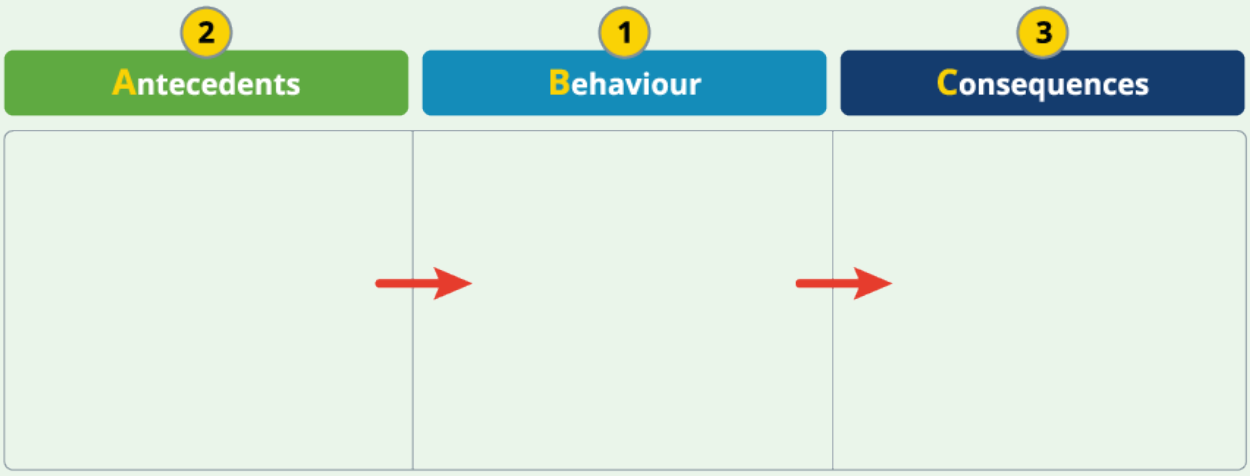
Activity

Identifying ABC

Read the following description and see if you can identify the antecedent, the behaviour and the consequence. Always start with the behaviour first, then the antecedent and then the consequence.

Lucy swears at her teacher, stands up, tips over her chair, knocks her book to the floor and sits outside the classroom at the top of the stairs whenever asked to begin handwriting. Lucy is escorted from the stairs to the office by a member of the administration team.

On a blank piece of paper rule three columns, one each for antecedents, behaviour and consequences. Take a moment to think of a disruptive student you have observed. Write down two of the disruptive behaviours demonstrated by the student in the behaviour column in observable and measurable terms. Now think back, what was the antecedent for each? Write those against each behaviour and what did the adults do after the behaviour happened? In other words, what were the consequences for each behaviour?



Created by Kay Ayre

Your answer should look something like this:

2 Antecedents	1 Behaviour	3 Consequences
The teacher asks Lucy to begin handwriting	Lucy swears at her teacher, stands up, tips over her chair, knocks her book to the floor and sits outside the classroom at the top of the stairs	A member of the administration team exits Lucy to the office

Created by Kay Ayre.

Here are two more examples of problematic behaviours with the antecedent and consequence. Make an effort to do your own.

2 Antecedents	1 Behaviour	3 Consequences
Told to pick up pencil and start work	Folds arms, head on desk	Sent to time away

2 Antecedents	1 Behaviour	3 Consequences
Asked to move to another seat	Rips up worksheet	Given lunchtime detention

Created by Kay Ayre.

Activity

Remember Molly?

Here is a reminder from the beginning of the chapter with greater detail:

The frantic phone call to the office came requesting immediate assistance in the Year one classroom. The teacher had instructed Molly to begin her handwriting task. Molly was holding the class to ransom (yet again) and the teacher was in the process of evacuation. Molly had taken the box of chalk from the shelf beneath the blackboard, had turned the ceiling fans up to the highest speed, climbed onto the desk and had begun to systematically throw handfuls of chalk into the spinning blades. Chalk ricocheted around the classroom like bullets from a machine gun and chaos reigned supreme. As a result, Molly is exited from the classroom by the deputy principal and taken to the office. This year, Molly's disruptive behaviour had escalated to being serious and unsafe.

Draw up three boxes (see below) and write down the ABC of Molly's behaviour. Start with the behaviour, then the antecedent and then the consequence.

2 Antecedents	1 Behaviour	3 Consequences

Created by Kay Ayre.

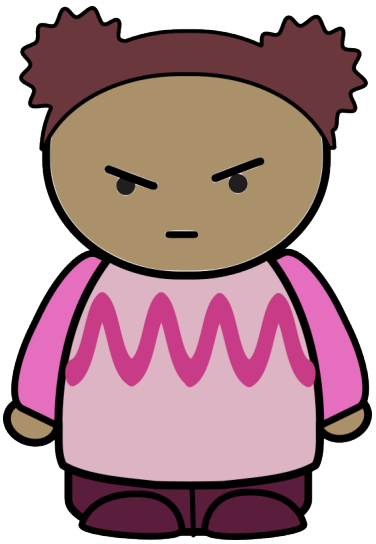
Did you have what is in the example below or something similar?

2 Antecedents	1 Behaviour	3 Consequences
The teacher asks Molly to begin handwriting	Molly stands on her desk and throws handsful of chalk into the spinning blades of the ceiling fan	Molly is removed from the classroom by the deputy principal and taken to the office

Created by Kay Ayre.

What could the function of Molly's behaviour be? Is it to access/get or avoid/get away?

Without data, it is impossible to know what the function of Molly's disruptive behaviour is. After direct observations to collect ABC data and discussions with the teacher, it was concluded that the function of Molly's behaviour was most likely to get adult attention and more specifically, get the attention of the deputy principal – and it worked! What better way to have the function met than to behave in an unsafe and dangerous fashion which automatically draws immediate attention from the school administration staff?



Mix and match character lily angry front by Talekids licensed under CC0.

Data collection associated with functional thinking results in a hypothesis or behaviour statement which is our 'best guess' as to why the behaviour is happening. A behaviour support plan is then written and is the plan of intervention based on the data collected not based on hearsay and the 'I reckon' opinions of others. This behaviour support plan details the hypothesis statement (what the behaviour looks like and why we think it is happening), behaviour goals, academic goals and strategies to prevent the behaviour from occurring, to teach the replacement behaviours (the appropriate way for the child to get what they want – feeding the function) and to reinforce the appropriate behaviour.

At six years of age Molly had a very clear picture of the function of her behaviour and she articulated it clearly as illustrated in the example incident that follows. In response to the teacher's call for help, the Deputy Principal had arrived at the classroom door and Molly seeing her there said: "I knew you would come. You have to come and get me if I am dangerous. It's your job!" So where to now with intervention for Molly? The function of Molly's behaviour needs to be fed. In other words, she has to be taught how to

achieve the same function (to access adult attention) in an acceptable way. How could that be done? How could Molly access the attention she needs from the deputy principal in a manner that is appropriate and acceptable for the context and all people involved?

Here is a small part of a completed ABC example for Molly:

ABC OBSERVATION TOOL

Name of student being observed: Molly Smith **Year:** 1B **Observer:** Ms Brown

Behaviour/s: Unsafe, dangerous, throwing objects, standing on furniture, leaving room without permission

Date	Time	Antecedent	Behaviour	Consequence	Possible Function
6/8/19	9:10	Teacher says "Time for handwriting. Take out your books"	Gets out of seat and wanders around the room	Teacher says to Molly: "Molly go and sit down, please"	Teacher attention
	9:15	Teacher direction "Molly take out your handwriting book and copy the first three words"	"No! I don't want to!" Puts head on the desk and knocks pencil to the floor	Teacher correction "Pick up your pencil and start your handwriting like everyone else"	Teacher attention or escape difficult task
	9:17	Teacher correction "Pick up your pencil and start your handwriting like everyone else"	Yells "I hate handwriting!" and gets out of chair and walks to front of the room	Teacher correction "Go back to your seat now Miss Molly or I will have to call the office"	Teacher attention or escape difficult task

Figure 2.2 ABC Observation Tool created by Kay Ayre and Govind Krishnamoorthy, licensed under CC BY-SA.

Follow the red arrow in this above example and notice how the consequence becomes the antecedent or trigger for the next behaviour. This is often (not always) the case. Completing an ABC requires that the disruptive behaviour is observed directly, that is that the observer (the teacher, teacher aide, behaviour support teacher or whomever) is watching the student demonstrate the disruptive behaviour within the environment that it is occurring. So, if the behaviour happens during Maths time in the classroom that is when and where the behaviour is observed.

COMPETING PATHWAYS

To this point you have closely observed and reflected on the relationship between the behaviour and the environment using the ABC. What happened immediately before the behaviour (the antecedent-A), the behaviour in observable and measurable terms (the behaviour – B) and carefully assessed what happened immediately after the behaviour by asking what did the adults do? (consequences – C). Remember, the reason the ABC was conducted was because the disruptive behaviour that was occurring needed to be changed because it was not acceptable. Changing behaviour requires a behaviour intervention plan or behaviour support plan that guides the implementation of the intervention strategies documented within it. The behaviour support plan is developed based on the

competing pathway (three pathways). The ABC information or data is now used to fill out what is called the competing pathway which is a critical component of any behaviour support plan. A competing pathway looks like this (the questions are prompts for the information that is to go into each box). This helps us to focus our thinking, functionally.

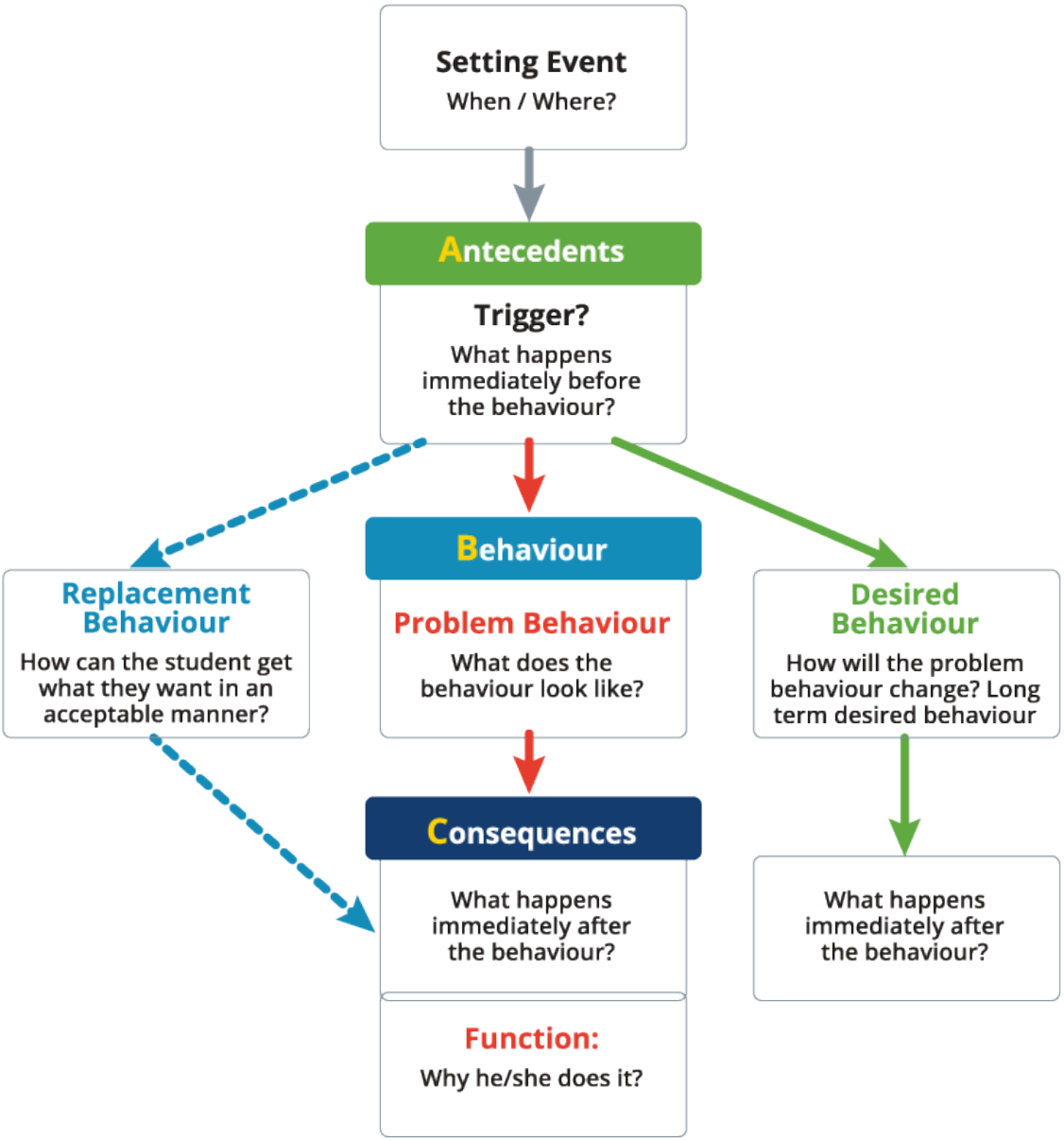


Figure 2.3 Competing Pathways created by Kay Ayre and Govind Krishnamoorthy, licensed under CC BY-SA.

Here is a completed example from the literature, for student Kelly (Loman, Strickland-Cohen, Borgmeier, & Horner, 2010):

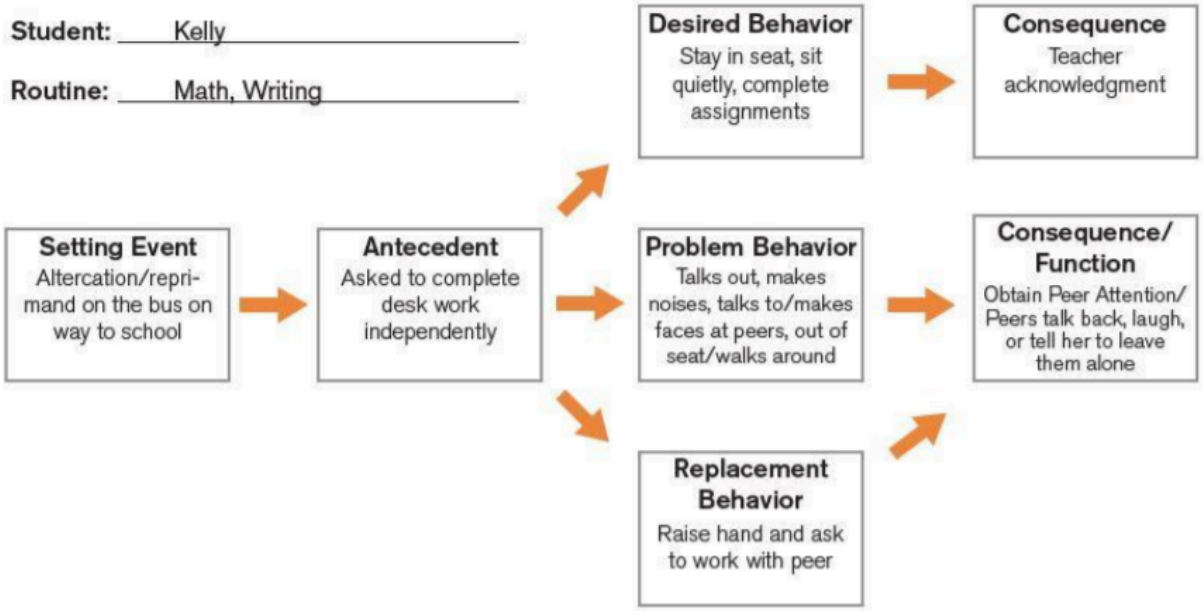


Figure 2.4 Reproduced with permission from Loman, S., & Borgmeier, C. (2010). Practical functional behavioural assessment training manual for school-based personnel (p. 57) Retrieved from http://pdxscholar.library.pdx.edu/cgi/viewcontent.cgi?article=1001&context=sped_fac. Futher reproduction of this information is not permitted without prior permission from the copyright holders.

Note how the replacement behaviour allows Kelly to still achieve the same function. In this case this means an acceptable way for Kelly to access peer attention. So rather than use the problem behaviours of calling out, making noises, pulling faces etc. she is taught to raise her hand and ask permission to work with a peer. New replacement behaviour, same function. Unless the replacement behaviour serves the same function, the child will not use it because there is 'nothing in it for them'. The disruptive behaviour gets them what they need so they will keep using it therefore the replacement behaviour must be worth their while and to be so, it must fill the same function for them as the disruptive behaviour does.

When deciding on a replacement behaviour we need to think about the following: What is it that (in the short-term) the child should be doing instead of the problem behaviour? What are all the other students doing that is appropriate to the task? What does the child need to do to access or escape and get what they need? We need to teach and reinforce it.

FROM COMPETING PATHWAYS TO SUPPORT PLANNING

With the competing pathway completed, now the behaviour support plan needs to be developed. The behaviour support plan will detail the strategies to prevent the problem behaviour, to teach the replacement behaviour and to reinforce the behaviours (replacement and desired behaviour). The plan also details how the adults involved need to respond. This is the way the behaviour support plan is usually set out with the strategies for each element of the competing pathway listed below each element.

This template is an easy to fill out behaviour support plan template. It clearly shows the alignment between the information in the A (antecedent), B (problem behaviour) and C (consequence) boxes and the intervention strategies corresponding to each. Antecedent strategies prevent, replacement

behaviours are taught through the teach strategies and consequence strategies reinforce the replacement and desired behaviour.

Reflective questions

1. Name three commonly held beliefs of causes of disruptive behaviour.
2. Who is famous for operant conditioning?
3. Behaviour is learned, lawful and _____.
4. Explain the importance of the ABCs of behaviour.

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Umbreit, J., Ferro, J., Liaupsin, C. J., & Lane, K. L. (2007). *Functional behavioral assessment and function-based intervention. An effective, practical approach*. Upper Saddle River, NJ: Pearson Education.

2.5 A DUAL PERSPECTIVE

The two functions of challenging student behaviour from a behaviourist perspective are to get something (a person, object, activity or sensory situation) or to escape or to get away (from a person, activity, object or sensory situation). We closely observe and reflect on the relationship between the behaviour and the environment using the ABC. What happened immediately before the behaviour (the antecedent- A), describe the behaviour in observable and measurable terms (the behaviour – B) and carefully assess what happened immediately after the behaviour asking what did the adults do? (consequences – C). This information is then used to inform our best guess (hypothesis) as to what the purpose or function of the behaviour could be. At the same time, the impact that trauma has on the child and their difficulty to learn and behave in an appropriate manner, is clearly understood.

When behaviour is trauma-driven, the child is in survival mode and they do not know "why" they are responding in the way they are. Asking the child affected by trauma, why they did what they did, is unreasonable and most children will not be able to articulate the reason or have any understanding of why. Asking the child "why" serves very little, if any purpose other than to perhaps retraumatise and increasing feelings of shame and unworthiness. What these children need, is for the adults to work out the "why" to guide and help them learn how to cope with being in a learning environment and demonstrate prosocial behaviours.

When hypothesising about the possible function of the challenging behaviour, knowledge of attachment, skills deficits and regulation coping are drawn upon to better inform behaviour interventions for those children who may have experienced trauma. The diagram below illustrates the relationship between the key elements of the transtheoretical trauma informed behaviour support model when considering how to give our best effort to help the children with trauma experience success at school.

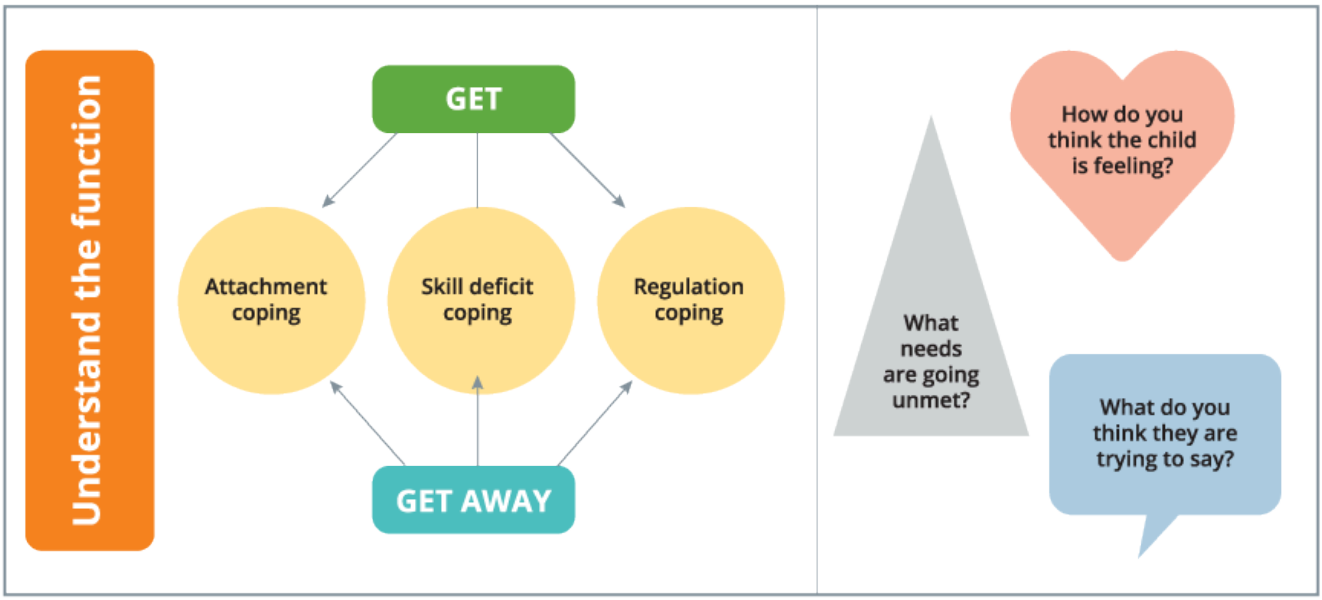

Figure 2.6 created by Govind Krishnamoorthy and Kay Ayre licensed under CC BY-SA.

It is important to remember that all children with trauma are individuals who react in very different ways and many will not demonstrate highly disruptive behaviour. However, many do, and it is critical that teachers look at any challenging behaviour as behaviour that possibly could be trauma-based.

Be mindful of teacher behaviour and strategies that are commonplace for example sending a child to time-out, to consider their behaviour may trigger retraumatisation for the child affected by trauma. Being 'sent away' is likely to stir up feelings of abandonment and isolation and reinforce the child's view that they are not worthy of adult love and care.

When faced with challenging student behaviour, teachers with an understanding of elements of the transtheoretical model know that functioning in a school situation is an extremely 'big ask' for some children with trauma histories. The fact that these children show up to school at all, is testament to their resilience and strength. Tread carefully and considerately and walk beside them. Be there. Be kind.

Listen

Interview with Tom Brunzell [41 min]

Listen to the interview with Tom from Berry Street in Melbourne on positive psychology for traumatised children.

View

Through Our Eyes: Children, Violence and Trauma [7 mins 53 secs]

This video discusses how violence and trauma affect children, including the serious and long-lasting consequences for their physical and mental health; signs that a child may be exposed to violence or trauma; and the staggering cost of child maltreatment to families, communities, and the nation.

Please note that the clip contains themes and images that may be distressing to some. Please feel free to stop watching the video if you are distressed.

A transcript and Closed Captions are also available within the video.

PART III.

PREVENT AND CONTAIN

Boy Child Sad by Myriams-Fotos licensed under CC0.

"The single most important issue for traumatised people is to find a sense of safety in their own bodies."
Bessell van der Kolk

Overview and learning objectives

Chapter three focuses on understanding the development of the brain and the impact of trauma on its capacity to learn and adapt. This chapter is organised into the following sections:

- How the brain develops
- Effects of child maltreatment on brain development

- Effects of disrupted brain development on academic and socioemotional functioning of children
- The window of tolerance model of self-regulation

On successful completion of this chapter, you should be able to:

- Understand the normal development of the brain and the role of its component parts in academic and socio-emotional functioning
- Explain the impact of trauma on key areas of the brain
- Utilise the 'window of tolerance' model to support traumatised students

INTRODUCTION

In recent years, there has been a surge of research into early brain development. Neuroimaging technologies, such as magnetic resonance imaging (MRI), provide increased insight about how the brain develops and how early experiences affect that development. One area that has been receiving increasing research attention involves the effects of abuse and neglect on the developing brain, especially during infancy and early childhood. Much of this research is providing biological explanations for what practitioners have long been describing in psychological, emotional, and behavioural terms. There is now scientific evidence of altered brain functioning as a result of early abuse and neglect. This emerging body of knowledge has many implications for educators when teaching and supporting children who have experienced abuse and neglect.

This chapter provides basic information on typical brain development and the potential effects of abuse and neglect. The information is designed to help you understand the cognitive, emotional, relational and behavioural impact of early abuse and neglect in children. As we begin to explore this development, you will be introduced to a variety of new concepts and terms.

3.1 HOW THE BRAIN DEVELOPS

What we have learned about the process of brain development helps us understand more about the roles both genetics and the environment play in our development. It appears that genetics predispose us to develop in certain ways, but our experiences, including our interactions with other people, have a significant impact on how our predispositions are expressed. Research now shows that many capacities thought to be fixed at birth are actually dependent on a sequence of experiences combined with heredity. Both factors are essential for optimum development of the human brain (Shonkoff & Phillips, 2000).

EARLY BRAIN DEVELOPMENT

The raw material of the brain is the nerve cell, called the neuron. During fetal development, neurons are created and migrate to form the various parts of the brain. As neurons migrate, they also differentiate, or specialise, to govern specific functions in the body in response to chemical signals (Perry, 2002). This process of development occurs sequentially from the 'bottom up,' that is, from areas of the brain controlling the most primitive functions of the body (e.g., heart rate, breathing) to the most sophisticated functions (e.g., complex thought) (Perry, 2000). The first areas of the brain to fully develop are the brainstem and midbrain; they govern the bodily functions necessary for life, called the autonomic functions. At birth, these lower portions of the nervous system are very well developed, whereas the higher regions (the limbic system and cerebral cortex) are still rather primitive. Higher function brain regions involved in regulating emotions, language, and abstract thought grow rapidly in the first three years of life (Zero to Three, 2012).

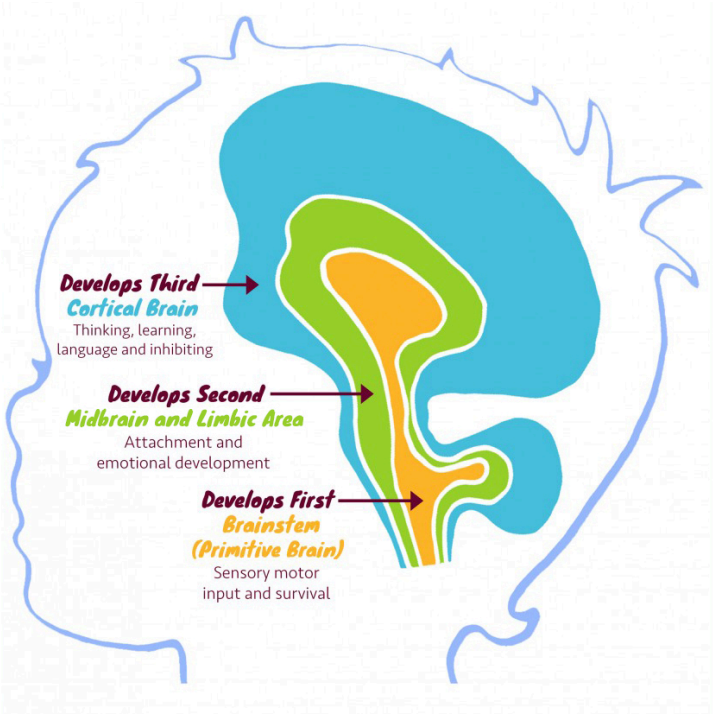

Figure 3.1: Image courtesy of Beacon House Therapeutic Services & Trauma Team | 2020 | www.beaconhouse.org.uk This diagram cannot be reproduced without prior perimission from Beacon House.

BRAIN DEVELOPMENT IN CHILDHOOD

Brain development or learning, is actually the process of creating, strengthening, and discarding connections among the neurons. These connections are called synapses. Synapses organise the brain by forming pathways that connect the parts of the brain governing everything we do—from breathing and sleeping to thinking and feeling. This is the essence of postnatal brain development, because at birth, very few synapses have been formed. The synapses present at birth are primarily those that govern our bodily functions such as heart rate, breathing, eating, and sleeping. The development of synapses occurs at an astounding rate during a child's early years in response to that child's experiences. At its peak, the cerebral cortex of a healthy toddler may create two million synapses per second (Zero to Three, 2012). By the time children are two years old, their brains have approximately 100 trillion synapses, many more than they will ever need. Based on the child's experiences, some synapses are strengthened and remain intact, but many are gradually discarded. This process of synapse elimination—or pruning—is a normal part of development (Shonkoff & Phillips, 2000). By the time children reach adolescence, about half of their synapses have been discarded, leaving the number they will have for most of the rest of their lives.

Another important process that takes place in the developing brain is myelination. Myelin is the white fatty tissue that forms a sheath to insulate mature brain cells, thus ensuring clear transmission of neurotransmitters across synapses. Young children process information slowly because their brain cells lack the myelin necessary for fast, clear nerve impulse transmission (Zero to Three, 2012). Like other neuronal growth processes, myelination begins in the primary motor and sensory areas (the brain-stem and cortex) and gradually progresses to the higher-order regions that control thought, memories, and feelings. Also, like other neuronal growth processes, a child's experiences affect the

rate and growth of myelination, which continues into young adulthood (Shonkoff & Phillips, 2000). By three years of age, a baby's brain has reached almost 90% of its adult size. The growth in each region of the brain largely depends on receiving stimulation, which spurs activity in that region. This stimulation provides the foundation for learning.

BRAIN DEVELOPMENT IN ADOLESCENCE

Brain imaging technologies have provided evidence of the brain continuing to grow and develop into young adulthood – with current research pointing to the brain continuing grow and develop into the thirties (Lebel & Beaulieu, 2011). Right before puberty, adolescent brains experience a growth spurt that occurs mainly in the frontal lobe, which is the area that governs planning, impulse control, and reasoning. During the teenage years, the brain goes through a process of pruning synapses—somewhat like the infant and toddler brain— and also sees an increase in white matter and changes to neurotransmitter systems (Konrad, Firk, & Uhlhaas, 2013).

As the teenager grows into a young adult, the brain develops more myelin to insulate the nerve fibres and speed neural processing, and this myelination occurs last in the frontal lobe. Brain imaging comparisons between the brains of teenagers and the brains of young adults have shown that most of the brain areas were the same—that is, the teenage brain had reached maturity in the areas that govern such abilities as speech and sensory capabilities. The major difference was the immaturity of the teenage brain in the frontal lobe and in the myelination of that area (National Institute of Mental Health, 2001). Normal puberty and adolescence lead to the maturation of a physical body, but the brain lags behind in development, especially in the areas that allow teenagers to reason and think logically. Most teenagers act impulsively at times, using a lower area of their brains—their 'gut reaction'—because their frontal lobes are not yet mature. Impulsive behaviour, poor decisions, and increased risk-taking are all part of the normal teenage experience. Given the dynamic nature of brain development in the teenage years, decision making during this developmental stage appears to be heavily influenced by heightened emotions, with limitations in the capacity for cognitive processes linked to the prefrontal cortex (Chamberlain, 2009).

PLASTICITY—THE INFLUENCE OF ENVIRONMENT

Researchers have coined the term 'plasticity' to describe the changes in the brain in response to changes in the environment, and its related patterns of activation in the brain (Perry, 2006). The rate and types of changes in neuronal pathways has been found to be different in each stage of development (Perry, 2006). For example, the lower parts of the brain – controlling basic functions such as breathing and heart rate – have been found to be less flexible, or plastic, than the higher functioning cortex, that control higher level cognitions. While the plasticity of the areas of brain like prefrontal cortex decreases as a child gets older, some degree of plasticity remains in the brain (Perry, 2006). Research continues to inform our understanding of lifelong learning, coping and resilience in the face of adverse events. The developing brain's ongoing adaptations are the result of both genetics and experience. Our brains prepare us to expect certain experiences by forming the pathways needed to respond to those experiences. For example, our brains are 'wired' to respond to the sound of speech; when babies hear people speaking, the neural systems in their brains responsible for speech and language receive the necessary stimulation to organise and function (Perry, 2006).

The activation of appropriate pathways in development has been found to be important. For example, research has found that the more babies are exposed to language in the form of caregivers

and adults speaking, the stronger their neural pathways related to speech and language. This principle of neurodevelopment has been referred to as 'use it or lose it' (Shore, 2015) where through processes of creating, strengthening, and discarding synapses that our brains adapt to the challenges and opportunities of their developmental environment. Regardless, all children need stimulation and nurturance for healthy development. When these are lacking in cases of maltreatment or deprivation, the child's brain development may be impacted. The brain's plasticity to its environment means that it changes in response to a negative environment just as readily as it will adapt to a positive one.

Regardless of the general environment, though, all children need stimulation and nurturance for healthy development. If these are lacking (e.g., if a child's caretakers are indifferent, hostile, depressed, or cognitively impaired), the child's brain development may be impaired. Because the brain adapts to its environment, it will adapt to a negative environment just as readily as it will adapt to a positive one.

SENSITIVE PERIODS

Current research on brain development suggests that there are sensitive periods for development of certain capabilities. These are referred to as 'windows of proximal development' – a time in the developmental process when certain parts of the brain may be most susceptible to particular experiences (Siegal, 2015). Animal studies have shed light on sensitive periods, showing, for example, that animals that are artificially blinded during the sensitive period for developing vision may never develop the capability to see, even if the blinding mechanism is later removed.

It is more difficult to study human sensitive periods, but we know that, if certain synapses and neuronal pathways are not repeatedly activated, they may be discarded, and their capabilities may diminish. For example, infants have a genetic predisposition to form strong attachments to their primary caregivers, but they may not be able to achieve strong attachments, or trusting, durable bonds if they are in a severely neglectful situation with little one-on-one caregiver contact. Children from Romanian institutions who had been severely neglected had a much better attachment response if they were placed in foster care—and thus received more stable parenting—before they were 24 months old (Smyke, Zeanah, Fox, Nelson, & Guthrie, 2010). This indicates that there is a sensitive period for attachment, but it is likely that there is a general sensitive period rather than a true cut-off point for recovery (Zeanah, Gunnar, McCall, Kreppner, & Fox, 2011).

While sensitive periods exist for development and learning, we also know that the plasticity of the brain often allows children to recover from missing certain experiences. Both children and adults may be able to make up for missed experiences later in life, but it is likely to be more difficult. This is especially true if a young child was deprived of certain stimulation, which resulted in the pruning of synapses (neuronal connections) relevant to that stimulation and the loss of neuronal pathways. As children progress through each developmental stage, they will learn and master each step more easily if their brains have built an efficient network of pathways to support optimal functioning.

MEMORIES

The organising framework for children's development is based on the creation of memories. When repeated experiences strengthen a neuronal pathway, the pathway becomes encoded, and it eventually becomes a memory. Children learn to put one foot in front of the other to walk. They learn words to express themselves. And they learn that a smile usually brings a smile in return. At some point, they no longer have to think much about these processes—their brains manage these

experiences with little effort because the memories that have been created allow for a smooth, efficient flow of information.

The creation of memories is part of our adaptation to our environment. Our brains attempt to understand the world around us and fashion our interactions with that world in a way that promotes our survival and, hopefully, our growth, but if the early environment is abusive or neglectful, our brains may create memories of these experiences that adversely colour our view of the world throughout our life.

Babies are born with the capacity for implicit memory, which means that they can perceive their environment and recall it in certain unconscious ways (Applegate & Shapiro, 2005). For instance, they recognise their mother's voice from an unconscious memory. These early implicit memories may have a significant impact on a child's subsequent attachment relationships. In contrast, explicit memory, which develops around age two, refers to conscious memories and is tied to language development. Explicit memory allows children to talk about themselves in the past and future or in different places or circumstances through the process of conscious recollection (Applegate & Shapiro, 2005).

Sometimes, children who have been abused or suffered other trauma may not retain or be able to access explicit memories of their experiences. However, they may retain implicit memories of the physical or emotional sensations, and these implicit memories may produce flashbacks, nightmares, or other uncontrollable reactions (Applegate & Shapiro, 2005). This may be the case with young children or infants who suffer abuse or neglect.

RESPONDING TO STRESS

We all experience different types of stress throughout our lives. The type of stress and the timing of that stress determine whether and how there is an impact on the brain. The National Scientific Council on the Developing Child (2014) outlines three classifications of stress:

- **Positive stress** is moderate, brief, and generally a normal part of life (e.g., entering a new child care setting). Learning to adjust to this type of stress is an essential component of healthy development.
- **Tolerable stress** includes events that have the potential to alter the developing brain negatively, but which occur infrequently and give the brain time to recover (e.g., the death of a loved one).
- **Toxic stress** includes strong, frequent, and prolonged activation of the body's stress response system (e.g., chronic neglect).

Healthy responses to typical life stressors (i.e., positive and tolerable stress events) are complex and may change depending on individual and environmental characteristics, such as genetics, the presence of a sensitive and responsive caregiver, and past experiences. A healthy stress response involves a variety of hormone and neurochemical systems throughout the body, including the sympathetic-adrenomedullary (SAM) system, which produces adrenaline, and the hypothalamic pituitary-adrenocortical (HPA) system, which produces cortisol (National Council on the Developing Child, 2014). Increases in adrenaline help the body engage energy stores and alter blood flow. Increases in cortisol also help the body engage energy stores and also can enhance certain types of memory and activate immune responses. In a healthy stress response, the hormonal levels will return to normal after the stressful experience has passed.

Please note that the above information on the three types of stress is reproduced with permission from the National Scientific Council on the Developing Child. (2014). *Excessive stress disrupts the architecture of the developing brain* (Working Paper 3). Retrieved from http://developingchild.harvard.edu/resources/reports_and_working_papers/working_papers/w p3/. Additional reproduction of this information is not permitted without prior permission from the National Scientific Council on the Developing Child.

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3.2 EFFECTS OF CHILDHOOD TRAUMA ON BRAIN DEVELOPMENT

Figure 3.2: Reproduced with permission from Australian Childhood Foundation (2016).

Just as positive experiences can assist with healthy brain development, children's experiences with childhood trauma or other forms of toxic stress, such as domestic violence or disasters, can negatively affect brain development. This includes changes to the structure and chemical activity of the brain (e.g., decreased size or connectivity in some parts of the brain) and in the emotional and behavioural functioning of the child (e.g., over-sensitivity to stressful situations). For example, healthy brain development includes situations in which babies' babbles, gestures, or cries bring reliable, appropriate reactions from their caregivers.

These caregiver-child interactions—sometimes referred to as 'serve and return'— strengthen babies' neuronal pathways regarding social interactions and how to get their needs met, both physically and emotionally. If children live in a chaotic or threatening world, one in which their caregivers respond with abuse or chronically provide no response, their brains may become hyperalert for danger or not fully develop. These neuronal pathways that are developed and strengthened under negative conditions prepare children to cope in that negative environment, and their ability to respond to nurturing and kindness may be impaired (Shonkoff & Phillips, 2000). The specific effects of maltreatment may depend on such factors as the age of the child at the time of the maltreatment, whether the maltreatment was a one-time incident or chronic, the identity of the abuser (e.g., parent or other adult), whether the child had a dependable nurturing individual in his or her life, the type and severity of the maltreatment, the intervention, how long the maltreatment lasted, and other individual and environmental characteristics.

EFFECTS OF CHILDHOOD TRAUMA ON BRAIN STRUCTURE AND ACTIVITY

Toxic stress, including child maltreatment, can have a variety of negative effects on children's brains:

Hippocampus: Adults who were maltreated may have reduced volume in the hippocampus, which is central to learning and memory (McCrory et al., 2010; Wilson, Hansen, & Li, 2011). Toxic stress also can reduce the hippocampus's capacity to bring cortisol levels back to normal after a stressful event has occurred (Shonkoff, 2012).

Corpus callosum: The corpus callosum is the part of the brain chiefly responsible for

interhemispheric communication and other vital processes, such as arousal, emotion, higher cognitive abilities. Preliminary evidence suggests that maltreated children and adolescents have decreased volume in the corpus callosum compared to non-maltreated counterparts (e.g., McCrory et al., 2010; Wilson et al., 2011).

Cerebellum: The cerebellum has been identified as being involved in the coordination of motor movements. Similar to the corpus callosum, the volume of the cerebellum has been found decreased when children have been exposed to maltreatment (McCrory et al., 2010).

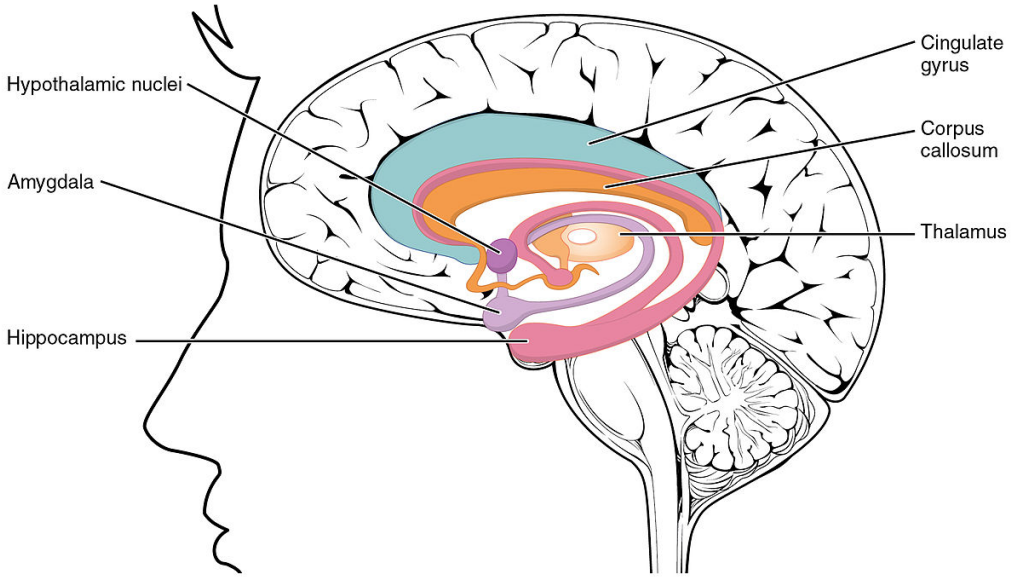

Figure 3.3: The Limbic Lobe, by OpenStax College licensed under CC BY.

Prefrontal cortex: Some studies on adolescents and adults who were severely neglected as children indicate they have a smaller prefrontal cortex, which is critical to behaviour, cognition, and emotion regulation (National Scientific Council on the Developing Child, 2012), but other studies show no differences (McCrory et al., 2010). Physically abused children also may have reduced volume in the orbitofrontal cortex, a part of the prefrontal cortex that is central to emotion and social regulation (Hanson et al., 2010).

Amygdala: Although most studies have found that amygdala volume is not affected by maltreatment, abuse and neglect can cause overactivity in that area of the brain, which helps determine whether a stimulus is threatening and trigger emotional responses (National Scientific Council on the Developing Child, 2010; Shonkoff, 2012).

Cortisol levels: Many maltreated children, both in institutional and family settings, and especially those who experienced severe neglect, tend to have lower than normal morning cortisol levels coupled with flatter release levels throughout the day (Bruce, Fisher, Pears, & Levine, 2009; National Scientific Council on the Developing Child, 2012). Typically, children have a sharp increase in cortisol in the morning followed by a steady decrease throughout the day. On the other hand, children in foster care who experienced severe emotional maltreatment had higher than normal morning cortisol levels. These results may be due to the body reacting differently to different stressors. Abnormal cortisol levels can have many negative effects. Lower cortisol levels can lead to decreased energy resources, which could affect learning and socialisation; externalising disorders; and increased

vulnerability to autoimmune disorders (Bruce et al., 2009). Higher cortisol levels could harm cognitive processes, subdue immune and inflammatory reactions, or heighten the risk for affective disorders.

Other: Children who experienced severe neglect early in life while in institutional settings often have decreased electrical activity in their brains, decreased brain metabolism, and poorer connections between areas of the brain that are key to integrating complex information (National Scientific Council on the Developing Child, 2012). These children also may continue to have abnormal patterns of adrenaline activity years after being adopted from institutional settings. Additionally, malnutrition, a form of neglect, can impair both brain development (e.g., slowing the growth of neurons, axons, and synapses) and function (e.g., neurotransmitter syntheses, the maintenance of brain tissue)(Prado & Dewey, 2012).

We also know that some cases of physical abuse can cause immediate direct structural damage to a child's brain. For example, according to the National Centre on Shaken Baby Syndrome (n.d), shaking a child can destroy brain tissue and tear blood vessels. In the short-term, this can lead to seizures, loss of consciousness, or even death. In the long-term, shaking can damage the fragile brain so that a child develops a range of sensory impairments, as well as cognitive, learning, and behavioural disabilities. Other types of head injuries caused by physical abuse can have similar effects.

View

First impression of violence [14 min 43 sec]

Watch this video to understand the impact of child maltreatment on brain development. Please note that the clip contains themes and images that may be distressing to some. Please feel free to stop watching the video if you are distressed.

A transcript and Closed Captions are also available within the video.

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3.3 EFFECTS OF CHILDHOOD TRAUMA ON BEHAVIOURAL, SOCIAL AND EMOTIONAL FUNCTIONING

The changes in brain structure and chemical activity caused by childhood trauma can have a wide variety of effects on children's behavioural, social, and emotional functioning.

PERSISTENT FEAR RESPONSE

Chronic stress or repeated trauma can result in a number of biological reactions, including a persistent fear state (National Scientific Council on the Developing Child, 2010). Chronic activation of the neuronal pathways involved in the fear response can create permanent memories that shape the child's perception of and response to the environment. While this adaptation may be necessary for survival in a hostile world, it can become a way of life that is difficult to change, even if the environment improves.

Children with a persistent fear response may lose their ability to differentiate between danger and safety, and they may identify a threat in a non-threatening situation (National Scientific Council on the Developing Child, 2010). For example, a child who has been maltreated may associate the fear caused by a specific person or place with similar people or places that pose no threat. This generalised fear response may be the foundation of future anxiety disorders, such as Post Traumatic Stress Disorder (PTSD)(National Scientific Council on the Developing Child, 2010).

HYPERAROUSAL

When children are exposed to chronic, traumatic stress, their brains sensitise the pathways for the fear response and create memories that automatically trigger that response without conscious thought. This is called hyperarousal. These children may be highly sensitive to nonverbal cues, such as eye contact or a touch on the arm, and they may be more likely to misinterpret them (National Scientific Council on the Developing Child, 2010). Consumed with a need to monitor nonverbal cues for threats, their brains are less able to interpret and respond to verbal cues, even when they are in an environment typically considered non-threatening, like a classroom. While these children are often labelled as learning disabled, the reality is that their brains have developed so that they are constantly on alert and are unable to achieve the relative calm necessary for learning (Child Trauma Academy, n.d.).

INCREASED INTERNALISING SYMPTOMS

Childhood trauma can lead to structural and chemical changes in the areas of the brain involved in emotion and stress regulation (National Scientific Council on the Developing Child, 2010). For

example, childhood trauma can affect connectivity between the amygdala and hippocampus, which can then initiate the development of anxiety and depression by late adolescence (Herringa et al., 2013). Additionally, early emotional abuse or severe deprivation may permanently alter the brain's ability to use serotonin, a neurotransmitter that helps produce feelings of wellbeing and emotional stability (Healy, 2004).

DIMINISHED EXECUTIVE FUNCTIONING

Executive functioning generally includes three components: working memory (being able to keep and use information over a short period of time), inhibitory control (filtering thoughts and impulses), and cognitive or mental flexibility (adjusting to changed demands, priorities, or perspectives) (National Scientific Council on the Developing Child, 2011). The structural and neurochemical damage caused by maltreatment can create deficits in all areas of executive functioning, even at an early age (Hostinar, Stellern, Schaefer, Carlson, & Gunnar, 2012; National Scientific Council on the Developing Child, 2011). Executive functioning skills help people achieve academic and career success, bolster social interactions, and assist in everyday activities. The brain alterations caused by a toxic stress response can result in lower academic achievement, intellectual impairment, decreased IQ, and weakened ability to maintain attention (Wilson, 2011).

DELAYED DEVELOPMENTAL MILESTONES

Although neglect often is thought of as a failure to meet a child's physical needs for food, shelter, and safety, neglect also can be a failure to meet a child's cognitive, emotional, or social needs. For children to master developmental tasks in these areas, they need opportunities and encouragement from their caregivers. If this stimulation is lacking during children's early years, the weak neuronal pathways that developed in expectation of these experiences may wither and die, and the children may not achieve the usual developmental milestones. For example, babies need to experience face-to-face baby talk and hear countless repetitions of sounds in order to build the brain circuitry that will enable them to start making sounds and eventually say words. If babies' sounds are ignored repeatedly when they begin to babble at around six months, their language may be delayed. In fact, neglected children often do not show the rapid growth that normally occurs in language development at 18–24 months (Scannapieco, 2008). These types of delays may extend to all types of normal development for neglected children, including their cognitive-behavioural, socio-emotional, and physical development (Scannapieco, 2008).

WEAKENED RESPONSE TO POSITIVE FEEDBACK

Man in black zip up hoodie by CottonBro licensed under CC0.

Children who have experienced trauma may be less responsive to positive stimuli than non-maltreated children. A study of young adults who had been maltreated found that they rated monetary rewards less positively than their peers and demonstrated a weaker response to reward cues in the basal ganglia areas of the brain responsible for reward processing (Dillon et al., 2009).

COMPLICATED SOCIAL INTERACTIONS

Toxic stress can alter brain development in ways that make interaction with others more difficult. Children or youth with toxic stress may find it more challenging to navigate social situations and adapt to changing social contexts (Hanson et al., 2010). They may perceive threats in safe situations more frequently and react accordingly, and they may have more difficulty interacting with others (National Scientific Council on the Developing Child, 2010b). For example, a maltreated child may misinterpret a peer's neutral facial expression as anger, which may cause the maltreated child to become aggressive or overly defensive toward the peer.

View

Repair of early trauma [11 min 17 sec]

Watch this video from Beacon House – a child trauma service from the United Kingdom – on how trauma affects the brain. Please note that the clip contains themes and images that may be distressing to some. Please feel free to stop watching the video if you are distressed.

A transcript and Closed Captions are also available within the video.

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3.4 EFFECTS OF CHILDHOOD TRAUMA ON ACADEMIC ACHIEVEMENT

The capacity of traumatised children and young people to learn is significantly compromised. Their neurobiology is stressed. Their relationships can feel unstable. Their emotional state is in flux. They find it difficult to stay calm or regain a state of calm if they feel distressed or perturbed. Change is perceived as dangerous. Their memory is under pressure. They are disconnected from themselves and time. Their behaviour rules them. New experiences and new information carry with them elements of threat and uncertainty.

Children and young people who have experienced toxic levels of stress and trauma find the demands of the school environment extremely challenging to navigate and benefit from. This is due to a range of factors. Firstly, toxic stress causes memory systems to degrade and fail. The more complex formed systems of memory are dissolved first. Without memory resources, learning is exceptionally difficult to consolidate.

Secondly, instead of following the natural rhythm which sees stress hormone level peaking in the morning and gradually wearing down during the afternoon and early evening, stress hormones in traumatised children can stay high constantly through the day. This contributes to limited attention span and difficulties with concentration. It also means that these children may experience eating and sleeping difficulties, which further impact on their capacity to engage positively with learning opportunities.

Thirdly, if trauma or stress occurs during the periods of time when the left hemisphere is more dominant in its maturation, then children and young people will experience difficulties with being able to process language, possibly leading to delays in language acquisition and comprehension. They are also more likely to experience difficulties with executing logic and sequencing tasks. They will therefore find maths and problem-solving tasks particularly testing. They will find narrative based techniques complex and at times indecipherable. At sport, they will struggle to read the play and flow of a game. They will need additional support to meet these challenges.

Finally, traumatised children and young people find the constant interaction with others at school a source of ongoing stress. School environments are semi-structured. They allow for change without the need for preparation. In these contexts, traumatised children and young people spend their energy just surviving. There is little room left for much else. Through adopting trauma informed approaches that are sensitive and predictable in their implementation, schools can open up a space for traumatised children and young people to learn.

THINKING FUNCTIONALLY – REGULATION COPING

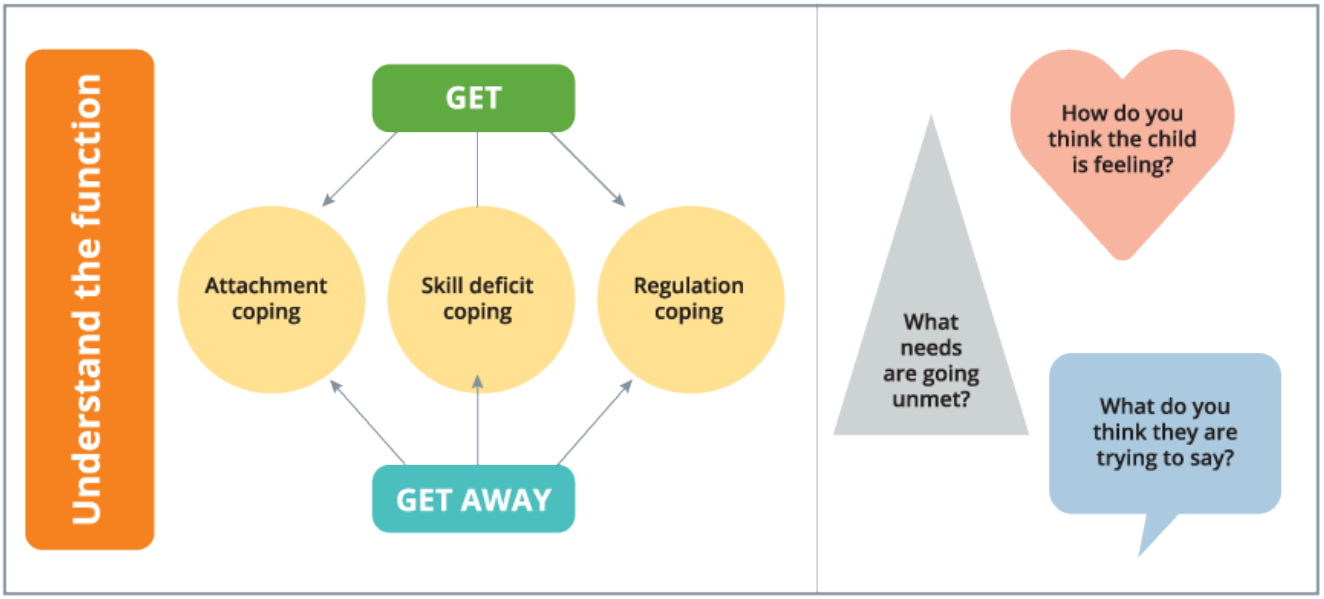


Figure 3.4: Under the function by Govind Krishnamoorthy and Kay Ayre licensed underCC BY-SA.

Children who are dysregulated and hyper-aroused cope by 'getting' access to sensorially soothing stimuli or objects or people who help them calm down. These children may also 'get away from' distressing sensory stimuli within the class (e.g., noise, sound, yelling voices) from people who maybe making them feel angry or anxious e.g., peers or adults or they may be trying to get away from school work that makes them feel anxious or bad about themselves because it is too hard.

Hypoaroused students- underaroused students may misbehave in an effort to cope by 'getting' access to sensory stimulating objects (e.g. prohibited items), experiences (e.g., running out of school) environments (shopping centre, oval) or people (e.g. antisocial peers). These students may also 'get away from' objects, experiences or people they find boring or underarousing e.g., boring school work, teachers, curricula activities they are not interested in.

3.5 THE WINDOW OF TOLERANCE

Every individual has what is known as a 'window of tolerance'. This means that there is a state of physical and emotional arousal that is tolerable and bearable, and when a child is within his or her window of tolerance, she or he can think, learn, love and relax. Most people can identify times when they have been outside the boundaries of their window of tolerance. At these times thinking or behaviour has become disrupted by intensified emotional and physiological arousal. Behaviours during these times are not normally chosen, and a lack of flexibility in responses is common. Either excessive rigidity or chaos are typical during these dysregulated episodes.

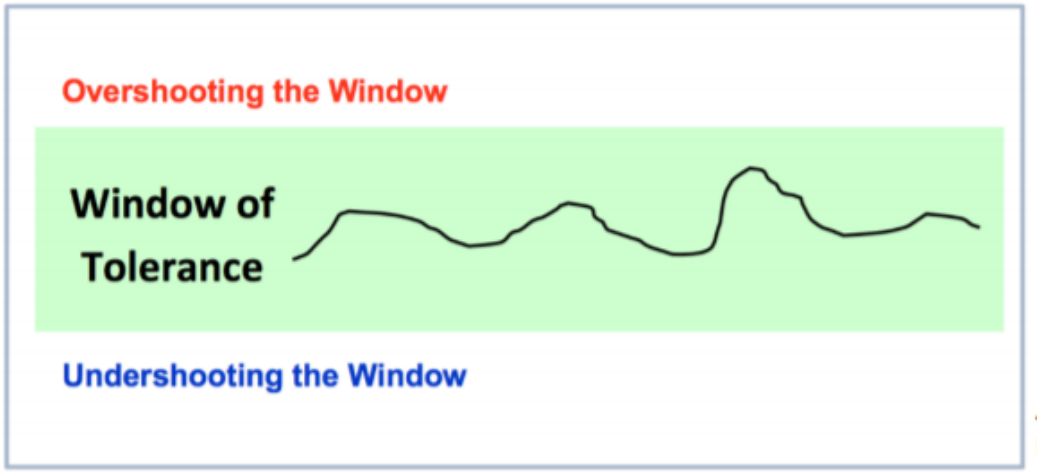


Figure 3.5: Reproduced with permission from the Australian Childhood Foundation (2016).

For traumatised children, small 'every day' things (like a parental request to brush their teeth, or a change of one classroom to the next) spirals them out of their window of tolerance. Traumatised children then swing into being hyper-aroused (overly aroused) or hypo-aroused (under aroused). You can expect traumatised children to be over or under aroused for most of the time and, in either state, their behaviour is out of their hands; they simply cannot control it no matter how hard they try. Their brain is not wired correctly and they do not have the ability to switch off behaviour. They are in automatic survival mode and they cannot think, reason or rationalise when feeling under threat.

OVERSHOOTING THE WINDOW: HYPERAROUSAL

Many traumatised young people have difficulty finding stillness. You might have noticed their darting eyes and a tendency to fiddle with something in their hands or how easily they startle. You might even notice yourself feeling a little stirred up or ill at ease when around them. You notice this because their

internal system that is primed to act to protect itself is communicating with your nervous system. These young people are likely to engage in actions such as fight or flight in the face of threat. We can expect them to move toward or away when they feel unsafe. These protective actions are deeply ingrained in the most primitive part of their brains and they have likely been used successfully in the past by the young person to help keep themselves safe.

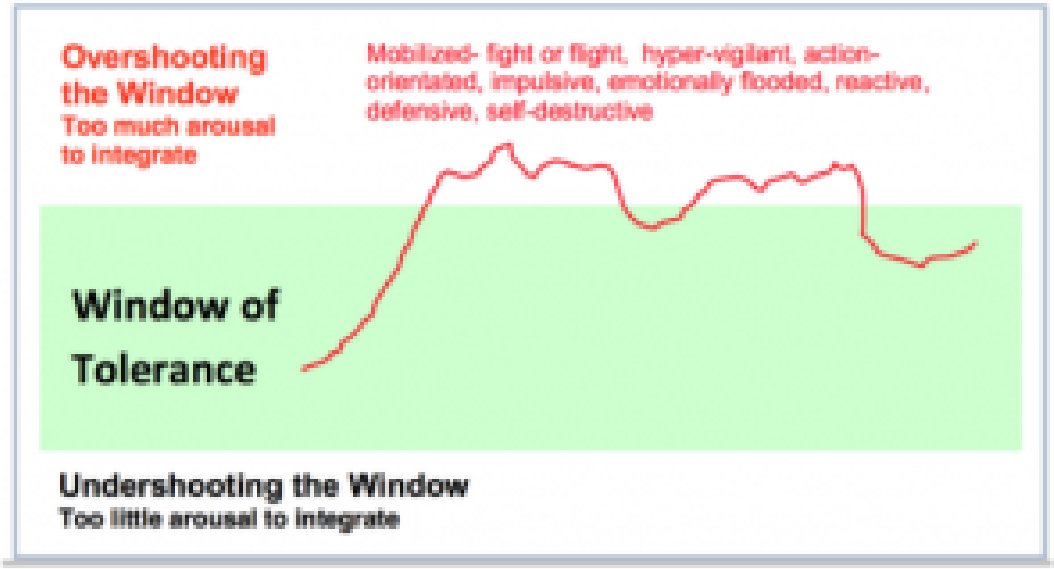


Figure 3.6: Reproduced with permission from the Australian Childhood Foundation (2016).

Children who are overly-aroused are in fight/flight. They run, hit, scream, shout, bite, spit, say hurtful words, avoid, squirm and disrupt. The brain says, "I'm in danger" and their body responds. Some physical cues suggesting too much arousal and an overshooting of the window of tolerance include:

- dilated pupils (to let light in to see better)
- lack of saliva making the mouth dry
- shallow breathing
- butterflies in the stomach
- faster heart beat
- excessive sweating
- tensed muscles (readied for action)
- agitated movement
- difficulty finding stillness.

Read

Case example – Gary

The bell sounds ending lunchtime. The teacher rushes towards her year nine class having missed lunch to handle a yard duty incident. Distracted and rushed she moves into the classroom and the students flow in behind her. As she sorts out her teaching materials two students begin throwing around a cap that one student has forgotten to remove after lunch. The teacher raises her head to spy her student Gary moving around the room trying to get his cap back. The teacher recognises the cap as Gary's because he is always wearing it in the yard. She sighs to herself as she recognises Gary as a student that is frequently unsettled and unproductive in her classroom. The class has barely begun, and he is already in the middle of the disruption she thinks to herself. The teacher moves forward and says firmly "I'll have that cap" and picks it up off the floor before Gary can dive for it. She announces that she will be keeping it until the end of the class as he is not supposed to have his cap in the classroom anyway. Gary squeals "that isn't fair". His chest puffs up and his eyes look wildly at her. His left fist tightens and the veins in his reddened neck become prominent. His face shows he is mad and his body seethes with anger as his arm and shoulder muscles tense. Without consciously thinking the teacher takes a step back from him. He yells at her, "I hate this f###ing school". She replies, frustration tightening in her body "Gary that is not appropriate language". Gary lunges towards his cap in the teacher's hand. The teacher drops the cap with a sudden surge of fear. Gary scrapes it up from the floor and takes off out of the classroom.

UNDERSHOOTING THE WINDOW: HYPOAROUSUAL

Some traumatised young people have endured extremely high levels of trauma. These young people might describe feeling empty and hollow at times of high stress. They might lack a sense of themselves at these times and describe not feeling anything in their body. At these times, they are moving into a state of protection that involves shutting down their system to protect themselves. These young people will not seek interaction with others and instead will retreat into themselves to endure the moment through a fortification of withdrawal.

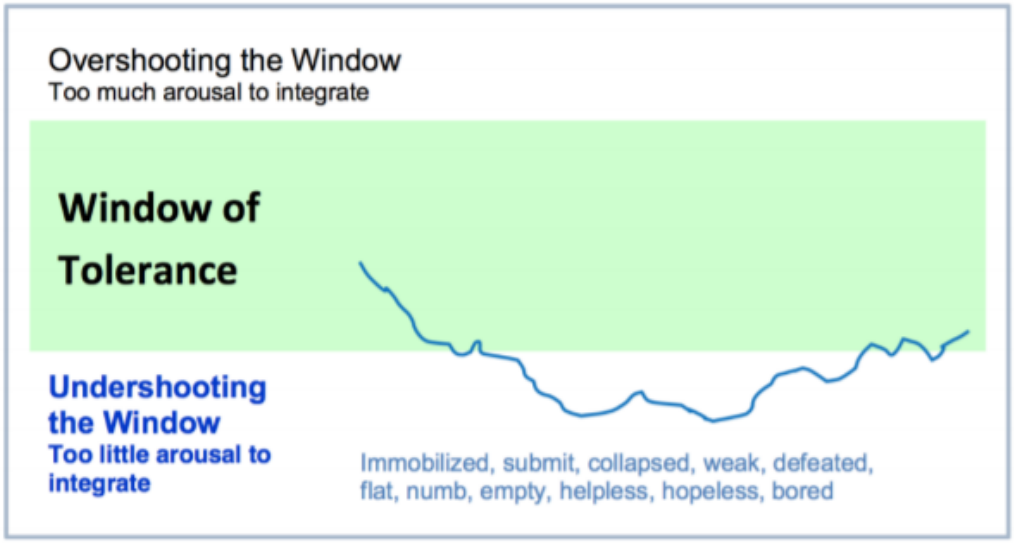


Figure 3.7: Reproduced with permission from the Australian Childhood Foundation (2016).

Under-aroused children experience 'system shut down'. They go numb, dead inside, feel nothing, zone out, feel empty, cannot connect and cannot think. They are like an empty shell. In both over and under arousal the child's heart rate is going as fast as a soldier's in battle. Their appetite is reduced, their tummy hurts, they are in a sweat, they shake, and they are hyper-vigilant to every tiny little detail in their environment. Some physical cues suggesting too little arousal and an undershooting of the window of tolerance include:

- slumped posture
- collapsed body
- endless stare with pin like pupils
- loose muscles
- slowed heart rate
- blank face

It can be helpful to remember that at the core of a trauma experience – is a loss of control. If children could stop their abuse, then they would. Traumatised children become experts at regaining the very control that they lost. Controlling behaviours often cause big challenges for adults. While the child does not know it, they are so often trying to resolve their primal feeling of being helpless in a punishing world.

Black and white child by Brother's photo licensed under CC0.

Read

Case example – Miranda

A teacher pauses as he goes to write Miranda's "Health and Human Development" semester report. For most students reports flowed easily for him but with the lack of submitted work and a large amount of absences he noticed next to Miranda's name in his attendance book he found himself struggling to find words for her. When he thought about her, the picture in his mind was of a shrunken, head lowered young person, hunched down in her chair at the back of the classroom. He found her really hard to read and he realised he had never seen her really smile like other kids. He recalled a difficult moment that occurred some time ago when he called upon her to answer a question after showing a sex education video to the class and how response-less she had been, just vacantly sitting there, face blank and slumped down in her chair. He had quickly called upon another student as he had felt a sense of disconnect and awkwardness. He felt a bit exasperated when he thought about her and didn't know what to do with her, how to engage her, nothing seemed to touch her. From what he understood Miranda was involved quite a bit with the school counsellor and he imagined she had a difficult home life. He wasn't sure about the best way to teach Miranda, but he knew something needed to change as presently not much was getting through to her.

Operating within the window of tolerance

When within their window of tolerance, a young person's physiological system is not stretched. They won't feel signs of fight, flight, freeze or collapse as their systems sense that they are safe. In their window of tolerance social engagement is available to them. They are better equipped to listen to others around them, interact cooperatively and learn. Some cues suggesting young people are in their window of tolerance:

- Body feels calm, settled, neutral
- Able to be socially orientated with those around them
- Able to be reflective
- Able think clearly
- Able to set boundaries
- Able to self-regulate
- Able to be mindful

Recognising those that overshoot and undershoot the window of tolerance in the classroom

Effective educational programs work to keep everyone within the window of tolerance optimal arousal zone. It is often easier to recognise those young people in the classroom who overshoot their window of tolerance compared with those who undershoot. These are likely to be the students who show their stress by moving towards or away from you. This movement is highly visible as we are biologically primed as social beings to notice others threatened movements to then gauge our own safety. For overshooting students looking to find safety, this involves an active re-negotiation of relationships, while for those who undershoot their window, seeking safety often involves slipping away from others in a passive attempt to find invisibility for a time. These students do not demand a response from others. In fact, they are working hard to be overlooked and with 24 or so other students in the classroom it is easy to not spot them.

3.6 USING THE WINDOW OF TOLERANCE IN THE SCHOOL CONTEXT

Thinking about introducing and implementing the 'window of tolerance' into a school context could be something to consider as a broader teaching group. Some questions to think about:

- Where and by whom would it be best introduced? E.g., in Homeroom or English or Math or to year level group gatherings?
- What are some ways it could be consistently supported across teaching contexts and classrooms?
- What are some ways it could be consistently supported and utilised by coordinators and principals? What are some ways students could be involved in its introduction and implementation?

STAYING IN THE WINDOW OF TOLERANCE

Introduce the window of tolerance model to your students. Talk about examples of when someone might overshoot or undershoot the window paying attention to what that might feel like in the body and normalising that exceeding the window happens for us all at times.

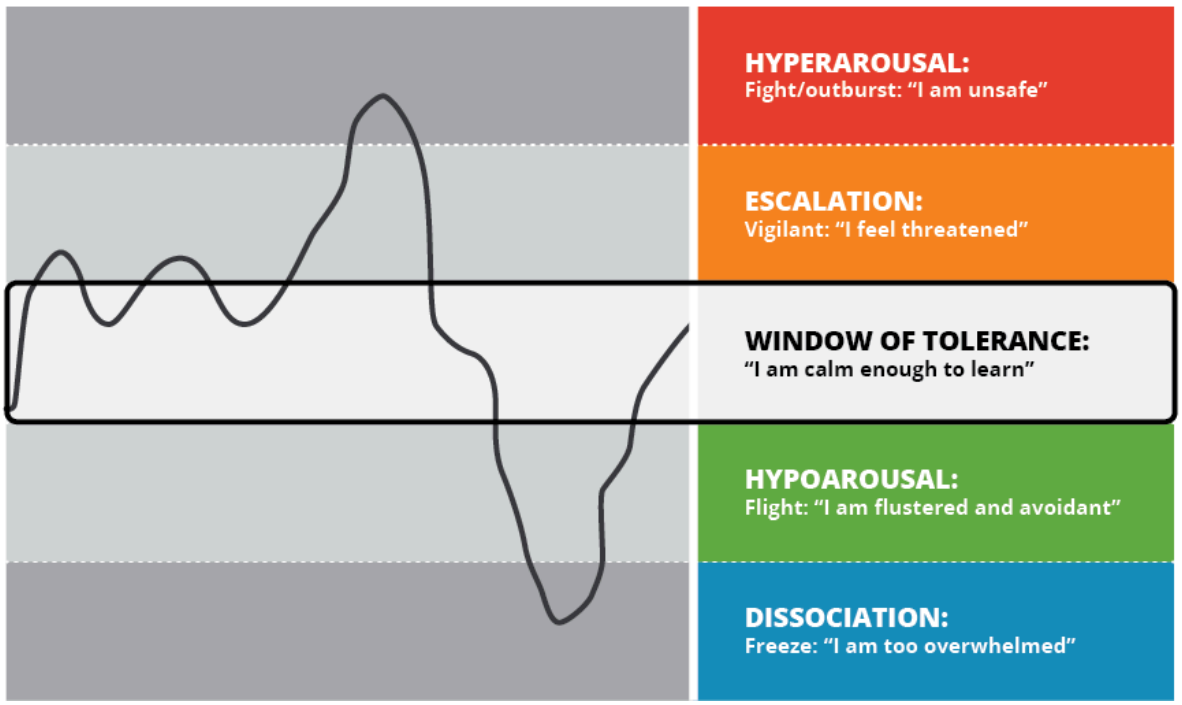


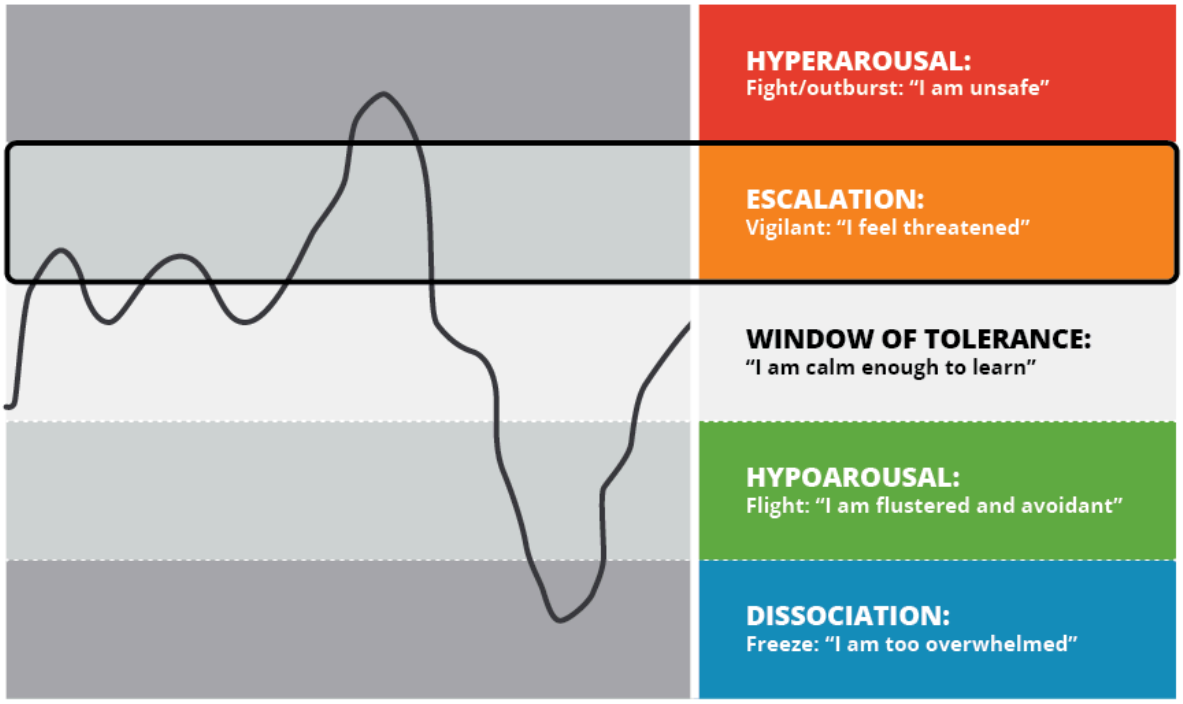
Figure 3.8: Created by Govind Krishnamoorthy and Kay Ayre licensed under CC BY-SA.

- Represent the window of tolerance concept in a concrete way. For example, it might be drawn on the white board or each student might have an A4 laminated version of the window at their desks.
- Institute window 'check ins' throughout class time to gauge views about where the group is at in terms of the window.
- Acknowledge contextual events that may be influencing where everyone is at with regard to their window e.g., approaching exams or social function.
- Model reflecting upon where you are in relation to your window of tolerance. You don't need to detail underlying reasons.

MANAGING ESCALATION (ORANGE ZONE): WORKING WITH YOUNG PEOPLE WHO ARE FREQUENTLY OUTSIDE OF THEIR WINDOW OF TOLERANCE

As a first step in working with young people who frequently find themselves outside of their window of tolerance we should acknowledge the important role their protective response/s have played for them in the past. It is wonderful that when they really needed it their brain and body found a way to survive. We also need to help young people hold on to a sense of safety in their daily life as much as possible. It is only when they don't sense safety that they will need their protective responses. With this in mind you might like to consider the following questions with the young person in a time of calmness:

- Where is the safest place for you at school?
- Where is the safest place for you in the world?
- Is there any way we can help you bring some of that place with you to school?
- Are there people at school that help you feel safe and okay? If so, who?
- Is there anyone you wish you could bring with you to school to help feel okay? (might be from family or a friend or might be a music or sport hero etc.) How might we help you bring something of this person with you to school?



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The responses to these questions could contribute to a plan built with the young person to help them more readily hold on to a sense of safety in their every day. The more a young person feels safe at school the less likely it is they will exceed their window of tolerance. Some other ideas for working with young people outside of their window of tolerance:

- Learn more about the body signs of increasing stress for the young person and for yourself.
- Offer students opportunities that will increase their sense of control and power.
- Recalibrate your expectations for young person's advancement- it may be that they aren't able to grasp all of the course material and the focus may need to be a social/regulatory one for a time.

MANAGING HYPERAROUSAL (RED ZONE): WORKING WITH YOUNG PEOPLE WHO OVERSHOOT THEIR WINDOW OF TOLERANCE

Children and young people who overshoot their window of tolerance have highly primed nervous systems ready for action. Their systems require calming through activity that allows them to slow down. We need to aim to help these young people find regulating movement. Some ideas for use with these students in the classroom include:

- Intersperse directed group activity breaks- e.g., yawn and stretch breaks, everyone walk once around the room without lifting your feet off the floor or like there is no gravity in the room, initiate Mexican waves, stand up turn around and sit down again.
- Incorporate more kinaesthetic learning opportunities.
- Plan movement breaks with young person- e.g., walk around the oval or opportunity to run an errand or to be able to connect with safest place in school (wherever that is for the young

person).

- Plan and practice an escape route with the young person should they need it.
- Work with colleagues and young person to create a plan for if they become activated and practice it.

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 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.

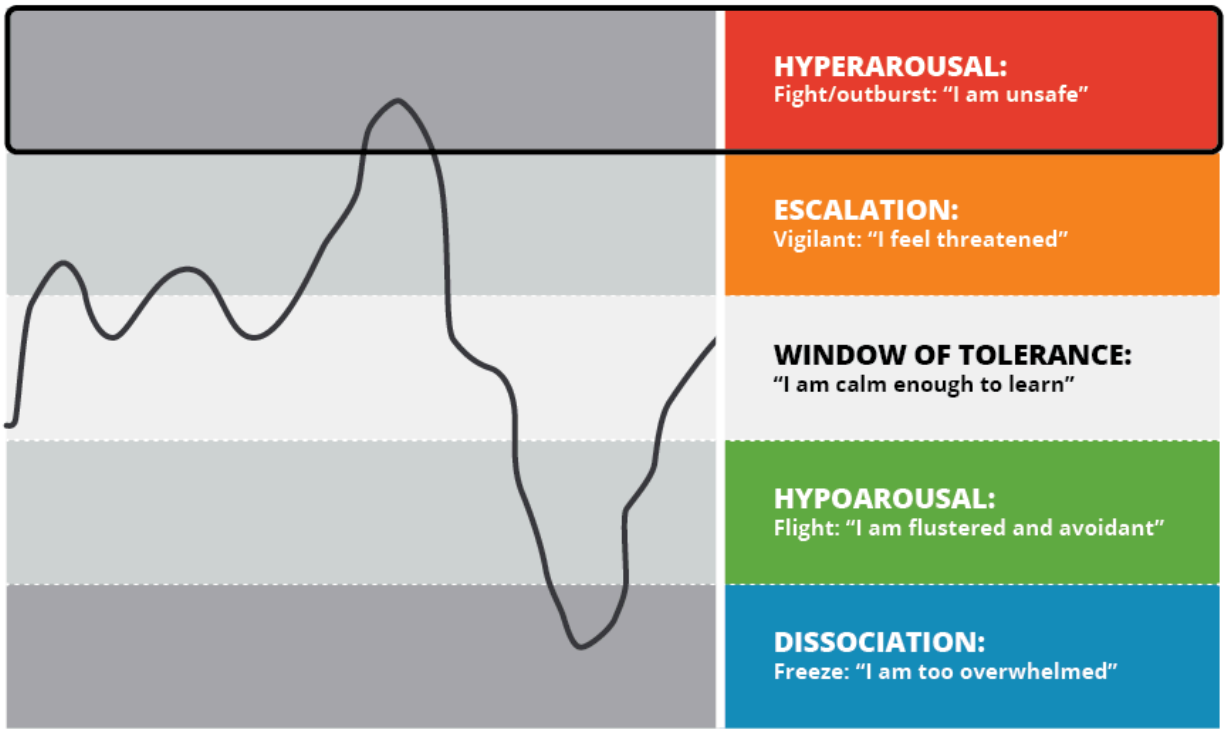


Figure 3.10 Created by Govind Krishnamoorthy and Kay Ayre licensed under CC BY-SA.

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, service or organisation you are working in.

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 or 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.

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 be 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.

MANAGING HYPOAROUSAL (GREEN ZONE): WORKING WITH YOUNG PEOPLE WHO UNDERSHOOT THEIR WINDOW OF TOLERANCE

Young people who undershoot their window of tolerance have nervous systems that can begin to shut down when they lose a sense of safety. These are the students that can become disconnected from themselves and the classroom and require gentle engagement to re-enter their window of tolerance. Some ideas for use with these students in the classroom include introducing short, sharp activities that bring young people into the present moment with a focus on what is happening in the here and now. Some examples include:

- Everyone point to something that's green.
- Tap your head and rub your belly at the same time, then swap.
- Find out what colour eyes the person next to you has.
- Push your big toes into the bottom of your shoes.
- Sensory stimulation.
- Everyone say three objects you can see, two things you can hear, and one thing you can smell.
- Incorporate kinaesthetic learning opportunities that have a sensory element to them i.e. activities that stimulate many of the senses.
- Create a space in the room for a sensory break e.g., cushion corner with textured cushions and calming posters and play calming music etc.

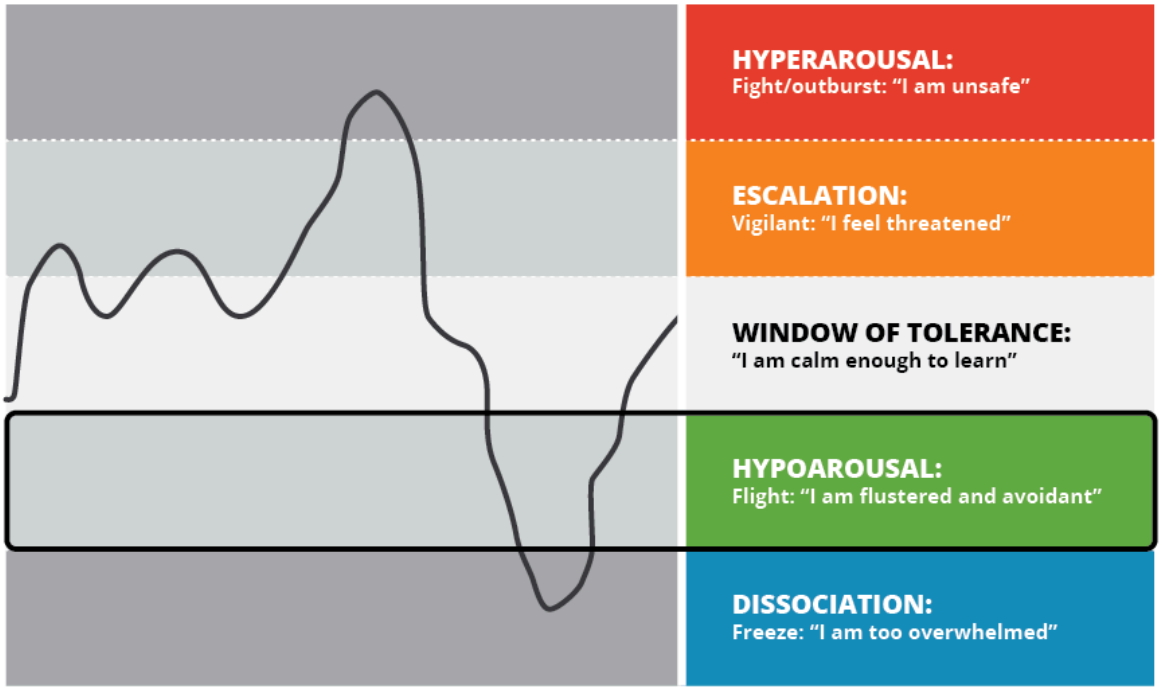


Figure 3.11: Created by Govind Krishnamoorthy and Kay Ayre licensed under CC BY-SA.

The window of tolerance is a model we could all apply to our lives. It may be a handy guide to help us better understand the shifting states of the young people we work with, as well as an opportunity to be more reflective about our own windows. It can help us better understand how available our students are to learn at any given time and it can provide us some direction around what a young person might need to re-establish themselves safely within their window of tolerance.

MANAGING DISSOCIATION (BLUE ZONE): WORKING WITH YOUNG PEOPLE WHO SEVERELY UNDERSHOOT THEIR WINDOW OF TOLERANCE

We all use dissociative responses in our everyday lives. Consider any time you focus on one particular task – this means you may not hear someone else speak or not engage in thinking about other topics. Children in particular use dissociation to facilitate their learning.

Abuse related trauma is caused by threatening and overwhelming experiences to children. As children develop, the experiences of trauma induce an avoidant response which becomes a template for engaging with their whole world. The brains of traumatised children move from adaptive survival responses to a generalised protective and defensive state. For children, it is more efficient to operate in this way. Trauma based dissociation stems from a child's forced absorption with the overwhelming experience of violence and threat. The child is primarily focused on avoiding the pain, shame and hurt of the abuse and comes to develop unconscious, or sub-cortical, responses to try to achieve this. In this abuse related context, dissociation can be seen as the spectrum of strategies, both conscious but particularly sub-conscious, used to not know something.

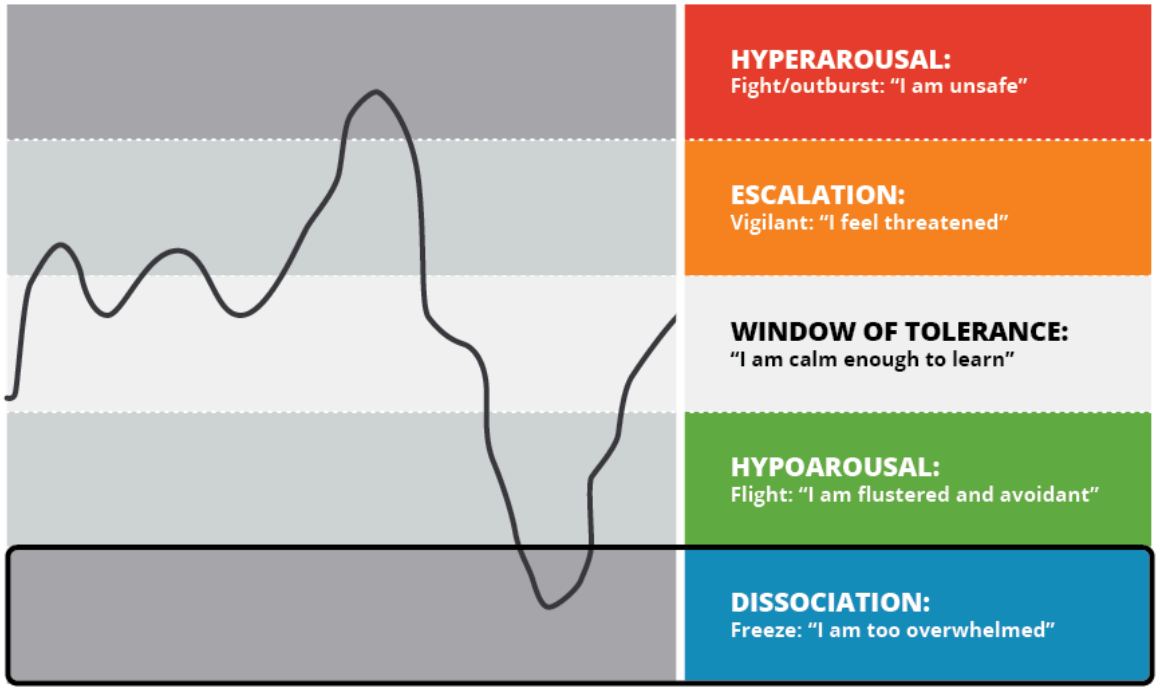
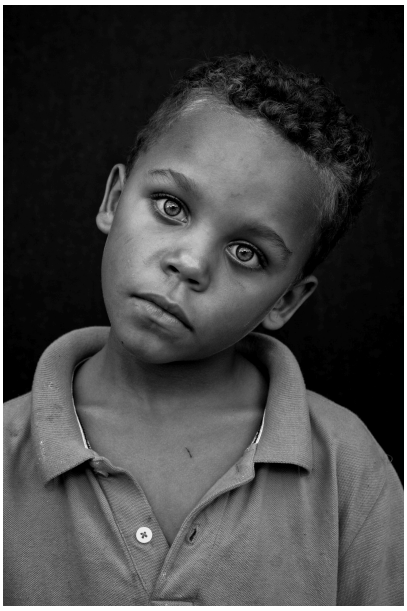


Figure 3.12: Created by Govind Krishnamoorthy and Kay Ayre licensed under CC BY-SA.

Dissociative responses stem from the contradictions inherent in the desire to distance the abusive actions with the drive to connect with those who are supposed to care for and respond to the child's needs. Because these actions are enabled in the lower subcortical or subconscious areas of the brain, children lack the capacity to evaluate and consequently regulate their responses. Children's responses can be difficult to notice because they are often internalised. The critical point for professional reflection is that these behaviours may impair the child's capacity to engage with their world. The following list gives an initial understanding of these manifestations. It is by no means exhaustive.

- Fluctuating attention ranging from minor 'vague outs' to trance states or blackouts. You might say something to yourself like, "This child is not even listening to me" or "I really don't think this child is understanding what I'm saying".
- Fluctuating moods and behaviour which might have you saying, "This behaviour is like it's from another child!"
- The child talks about alternate selves or imaginary friends who are controlling their behaviour. You might reflect that, "I have never heard an imaginary friend described like that before".
- Depersonalisation or feeling disconnected from self. You might have an experience where the child doesn't recognise themselves in the class photo.

- Derealisation or feeling disconnected from the world. You may not even notice this occurrence but the child might talk about or experience the world as being "foggy" or "like I'm in a movie".
- Withdrawing from all external stimuli or communication. There may be a description of this child as, 'completely shut down'.
- No response to questions or answers them in an unclear and unfocused way. Again you may think "That child is just not listening to me."
- Gazing into the distance. Your reflection may be that, "this is just not a child who is thinking about their weekend plans".
- Intrusive thoughts and feelings, including flashbacks. You may notice, "that child really is uncomfortable when I ask the class to close their eyes".



Boy in polo shirt licensed under CC0.

- Numbness- both physical and emotional. You may note to yourself, "this child doesn't seem to respond when I touch them".
- Self-injury. You are more likely to notice this or be informed of concerns for the child by their friends.
- Excessively compliant behaviour. This can be the most difficult because you are most likely to think, "this child is so good- they seem to be dealing with their experiences really well".

You, as the teacher in the classroom or in the school yard, can help a child who has dissociated to reorient to the class or the school ground. You can also work together with the child to minimise dissociative experiences in the future. Helpful responses when a child dissociates include:

- Reassuring the child that they are safe (remember dissociative behaviours stem from fear, rage, shame, helplessness, loss, confusion, and other difficult feelings; not wilful manipulation or laziness).
- Responding empathically (e.g., "You look scared, I'm sorry the siren scared you").
- Suspending confrontation until a child is more present.
- Allowing the child to quietly go to a 'designated safe space' within the classroom (e.g., reading corner or a spare table).
- Accepting the child's feelings even if they do not make sense to you by letting the child know that all his feelings are accepted by you (even if you don't understand why the child is responding the way he is at a given situation).
- Encouraging the child to utilise more appropriate ways to express difficult feelings (for example, scribble or draw, put feelings into words in a journal, squeeze a squeeze-ball, go for a run in the gym or engage in some other physical activity which safely discharges intense feelings) Avoiding telling or asking for the 'positive part' of the child Allowing the child to visit the counsellor or sit in the principal's office to calm down, and calling the supportive

caregiver.

- Presenting consequences for undesirable behaviour only after the child has calmed down.

Helpful responses for working with a child at a time when the dissociation is not happening and to decreasing the child's need to dissociate include:

- Developing a cue word with the dissociative child that can be used to bring the child back to the present.
- Developing agreed upon hand signals to use in front of the child to warn them that they're drifting off in order to bring them back to the here and now.
- Learning to recognise, and when possible eliminate, the triggers (i.e., unexpected touch, harsh voice) that cause the child to dissociate.
- Letting the child know ahead of time when a trigger is unavoidable (e.g., if leaving the classroom results in aggressive or immature behaviour, it can help to remind the child of an upcoming transition before the class is to leave, and reassure them they are safe).
- Letting the child have a safe-object in their desk to help him 'pull it together' if they are feeling overwhelmed (often times simply knowing the option is available already helps the child feel safer and feeling safer reduces the need to dissociate).
- Limiting surprises.
- Creating a predictable routine.
- Pairing the child with a supportive, caring peer for activities which raise the child's anxiety (e.g., class trip, recess, a trip to the bathroom).
- Playing music the child associates with safely.
- While these responses may seem at first glance as 'coddling' or 'rewarding bad behaviour,' they will help the child reorient to the present situation faster, handle themselves better in the classroom, and accept responsibility for their behaviour.

While these steps may seem time consuming, they need not take much time, in that they can deescalate, rather than escalate, a problem, they may save you time. In addition, they often take even less time as the 'routine' becomes more familiar (to both of you) and the child learns to associate your voice and words with reorienting.

You may worry that such 'coddling' may make it worth it for the child to act out in order to get that special attention. With dissociation, however; these phrases have a different effect—they increase safety and thus help the child not to become overwhelmed and need to dissociate. This will most likely serve to reassure the child that you care, that they are safe with you and can trust you to help them when they feel overwhelmed, agitated, shut down or 'spaced out'.

You may worry that other children in the class will resent the 'special treatment' that the child will be getting. However (and especially if a child is aggressive or explosive), classmates often welcome less drama and a calmer classroom. Moreover, classmates often follow the teacher's modelling of offering support and compassion if the child gets upset.

Classroom intervention cannot and should not take the place of specialised assessment by a professional knowledgeable in the area of trauma and dissociation (and, if needed, trauma treatment

where the child can be helped to deal with the issues that underlie the dissociation). Nonetheless, simple steps can assist both you and the child in feeling more in control, and can help make school experience a safer one for the child.

QUESTIONS FOR CONSIDERATION

Three questions about the student's resources:

- In what situations is the young person most likely to be able to maintain themselves within their window of tolerance and thus utilise social engagement with others and feel safe?
- Are there particular people that the student feels most safe with?
- In what situations are the young person's protective responses most likely to be shown?

Five questions to take into the classroom with you:

- Where is the young person in relation to their window of tolerance?
- How do I know?
- Where am I in relation to my window of tolerance?
- How do I know?
- What do I need right now to maintain myself in my window of tolerance?

Three questions to share with colleagues:

- What are some ways to share knowledge about the window of tolerance framework amongst teachers and students?
- What are some strategies you already use to help students maintain themselves within their windows of tolerance?
- What are some things you do to maintain yourselves within your windows of tolerance?

Reflective questions

1. Name the three ways in which trauma impacts the brain.
2. What are the five zones of the 'window of tolerance' model?
3. How can teachers help student who are dissociative?

Read

Additional reading

Read the following: Tobin, M. (2016).Childhood trauma: Developmental pathways and implications for the classroom. Changing Minds: Discussions in Neuroscience, *Psychology and Education*, *3*, 1-19. Australian Council for Educational Research.

PART IV.

CONNECT AND VALIDATE

Back view photo of woman carrying toddler by Flora Westbrook used under CC0.

Overview and learning objectives

Chapter four focuses on an introduction to the theory of attachment and the significant impact that the types of attachment patterns have on the traumatised child's capacity to learn. Secure and insecure attachment will be explored and within these two broad categories the sub-categories of avoidant, ambivalent and disorganised attachment will be discussed. In addition, Reactive Attachment Disorder as a diagnosable disability will be considered.

On successful completion of this chapter, you should be able to:

- Understand the key concepts of attachment theory
- Describe the different types of attachment patterns
- Explain how attachment, regulation and skills coping impact learning
- Understand the consequences of childhood trauma and attachment disruption
- Apply your knowledge to two case study scenarios – Max and Sam

INTRODUCTION

In chapter two you were introduced to positive behaviour support and thinking functionally about challenging student behaviour. To understand challenging behaviour as the result of trauma, an understanding of attachment and the implications of disorganised attachment on learning and the child's ability to function is essential.

4.1 ATTACHMENT

Read

True story

The Senior Guidance Officer knocked on the door of the Intervention Centre. With her was a small boy, Max, who was younger than the stipulated age range of 10 – 15 years. This was a 'regional' case so Max's age was irrelevant. He was eight years old. The information offered at this point in time was "You do not need to know the details of what this little boy has suffered. Just start with helping him learn how to be at school and not to hit and punch people."

Welcomed into the classroom, Max was guided by the Intervention Centre teacher and encouraged to choose any activity he wished. Hesitant, silent and avoiding eye contact at all costs, he gathered the big pillows from near the book display, dragged them to the large table in the front corner of the room beside the door, climbed under the large table and used the pillows to barricade himself in. And there he stayed until home time.

This day was the beginning of a four-year relationship. A relationship that saw heartache, tears and joy. A relationship that made a positive difference to the life of this small boy who had experienced complex trauma, the nature of which no child should ever have to endure.

ATTACHMENT

"A key adult can really make the difference" (Bomber, 2009, p. 58).

What is attachment? Human beings need connections. They need to feel safe and secure. We explore our worlds connected to and immersed in the experiences of others who are the important people in our lives. Donald Winnicott (1964) said "There is no such thing as a baby; there is a baby and someone". Babies are social little beings that need to live connected with the other people in their world. This need is one of instinct and it is instrumental in their survival. Whatever happens in their environment and the experiences that they have within it, becomes the content of their brain. If we think of the baby's brain as a blank book, everything they experience is written into the pages and informs what happens next. The relationship with the parent or carer is the author of the book and literally determines the structure and the functioning of

the baby's brain. Over the years as the baby grows, the experiences they have fill the chapters of the brain and shape the person they will become both socially and mentally.

Feeling safe allows infants and children to explore with confidence, demonstrate flexibility and take risks knowing they are supported and cared for. The role of the parent or caregiver in meeting the needs of the infant and nurturing positive relational interactions, is critical to the development of secure attachment. The primary attachment figure is the adult to whom the infant turns in times of crisis when they need comfort, security and protection. But what if the attachment figure is the person who is hurtful, abusive and frightening? What if when a baby cries, they are not picked up, held tenderly and reassured that they are loved, and everything will be alright? What then? When a parent or carer comforts their crying baby with consistent and caring behaviour, their actions are the beginnings of teaching the baby how to self-regulate. If the caregiver is unable to consistently respond, secure attachment is difficult to form, and this has a detrimental effect upon social emotional development.

Active adolescent and affectionate child licensed under CC0.

As we know, early childhood, especially the first three years, is the time when the brain absorbs information at a rapid rate. The contents of the brain are constantly making connections perpetuating learning and exploration that is switched on by the richness and predictability of the parent/carer relationship. The attachment the child feels is governed by their experience of being safe and having their needs met. It is within this relationship that the child makes sense of the world and their place in it (Perry, 2009). It is here that they build a sense of self-worth, trust in others, the capacity to manage emotions and solve problems. When the relationship is one of fear and abuse, the traumatised child will most commonly develop poor self-worth, thoughts of shame and being unlovable (Tobin, 2016).

Research has found that before children have developed what is called explicit memory that is memories of events that are factual, logical and language based, they remember what happens to them through implicit memory. Implicit memory is memory without words that is imprinted on the brain through the intense feelings experienced through for example sight, smell and sound. So, a baby, will from the earliest stage of development, remember and respond to the memory without having the words – they feel it (de Thierry, 2015). Attachments that are secure, wrap the child in a protective layer that provides a safe space where capacity can be built, and hopeful futures can flourish.

ATTACHMENT THEORY

John Bowlby (1958) is the founder of attachment theory. Attachment theory attempts to explain attachment and attachment behaviour. Attachment behaviour is the observable action that the person does to be able to be physically close to the attachment figure and remain there. Attachment behaviour is evident throughout our life, and to know there is a significant 'attachment' person who will help us in times of need provides us with protection. Attachment develops across the first three years of life (Breidenstine, Bailey, Zeanah, & Larrieu, 2011).

Ainsworth was a colleague of Bowlby's and together they were the first to suggest that a baby or child did know what was happening and felt the effects of having born witness to the loss of a caregiver or a traumatic event. Bowlby conceptualised the notion of a 'secure base' and in 1978 together with her colleagues, Ainsworth investigated this notion of a secure base concluding that the mother is the base from which the infant explores the world. Further, Ainsworth (1979) categorised attachment into secure and insecure and further sub-categorising insecure attachment into resistant, avoidant and disorganised attachment. Together with Bell, the Strange Situation Procedure was developed in 1970.

View

The power of attachment [2 mins 48 sec]

Watch Dr. Edward Tronick's seminal 'still-face experiment,' which is a powerful illustration of child attachment and the impact of abuse and neglect. A transcript and Closed Captions are also available within the video.

Research has categorised attachment into four types:

- Secure
- Insecure avoidant
- Insecure ambivalent
- Disorganised

Secure attachments are protective by nature and insecure attachments serve as risk factors. Children with secure attachment have an equal need for proximity and exploration. It is important to remember that attachment types can change over time and that an attachment type, is not a diagnosis. Following is a brief outline from the child's perspective of each of the attachment types:

- **Secure attachment –** "I feel safe and loved. The adults in my world are nurturing, respond quickly and calmly when I am upset, fill my basic needs, they interact warmly and are joyful about me. I trust them."
- **Avoidant attachment–** "I feel detached. The adults in my world are indifferent about me. They give me very little emotional support, so I rely on myself and ignore other people. I prefer to be on my own."
- **Ambivalent attachment–** "I feel misunderstood. The adults in my world love me one minute and hate me the next. I throw a wobbly to get what I want. I am clingy, demanding and needy."
- **Disorganised attachment –** "I feel frightened all the time. The adults in my world are scary and mean. I live in fear and I worry all the time."

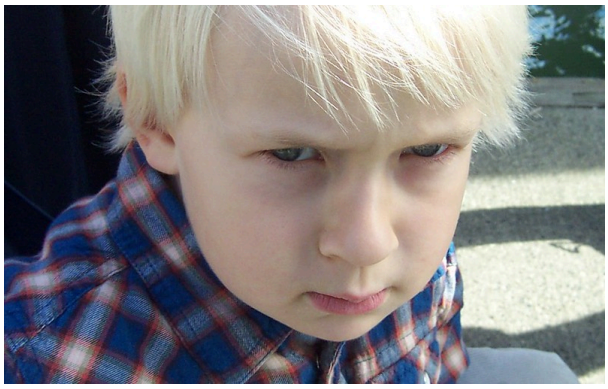
SECURE ATTACHMENT

Girl child by Alteredego licensed under CC0.

The function of secure attachment is safety and protection. In the relationship of secure attachment, the vulnerable child has their emotional and physical needs met and develops a feeling of confidence and calm. The child learns to trust and has an expectation that a caring adult will respond in a loving and caring manner when meeting their needs. Secure attachment allows the child to learn through the demonstration by the caring adult, how to self-regulate their behaviour and therefore as they grow become more able at controlling emotions and impulses (de Thierry, 2015; Howard, 2013; Sorrels, 2015). The secure child has a view that embodies compassion and empathy for others as well as competency and belief that they are loved and valued.

How does the child feel? Happy, safe and supported. They are more cooperative and can adapt more easily to the academic and social demands of school.

AVOIDANT ATTACHMENT



Angry child by Gerry Thomasen licensed under CC-BY.

The child with avoidant attachment avoids building a relationship with the teacher and instead focusses on the task. Contact with people means uncertainty and therefore should be avoided. In infancy, the child's mother has struggled to cope with her own distressful situations and anger and therefore has struggled to adequately meet the baby's emotional needs. Lack of physical contact can lead to the child avoiding being close to others. In class this child often presents as withdrawn and distant.

How does the child feel? Unwanted, fearful, anxious and angry.

For the teacher, Geddes (2006) suggests that the best strategy is to "turn towards the task" (p. 83). The task provides a buffer between the student and the teacher and allows the teacher to be nearer the child without this proximity being overwhelming and triggering a negative response. The task therefore should be the focus of intervention.

AMBIVALENT ATTACHMENT (OR RESISTANT ATTACHMENT)

Child crying for Mama by Oscarwcastillo licensed under CC0.

The child with ambivalent attachment demonstrates behaviours that goes in swings and roundabouts demonstrating opposite behaviours. For example, ambivalence is on the one hand they can be clingy and on the other wanting to be independent. They can also demonstrate aggressive and destructive behaviours (Geddes, 2006). Characteristic of this pattern of attachment is parenting with few boundaries and little control. Children with ambivalent attachment often have poor school attendance and their behaviour is controlled by the fear of not having their needs met.

How does the child feel? Vulnerable, separation anxiety, uncertain.

DISORGANISED ATTACHMENT

Think back to the PBS triangle in the chapter one. Remember the three tiers of intervention – the green, yellow and red zones? While the behaviour of children with trauma associated with the various patterns of attachment can be considered 'red zone' behaviours requiring intensive individualised support, children with disorganised attachment are often easily identified as being in the red zone for their behaviour because their behaviour at school can be described as serious and disruptive. This behaviour is often visible for all to see and more often than not, it is the type of behaviour that results in suspension and exclusion.

Behaviours demonstrated can include aggression and meltdowns as well as complete 'shut down' and withdrawal type behaviours. This highly challenging behaviour may be reflective of a life of chaos and dysfunction. These students demonstrate factors associated with both ambivalent and avoidant attachment patterns (Sorrels, 2015). Possible happenings in this life may have been parents who experienced high levels of stress, substance abuse, mental illness making them unavailable to the child and scary. In some cases, the result for the child may have been to have witnessed or been a victim of abuse (physical, sexual, verbal) and neglect. These children demonstrate behaviour that is fueled by uncertainty and threat and therefore they are in a constant state of hypervigilance.

Little boy hiding by Ambermb used under CC0.

The child with disorganised attachment needs a safe-haven. A space that is safe, secure and predictable. They live with fear, anxiety and helplessness. Every day is about survival. Where in this picture of the traumatised child with disorganised attachment thinking is there any spare space for anything else? Enter the teacher with genuine care and consideration.

How does the child feel? Overwhelmed by fear, anxiety and helplessness. Unlovable and shameful.

Read

Additional reading

Read Ziegler, D. (n.d). Understanding and treating attachment problems in children: What went wrong and how problems can be fixed.

Table 4.1 Types of attachment

Attachment type	Characteristics	Home dynamic
Secure	• Well adjusted • Pleasant • Responds well to appropriate authority • Responds well to appropriate requests • Accepts comfort when hurt or upset • Confident • Curious • Has a drive to master their world • Takes appropriate risks and tries new things • Persistent, able to cope with challenges	• Parents are nurturing • Parents have emotional strength and maturity • Parents respond quickly and warmly to the child's distress and basic needs • Parents find joy in meeting the needs of their child • Parents play and interact with their child
Insecure avoidant	• Self sufficiency beyond the child's years • Uncomfortable with intimacy • Seemingly fearless • Difficulty accepting help or comfort when hurt or upset • May seem withdrawn or emotionally flat, with unexpected meltdowns • May seem persistently angry and blame others for anything that goes wrong • May be sullen and oppositional • May lack empathy • May be aloof, a loner	• Parents may be dismissive of child's needs and emotions • Parents may be overwhelmed by child's needs • Parents may lash out in frustration at the child • Parents often overwhelmed by responsibilities or circumstances, such as mental or physical illness, domestic violence, addiction, poverty or single parenthood • Parents often lack a support system • Parents may provide for child's physical needs but ignore child's need for emotional connection
Insecure ambivalent	• Demanding and clingy • Difficulty to satisfy • Low tolerance for frustration • Uses temper tantrums or crying to manipulate • Fidgety • Compulsive • Poor concentration skills	• Parents respond inconsistently to child's needs – sometimes in loving, nurturing way, sometimes in frustration and anger • Parents often overwhelmed by responsibilities or circumstances, such as mental or physical illness, domestic violence, addiction, poverty or single parenthood • Parents often lack a support system • Parents are intrusive • Parents are not adept at perceiving and reading the child's cues

Disogranised	• Lives in constant state of alarm • Hypervigilant • Misinterprets social cues • Highly reactive to sensory cues in the environment • Displays behaviour that seems bizarre or strange • Prone to meltdowns • May vacillate between a hyperaroused state and a withdrawn state • Unpredictable behaviour	• One or both the parents are abusive • Chronic domestic violence • Parents are profoundly neglectful • Very little interaction or human contact • Parents may be mentally ill and/or addicted to substances • Family may be constantly moving to avoid authorities

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REACTIVE ATTACHMENT DISORDER (RAD)

Another attachment pattern is reactive attachment disorder (RAD). Students with RAD typically have serious aggression problems often hurting others and shows little empathy or remorse. Safety seeking behaviours, anxiety and depression are characteristic of the condition coupled with an inability to be genuinely affectionate with others or to develop strong connections. Students with RAD feel the need to be in control and may demonstrate bossy, argumentative and defiant behaviours. Reactive attachment disorder is a mental health disorder diagnosed according to the criteria in the Diagnostic and Statistical Manual of Mental Disorders: DSM-5 (American Psychiatric Association [APA], 2013). Here it is characterised as a stress-related disorder which can only be caused by a lack of adequate care (social neglect) during childhood. Children with RAD demonstrate withdrawn, internalising type behaviours. RAD is only diagnosed in children and must be evident within the first five years of life.

RAD is a deficit in the child's capacity to manage how they feel. As in the previous section when we looked at attachment types, if we think about RAD from the perspective of the child with it, characteristics could be described as follows:

- I do relationships and conflict poorly because my social, emotional and behavioural skills are ineffective in my interactions with others. It is the frequency, duration and intensity of my difficulties in many settings, that sets me apart.
- Why am I like this? My need for comfort, nurturing and connection as a baby/young child were not met. My world is or has been, one of neglect, fear and hurt. As a result, I cannot articulate my feelings and thoughts.
- I threaten, I throw tantrums, I am aggressive, I am demanding of your attention, I am manipulative, charming and angry. Behaving like this is the only way I can control relationships.

Remember that it is not our place to diagnose but to understand. Regardless of the type of attachment difficulty a child may have, they all need:

- Safety
- A caring adult who will be there
- Emotional support
- Understanding
- Behaviour support
- Routines and consistency

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4.2 ATTACHMENT, SCHOOL AND LEARNING

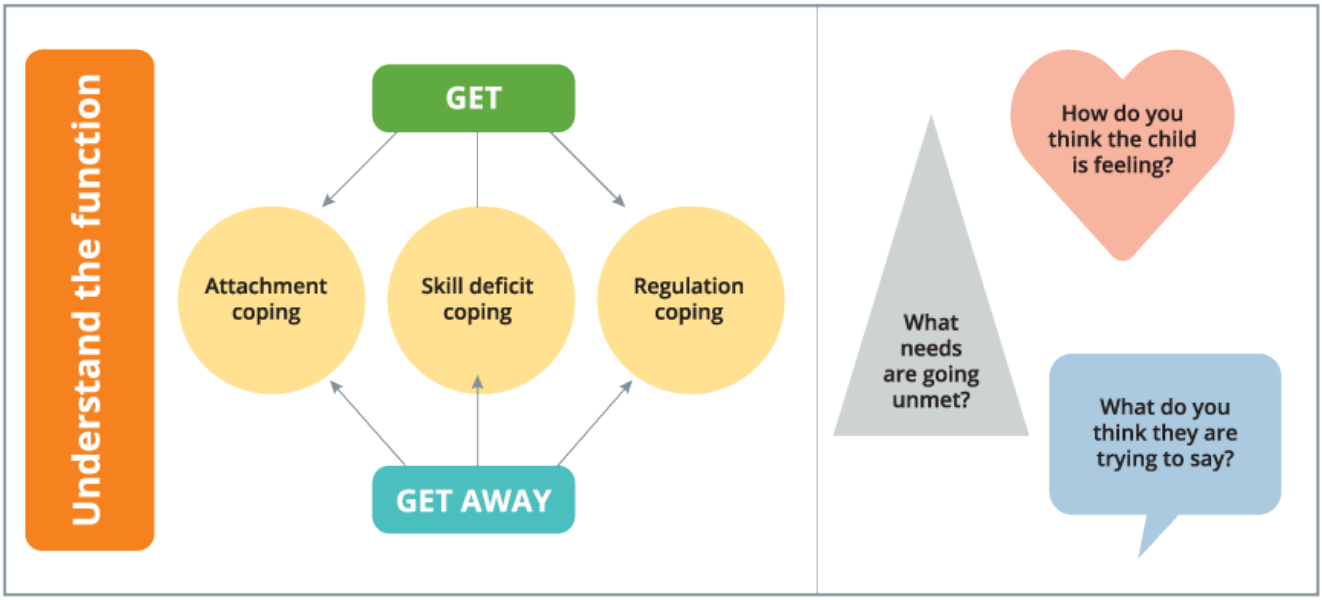


Figure 4.2 Understand the function by Govind Krishnamoorthy and Kay Ayre licensed under CC BY-SA.

When we are thinking functionally about the function of behaviour in terms of attachment coping, we must start with considering the attachment and relationship styles of the student with trauma. Students who have attachment difficulties engage in misbehaviour in an attempt to cope by 'getting' control over people – adults and other children – through coercion, deception and aggression (verbal, physical). These children may have learned to use such behaviours to get them access to preferred activities and objects and proximity to adults. The knowledge of such functions helps us give these students what they need to meet these needs in an appropriate manner, while helping them learn new ways of coping. Instead of seeking control, we can provide these students with a sense of predictability in relationships through explicitly teaching rules, consequences and routines.

Control can also be provided to these students through choices in the classroom – in academic or social activities. The teaching of appropriate social skills – both explicitly and implicitly – help these students leave prosocial and interpersonal ways of having their needs met, while building on a sense of safety and trust in the classroom. These kids may also 'get away from' adult and peer relationships by not trusting others, by being hypervigilant about being betrayed, humiliated or taken advantage of, they may withdraw from relationships or act as though they do not require any friendships with peers or support from adults. It is possible that these children have learnt to engage in such behaviours as assertive and appropriate expressions of their needs and feelings to adults in the past has not led to the adults (e.g. parents, carers, other teachers) responding to them in a safe, calm,

caring and consistent manner. In this way, misbehaviour represents a miscommunication of the student's need to feel safe in relationships and be part of a trustworthy and loving community of children and adults.

How are we going to do this? How are we going to put this into practice? Let us look at the following framework to help us.

PLAN, PROMPT, PAUSE, PUSH-OFF

Education Queensland in 2007, published *The Essential Skills for Classroom Management* (ESCM) as an important component of the Better Behaviour Better Learning professional development program. As the name suggests, the 10 skills outlined are essential to the management of student behaviour in all classrooms from early childhood to secondary and adult learning contexts. As popular today as when first introduced, teachers, both novice and experienced, continue to benefit from learning, practising, embedding and revising, these crucial skills. The 10 essential skills are:

1. Establishing expectations
2. Giving instructions
3. Waiting and scanning
4. Cueing with parallel acknowledgement
5. Body language encouraging
6. Descriptive encouraging
7. Selective attending
8. Redirecting to the learning
9. Giving a choice
10. Following through

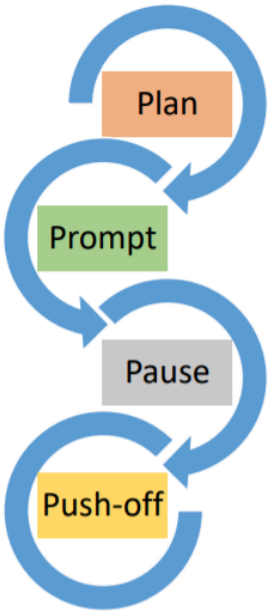


Figure 4.3 by Govind Krishnamoorthy and Kay Ayre licensed under CC BY-SA.

The terms 'prompt,' 'pause' and 'push-off' used here are from essential skill seven – selective attending and have been adapted to illustrate a trauma informed approach to positive behaviour support. Elements from across the 10 essential skills are inherent in the discussion that follows as part of quality teaching practice and you are encouraged to familiarise yourself with or revise the content of the essential skills so that they become an integral part of your daily classroom practice. We will now look at plan, prompt, pause and push-off in the context of our understanding of the challenging behaviour demonstrated by children with trauma.

PLAN

Figure 4.4 by Govind Krishnamoorthy and Kay Ayre licensed under CC BY-SA.

"Planning is our best strategy for prevention."

It is best to prevent the behaviour from happening in the first place in preference to picking up the pieces after the damage is done. Plan the classroom environment, plan the activities, plan your words, plan your actions, plan your attitude, plan your reinforcement of appropriate behaviour, plan what to do if everything does not go to plan. When planning, the teacher needs to 'tune in' to the student to see if they are about to flip their lid? What are the signs for this child that they are not feeling safe, secure and balanced? Are they in their window of tolerance? Is safety an issue?

PROMPT

Figure 4.5 by Govind Krishnamoorthy and Kay Ayre licensed under CC BY-SA.

There are two key choices for prompting:

- Follow the child's lead which means use prompts and strategies to bring the child back into the window of tolerance. Reminding and reinforcing language is used.
- Take charge which means use prompts and strategies to ensure the safety of the child with trauma, the rest of the children, staff and yourself. Connecting and redirecting language is used.

Following the lead of the child demonstrating the challenging behaviour is something teachers need to do as much as possible. Take charge only when necessary. The language used for each of these choices, following their lead and taking charge, is very important to the success of implementation so let us look at each type of language a little more closely.

Reminding language (following their lead): Keep reminders brief, describe and praise appropriate behaviour, use a neutral tone of voice and body language. For example: "Joshua, group time rules." "We are going to assembly in five minutes. How do we show active listening?"

Reinforcing language (following their lead): Use specific description, model what you expect showing them explicitly what it looks like and sounds like, tell them what they should be doing not what they shouldn't be doing. Provide plenty of positive feedback. For example: "Thank you for putting your book away immediately." "You have used capital letters at the beginning of every sentence and remembered the full stops."

Connecting language (taking charge): Taking charge means being in control without being controlling. Creating connections includes: managing your reactions, consequences not punishment, setting limits, providing choices, acknowledging good decisions and choices that the child makes and supporting parents and carers.

Redirecting language (taking charge): Be respectful and calm, replace questions with commands, be specific, concise and in control, focus on the immediate behaviour that is needed and do not "pick up the rope". "Do not pick up the rope" means do not get dragged into responding to secondary conversations that the child uses to redirect you away from the focus of the situation. These will sound like "You hate me anyway," "You never help me when I ask". "This is too hard". "This school

sucks" and the like. Some examples of specific redirecting language are: "Put that toy away" (not "Do you want me to take that toy?"), "Help Julie pack up the calculators please" (not "Be nice") "Eyes on me" (not "Will you look at me?").

Using the PACE model (Hughes, 1997) helps teachers to help the child with trauma feel connected. PACE stands for playfulness, acceptance, curiosity and empathy and helps to find the balance between following their lead and taking charge.

- **P**layfulness – delighting in the student; reduce fear of making mistakes or getting into trouble all the time. Having fun and using humour to diffuse tension. "I know you don't like tidy up time so let's sing while we all tidy up together."
- **A**cceptance– separating the behaviour from the child. reinforcing your commitment to them; listening and showing understanding. Focusing on the child and not the behaviour and trying to understand because whatever it is, it makes sense to them and they need to be able to tell you their story. Behaviour limits are set and consequences applied. "I know you find it hard to manage your anger and you will have to help me fix up the mess, but at the moment come and sit with me until you feel calmer."

Tower building blocks by FeeLoona licensed CC0.

- **C**uriosity and reflection – taking an interest, showing concern, 'wondering' out loud. Taking an interest, showing concern, clarifying what you have heard. This is about asking questions you already know the answer for and 'wondering' out loud "I wonder if that question means…" "I wonder if you tried," "I wonder if you had troubles yesterday because you were worried about your mum visiting on the weekend?" Help the child come up with their own solutions.
- **E**mpathy – putting yourself in their shoes. "I am sorry that that happened to you." "I feel sad for you." Empathy relieves shame and is much better than praise in many situations which can tend to escalate a negative reaction.

As Hughes (2009) notes, the PACE approach is equally as beneficial for adolescents as it is for younger children. PACE is an attitude and sends the message to the adolescent that the "intention is to come to deeply know, accept, and value the adolescent, joining with him in areas of his life-story that are stressful, confusing or full of conflict and shame" (Hughes, 2009, p. 126). In implementing the PACE attitude and way of working with the adolescent, it is important to match the emotion portrayed through the words and nuances, the talk of the adolescent. If the adolescent speaks quickly and with conviction and agitation for example, the adult needs to respond in the same manner. This reassures the adolescent that the adult is genuinely trying to understand without judgement thus the adolescent will most likely remain engaged in the conversation.

More time listening and less time talking

Establish joint attention. Joint attention means that both people in the conversation are paying genuine attention to each other. They care what the other person is saying rather than biding their

time, so they can speak and say what they want to say. Joint attention also reflects a focus on a joint topic that is, a topic both parties are interested in. It is always helpful to follow the adolescent's lead in the conversation rather than continuously trying to force the conversation the adult's way. This is not about fixing the child or young person or focusing on problems only.

Having the right intentions

This is where an adult intention of 'fixing' the child or young person will not be helpful in developing a relationship where there is a balance of investment of sharing the self, from both parties. The goal is for both the adult and the child or young person to feel they have had a positive impact upon the other, their contribution and place within the relationship is worthwhile for each of them. The ongoing growth of this relationship will be characterised by awareness. The relationship must hold meaning for the child or young person and for the adult to be successful.

PAUSE

Figure 4.6 by Govind Krishnamoorthy and Kay Ayre licensed under CC BY-SA.

Pausing is a skill that teachers generally are not good at. As a rule, they tend to 'fill in the quiet spaces' with teacher talk. It is important that the child is given time to process what has been said and what it is that has been asked of them (this is why having a visual timetable either in words, pictures or both and other alternatives to just 'talk' are important for not just the child with trauma and students with autism spectrum disorder, but for all children). The child with trauma often has memory difficulties and may require additional time to comprehend. Give an instruction and wait five seconds before giving another. Paraphrasing is also helpful if the child is having difficulty understanding.

Pressure to provide a response could contribute to anxiety and further reduce the child's executive functioning (the ability to switch attention from one thing to another, prioritise, make decisions and plan) and engagement.

PUSH-OFF

Figure 4.7 by Govind Krishnamoorthy and Kay Ayre licensed under CC BY-SA.

With children who have experienced trauma the 'push-off' strategy is particularly helpful in keeping them calm and giving them space to process and adjust. This is because many have a limited tolerance for proximity and adult contact. As relationships slowly become stronger and more trusting the child may be accepting of the teacher being closer to them for longer. Remember the child with ambivalent attachment who could be clingy? They need to slowly learn to function independently from the teacher, but this all takes time, consideration and care. It is important to remember that 'push-off' is not punishment delivered by the teacher. The message to the child is that the teacher is available to the child whenever needed. Push-off is always used in conjunction with the other strategies.

"Be insistent, committed and kind."

Children with trauma put up barriers to relating and becoming close to teachers and other adults. Think about their experiences with grown-ups and the fact that they have no reason to trust any of them given what has happened to them at the hands of some. Once the relationship is

established, they will do everything they can to sabotage it and ensure that the teacher behaves in the way they have come to expect grown-ups to behave and also to further reinforce their belief that they are not worthy of love and care. What they need from teachers is unconditional support and encouragement. Remember, the behaviour of the child who has experienced trauma reflects their history.

Listen

Interview with Dave Ziegler [20 min 47 sec]

Listen to this interview with Dave Ziegler on helping traumatised children learn.

4.3 PUTTING IT INTO PRACTICE

Read

Remember Max?

Remember Max who arrived at the Intervention Centre and silently went about barricading himself into a corner using the reading corner pillows?

For the purposes of this case study we will describe Max's attachment pattern as disorganised attachment. A pattern that arises when a child is in a relationship where the adult is frightening to the child and often the adult is frightened of the child. Max's behaviour in the classroom could be described as him needing to be in constant control at all times and he would be verbally and physically aggressive. So how was Max feeling? Anxious, fearful and unsafe.

Max's fear meant that he needed to make sure he was in control. To do that he would be mean to others, provoking them, hitting them, knocking their belongings onto the floor. Max's angry and aggressive behaviour was hiding his anxiety and allowed him to 'control' the teacher. Max's particpation in activities was overridden by his anxiety and hypervigilance.

HOW WILL WE SUPPORT MAX?

There are many strategies that while they are targeted to a specific child's needs, they are effective strategies from which all children can benefit. Highly effective teachers will probably be already employing many of the strategies suggested as a matter of course and just need to be made aware of the purpose of these in relation to individuals like Max who need specific attention, care and lots of reassurance. Suggestions may include:

"I can't explore the world. I am too busy ensuring I am safe," (Golding et al., 2013).

- Ensure predictable, consistent routines.
- Provide 'sanctuary' – a safe space to retreat to when feeling overwhelmed. For Max this would mean making sure there were extra pillows, so his barricaded corner could remain intact.

- Teach calming routines (ensure these are doable and appropriate).
- Give lots of teacher attention. Have a concrete object that represents time with the teacher so Max knows he can use these to access teacher attention if it is not possible to do so immediately. For example, clothes pegs or Unifix blocks or cards (teacher time owed) work well as visuals to swap for teacher attention time.
- Preferred activities first, followed by non-preferred activities.
- Genuine praise and encouragement.
- Give Max an element of control (or the illusion of control). For example, he can choose which tasks to complete first, where he will sit, what pencil/pen he wants to write with or he can negotiate from the choices given how much of the task he will complete (none, not being an option).
- Small, small steps. Be patient.
- Can you imagine what it must be like to be Max? Put yourself in his shoes.

SAM IS HAVING TROUBLE AT SCHOOL

Remember that much of classroom behaviour management assumes that children know how to do relationships. It is assumed that children know and understand how to respond to authority, respect, trust and obedience when in fact the child with trauma is often wired to respond to mistrust, cruelty and survival.

Read

Information snippet one

Sam is a nine-year-old boy in your class. It is the start of term and Sam is being disruptive in class. He often yells out in class at other students, refuses to attempt or complete set tasks and throws his equipment to the floor, finding it hardest to concentrate and do his work in Maths and English.

He has been aggressive with other students in break times sometimes pushing, hitting, threatening to punch and swearing. He is often noticed to raise his voice with teachers on playground duty, often resulting in arguments. Sam has been suspended twice and is sent to the principal's office almost daily. At the Principal's office Sam is observed to be calmer. He has spoken to the Principal about his parents – becoming quite upset and tearful discussing this topic.

Why is Sam behaving like this?

Thinking functionally about Sam's behaviour, firstly the problematic behaviour needs to be defined in observable and measurable terms. What does Sam's behaviour look like? It looks like hitting, throwing equipment to the floor, yelling at other students etc. Next, what are possible antecedents or triggers for this behaviour? So, what is or in this case could be, happening immediately before the problem behaviour? Perhaps he has been told to complete a writing task, or Maths task, he may have asked to

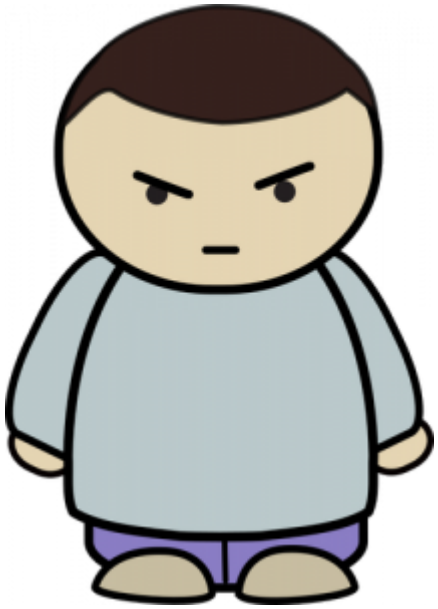
join a game and been told that he was not welcome, or teachers or peers may move into his personal space. Finally, consequences or what happens immediately following the problem behaviour? What do the adults do? He is sent to the principal's office, suspended, and probably frequently withdrawn from the playground (detention of some sort).

What is the possible function of Sam's behaviour? Is it to access or escape?

Speculate now, based on the information provided, what possible setting events may have impacted Sam. So, what factors beyond the school gate, would need to be considered by the teacher to lessen their impact in the classroom? Sam could be tired, hungry, anxious and worried (for example he may be worried for the safety of someone at home when he is at school).

To lessen the likelihood that the loud and aggressive Sam will appear, in what ways can the teacher alter or take away the antecedents or introduce new antecedents? How might the consequences be changed or new ones introduced? In other words, what antecedent and consequences intervention strategies could be employed?

The goal of the antecedent and setting event strategies is to prevent the challenging behaviour from happening. Examples could be: provide breakfast, class munch and crunch time (fruit for sharing just after class begins), parking bay (quite time, time-in, quiet corner) where the child can go as a transition to participating immediately upon their arrival at class.



Angry boy by OpenClipart licensed under CC0.

Consequence strategies withdraw or alter what is currently happening after the challenging behaviour and is maintaining it or supporting it to continue. The goal is to reinforce desired behaviour. Thinking functionally, consequence strategies are positive and encourage the replacement behaviour. The focus is on increasing appropriate behaviour. Examples could be: praise regularly, non-preferred task (small chunk of work) followed by a preferred task (drawing, reading, computer time), requesting a break (break time card/timer), time with teacher.

Read

Information snippet two

At the parent-teacher interview, you learn that Sam's parents have split up recently and that he has been living with his maternal grandmother since the start of term. Sam's mother tells you that there has been domestic violence in the house and Sam may have witnessed some of the verbal and physical aggression. Sam's mother tells you that his grandmother finds it hard to set limits with Sam and is afraid of his aggression. Sam's mother is happy for the school guidance officer to speak to Sam's mental health team for more information.

What needs are going unmet for Sam?

Having thought functionally about Sam's behaviour and come up with some setting event and antecedent intervention strategies and some consequence-based intervention strategies, now consider what needs could be going unmet for him. Do you think he would feel safe? Would he feel secure and trusting of the adults around him? Does Sam know that anyone at school truly cares about him? Who will be Sam's key person?

Sam must feel safe so that he can begin to participate in school life. For Sam to feel safe, a relationship needs to be built with a key adult who gets to know Sam and understands he is a child with complex emotions who requires unconditional support. What can the teacher do to meet these needs? How will safety, relationship building, emotional needs and discipline be addressed? Will Sam need to be taught a replacement behaviour and other social skills? What is Sam's level of maturity? Sam needs reliable and consistent routines that focus on keeping people safe. There needs to be a planned response for critical incidents. Perhaps there are small group activities targeted at those children who require more intensive social skilling. Explicit teaching of desired behaviours – never assume that a child knows what the desired behaviour looks like – break the behaviour down into steps and then model and practise and reinforce the behaviour. The best time to do this, is when the child is not being disruptive. See chapter five for social skilling as part of social-emotional wellbeing.

Sam like Max is controlling and spends his time checking on others around him to ensure his safety. How is Sam feeling? Do you think he copes well with stress? Would a busy, stimulating classroom help Sam or hinder his ability to be calm?

The picture so far...

Sam needs to feel safe and secure. He needs a key person to build a relationship with him and be an advocate for him. Interventions to alter the antecedents and the consequences as well as lessen the impact of setting events, can be made to classroom environment to lessen the likelihood Sam will be disruptive in the classroom and playground. Predictable, structured days are needed with opportunities provided for Sam to escape or access (depending on the function of his behaviour) using appropriate behaviour. Therefore, a replacement behaviour and some social skills will need to be taught to Sam. Clear links will need to be made for Sam between his behaviour and the consequence and it is important that calm and consistent discipline be implemented to avoid confrontation and 'battles'. Co-regulation demonstrated by adults will help Sam to manage his emotions.

Read

Sam this morning...

Sam was suspended last week and has arrived at your classroom looking irritable and tired.

He walks into class and does not make eye-contact with you when you say hello to him. You notice that as soon as he sits in his seat he puts his head on the desk.

The first lesson for the day is Maths and all the kids have taken out their Maths books, except for Sam. What do you do?

Plan: How are you feeling at this point? Is Sam in his 'window of tolerance?' Are there any early warning signs? Any safety issues? What antecedent strategy can you implement? What can you do immediately to lessen the likelihood of an emotional explosion? You may move close to Sam and use a whisper to tell him that he can have 10 minutes in parking bay before he needs to begin his Maths. He might be given a piece of fruit to eat while he is having 'calm' time (an antecedent and setting event strategy).

Prompt: How will you respond to Sam not taking out his book? How can you do this without escalating his behaviour? Think about where you will stand, what your body language looks like, check your tone of voice, what words will you use? You might move Sam to parking bay and tell him when he goes to his desk after he has completed five of the 10 Maths operations he can have 10 minutes drawing time (a consequence strategy).

Pause: How will you know if your prompting has worked? What will you be looking for? Sam will move to the parking bay (in his own time – don't be pushy) and when his time is up or when he is ready, return to his desk and begin his non-preferred task. He will appear less agitated and will demonstrate fewer aggressive behaviours.

Push-off: How will you know when to move away from Sam? How will you do this? Each child is an individual and this is why it is critical to know your children well. It may be that you move away straight away. It may be that you sit on a chair beside Sam for a while and then 'lap' the classroom assisting other students and then come back to Sam. You might teach from behind Sam's chair and then gradually move away to check student work. It is unreasonable to expect that Sam will behave perfectly all of a sudden. He will be aggressive, he will refuse to follow instructions and he will continue to have emotional outbursts. The teacher's job is to lessen the frequency, duration and intensity of this behaviour as best they can.

Children like Max and Sam who have a type of attachment at the most severe end of the continuum, disorganised attachment, are amongst the most concerning to teachers. Behaviour management strategies that are typically used are rarely effective with children like Sam and Max because they live in a state of dysregulation and fear where survival is paramount, and adults cannot be trusted. Praise and acknowledgement for example are often perceived by the child affected by trauma as ingenuine adult remarks. Therefore, building connections is the first step to helping the child feel safe and secure. It is from this 'felt safety' foundation that trust can be formed. Trust is the foundation of their readiness to learn and they learn best implicitly, through the interactions with you and watching you closely. Everything you do as a teacher is modelling to them and they are learning by watching.

View

Childhood trauma: What every teacher needs to know [1 min 15 sec]

Watch this video on what every teacher needs to know about childhood trauma.

Reflective questions

1. Name the four types of attachment.
2. What is the name of the theorist attributed with Attachment Theory?
3. PACE stands for Playfulness, _____, Curiosity and_____.
4. What is the main purpose of setting event and antecedent strategies?
5. List some typical feelings of the child with trauma.

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PART V.

TEACH AND REINFORCE

Welcome board by Geralt used under CC0.

"Traumatised children expect the worst and focus on the negative. If you understand this, you will be better prepared for it." – Dave Ziegler

Overview and learning objectives

Following on from chapter four, which explored attachment and the crucial importance of these earliest relationships, this chapter focuses on social emotional wellbeing and the relationships formed as children grow. A child's first socialisation experience is through attachment with another. The social emotional needs of the child with trauma are substantial because as we know the early attachment experiences of a child in infancy, the

relationships with the primary caregiver, and the nature of those relationships significantly impacts the quality of mental health (Bayat, 2015).

Teachers can do much to forge strong connections with the child, build connections between the child and the people in the school, build connections between the school and the child's world beyond the school, and validate the child as a person worthy of care. Connecting and validating helps the child to feel connected and begin to feel a true sense of belonging.

On successful completion of this chapter, you should be able to:

- Understand the nature of social-emotional competence
- Provide examples of some social-emotional skills necessary for children's wellbeing
- Explain challenges in supporting the social-emotional needs of children with attachment difficulties
- Name key teaching strategies for promoting social-emotional competence
- Understand the key elements of Social Cognitive Theory

INTRODUCTION

Trauma impacts development disrupting cognitive, physical, and social and emotional development. Living in a constant stressed state of fear and heightened anxiety is toxic to the body and with every ounce of energy focussed on survival, the child with trauma has
little space left to learn or the capacity to be a social, regulated person. This struggle is for many children with trauma, seen most clearly in difficulties with relationships, friendships and behaviour. Remember that the chronological age of the child with trauma does not often match where they are developmentally, so when implementing strategies to help, it is the developmental age and capacity of the child that needs to be considered first and foremost. Teachers make mistakes, miss the signs, reflect on their own behaviour that sometimes they deem as not helpful and things go wrong. When bad situations and days happen, it is important that relationships are repaired, and we keep moving forward with our 'best effort'.

Bomber (2009) reminds us that fundamental to forming strong relationships with traumatised adolescents is to ensure we keep them in mind. This is how we help the child to gain a sense of emotional stability. Ideally, the person providing the secure base would be able to do so in the long term (for several years), committed to genuine helping and the willing surrender of their time. The adolescent with trauma (just like some children with trauma) quite likely does not have the skills to form relationships. Further, they tend to misread the signs inherent in comments, body language and tone of voice, reacting in ways (for example using aggression) that are totally understandable if you live your school day looking for threats but unacceptable within the school context. Moreover, they are often aware that they do not 'do relationships' as well as others and this further adds to their feelings of poor self-esteem and self-worth.

"It will take me a longer while to catch up with myself, so don't be fooled by my age"(Bomber, 2009, p. 52).

Many children with trauma lack an understanding of the skills that are needed to establish and maintain relationships, and this results in them having few friends. Behaviour such as being overtly

controlling (the child with trauma has had no control over things that have happened to them), not taking turns, aggression and showing little empathy for others. The period of adolescence is one of comparison with others. For the adolescent with trauma, when they compare their life to others, their life (and I quote) 'sucks big time!' Developing social-emotional competence helps fill the gaps from disrupted relationships and makes the life of the child with trauma 'suck a little bit less'.

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5.1 SOCIAL-EMOTIONAL COMPETENCE

Read

True story

"Teach him how to be a little boy at school," was the request from the Senior Guidance Officer as she stood at the Intervention Centre door with Elliott. The Intervention Centre was for students who had been suspended or excluded from school. It was a temporary placement for behaviour intervention and support to reintegrate the student back into the school environment. Most students were at the Intervention Centre for 8-10 weeks, some longer. "He has had a rough little life and just needs someone to play with him and help him learn what it is to be a child. Next time he is violent the school will exclude him" she continued.

Elliott and I went to play on the carpet and I rolled out the car mat between us and handed Elliott a toy car. He looked at it, turned it over, looked back at me and waited. He had no idea what to do with it. I placed my car on the road and made "broom, broom" noises. Elliott just watched, holding his car tightly in his hand.

And so it went like this for many days. I played, narrating what I was doing and feeling and Elliott watched. At the end of two weeks, he bravely put his car onto the mat and mimicked "broom, broom." It was like Christmas. I was thrilled.

Elliott was eight years old. He had lived in a series of foster care situations since he was two years old. Removed from his home due to severe neglect and abuse, Elliott had no concept of caring or compassion but he was learning ever so slowly how to be a little boy and that is why his eight week stay at the Intervention Centre became a year.

SOCIAL-EMOTIONAL COMPETENCE

Competence in social emotional learning is recognised as having a significant influence on a child's school readiness, school adjustment and academic achievement (Beamish & Saggers, 2014). Supporting the social emotional health of children is integral to teaching. Social emotional learnings develop resilience in children and foster positive wellbeing. The Collaborative for Academic, Social and Emotional Learning (CASEL) is a leader in the field of social emotional learning. Formed in 1994, this group of American educators, child advocates and researchers, introduced the term social and emotional learning. CASEL (2020, para. 1) define social and emotional learning in the following way: "Social and emotional learning (SEL) is the process through which children and adults acquire and effectively apply the knowledge, attitudes, and skills necessary to understand and manage

emotions, set and achieve positive goals, feel and show empathy for others, establish and maintain positive relationships, and make responsible decisions."

It all begins in early childhood, the tone is set, the path laid out and the future sketched. So much that happens in the early years significantly impacts future quality of life. Being ready for school, functioning effectively at school, interacting positively with people at school and being academically successful at school, are governed by social-emotional competence (Bailey, Denham, Curby, & Bassett, 2016; Bayat, 2015; Denham, 2010). Generally speaking, emotional competence is about understanding feelings and social competence is about effective interactions and relationships. Relationships – secure, safe and attached. While recognising that each child is unique and will have needs original to themselves, we will begin with evidence-based strategies known to be helpful for all children with trauma.

KEY FACTORS TO SUPPORT SOCIAL-EMOTIONAL COMPETENCE

Learning, relationships and emotions go hand in hand. Without the capacity to navigate the social world of school with a firm grasp on emotions, learning becomes problematic. Experiences teach skills and if an experience is repeated, the skill or skills associated with it, together with the response, become imprinted in the brain. For the child with trauma there is often a mismatch between highly developed responses e.g., for survival and underdeveloped responses needed for school success (Blaustein, 2013).

At the core of helping children with trauma develop their social-emotional competencies is teaching new behaviours. For those children who have not had the opportunity of experiencing quality attachment and having care and considerate behaviours modelled to them, behaving in a socially appropriate manner eludes them as it has not been part of their life and therefore, they have little to no experience of it. New behaviours that are an appropriate means of communication that get the child what they want in a manner that is acceptable in the space or environment and acceptable to, the people within it, need to be explicitly planned and taught. These behaviours are what behaviourists call replacement (or alternative) behaviours. In addition to learning new behaviours naming emotions is critical to developing emotional competence and self-regulation. Naming emotions is the first step to coping with them, so it is important that the child with trauma develops a vocabulary to name their feelings (Hertel & Johnson, 2013).

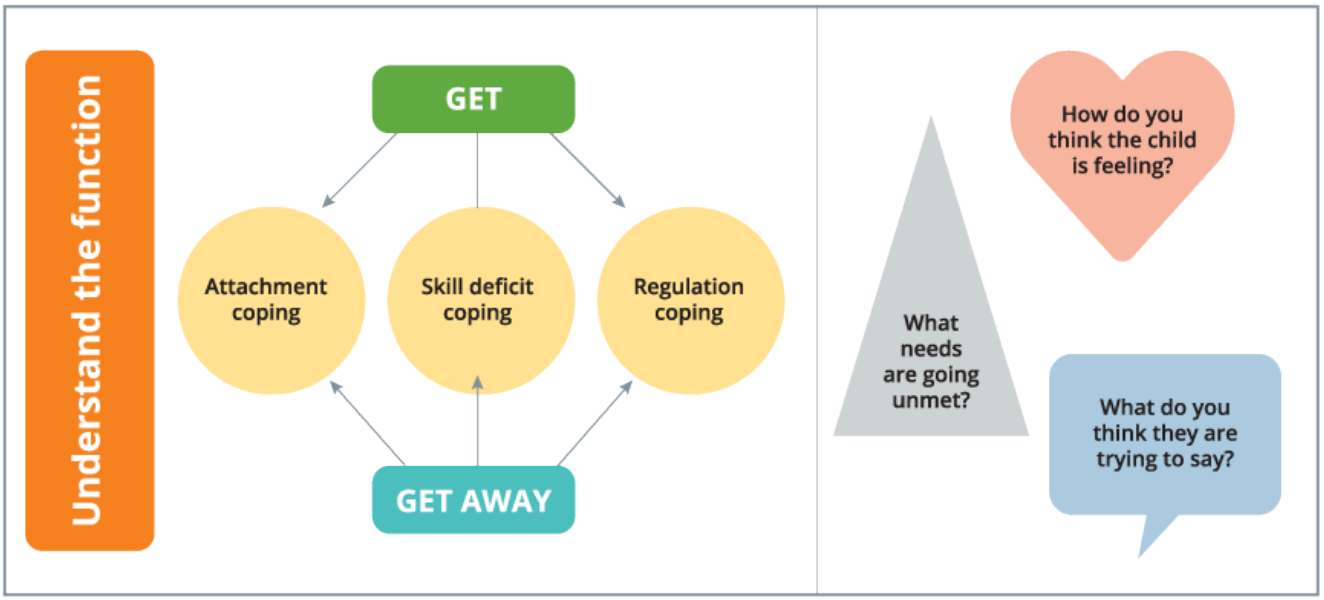

Figure 5.1: Understand the function by Govind Krishnamoorthy and Kay Ayre licensed under CC BY-SA.

A key component of social-emotional competence are social skills. As with teaching behaviour, these need to be intentionally planned and taught with the purpose of the skill clearly explained to the child. Skills such as turn taking, sharing, joining in and problem solving are essential skills for the child to master so that they can participate to the best of their ability within the learning environment and establish friendships through positive interactions with their peers. Broken attachments, lacking social skills, difficulties regulating emotions and establishing relationships, the child with trauma needs support to learn and grow. From the foundation that all learning is relationships, the teacher is kind, flexible and attuned to the student's unique needs, building trusting spaces for learning and helping the student with trauma build regulation skills through modelling, teaching and listening.

With reference to "positive replacement behaviours" (Gresham, 2015, p. 199), Gresham makes the clear distinction between social skills, social tasks, and social competence. Social skills are the explicit behaviours that a child demonstrates that are needed to complete a social task. Social tasks are things like making friends, joining in and playing games. Social competence is the ability of the child to demonstrate a social task successfully as judged by another (a teacher, peer, parent) against a set of criteria (Gresham, 2015, p. 199) and therefore in the demonstration of that social task show a degree of competency in executing the social skill or skills needed for that social task.

The upcoming sections focuses more broadly on social-emotional competence in relation to the period of a individual's life.

View

Five keys to social and emotional learning

[6 mins 2 secs]

Watch this short video on the five keys to successful social and emotional learning. Choose one of the keys and think about what this would look like for the child with trauma in your context.

A transcript and Closed Captions are also available within the video.

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5.2 THE SOCIAL-EMOTIONAL NEEDS OF THE YOUNG CHILD

As introduced in detail in the previous chapter on attachment, the first formation of relationships is critical to future experiences and the social-emotional wellbeing of the child. The development of safe and secure relationships within which children learn how to manage emotions and self-regulate form the blueprint for successful future regulation of emotions and social competence.

There are quite a few evidenced-based programs that promote social-emotional learning for young children and at the same time reduce disruptive behaviour.

Take a look at the Teaching Pyramid. The teaching pyramid originally developed by Fox, Dunlap, Hemmeter, Joseph and Strain (2003) is a positive behaviour support framework that outlines practices to prevent challenging behaviour and promote social-emotional competence in children. The foundation is relationships. Quality relationships with children, families, colleagues and other practitioners, are the base from which evidence-based strategies can be implemented to cater for social emotional needs of children.

Two kids in school uniform by Cyberscooty used under CC0.

The teaching pyramid is an example of a multi-tiered framework particularly designed for supporting social emotional learning in early childhood contexts. Multi-tiered frameworks consist of the following three tiers of intervention and support: Universal or tier one, targeted or tier two and intensive or tier three. The tiers of the teaching pyramid reflect the same focus areas: promotion (universal), prevention (targeted) and intervention (intensive). The goal of a multi-tiered framework is to endeavour to provide support to all children across social, emotional, behavioural and academic domains of development, to promoting positive behaviour and reduce the occurrence of disruptive behaviour (Bayat, 2015; Hemmeter et al., 2012). Promotion (universal tier one) is targeted at all children, prevention (targeted tier two) at smaller groups of children and intervention (intensive tier three) at individual children with more intensive needs. For most children, the universal level will probably be enough, however for children with trauma, the secondary prevention and tertiary intervention tiers are more likely to better address their needs. Let us have a closer look at the key features of each tier of the teaching pyramid.

Promotion (Universal tier 1): Building relationships between teachers and children, teachers and caregivers and children and children. It is also important to include here those adults who are

significant in the child's life beyond the school and home such as practitioners from government and community agencies, if applicable.

Prevention (targeted tier 2): Focused teaching of social and emotional skills needed to solve problems, demonstrate feelings and develop friendships. The 'teachable moments' throughout the day are the perfect opportunities for this teaching.

Intervention (intensive tier 3): For those individual children needing targeted support. Functional behavioural assessment to ascertain the function of behaviour and develop an intervention plan, is the focus of this tier. Teaching new appropriate behaviours to replace the inappropriate behaviours – new behaviours that serve the same function but are acceptable in the environment. The evidence-based practices of the teaching pyramid are equally important to consider for the primary aged child and the adolescent.

STRATEGIES TO HELP

Bailey, Denham, Curby and Bassett (2016) found that emotional and organisational supports were significant factors in guiding social-emotional learning and self-regulation in pre-schoolers (four to five-year-olds). The authors found that a classroom that was emotionally supportive reduced behaviour problems and increased social competence. Plenty of opportunity was given for children to self-regulate within an environment of safety where expression and learning were valued, and close relationships were formed. These classrooms were well-organised promoting high levels of learning engagement with clear expectations taught and understood (this would equate to the universal promotion area of the teaching pyramid).

Meeting the child where they are emotionally and socially is a key underpinning strategy for developing social-emotional competence in children. Whatever the strategy, research has shown that it is important for children to learn, practise, view and talk about the new skill with examples to illustrate what it looks like, sounds like and feels like (Corso, 2007). For those children who have experienced complex trauma the following strategies have been shown to be very helpful in assisting them to regulate emotions:

- Name your emotions. Talk aloud so there is connection between feeling and words.
- Make clear links between the emotion and the event.
- Use a feeling die (use at carpet time for children to tell about the time they felt…).
- Dance to different kinds of music and talk about how it feels.
- Explicitly teach children how to read the nonverbal cues of others. Why do people frown, grimace, look upset?
- Read picture books that discuss emotions. An article by Harper (2016) discusses how picture books can be useful in developing social-emotional competence.

When you live a life of mistrust and hurt, your internal workings tell you that relationships with others are not a good idea because they are unsafe and to protect yourself it is easier to just avoid them all together. How does this child know how to form and 'be in' friendships with others? They don't. They need to be taught. Sorrels (2015) details the following social skills:

- **Empathy –** Children from chaotic backgrounds often arrive at school 'not ready to learn'.

Providing time to check in nurtures empathy, encourages regulation and shows care and concern.

- **Turn-taking –** my turn, your turn (This is not sharing. Sharing is different. We share collage materials and food; we take turns going through the tunnel and down the slippery dip). Children with trauma have lost so much, they do not want to give-up anything so find turn-taking difficult. Use timers, visuals and solve problems aloud.
- **Sharing –** children with trauma 'accumulate stuff' whenever they can because they fear the opportunity may never arise again. They are fearful of not having. They are not greedy. Plan activities where they can practice sharing and ensure they know what it looks like and sounds like to share.
- **Joining in –** join the game with the child and stay and play for a moment by guiding them in and helping them engage.
- **Conflict resolution –** talk through situations of conflict. The child with trauma is often overwhelmed by these situations. Remember Elliott from the true story at the beginning of the chapter? He used to climb into a cupboard and slide the door almost shut (the track was fixed so that the door could not be fully closed). Many children with trauma will hide in times of conflict.

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Read

The Center on the Social and Emotional Foundations for Early Learning

Read the following resources from the Center on the Social and Emotional Foundations for Early Learning:

- Strategies for teachers
- "What Works Briefs" (practical strategies and handouts)

View

Promoting Social Emotional Competence

[27 min 40 sec]

Watch this video on social and emotional competence. A transcript and Closed Captions are also available within the video.

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Bailey, C. S., Denham, S. A., Curby, T. W., & Bassett, H. H. (2016). Emotional and organizational supports for preschoolers' emotion regulation: Relations with school adjustment. *Emotion*, *16*(2), 263-279.

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5.3 THE SOCIAL-EMOTIONAL NEEDS OF THE PRIMARY AGED CHILD

"Children living with trauma are brave, courageous and resilient. School days are often a struggle. Just being at school is testament to their fortitude."

In the primary years of school, the child is adjusting to greater demands with academic tasks, forming friendships and experiencing failure (Snowden et al., 2009; Woolfolk & Margetts, 2013). Friendships become increasingly important and peer group pressure increases significantly. This is the age for 'a best friend'. The primary school child begins to think of their sense of self in comparison to others. The views of key adults are important as is their belief in themselves to complete tasks in which they strive to be successful.

When supporting the primary school child with trauma (as with all children with trauma) teachers need to focus on what the individual child's needs are. Teachers need to ask themselves what is the emotional age of the child? Most children who have experienced complex trauma and therefore have attachment difficulties, hide behind a confident façade that hides their need to be dependent on adults.

STRATEGIES TO HELP

- Provide lots of praise (genuine and descriptive) and acknowledgement. Build the very fragile sense of self-worth that exists within the child with trauma.
- Demonstrate your belief in the child by giving them opportunities to take on leadership-type roles in the classroom so they are 'in-charge'.
- Clear boundaries and high expectations.
- Focus on connection not correction – relationships are everything.

Children having their exam by Arthur Krijgsman licensed under CC0.

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5.4 THE SOCIAL-EMOTIONAL NEEDS OF THE ADOLESCENT

The social-emotional needs of the adolescent are similar in many ways to the young child but with add-ins. For example, the adolescent has a strong focus on self and experiences the complications that come with hormones and puberty. Young people going through the stage of adolescence need to belong and feel connected, and they need emotional and social skills. Not all adolescents have had the chance to develop these skills so it should not be assumed that all adolescents have acquired these skills and indeed can competently demonstrate them. The adolescent as is the case with the younger child, does not have superpowers that allow them to become socially and emotionally competent through 'magic'. All children who struggle with social-emotional competence need to be taught social and emotional skills.

Young teenage girl by Greyerbaby used under CC0.

Main and Whatman (2016) note that there is a "window of opportunity" (p. 1067) for the early adolescent who finds themselves embedded in a world of greater challenges both socially and academically. The authors remind us that the foundation of emotional stability is a strong relationship with a significant adult and having friendships with peers that are productive and respectful. Having a sense of belonging and connectedness significantly contributes to resilience and reduces the likelihood of disengaged and disruptive behaviours.

During adolescence concern with self-concept, self-esteem and appearance is greater than during the primary school years and can often lead to heightened anxiety and worry for some (Snowman et al., 2009). The inability to cope with these emotions can manifest into emotional disorders such as depression, eating disorders and substance abuse. This focus on self (self-conscious and self -centred behaviour) coupled with the flood of emotions that accompany the developmental changes of this adolescent stage, can create havoc for the social-emotional wellbeing of some adolescents. It is important to remember that while many adolescents do experience some social, emotional and behavioural hurdles, most of these hurdles fail to become significant difficulties.

The following table is a compilation of key factors of social and emotional development developed from Snowman et al. (2009) and typical behaviours of the traumatised child of the same age from Wiebler (2013).

Early childhood		Primary		Secondary	
Key social emotional factors	Behaviours of the child with trauma	Key social emotional factors	Behaviours of the child with trauma	Key social emotional factors	Behaviours of the child with trauma
✳Open display of emotions ✳Beginning to develop self-control (anger outbursts and jealousy) ✳Difficulty reflecting on self ✳Rapidly changing friendships	✳withdrawal ✳ blow ups/tantrums ✳upset when being left by someone ✳lash out in anger ✳hyperaroused ✳destroying materials ✳aggression	✚Emotionally sensitive ✚Sensitive to criticism and difficulty adjusting to failure. ✚Stable sense of self ✚Same-sex friendships, more selective	✹somatic complaints e.g headaches, stomachaches ✹withdrawal ✹aggressive ✹bullying ✹noncompliant ✹anxiety and worry ✹ restlessness	★Self-image and self-efficacy are important ★Self-conscious and self-centred ★Dramatic changes in sense of self ★Peer group and close friendships	★feelings of in-justice ★rebellion ★risk taking ★reckless ★self-destructive ★withdrawal ★fear ★depression ★anxiety

Table 5.1: Key factors of social and emotional development by Kay Ayre used under CC BY-SA.

The secondary school space is full of transitions and changes. Transitions from room to room, teacher to teacher, subject to subject, physical changes from child to young adult, change for some from being known at primary school to being 'lost' amongst many. Changes everywhere. Changes that overwhelm. Keep the adolescent in mind.

STRATEGIES TO HELP

- Teach effective social communication skills for example: classroom positive graffiti walls (messages and art work); encouraging journal writing (no one reads it without owner permission); use alternatives to words (visuals, hand gestures, signs); model expression of emotion by reading an entry from your teacher journal (it is important that when students write in their journals the teacher does the same).
- Take advantage of the social opportunities in the school.
- Be a relationship coach. Be a role model in how to interact with others (Hertel & Johnson, 2013).
- Give feedback when social situations do not work out as planned.
- Ensure the peer group is included where appropriate so they too can be supportive and instrumental in helping.
- Establish a check-in time and place.
- Minimise the changes wherever possible.

We cannot change the past but with understanding, care and connection we can help to mend the fractures in the life of the child affected by trauma.

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5.5 SOCIAL COGNITIVE THEORY

In chapter two, we examined behaviour theory in detail and how it forms the foundation of our ability to think functionally about challenging student behaviour. Behaviour theory, you will remember is associated with BF Skinner and focuses on behaviour being observable and measurable and influenced by the environment in which it occurs. Consequences maintain or reinforce the behaviour. While no apology is made for the behavioural perspective of the book being predicated on behaviourism, it is important to always consider other theories of learning from which we can draw to provide a deeper, more comprehensive understanding of learning (behaviour is learning too). Therefore, a brief introduction to social cognitive theory is presented here to promote critical thinking beyond behaviour theory alone, to inform our practice.

SOCIAL COGNITIVE THEORY

Albert Bandura by Albert Bandura used under CC BY-SA.

Social cognitive theory has developed from the work of Albert Bandura. Founded in behaviourism, the inclusion of the cognitive aspects of learning have seen a greater balance develop between the behaviourist perspective and cognitive psychology. This balance has also been reflected with the change of the name from its original title of social learning theory to social cognitive theory (Ormrod, 2014). The basic premise of social cognitive theory is that a person's behaviour is the result of three reciprocal factors. These are behaviour, personal characteristics and the environment. Behaviour is about the social world and the influence of other people's behaviour on our own behaviour. The focus is on shared experiences with others and the molding of a child's behaviour through the modelling of that behaviour by others and subsequently the imitation of that behaviour. This requires the child to look, remember and do (Hoffnung, et al., 2019).

Modelling, observing and copying behaviour are key elements of social cognitive theory. Teacher behaviour has a very significant impact on student behaviour. What teachers do is closely scrutinised by students therefore it is critical that teachers demonstrate desired behaviours. Bandura (1986) noted that there were four key components needed for learning from modelling to be successful. These were attention, retention, motor reproduction and motivation. Let us look at how the basic assumptions of social cognitive theory may apply when teaching social emotional skills to students (Ormrod, 2014, pp. 299-300).

- **People can learn by observing others.** While it is important to make time to explicitly teach social emotional skills to students it is equally as important to provide them with opportunities to observe and watch these skills being modelled.
- **Learning may or may not lead to behaviour change** that is learning is a mental change that may not be demonstrated in observable and measurable behaviours. While students may understand the importance and application of social emotional skills in a cognitive intellectual manner, the application of these skills in real life situations may require reteaching and scaffolding before these students can autonomously use these skills in their life.
- **Cognitive processes influence motivation and learning.** Having goals and expectations are important for motivation and self-efficacy (a person's belief in their own ability) is instrumental in effort and persistence toward achieving goals. It is important to recognise that anti-social behaviours have served an important function in a student's life in getting their needs met. Self-efficacy and trust in the ability of prosocial social emotional skills in getting their needs met requires setting up supports and situations that provide these students with small successes and feelings of accomplishment.
- **People and their environment influence each other.** Social cognitive theory posits people influence their environment and do so intentionally. It is important to remember that the use of prosocial behaviours may not be adaptive for students that continue to live in abusive and neglectful environments. Given this it may be that the student may require additional support in learning and using social emotional skills. It is also worth noting that some students may have already developed a bad reputation amongst their peer group which may disincentivise the use of social emotional skills. Supporting the development of safe relationships across the school community will help provide the student with the safety to learn academic and social emotional competencies.
- **Behaviour becomes more and more self-regulated**. As we grow from infancy, we take greater control of our own behaviour and thinking to achieve and learn, we learn to self-regulate. While these students may experience set backs it is important to observe and document times when these students have demonstrated the ability to be self-regulated through the use of prosocial skills.

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5.6 SOCIAL SKILLS

THINKING FUNCTIONALLY – SKILLS DEFICIT COPING

Students with challenging behaviour may experience deficits in their academic and social emotional capacities. In times of stress associated with academic and social challenges, such deficits can leave them feeling vulnerable. Their efforts to cope may be to get feelings of mastery, agency and competence through engagement in disruptive and anti-social behaviour e.g., being the class clown, being the toughest child in the class. These students may also be looking to get away from feelings of shame and embarrassment linked to their delayed capacities compared to their same aged peers.

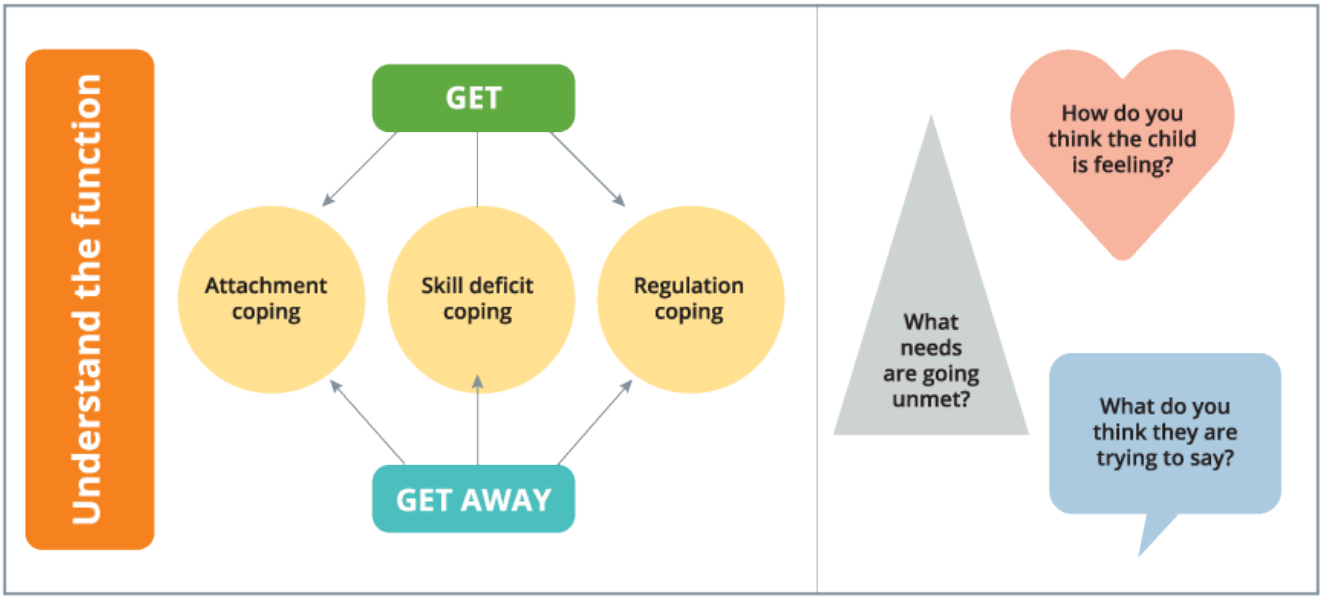

Figure 5.2 Understand the function by Govind Krishnamoorthy and Kay Ayre licensed under CC BY-SA.

Such behaviours may include lying, attempting to cheat on tests, being secretive or teasing and bullying others on perceived areas of incompetence to pre-empt others picking on them first. Building on these student's social emotional capacities would benefit them academically and socially while reducing the need for these students to engage in these maladaptive coping behaviours.

SOCIAL SKILLS

Remember from chapter two the competing pathway and replacement behaviour? When we think about disruptive behaviour from a functional perspective we think about what replacement behaviour we can teach the child that is acceptable to the context and the people in it. This

replacement behaviour is what we want the child to do to get what they need instead of the current serious, disruptive behaviour they are using to get what they need. Therefore, the replacement behaviour must serve the same function as the serious, disruptive behaviour (that is, it must be an acceptable way for the child to either get or escape) otherwise there is no point in the child using it. If a replacement behaviour does not serve the same function as the disruptive behaviour then the child will not use it. Instead, they will continue to use the serious, disruptive behaviour that did fill the function of enabling them to get or escape because it is working for them.

The goal is to teach a replacement behaviour that works better for the child than the disruptive behaviour and if the replacement behaviour does work better than the disruptive behaviour, the child will use it and keep using it because it works for them. Replacement behaviours need to be more efficient and effective than the disruptive behaviour and this includes taking less effort to demonstrate. Many replacement behaviours are associated with social skills and teaching the child how a particular behaviour looks and sounds in context. Often we assume that a child knows what an expected behaviour looks and sounds like without stopping to think what if? What if, that behaviour does not exist in the child's world beyond school? What if, that behaviour has never been demonstrated to the child? What if there has never been reason for that behaviour to be used?

Because many disruptive behaviours can be triggered by a lack of social skills, social skills are a crucial ingredient in any intervention into disruptive behaviour. Social skill difficulties according to Gresham (2015, p. 202) fall into two categories either acquisition deficits or performance deficits. Acquisition deficits are about the child not having had opportunity to acquire the skill. Lack of knowledge of the skill, not understanding where and when it should be used or how it looks, make this a 'can't do' problem.

Performance deficits on the other hand can be thought of as a 'won't do' problem. The child knows how to demonstrate the skill but won't. So, this is a performance problem tied to motivation not a learning problem and this is where knowing and changing the antecedents and consequences, play a critical role in increasing the frequency that these skills the child won't do, will be performed.

Read

Social Skills Improvement System

Classwide Intervention Program (SSIS-CIP)

Read about the Social Skills Improvement System – Classwide Intervention Program (SSIS-CIP) developed by Gresham and Elliott. The program focuses on teaching ten skills which have been proven by research to be the most critical skills according to teachers for students from prep through to adolescence. The ten skills are outlined within the reading. While it is a manualised program written within an American specific education context, it lends itself well to be an excellent framework to structure the teaching of social skills to children demonstrating serious, disruptive behaviours.

Gresham (2015, p. 210) notes the theory of change model derives, in part, from social learning theory (Bandura, 1977, 1986). This model uses strategies from social learning theory such as modelling (vicarious learning and observation), coaching (verbal instruction) behavioural rehearsal (practice)

and feedback/generalisation. Within the theory of change model, social skills are taught following six steps:

1. **Tell (coaching) –** the skill is defined, why is it important is discussed and the steps needed to demonstrate the skill are outlined.
2. **Show (modelling) –** appropriate and inappropriate behaviours are modelled, and visuals and video clips are also used. The importance of modelling is well supported by the research as a highly effective strategy.
3. **Do (role playing**) **–** review, revise, explain and demonstrate through role play the new social skill.
4. **Practice (behaviour rehearsal) –** the child practises the new skill within the context in which the problem occurred as well as wherever else the skill may be needed.
5. **Monitoring progress (feedback and self-assessment) –** reflecting on own progress. The teacher monitors and keeps written notes and gives feedback to the child during the teaching of the skill.
6. **Generalise (generalising across contexts) –** the child uses the skill in various contexts – in different areas/situations in the school.

While the steps above build upon each other in the order listed, more than one strategy can be used at the same time. For example, coaching and modelling would most often be used simultaneously to complement each other and strengthen the child's understanding of the skill being taught. The six steps apply to developing social skills of both acquisition and performance.

In summary, social skills are learned behaviours that are viewed as acceptable for the context within which they are performed. Social skills help children to interact positively with others. Throughout childhood development, variations will exist in the strengths and weaknesses of social skills and therefore the child's competence in performing them. Developing social competence is critical for all children so that they can demonstrate behaviours necessary for building positive relationships with others (e.g., teacher and peers) and engage successfully in learning.

Discover

BeYou

The BeYou site has a wealth of resources and information to support children with behaviour and social-emotional learning. Explore the many topics available and implement the strategies where applicable to your context.

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PART VI.

SURVIVE AND THRIVE

Teach Word Scrabble by Wokandapix used under CC0.

Overview and learning outcomes

Chapter six focuses on understanding the impact of working with traumatised students on educators and educational organisations. This chapter is organised in the following sections:

- The impact of trauma on educators and helpers
- Self-care and managing secondary trauma
- The impact of trauma on schools and other organisations

- Becoming a trauma informed school

On successful completion of this chapter, you should be able to:

- Understand the risks and impact of working with challenging students on educators
- Identify key self-care strategies that teachers can use
- Explain the parallel processes of working with traumatised students on schools and other organisations
- Understand the key stages of trauma informed organisational change.

INTRODUCTION

Each year, millions of children are exposed to some form of severe traumatic event. Many of these children are victims of physical, sexual or emotional abuse or neglect. Many thousands more have been traumatised by natural disasters (e.g., tornadoes, hurricanes, floods), automobile accidents, drowning, community violence or interpersonal violence they witness in their own homes. The trauma suffered by these children is not benign. It can result in serious and chronic emotional and behavioural problems that are very difficult to treat. And each year, day after day thousands of teachers, caseworkers, police officers, judges, pediatricians and child mental health professionals work with and try to help these children. And each year, parents, grandparents, foster parents care for these children.

All too often the adults are working in difficult, resource-limited situations. The children may present with a host of problems that can confuse or overwhelm their teachers. The pain and helplessness of these children can be passed on to those around them. Listening to children talk about the trauma, trying to work in a complicated, frustrating and often 'insensitive' system, feeling helpless when trying to heal these children – all can make the adults working with these children vulnerable to develop their own emotional or behavioural problems.

The purpose of this chapter is to present an overview of the topic of secondary trauma. The goal is to understand how to better support traumatised students by making sure we are at our best. The better we understand how working with traumatised children affects us both personally and professionally the better able we will be to serve them. In order to remain emotionally healthy ourselves it is critically important that we understand how the elements of a child's trauma can affect both individuals, like teachers, and organisations like schools. All professionals working with traumatised children can learn approaches and strategies to protect themselves from being emotionally overwhelmed by this work. In the end, the ability to help traumatised children depends upon our ability to stay emotionally healthy and motivated in difficult and often frustrating situations.

6.1 CARING FOR THE EDUCATOR: THE CHALLENGE OF WORKING WITH TRAUMATISED STUDENTS

"It is one of the most beautiful compensations of this life that no man can sincerely try to help another without helping himself"- Ralph Waldo Emerson.

SECONDARY TRAUMA

Secondary traumatic stress has been defined as the experience of stress and distress experienced by those who become aware of a traumatising event impacting another person. According to Charles Figley (1995, p. 6), secondary traumatic stress is "the stress resulting from wanting to help a traumatised or suffering person". Until recently, when we spoke about persons being traumatised we were speaking of those people who were directly exposed to the trauma. It has only been recently that researchers and practitioners have acknowledged that persons who work with or help traumatised persons are indirectly or secondarily at risk of developing the same symptoms as persons directly affected by the trauma. Clinicians and parents who listen to their clients or children describe the trauma are at risk of absorbing a portion of the trauma.

Secondary traumatic stress is sometimes confused with burnout. It should not be. Pine and Aronson (1981) define burnout as a state of physical, emotional, and mental exhaustion caused by long term involvement in emotionally demanding situations. Unlike secondary traumatic stress, burnout can be described as emotional exhaustion, depersonalisation and a reduced feeling of personal accomplishment. Burnout is a condition that begins gradually and becomes progressively worse. Secondary trauma, conversely, can occur following the exposure to a single traumatic event. When there is some interaction between the adult professional (or caregiver) and the traumatised child secondary trauma can occur.

Secondary traumatic stress refers to the presence of Post-Traumatic Stress Disorder (PTSD) symptoms caused by at least one indirect exposure to traumatic material. Several other terms capture elements of this definition but are not all interchangeable with it.

Table 6.1 Secondary stress and related conditions: sorting one from another

Compassion fatigue, a less stigmatising way to describe secondary trauma stress, has been used interchangeably with this term.	**Vicarious trauma** refers to the changes in the inner experience of the therapist resulting from empathetic engagement with a traumatised client. it is a theoretical term that focuses less on trauma symptoms and more on the convert cognitive changes that occur following cumulative exposure to another person's traumatic material.
Compassion satisfaction refers to the positive feelings derived from competent performance as a trauma professional. It is characterised by positive relationships with colleagues, and the conviction that one's work makes a meaningful contribution to clients and society.	**Burnout** is characterised by emotional exhaustion, depersonalisation, and a reduced feeling of personal accomplishment. While it is also work-related, burnout develops as a result of general occupation stress. The term is not used to describe the effects of indirect trauma exposure specifically.

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Bruce Perry and the Child Trauma Academy (2014) have identified several reasons why professionals working with maltreated or traumatised children are at increased risk of developing secondary trauma:

Empathy

Empathy is a valuable tool for educators working with traumatised students. Our compassion and care for these children helps them, not because we talk to them or at them, but because we are emotionally there for them when the other adults in their life are frightening or preoccupied with other matters. However, by empathising with a child or 'feeling their pain,' the teachers become vulnerable to internalise some of the child's trauma-related pain. We take on their pain as if it was our own, and this leads to becoming emotionally drained and fatigued.

Insufficient recovery time

Teachers working with children and families are sometimes required to listen to children describe some horrific situations they have experienced. Some teachers become secondarily traumatised by having to listen to the same or similar stories over and over again without sufficient recovery time.

Hourglass by Nile used under CC0.

Unresolved personal trauma

Many teachers have had some personal loss or even traumatic experience in their own life (e.g., loss of a family member, divorce). To some extent, the pain of experiences can be 're-activated'. Therefore, when professionals work with a student who has suffered a similar trauma, the experience often triggers painful reminders of their own trauma.

Children are the most vulnerable members of our society

Young children are completely dependent on adults for their emotional and physical needs. When adults maltreat these vulnerable persons, it evokes a strong reaction in any person with a sense of

decency and morality. At times, the senseless and almost evil nature of some of the trauma inflicted on children shakes one's sense of humanity.

Isolation and systemic fragmentation

When individuals feel valued and are in the presence of others who respect and care for them, they are more capable of tolerating extreme stressors. Clearly this means that the current practices in education – specifically, individual educational practice rather than team-oriented practice within a fragmented system with high-turnover – are a set up for increased stress for individuals working in that system.

Lack of systemic resources

A lack of economic and personnel investment in front-line services for high-risk children exacerbate each of the problems listed above. In our current socio-political climate, no public system is likely to address adequately the issues related to development of secondary trauma in front-line personnel. The task of addressing these problems, then, falls to the mid-level leader, supervisors, program directors and others who are working to create a positive work climate for their co-workers.

SECONDARY TRAUMA: INDICATORS AND WARNING SIGNS

Individuals affected by secondary stress may find themselves re-experiencing personal trauma or notice an increase in arousal and avoidance reactions related to the indirect trauma. The signs and symptoms of secondary traumatic stress are similar to those experienced by survivors of traumatic events. These symptoms include hypervigilance, hopelessness, excessive feelings of guilt, and even physical ailments, such as headaches, and irritable bowels (Figley, 1995). More signs and symptoms of secondary traumatic stress are highlighted in the table below.

Table 6. 2 Signs and symptoms of secondary traumatic stress

Hypervigilance	Social withdrawal	Insensitivity to violence	Disconnection
Hopelessness	Minismising	Illness	Poor boundaries
Guilt	Anger and cynicism	Fear	Loss of creativity
Avoidance	Diminished self-care	Chronic exhaustion	Inability to embrace complexity
Survival coping	Sleeplessness	Physical aliments	Inability to listen or avoidance of clients

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These difficulties have been found to interfere with capacity for individuals to offer support, by diminishing their willingness and capacity to listen to others, an inability to tolerate uncertainty and complexity and chronic feelings of fatigue and exhaustion (Figley, 1995). Client care can be compromised if the therapist is emotionally depleted or cognitively affected by secondary trauma. Some traumatised professionals, believing they can no longer be of service to their clients, end up leaving their jobs or the serving field altogether. Several studies have shown that the development of secondary traumatic stress often predicts that the helping professional will eventually leave the field for another type of work (Pryce et al., 2007).

IDENTIFYING SECONDARY TRAUMA

Supervisors and organisational leaders in child-serving systems may utilise a variety of assessment strategies to help them identify and address secondary traumatic stress affecting staff members. The most widely used approaches are informal self-assessment strategies, usually employed in conjunction with formal or informal education for the worker on the impact of secondary traumatic stress. These self-assessment tools, administered in the form of questionnaires, checklists, or scales, help characterise the individual's trauma history, emotional relationship with work and the work environment, and symptoms or experiences that may be associated with traumatic stress (Figley, 2004).

Supervisors might also assess secondary stress as part of a reflective supervision model (Pearlman & Saakvitine, 1995). This type of supervision fosters professional and personal development within the context of a supervisory relationship. It is attentive to the emotional content of the work at hand and to the professional's responses as they affect interactions with clients. The reflective model promotes greater awareness of the impact of indirect trauma exposure, and it can provide a structure for screening for emerging signs of secondary traumatic stress. Moreover, because the model supports consistent attention to secondary stress, it gives supervisors and managers an ongoing opportunity to develop policy and procedures for stress-related issues as they arise (Pearlman & Saakvitine, 1995).

Formal assessment of secondary traumatic stress and the related conditions of burnout, compassion fatigue, and compassion satisfaction is often conducted through use of the Professional Quality of Life Measure (ProQOL), as seen in the resource below (Craig & Sprang, 2010; Sprang et al., 2007; Stamm, 2010; Stamm et al., 2010). This questionnaire has been adapted to measure symptoms and behaviours reflective of secondary stress. The ProQOL can be used at regular intervals to track changes over time, especially when strategies for prevention or intervention are being tried (Stamm, 2010).

Discover

The Professional Quality of Life (ProQL) measure

The Professional Quality of Life (ProQL) measure can help teachers assess their own coping and self-care. Complete the measure to reflect on your own self-care practices and areas of need.

View

Emotional Mastery by Dr Joan Rosenberg [15 mins 17 sec]

Watch this short clip to learn an innovative strategy and surprising keys for experiencing the challenging

emotions. Please note that the clip contains themes and images that may be distressing to some. Please feel free to stop watching the video if you are distressed.

A transcript and Closed Captions are also available within the video.

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6.2 THE TEACHER MUST SURVIVE: SELF-CARE AND MANAGING SECONDARY TRAUMA

Anyone who lives and works with traumatised children may be affected by secondary traumatic stress. As we've seen in earlier sections, we are all, at all times, both vulnerable and resilient. Educators and educational systems have an ethical duty to build resilience and reduce vulnerability in themselves and their colleagues as secondary traumatic stress is a health and safety issue. In this section we will look at two broad domains of self-care: strategies for the prevention of secondary traumatic stress and strategies for the management of secondary traumatic stress.

PREVENTION

Prevention is better than cure, but the disorders cannot always be prevented. Training, support and coaching can all reduce the risk of teachers developing secondary traumatic stress disorder in the first place. When stress disorders do develop, various methods – in addition to training, support and supervision – can be used to treat the condition.

Prevention strategies: training and professional development

Team Hands Success by Gerd Altmann licensed under CC0.

Understanding what secondary trauma is and what causes it reduces a person's vulnerability and increases resilience. Training which increases understanding in the network of support around for teachers and groups of educational staff, increase their resilience. Training in managing stress will increase a teacher's ability to respond to stress in ways that are less damaging. Enhancing the teacher's professional knowledge and skills in trauma informed practice, increases their sense of professional identity, while also improving their capacity for teamwork and communication. Similarly, training aimed at personal development also increases the teacher's sense of having an identity outside of work. Improving skill in sport, or some other pursuit such as music or dance increases the sense of joy in living which helps to protect us from the effects of stress. Educators and support staff in roles or location where no training has traditionally been offered or who would find it difficult to attend courses can utilise techniques such as online learning and distance learning or combinations of different learning methods.

Prevention strategies: support

An audit of one's social support network, and methods to increase the quality of the support one is receiving, is possibly the most useful exercise in self-care. Informal support may come from people within the individual's network who are familiar with the concept of secondary traumatic stress disorder and who recognise the signs. Teachers benefit from including at least one 'trusted challenger'-someone who understands the dynamics of trauma and will point out changes in an individual and ensure that they get treatment.

Formal support may come from structures set up by the school or education department, such as peer support groups, who understand the dynamics of trauma; experienced mentors or people who know a particular traumatised child; or telephone or online helplines. It may also come from other organisations such as support groups and self-help groups.

Prevention strategies: coaching

Coaching and feedback on one's teaching practice from senior educators within the department or school, line managers or specially designated pedagogy or behaviour management coaches within the school context. Regular de-briefing or feedback sessions that look for any changes that might indicate that the person is developing a secondary stress disorder is critical for good self-care. Such coaching can only be effective when there is a school climate that embraces a 'growth mindset' – supporting teachers to be thoughtful in their practice; feeling safe in making mistakes and learning from their mistakes. Coaches and consultants external to the school can also help educators to reflect on processes, policies and practices within the school that are working well and those that may require changes.

Building capacity among staff in educating and supporting students with diverse needs requires a multidisciplinary approach, with consultations from experts in education, psychology, occupational therapy, medicine and speech pathology. These professionals bring with them unique perspectives on the prevention of secondary traumatic stress in staff, while providing specific advice for particular difficulties. These could include problems with drugs and alcohol, mental health, eating disorders, and other challenging problems that educators may find difficult managing in the school setting.

MANAGING SECONDARY STRESS DISORDER

Even with appropriate training and supervision, it is not always possible to prevent secondary traumatic stress disorders. However, these disorders are always treatable. It is the nature of secondary trauma that people who are suffering from it do not recognise the condition in themselves. Members of leadership groups who supervise teachers and other educational staff are equally vulnerable to developing secondary traumatic stress disorders, with consequent effects on their own performance and perceptions. Schools need to recognise these risks. They have a duty of care towards teachers and support staff to ensure that anyone who develops a stress disorder as a result of their work is supported in engaging in the treatment required to make a full recovery.

Physiological self-management

Before anyone can be helped by treatment, they need to recognise that they have a secondary traumatic stress disorder. As well as discussing this with a 'trusted challenger,' this may involve showing the person evidence of the effects on their cognitive processing, memory, emotional and social functioning and so on. There are several self-assessment tools available for free on the internet which can help with this process. They can be found online and be downloaded for use as self-reflection or discussions with members of your formal and informal support network.

Yoga meditation exercise by Clker-Free-Vector-Images licensed under CC0.

There are effective remedies which will restore the person's ability to manage stress, relax and feel pleasure – relaxation techniques, massage, yoga, exercise and music, among others. The key is to practice techniques with awareness of the body's response to the activity. As soon as there is a feeling of relaxation and pleasure, the person should consciously note this. Keeping a diary or keeping a record of recovery can be helpful. After recovery, the person needs to monitor their state of mind and wellbeing and build in strategies to ensure that they stay well.

Psychological therapies

There are a variety of psychological therapies that can address the symptoms of secondary traumatic stress disorders. For example, teachers working with challenging students in stressful environments can start to develop distorted thinking patterns that persist and require psychological therapy. Similarly, working in such extremely stressful environments for prolonged periods of time can lead to habits such as alcohol abuse, gambling and other dependency behaviours that require treatment focused on these maladaptive behaviours. Working with traumatised students and their families can also trigger unresolved trauma from any time in the life of the teacher, which may or may not have a direct relationship to the child's trauma.

Other therapeutic interventions

As we have seen in the previous chapters, children who live with trauma are regularly hyper-aroused or dissociated. Hyperarousal leaves children requiring soothing, calming environments which will help diminish their arousal. Such environments are also important for teachers working in stressful environments. Similarly, educators prone to withdrawing or zoning out when stressed will benefit from stimulating environments which help put them back in touch with their feelings. Some people also find complementary therapies such as massage, reflexology and so on beneficial.

Charles Figley (2002) wrote about the need to enable and empower people who give care to others to receive care in their turn. For their own sakes, and for the sake of the children they teach, educators need to be there for the child who experience trauma, while remaining in control of their own anxiety. They also need to realise the value of paying attention to their own needs and wellbeing as well as those of the children they care for.

View

Healthy Brain Platter

[5 mins 45 secs]

Watch this short clip to learn about the 'healthy brain platter' by Daniel Siegal – a framework for thinking about self-care. Please note that the clip contains themes and images that may be distressing to some. Please feel free to stop watching the video if you are distressed.

A transcript and Closed Captions are also available within the video.

Read

Teacher self-care by Education Queensland

Read the tip sheets series on 'Teacher Self-Care' from Education Queensland. It relates to supporting traumatised students in the classroom. The resource offers some practical tips and strategies for self-care for teachers.

View

Taming the gremlins: teaching and the challenges of self-care [5 mins 30 sec]

Watch this short clip to understand the common traps educators fall into that impacts their capacities for self-care. Please note that the clip contains themes and images that may be distressing to some. Please feel free to stop watching the video if you are distressed.

A transcript and Closed Captions are also available within the video.

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6.3 WE'RE ALL IN THIS TOGETHER: IMPACT OF SECONDARY TRAUMA ON ORGANISATIONS

Secondary stress is a health and safety issue for schools. Schools need to recognise it as a potential hazard for carers and staff. Risk assessment requires that schools assess the possible risks that could arise from hazards and daily stressors. They must also have strategies to reduce and manage the sources of stress for teachers and support staff in schools. Managers and supervisors need to understand why secondary stress could affect people's ability to care for foster children or perform to their usual standard at work. They also need to recognise the benefits of the school having strategies to prevent and support staff in seeking treatment for secondary stress. It's important that such action do not depend on one or two interested individuals, but be incorporated into the whole organisation's policies and procedures.

IMPACT OF TRAUMATIC STRESS ON SCHOOLS

To understand the impact of traumatic stress on organisations, it is useful to review our understanding of the impact of trauma on children. As seen in the previous chapters, children who are exposed to violence and other forms of traumatic experience, including neglect – particularly if these stressors are recurrent or chronic – may respond with a complex variety of problems. They are unable to keep themselves safe in the world and often put other people at risk for harm as well. They are chronically tense and hyper-aroused with hair-trigger tempers and a compromised ability to manage distressing emotions. This emotional arousal interferes with the development of good decision-making, problem solving skills and conflict resolution skills and as a result, the ability to communicate constructively with others does not develop properly. This results in grave cognitive, emotional and interpersonal difficulties.

As a consequence, self-correcting skills that involve self-control and self-discipline fail to develop properly. Breaches of trust that are a result of failed interpersonal relationships lead to problems with trusting or constructively collaborating with authority figures. These failures lead to a progressive lack of integration among the various cognitive, emotional, and interpersonal functions required of human beings in complex societies. This lack of integration produces basic deficits that result in demoralisation, loss of faith, helplessness, hopelessness, the loss of meaning and purpose and the spiralling degradation of repetition and avoidance. Lacking the necessary skills to deal with overwhelming emotions, young people frequently resort to substances, behaviours, and destructive relationships that will help them avoid the shame of failure, the anger of unjust treatment, and the grief of recurrent loss. Parallel difficulties may be found in organisations that attempt to serve these individuals.

Empty classroom by Dids licensed under CC0.

Today, organisations like schools are experiencing significant stress. In many schools, neither the staff nor the administrators feel particularly safe with their clients or even with each other. Atmospheres of recurrent or constant crisis severely constrain the ability of staff to constructively confront problems, engage in complex problem-solving, and involve all levels of staff in decision making processes. Communication networks tend to break down under stress and as this occurs, service delivery becomes increasingly fragmented. When communication networks break down so too do the feedback loops that are necessary for consistent and timely error correction. As decision-making becomes increasingly non-participatory and problem solving more reactive, an increasing number of short-sighted policy decisions are made that appear to compound existing problems.

Unresolved interpersonal conflicts increase and are not resolved. As the situation feels increasingly out of control, organisational leaders become more controlling, instituting ever more punitive measures in an attempt to forestall chaos. Staff respond to the perceived punitive measures instituted by leaders through acting-out and passive-aggressive behaviours. As the organisation becomes more hierarchical there is a progressive and simultaneous isolation of leaders and a 'dumbing down' of staff. Over time, leaders and staff lose sight of the essential purpose of their work together and derive less and less satisfaction and meaning from the work. Standards of care deteriorate, and quality assurance standards are lowered in an attempt to deny or hide this deterioration. When this spiral is occurring, staff feel increasingly angry, demoralised, 'burned out,' helpless and hopeless about the people they are working to serve. Ultimately, if this deadly sequence is not arrested, the organisation begins to look and act in uncannily similar ways to the traumatised clients it is supposed to be helping.

PARALLEL PROCESSES

The concept of parallel processes is a useful way of offering a coherent framework that can enable staff and leaders to develop a way of thinking 'outside the box' about what has happened and is happening to their service delivery systems, based on an understanding of the ways in which trauma and chronic adversity affect human functioning. Smith et al. (1989) describe parallel processes as

occurring when two or more systems – whether these consist of individuals, groups or organisations – having a significant relationship with one another. When this occurs, these systems tend to develop similar affects, cognitions and behaviours, which are defined as parallel processes. Parallel processes can be set in motion in many ways, and once initiated leave no one immune from their influence.

Students bring their past history of traumatic experiences into schools, consciously aware of some of their challenges but unconsciously struggling to recover from the pain and loss of their past. They are greeted by well-meaning teachers, subject to their own personal life experiences, who are more or less deeply embedded in entire systems that are under significantly stress. Given what we know about exposure to childhood adversity and other forms of traumatic experience, the majority of teachers and educational staff have experiences in their background and that similarity may be more or less recognised and at varying levels of resolution (Felitti et al., 1998). The result of these complex interactions between the traumatised students, stressed teachers, pressured schools, and a social and economic environment that is frequently hostile to the aims of recovery and support is often the opposite of what was intended. Teachers in schools of high rates of behavioural difficulties suffer both physical and psychological injuries and thus become demoralised and hostile. Their counter-aggressive responses to the aggression of the students help to create a culture of punitive responses.

Sad businessman thinking about problem by Andrea Piacquadio licensed under CC0.

Leaders become variously perplexed, overwhelmed, ineffective, authoritarian or avoidant as they struggle to satisfy the demands of their superiors, to control their staff and to protect their students. When educational staff and other support staff gather together in an attempt to create an approach to complex problems, they are often not on the same page. They share no common framework that forms the basis to their problem-solving. Without a shared way of understanding the problem, what passes as support may be little more than labelling and punitive or insufficiently thought out behaviour management approaches. When troubled students fail to engage or respond to these strategies, they are labelled again, given more warnings and consequences and termed 'too difficult' or 'too damaged' to engage in a school environment.

In this way, our school systems inadvertently but frequently recapitulate the experiences that have proved so toxic for children we are supposed to help. Just as the lives of children exposed to repetitive and chronic trauma, abuse and maltreatment become organised around the traumatic experiences, so too can entire systems become organised around the recurrent and severe stress of trying to cope with a flawed mental model based on individual deficits and diagnoses, which is the present underpinnings of our educational systems. When this happens, it sets up an interactive dynamic that creates what are sometimes uncannily similar processes at various levels of organisations and departments. Trauma theory brings context back to educational institutions, while integrating the importance of the biological discoveries of the last several decades. There are currently significant efforts directed at helping schools become trauma informed. In the following section we describe a framework put forward by Sandra Bloom (2010) for school staff and leaders to become more

sensitive to the ways in which individuals and groups of people exposed to overwhelming stress can be supported.

SAFETY

Schools and classrooms can become an unsafe – physically and emotionally – for students and teachers. This can happen either through teachers having to manage physical and verbal aggression of students or by the management of risky behaviours such as self-harm or sexualised behaviours from students. When this occurs, the basic trust that supports complex problem solving and high productivity is eroded. The list of behaviours that can trigger mistrust in staff is a long one and includes both verbal and nonverbal behaviour: silence, glaring eye contact, abruptness, snubbing, insults, public humiliation, blaming, discrediting, aggressive and controlling behaviour, overtly threatening behaviour, yelling and shouting, public humiliation, angry outbursts, secretive decision making, indirect communication, lack of responsiveness to input, mixed messages aloofness, unethical conduct – all can be experienced as abusive managerial or supervisory behaviour (Ryan & Oestreich, 1998). According to Bill Wilkerson, CEO of Global Business and Economic Roundtable on Addiction and Mental Health, "mistrust, unfairness and vicious office politics" are among the top ten workplace stressors (Collie, 2004).

EMOTIONAL CONTROL

Pekrun and Frese (1992) have argued that emotions are among the primary determinants of behaviour at work. Emotion can profoundly influence both social climate and the productivity of companies and organisations. Under normal conditions, a school manages and contains the emotional contagion that is an inevitable part of functioning within groups of human beings. This is done through normal problem-solving, decision making, and conflict resolution methods and school policies and procedures that must exist for any school to operate effectively. These are the norms that enable groups of teachers and students to tolerate the normal amount of anxiety that exists among people working on a task, tolerate uncertainty long enough for creative problem solutions to emerge, promote balanced and integrated decision making so that all essential points of view are synthesised, contain and resolve the inevitable conflicts that arise between members of a group and complete its tasks (Bloom, 2004).

In organisations under chronic, relentless stress, however, this healthier level of function is likely sacrificed in service of facing repetitive emergency situations and entire organisations may begin to look like highly stressed individuals. Traumatised people often develop chronic hyperarousal as the central nervous system adapts to the constancy of threat. Similarly, schools may become chronically hyper-aroused, so that everything becomes a crisis. When this happens, the capacity to prioritise what is important and what can be postponed is lost. Stress levels universally increase for everyone and, as one principal has said, "it's like managing with your hair on fire". Under conditions of chronic crisis, emotional distress escalates, tempers become short, decision making becomes impaired and driven by impulse, while pressures to conform reduce individual and group effectiveness (Ryan & Oestreich, 1998).

ORGANISATIONAL AMNESIA

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Just like individuals, if they are to learn, schools must have memory. Some modern philosophers believe that all memories are formed and organised within a collective context (Halbwachs, 1992). Organisational memory refers to stored information from an organisation's history that can be brought to bear on present decisions. Knowledge about the history of a school or educational department, like individual knowledge, exists in two basic forms: explicit knowledge, which is easily codified and shared asynchronously; and tacit knowledge, which is experiential, intuitive and communicated most effectively in face-to-face encounters. Explicit knowledge can be articulated within formal language. It is that which can be recorded and stored in the more concrete organisational storage bins: records, policies and procedure manuals, training curriculums, orientation programs, organisational structures and links of authority, and other written and promotional materials (Weick, 1979).

Tacit knowledge is that knowledge which is used to interpret the information – knowledge that is more difficult to articulate with language but lies in the values, beliefs and priorities of an organisation (Lahaie, 2005; Othman & Hashim, 2004). Tacit knowledge resides within the individual memories of every person who is or has ever been a part of the organisation is cumulative, slow to diffuse, is rooted in the human beings who comprise the organisation, and create the organisation's culture. Every teacher who leaves a school takes a part of the school's memory with them. As a result, over time and with sufficient loss, the educational institutions develop what's referred to as 'organisational amnesia' that affects learning and adaptation of the staff to the demands imposed on them (Kransdorff, 1998). Organisational amnesia becomes a tangible problem to be managed when there is a loss of collective experience and accumulated skills through the trauma of excessive downsizing, layoffs or people choosing to leave an organisation.

The result of organisational amnesia may be a deafening silence about vital but troubling information, not dissimilar to the deafening silence that surrounds family secrets such as incest, or domestic violence. There is reason to believe that maintaining silence about disturbing collective events may have the counter-effect of making the memory even more potent in its continuing influence on the individuals within the organisation as well as the organisation as a whole, much as silent traumatic memories continue to haunt traumatised individuals and families.

COMMUNICATION

Under increasing levels of organisation stress, the vital communication that is the lifeblood of an organisation starts to break down. As stress increases, perceptions of staff narrow, and the consideration of contextual information is lost and circumstances relating to staff working together as a group deteriorates to more extreme levels before they are noticed. All of this leads to more puzzlement – both among staff, school leaders and higher-level administrators.

Communication is necessary to detect errors and oversights, and risky situations and crises tend

to create the need for processes by which information is communicated from teachers in the classroom to the school leaders within educational institutions. These pathways of communication – to and from the school leaders – that is often compromised and become are of poor quality when under stress or pressure. Without such communication, staff and the school community are not provided with appropriate feedback and do not learn or know how to function better into the future. Research has shown that organisations are exceedingly complex systems that can easily drift toward disaster, unless they maintain resources that enable them to learn from unusual events in their day-to-day functioning (Marcus & Nichols, 1999).

Organisations that already have poor communication structures are more likely to handle crises poorly (Kanter & Stein, 1992). Instead of increasing impersonal communications, staff in crisis are likely to resort to the excessive use of one-way forms of communication. Under stress, the staff in supervisory and leadership positions in organisation tend to focus on the delivery of top-down information flow – largely characterised by new policies, procedures and processes intended to control what staff and student can and can't do. Feedback loops – pathways for how information is communicated between members of a group – erode under such circumstances of stress and morale starts to decline as the initiatives and work requirements that are communicated do not alleviate the stress or successfully resolve the problems faced by the teachers.

AUTHORITARIANISM

When danger is real and present, effective leaders take charge and give commands that are obeyed by obedient staff, thus harnessing and directing the combined power of many individuals in service of helping the institution excel, be continued to be funded and supported into the future. When a crisis occurs, the 'centralisation of control' is significantly increased, with leaders tightening reins, concentrating power at the top and minimising participatory decision making – seeking the thoughts and opinions of staff less and less when making decisions (Kanter & Stein, 1992). This is referred to as an authoritarian style of leadership. Even where there are strong beliefs in the democratic way of life, there is always a tendency in institutions like schools, and in the wider society, to regress to simple, hierarchical models of authority as a way of preserving a sense of security and stability. It's important to note that this is not just a phenomenon of leadership – in times of great uncertainty, everyone in institutions colludes to collectively bring into being authoritarian organisations, as a time-honoured method for providing at least the illusion of greater certainty, predictability and therefore reducing anxiety amongst staff (Lawrence, 2015).

However, when a state of crisis or situations of heightened risk are prolonged, repetitive or chronic, there is a price to be paid. The tendency to develop increasingly authoritarian ways of working in institutions is particularly troublesome for organisations like schools. A chronically high level of stress results in a school climate that promotes authoritarian behaviour and this behaviour serves to reinforce existing hierarchies and create new ones. Communication exchanges become more formalised and a one-way street – from leaders down to staff and not the other way around. Command hierarchies become less flexible, power becomes more centralised, staff on the ground stop talking openly and, as a result, important information is lost from the system (Weick, 2001).

The centralisation of authority means that those at the top of a hierarchy will be far more influential than those at the bottom, and yet better solutions to the existing problems may actually lie in the hands of those with less authority. Authoritarian leadership is likely to encourage the same leadership style throughout the organisation. The loss of democratic processes results in

oversimplified decision making and the loss of empowerment at each organisational level reduces morale and increases interpersonal conflict. As a result, the organisational norms of the behaviour of all staff are likely to support punitive and exclusionary consequences and failures in being empathetic when managing difficult situations. When such authoritarian behaviour goes unchecked, staff members can become bullies.

SILENCING OF DISSENT

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The greater the authoritarian pressures in an organisation and the greater the chronic stress, the greater is the likelihood that strenuous attempts will be made to silence those who might disagree with the decisions and choices being made in these institutions. Empirical data show that 'organisational silence' emerges out of staff members' fear to speak up about issues or problems they encounter at work (Morrison & Milliken, 2000). These underground topics become the 'unspeakable' topics become the undiscussables in an organisation, covering a wide range of areas, including decision-making, procedures, managerial incompetence, pay inequity, organisational inefficiencies and poor organisational performance (Ryan & Oestreich, 1998). Dissent is even less welcome in organisations characterised by chronic stress when dissent is seen as a threat to the staff needing to act in a unified manner. As a result, the quality of how problems are analysed, and decisions made deteriorates. If this cycle is not stopped and the organisation allowed opportunity to recuperate, the result may be an organisation that becomes destructive – similar to how severe traumatised children behave (Bloom, 2004).

DECISION-MAKING AND CONFLICT MANAGEMENT

As systemic stress increases, and authority becomes more centralised, organisational decision-making processes are likely to deteriorate, becoming less complex, more driven by impulse, with a narrowing focus and attention only to immediate threat. Long term consequences of decisions may not be considered, and alternatives remain unexplored (Janis, 1982). As work-related stressors increase, staff develop negative perceptions of their co-workers, and organisational leaders and this may precipitate serious decreases in job performance. Conflict over the tasks needing to be completed can be useful, but emotion inevitably accompanies such conflict in stressed organisations. Without good conflict management skills in the staff group, tasks-related to conflict can lead to even more misunderstanding, miscommunication, and increased team dysfunction, instead of providing the kind of enriching conversations that can lead to creative problem solving. Over time, it becomes apparent that people in the staffing group do not like and respect each other and spend their time in personal conflicts, while the group as a whole performs badly. Chronic stress puts an added burden on old conflicts, which are likely to emerge and propagate new conflicts.

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Hierarchical structures concentrate power and, in these circumstances, power can easily come to be used abusively and in a way that perpetuates rather than attenuates the concentration of power. Transparency disappears, and secrecy increases under this influence – staff members are left feeling uncertain about changes within the organisation. Communication networks become compromised as those in power become more punitive, and the likelihood of errors being made increases as a result. In such situations, conflicts tend to not be addressed and remain unresolved, tensions and resentment mount under the surface of daily interactions between staff and between staff and students.

DISEMPOWERMENT AND LEARNED HELPLESSNESS

Learned helplessness in workplaces has been defined as a debilitating cognitive state in which individuals often possess the skills and abilities necessary to perform their jobs, but exhibit suboptimal or poor performance because they attribute prior failures to causes which they cannot change, even though success may be possible in the current environment (Campbell & Martinko, 1998). In controlling, non-participatory work environments, every subsequent lower level of employee is likely to become progressively disempowered. After years, decades and even generations of controlling management styles, reversing this sense of disempowerment can be very difficult, particularly under conditions of chronic, unrelenting organisational stress. Helpless to protect themselves, feeling embattled, hopeless and helpless, the staff and management often engage in 'risk avoidance' behaviours where risk management policies prevent health change, adaptation, creativity and innovation.

INCREASED AGGRESSION

The most feared form of workplace aggression is physical violence, but there are several other forms of aggression that can be seen in the workplace. These can take the forms of dirty looks, stealing, hiding needed resources, threats and insults, ignoring input, unfair performance appraisals, spreading rumours, intentionally arriving late to meetings, failing to pass on information and failing to warn of potential danger. All of these actions on the part of management, staff and students are subtle forms of aggression. Stressful times are difficult for employees and as interpersonal conflict increases, it is likely that workers will express their anger, frustration and resentment in a variety of way that have a negative effect on work performance. Frequently, bureaucracy is substituted for participatory agreement on necessary changes, and the more an organisation grows in size and complexity, the more likely this is to happen (Huberman, 1964). Research has demonstrated that

poorer the performance gets, the more punitive leaders become, and that very possibly just when leaders need to be instituting positive reinforcing behaviours to promote positive change, they instead become increasingly controlling and punishing (Sims, 1980). A sure sign of an increase in aggression in the workplace is an escalation of vicious gossip and unsubstantiated rumour. Research shows that 70% of all organisational communication comes through this system of informal communication, and several national surveys have found that employees used 'the grapevine' as a communication source more than any other vehicle of communication (Crampton et al., 1998). Not only that, but the grapevine has been shown to communicate information far more rapidly than formal systems of communication. All of this lends itself to the promotion of a toxic environment.

UNRESOLVED GRIEF, RE-ENACTMENT AND ORGANISATIONAL DECLINE

Losses to the organisation are likely to be experienced individually as well as collectively (Carr, 2001). For the same reason, failure of the organisation to live up to whatever internalised ideal the individual has for the way that the organisation should function are likely to be experienced individually and collectively as a betrayal of trust, a loss of certainty and security, a disheartening collapse of meaning and purpose. Sudden departures of key leaders, the sudden death of a fellow teacher or loss of colleagues due to downsizing can be experienced as organisationally traumatic. It is clear that the ways in which grief, loss and termination are handled have a significant impact on employee attitudes. Unresolved grief can result in an idealisation of what has been lost that interferes with adaptation to a new reality. The failure to grieve for the loss of a leader may make it difficult or impossible for a new leader to be accepted by the group.

Traumatised individuals are frequently subject to traumatic re-enactments – a compulsive reliving of a traumatic past that is not recognised as repetitive and yet, which frequently leads to re-victimisation experiences. Such 're-enactment' is a sign of grief that is not resolved. An organisation that cannot change, that cannot work through loss and move on, is likely to develop patterns of re-enactment, repeating past failed strategies without recognising that these strategies may no longer be effective. This can easily lead to organisational patterns that become overtly abusive. The rigid repetition of the past and the inability to adapt to change may lead to organisational decline and possibly dissolution. All of these behaviours can be seen as inhibitors of organisational learning and adaptation.

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Organisational change is always challenging, and all too frequently fails (Pascale et al., 2000). But constant and rapid adaptation to a rapidly changing environment becomes a basic necessity for organisational survival. In supporting traumatised students, survivors of traumatic life events and sustained adversity, it has become clear that having a different way to assess and understand past and current problems is frequently the beginning of a healing and event transformative process. If teachers of a trauma informed school can similarly adopt a trauma informed mindset and approach to working, that enables them to collectively assess and constructively respond to recurrent stress in a different way, transformative, sustainable, and inclusive organisational change may be possible.

Read

'Creating sanctuary in the classroom' by Sandra Bloom

'Creating sanctuary in the classroom' by Sandra Bloom outlines trauma-informed processes and strategies for educators.

View

The Staffroom [27 mins]

Watch episode one of 'The Staffroom' – a three-part documentary as part of the ABC's Compass program. The show explores the demands and pressures of being a teacher in Australian public schools. Please note that the clip contains themes and images that may be distressing to some. Please feel free to stop watching the video if you are distressed.

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6.4 TRAUMA INFORMED ORGANISATIONAL CHANGE AND SUPPORT

Strategies that focus on trauma informed practice can draw upon the knowledge gained from helping children and adolescents who have survived traumatic experiences. Danger and losses that attend the loss of safety are usually wake up calls that urge individual survivors and schools to recognise that it is time for change. But once we start facing problems, they are generally bigger – more complex – than they appear at first glance and it is difficult to know where to start. When faced with complexity it is important to have some kind of cohesive framework that helps structure the development of an action plan for change. In schools, it is essential that the students and the school staff get on the same page so that their goals and strategies for achieving those goals are aligned. Similarly, from a whole school perspective, it is critical that staff members, administrators, and when relevant, board members agree on basic assumptions and beliefs about their shared mission, desired outcomes, and methods for achieving their goals. For traumatised students, this includes both social-emotional, as well as behavioural goals.

For individuals and for school systems, this requires a rigorous process of self-examination and the development of a core system of meaning that will guide behaviour, decision making, problem-solving, and conflict resolution. Such a process involves the willingness to temporarily reflect on the past, create a culture of inquiry to examine problems, and commitment of sufficient time to engage in honest dialogue. Constructive discourse, however, depends on good communication and recovering individuals need to learn how to listen and how to talk. Likewise, chronic systemic problems lead to communication breakdowns and the loss of feedback loops within organisations. As a result, an organisation like a school or an education department must learn how to reconnect and integrate with various parts of itself.

People doing handshakes by Fauxels licensed under CC0.

This can only occur by practicing democracy in action, not just in theory. Thus far in human evolution, democracy is the best method we have created to approach the problem of complexity. There is little about modern life that is not complex, and this is particularly true in addressing the problems related to trauma and its impact on individual and social existence. To heal, individuals must learn to modulate emotional arousal so that emotion does not interfere with the cognitive processes necessary to ensure good decision-making and problem solving. It is through participation in work groups, teams, and meetings that routine emotional management occurs within organisational settings. Crisis-driven organisations sacrifice

communication networks, feedback loops, participatory decision making and complex problem solving under the pressures of chronic stress and in doing so, lose healthy democratic processes and shift to innovation and risk-taking resulting in an inability to manage complexity. The cure for this situation is more democracy. This requires leadership buy-in and immersion in the change process, an increase in transparency, and deliberate restructuring to ensure greater participation and involvement.

Democratic participation requires a level of civil discourse that is missing in many organisational settings, including schools, due to a lack of conflict resolution mechanisms within the organisation. To be healthy, organisations must have the goals of conflict resolution as organisational goals. This means learning to walk the talk, embedding conflict resolution strategies at every level, not turning them over to a separate department or individual who is the formal instrument of conflict resolution. An environment that encourages participatory democratic processes, complex problem-solving and routine conflict resolution is an environment that encourages social learning. In an environment of social learning, every problem and conflict are seen as an opportunity for growth and learning on everyone's part (Bloom, 2004). In this way, the correction of errors becomes a challenging group educational process instead of a method for punishing wayward individuals. This requires a growth in understanding of the power of group processes.

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"Is it working?" is the question that an organisation like a school needs to repeatedly ask itself. Healing from trauma and chronic stress requires change and movement since the hallmark characteristic of stress is repetition and resistance to change. Like individuals, organisations often keep repeating the same strategies that never work, or that do not work any longer and then attribute failure to the children that are being served instead of the methods that are being used to help them change. Change can be frightening and dangerous or change can be exciting and even fun. This depends a great deal on the values and vision that the members of a school are willing to share together and share with the students. The hopelessness, helplessness, and loss of faith that accompany trauma and chronic stress are signs of stagnation that can only be overcome through creating a different vision of possibility toward which every change can be measured. An organisation that heals from its own past history of chronic stress and trauma and rejects the notion of inevitable crisis is an organisation that is able to contain the emotional turmoil so characteristic of working with traumatised students without becoming 'trauma organised' itself. This is what is meant by a 'trauma informed system'.

PRINCIPLES OF TRAUMA INFORMED ORGANISATIONS

Trauma informed organisations are characterised by seven dominant principles of practice that include:

- Culture of nonviolence: helping build safety skills and a commitment to higher goals.
- Culture of emotional intelligence: helping to teach emotion management skills to both staff

and students.

- Culture of inquiry and social learning: helping to build cognitive skills.
- Culture of shared governance: helping to create civic skills of self-discipline and administration of healthy authority.
- Culture of open communication: helping to overcome barriers to healthy communication, reduce acting out, enhance self-protective and self-correcting skills, and teaching healthy boundaries.
- Culture of social responsibility: helping to rebuild social connection skills, establish healthy attachment relationships.
- Culture of growth and change: helping to restore hope, meaning, purpose and empower positive change.

The impact of creating such trauma informed cultures should be observable and measurable. The outcomes we should expect to see include:

- Less violence including physical, verbal, emotional forms of violence.
- Systemic understanding of complex biopsychosocial and development impact of trauma and abuse with implication for response.
- Less victim-blaming, less punitive and judgmental responses.
- Clearer more consistent boundaries, higher expectations, and related rights and responsibilities.
- Earlier identification of and confrontation with perpetrator behaviour.
- Better ability to articulate goals, create strategies for change, justify need for holistic approach.
- Understanding how trauma re-enactments occur within organisations and contribute to resistance to change.
- More democratic environments at all levels of an organisation.

Through the implementation of trauma informed practices, staff members engage in prolonged dialogue that serves to surface the major strengths, vulnerabilities and conflicts within organisations. By looking at shared assumptions, goals and existing practices, staff members from various levels of the organization are required to share in an analysis of their own structure and functioning, often asking themselves and each other provocative questions that have never been overtly surfaced before. The emphasis on the development of more democratic, participatory processes is critical because these are the processes most likely to lend themselves to the solution of very complex problems while improving staff morale, providing checks and balances to abuses of power and opening up the community to new sources of information.

LEADERSHIP IN TRAUMA INFORMED PRACTICE

Implementing trauma informed practice begins with the development of a core team that represents participation from every level of the organisation to ensure that every voice is heard. It is vital that all key organisational leaders become actively involved in the process of change and participate in

this core team. Experience has that courageous leadership is always the key to systemic change and without it, substantial change is unlikely to occur. This change process is frightening for people in leadership positions and they rightfully perceive significant risk in opening themselves up to criticism, in levelling hierarchies and sharing legitimate power. The gains are substantial, but a leader only finds that out after learning how to tolerate the anxiety and uncertainty that inevitably accompanies real change. Since few of us have much real-life experience with operating within democratic systems, learning how to be an effective democratic leader necessitates a shared and often steep learning curve.

The responsibility of the core team will be to actively represent and communicate with their constituency and to become trainers for the entire organisation. The care team will work out team guidelines and expectations of involvement for individual team members as well as a meeting schedule. The core team will also need to decide on safety rules for the constructive operation of the team itself. Ultimately the core team will be responsible for the development and implementation of a curriculum aimed at including the entire organisation in the change process. The ultimate goal is to maximise the sharing of information that is so vital to healthy trauma informed organisations.

ADOPTING A WHOLE SCHOOL TRAUMA INFORMED PRACTICE APPROACH

Phase 1: Looking at the organisation's history

The first task of implementing trauma informed practice is to review an organisation's history, using the past to help us understand the present. The focus then shifts to the fundamental question of "are we safe?" Similar to the applications in individuals, organisational safety is understood as occupying four domains, all of which must be in place for an organisation to be truly safe: physical, psychological, social and moral safety. The question "how do we manage emotions as a group?" requires a review of the change processes inherent in every organisation. Staff are asked to anticipate the inevitable resistance to change that is a fact of life in every organisation. They require all staff to review their style of managing emotions, the way decisions are made, and conflicts are resolved. "How do we deal with loss?" touches on how the organisation deals with the losses that are inherent in every setting – staff leave, leaders depart, funding changes lead the loss of whole parts of a particular program or section of the organisation, students fail and sometimes, in tragic circumstances, members of the community die. The inability to deal with losses may lead to a system whose growth is arrested, similar to the impact of unresolved grief in the lives of individuals. A focus on the future of an organisation lends itself to the opportunity to being creating a new vision of what the organisation can be and do if it can move again. In this way, team members together begin to forge a different model of how they want to work together to achieve organisational goals.

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Phase 2: Values and vision

The second phase of implementation involves the core team identifying the most important organisational values and identify areas where the organisation is not actually living those values.

The discussions about shared assumptions are likely to begin with an assumed consensus that is actually false – profound conflicts are likely to have been bubbling under the service for quite some time but have never been clearly articulate. The core team must surface these conflicts, evaluate the impact on the functioning of the organisation, and decide on the values they are willing to share – and act on – together. Then the core team develops a statement on how they would like the staff and administrators to view their children and adolescents; to view each other and the organisation as a whole. Through this shared group existence, the core team members experience open and transparent decision making and personal feedback that is so valuable in a trauma informed organisation (Kennard, 1998).

Phase 3: Democratic communication processes

Didactic presentations and discussion will help the core team members learn about what it means to engage in more democratic processes on the part of educational leaders, staff, and students, particularly in terms of the simultaneous increase in rights and responsibilities. They must learn about the basic principles that go into creating and sustaining a trauma informed environment. They evaluate the existing policies and procedures that apply to staff and clients and ask whether or not they are effective in achieving the goals that they strive for. The team begins to draft a program constitution and develops a comprehensive plan for the steps they should take to close the gaps between the school they want to be – based on their values and vision – and the school as it exists in the present. This process focuses on inclusiveness, participation, rights and responsibilities, decision-making, conflict resolution, rules and norms, consequences for risky and unsafe behaviour, responses to stress and to violence, responses to secondary trauma and self-care and continuance and maintenance of normative standards.

Phase 4: Teamwork and collaboration

The next focus of implementation is on teamwork, collaboration and systems integration. The core team develops a vision statement for how they believe the work groups or teams should function together to produce a more democratic and cohesive staff group. They then develop a plan for the steps they will take to improve teamwork and collaboration in order to make that vision a reality. The team also begin the process of developing a statement of expectations for staff around their responsibility to confront each other in a constructive manner and initiate a plan to increase the conflict resolution resources within the school.

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Phase 5: Understanding trauma and its impact

Studying and understanding concrete information about the impact of trauma on children, adults, families and systems is vital for creating a trauma informed school system. Supplementing didactic and experiential training, core team members need to stay updated on the latest research and findings on the impact of child maltreatment, family violence, and community violence on students. Discussion focuses on the way in which the knowledge about traumatic stress needs to be integrated

into the existing policies and procedures of the organisation including the impact of exposure to vicarious trauma and its impact on organisational function.

Phase 6: Creating and reviewing school procedures and processes

In the next phase of implementation, the core team develops a plan for consistent review and response to incidents that breach the safety of teachers and other students. They will identify what student behaviours and what staff behaviour may have led to the incident occurring. It may be beneficial to include trauma informed practice experts and consultants in these procedures. A trauma informed approach emphasises the creation of a nonviolent environment with interventions and strategies designed to minimise the probability of such behaviours occurring again. The core team develops or reviews an intervention plan to use with the student and with each other in high risk and escalating situations. They will develop or review policies for the thorough debriefing after any incidents of violence or loss and develop a plan to train staff as required.

It is also worth periodically reviewing and revising grievance procedures as well as performance reviews to reflect the emphasis on safety and emotion management of the staff. The core team will outline how the school organization should address issues relating to be more trauma informed and what it takes to build a better future and to change the trajectory of student's educational journey from what it has been to what it can be.

Read

Headspace school support

Check out this information sheet from Headspace School Support on coping following the death of a student, or students by suicide. The resource has some good general tips for self-care and coping.

REFERENCES

Kennard, D. (1998). *An introduction to therapeutic communities*. Jessica Kingsley Publishers.