Trauma Informed Care Protocol

Enhancing the Capacity to combat chiLd abuse through an Integral training and Protocol for childcare professionalS

This project has received funding from the Rights, Equality and Citizenship (REC) Programme of the European Union under grant agreement No 101005642.

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ECLIPS

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INTRODUCTION:

Why we need trauma-sensitive childcare

> ***Let no one lift me up high unless they keep holding me until I grow up for real. Let those who want not just to hear but also understand me squat next to me here, so that our heartbeat be close together.***
>
> (F. Birtalan: Until I grow up)

As a professional[1] who regularly works closely with young children, you are responsible for offering them and their caregivers a safe and nurturing environment. Childcare professionals are increasingly acknowledged for their role in the development and well-being of children and their families. This protocol is intended for every childcare professional, as it is more than likely that they will encounter children who suffer from trauma and child abuse, with chapters dedicated to paediatricians and health visitors[2], who accompany families on their journeys to care for the youngest children.

1 There are many terms that describe different forms of organised/professional childcare services and organisations (e.g., preschool, day-care, childcare, nursery, nursery school, kindergarten, nanny services). Throughout the protocol we have used a general term "childcare professional" and "childcare organisation" as an umbrella term of many childcare professions and forms.

2 Health visitors: professionals working in home-visiting programs established for children between 0-3.

Everyone who is present in the life of a child has a trauma-sensitive role to play. With this protocol, we seek to inspire professionals on their journey towards trauma-sensitive care. If trauma-sensitive care can become embedded in the daily work of childcare services, we can improve the resilience of everyone involved: the children, their families and (you) the professionals.

In the framework of the ECLIPS project *("Enhancing the Capacity to combat chiLd abuse through an Integral training and Protocol for childcare professionalS" (ECLIPS), REC-RDAP-GBV-AG-2020-101005642.)*, four partners from four countries have worked together to develop awareness and skills concerning detecting, referring and treating trauma-symptoms after child abuse and neglect in the 0-3-year age group. Universities from Belgium and Italy (UC Leuven-Limburg and UNIMORE) and foundations working in the field from Hungary and Latvia (Pressley Ridge Hungary and Centrs Dardedze) developed two differently focused pieces of material to support professionals in detecting and tackling child abuse and trauma in children aged 0-3 years:

a **Screening and Referral Tool** and a **Trauma Informed Care Protocol**[3].

The pieces of material are also accompanied by a VR-tool-equipped training programme.

The two pieces of material together form a single unit. The first piece of material, the **Screening and Referral Tool (which can be found here)** provides, among other things:

- Essential knowledge about child abuse and its consequences and signs of child abuse
- Useful considerations on how to communicate with parents about what is observed in their child's behaviour, emotional state, development, needs
- How to screen and refer suspected or known child abuse to the authorities
- You are currently reading the second part of the material, the **Trauma Informed Care Protocol**, which offers insight into trauma-sensitive care. This protocol, offers childcare professionals information and guidelines on
- Adverse childhood experiences and trauma, their importance in early childhood
- What does it mean to work in a trauma sensitive way - at both an organisational and a personal level
- Specific tips on trauma sensitive work with children aged 0-3 years

Short explanations of key terms are offered at the end of the protocol (Chapter 5: Glossary). The protocol is also accompanied by posters that can be used as visual aids for the everyday trauma sensitive work.

Professionals working with young children have knowledge about normal child development and are aware that development can be affected by certain conditions. For example, prematurely born babies are (ideally) provided supportive care to help their healthy development and reasonable attention is given to the fact that developmental milestones might be achieved differently in their case. The same awareness and conscious course of carefully planned actions are rarely present

3 Our work was supported by groups of policy makers, professionals and parents, applying the user-centred methodology of living labs in all the four countries.

towards children who are victims of domestic violence, child abuse and neglect, due to the hidden nature of these adversities, and the lack of informations and tools professionals can use[4].

While scientific knowledge is on the rise on how adversities may affect brain development, behavioural and emotional difficulties displayed by traumatised children are often misunderstood or misinterpreted. Domestic violence and child abuse are still topics that often become sensational or remain taboo. Childcare professionals who have to face the phenomenon in their daily work might have difficulty finding guidance on how to handle the cases in a helpful, constructive manner.

Dedication to the best interests of the child is one of the core values of the most widely accepted human rights instrument, the Convention on the Rights of the Child (1989). This dedication can only be achieved through conscious actions. Being aware of the highly detrimental effect of child abuse and neglect and the lack of useful guidelines available for childcare professionals working with affected children, this protocol has been created with the aim of supporting professionals who come into contact with our youngest children and want to care for them in a trauma-sensitive way.

After reading this protocol you will have a solid understanding of trauma and its impact on young children, and as a professional you will be able to find ways to respond to babies and toddlers, primary caregivers[5] and childcare professionals who may have faced stressful childhood experiences within the care-giving mandate.

> ***"You don't have to be a therapist to be therapeutic."***
>
> (Ford & Wilson, 2012, p. 12)

As a childcare professional, you play an essential role in shaping children's experiences outside the home environment. Early childhood adversity is a topic that has been widely covered (see Lund et al, 2020), but it is only recently that we have started to recognize adverse childhood experiences as a major public health challenge that can be largely resolved by adequate prevention and intervention (Petrucelli et al, 2019). **Trauma-sensitive care has been highlighted as a way to ground our understanding and respond to the impact of trauma such that it prioritises safety and well-being while focusing on the strengths of the child and their primary caregivers.**

Young children exposed to domestic violence cannot depend on their primary caregivers to provide a safe environment in which to live and grow, so the role of the childcare professional becomes even more essential: **they provide children with a safe environment in which to grow, learn and develop.** Unfortunately, many babies and toddlers carry the invisible burden of negative past experiences which, if not well understood, can impair their capacity to develop and benefit from the positive elements supplied by their environment.

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4 The ECLIPS project started with a research conducted in all the four partner countries on training, knowledge and application of screening and referral of child abuse, on trauma and trauma informed care in the age group 0-3. Our results have shown that currently there is a lack of knowledge and training with respect to the formal recognition of possible domestic violence. Childcare professionals mainly rely on their own experience and gut feeling regarding the screening and referral of possible cases, and there is a lack of theoretical and practical knowledge regarding trauma-sensitive care, an absence of definitions or protocols on trauma-sensitive care with respect to the 0-3 age group, and a lack of specific protocols, guidelines and instruments for this age group.

5 Within the protocol we use general term "primary caregivers" that includes child's parents, foster parents or adoptive parents, and other caregivers involved in caring for and rising the child (e.g., grandparents).

This protocol explores the meaning and impact of trauma and offers advice on how to work in a trauma-sensitive way with children aged 0-3 years, particularly for nurseries, health visitors and paediatricians. Understanding how the brain, body and mind respond to trauma may help to gain a better understanding of trauma histories of others and ourselves and how such histories influence our present behaviours, thoughts and feelings. Childcare professionals working according to the principles of trauma-sensitive care can ensure **brief, momentary supportive interactions through their conscious presence.** These interactions and trauma-sensitive interventions are viable if professionals are equipped with up-to-date knowledge and appropriate institutional support.

In your journey towards trauma-sensitive care, you might find that materials refer to 'trauma-informed care' instead of 'trauma-sensitive care' (definitions see in chapter 5). Both terms generally refer to the same principles but they represent a different setting and user. Trauma-informed care applies more to specialised settings and is often more treatment-focused. The setting often works with exclusive groups of people, for instance children who have suffered from child abuse. Trauma-sensitive care is a type of care that is more applicable to generalised care settings. It serves all people, some of whom have suffered trauma.

It is important to acknowledge the difference as both types of care and settings have a different role. The term 'trauma-sensitive care' helps to recognize that childcare professionals do not have to be therapists. It also helps to emphasise that supporting children with trauma requires an organisational (and even societal) perspective that should be embedded in the existing approaches on how to prioritise healthy development, well-being and safety.

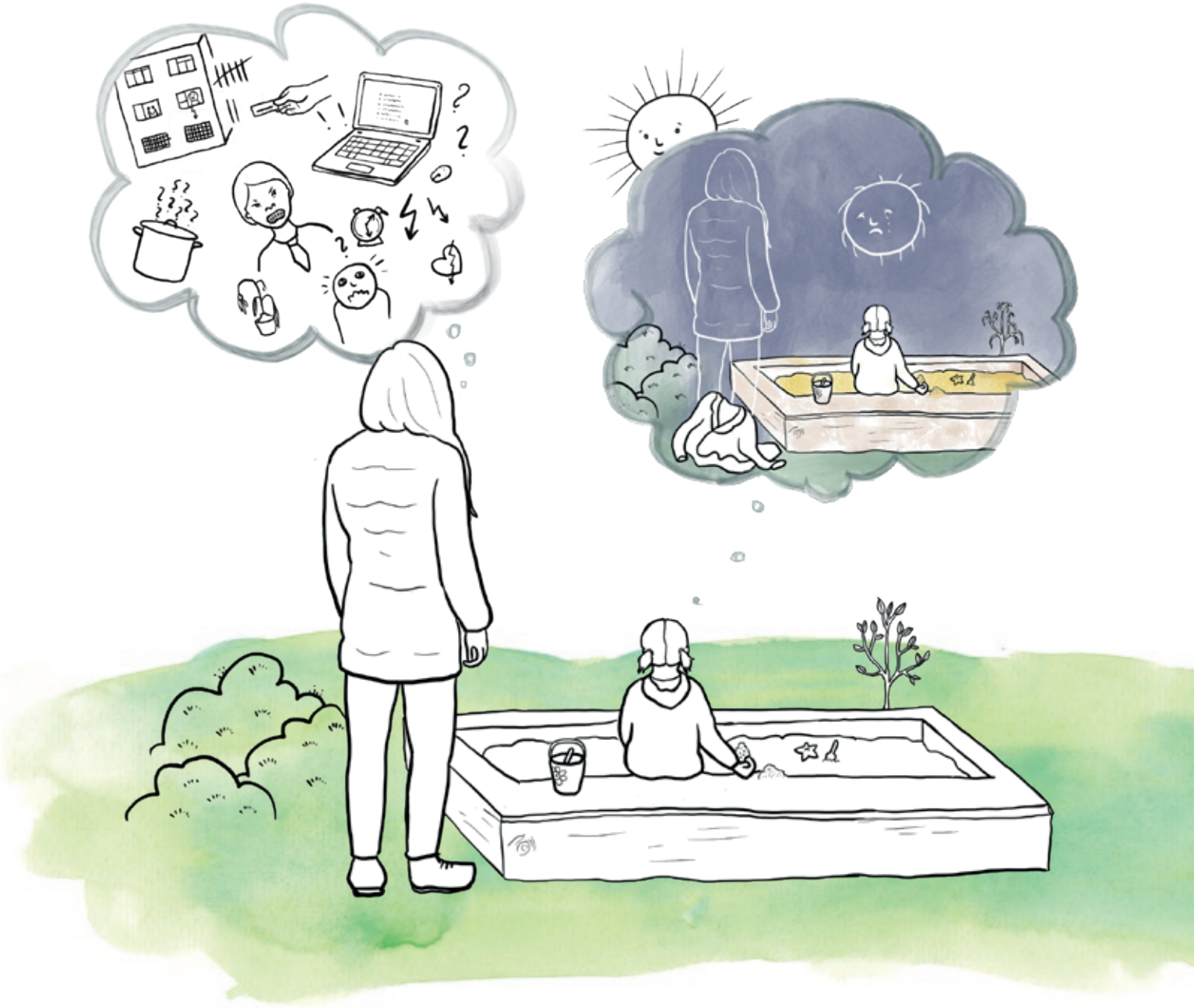
Before starting, we would like to acknowledge the limitations of this protocol. Given the complexity of this topic, this protocol does not aim to cover the whole topic extensively. What it does instead is offer an introduction and a coherent clarification that can be built upon and stimulates further exploration. Because the field of trauma-sensitive care is continuously developing, the protocol merely offers a snapshot of the current knowledge and research, but evidently it leaves many gaps. The suggestions included in this protocol *are not a substitute for specialised care, nor are they a guideline for diagnosing trauma*. Good practices suggest involving specialised and multidisciplinary healthcare support to address the holistic needs of the children who need it.

This protocol was written especially for childcare professionals, who come into contact with many children, of whom some may have experienced or are experiencing trauma. We targeted specific professionals - nursery workers, healthcare visitors and paediatricians - because they are often a recurrent and reliable contact outside the home environment. The protocol is a guideline that is meant to inspire preventive actions and to encourage knowledge, skills and attitude to tackle trauma among and its impact on our youngest age group.

If you are reading this protocol, it means that you have taken the first step towards including trauma-sensitive care in your work with children aged 0-3 years. It is impossible to expect that you will be able to deliver an integrated approach immediately after having read this document. Rather, exploring this document means creating an opening for leadership and willingness to deal with barriers towards a trauma-sensitive approach and a commitment to enhance the response at each level of your organisation.

CHAPTER 1.

What are stressful childhood experiences? How to define trauma?



“ ***Too much too soon, too fast*** ” (Peter Levine)

After reading this chapter you will have a clearer understanding of what the role of stress and adverse childhood experiences plays in the everyday behaviour of both children and adults.

1. Stress: The good, the bad and the ugly

We all face stressful situations more often than we acknowledge. Think about those times when you may struggle with busy work days, when your finances need extra attention or when you face relationship challenges. However, we can also regard stress as an added value to our lives, which it often is. It keeps us alert, motivated and ready to avoid harmful situations. Imagine when you got married or when you had to take an important exam. The stress might flow through your body, but that feeling might also make you feel ecstatic. It is the power of ***good*** stress that may boost you to challenge yourself and further grow as a person. But stress is not always a good thing, unfortunately. Stress can become a problem when it is prolonged, when the stressor is more severe than we can handle or when we lack emotional support to help us cope with the stressor. Under such circumstances, ***bad*** stress may manifest itself in emotional or physical tension such as migraines, exhaustion, alcohol abuse, irritability or muscle soreness. Where good stress may stimulate your creativity and growth, bad stress will reduce your productivity. Our bodies are not designed to have to face stress constantly but if and when it does happen, things can become ***ugly***. Stress that keeps on lasting can have a detrimental effect on our physical and psychological well-being. Long-term stress may cause a dysfunctional immune system, an inability to think clearly and will lead to mental health problems like depression or anxiety (Baffour, 2016).

This protocol purposefully starts with broadly addressing the good, the bad and the ugly stress. If we can acknowledge the difference, we can understand that some stress is normal and that dealing with stress is part of everyone's lives. Everyone will experience some kind of arousal or excitement, or some level of everyday stress. The number of moments in a day where we find ourselves completely relaxed may be rather limited. We need a certain tension to perform our daily tasks attentively. So there is nothing wrong with a certain amount of stress or tension. However, there is a limit to the level of stress that we can bear and still be able to function.

2. The window of tolerance and its role in traumatisation

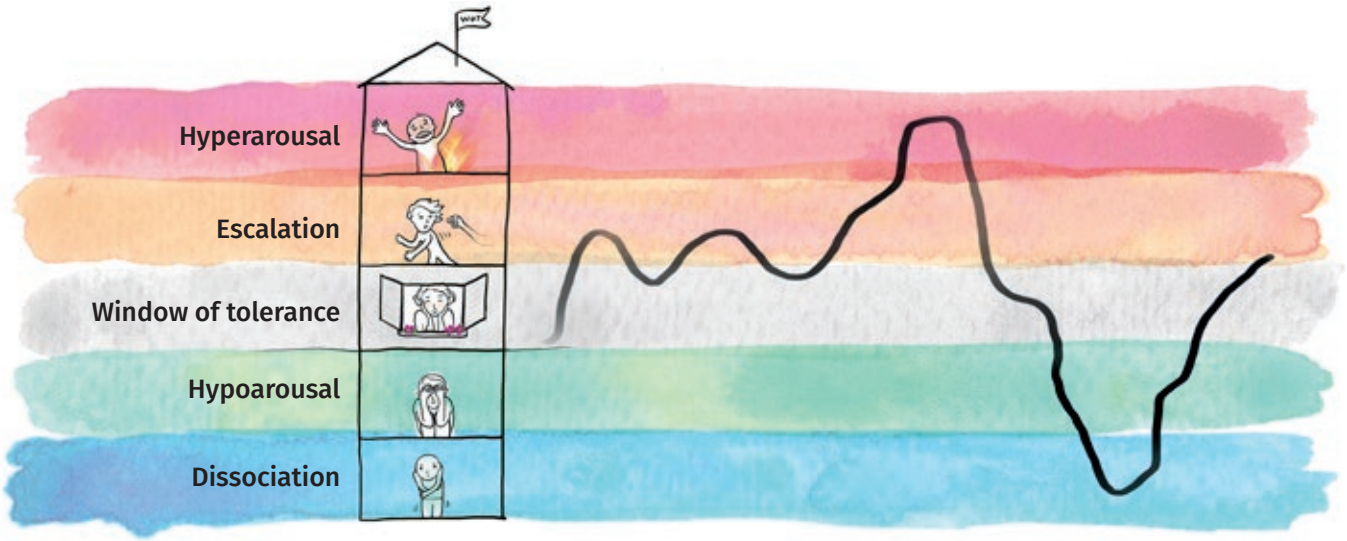
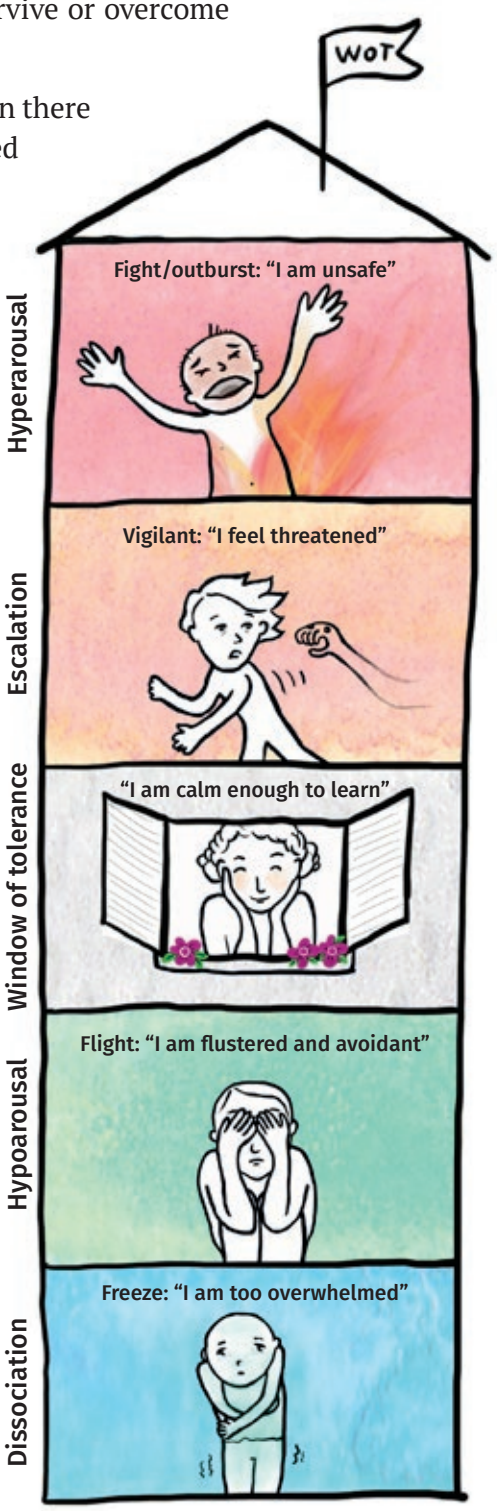


Figure 1. Window of Tolerance (Illustration by Emese Iványi)

We **function optimally** when all the parts of our brain can cooperate properly. The 'window of tolerance' (Siegel, 1999) is a concept that helps us understand and describe the impact of stress on body and brain functioning.

As long as we find ourselves within our own window of tolerance, we can process information, focus on tasks, and be creative. But once our upper limit has been reached, our body and brain become hyper-aroused. The **hyper-arousal state** is also known as the fight-flight-active freeze-response and heightens our activity and energy. Our body is highly vigilant. On a personal level it can be experienced as difficulty in concentrating, irritability, anger, panic, anxiety, startled responses and self-destructive behaviour, among other things. Most people can identify as they have been outside the boundaries of their own window. At these times, thinking becomes disrupted by an intensified bodily and emotional arousal. Behaviours in hyper-arousal are automatic, they happen without consciously reflecting on the situation. We also know these reactions as we see them in animals: a deer freezes to observe the situation and runs away from a lion, lions fight for a prey. These reactions are very useful when we have to survive or overcome danger.

However, we also find ourselves fleeing, fighting or freezing when there is no actual danger. For children and adults that have experienced many unsafe situations, it can be more challenging to regulate emotions. Their window of tolerance, the arousal level that feels bearable and allows for them to function effectively, becomes quite narrow. In those cases, it can be especially difficult to stay grounded. The permanent arousal level is usually higher and they reach their upper limit faster. Moreover, they expect more danger, even when there is no danger from another perspective. Their brain keeps them on their toes because it feels more comfortable to be able to respond quickly when there is no danger, rather than being late when there is danger. Where children are concerned, we can see that they have a hard time focusing, they often cry, push, run away, and close themselves off from others more often than what you would expect from a child of their developmental age.



If our stress level further heightens or remains high, we might reach the lower limit of our window of tolerance. **The hypo-arousal state** is known for the passive freeze reaction and dissociation. This is, in essence, a beautiful survival mechanism designed by our brain. Our body prepares for severe damage and wants to reduce the impact as much as possible. Our consciousness narrows, we feel like we are no longer really 'present' and we might experience amnesia in a later instance. Our heart beats slower so we do not lose any blood if we are injured. Hormones are released to make us experience less pain. When our body is in the hypo-arousal state, our chances of survival will be higher if, for instance, we are involved in a car accident. Taking an example from the wildlife again, small prey animals like mice freeze to escape the attack of their predator.

However, experiencing hypo-arousal in an ordinary situation is dysfunctional. A child in hypo-arousal might seem absent

and pays little or no attention to the outside world. It is important to note that this state can occur even if the danger is only perceived from within, and to an outside observer this absence may seem incomprehensible and rude. Nevertheless, the experience inside can be as intense as during an inescapable situation against a bear attack, even if the bear is not actually there.

Looking at the window of tolerance we can understand better that a person can only grow and develop in the optimal arousal zone. It should be our priority to ensure that all children feel as safe as possible, as often as possible. Young children naturally have a smaller window than adults, as they are still slowly exploring the outside world. They still need to be regulated by caregivers around them, as they do not have their emotional regulation system developed yet. For young children, the size of the window of tolerance is attuned to the experiences in the primary caregiving relationship. A young child is continuously developing and has to learn how to regulate his/her own emotions and stress. **Young children need reliable and predictable caregivers for the regulation of their emotions and stress. The 'window of tolerance' of the primary caregiver(s) is an important indicator in the process of learning to regulate oneself.**

What can we do?

Reflect on how and why children do certain things. You might notice that a child is struggling in how they express themselves, in the tone of their voice. Try to really listen and observe a child. Think about the needs that this specific child might have and how these needs can be addressed. This calm state of listening and observing will encourage children indirectly to strengthen the trust they have in themselves and in their environment. Less energy needs to be spent on being alert for danger and more energy will remain to control impulses.

3. Adverse childhood experiences

Children are developing continuously. Children in safe and warm environments are likely to develop a brain that is attuned to a kind world with caring adults surrounding them. They grow up feeling safe, capable and acknowledged. But stressful experiences can have an enormous impact on the development of their nervous system. Children in unsafe environments are likely to develop a brain that is attuned to a world where they need to be attentive for possible danger and where anyone can pose a threat. They quickly learn to trust nobody. The effects of growing up in an unsafe environment have been documented in the 'Adverse Childhood Experiences' (ACE) study (Felitti et al., 1998) and constantly investigated and elaborated upon since the original study was published (eg. Lund et al, 2020).

Adverse childhood experiences (ACEs) are generally considered being chronic and repeated, having occurred or started during childhood, and happen within the context of the child's relationships. **It is the experience of a severely stressful event without the safe support of a caregiver that decides the gravity of the impact and less the situation itself.** From a vast body of research we already know that experiencing these adverse events during childhood can have a cumulative impact on the risk for numerous physical, mental and social health problems far into adulthood. Based on the research (Felitti et al., 1998) we generally include 10 common adverse childhood experiences:

- Physical abuse
- Emotional abuse
- Sexual abuse
- Physical neglect
- Emotional neglect
- Growing up in a household with mental illness
- Growing up in a household with incarceration
- Growing up exposed to intimate partner violence
- Growing up exposed to substance abuse or dependency
- Growing up with absence due to parental separation, divorce or death

In Europe, approximately one in four children have experienced one ACE and one in five have reported two or more ACEs (Bellis et al., 2019). Experiencing one or multiple adverse experiences can strongly interfere with a child's ability to develop and learn, to grow and explore. And that detrimental effect lasts a lifetime. People who have experienced more adverse experiences in childhood, also have more diseases, greater levels of depression, suffer more from alcoholism and are in poorer physical health during adulthood (Bellis et al., 2019).

Regarding the 0-3 age group, there are several additional experiences (some of which are listed among the ACEs, some are not explicitly) that might be considered important to distinguish[6].

- Growing up in a context of postpartum depression
- Constantly being shamed and humiliated (both emotional and physical abuse)
- Growing up in a household with a disabled or injured caregiver or sibling
- Experiencing severe injuries or persistent illness
- Growing up with a lack of 'good enough' (Winnicott, 1963)
  parental attention due to parents' divorce
- Growing up with a varying quality of care due to caregivers' busy schedules
- Having exercises to support normal development, as advised by professionals,
  but ignored by caregivers, thus hindering the child's development
- Being denied basic care and care equipment by caregivers
- Being placed for adoption or in foster care

Despite its prevalence and dramatic consequences, most childcare professionals have no relevant training on ACEs and how to deal with children experiencing them[7]. Seeking to address adverse experiences can be difficult because of the sense of pain, blame and disconnection that trauma creates. Moreover, young children in particular are limited in their power to have influence on adverse experiences because of their age, size and status as children. Children mostly depend on their adult caregivers to support them in their recovery process. **This offers a prevention perspective: if we can reduce the impact of adverse experiences on young children, we can reduce the burden and negative outcomes in their lives.** However, if children are exposed to these kinds of adverse experiences that overwhelm their ability to cope, trauma can occur.

6 The list was compiled by the Hungarian living lab members of the ECLIPS project.

7 According to the outcome of the research conducted in the context of the ECLIPS project in four European countries (Belgium, Italy, Hungary and Latvia).

4. Defining trauma — traumatic events, stress and care

In the last few years, trauma has become a commonly discussed topic in the media: books, movies and articles on the topic are more widely available. We often hear that trauma leaves an imprint on the brain, the functioning of our nervous system and our reactions to stress (Winfrey & Perry, 2021). The long-term effects of emotional shock or prolonged stress can be carried for a lifetime (van der Kolk, 2014). But what is trauma?

When we ask people[8] what the word trauma brings to their mind, they often begin to list difficult life events, tragedies, such as serious, fatal illness, death, unexpected loss of a close relative, natural disasters, experiencing war, fleeing or migrating and traffic accidents. A second thought includes events describing physical and then emotional abuse, such as domestic violence, sexual abuse, physical abuse such as beating, or violent behaviour of parents, caregivers, mental abuse like humiliation, degradation or verbal abuse. At the end of the list may appear physical and mental neglect. Here a longer conversation can be held about what can really be considered trauma: because, after all, we all know (and we can emphasise it with a number of specific stories) that individual life events do not affect everyone in the same way. What is more difficult to explain is **what makes a life event traumatic and unprocessable for some, and why it seems to make others stronger and emerge as winners.**

Various definitions of trauma have been provided by experts in the academic world. Research and understanding is ongoing. New, more accurate, deeper knowledge about the impact of trauma and its treatment possibilities is emerging in the scientific world practically every day. In this protocol, we will focus on Bruce D. Perry's definition of trauma, taking into account the latest scientific findings.

Bruce D. Perry emphasises individual responsiveness in his definition, with a particular focus on the shift in the functioning of our nervous system that orchestrates our responses given to stress. This nervous system that dictates how we process stress is often called our 'stress response system'. In our material, we will primarily use this definition of trauma and the 'trauma lens' that is to be used when offering trauma-sensitive care.

> ***From a neurodevelopmental perspective, trauma is not the event – it is the individual's response to the event. Traumatic stress occurs when an extreme experience overwhelms and alters the individual's stress-related physiological systems in a way that results in functional compromise in any of the widely distributed stress-response systems (e.g., neuroimmune, neuroendocrine, autonomic and central nervous system network).***
>
> (Ungar & Perry, 2012, p. 125)

As suggested by Perry, to understand the complexity of trauma, we should first think about the rules of functioning of the stress response system.

Experiences during childhood, whether positive, negative or downright harmful, have a direct impact on brain development, on the emerging neural pathways and dominant neural responses (explained in detail in the example below). Similarly, stress directly affects our nervous system. This means that early life events 'tune in' to our nervous system, the functioning of our brain, and this 'tuning' can be observed directly in behaviour.

Imagine children who often experience 'bad stress' (extreme, prolonged or unpredictable) in their family or caregiving environment. In other words, they experience fear or threat. Their 'operating system' is then 'tuned in' to fear, flight and unpredictability. This operating system develops stress

8 Observation made during the focus group interviews that were conducted as part of the ECLIPS research.

responses and behaviours that help them somehow avoid or endure the threat next time. In their care environment this is a useful, adaptive function, as they either run away from the threat (flight), or they become threatened (fight) or escape into an emotional state in which they ignore the situation or person causing the fear (freeze) which happens mostly when the threat becomes inescapable. Due to attunement of their nervous system, these children live in a state of fear or threat, this is the way they spend their days in the communities they belong to. Their days are about avoiding the fear and dread caused by any further threatening situations. Any new, unknown, unexpected or even known or expected stimuli, even those which can be imperceptible to others, can trigger a reaction of fear, fleeing or offensive behaviour. Thus, **adaptive behaviour in coping with threatening stimuli in the home environment will be downright detrimental in the peer group or organisational environment, possibly triggering further punishment, exclusion or rejection.**

When working with children with such negative life experiences, it can make our job of caring much easier if we are looking for the answer to the question **"What happened to them?"** in every child's case. Answering this question can help us find the life events that left behind traces in the behaviour of the child or peer group.

Returning to the definition of trauma, it must be emphasised at this point that several frameworks exist to define trauma that exceed the context of this protocol. We work with the version which helps us best to describe and understand childhood trauma and its impact on development. So, for a better understanding of the phenomenon, we use a definition founded on three pillars: these three pillars are **event, experience** and **effect** (Substance Abuse and Mental Health Services Administration, 2014).

Imagine a group of small children going for a walk. They are late, the other children are waiting for them in front of the building. There are several people helping to dress the children, in a slightly more tense mood due to the delay. The older little child, who has been attending the nursery for two years, dresses up alone, sings a song in a low voice, and bears much of the urgency around him. Another, smaller child struggles to pick up her shoes, is called by one of the caregivers and is repeatedly warned to stay where she is until she is done. This is when an adult enters the picture, seeing the urgency, trying to help the kids and taking a bigger, more dynamic step next to the child struggling with her shoes. The adult's hands are raised higher because of the dynamic step she took. The little child only notices the swing of the hand, shrinks, barely breathes, and then begins to cry, gasping for air. A third child who sees this from a distance, turns his back on the others and stops dressing, plays with a nearby toy for a few minutes, then continues to dress and joins the others in line.

In this everyday situation **(event)** that occurs at any time, we see three different reactions **(experiences)** and three different **effects** can be predicted based on the observation.

In the life of the older child who has been in the nursery for two years, this is a recurring situation. He has developed a self-reassuring strategy to control his stress response system so that experience can help him cope and further strengthen his resilience.

In the life of the child with the most intense stress response, tension, its dysregulation and unpredictability are always present in the home environment. Her experience in this ordinary situation cannot be separated from the experience at home (e.g. she is harassed at home when she is not dressed, impatiently approached when something fails at first, sometimes beaten when she is clumsy, etc.). Her stress response system reacts intensely and the dynamic movement immediately triggers the fear

and escape response. **If the 'operating system' of a child is tuned this way, these ordinary, more tense situations are expected to lead to emotional outbursts or collapses in most cases.** Her reaction can be exacerbated and can even show symptoms of chronic stress in all situations where there is a higher level of stress around getting dressed, getting started and getting ready.

The third child sitting further away also produces a higher intensity stress response, but has an instinctive strategy which helps him reduce his stress level (he turns away and plays for a few moments). This experience can still show up for a few days in periods of moderate stress like dressing and starting up again when he can respond with a higher intensity again, and if he does not experience another similarly tense situation, the effects will disappear in a few days. This can also be considered an acute stress response, if there is really only a few days of insecurity around dressing and getting ready.

The above example illustrates that **understanding the effects of trauma is primarily aided by thinking in the triangle of** event-experience-effect **and trying to map the impact of the traumatic event on our stress response system.** It is useful to do it with the idea of the window of tolerance in mind. Remember that young children and people who have experienced unprocessed trauma in the past usually have a smaller window, not necessarily for every stress situation but at least for those situations that remind them of a trauma (this is called a trigger).

When our stress response system is 'tightly' adjusted and our window is narrow, our reactions to the outside stimuli will be more sensitised and many things will fall outside our window of tolerance. Our smoke detector in the brain (the amygdala) kicks into action faster when, in fact, there's really only a little bit of smoke (we're triggered) (van der Kolk, 2014). A trigger can include sensory information (an image or how someone laughs, a smell, a sound, a touch) or verbal information (what is being said, but certainly also the way someone says something that activates a stressful memory). Depending on our previous experiences, such triggers can provoke hyperarousal or hypoarousal states. Sometimes it may also be that we respond with hyperarousal and then if the stressor persists, we switch to hypoarousal.

Returning to the definition of trauma, it is important to emphasise that **in cases where there is no violence, abuse or other serious traumatic event, but inadequate, positive care is lacking, we can also talk about traumatic effects.** Similarly, it results in an intense stress response if the primary caregivers are impatient or hurried, if the child is not safely held and emotionally regulated in the primary relationship, if parental tension and stress is tangible when they are dealing with their children or even if institutional exclusion, bullying, and shame are present in the life of a child and there is no institutional response. All of these situations have an effect similar to experiencing physical abuse or a major natural disaster.

Trauma and adverse childhood experiences clearly have an impact on the individual's health, even if the extent of it may vary from person to person. The impact depends on genetic predisposition, developmental status at the time of the trauma suffered, traumas experienced and processed or partially processed by the family and, to a very large extent, the healing effects of accessible, mature, healthy social relationships and communities.

This outlook and the different definitions of trauma can help practitioners understand the complexity of this phenomenon, the variety of effects and the diverse components along which very different outcomes can be seen following a traumatic event.

What can we do?

Handle children with care and support them. Tell them repeatedly that you believe in them. Again and again, be patient in guiding and teaching them. Tell them that you are there for them. Show them that you can be trusted. Give children boundaries and focus on what is going well. Children need to hear from others that they matter and that they have many qualities.

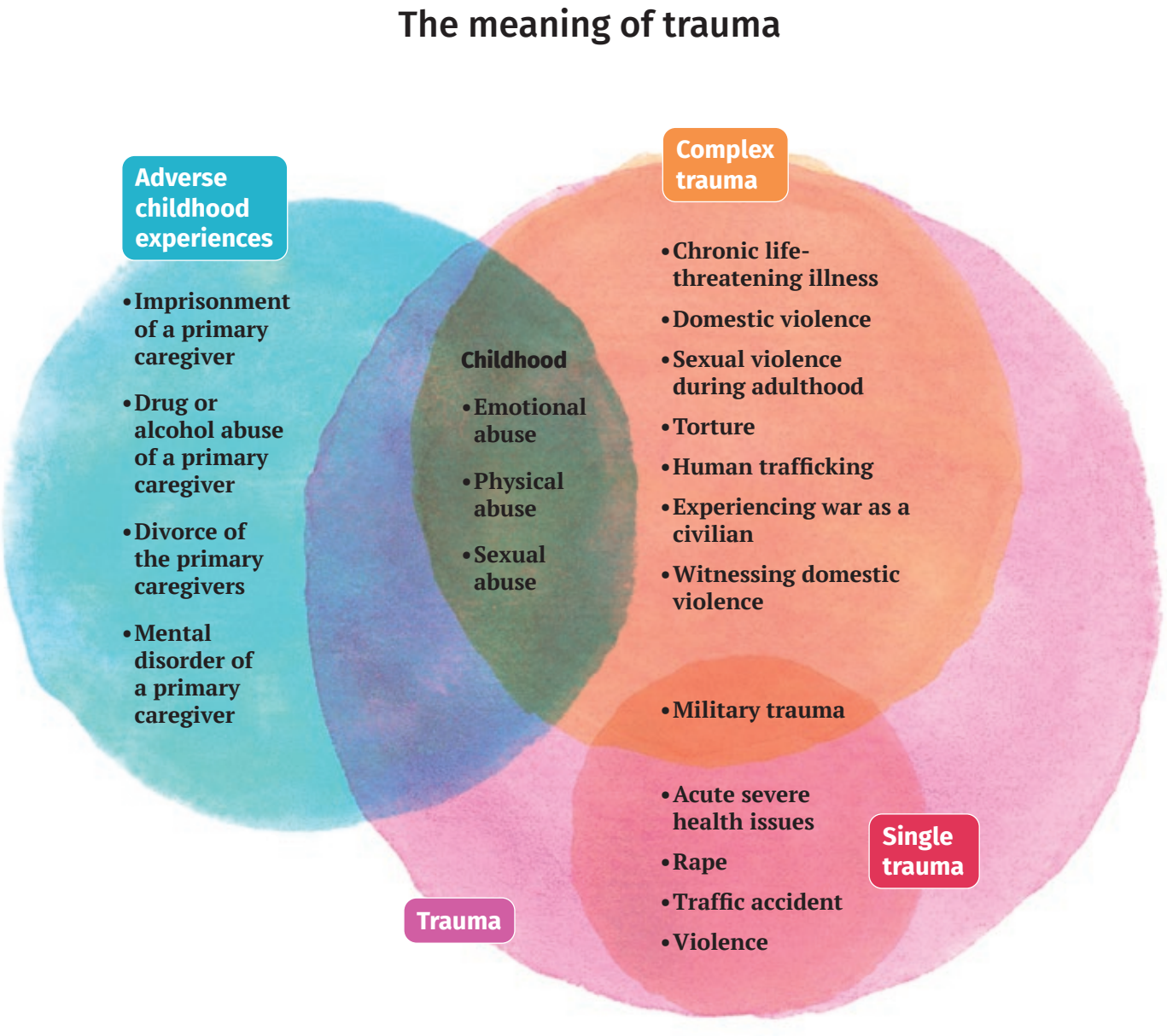


Figure 2. (Image by Emese Iványi, based on *National Health Service Education for Scotland (2017) Transforming Psychological Trauma, p. 20.* Retrieved from https://bit.ly/38IAGeS)

5. Trauma within the child-caregiver relationship

The most powerful and difficult to interpret, understand and accept among all traumatic events are those that involve the primary caregiver abusing the child (physical and mental abuse), neglecting them emotionally or physically, torturing them, not caring for them properly or where there is a little or no attunement between the child and the adult which leads to harmful experiences. It is important to emphasise here that the above-mentioned adverse events can in many cases be traced back to unprocessed trauma in the primary caregiver. This does not mean that we can dispense with their responsibility in the case of abuse or neglect, instead it means that in their case asking the question "What happened to you?" is equally appropriate, as their support and the recovery of their children can only start and achieve results from here. **The question "What happened to you?" can open the path to healing along which the child, the family and the whole institution can embark** (Winfrey & Perry, 2021). As long as we ask the question "What's wrong with you?" we can approach very closely the dynamics where the detection of abuse is the focus, where questioning, sanctioning and punishing take the place of the healing, restorative attitude. In this scenario the victim remains the sufferer, the perpetrator remains the offender, and as such the relationship between the two will be impossible to heal, which is the most important objective in case of caregiver-child relationships.

Trauma in the primary caregiver relationship severely rewrites the functioning of the stress response system and attachment[9] patterns (Hambrick et al. 2019). Underlying this is a developmental rule. The most important function of the primary relationship is regulation, and here we refer to the regulation of stress levels resulting from the inevitable alterations of daily life functions (hunger, changes in body temperature, nervous system fatigue, stress caused by discomfort or pain, sleep or waking, etc.). A supportive, safe and relaxed relationship reduces stress. A relationship that does not respond to a child's needs in an attuned manner, a stressful, frightening, neglecting or abusive relationship increases stress. Abuse and neglect in the context of the primary caregiver relationship virtually completely knocks out and destroys the stress response system. It can become a vicious circle in the life of a developing child, because the person who is responsible for providing care cannot co-regulate. High stress levels do not allow connection. Thus, the child remains dysregulated, in a high-intensity stress, and in a condition in which he/she is unable to connect, while the connection would be vital to regain control. In these situations secondary caregivers, professionals who are knowledgeable about trauma and its effects may be able to lend an intermediate connection, a healing presence to both the primary caregiver and the child. In this interface both the child and the primary caregiver have the opportunity to learn how to regulate and regain control.

What can we do?

Acknowledge that children who suffer from trauma may express their suffering unintentionally through tantrums, irritability or panic. If you maintain this perspective, your own reaction to their behaviour may change in a positive way. Acting angrily will only lead to more tension and stress. When you connect to the child in ways that are soothing, like singing, rocking, rhyming, you will achieve much more. Children who have learned that the world is a dangerous place, will go into fight or flight mode much faster.

9 Attachment is explained in the next chapter

6. Regulate, relate, reason

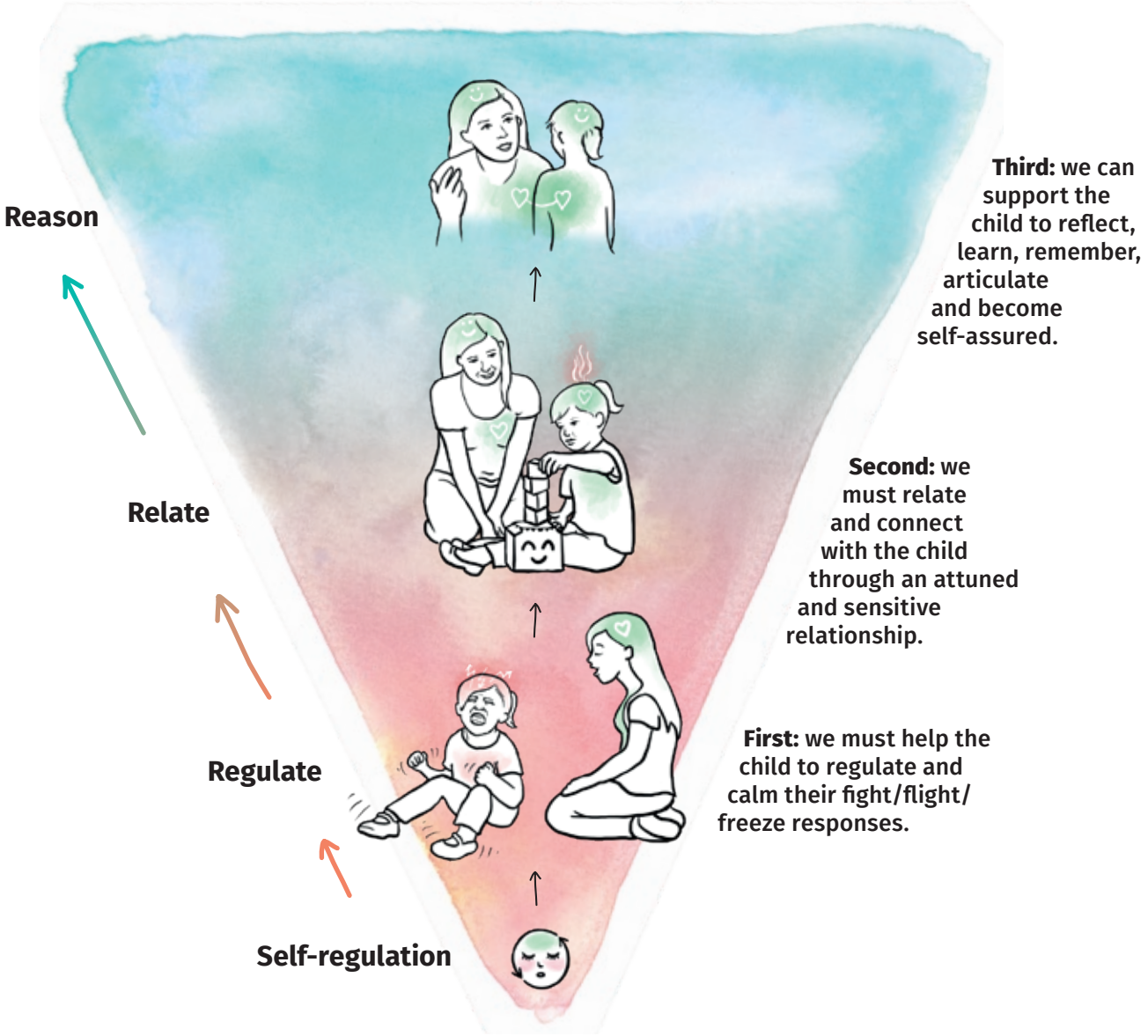


Figure 3. (Image by Emese Iványi, based on *Beacon House Therapeutic Services & Trauma Team, 2019*)

Trauma-sensitive care means being aware of our actions in all circumstances when we work with children. Traumatised children act in a way which can easily trigger adults or other children as well. When we are triggered, we lose our ability to act consciously.

The first thing to be done in these cases is to regulate ourselves: become aware of our own window of tolerance, the stress that we are experiencing, and try to sink back. (Think about the advice on aeroplanes: first put the oxygen mask on yourself and then help the child next to you.) It will de-escalate the situation, even if our reaction is comprehensible given the circumstances.

The next step is to regulate the other, in this case the child, primary caregiver or the childcare professional. As soon as we function within our own window, we can regulate the other, for example by going to a quiet place together.

The following step is to restore the bond. Only when the other becomes calmer is the relationship possible again. Try to do something together that restores your bond (like playing together).

Eventually, reasoning is possible again: Afterwards, if the other can function completely in their window of tolerance again, you can talk about it. Awareness of action is only possible after all persons involved are completely relaxed again.

Also pay attention to the fact that the other might not be able to do anything about being outside their window, especially a child who does not have the necessary neurobiological functions developed yet. Being in a state of hyper- or hypoarousal happens to them. Try to avoid guilt and shame around this topic as much as possible to support the other to learn and gain insight into their window of tolerance and the situations or triggers that push them out their window. Evidently, this can be very demanding. It is okay to sometimes feel unable to intervene or to handle the situation. It is important to relate and reason, even after experiences of failure, as a way to restore trust.

What can we do?

Try to bring the child back to the present. There is no magical trick to regulate a child. Try to be there for them in the moment and express warmth, calmness and reassurance. Warmth is the best remedy for a state of stress. Talk with a soft voice and be present in a relaxing way. Reassure the child.

After reading the first chapter, here are some exercises to help you put into practice what you have read. If you like, take a look at the following exercises and try them out with your colleagues. It can add a lot to the exercises if you also make time to talk about the experiences with each other.

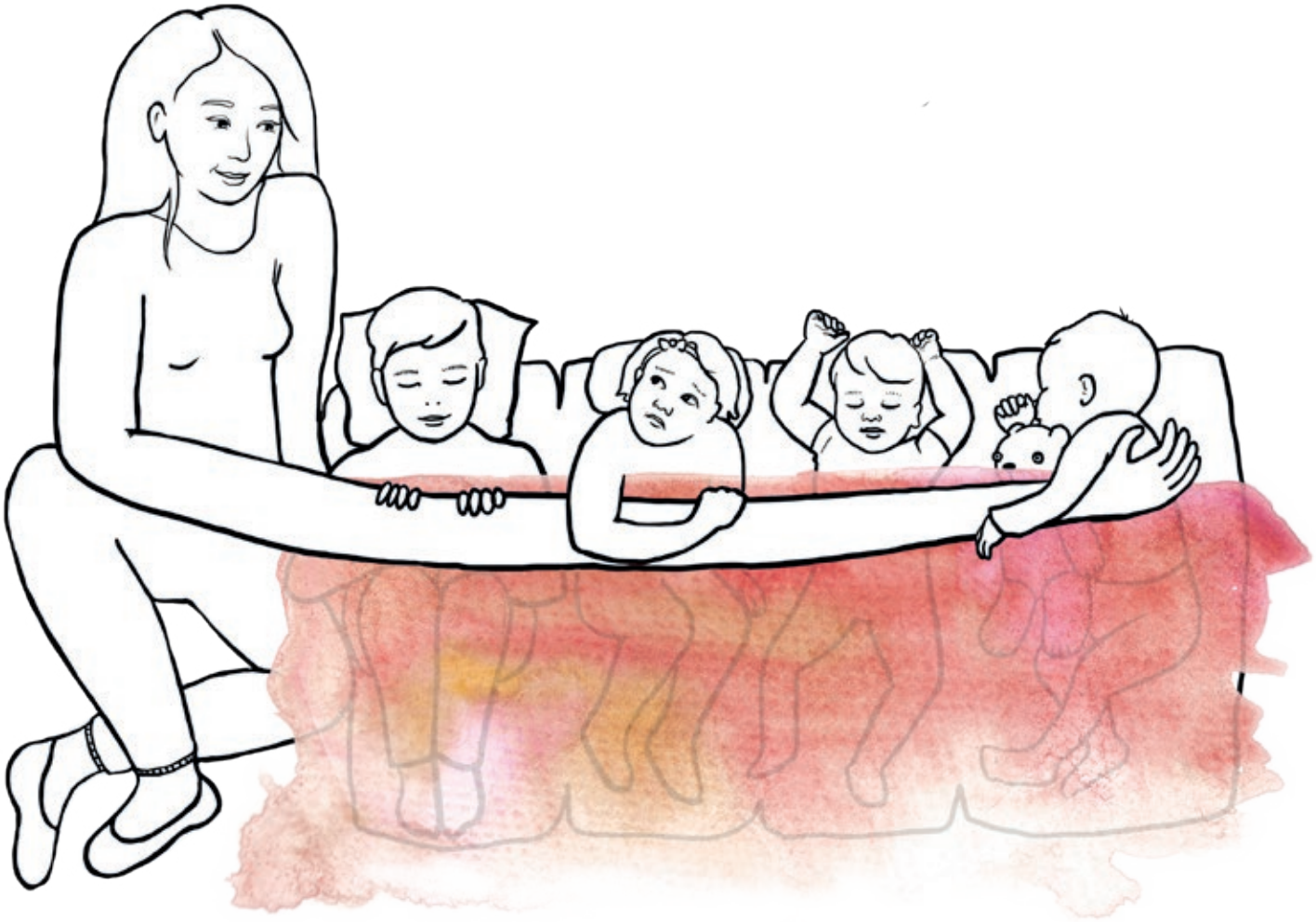
"You don't have to be a therapist to be therapeutic."

(Ford & Wilson, 2012, p. 12)

- Observe your strengths, inner resources and presence that you tend to mobilise in everyday normal or critical situations. What are they? Mention a few.
- Please choose a few from your list and be mindful of them over the next two weeks. Try to apply them consciously and mindfully. Make notes of your experiences.
- Think about the life stories of two or three young children and their families that you know. How do you think you can interpret the event - experience - effect trauma definition in their case?
- If you have the opportunity, observe the children you've chosen in everyday situations. How do they behave during an unexpected event? How might their past experiences determine their present behaviour in response to the unexpected event? Try to answer the question "What happened to them?".
- Think about the children you work with and those around you in terms of relational/complex trauma.
- Are there young children in your life whose primary attachment relationship has led to trauma? How can you relate to them? What do you tend to look for in your own feelings and patterns of attachment when you try to reach out to them, whether in ordinary, neutral or crisis situations?
- How can you apply the behavioural patterns described in the window of tolerance concept to your work? How does it affect your behaviour, i.e. the size of your own tolerance window, when dealing with a crisis situation in your work?
- Adverse childhood experiences have been present in almost all of our lives. Pick one or two young children and their families and think about what early experiences may have characterised the life of the young child/family.
- If you like, think about what your early life experiences were like. How do you think they affect your well-being?

CHAPTER 2.

The body keeps score[10]: What trauma does to our youngest children



> ***As human infants, we do not possess strong muscles like a little foal, we cannot stand on our legs a few hours after having been born. We rely completely upon the benevolence of the people surrounding us.***
>
> (Orosz & S. Nagy, 2021, p.19)

After reading this chapter you will have a deeper understanding about the importance of the early years of life and the effects of trauma on the central nervous system.

10 Bessel van der Kolk, 2014

If we compare a newborn infant with a two-year old toddler, we will see enormous differences - a completely defenceless baby becomes an energetic child who is able to walk and run, talk and sing, go and get what he/she wants. Is there any other period in our lifetime when we see changes of such magnitude?

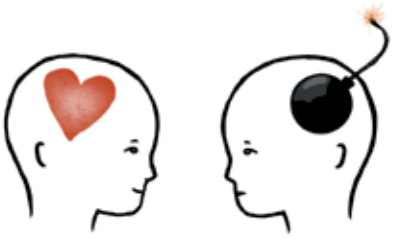
1. Development in the early years

The development of young children can be understood from various perspectives and domains. For this protocol, we focus on neurobiological and psychosocial development, knowing that this is only a small part of children's general development. Understanding trauma through the lens of development is necessary because it helps us understand how trauma can negatively impact child development and what we can do to support children to get back on their optimal developmental journey.

Why the first 1000 days matter so much

The first three years of life – starting as early as conception – are a particularly sensitive time for development regarding physical and mental health. A young child is like a sponge, strongly influenced by its surroundings. During this age period, the brain is developing at an exceptional rate – especially when stimulated by positive external stimuli, ensured by affectionate primary caregivers.

The brain is organised and matures in a hierarchical fashion. It starts at the basic, primitive regions and evolves into a complex system. This sequential manner of development allows for each part and function of the brain to build upon each other. If lower parts of the brain do not receive the appropriate stimuli to develop, those functions building upon them will also suffer and will not work optimally (Perry, 2004): just imagine a building where the foundation is inadequate – it won't be stable.



Neurodevelopment is most intense from conception through the first 1000 days. Babies are the most susceptible and vulnerable in these first years of life: their rapidly developing brain is malleable and can be shaped the most through their experiences and the caregiving they receive. Everyday, we know more and more about what happens to the foetus while in their mother's womb and during birth - the prenatal and perinatal period. These nine months affect both the mother and the foetus heavily. Several factors contribute to the optimal foetal development, for instance the mother's safety, the mother's mental health status, the stability in their everyday life. Basically, everything that happens in the mother's environment counts. A stable and calm pregnancy creates an ideal head start for the foetus and helps create a secure bond between the mother and the baby. However, issues the mother experiences - for instance, chaos, depression, violence, illness, any potentially traumatising events, and so on – will also have a negative impact on development in the long run. This growth continues to be rapid and of critical importance up to the age of three, as can be seen on Figure 3 (Perry, 2004).

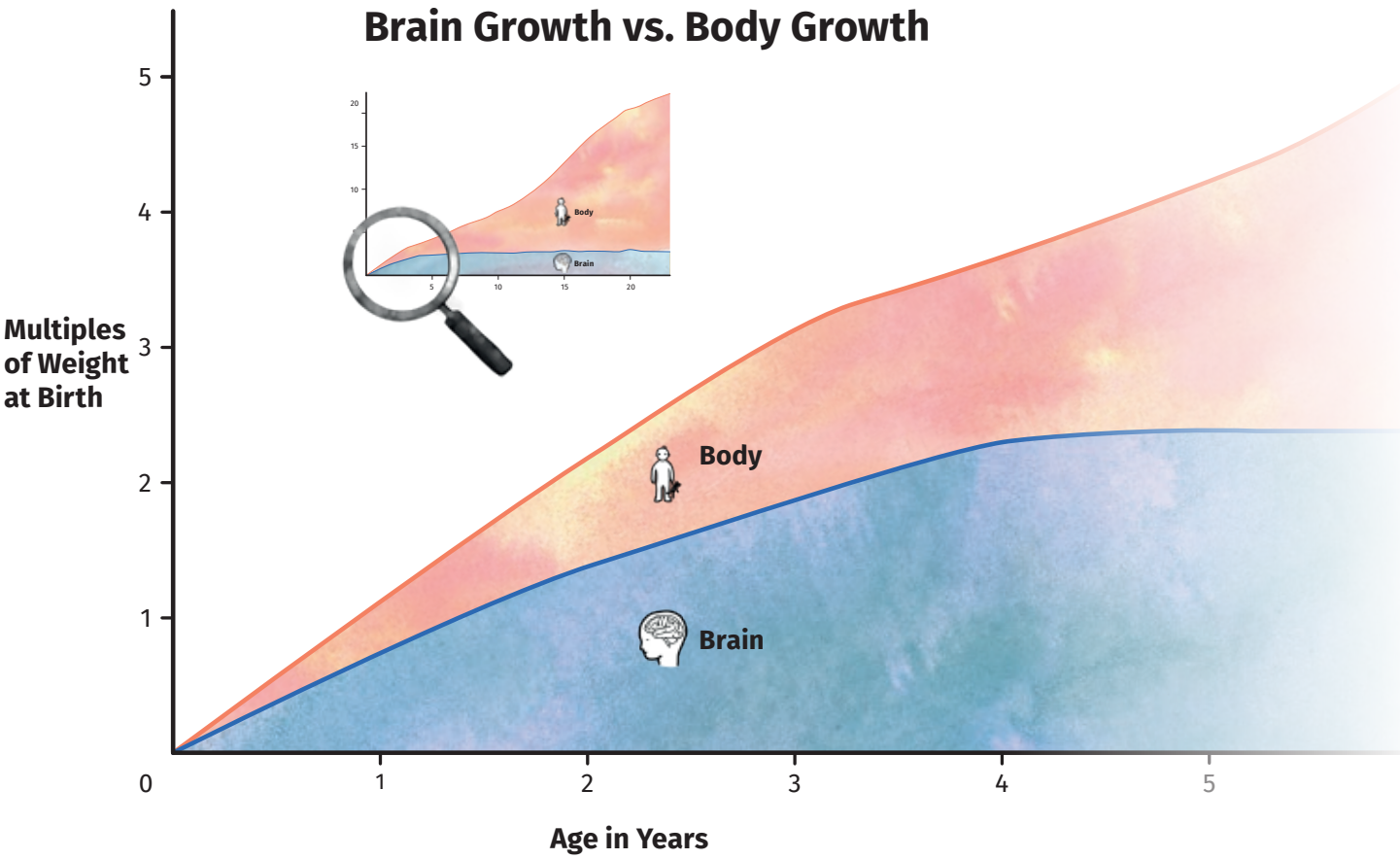


Figure 4. (Image by Emese Iványi, based on *Bruce D. Perry, 2004*)

Repetitive experiences that children receive at this stage form connections and are stored within and between different brain areas, allowing progressive growth of personal skills, talents and abilities. For this age group, the most important and fundamental need is the pursuit of comfort and reassurance. **Before learning to comfort - or regulate - themselves, babies depend on their primary caregivers for comfort and reassurance.** These needs are generally met by establishing a secure base with their primary caregivers. Trauma and neglect do the opposite. They contribute to disorganisation and stimulate stress and the inability to regulate themselves.

What can we do?

Create opportunities to show how someone can express their emotions safely. By explaining alternatives, but also by being an example yourself. It is healthy to show your emotions. That is how children learn that it is okay to have emotions and to express them in an acceptable manner. It is important to welcome emotions, even difficult ones. It is okay to cry, to feel angry or to feel ecstatic, as long as it is not overwhelming to the children.

Attachment

Attachment arises naturally in every child. It is the child's innate tendency to seek support from someone stronger, an adult who can protect and help the child. When babies form a relationship with their caregivers, it is called **bonding**. This process starts and develops very early, in the womb, and can be influenced by everyday events that affect the mother, both positive and negative. The relationship can turn out in different ways, depending on its nature and quality (Perry, 2001).

Every child bonds during the first years of life, but not every child will be able to bond securely. Even under appalling conditions, children become attached to adults, even when those adults mistreat them. How the child is cared for is therefore especially important during this period. At birth, a process of mutual attunement between the caregivers and the child, something that can be seen as the preparation for the later attachment relationship. This mutual attunement is around everyday events: the baby cries, is comforted and feels satisfied. The caregiver smiles at the baby, the baby smiles back and they have fun together. However, if this attunement does not take place in harmony or if there is no attunement at all (for example in cases of neglect), the child's signals can become distorted or muted.

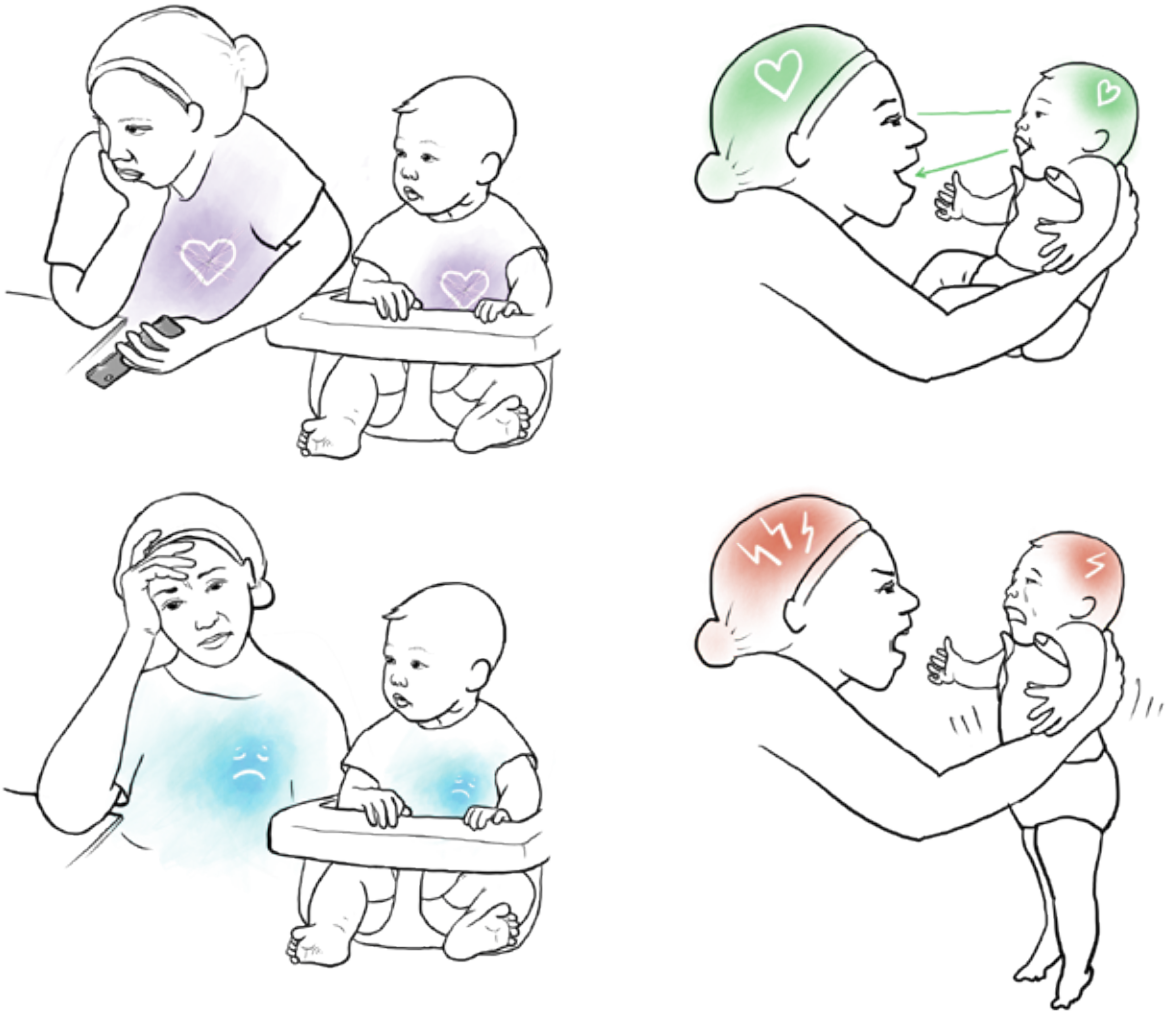


Figure 5. (Image by Emese Iványi, based on drawings used by the *Neurosequential Network*)

In the process of bonding a continuous "there and back" feedback loop develops between the baby and the primary caregiver, which helps to develop **attachment**. Children can have a safe, secure attachment with their caregivers if this feedback loop is generally positive and reassuring. Similarly, if the feedback loop is disturbed, the bonding and the attachment will be disturbed as well. Infants who cannot rely on their primary caregiver as a source of safety, constancy and love, will develop an insecure attachment: they could develop avoidance behaviour, they might resist the interaction with their caregiver, or have a disorganised attachment pattern where approximation, avoidance and resistance appear mingled. A common difficulty is postpartum depression, which can be triggered at the time the mother gives birth. The mother experiences very intense emotional ups and downs, which are difficult to manage. This also affects her emotional availability towards the

infant, who relies on her positive, reinforcing feedback, and its absence may also contribute to an insecure attachment. Infants who formed an insecure attachment are more prone to developmental delays, emotional functioning issues, or have problems regulating their behaviour. This emotional relationship also will determine how the baby forms relationships with other people later on in his life (Crowell et al, 2002).

The kind of care given children is key in how secure the attachment they develop will be. The number of interactions is also of great importance: infants need a great deal of repeated interaction so that their brains are organised accordingly. A newborn whose primary caregiver gives a great deal of predictable, attuned, rhythmic, responsive and sensory-enriched care (touch, smell, voice) will have a healthy, positive bonding and secure attachment. For example, regular and ample hugging, rocking, singing, laughing and face-to-face activities help significantly to develop this positive emotional relationship. The importance of a secure attachment cannot be emphasised enough: healthy relational interactions can counterbalance adverse events and trauma.

Attunement is also a critical factor in forming a secure relationship: it means reading and responding to the cues of the other person (Perry, 2001). It is an interactive process that provides the building blocks for the ability to mentalize, that is, to understand the mental state of other people and of ourselves (Fonagy and Target, 2005). If the parents are attuned, they will be more likely to know what the baby needs and be able to respond to those needs. This also contributes to the feeling of security. The advantage of attunement is that it can be learnt by watching for the non-verbal signs given by the baby.

Children show attachment by looking for and engaging in contact with their caregivers when they feel afraid, sad, insecure or ill. In attachment behaviour, it is important that the child is attuned to a secure base. That secure base offers a solid foundation for the child from which to explore and to return to when he/she feels insecure.

What can we do?

When you have rarely experienced empathy, it also means that the consequences of others behaviours towards you were not acknowledged. Thus, it can be challenging to understand how to reflect on the consequences of your own behaviour towards others. Children who are struggling are often unaware that their behaviour is disrupting others. It does not mean that these children are selfish. It means that these children have difficulties in how they relate to others.

Role of attachment in trauma-sensitive care

As has been observed, during an infant's development, timing is an important factor. Babies need certain experiences – a lot of sensory-enriched, consistent and nurturing interactions – in certain periods of life so that their brains can develop optimally. Should they be deprived of these experiences, they will definitely need extra help later to catch up.

However, it does not mean that developing a secure attachment is only possible in early childhood. It is sometimes assumed that a child who grows up in a problematic parenting environment has only limited opportunities available to gain secure attachment experiences (Juffer, 2010). Based on theory and available research, no critical period has been demonstrated in which children can develop a secure attachment (Van Ijzerdoorn, 2010). On the contrary, attachment theory assumes that children from problematic parenting environments can be supported with positive, corrective

attachment experiences (Bowlby, 1988). There is no certain age at which that stops: attachment styles can even be formed and changed in adulthood (Siegel, 2020). It might take longer to realise secure connections in the course of the years, especially when a child has little confidence in other people. However, it should be emphasised that the child's attachment can be impacted long after the first 1,000 days and that the child will benefit from being offered safe and nurturing environments.

Therefore, although much depends on the quality of primary caregiving and negative early life relational experiences have the ability to shape the child's developing nervous system, **relationships outside the primary bonds can also be protective and reparative. We should take into account the healing power of conscious, sensitive, healthy relationships.** As mentioned above, *'you don't have to be a therapist to be therapeutic.'* Teaching caregivers about the core concepts of bonding, attunement and attachment could improve children's attachment patterns significantly and reduce the potential of trauma as well. Where head-start organisations provide trauma-sensitive care, childcare professionals communicate the importance of attachment, nurturing and consistent interactions, and support the parents in building a positive emotional relationship with their kids.

It happens often that traumatised children are moved from therapist to therapist, institution to institution, foster home to foster home, community to community to find the best solution. Unfortunately with this method our systems often exacerbate or even replicate the relational impermanence and trauma of the child's life (Ludy-Dobson, Perry 2010).

We normally expect healing only from different therapies where children spend one or few hours a week. Even if the role of these therapies is important, they are often only episodically present in the life of the family or child. **We still underestimate the powerful therapeutic impact of caring teacher, childcare professional, health visitor, doctor, neighbour, grandparent, and a host of other potential "co-therapists"** (Ludy-Dobson, Perry 2010).

> ***"Future effective therapeutic interventions — both preventive and healing — must be developmentally informed and trauma sensitive. There is much to learn, yet we know enough now to begin to evaluate and modify our current therapeutic practices, programs, and policies to take full advantage of the biological gift of the healing power of relationships."***
>
> (Ludy-Dobson, Perry 2010. p.39)

What can we do?

Not all children have the chance for a nurturing and consistent, attuned relationship but it is never too late to start one. Making sure the baby or toddler can relate to one or more persons who can understand their needs and respond to them in an attuned manner can be impactful. Creating a great deal of nurturing and/or bonding moments will foster a positive relationship. Physical contact such as hugging, rocking, rhythmic activities are really important at this age and can be helpful, however, first please ensure that what you are doing is safe for the child, establish how much proximity they can take, and go from there.

Childcare professionals can have a huge influence on attachment by being a caring, reliable, regulating adult. If you show children that they can count on your support and they can make mistakes without being rejected, and when you offer warmth, the children will take small steps in learning to trust themselves and their environment.

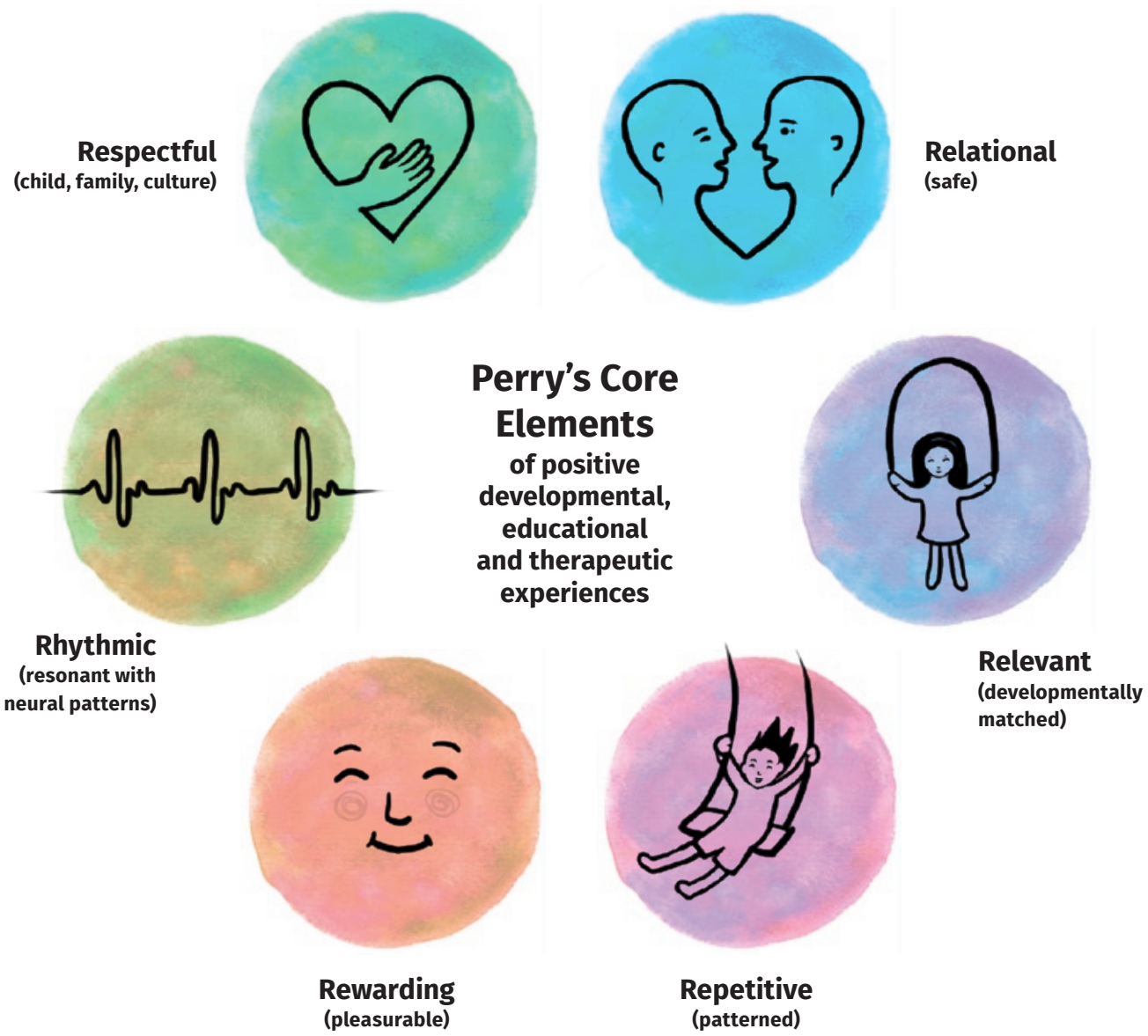


Figure 6. (Image by Emese Iványi, based on an image created by *Hidden Treasure Therapy*)

2. Mentalization and its importance in trauma-sensitive care

As discussed above, building a trustful relationship can be based on learning and responding to the infant's needs. This is where a fundamental human skill, mentalization plays a crucial role.

What is mentalization?

Mentalization is an ability based on an early attachment relationship, **the ability to interpret behaviour in relation to internal mental states. Such internal states can be desires, feelings, thoughts, beliefs, intentions or opinions** (Fonagy & Target, 2005). So when we mentalize our own or others' feelings, thoughts or desires, we do it to make it easier to understand behaviours.

With a few exceptions, this is a basic, natural approach we all use. For example, if we see someone rushing toward a train station, glancing frequently at their watch, we will speculate that the person is late and still wants to catch the train (attribution of intent to his behaviour). When we see someone crying, we immediately assume that they are sad (emotion behind the behaviour). Before an exam, a person standing pale with trembling hands is assumed to be nervous, anxious about the situation waiting for them (emotion behind the behaviour).

So we are able to distinguish external and internal worlds.

However, we can mentalize not only the other, but ourselves as well. We have access to our own internal states. I can think about what could be the reason I talked angrily to my colleagues: Am I feeling offended? Am I overwhelmed or haven't I eaten anything since breakfast? So we are able to think about our own internal states, to label our feelings, which also helps to regulate our own behaviour.

How does this skill develop?

Acquiring the ability to mentalize is similar to learning a language: just as one learns to speak, so does one learn to mentalize. However, just as we can all learn to write and speak more elegantly, we can also learn to mentalize more effectively and consistently (Allen et al., 2011). The quality of our early attachment relationships plays a key role in mastering mentalization. After birth, the primary attachment person is ideally able to interpret the baby's behaviour along internal states and help to regulate them. They understand that when a child cries he expresses some internal need. For this reason they try to find a solution in tune with it, helping the child to regulate their internal condition. If a baby squeaks loudly around lunch time, puts his fist in his mouth, salivates and after a while begins to cry, the primary caregiver will come up to him, reflect on his supposed feeling and offer a solution: *"You must be very hungry! Come on, I will feed you."* With this reaction the parent acknowledges the emotional state, reflects in a contingent, "marked mirroring" way and offers a solution to it (Fonagy et al., 2018) . These experiences help the children to label and regulate their own emotions later on and to learn that their feelings and internal states are not the same as the caregiver's feelings and internal states. This is how they learn to mentalize. In this way, they also learn that negative feelings can be tolerated and controlled.

How does trauma affect mentalization?

The ability to mentalize "collapses" as a result of intense overwhelming feelings, and works erroneously and clumsily (in the heat of an argument, we often find it difficult to consider and understand the other's perspective, and only when our temper has subsided can we reconsider what could have been behind this behaviour).

Due to environmental stressors (neglect, abuse, starvation, inadequate hygienic conditions, chaotic environment, etc.), children and adults who are often exposed to excessive stress, find it difficult to interpret their own internal states, the feelings behind their often impulsive behaviour. To be able to recognize their emotions, attribute internal states to others and themselves, they would need a stable, secure, predictable framework and relationship. As a result of prolonged trauma, the nervous system often settles into a state of constant readiness, somehow as if the danger could come at any moment. In such a state, there is no capacity for a change in perspective, for mentalization. **The nervous system is set up to survive, to be alert, to be ready to fight or flight or freeze. In such cases, it seems unnecessary to interpret and regulate one's own and the other's internal**

state. As a result, a more intense behavioural response may be much more common in people who have experienced trauma, as this is the adaptive solution in the current emergency. The difficulty is that this state of readiness, the fight-flight-freeze reaction, can persist even when the situation appears to be neutral and harmless.

Why is it so important in the cases of 0-3-year-old children?

Taking care of babies and toddlers can sometimes be overwhelming even for well-balanced, relaxed adults. If the adults who are present for the child are stressed out, living constantly under stressful conditions, or traumatised, they can live their days in an alert mode and interpret very common situations as a threat (eg. a baby crying for a longer time or a toddler dripping water at the table). As such, their mentalization ability can collapse faster or more frequently. This in itself can cause anxiety in children and make the process for learning how to recognize and control their own emotions and mental states more difficult and slower as their states are not well mirrored.

Both for children and adults exposed to prolonged stress it is essential to be in a safe environment where they can experience a sense of control, where everything is familiar and predictable, so the nervous system can stay calm. In this state of calm they can best be helped to interpret their own and the other's inner states, i.e. mentalize. **It is crucial to have as many healthy, safe, mentalizing relationships as possible for a child who has experienced trauma.** These are relationships where children can experience thinking about themselves or someone else, wondering what may be behind their behaviour. These are also relationships where the question "What happened to you?" arises. These interactions will help them to think about themselves and the others, to understand their feelings, and to regulate them. As a result of the effective operation of mentalization skills, we will be able to take a stand, understand and resolve misunderstandings, communicate assertively, collaborate, build secure relationships with others, love and care for ourselves and others.

What can we do?

Continue addressing dysfunctional behaviour and explaining why certain behaviour or certain expressions of emotions are not okay. Also, continue addressing positive behaviours and explaining why these behaviours are desirable. Things that we might find self-evident may not be self-evident to others. Children might not be aware of the things they do when they are outside of their window of tolerance. Their intense emotions are often expressed in their behaviour. Help them name any feelings that may be behind the behaviour. By helping them name the feelings, we also help them regulate behaviour and emotion.

3. Trauma symptoms in early childhood

Young children who are affected by trauma are more sensitive to stressful events in comparison to peers. Their bodies and minds are more primed to expect danger or stress. Consequently, babies and toddlers who have experienced adverse events are less eager to explore and develop as they can feel their safety and well-being is threatened by such transitions. Provision of a safe and attuned environment where reliable and consistent care that is patterned and repetitive is the best approach to optimising children's development.

Children are not small adults. The events that they might find traumatising might differ from those that would affect adults, for example, being left alone. The way children show their distress varies depending on gender, age and developmental capacities. The youngest children are more likely to 'freeze' because they have fewer opportunities to fight or to flee a stressful situation. The main symptoms of trauma in infants and toddlers include:

- Regression and loss of recently acquired skills
- Disturbance of sleep and feeding schedule compared to the child's previous schedule
- Clinginess and random attachment
- Fussiness, challenging to calm, hyperactivity, withdrawal and lack of exploration and responsiveness
- Developmentally inappropriate sexualised behaviours

Common behavioural problems among young children who have suffered trauma include difficulty regulating, impaired cognitive capability, achieving developmental milestones with significant delay and difficulties in developing relationships with peers and/or adults. These are general symptoms and it is important to acknowledge that every child is different. **Children who experience the same stressful situations will be impacted in a different way. Children who have similar symptoms might have very different experiences.** Generally, we can say that trauma interferes with normal development and disrupts the behaviour that we are accustomed to for a specific child. For example, it can be perceived as a 'red flag' when a child that normally explores a lot, suddenly no longer does.

Symptoms trauma/PTSD in adult	**Some symptoms of trauma in babies/toddlers** (for an exhaustive list please see the Screening and Referral Tool)
Re-experiences unpleasant memories, images, intrusive thoughts of the trauma	Memories are more physical/sensory. (Babies and toddlers have little or no language, they store memories mainly in their physical memory), which can be: sounds, smells, touches, …
Avoidance of situations that remind the child of the trauma	Avoid = explore less
Negative thoughts (e.g. it's my fault) and blunted feelings	React apathetically (child avoids all contact, child's muscle tension is very low and facial expression is flat)
Strong irritability (e.g. rapid startle) or hyperactivation (e.g. poor sleep)	Very quickly overstimulated (more than average), difficult to comfort (or when comforting him-/herself shuts down), has more than average difficulty with transitions and unpredictability, gets angry or agitated faster.

What can we do?

What you do as a childcare professional matters. Children who suffer from trauma often have a smaller window of tolerance in which they function optimally. It is our shared responsibility to calm their nervous system and to support children to regulate themselves. By regulating ourselves we can serve as an example. An inpatient voice will trigger stress and danger in the child.

4. Resilience

Imagine a child that is learning to walk. Think about the number of times that child trips and tumbles (on average 17 times an hour!). Now picture yourself failing 17 times during an hour when you are trying to accomplish something. That would be discouraging right? But do children stop learning to walk? No, they get up and keep moving. That is a great way to understand resilience.

Resilience is considered the ability to bounce back when faced with mishaps and setbacks. A variety of traits are involved including determination, optimism, faith and hope. We are not born with resilience. It changes continuously and researchers are now describing resilience as a muscle: the more you exercise it, the stronger it gets, especially in our youngest children whose thinking patterns and brains are at their most flexible.

Each child is exposed to different levels of trauma but they also have a personal set of traits that help protect them against the impact of trauma. Having experienced one or multiple adverse childhood experiences does not mean that the child is doomed to experience negative outcomes in life. Two crucial factors play a role in resilience: a child's own characteristics and the influence from their family, community and support systems. It is becoming clear that the negative outcomes of ACEs can be counteracted with care, support and a sense of safety. Through positive relationships, children can learn to develop processing skills and so adopt healthy ways to cope with stress.

What can we do?

Actively support resilience by letting children experience positive situations. For instance, you can organise positive activities with the other children and with the childcare professionals. Invite children to try things that they are good at so they can have experiences of success. Act as a role model for the children. Show the children that they are part of the group.

After reading the second chapter, these exercises might help you put into practice what you have read. If you like, take a look and try them out with your colleagues. It can add a lot to the exercises if you also make time to talk through the experiences with each other.

- For the "first 1000 days", think about the life stories of 2-3 young children and their families that you know. Make a brief note of the life events that characterise these children's life events, whether they sustain, empower, risk or harm.
- In the context of attachment, think with your colleagues about 2-3 young children: who is the primary attachment figure for these children and what is their relationship with them? What other attachment figures surround them? Draw the web of relationships that provide security for the child.
- "When we mentalize, we think about our own or others' feelings, thoughts, desires, etc., in order to better understand behaviour." Today, give yourself some time and observe yourself and your own mentalizing processes. It's always easier to listen to ourselves first, so start with yourself. Pick one work situation during the day when you experienced a powerful feeling. Find out when the feeling started, what triggered it, what action followed. Take some time to reflect and get a better understanding of the motives of your own behaviour.
- Now choose a small child, observe his/her behaviour and try to understand it. What might he/she be feeling, what needs might he have, what thoughts, desires, feelings are driving his behaviour? Make a note of your thought process.
- Trauma disrupts normal, habitual development and leaves its mark on behaviour. Are any of the young children in your care now experiencing sudden changes in behaviour? Think about what happened to him/her? Gather information, talk through the change with a colleague.
- Talk about the trauma that has affected the child and his/her family, what sign did you first notice and link the change to. Look at the table for trauma symptoms in young children. Do you recognize them? How did you elaborate your answers to the 'What happened to you' question?
- To work through the concept of resilience, please choose two young children who have experienced similar traumatic life events and whose stories of recovery from trauma and the outcomes are different. Think about what led to the different outcomes and empowerment for one child and what led to slower development and challenging behaviour for the other child. Think about the individual characteristics

CHAPTER 3.

It's in the attitude: How to organise trauma-sensitive values in childcare organisations

> ***Fire can warm or consume, water can quench or drown, wind can caress or cut. And so it is with human relationships; we can both create and destroy, nurture and terrorize, traumatise and heal each other.***
>
> (Bruce Perry)

This chapter was written with a special focus on trauma sensitivity at the level of organisational settings, thus especially for coordinators of childcare organisations and those professionals who are willing to take leadership in the transformation process towards a trauma-sensitive way of working..

1. Default values and operation at the organisational level

The trauma that affects many young children happens in the context of relationships. This may happen within, but is not exclusive to, the family and the group of primary caregivers. Recovering from trauma is best supported with healing relationships. Therefore, if you encounter a child that is exposed to trauma, it is important that the relationship you build can contribute to their recovery. Even our smallest interactions can make a difference. **Research shows that warm and stable connections can support young children in their recovery from trauma** (Ungar & Perry, 2012). Children that have safe connections (where adults are able to attune to and mentalize their feelings and behaviour) are able to build on their strengths and interests, and generally continue to foster healthy social relationships throughout their lifetimes.

A trauma-sensitive childcare organisation means that the organisation and employees (1) understand how **trauma affects the children's development** and how trauma leaves young children vulnerable to further harm: the younger, the more vulnerable; (2) actively prevent trauma through building **safe, predictable and trusting relationships**; and (3) understand that children, parents and childcare professionals should be seen in the **context of their own (stressful) experiences** (Fredrickson, 2019).

The good news is that some of this might be recognizable as **most childcare professionals already integrate trauma-sensitive actions as a default. They are predictable, create a safe environment to explore and learn, provide presence and consistent care and promote warm relationships – all trauma-sensitive actions that are generally rooted in empathy and compassion and in validating how experiences impact our behaviours, feelings and thoughts.** However, it is important that we encourage all childcare professionals to work trauma-sensitive, regardless of gut feeling or experience on the job: hence this protocol. Moreover, **trauma-sensitive care is more than just actions, it also involves attitude, knowledge and a conscious way of working.** Trauma-sensitive care in childcare is based on your knowledge of how trauma affects children, taking into account that their experiences can be reflected in their behaviour, thoughts and feelings. Being trauma-sensitive means that you are aware of the effects of trauma and you keep these in mind when working with children, primary caregivers, your colleagues and other professionals. Looking through a trauma-sensitive lens shapes our knowledge, actions and attitude.

Organising trauma-sensitive prevention in childcare involves

- The organisation acknowledging that **trauma is not a "home problem"**. The organisation does not blame caregivers or children: the attitude is that being a parent is a hard job and it can be learnt. Instead of seeing a child behaving "badly", **they see a child struggling** with difficult experiences. A child's behaviour may be the result of the activation of a traumatic memory.
- The **organisation investing in awareness** (knowledge, skills and attitude) of trauma and its impact for employees, caregivers, partners and children.
- The organisation acknowledging that children affected by trauma are the least likely to seek help due to feeling unsafe. The child's need for **physical and psychological safety** is taken into consideration.
- The organisation making **room for the personal and cultural background** of the children and their surrounding caregivers. The experiences of a particular cultural group in relation to past traumas, racism, immigration, or intergenerational traumas are taken into account as they also impact the individual level.

- The child and its caregivers being in **close contact** with the organisation and there being room to talk about anything that might be relevant. Each encounter is an opportunity to offer a safe space and rebuild trust.
- The organisation organising activities that **strengthen resilience** of children and caregivers.
- The organisation working trauma-sensitively into the **daily structure** but also into **moments of crisis** (Fredrickson, 2019).

Approaching trauma while focusing on children and their caregivers is the most effective way to deal with the effects and consequences of trauma. The goals of trauma-sensitive care are effective prevention and treatment. However, becoming a trauma-sensitive organisation is a lengthy, step-by-step process that needs constant effort (JBS Int. & Georgetown University, 2016).

A supporting and effective staff

An organisation can only function if the staff members generally feel well, get their share of freedom and can pursue their passion without too many obstacles. By focusing on new perspectives, skills and strategies, childcare professionals are able to promote social-emotional functioning and address problems as well as future concerns. Teaching childcare professionals can be challenging: research[11] has shown us that they generally feel under-equipped to cope with children with trauma and are often torn between the needs of the child, of the other children and of their own. From a preventive perspective, it is important that trauma-sensitive care is designed to assist all children, their caregivers and the staff. A trauma-sensitive staff:

- Is familiar with the range of experiences that might affect children and their caregivers
- Knows strategies to engage and soothe children and their caregivers
- Has the capacity to self-regulate (on group and individual level)

2. Principles of trauma-sensitive care

As the main principle, trauma-sensitive care in childcare organisations acknowledges that traumatic experiences can impact children in various ways. Trauma-sensitive care is not a method to treat trauma, but rather aims to provide support in a way that is accessible and appropriate for children and their caregivers who possibly have experienced trauma. There are six basic principles that characterise trauma-sensitive care in childcare (SAMSHA, 2014):

1. Safety - ensuring physical and emotional safety.

2. Predictability - creating an atmosphere of clarity, consistency and respect for personal boundaries

3. Support - helping families to build on each other's strength

4. Partnership - repeatedly focusing on shared decision making

5. Presence - welcoming and respecting that each individual has rights and responsibilities

6. Inclusion - actively moving past stereotypes and biases and stimulating intersectionality

11 The research conducted in the framework of the ECLIPS project

Applying these basic principles allows for a different interpretation and customisation to different types of cultures and contexts, without forcing specific, prefabricated methods and provisions. Besides the six basic principles of trauma awareness, the following question is worth considering:

How do I define my role as childcare professional towards children and their caregivers?

Basic principle 1.

SAFETY

The first principle is about ensuring physical and emotional safety. It is essential that the people who work in the organisation, as well as children and their caregivers who go there feel physically and mentally safe. Making the physical environment suitable is very important to provide everyone with a calm and safe environment. For instance, if there is no suitable space and time for a parent to share any difficulties with the childcare professional, and there is an opportunity for that only in the corridor in front of other parents, the principle of safety can be infringed. If the general operation of the organisation is cannot be traced and is not clear, if the communication is misleading, people's sense of security will not be stable.

Everyone should be aware that experiencing safety is essential for both the children and the caregivers who receive the service, as well as for the staff members who provide the service.

Basic principle 2.

PREDICTABILITY

The second principle is about creating an atmosphere of clarity, consistency, and respect for personal boundaries. Organisational decisions and changes regarding the educational plans or actions that should be taken in the life of the children are transparent. Children and family members, staff and others involved in the organisational plan are involved in making decisions, each at his/her own level of understanding and involvement. The primary goal of this is to create and maintain an atmosphere of trust with children, families and childcare professionals.

Basic principle 3.

SUPPORT

The third principle is about helping families to build on each other's strength. A trauma-sensitive organisation provides support for children and their caregivers in positive growth in many ways. Communities are the most powerful healing resource when trauma has occurred and there is a need for informal support. We should use our own internal resources and support groups (families in similar life situations, trauma survivors, etc.) for recovery. As an example, childcare professionals can organise positive parenting groups from amongst their own clients, or support groups for disadvantaged families (both practical and emotional support).

Basic principle 4.

PARTNERSHIP

The fourth principle is about repeatedly focusing on shared decision making. Partnership is essential when working with traumatised children. The effects of vicarious trauma places a huge burden on childcare professionals and is an extra source of stress, so working as partners, experiencing trust and safety is essential in these challenging settings. Coordinators shall emphasise working together in partnership, in an equivalent and recognized manner. Every individual is welcome with all their talents, characteristics, experiences, achievements and they are all equally valuable. Coordinators emphasise that all professionals working with the child and caregivers have a significant role to play in recovering from trauma – *You don't have to be a therapist to get a therapeutic effect* (Ford & Wilson, 2012).

Basic principle 5.

PRESENCE

The fifth principle is about welcoming and respecting that each individual has rights and responsibilities. The organisation builds on the strengths and experiences of the children and their caregivers, believing in their resilience and their potential to recover from trauma. Childcare professionals are aware that people experiencing trauma are often excluded, weak in terms of their social position, and therefore consciously pay attention to welcoming all feelings and experiences.
The organisation supports the development of self-assertion skills and stimulates the potential of children and their families. Children and their families are supported while correcting the feeling of loss of control and competence resulting from the long-term effects of trauma. This can be helped if the organisation provides them choices and decisions about therapeutic plans and interventions.

The organisation recognizes that the resources of its childcare professionals are used heavily by being aware of trauma and therefore strengthens and supports them. Coordinators support employees in focusing on the core of their job. They are also supported when dealing with challenging situations, children or caregivers or when recovering from and working with their own traumas.

Basic principle 6.

INCLUSION

The sixth principle is about actively moving past stereotypes and biases and stimulating intersectionality. Intersectionality is defined as the phenomenon that each individual in a society experiences inequality, identity and emancipation differently on the basis of such intersecting factors as culture, gender or past experiences. Focusing on one factor is too one-sided to explain the complexity of discrimination or privilege.

The organisation and the staff actively work against the emergence of stereotypes and prejudices, and offer access to gender responsive services. Treatment plans include the healing potential of culture and traditions. The protocols, procedures and arrangements of the organisation take into account the cultural, ethnic, and racial characteristics. It recognizes historical traumas and considers their potential effects.

3. Trauma awareness in the daily functioning of the organisation

A single training session (regardless of length) or the mere distribution of the protocol will not be sufficient. What will fulfil the requirement to implement or maintain trauma-sensitive awareness is structural implementation, supervision, continuous skill practice, intervision, and repetition of the trained knowledge, skills and attitude (Cutuli et al., 2019). As to organisation, we define four key implementation domains for working in a trauma-sensitive manner with young children, some of whom may be experiencing trauma. The key implementation domains should be part of the structural functioning of the childcare service and, preferably, it should be stimulated at a macro level (for instance by policy agencies) by enabling child-free hours and by facilitating physical and mental support for childcare services.

The first key implementation domain includes implementing **systematic screening for trauma (see Screening and Referral Tool)**. Trauma is common and trauma-related symptoms are more difficult to treat when they are not detected early and effectively (Roberts et al., 2019). Unrecognized, unaddressed trauma can impede mental health and lead to worse outcomes. Without screening, the history of trauma often goes undetected. It is important that professionals are trained in the use of screening procedures based on more than gut feeling or experience, but stem from scientific research (Cutuli et al., 2019). Systematic screening and recognizing trauma is essential in the work process. The childcare organisation should support children and their caregivers and if possible, redirect them to trauma-specific therapeutic services.

The second key implementation domain is to stimulate **training and (professional) development of employees**. Professionals working at childcare services are various in their background education and experience. Lifelong training for all childcare professionals is essential and should be taken into account when hiring a new employee, when supervising the workplace and when evaluating performance. Training programmes should add to the self-sufficiency and mental well-being of the employees (Walkley & Cox, 2013). The physical environment should take the needs of the employees to rest and recharge into consideration.

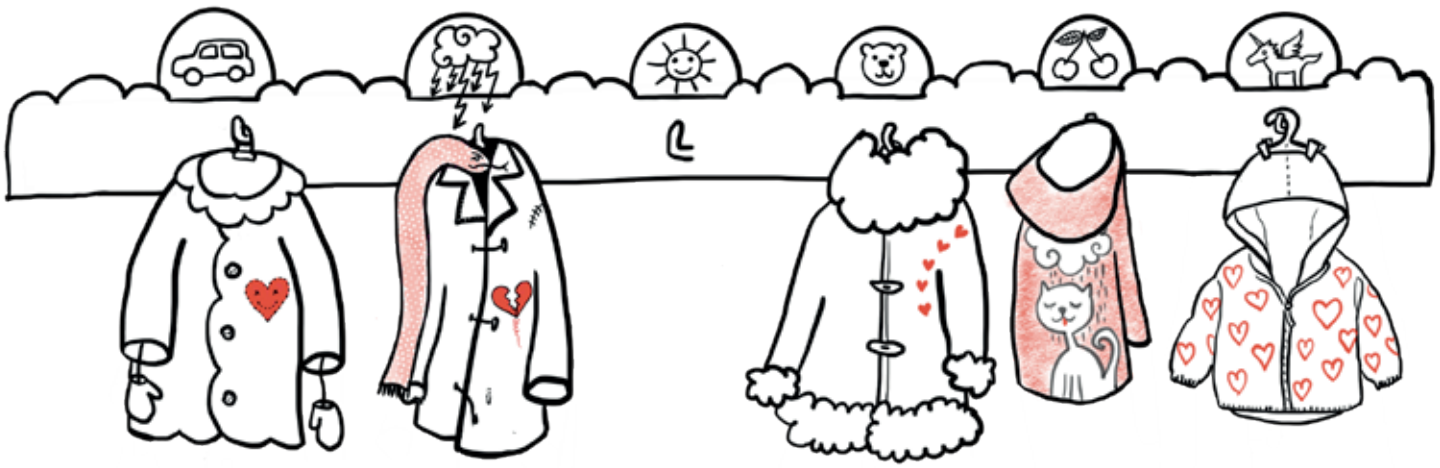
The third implementation domain is to **include evidence-based, working practices**. When working with children, the latest scientifically sound methods and practices should be used. The organisation should monitor what methods and practices are used and evaluate the effectiveness and efficiency of these methods in consultation with the childcare professionals (Cutuli et al., 2019).

The fourth and last key implementation domain is to facilitate **collaboration and cooperation between systems**. The childcare services and its employees should be encouraged to address other services and employees in a trauma-sensitive manner as well. This implies the recognition of the effects and significance of trauma, and the use of strategies that support safety and empowerment, even when other systems do not operate in a trauma-sensitive manner (Walkley & Cox, 2013). At an individual level, this could include speaking respectfully or involving families in decision-making procedures related to the needs of the child. At an organisational level, this could also include the leaders developing structures for monitoring the level of engagement and partnership with children and their caregivers.

Collaboration and cooperation also include recognizing that there are certain situations where a child may need more support in addition to trauma-sensitive care. Recognizing and communicating this is not always easy, so there needs to be an opportunity to think through these situations with a professional mentor or supervisor. If the child needs support in other areas, it is necessary for professionals to think together, to talk with the primary caregivers and involve the child in a way that is comprehensible and to help each other in order to ensure the child's development. This kind of protective network is what can lead to real healing. Moreover, before support can be established, it must be established that it is needed. We might ask ourselves when we should start addressing other caregivers or other professionals. This is often a grey area. There is no fixed guideline that can tell you which children need additional support and which do not. In acute safety situations or when the development is delayed, it is important to speak about it with your colleagues, with the child and with the caregivers of the child. Questions that might help you to decide if the situation needs additional support (possibly from specialised organisations) are:
"Do you have insights into the parenting of this child?", "Could the parenting be under pressure and what factors might contribute to that pressure?". In these contexts it is important to exchange reflections, discuss the possibilities with a colleague.

CHAPTER 4.

Let's get to work: Trauma-sensitive care provided for children age 0-3



> *"The human soul doesn't want to be advised or fixed or saved. It simply wants to be witnessed — to be seen, heard and companioned exactly as it is. When we make that kind of deep bow to the soul of a suffering person, our respect reinforces the soul's healing resources, the only resources that can help the sufferer make it through."*
>
> (Parker J. Palmer)

The aim of this chapter is to offer trauma sensitive handholds for childcare professionals, health visitors and paediatricians for their daily work with children 0-3.

A. TRAUMA AWARENESS IN NURSERY CARE

1. The principles of trauma-sensitive care in nursery care

Considering and applying trauma-sensitive principles provides a framework in which primary caregivers, professionals and children can feel equally safe. If we are to create a trauma-sensitive institution, we need to apply the trauma-sensitive principles at both the organisational and the individual levels.

This safe framework should be provided by nurseries as organisations so professionals can work to their best knowledge, parents can experience the nursery as a safe space for themselves, and their children can be in an environment where their development is best supported.

In the following section we gathered a few thought-provoking questions that could help you think through which principles are already applied and evident within the institution you work for, and which areas are the ones where some development is needed. After thinking over the questions, we gathered a few tips that can help you apply the principles at an organisational level in nursery care.

We recommend that the leaders of institutions browse through the questions to support their institution through the process of implementing trauma-sensitive care in most efficiently.

CHECKLIST FOR CHILDCARE SERVICE COORDINATORS

This checklist can be used for childcare organisers or coordinators who want to evaluate the level of trauma sensitivity of the childcare organisation. An optimal way to use this checklist can be the following:

- Use the questions below to reflect on the way the basic principles are already embedded in the childcare organisation, and where there is room for improvement.
- Write down your (group) reflections.
- Based on these reflections, complete an action plan that stimulates you to consciously evolve towards more trauma-sensitive care.
- Try to answer as truthfully as possible. Do not interpret this checklist as a test or a quiz. There are no right or wrong answers.
- To assess change, aim to reflect on each principle at least once or twice a year.

SAFETY

The primary goal of this principle is to create a sense of safety in nursery care: at the organisational level for the staff, and at the implementation level for children and their caregivers.

FOCUS: CHILDCARE PROFESSIONALS

Reflection questions on the principle of safety	Tips to ensure safety
Does the organisation actively ensure that childcare professionals feel **physically safe**?	• The organisational environment should provide security and predictability (suitable spaces for different activities). • Create guidelines on what to do in case of emergencies (first aid rules, number of ambulances, etc.). • Establish accessible and widely-known protocols and training for emergency situations. • Establish a child protection protocol and training programme in the institution.
Does the organisation actively ensure that childcare professionals feel **emotionally safe**?	• Clear agenda and daily routines, policies, frameworks and rules for everyone (children, caregivers, childcare professionals, supervisors) • Clear, kind and respectful communication with everyone. • A set of standards and an atmosphere where everyone feels free to ask questions, give and receive respectful feedback.
Is there a place for adequate privacy (e.g. for important conversations with caregivers) for childcare professionals, for children and for caregivers?	The organisational environment should provide security and predictability (suitable spaces for different activities).
Are the childcare professionals trained to communicate and act upon safety incidents? (eg. impulsive actions between children)	Provide communication (guidelines) and training about: • What does a childcare professional do when a safety incident occurs • How can childcare professionals communicate with children about these incidents • How can childcare professionals communicate with parents about these incidents (You can read more about communication practices in the Screening and Referral Tool, which you can find here.)

FOCUS: PRIMARY CAREGIVERS

Reflection questions on the principle of safety	Tips to ensure safety
Are the first contacts with caregivers welcoming, respectful, and engaging?	Be aware that for many parents, the first meeting can be a difficult and possibly anxiety-provoking experience. Communicate sensitively in response to this situation: • introduce yourselves; • set out the purpose and the framework of the conversation (how much time you have, what you need to talk about first); • listen carefully to their introductions; • give them enough time to formulate their questions; • if there is not enough time to discuss everything, indicate when and where you can continue the conversation or where you can find more information; • if you find that they are anxious about the new situation, indicate that this is perfectly understandable. The childcare professional takes into account the views of the caregivers and is present with a kind, curious attitude.
Do caregivers receive clear explanations and information about each task and procedure? (eg. afternoon nap arrangements)	Be aware that what is already familiar to you may be unfamiliar to a new member. Take the time to explain precisely the habits, tasks and procedures. Allow enough time for them to ask questions and clear up any uncertainties they may have.
Are childcare professionals attentive to signs of caregivers' discomfort or unease? Do they understand these signs in a trauma-sensitive way?	Mentalization skills can help to reflect on the feelings and intentions behind my own behaviour and that of others. If an event is too intense and stressful, supervision could help to better understand the overwhelming situation.

FOCUS: CHILDREN

Reflection questions on the principle of safety	Tips to ensure safety
Does the organisation's daily routine provide security for children?	Inform children when/what will happen and who will be with them on a regular basis. A board on the wall could be used to display this information, so that children can look there when they are unsure about what to expect.
Do we support a clear, clean and safe physical environment for children?	The children's environment should not be too crowded. There should be clear signs for the children to understand exactly which space is used for what (this is where we do arts and crafts, this is where we listen to stories, this is where we sleep)
Are the childcare professionals of the organisation aware of the child's developmental history?	The childcare professional should have sufficient information about the child's developmental history. To ensure this, collect information from parents, other professionals (if necessary). The parents should be informed of the reason and purpose for this. Have a notebook for each child to follow their history, make regular notes.

My notes and reflections on the principle of SAFETY

Plan of action for the SAFETY principle

GOAL What goal do we want to achieve?	**ACTION** How can we achieve this goal?	**STEPS** What support do we need (and from whom)?		**TIMELINE** How are we going to act?
		TASK	**MANAGER**	

PREDICTABILITY

The primary purpose of this principle is to ensure that the nursery care operates structurally and transparently.

FOCUS: CHILDCARE PROFESSIONALS

Reflection questions on the principle of predictability	Tips to ensure predictability
Does the organisation have clear expectations and requirements for the role and mandate of the different childcare professionals?	• There should be a job description available to all. • The arrival of a new professional is preceded by a mindful selection, based on the principles of trauma awareness. • The new professional will be provided with input training and preparation. • The work of the childcare professionals is supported by supervision and mentoring
Does the organisation have information available on the supporting network? (When? From whom? How? What is the context for this?)	Guidance on what support is available within the institution and what forms of support are available outside the institution.
Is the organisation ensuring respect for professional and personal boundaries?	It's a pleasure to work in a warm, friendly environment, but it's important to make sure that your personal and professional boundaries don't cross to the point where it becomes difficult to work professionally (e.g. being the professional mentor of your flatmate, or feeling the obligation to work extra hours because there is an overlap between the fact that you love your job and there is need)) Create a guideline about how the coordinator(s) can ask for help and support positively. Invite childcare professionals regularly to share feedback on their own boundaries and how they can be respected.

FOCUS: PRIMARY CAREGIVERS

Reflection questions on the principle of predictability	Tips to ensure predictability
Do I ensure clear information about the childcare organisation with regard to what will be done, by whom, when, why, under what circumstances?	The communication of new information and changes is understandable to everyone, the childcare professionals have the opportunity to ask their questions. The involvement of professionals in professional decisions is allowed. The responsibilities and spheres of activity are clear, everyone is aware of these. There is a policy about worrisome signals. Childcare professionals and caregivers are familiar with the policy. It is made clear how parents can express their own worries and stress.
Is it clear for primary caregivers how, where and in what form they can have a conversation with the childcare professionals? Are childcare professionals accessible and approachable for primary caregivers?	Mutual communication with parents greatly helps the work of the nursery. Obviously, childcare professionals have a lot of work to do, so it is a great help to them and to the carers if there is a clear framework for when and how to talk to them. It is important to set out clearly the frame for this communication. E.g. when can you talk face-to-face? What other channels can be used for dialogue (email, phone, what time)? What time is appropriate to communicate?
Are childcare professionals attentive to signs of caregivers' discomfort or unease? Do they understand these signs in a trauma-sensitive way?	Mentalization skills can help to reflect on the feelings and intentions behind my own behaviour and that of others. If an event is too intense and stressful, supervision could help to better understand the overwhelming situation.

FOCUS: CHILDREN

Reflection questions on the principle of predictability	Tips to ensure predictability
Is the daily agenda predictable and familiar to children? Do the children know which childcare professional they can expect at which time of day?	Clear visual cues for children about the day's activities and programmes The daily routines and the agenda should be clear and predictable for children and parents as well.
If there is a change in the daily organisation, are the children informed in time?	Both parents and children are informed about the changes in time if that is possible.

My notes and reflections on the principle of PREDICTABILITY

Plan of action for the PREDICTABILITY principle

GOAL What goal do we want to achieve?	ACTION How can we achieve this goal?	STEPS What support do we need (and from whom)?		TIMELINE How are we going to act?
		TASK	MANAGER	

SUPPORT

The primary purpose of this principle is to encourage nursery directors to facilitate mutual support among staff members, and motivate childcare professionals to facilitate communication between primary caregivers and the development of different support groups, circles and smaller communities.

FOCUS: CHILDCARE PROFESSIONALS

Reflection questions on the principle of support	Tips to ensure supportive communities
Does the organisation actively connect with other, external childcare organisations?	Mutual cooperation between professions is essential to run an effective childcare service. We recommend organising periodic meetings (even online) where it is possible to meet with the health visitors, paediatricians, child protection specialists, and professionals from the pedagogical services. Experience shows that if there is already a familiarity between professionals, it is much easier to cooperate in difficult situations.
Are childcare professionals offered development, training, or other support opportunities to assist with work-related challenges and difficulties? To build on childcare professionals' skills and abilities? To stimulate their career goals?	Organising training sessions provides childcare professionals the opportunity for professional development that acts as a highly motivating factor and also increases long-term commitment. We suggest that a system be set up for this to outline who can take part in which training courses and when, and possibly also organise internal knowledge sharing and peer learning opportunities. Create regular opportunities where childcare professionals can ask for help or express worries within the team or towards their supervisor.
Does each childcare professional feel supported when they face challenges in their work? "We are all in this together."	Where there is child abuse, it is possible that the anyone experiencing the problem is left to deal with it on his/her own and because it is a difficult situation to cope with, that person may experience difficulty managing it. It is recommended that in these and other emotionally distressing situations there should always be more childcare professionals involved as a system of support in addition to the possibility of supervision if necessary. Trust between childcare professionals is not always self-evident. The organisation should create trust between childcare professionals both formally and informally (lunches, team-building exercises, etc.)

FOCUS: PRIMARY CAREGIVERS

Reflection questions on the principle of support	Tips to ensure supportive communities
Do primary caregivers have the opportunity to meet in formal (for instance, a primary caregiver meeting) and non-formal settings to talk and form a community?	There is an enormous potential in having a supportive, strong community of parents in the nursery. It is advisable to organise formal and informal meetings with parents to support the creation of this community. For example: • a parent academy on current topics, • a parent-child day, • gardening and planting flowers together in the nursery. • clothing and toy exchange events
If a family is going through a difficult period, are they supported enough by the professional, parental and local communities? Can we verify whether such support is actually available and effective?	A strong community of parents can place a protective net around those who are in more vulnerable states. In addition, it is worth looking again at this from a professional point of view, what help does the family need, what organisations can be involved to help. If there is no change, reflect on the reasons for this. The logistics of this shouldn't be the responsibility of one person, it is good to have a protocol about it that is widely known.

FOCUS: CHILDREN

Reflection questions on the principle of support	Tips to ensure supportive communities
Do we support children in building positive social relationships? If it is challenging for a child to relate to others, are we providing enough support? And in doing so, are we taking the developmental history and the personal boundaries of the child into consideration?	We need to pay special attention to children who may have difficulties with peer and adult relationships and reflect on the reasons. This requires a thorough knowledge of the child's developmental history.

My notes and reflections on the principle of SUPPORT

Plan of action for the SUPPORT principle

GOAL What goal do we want to achieve?	ACTION How can we achieve this goal?	STEPS What support do we need (and from whom)?		TIMELINE How are we going to act?
		TASK	MANAGER	

PARTNERSHIP

The primary goal of the principle is to develop forms of support that are available within the nursery and provide training and mental health support for the staff.

FOCUS: CHILDCARE PROFESSIONALS

Reflection questions on the principle of partnership	Tips to ensure partnership
Do the childcare professionals of the institution provide mutual professional support to each other? Does the organisation allow childcare professionals to say "no, I can't do this"? And in such cases, can the childcare professionals safely rely on the others?	The head of the institution will talk to the staff from time to time to give them a chance to give each other feedback. The purpose of the conversation is to provide support and promote common development. Childcare professionals need to feel that they can say 'no' without consequences to things that are beyond their professional or personal boundaries.
Is the organisation offering childcare professionals enough support opportunities (for instance, open office hours)?	Provide open office hours for childcare professionals to ask any questions and address difficulties or uncertainties they may have.
Is there a fair distribution of responsibilities among childcare professionals in terms of experience and workload? Is there someone who has too heavy a workload and who lacks support?	The organisation should assess how the workload is distributed amongst childcare professionals. We need to be aware of any overload and be able to organise support and help accordingly. Create regular opportunities for childcare professionals to talk about workload and responsibilities. Writing down the hours worked and the time spent on tasks can also give an objective picture of whether someone is overworked.

FOCUS: PRIMARY CAREGIVERS

Reflection questions on the principle of partnership	Tips to ensure partnership
Is the relationship between professionals and primary caregivers based on collaboration and mutual respect? Does the childcare organisation communicate and display the attitude that the caregivers are the ultimate expert on their own experience? Are the competencies of the professional and the primary caregivers mutually acknowledged? Do the professionals and the primary caregivers acknowledge each other's competencies?	Caregiver-childcare professional interactions could unconsciously become a hierarchical dynamic. This requires special attention, the relationship should be based on a partnership between the professional and the caregivers and not on a hierarchy. It is important to listen to the parents' experiences and knowledge about their child, attentively. Communication should be mutually respectful from both sides. The competence of parents and that of professionals are mutually recognized and respected. Caregivers should have the opportunity to ask any questions or report difficulties to the childcare professionals in a safe setting. Adequate space and time should be available for these kinds of communication.

FOCUS: CHILDREN

Reflection questions on the principle of partnership	Tips to ensure partnership
Are we looking at children as capable and competent agents? Do we treat children with the same respect that we expect them to show everyone else?	It's probably easy to answer yes to these questions, but there are still many situations where we can be overwhelmed, lose patience, find it difficult to relate to or understand a child's behaviour. If we experience this in ourselves or in our childcare professionals, it is important to provide opportunities for self-care and rest. The organisation needs to be alert to this and provide opportunities for healing.

My notes and reflections on the principle of PARTNERSHIP

Plan of action for the PARTNERSHIP principle

GOAL What goal do we want to achieve?	**ACTION** How can we achieve this goal?	**STEPS** What support do we need (and from whom)?		**TIMELINE** How are we going to act?
		TASK	**MANAGER**	

PRESENCE

The purpose of the principle is to ensure that the staff in nursery care has support at the organisational level to maintain motivation, prevent burnout and work with traumatised families. It is important to build on the strengths of parents and staff.

Creating a sense of control in small decision-making situations can help traumatised families and children who must often live in circumstances where they have no control.

FOCUS: CHILDCARE PROFESSIONALS

Reflection questions on the principle of presence	Tips to ensure presence
Has the organisation developed a perspective on how to handle moral injuries as an organisation and as a team and how to cope with those feelings? Moral injury means that childcare professionals might experience personal challenges and difficulties when their moral expectations and beliefs are violated. The consequences can include feelings of guilt, shame, anger and betrayal. For instance, a childcare professional may have gone out of his/her way to address organisations who specialize in child abuse, but still do not act on the situation. The childcare professional might feel very angry and betrayed.	Create opportunities for dialogue about these feelings and experiences. Connect with (external) professional support for childcare professionals Reach out to childcare professionals in these situations and check up on them: How are you feeling today? Validate their feelings if possible.
Does the organisation offer the childcare professionals opportunities to present their new ideas?	It is important that staff members feel they have the opportunity to present and use their ideas on professional issues. These transfers of knowledge and good practice should be given regular time.
Does the organisation build in small choices that make a difference for childcare professionals? (eg. possibility to express personal preferences regarding means and timing of communication)	If there is an opportunity to do so, it is important that professionals have a choice about things such as when they have office hours, what training they take, when parents can contact them and in what form.

FOCUS: PRIMARY CAREGIVERS

Reflection questions on the principle of presence	Tips to ensure presence
Does the organisation pay attention to the family's own strengths and resources?	Even in difficult situations, it is important to be aware of the strengths of the family, what they and we can build on. It's easy to fall into the trap of focusing on weaknesses. To get a more balanced picture, we can use the SWOT analysis methodology (see figure xx below) (Kenton, 2021) to establish and list the family's strengths, weaknesses, opportunities and potential risks. With this method, it is easy to spot if you are focusing too much on weaknesses.
Does the organisation build in small choices that make a difference?	Give freedom of choice, in those situations where it is possible. Make it possible for people to change opinions without feeling guilty. Inform childcare professionals, caregivers and children about the alternatives and the possible consequences. Simplify and clarify decision rights.

Figure 7. SWOT - Strengths, Weaknesses, Opportunities, Threats (Based on *Kenton, 2021*)

FOCUS: CHILDREN

Reflection questions on the principle of presence	Tips to ensure presence
Does the organisation treat children with respect in all circumstances?	The childcare professional should build on the child's strengths, taking into account the children's individual developmental rhythm
Does connecting with children provide security?	The childcare professional adapts the activity to the children's level of development
Does the daily organisation give the children a choice in activities and tasks that help them grow?	The childcare professional is able to take into account the differences between biological and developmental states Children are also surrounded by the attitude that if the situation gives them the opportunity, they have a choice about things and the opportunity to say no to things. Dr Bruce Perry's 6R approach is based on the principle that activities that are characterised by these qualities have a healing effect on the nervous system. (See Figure 6 on Page 31.) These activities are: • Relational (safe) • Relevant (developmentally-matched to the individual) • Repetitive (patterned) • Rewarding (pleasurable) • Rhythmic (resonant with neural patterns) • Respectful (of the child, family, and culture)

My notes and reflections on the principle of PRESENCE

Plan of action for the PRESENCE principle

GOAL What goal do we want to achieve?	ACTION How can we achieve this goal?	STEPS What support do we need (and from whom)?		TIMELINE How are we going to act?
		TASK	MANAGER	

INCLUSION

The purpose of the principle is to promote that childcare professionals are aware of, and thus respect the diversity, educational styles and family characteristics of the children they work with.

FOCUS: CHILDCARE PROFESSIONALS

Reflection questions on the principle of inclusion	Tips to ensure inclusiveness
Is the organisation open and inclusive towards all childcare professionals, regardless of gender, age, religion or origin? Are childcare professionals encouraged to become familiar with other relevant cultures, with their experiences, stories and explanations?	The organisation actively moves past cultural stereotypes and biases (e.g., based on race, ethnicity, sexual orientation, age, geography), offers gender responsive services, leverages the healing value of traditional cultural connections, and recognizes and addresses historical trauma It is important for professionals to raise awareness of the traumatic effects of poverty and deprivation and its consequences. The difficulties and possible transgenerational traumatic effects of belonging to an ethnic minority are taken into account.

FOCUS: PRIMARY CAREGIVERS

Reflection questions on the principle of inclusion	Tips to ensure inclusiveness
Is the organisation open and inclusive towards all families, regardless of gender, age, religion or origin? Are caregivers encouraged to get to know other caregivers and childcare professionals in formal and informal moments? Is there room for childcare professionals to support caregivers without having to 'fix' the problem?	Avoid judgements and expectations based on your own values and professional standards when communicating with parents. Communication with parents should always try to be inclusive, open and calm. Offer practical explanations. Things that might be self-evident to you, might not be so self-evident to others.

FOCUS: CHILDREN

Reflection questions on the principle of inclusion	Tips to ensure inclusiveness
Is the organisation open and inclusive towards all children, regardless of gender, age, religion or origin? Is there a sensitive climate introduced in the organisation, meaning that all daily contacts with children are based on these six principles? Does the organisation actively build on the resilience and strengths of each individual child?	Create a guideline about how children can become familiar with other cultures than their own. Keep expectations at a realistic level so that children can experience success. offer plenty of practical explanations. Things that might be self-evident to you, might not be so self-evident to others. Give children personal and specific compliments.
Are childcare professionals open to differences in the daily habits that children have? (be open to understand and accept, keeping in mind that an institution cannot be fully adapted to individual needs).	Be attentive, accepting and guide children towards the common values avoiding guilt and shame. (Be aware that it is a very difficult process both for you and the child.)

My notes and reflections on the principle of INCLUSION

Plan of action for the INCLUSION principle

GOAL What goal do we want to achieve?	ACTION How can we achieve this goal?	STEPS What support do we need (and from whom)?		TIMELINE How are we going to act?
		TASK	MANAGER	

2. Trauma-sensitive care in the daily practice of nursery settings

In this chapter, we have collected specific, useful practices and methodological elements that, together with the consideration of the six principles, can effectively support the operation of a trauma-sensitive nursery.

WITH FOCUS ON THE CHILD

Children need structure and routines. When the day is predictable, children will feel safe to explore. This can be implemented taking into consideration these suggestions:

Create structure

- Organising a joint start-up and closing moment
- Visualising the daily routine with illustrations, rituals
- Offering children control over their daily structure when possible
- Creating soothing transitions (through music and songs)

Build in moments of rest

- Organising sensory exercises in low-stimuli spaces
- Offering physical proximity (sitting on the lap, singing, reassuring)
- Introducing children to nature and animals
- Using white noise during nap time
- Introducing baby massage
- Introducing toddler yoga

Work rhythmically and development-stimulating

- Playing music for and with children
- Offering caregiver-child workshops to make music together
- Dancing
- Stimulating sensory play (with feeling, exploring and playing with sand or water)

Develop an acclimatisation policy

- Creating and implementing an acclimatisation policy for all new children
- Asking caregivers to take some photos of the home environment that can be presented to the children at the childcare organisation when they feel distressed
- Giving caregivers some photos of the childcare environment to look at at home, so children can get used to the childcare environment

- Creating and implementing an acclimatisation policy for children who are transitioning to another group within the childcare organisation
- Offering a planning/habit board for children in a visible and accessible place, which they can follow to understand daily routines
- Stressing the importance of a goodbye which does not necessarily need to be short
- Stimulating the physical connection between home and the childcare organisation (through smells, pictures, and routine)

Communicate positively

- Speaking tailored to the age of the child
- Smiling and laughing together
- Mirroring in communication of emotions (mirror play)
- Expanding one-on-one time structurally
- Playing together with children
- Involving children in preparing an activity
- Giving children ownership and control when possible
- Acknowledging emotions (both enjoyable and difficult emotions)

Personalization

- Creating a space that belongs to the children
- Integrating children's point of interest into the space
- Create a safe space for them where they can put their own stuff (clothes,toys, drawings)

Mentalization

- Supporting mentalization through play
- Reading aloud to recognize feelings and learn to give language to situations
- Reading child appropriate books about feelings and stressful situations
- Organising puppet shows on themes that engage children
- Telling stories about 'who is this child' and 'what has the child been through'
- Giving language to experiences
  - Expressing what you do and what you think and what you feel about it
  - Express what the child might think and feel, specially in an overwhelming situation
  - If the situation is calmer, ask about the children thoughts and feelings
  - Encourage them to express their feelings
  - Teach them that all the feelings are relevant
- Thinking about how you are involving children that speak other languages at home

WITH FOCUS ON THE PRIMARY CAREGIVER

Children need structure and routines. When the day is predictable, children will feel safe to explore. This can be implemented taking into consideration these suggestions:

Add rest/relaxation for caregivers

- Rethinking your space without it taking a whole renovation, looking at how you can arrange the space differently to give caregivers a space.
- Creating a peaceful atmosphere at drop-off and pick-up times
- Focusing on accessibility (open door policy)
- Organising a coffee/breakfast corner for caregivers
- Having a chair where caregivers can breastfeed or cuddle with their children
- Creating a physical space where caregivers can speak freely
- Organising a play area especially for children and caregivers

Increase caregiver involvement

- Focus on the connection between child and caregiver, without expecting anything additional from caregivers. This does not mean being focused on 'what can caregivers do' because that increases the threshold to get involved and gives floor to resistance. Also pay attention to micro-discrimination if you address caregivers based on their cultural background.
- Organising trips with children and caregivers
- Having reading moments with caregivers
- Having a caregivers' party

Connect with caregivers

- Build firm trust by connecting with caregivers daily not just when there are problems. Involve parents concretely in a systematic way concerning the development of their own child. Bring caregivers together around important themes of children's development
- Focusing on a relationship of trust throughout the year
- Communicating positively with caregivers about the child's day at the nursery
- Asking open questions and showing interest in parents
- Showing interest in the identity of the caregiver(s)
- Paying attention to caregivers
- Promoting the connection between home and the nursery
- Tailoring communication to the needs of the caregivers
- Discussing themes related to the development of the child with caregivers
- Systematically facilitating contact between caregivers
- Talking with caregivers about how it is going at the nursery
- Encouraging informal talking moments between caregivers
- Giving caregivers the opportunity to ventilate
- Organising formal caregiver evenings and training sessions
- Offering information through posters, flyers and videos

Search for solutions with caregivers

- Expressing your understanding for caregivers
- Helping to find a solution for caregivers' problems
- Being able to work outreaching (taking initiative by visiting caregivers and offering support)
- Collaborating with external organisations for targeted referral

WITH FOCUS ON THE STAFF

Build in structure (not only in the group)

- Organising the staff so that someone can call on their colleagues in times of need
- Thinking consciously about team composition
- Creating a physical space where the staff can take a rest without children and caregivers
- Offering breathing exercises for staff

Raise awareness about self-regulation

- Having a regular break
- Composing a 'first aid kit' for every staff member that helps them find calm (tea bag, music, etc.)
- Creating a habit board for childcare professionals: writing down what works for everyone to calm down

Build a relationship of trust between childcare professionals

- Creating a warm atmosphere: e.g. being able to have a break together
- Asking childcare professionals 'how are you?'
- Focusing on team building
- Encouraging a bond of trust and communication
- Taking each other's likes and dislikes into account
- Making room to be able to ventilate together in a positive way
- Having sessions to talk about self-care, stress, etc.
- Organising separate interviews with the team leader

Structure the network and construct a social map

- Organising and using the professional network of the nursery
- Stimulating training, supervision and intervision (team meetings)
- Making room for repeated and refreshed education
- Document the network to find information and appropriate care sooner

3. Handholds for crisis moments

A crisis response often stems from a stressful reaction. This is not done on purpose or deliberate. Sometimes we are not able to calm ourselves down. This is especially true for young children. To build a relationship and to make room for development, it is important to follow three steps to help someone to calm down.

Regulating implies a way of physically calming down and consciously stepping away from the fight, flight or freeze response. Relating or connecting is followed, as a way of making contact and showing that you are there for someone. Finally, reasoning means a way of talking about what happened and giving meaning to feelings, thoughts and behaviour.

This sequence is especially important because in a high arousal state, the 'smart' part of the brain (neocortex) is less available than in a 'calm' state. That is why we first regulate the nervous system with rhythmic, repetitive predictable stimuli, and then, when the nervous system is in a calm state again, give a more complex explanation of the event.

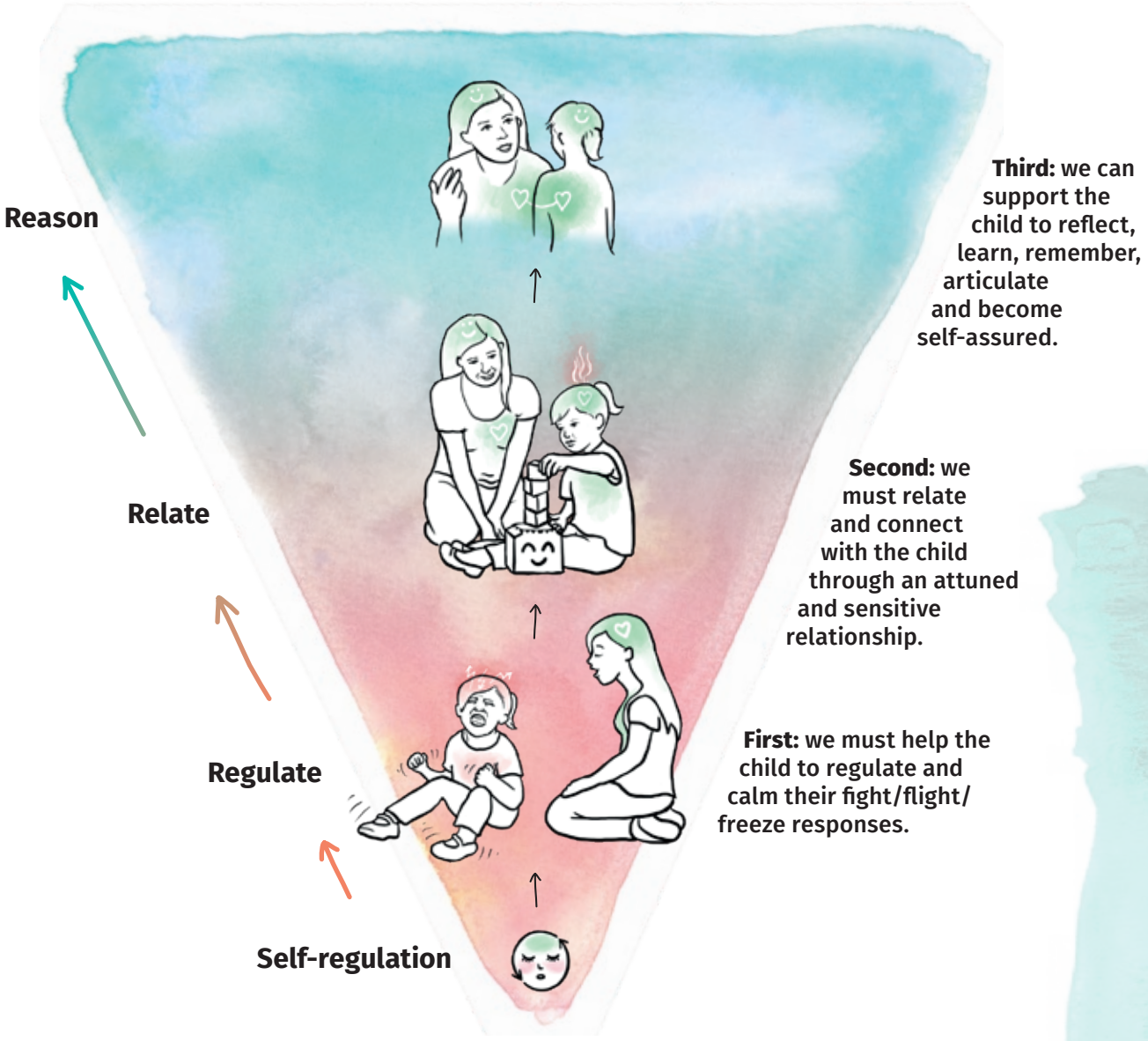


Figure 8. (Image by Emese Iványi, based on Beacon House Therapeutic Services & Trauma Team, 2019)

WITH FOCUS ON THE CHILD

Regulate

- Adjusting to a child in crisis
- Offering a quiet or safe space (low stimulus)
- Playing recognizable songs
- Being close without being threatening
- Providing an alternative to threatening behaviour (tearing scrap paper, biting into a kitchen towel, etc.)
- Go for a rhythmic walk together

Relate

- Doing something soothing together (reading, singing, playing)
- Offering one-on-one time
- Using a cuddle, low-stimuli corner
- Gaining insight into what caregivers do at home in crisis situations
- Following what the child allows and indicates

Reason

- Talking about what happened and the possible feelings the child has experienced
- Naming the behaviour that is not okay, but do not put the blame on the child
- Naming what you see ('such heavy tears')
- Naming the emotion the child might have ("probably you were really upset/angry/anxious")
- Using 'and' instead of 'but' ("We had fun but now we need to clean up" becomes "We had fun and now we need to clean up")
- Re-enacting with the child what happened

WITH FOCUS ON THE CAREGIVER

Regulate

- Asking caregivers in crisis inside and guiding them to a quiet space
- Giving caregivers time to talk
- Confirming what you see
- Asking what the caregiver needs or what might help

Relate

- Mentioning the experiences related to the caregiver that makes you proud (of them)
- Emphasising that you are both trying to tackle a problem, not each other
- Using short sentences ("I see you are upset")
- Validating their feelings (with words, tone of voice)
- Asking what the caregiver needs
- Telling caregivers that your bond is important to you when they lash out

Reason

- Following up afterwards: how are things going on now?
- Asking 'can we talk about what happened?" instead of asking 'why'-questions
- Don't make quick conclusions after the event, try to stay curious about what happened at every level

WITH FOCUS ON THE STAFF

Regulate

- Gaining insight into your own stress triggers and how you can calm yourself down
- Discussing with your colleagues what helps you calm down
- Being aware that you cannot calm someone else down when you are not calm yourself
- Practising regulatory skills (such as breathing exercises, walking, etc.)
- Looking for peace and quiet when you are in crisis
- Learning to appeal to childcare professionals when you are in crisis
- Installing guidelines within the team to deal with crisis
- Ask for help if you can't regulate yourself alone

Relate

- Getting to know your childcare professionals and noticing when they are stressed
- Checking in with your childcare professionals regularly
- Being aware that caregivers may act out due to their stress and that it is not personal

Reason

- Following up afterwards: how are things going on now?
- Asking 'can we talk about what happened?" instead of asking 'why'-questions

Adaptive Response	REST	VIGILANCE	FREEZE	FLIGHT	FIGHT
Predictable De-escalating Behaviors (behaviors of the teacher or caregiver when a child is in various states of arousal)	Presence Quiet Rocking	Quiet voice Eye contact Confidence Clear simple directives	Slow sure physical touch "Invited" touch Quiet melodic words Singing, humming music	Presence Quiet Confidence Disengage	Appropriate physical restraint Withdraw from class TIME!
Predictable Escalating Behaviors (behaviors of the teacher or caregiver when a child is in various states of arousal)	Talking Poking Noise Television	Frustration, anxiety Communicate from distance without eye contact Complex, compound directives Ultimatums	Raised voice Raised hand Shaking finger Tone of voice, yelling, threats Chaos in class	Increased or continued frustration More yelling Chaos Sense of fear	Inappropriate physical restraint Grabbing Shaking Screaming
Regulating Brain Region	NEOCORTEX Cortex	CORTEX Limbic	LIMBIC Midbrain	MIDBRAIN Brainstem	BRAINSTEM Autonomic
Cognition	ABSTRACT	CONCRETE	EMOTIONAL	REACTIVE	REFLEXIVE
State	CALM	ALERT	ALARM	FEAR	TERROR

Figure 9. Based on a material used by the Neurosequential Network

4. Handholds for discussing worries with primary caregivers

This part is complementary to a section from the other material of the ECLIPS project, 'guidelines for communication with parents' in the Screening and Referral Tool.

Prepare the conversation

- As a rule, invite both parents to the conversation. Both parents have a responsibility towards their child. You will need the engagement and agreement of both parents to decide on possible actions. Inviting both parents also allows for building on mutual trust.
- Facts are not assumptions. Think about what you have observed and what you have interpreted and divide those two. The observations can be offered as facts: "I have noticed that Sara has had a harder time this last period for some reason. For instance, I saw that Sara pushed over 4 children in two days". The worries are part of your interpretation: "I am afraid that this behavioural change may be caused by distress and that feeling could escalate if we do not intervene.
- Make time to have the conversation.
- Decide on who will be involved in the conversation and inform parents in advance
- Think about your aims.
- Reflect on the current safety level of the child.
- Talk about the conversation with colleagues. Your perspective is only one viewpoint. It is important to see how you can see it differently.
- Already think about the first sentences you want to say. They could set the tone of the entire conversation.
- This situation might weigh on you as a childcare professional. Let colleagues support you, but also allow them to set boundaries if you get dragged in by your emotions.

Focus points during the conversation

- Explain the framework and position of the childcare organisation.
- Be clear and cut to the chase about your worries.
- Acknowledge parents for their commitment and effort for the child, but also don't be afraid to define possible destructive behaviour.
- Speak about their feelings of rejection.
- Tell them that you understand their feelings.
- Make time to discuss the consequences for the child on different levels: physically, emotionally, cognitively, relationally, socially, etc.
- Ask the parents if they can put themselves in the position of the child.
- Give boundaries to parents when they externalise too much. What can they do themselves, as parents?
- Reflect on how willing the parents are to seek further support:
  - Ask them if they are able to hear your concerns.
  - Offer information about organisations that might be able to support them.
  - Make some specific agreements about the safety of the child.
- Talk about what message the parents can give the child after the conversation.

Focus points about attitude

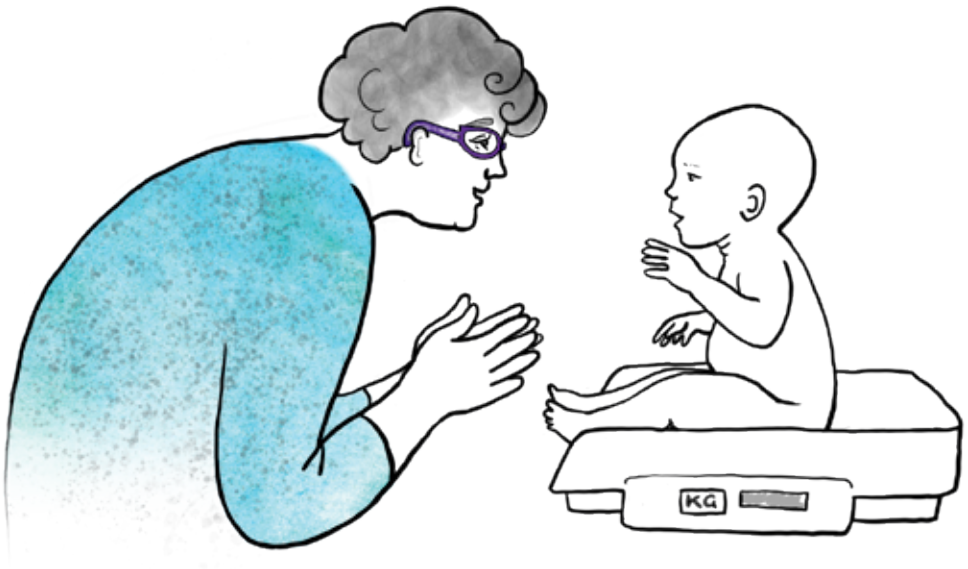
- Be caring, but also direct.
- Try to assess the problem/worries in as detailed a manner as possible.
- Make sure the parents feel safe.

How to avoid pitfalls:

- Address the parents yourself.
- Be open.
- Don't doubt yourself or your own feelings (but keep being reflective on yourself, try to ask for supervision if needed).
- Avoid blaming the child:
  - always start from your observations;
  - do not use statements or quotes from the child.

For more general ideas about how to communicate with parents please see the Screening and Referral Tool.

B. TRAUMA AWARENESS IN HEALTH VISITOR PROGRAMMES[12]



Due to the nature of the work of health visitors, these professionals are more likely to witness harmful conditions, signs of uncertainty or poverty, even specific trauma, abuse or violence in the families they visit. Their work is also complicated by individual family members, various professionals or the primary caregivers themselves possibly judging the same situation differently, and each family member may cope dissimilarly with various challenges or traumas. Due to the shortcomings of the legal framework regarding their work (in Hungary), they often find themselves in dangerous situations and experience the effects of secondary trauma[13].

Because of the aforementioned reasons, it is essential to develop a trauma-sensitive home visit protocol that provides expert, high-quality support for families and guarantees to protect the mental health of health visitors. This is important also because, according to their mission, the aim of a health visitor is to serve the development of the child and the family with a preventive approach and mental health aspects are significant in all areas of their activity. Therefore, health visitors are using their entire personality while working and can work most effectively by building on a mutually established, trusting relationship.

The members of the living lab recommended the introduction of the six trauma sensitive core values at the organisational level by following the viewpoints and questions mentioned below. The list should be reviewed annually.

It is recommended to consider the set of guidelines and questions with the involvement of all participants in a local community of health visitors, a work team or even a general practice partnership. However, it is still relevant to consider these questions for all health visitors, even if they prefer to do their job alone due to their working conditions. The answers ensure the introduction of trauma sensitive care by pinpointing the areas where further development and clarification are needed.

12 Considering the specifics of the health visitor service in Hungary the development of the trauma sensitive protocol was carried out together with a professional advisory group. Apart from the discussions in the living lab, a focus group session was organised with 11 health visitors, many of them in leading positions

13 Comment by a focus group interview member

SAFETY

The primary goal of this principle is to create a sense of safety in health visitor care: at an organisational level for health visitors and at the implementation level for families.

Aspects to increase security:

FOCUS: HEALTH VISITOR

- The health visitor has short descriptive material that describes the steps and process of care; describes a wide range of the health-visitor work.
- The health visitor has knowledge and skills about trauma-sensitive care, the effects of trauma on development, the stages of child and family development, crisis communication, and positive educational tools.
- Before the visit there is time to prepare for the visit:
- Collecting information about the family, family history;
- Formulating the main messages that should be conveyed to family;
- Gathering questions to help to learn about family history;
- Arranging for the family to be visited with a representative of another institution involved in your family's life;
- Making an appointment about your visit with your family.
- The health visitor is physically safe during the visit and may visit the family together with someone else if necessary.
- After the visit, the health visitor can get help in the form of supervision, case management or intervention.
- The organisation of health visitors provides physical and legal protection for its employees.

FOCUS: FAMILY

- Before the visit, the family learns about the health-visitor system and the levels of service.
- The family has the opportunity to discuss the date of the visit with the health visitor
- The family receives information about the purpose and main topic of the next visit
- The family receives information about the participants of the visit
- The family can ask questions either before or during the visit
- The family can give feedback to the health visitor or their supervisor about the quality and effectiveness of the visit

PREDICTABILITY

The primary purpose of this principle is to ensure that the health-visitor care operates reliably and transparently.

Placing confidence in the health visitor and their work could be increased if all participants in the family and in the care system are aware of the tools and steps that can be used during the process of care. The professional advisory group highlighted the key role of screening in prevention, but stressed that information-seeking questionnaires are often traumatic in themselves by being rigid, even crossing participant boundaries and focusing on deficiencies. In most cases, the success of gathering information depends on the health visitor's communication strategy and social skills.

FOCUS: HEALTH VISITOR

- The health visitor is well-informed about his/her speciality and is able to introduce it briefly to the family;
- The health visitor consciously expresses the importance and purpose of care and everything in which she can support the family;
- Health visitors increase their own reliability every time they explain the purpose of the examinations and questionnaires. They express that these activities provide prevention and, if necessary, finding the most appropriate help for the family;
- Based on their knowledge and professional skills, they are able to teach and shape the family, they have an impact on the positive development of the family;
- Health visitors consciously build on the strengths of the family and set developmental goals based on these;
- Health visitors consciously build relationship based on trust and use the power of it even when they are in an emotionally difficult situation with the family.

FOCUS: FAMILY

- Families understand the purpose of the visit and the possible outcomes;
- During the visits, they experience that the health visitor is part of the support and prevention system;
- They express their trust towards the health visitor, share current questions and doubts about the child's development, they experience that they receive help when they need it;
- They feel that they can get proper help, information and knowledge from the health visitor;
- It is clear to them who are the members of the reporting system[14], who can report how, who can report when, what steps are expected after the reporting.

14 The Hungarian Child Protection Act (HCPA) of 1997 in its 17th paragraph establishes a **mandatory reporting system**, and obliges all the relevant parties (paediatricians, health visitors, childcare professionals, teachers, police, etc.) to report suspected cases of child abuse or neglect to the **local child welfare services**.

SUPPORT

The primary purpose of this principle is to encourage health visitors to facilitate communication between clients and the development of different support groups, circles, and smaller communities.

The health visitor often plays a mediating and supportive role in small communities, where they create the space and opportunity for caregivers living in the same conditions or facing similar challenges so they can support each other while spending time in a common space. These semi-informal spaces play a natural protective role in the life of the community, either in resolving crisis situations or in recovering from or preventing trauma. Connecting, participating in the community also protects the health visitor, they can receive feedback, see the results of their work and they can experience the acceptance and gratitude of the community. These are the strongest protective factors against secondary trauma and burnout. The effects can be enhanced by involving other health visitors and associates in the community and they can even create a supportive community for themselves. Basically, there are grass-roots initiatives in everyday work but policy support is important in all of these, which can provide a basis and framework for the creation of support groups.

FOCUS: HEALTH VISITOR

- The health visitor organises a self-help group for caregivers, and/or should partner with various partner institutions eg.: antenatal groups, parent-baby clubs, life coaching programmes, family planning programmes;
- The health visitor is trained in the most basic group management techniques, feels safe in the group, is able to shape and frame the conversation;
- The health visitor encourages and supports the development of relationships between group members, emphasises the importance of relationships and their protective role against trauma;
- Professionals working in one geographical area create a supportive professional community, thus protecting themselves from the effects of burnout and secondary trauma.

FOCUS: FAMILY, COMMUNITY

- Participating caregivers and families feel safe in the group, share their questions, shape the community;
- Each occasion and all relationships that develop have an impact on the smaller community, they also connect and support each other in other areas of life;
- The health visitor and other professionals are also members of the community-based group.

PARTNERSHIP

The primary goal of the principle is to develop forms of support that are available within the organisation of health visitors and provide training, further training and mental health support for health visitors.

The efficiency and success of the work of professionals can usually be significantly improved by the cooperation of those working in other fields. The cooperation depends to a large extent on the personality, communication and knowledge of the professionals in this field, the organisational culture of the cooperating institutions.

In terms of trauma awareness, working with caregivers and parents is also essential since "you don't have to be a therapist to achieve a therapeutic effect." It helps professionals and caregivers work together to recognize each other's unique knowledge. The health visitor has a special expertise and, in addition, the skills and competencies with which they can represent this expertise in a credible, determined and conscious way. The parent has a unique knowledge of their own child, and they still own this specific knowledge even if they do not take the best care of their child. Mutual sharing and mutual recognition of these two types of knowledge is the key to cooperation between a health visitor and a caregiver.

FOCUS: HEALTH VISITOR

- The health visitor organisation promotes mutual recognition, respect and partner communication between health visitors;
- Encouraging and strengthening each other's professional and personal support, which is characteristic of the organisational culture;
- The organisation provides formal and informal spaces and channels to support each other (supervision, intervision, case discussion, team discussion, time for rest, celebration, team building, mentoring, professional support, teaching and supporting young health visitors);
- The health visitor receives support during training so that his/her communication with caregivers is authentic, determined, and they are able to deal with difficult communication situations effectively. In particular, it is important to provide concrete knowledge on how to deliver trauma-informed messages, what a trauma-informed message looks like;
- The health visitor can discuss current difficulties and questions with childcare professionals, and the childcare professionals support them emotionally and professionally regarding difficult cases;
- Experienced health visitors support their young childcare professionals, as mentors they help them learn, process and understand their experiences.

FOCUS: FAMILY

- Caregivers experience cooperation, recognition, and support during the encounter with health visitors;
- Caregivers give and receive feedback on cooperation and partnership.

PRESENCE

The purpose of the principle is to ensure that health-visitor care at the organisational level supports its staff in maintaining motivation, preventing burnout and working with traumatised families.

A trauma-sensitive organisation recognizes that its employees' resources are heavily used while working with trauma, and therefore strengthens and supports them. Providing opportunities for supervision or intervision is essential for this.

It is equally important that the health visitor receives support in problematic cases and decision-making situations. In the event of a police or court hearing, have a representative who will lead and support the health visitor in the process.

FOCUS: HEALTH VISITOR

- The professional organisation provides its employees with the opportunity for supervision, case discussion and intervision;
- The professional organisation creates cooperation agreements with other organisations from the reporting system, provides its professionals with the opportunity to work together with representatives of other professions;
- The professional organisation organises and implements communication campaigns together with other members of the reporting system, standing for the same message about the work of a health visitor, trauma, abuse, neglect and possible support and assistance opportunities;
- The organisation and the leaders recognize the knowledge and efficient work of the professionals, and give feedback on it;
- The leader supports the consideration and implementation of new initiatives from professionals;
- The manager takes into account the opinions and suggestions of the experts in each case and resolution;
- The health visitor receives support in all police, court and guardianship proceedings;
- The health visitor receives support in a decision-making situation. In the course of their preventive work, they consult the lead health visitor, child protection expert, relevant reporting system member or person in a coordinator or management position who has insight into the situation and can support their decisions, before making further steps. This helps ensure a multi-faceted, more complex approach, which can be truly achieved through collaboration between the different fields of the child welfare services and further support professions;
- The lead health visitor supports and encourages the organisation of a regular interdisciplinary round table and supports the participation of childcare professionals;
- The health visitor knows what type of support he/she can call for and mobilise to help the family in each problematic case.

FOCUS: FAMILY

- Caregivers feel that the health visitor acknowledges their efforts, they think through the suggestions and possibilities together;
- Caregivers are encouraged when they suggest resolving a more difficult situation by themselves;
- Caregivers experience that the health visitor respects and recognizes them even in difficult situations.

INCLUSION

The purpose of the principle is to promote awareness amongst health visitors of, and so respect for, the diversity, parenting styles and family characteristics of the families they work with.

Based on the suggestions and insights of the team of experts, there is a lack of training in this area. During college training a greater emphasis should be put on enriching the knowledge of students about multicultural-education, different parenting styles, up-to-date knowledge and research outcomes.

FOCUS: HEALTH VISITOR

- The health visitor has up-to-date, well-grounded and research-based knowledge of the cultural, ethnic and socio-cultural characteristics, lifestyle habits and traditions of the families and clients living in her care area
- The health visitor provides equal care, attention and support to all her clients, regardless of their gender, ethnicity, religion or background
- The health visitor takes into account the characteristics of her clients and provides them with the most appropriate and acceptable support they need

FOCUS: FAMILY

- Families are treated equally and inclusively during visits to the health visitor;
- The family finds that the health visitor takes into account the family's habits, competencies, strengths and supports them in a personalised manner based on this.

The aforementioned viewpoints and questions should be considered in general, but also in the following areas of activity.

Themes:

- Women's protection
  - Youth health visitors: they can help young people with contraception and cancer screening
  - Help and support in family planning even before pregnancy
- Parental care and counselling
  - Who came from where, from what situation? Bearing in mind differences;
  - The child appears in the family space even in the preconception period, during the period of pregnancy it is important to think about the emotional, mental and transgenerational effects of the child's arrival, to support the young couple in this;
  - Visit during the postpartum period – with a special sensitivity, person-centred approach

Focus on:

- Feeding, breastfeeding, hygiene;
- Childbirth experience - special attention to the traumas around childbirth that affect the mother; in most families 1-2 years after giving birth a mother with PTSD is at the centre of the family and is expected to take care of the family.
- Close monitoring until the age of one and a half:
  - Status check, age-related - visit combined with status - prioritising the home environment.
- Status check performed by a counsellor:
  - The location - creating a child-friendly room;
  - How do we take care of a child? What is crucial in this case, what is not (eg. weighing if the child is opposing);
  - How to communicate with the caregivers?
  - Information about vaccinations, orientation, supporting the administration of vaccines.

Collaborations with other professions:

- Paediatrician
  - transparency, appropriate place, time and space for joint discussions and, if necessary, joint visits.
- Child protection system
  - Reporting;
  - Case conferences;
  - Joint visit with a child welfare specialist.
- Nursery
  - Two-way flow of information, not just if there is a problem.
- Hospital
  - Connect health visitor with the hospital during childbirth - obstetrician and midwife can discuss experiences of pregnancy and childbirth.

C. TRAUMA AWARENESS IN PAEDIATRICS

Family paediatricians play an important and unique role in the lives of families with children. Not only do they have the opportunity to accompany the family and the child through childhood years, but they also represent a fundamentally important and reliable source of information and advice.

Somatic symptoms can be related to adverse experiences and trauma (see Chapter 2.), which makes paediatricians fundamental agents in trauma awareness and trauma sensitive care. For the screening and recognition of trauma symptoms in children 0-3 a thorough guide was developed in the Screening and Referral Tool, in the context of the ECLIPS project.

1. Principles of trauma sensitive care

Going through the six trauma-conscious core values (see Chapter 3), the following observations were made by practising paediatricians[15].

SAFETY

The primary goal of this principle is to create a sense of safety in paediatric care: at an organisational level for paediatricians and at the implementation level for families.

15 A group of paediatricians in Hungary was involved in the elaboration of this part of the protocol: apart from conversations in the living lab, two focus group sessions were organized.

Safety in paediatric care can be ensured in the following areas:

- **Long-term commitment** between families and paediatricians helps promote safety.
- If there is respect and trust in the **relationship between the doctor and the child**, it can also increase the sense of security in the child, the parent and the professionals.
- Awareness of the obstacles like **work overload and lack of time**, which can significantly limit the experience of a safe environment for professionals, parents and children.
- The importance of training and raising awareness: **being informed about trauma**, what does it mean, how is it recognizable in everyday practice. Being informed about the importance of ACEs in a medical perspective. Paying due attention to traumatisation and its somatic effects in everyday practice. Being aware of the responsibility as a paediatrician.
- **Legal background and protocols** to make paediatric care safe and predictable are normally available. Practical knowledge of these protocols and an easily accessible knowledge base can increase the trauma awareness of paediatric care.
- **Communication with parents** is essential in building a safe environment (see next).

PREDICTABILITY

The primary purpose of this principle is to ensure that the paediatric care operates dependably and clearly.

Based on the experience, the reliability and transparency of paediatric care is greatly influenced by:

Communication with parents:

- If parents know what is happening, if they feel they are personally respected and their opinions are respected, if doctors are understandable when they communicate with them, do not qualify or discriminate, this will increase the sense of security experienced when accessing the child's GP care.
- Giving positive feedback, supportive attitude and active listening all help to build trust, just as using mentalization and trying to visualise the situation from the point of view of the child and the parent.
- When there is already a relationship of trust established between paediatrician and family, asking the parents questions could help them to share personal informations. At this point the paediatricians can offer advice and guidance. Basic rule: there are no dumb questions.
- It is essential to verify whether the information provided is really understood by the parents.
- Offering psychoeducation: explain to parents what role they have in pain alleviation, how they can help and avoid possible traumatic effects. Explain their role in the relationship the child will have with physicians in general. As an example sentences like "don't worry, the doctor won't hurt you" or "don't worry, the torture will be over soon" can lead to constant distress when the child needs to receive medical care.
- Discussing normal development with parents and what can be viable expectations towards their children (eg. children might behave in an opposing manner after the age of 18 months, or parents can expect their children to calm down if they can remain calm).
- Communicating suspected abuse/neglect with parents in a way that does not break trust (for further informations on that see the Screening and Referral Tool, and Handholds for discussing worries with primary caregivers on page 79 in this protocol).

- **Competent professionals.** Knowledge of normality and knowledge of the effects of different life experiences.
- During the mandatory screenings paediatricians should have experience and **knowledge of when to refer cases**, using **appropriate communication** with parents in these cases (see above).
- **Capacity to respond** to help-seeking questions, problems raised by parents. For this an easily accessible, reliable knowledge base is necessary.
- **Cooperation with other professions** (child welfare system, childcare institutions, health visitors) and respect for each other's work. The flow of information is indispensable for the paediatricians to understand possible signs of trauma in context.
- **Obligation to keep notes on the development of children.** These notes should be available and traceable even if the family changes location, and should follow the child up to age 18. The availability of designed worksheets especially for taking notes on possible child abuse cases would be an asset.

SUPPORT

The primary purpose of this principle is to encourage paediatricians to facilitate communication between clients and the development of different support groups, circles, and smaller communities.

Paediatricians' advice and suggestions have influence on caregivers. By **recommending available parent groups and online communities**, doctors help their clients find supportive communities.

To make it happen paediatricians need reliable sources of information about existing opportunities, working groups and useful resources on trauma and trauma-sensitive care.

PARTNERSHIP

The primary goal of the principle is to develop forms of support that are available to paediatricians and provide training and mental health support them.

As it was already mentioned before, **cooperation between professionals who have information about the family and the child is essential**. Paediatricians should be involved in case discussions about the family and/or the child, be informed about divorce, child replacement or mental disorders of the parents.

Associations and support groups for paediatricians can promote information flow, mutual encouragement and motivation. The urge to provide trauma-sensitive care can be regarded as an extra burden for professionals, but acknowledgement and appreciation within the profession and from fellow practitioners can facilitate the process.

PRESENCE

The purpose of the principle is to ensure that paediatric care at the organisational level supports its staff in maintaining motivation, preventing burnout, and working with traumatised families.

Paediatricians rarely have access to supervision, and/or the importance of it might not be part of the organisational culture. **It is crucial to make the availability and importance of professional support groups, supervision and relevant training clear and apparent.**

Apart from supervision, professional associations and informal physician groups help them to deal with difficult cases, learn about good practices, and strengthen motivation[16].

INCLUSION

The purpose of the principle is to promote paediatricians' awareness of, and thus respect for, the diversity, educational styles and characteristics of the families they work with.

Providing adequate information for parents, knowledge and respect for parental and child rights, **clear and understandable communication without qualification and discrimination** are prerequisites for a work that respects differences and individual characteristics.

16 The availability of online support groups of paediatricians became especially important during the COVID-19 pandemic

2. The quality of trauma-sensitive care in paediatrics

Paediatricians only meet the child and the family during short and periodic visits - how is it possible to be trauma sensitive in this short a period of time? How can periodic examinations be conducted in a trauma-sensitive manner? The below mentioned points and advices might help to guide paediatricians answering these questions.

IMPORTANT FACTORS

- **The environment**: the waiting room and the doctor's office
  - physical characteristics of the setting (welcoming, colours, toys, places to sit, room for breastfeeding and changing nappies, etc.)
- **General attitude** of the nurse and the doctor (openness, interest vs. administration-focused)
- Trauma-aware administration of **vaccinations**
- Communication about **childbirth**. Postpartum depression screening, supporting mothers to process childbirth, offering psychoeducation on the importance of the topic.
- Paediatricians can greatly influence the child's attitude towards medical care which will last a lifetime.

ADVICE for paediatricians

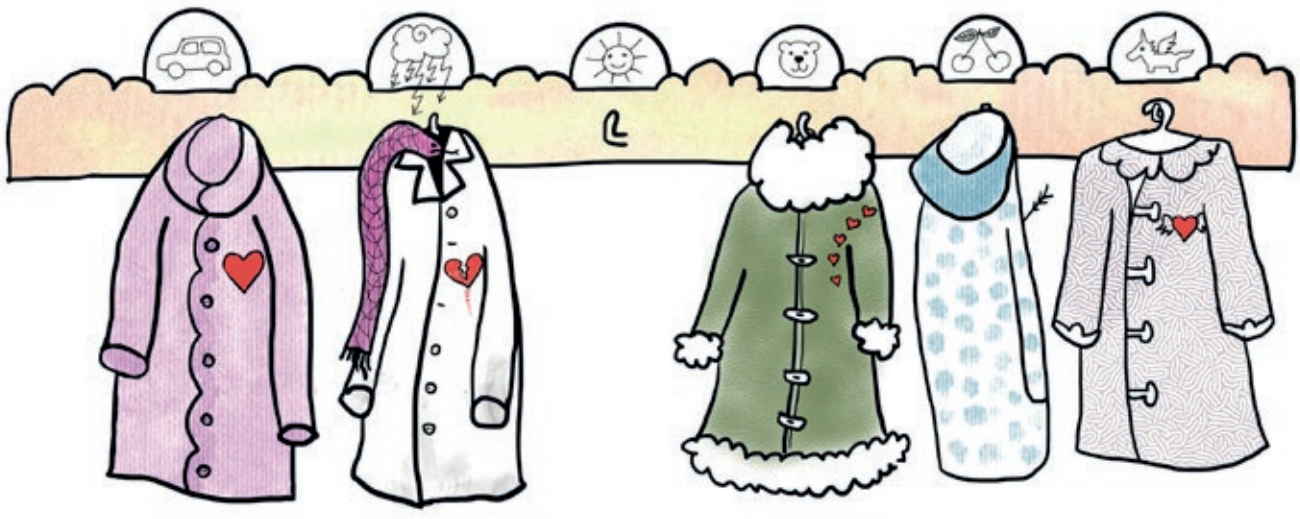
- Establish contact and have an active, working connection with other professionals in contact with the child and the family (childcare professionals, psychologists, health visitors, child welfare system). Participate in case discussions, stay informed.
- Track personal notes on suspects and observed phenomena, which are not necessary for medical information. This information should not be available online to protect the subject.

ADVICE at policy level

- Physicians should have access to and be able to edit relevant and useful medical record template for children 0-18, its use should be uniform and obligatory (with content like hospitalisations, treatments diagnosed and provided, main medical risks).
- The system to edit these records should be suitable for tracking changes in the physical condition of children. Relevant information for physicians should be available to see processes and understand physical conditions in the context of life events.
- Creating a separate section for relevant life history is also recommended (e.g. divorce, death in the family, poverty, etc.), and making it available only to concerned professionals (e.g. not available to laboratory physicians).
- Reduce administrative workload of paediatricians.
- Establish reliable sources of information about existing opportunities, working groups and useful resources on trauma and trauma-sensitive care.
- Training and sensitisation on a yearly basis.

CHAPTER 5.

Supplementary materials



Glossary

In the glossary, we create an alphabetical list of common terminology with their explanations.

1,000 days: The first 1,000 days refer to the first period of a child's life, starting from conception until they have reached 2 years of age. During this period, the brain, body and stress systems develop significantly, making it the most critical period in development.

Abuse: Anyone who causes physical or mental injury or pain to a child. Those who do not prevent or report the harm caused to the child even though they know about it or have witnessed it may be at least partly guilty of abuse.

Types include physical, emotional, sexual abuse, Münchausen by proxy (when an adult caregiver invents or intentionally induces symptoms). Parental alienation and if the child is endangering him-/herself are also considered as forms of abuse.

Adverse Childhood Experiences (ACEs): ACEs include three categories: abuse, household challenges and neglect. Experiencing these events during childhood are linked to worse outcomes later in the child's lifetime.

Attachment: "a special bond characterized by the unique qualities of the special bond that forms in maternal-infant or primary caregiver-infant relationships. The attachment bond has several key elements: (1) an attachment bond is an enduring emotional relationship with a specific person; (2) the relationship brings safety, comfort, soothing and pleasure; (3) loss or threat of loss of the person evokes intense distress." (Perry, 2001, p. 2.)

Domestic violence: A subset of violence, mostly physical violence, which is directed at specific victim(s) within the household.

Mentalization: Mentalization is the ability to understand your own behaviour and that of others based on mental states. Mental states can be feelings, thoughts, needs, goals and reasons. We all mentalize when we interact with each other but we are rarely aware of it. Development of this ability is based on the early attachment relationship (Fonagy & Target, 2005).

Neglect: Neglect occurs when the infant or child does not receive the care he/she needs in order to develop. This significantly harms and decelerates the child's health and impedes somatic, mental and emotional development. When we are assessing trauma, we ask questions like:
"What happened to this child? What didn't happen to this child? What didn't he/she receive? What did he/she miss?" Neglect is part of the answer to the last questions.

Neocortex: it is the smart part of our brain, a highly organised structure present in all humans that processes sensory, motor, language, emotional and associative information.

Regulate-relate-reason: When triggered, one needs to follow a simple 3-step process in order to achieve a resolution. Step 1 is regulating ourselves: become aware of our own stress window and try to sink back. Then regulate the child/parent. Step 2 involves restoring the bond. Only when the child/parent becomes calmer is the relationship possible again. Step 3 is when reasoning is possible again: afterwards, if the child/the parent is again functioning completely in his/her stress window, you can talk about what happened.

Subcortical: relating to, involving, or being a part of the brain below the cerebral cortex.

Trigger: Something that can remind a person of a trauma. A trigger can include sensory information (an image (e.g. how someone laughs), a smell, a sound, a touch) or verbal information (what you say, but certainly also the way someone says something that reminds you of the (traumatic) event).

Vicarious trauma: "the traumatic impact on those who feel the intensity of the traumatic event through another person. Children of Vietnam veterans, for example, have been reported to exhibit emotional, behavioural and physiological symptoms similar to their parents with post-traumatic stress disorder (PTSD). (…) The power and intensity of the actual event can be powerful enough to impact others even though they were not themselves witness to or threatened by the actual experience." (Perry, 2014, p. 10.)

Window of Tolerance: Everyone has a 'window of tolerance' within which we function. We can process and react to information from the outside world consciously only and exclusively if we can tolerate them. If we function 'inside' our window of tolerance, we are in the zone of optimal arousal. Here our parts of the brain (the cortex and the lower parts of the brain) work optimally with each other.

A model for organizational trauma-informed care

Trauma Aware	• Recognizes the need for TIC and trauma champions • Articulates a need for a TIC approach • Uses a data-driven approach to validate the need for TIC
Trauma Sensitive	• Understands the impact of trauma on children, families and providers • Demonstrates agency readiness to become trauma informed • Creates process and structures to deliver TIC
Trauma Responsive	• Collects information about TIC opportunities • Reviews policies and practices with a trauma informed lens • Prioritizes and creates plans to address TIC needs and opportunities
Trauma Informed	• Implements and monitors TIC efforts • Adopts trauma informed policy and practice and institutionalize these changes • Monitors the impact of TIC culture changes on client outcomes

Figure 8. Based on *Bremd and Sprang (2020)*

Trauma definitions

"Individual trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that **has lasting adverse effects** on the individual's functioning and mental, physical, social, emotional, or spiritual well-being." (SAMHSA, 2014)

Peter Levine defines trauma as any experience that is **"too much, too soon or too fast"** (Ives, 2020). Levine emphasises that any event with which the body and the individual cannot cope at that moment, and where the stress response dominates the behaviour has a traumatic effect. However, the reaction to unrealistically strong, overwhelming stimuli is natural and necessary.

Dr. Gábor Máté, physician and trauma researcher, underlines the effects of trauma, the inner change, and the work that the individual has to do as a result of the trauma. "Trauma is a psychic wound that psychologically hardens and then blocks growth and development. (…) Trauma is not what happens **to us**, trauma is what happens **in us** as a result of what happens to us. Trauma is the scar that makes us less resilient, more rigid, less feeling, more defensive." (Caparotta, 2020)

References

Abraham, J. (2016). Creating a Culture of Trauma Informed Care within Your Agency Alliance Health Center. Retrieved from https://2016traumainformedcareconference.weebly.com/uploads/1/4/0/6/14060029/creating_a_culture_of_trauma_-_james_abraham.pdf

Allen, J. G., & Fonagy, P. (2006). Handbook of mentalization-based treatment. Wiley.

Allen, J. G., Fonagy, P., Bateman, A., & Bulath Máté. (2011). Mentalizáció a klinikai gyakorlatban. Oriold.

Ayre, K., & Krishnamoorthy, G. (2020). Trauma informed behaviour support: a practical guide to developing resilient learners. University of Southern Queensland.

Baffour, F. (2016). Love your Authentic Self. (n.p.).

Bellis, M. A., Hughes, K., Ford, K., Rodriguez, G. R., Sethi, D., & Passmore, J. (2019). Life course health consequences and associated annual costs of adverse childhood experiences across Europe and North America: a systematic review and meta-analysis. The Lancet Public Health, 4(10), e517-e528. https://doi.org/10.1016/S2468-2667(19)30145-8

Boullier, M., & Blair, M. (2018). Adverse childhood experiences. Paediatrics and Child Health, 28(3), 132-137. https://doi.org/10.1016/j.paed.2017.12.008

Brend, D. M., & Sprang, G. (2020). Trauma-Informed Care in Child Welfare: An Imperative for Residential Childcare Workers. International Journal of Child and Adolescent Resilience, 7(1), 154–165. https://doi.org/10.7202/1072595ar

Caparotta, M. (2020). Dr. Gabor Maté on Childhood Trauma, the Real Cause of Anxiety and Our 'Insane' Culture. Retrieved from https://humanwindow.com/dr-gabor-mate-interview-childhood-trauma-anxiety-culture/

Crowell, J. A., Treboux, D., Gao, Y., Fyffe, C., Pan, H., & Waters, E. (2002). Assessing secure base behavior in adulthood: Development of a measure, links to adult attachment representations and relations to couples' communication and reports of relationships. Developmental Psychology, 38(5), 679–693. https://doi.org/10.1037/0012-1649.38.5.679

Cutuli, J. J., Alderfer, M. A., & Marsac, M. L. (2019). Introduction to the special issue: Trauma-informed care for children and families. Psychological Services, 16(1), 1-6. http://dx.doi.org/10.1037/ser0000330

Fallot, R. D. (2015) Creating Cultures of Trauma-Informed Care (CCTIC): A Fidelity Scale.

Felitti, V. J., Anda, R. F., Nordenberg, D., Williamson, D. F., Spitz, A. M., Edwards, V., Koss, M. P., & Marks, J. S. (2019). Relationship of Childhood Abuse and Household Dysfunction to Many of the Leading Causes of Death in Adults: The Adverse Childhood Experiences (ACE) Study. American Journal of Preventive Medicine, 56(6), 774–786. https://doi.org/10.1016/j.amepre.2019.04.001

Fonagy, P., Target, M., Milák P., & Al, E. (2005). Pszichoanalitikus elméletek a fejlődési pszichopatológia tükrében. Budapest Gondolat.

Fonagy, P., Gergely, G., Jurist, E. L., & Target, M. (2018). Affect regulation, mentalization, and the development of the self. Routledge.

Ford, J. and Wilson, C. (2012). SAMHSA's Trauma and Trauma-Informed Care Experts Meeting.

Fredrickson, R. (2019). Trauma-informed care for infant and early childhood abuse. Journal of Aggression, Maltreatment & Trauma, 28(4), 389-406.

Hambrick, E. P., Brawner, T. W., Perry, B. D., Brandt, K., Hofmeister, C., & Collins, J. O. (2019). Beyond the ACE score: Examining relationships between timing of developmental adversity, relational health and developmental outcomes in children. Archives of Psychiatric Nursing, 33(3), 238-247.

Harris, M., & Fallot, R. (2001). Creating cultures of trauma-informed care (CCTIC): A self-assessment and planning protocol.

Ives, E. (2020): Peter Levine and Somatic Experiencing. Psychiatry Mental Illness, 3(1): p. 101

JBS International, Inc., & Georgetown University National Technical Assistance Center for Children's Mental Health. (2016). Creating trauma-informed provider organizations. Retrieved from http://gucchdtacenter.georgetown.edu/data/issues/2015/0215_article.html

Kenton, W., & Scott, G. (2021). Strength, Weakness, Opportunity, and Threat (SWOT) Analysis. https://www. investopedia. com/terms/s/swot. asp.

Juffer, F. (2010). Beslissingen over kinderen in problematische opvoedingssituaties: Inzichten uit gehechtheidsonderzoek. Research Memoranda, 6, 1-51.

Lund, J. I., Toombs, E., Radford, A., Boles, K., & Mushquash, C. (2020). Adverse childhood experiences and executive function difficulties in children: A systematic review. Child Abuse & Neglect, 106, 104485. https://doi.org/10.1016/j.chiabu.2020.104485

McCrory, E., De Brito, S. A., & Viding, E. (2011). The Impact of Childhood Maltreatment: A Review of Neurobiological and Genetic Factors. Frontiers in Psychiatry, 2. https://doi.org/10.3389/fpsyt.2011.00048

Perry, B. D (2001). Bonding and attachment in maltreated children. Consequences of emotional neglect in childhood. Adapted in part from Maltreated Children: Experience, Brain Development and the Next Generation. W.W. Norton & Company, New York.

Perry, B. D. (2004). How the brain develops: The importance of early childhood. Video Series 1, Understanding traumatized and maltreated children: The core concepts.Child Trauma Academy – DVD Series 1, Educator's Package.

Perry, B.D. & Dobson, C. (2010). The role of healthy relational interactions in buffering the impact of childhood trauma. In (Gil, E., Ed) Working with Children to Heal Interpersonal Trauma: The Power of Play. Guilford Press, New York.

Petruccelli, K., Davis, J., & Berman, T. (2019). Adverse childhood experiences and associated health outcomes: A systematic review and meta-analysis. Child Abuse & Neglect, 97, 104127. https://doi.org/10.1016/j.chiabu.2019.104127

Roberts, S. J., Chandler, G. E., & Kalmakis, K. (2019). A model for trauma-informed primary care. Journal of the American Association of Nurse Practitioners, 31(2), 139-144. https://doi.org/10.1097/JXX.0000000000000116

SAMHSA (2014). SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach SAMHSA's Trauma and Justice Strategic Initiative. Retrieved from: http://store.samhsa.gov/product/SAMHSA-s-Concept-of-Trauma-and-Guidance-for-a-Trauma-Informed-Approach/SMA14-4884

Selye, H. (1976). The stress of life. New York Mcgraw-Hill.

Siegel, D. J. (2020). The developing mind: How relationships and the brain interact to shape who we are. Guilford.

Ungar, M. & Perry, B.D. (2012) Violence, trauma and resilience. in (R. Alaggia & C. Vine, Eds) Cruel but Not Unusual: Violence in Canadian Families pp. 119-143 WLU Press, Waterloo, CA 2012

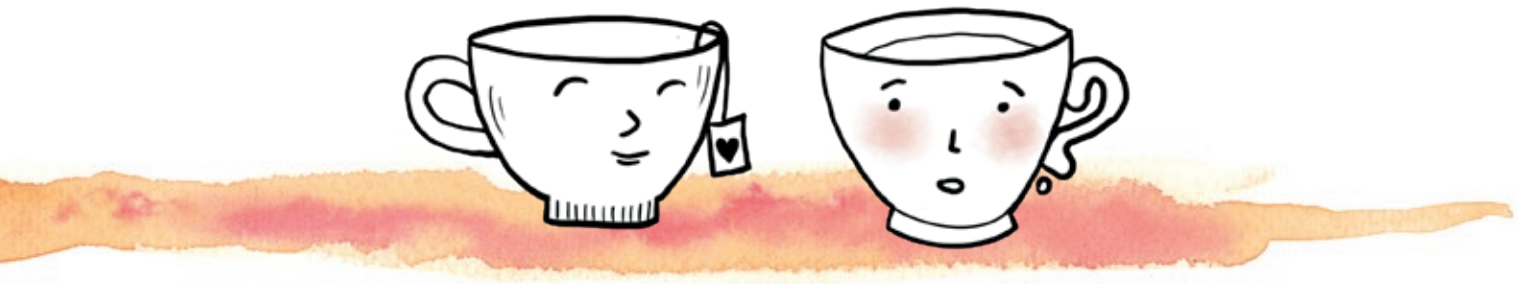
UN General Assembly, Convention on the Rights of the Child, 20 November 1989, United Nations, Treaty Series, vol. 1577, retireved from: https://www.refworld.org/docid/3ae6b38f0.html

Van der Kolk, B. (2014). The body keeps the score: Mind, brain and body in the transformation of trauma. Penguin Books.

Walkley, M., & Cox, T. L. (2013). Building trauma-informed schools and communities. Children & Schools, 35(2), 123-126. https://doi.org/10.1093/cs/cdt007

Winfrey, O., & Perry, B. D. (2021). What Happened to You?: Conversations on Trauma, Resilience, and Healing. Flatiron Books.

Winnicott, D. W. (1963). The child, the family, and the outside world. PenguinBooks.



“As human infants, we do not possess strong muscles like a little foal, we cannot stand on our legs a few hours after having been born. We rely completely upon the benevolence of the people surrounding us.”