

# Calmer classrooms

A guide to working with  
traumatised children



## **Acknowledgements**

This resource was commissioned by the Child Safety Commissioner. It was written by Laurel Downey, Manager, Practice Development and Training, Take Two, Berry Street Victoria. Laurel would like to acknowledge her Take Two colleagues, Annette Jackson and Lisa McClung for their contribution to her work.

The development of the resource was managed by Maree Tehan, Office of the Child Safety Commissioner.

Many people contributed to the resource by providing suggestions and feedback. They include teachers from State and Catholic primary and secondary schools, staff from the Department of Education, the Office for Children, Department of Human Services, and community service organisations.

Published by the Child Safety Commissioner, Melbourne, Victoria, Australia  
June 2007

© Copyright State of Victoria, Child Safety Commissioner, 2007

This publication is copyright. It may be reproduced in whole or in part for study or training purposes, subject to the inclusion of an acknowledgement of the source and no commercial usage or sale.

Also available at [www.ocsc.vic.gov.au](http://www.ocsc.vic.gov.au) or phone the Office of the Child Safety Commissioner on 03 8601 5884

Printed by Penfold Buscombe. Edited by Margaret Jacobs

### **Author**

Laurel Downey, Manager, Practice Development and Training, Take Two, Berry Street Victoria.

Take Two is a statewide developmental mental health service providing a therapeutic response to infants, children and young people who are clients of Child Protection. Take Two provides a service to over 550 traumatised children every year, who are referred by Child Protection workers.

Front cover illustration by Daniel, Year 1/2

# Foreword



This booklet assists kindergarten, primary and secondary teachers, and other school personnel in understanding and working with children and young people whose lives have been affected by trauma. The majority of such children will have come from backgrounds of abuse and neglect, although some of them will have suffered as refugees, or experienced war or dislocation overseas. An even smaller number will have experienced illness, painful medical interventions or one-off traumas such as disasters or accidents.

*Calmer Classrooms* particularly addresses the needs of children who have been traumatised by abuse and neglect. These children may be involved in the child protection and family support systems. Some may not be able to remain in the care of their families and are living in foster care or other forms of state care.

I urge teachers and all those involved in children's education to take some time to consider the detail of this publication.

Abuse and neglect can have a severe, long lasting impact on children's overall development, which often has the effect of reducing their capacity to concentrate and to learn. By understanding and building relationships with traumatised children, teachers can make an enormous contribution to their lives. Children who develop an attachment to their school and a love of learning will have greater resilience in the face of adversity than those who do not.

Throughout this booklet, infants, children and young people will be referred to as 'children' in keeping with my strong view that, up until the age of 18, all young people are in need of nurturing and loving care.

A handwritten signature in black ink that reads "Bernie Geary". The signature is written in a cursive style with a horizontal line underneath the name.

Bernie Geary OAM  
Child Safety Commissioner

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

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

# Contents

<b>Foreword</b> .....	<b>i</b>
<b>Introduction: The role of teacher, school and support systems</b> .....	<b>iv</b>
<b>Section One: Experiencing abuse and neglect often leads to trauma and disturbed attachment</b> .....	<b>1</b>
Attachment and early security: building resilience .....	2
Attachment, trauma and the impact on development .....	3
<b>Section Two: The impact of abuse and neglect on learning</b> .....	<b>9</b>
Case studies .....	10
Impacts on academic performance and social functioning .....	11
Academic performance .....	12
Social functioning .....	13
Affect dysregulation: seen as hyperarousal or dissociation .....	15
Shame: can increase affect dysregulation .....	15
<b>Section Three: Calmer classrooms – relationship-based practices</b> .....	<b>17</b>
Creating connection and defusing conflict .....	18
Planning for challenging incidents .....	22
Teaching Indigenous children .....	25
Self-care for teachers .....	26
Participating in systems: the care team approach .....	27
Conclusion .....	28
<b>A snapshot</b> .....	<b>29</b>
<b>Appendix A: Child Protection and out-of-home care</b> .....	<b>31</b>
<b>Appendix B: Partnering Agreement</b> .....	<b>33</b>
<b>Useful resources</b> .....	<b>34</b>
<b>Glossary</b> .....	<b>35</b>
<b>References</b> .....	<b>36</b>

# Introduction

## The role of teacher, school and support systems

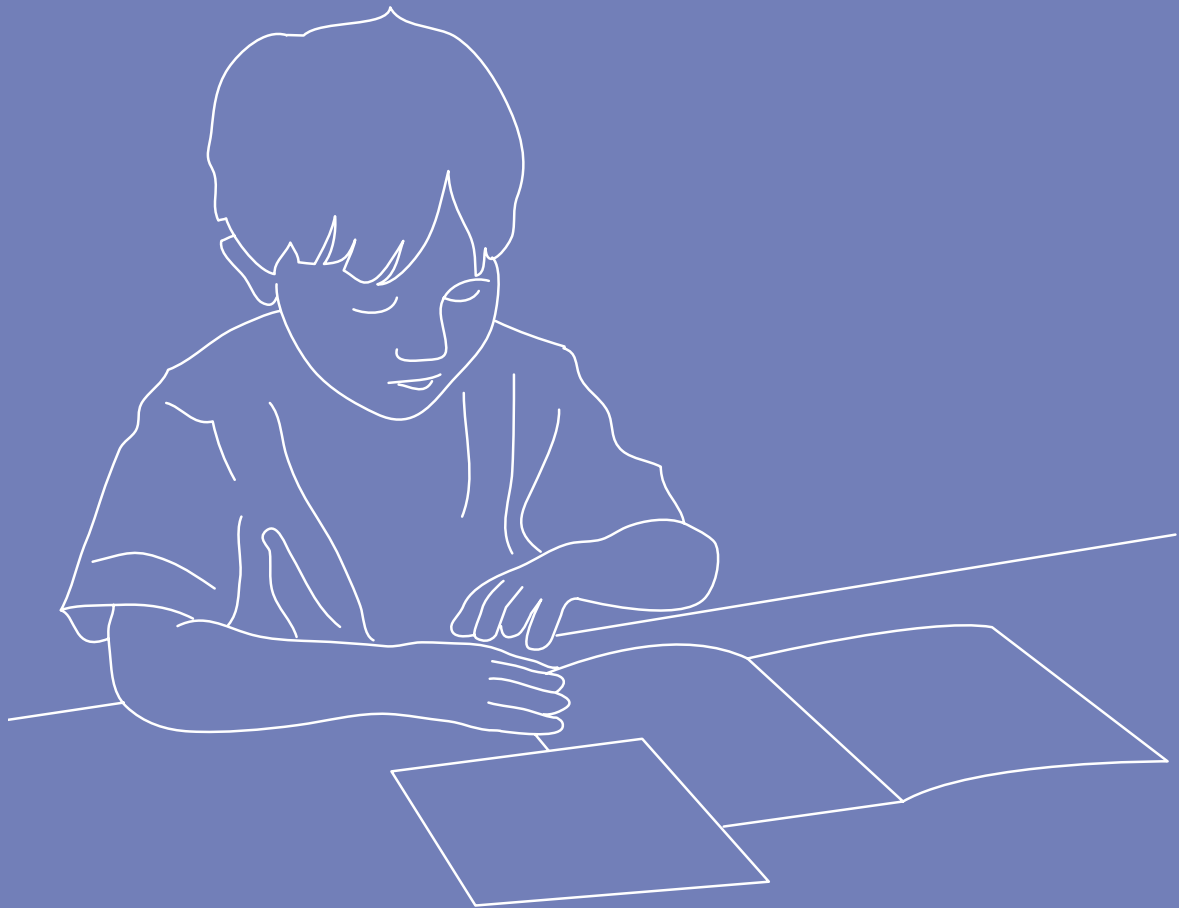
Both research and wisdom show us that regardless of the adversity they face, if a child can develop and maintain a positive attachment to school, and gain an enthusiasm for learning, they will do so much better in their lives. The role of teachers in the lives of traumatised children cannot be underestimated.

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

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

# Section One

## Experiencing abuse and neglect leads to trauma and disturbed attachment



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

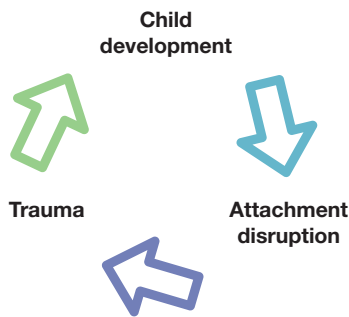


Figure 1 Trauma triangle

### An integration of theories

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

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

## Attachment and early security: building resilience

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

### Early security

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

### Attachment theory

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

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

An example of this is the experience of a young child who, upon seeing the front door open wanders into the front yard, to be confronted by a large dog which rushes at them, growling and barking. A parent or caregiver hears the noise, and if competent, rushes out, shoos away the dog, picks up the child, holding tight, speaking in a calm and soothing voice, until the child is calm again. The alternative picture is the caregiver who runs out, grabs the child by the arm, smacks her bottom and drags

her inside, shouting 'what were you doing out there, I told you not to go out the front door'. Both parents have been frightened, but one acts to comfort the child while the other acts on their own raw emotions. If we don't get attuned and loving early care ourselves, we tend to act on our emotions, not being able to think or put the other's needs first.

### Early security builds resilience

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

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

## Attachment, trauma and the impact on development

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

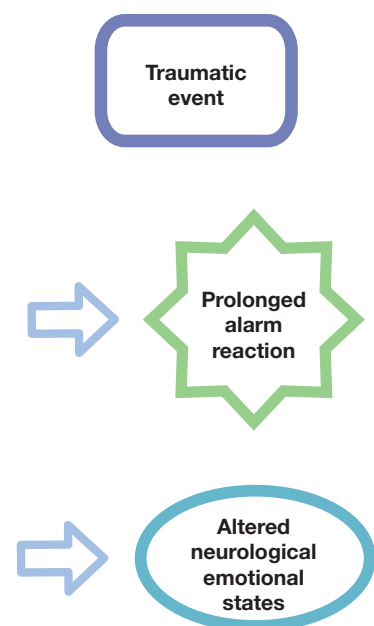
This sub-section goes on to describe other impacts of trauma: disruption to thinking, the effects of neglect, problems in traumatised communities, and self-harm and addiction; it concludes by outlining the context in which recovery can occur and the importance of understanding the child's complex layers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

### Trauma theory

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

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

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



**Figure 2** Trauma alters neurological states

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

and organised brain, which can create difficulties; however in infants and children it has a detrimental impact on the developing brain (van der Kolk & McFarlane, 1996).

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

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

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

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

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

### **Impact on the brain and body**

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

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

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

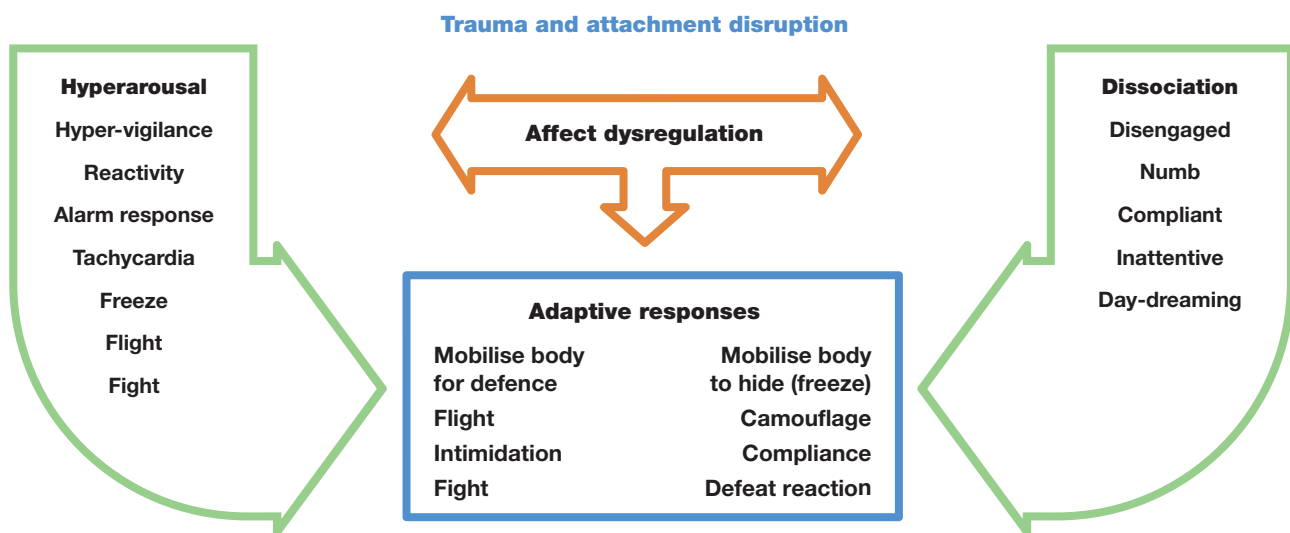
### Affect dysregulation

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

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

Dissociation can also be described thus:

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



**Figure 3** Trauma, attachment disruption and affect dysregulation

### Neglect

The issue of neglect illustrates the need for integration of trauma and attachment theories. Each time a young child is left cold, hungry, dirty or unattended this experience triggers a fear response, which turns to

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

terror if it goes on for long. This fear or terror will have the same effect on the brain and body of the child as abuse. The terror is also compounded by the lack of stimulation usually seen in neglect, which slows brain growth and social development. It is further compounded by the lack of an attuned attachment relationship, where the child is not getting the opportunity to understand themselves and others within a loving relationship. Neglected children are therefore compromised in many ways.

### **Trauma affects thinking**

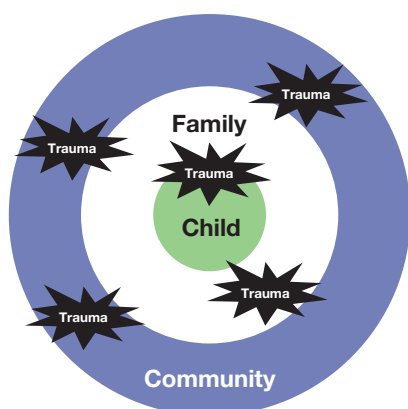
One of the most difficult issues for teachers and others who interact with traumatised children is the problems they have in thinking. They often seem to have very disorganised minds: they forget things, leave their clothes where they fall, leave their toys and other mess for others to clean up after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

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

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

### **Traumatised communities**

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



**Figure 4 Trauma can affect all levels of the community**

### **Self-harm and addiction**

Self-harm can be difficult to understand, but is very common in traumatised or stressed children. The reasons for it can be different for different children. Some self-harm because they become 'addicted' to the endorphin release that accompanies traumatic stress, and will

cause trauma to themselves to obtain that endorphin release. Others have developed a profound self-hatred and act that hatred out on their bodies. Some suffer from deep depression and their self-harm is closely associated with a wish to end their pain, which can become suicidality when severe. Still others self-harm to overcome the numb and alienated feelings that come from dissociation, where the self-inflicted pain is an attempt to feel something rather than feel nothing. Another group who have been abused may internalise the aggression of the abuser and then become the victims of their own aggression (Cairns, 2004).

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

### **Intervention and recovery**

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

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

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

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

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

### **Complex layers of experience**

Children who have been abused and neglected will often have complex layers of experiences of adversity. Their infancy may have been insecure

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

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

# Section Two

## The impact of abuse and neglect on learning



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

# Case studies

The following case studies are compiled from stories about the lives of children in the child protection system.<sup>1</sup>

## Case study one: Jasmine

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

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

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

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

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

## Case study two: Michael

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

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

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

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

currently unknown. It appears that Michael's father, Charlie, was very violent to Vivien, with past police reports indicating significant injuries to her body.

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

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

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

<sup>1</sup> See Appendix A for brief description of child protection.

### Case study three: Danielle

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

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

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

caring for Danielle and hopes she will settle down enough to come back to her.

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

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

## Impacts on academic performance and social functioning

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

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



**Figure 5 Academic and social impacts of trauma**

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

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

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

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

## Academic performance

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

### Reduced cognitive capacity

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

### Sleep disturbance

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

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

### **Difficulties with memory**

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

### **Language delays**

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

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

## **Social functioning**

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

### **Controlling behaviours**

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

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

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

### **Attachment difficulties**

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

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

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

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

### **Poor peer relationships**

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

### **Instability of living situation**

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

Moving frequently reduces the child's ability and desire to attach to the new school. Children often feel as though they stand out as the newcomer and don't have the relationship skills to make new friends and get on well with others. Of all our three case studies, instability has had

---

<sup>2</sup> See Appendix A for a description of Victoria's out-of-home care service.

the most marked effect on Danielle, interfering with her attachment to school and capacity to have meaningful friendships. This instability has also meant she has missed large sections of curriculum and is far behind her peers.

In 2003, the Department of Human Services and the Department of Education established the *Partnering Agreement* to acknowledge their shared responsibility regarding educational outcomes for children living in out-of-home care. See Appendix B for more information on the Partnering Agreement.

## Affect dysregulation: seen as hyperarousal or dissociation

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

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

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

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

## Shame: can increase affect dysregulation

Children who have been abused and neglected often have intense shame responses to perceived failures or insults and to the experience of being disciplined. It is as if all the humiliation of the abuse is triggered any time they perceive themselves as failing or wrong, leaving them

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

feeling intrinsically bad and worthless. Being overwhelmed by shame increases affect dysregulation and often leads to aggressive outbursts. Many traumatised children try very hard to control their environments so as not to feel this paralysing shame. Michael experiences extreme and paralysing shame when he can't do something or does not succeed in front of his peers. He becomes very silly or aggressive at these times. Danielle rarely speaks about her feelings of shame, but her presentation and behaviour indicate extremes of shame, particularly in relation to her sense of self-worth and feelings about her body.

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

# Section Three

## Calmer classrooms – relationship-based practices



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

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

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

### **The relationship-based approach**

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

The suggestions in this section may help teachers to manage such children without expelling them from mainstream schooling. Teachers may need extra help, in terms of both time and energy in the classroom, and support and reflective space outside it. Traumatised children are challenging; however when they are responded to with patience and care can come to see school as a safe, supportive place where they can learn and grow. Most of the examples that follow have been developed for primary age children, and can be adapted for older children and adolescents. This focus on younger children reflects the sad fact that many of the most difficult children and young people in the education system have left or been expelled by age 12–14, and either continue without access to education or are educated in alternative settings.

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

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

## **Creating connection and defusing conflict**

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

## Understanding the child

The most effective strategy a teacher has is a clear understanding of the child, their history and the reasons behind their behaviour. Many children with abuse and neglect histories are developmentally much younger than their chronological age. It has been found that teachers who manage their behaviours with this in mind develop empathy for the child, which helps them to feel understood and valued.

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

## Managing your own reactions

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

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

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

## 'I see you need help with'

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

When you become aware of misbehaviour try saying:

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

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

## Structure and consistency

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

For example some children will struggle when they have to move from their own classroom to the art or music room, and may need close

supervision and support during these transitions. This is much more difficult to manage in the secondary education system, where there are many transitions in every day. If possible set up a system for the child, so that they have structure and routine even as they move between classrooms, or enlist teachers or older, responsible students to assist the child find the right books and equipment and get to class on time.

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

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

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

### **Setting limits on unacceptable behaviour**

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

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

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

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

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

### **Time in, not time out**

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

### **Connecting**

Children with complex difficulties often swing between withdrawn, dissociative responses to internal affect dysregulation and hyperaroused, silly or aggressive responses. Some children will be consistently dissociative, withdrawn and spaced out but internally chaotic and anxious. They will be unlikely to take in new information, think clearly or make decisions while in this state. Children with a history of abuse and neglect who present as very compliant or withdrawn, look spaced out, or are unable to give full concentration, respond well to gentle and consistent attempts to connect with them, to bring them back to themselves. A light touch or direct word may help when dissociation

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

is noticed. Try to gain eye contact by asking for it (gently). Be aware that the dissociative child is missing chunks of information through inattention, and try to help them catch up. Alert parents, carers and other professionals of your concerns.

### **Consequences, not punishment**

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

'When you are calm I want you to apologise to Jane for hitting her, and I would like you to help her to tidy up her table.'

'Instead of going outside at recess I want you to stay with me and we will put all the books back on the shelves that you tipped on the floor.'

'Seeing that you spent a lot of time swearing this morning, I want you to come to the library with me and we will look up some other words you might use when you are angry.'

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

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

### **Structure choices to remain in control**

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

'Do you want to wear your coat or carry it to the playground?'

'You can finish that work sitting down or standing up.'

'You can finish that work now or at recess.'

'If you don't want to put your hat on I'll have to wear it!'

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

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

### **Acknowledge good decisions and choices**

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

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

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

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

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

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

### **Support the parents and carers**

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

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

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

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

### **Maintain your role**

Remember that you are the child's teacher and that sometimes these children pull you into intense relationships with them. It is sometimes tempting (and quite normal) to imagine taking the child home to live with you, as you may think you could do a good job of parenting this child. The child may also express a wish to come and live with you. Find someone to talk to about these fantasies: it is often better for the child to have you as a competent, caring teacher, than for them to think you might be a better

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

parent or carer than the one they have. Children move on at the end of the year, and can experience this as rejection by you if you have offered too much.

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

## Planning for challenging incidents

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

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

### **Establish safety**

The immediate safety of the child, other students, teachers and staff needs to be ensured. Move the child away from others, towards a space the child regards as safe (discuss this with the child beforehand). Use school personnel known to the child. Make sure there are enough adults to contain the child. If necessary, seek out assistance in learning restraint techniques, if this is going to be necessary; however don't use them unless no other method is effective.

Make sure any injured children or staff are attended to. If there is a likelihood of extreme violence, the police may need to assist.

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

### **Maintain self-regulation**

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

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

### **Calm the child**

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

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

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

### **Assist the child to understand what happened**

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

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

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

### **Consequences**

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

### **Help the child to take responsibility**

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

### **Speaking to other children**

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

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

### **Review the plan**

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

## Teaching Indigenous children

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

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

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

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

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

Indigenous students will do better if others from the same culture are in their class and in their school. This reduces isolation and the feeling of difference. It may be helpful for children to move to another school where there are more Indigenous students.

### **Abused and neglected Indigenous students**

Teachers should be able to recognise the signs of trauma, which may result from domestic violence, drug and alcohol or adult mental health problems at home. Knowledge of the historical trauma suffered by Indigenous people will fill out the teacher's understanding of the child. Knowing about the removal of the Stolen Generations is particularly

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

### Teachers need to remember to

- educate themselves about the history of Aboriginal and Torres Strait Island peoples, including the history of removal and disruption
- include Indigenous studies in the curriculum
- be sensitive to the possibility of abuse and neglect
- include narrative story telling teaching methods
- watch for hearing loss
- understand the child's perception of family
- acknowledge grief and loss
- make use of liaison workers to get to know families.

important, as this has caused intergenerational problems with attachment and appropriate child-rearing practices. Children already in the Child Protection and out-of-home care systems will present with the range of difficulties described here already, and will need similar support to other abused children. The differences lie in the complexity of the lives of Indigenous families, and their communities.

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

Schools with Indigenous children should have Indigenous liaison workers, and teachers should get to know them, as they can assist in connecting the teacher with the child's family and help with understanding the family's reluctance to engage with school personnel. Teachers may need to visit families to talk to parents rather than expect parents to come to them, but will need to be introduced first by the liaison or other Indigenous support person. Many Aboriginal parents will have had negative experiences of school themselves, and may be frightened of or angry with school personnel.

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

## Self-care for teachers

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

### Reducing stress: the three Rs

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

#### Reflection

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

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

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

## Regulation

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

Manage your own emotions and responses by:

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

## Relaxation

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

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

## Participating in systems: the care team approach

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

The forums that maintain collaboration and cooperation between parents, carers, agencies and institutions are often called 'professionals meetings', 'case management meetings', or 'care team meetings'. Children in out-of-home care will often have care teams.

*When children are living in out-of-home care the Partnering Agreement between the Department of Human Services and the Department of Education should come into play. This agreement can form part of the discussion of collaborative practice undertaken within the care team.*

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

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

### Children and therapy

Many traumatized children attend therapy, either through CAMHS (Child and Adolescent Mental Health), Take Two, Sexual Assault Centres, the Gatehouse Centre or a private practitioner. Therapists place a high level of importance on the teacher's experience and perspective of the child, as the child's experience of school is a valuable resource for the therapist in understanding and working with them. Many therapists will ask teachers to fill out questionnaires, such as the Strengths and Difficulties Questionnaire (SDQ) or a Behaviour Checklist. The child's therapist can also be a resource for the teacher, in helping to understand the child's history and the reasons for their responses in the classroom.

- In a care team the focus on the changing needs of the child allows for consistency of approach. In practice this means that the child experiences consistency in their interactions with everyone in the system.
- Many decisions can be made by the team, as there is shared information about the child.
- The care team approach allows for the group to think together about the child, and to process some of the difficult emotions and anxieties aroused when working with them.
- The care team supports the child's learning, development and growth, as well as their healing from trauma and disrupted attachment.
- The care team promotes proactive rather than reactive responses to the child.
- Care teams provide an opportunity to identify positive changes in the child's life, no matter how small.
- Care teams ensure that effective coordination and information-sharing strategies have been implemented.

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

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

## Conclusion

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

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

# A snapshot

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

This pain comes from:

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

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

## The impact of trauma on learning

**Affect dysregulation**—making children hyperaroused or dissociated

**Shame**—which can produce overwhelming affect dysregulation

**Reduced cognitive capacity**—due to early deprivation and/or affect dysregulation

**Difficulties with memory**—making learning harder

**Language delays**—reducing capacity for listening, understanding and expressing

**Need for control**—causing conflict with teachers and other students

**Attachment difficulties**—making attachment to school problematic

**Poor peer relationships**—making school an unpleasant experience

**Unstable living situation**—reducing learning, and capacity to engage with a new school

## Classroom practices for dealing with traumatised children

**Understand the child** Understanding trauma and attachment difficulties brings compassion and empathy; understanding that the child may be developmentally younger than their chronological age will guide teaching practices.

**Manage your own reactions** Working with traumatised children can bring strong emotions; staying calm will help the child to calm themselves.

**I see you need help with ...** Help children to comply with requests. Because they don't necessarily want to please adults, helping them comply will avoid power battles.

**Structure and Consistency** Traumatized children often have little internal structure and need firm boundaries, rules, expectations and consequences—applied with sensitivity and calm.

**Time in, not time out** Traumatized children experience time out as yet more rejection, increasing their feelings of shame and worthlessness; time in keeps them engaged in a relationship.

**Connect** Dissociative children, who are often quiet and compliant, need gentle and consistent attempts to connect with them.

**Consequences, not punishment** Use natural consequences that relate to the problem behaviour and are designed to repair damaged property or damaged relationships.

**Structure choices to remain in control** Offer choices with humour and creativity to avoid power battles; keep the child responding to you rather than allowing them to control the interaction.

**Acknowledge good decisions and choices** Traumatized children often don't respond well to praise, but still need positive reinforcement for doing something well: comment on the job well done rather than intrinsic characteristics.

**Support parents and carers** Get to know the parents or carers; keep up good communication and don't communicate through the child. Try to be understanding and compassionate: living with a child who has trauma and attachment difficulties can be very stressful.

**Maintain your role** Don't be tempted to move too far out of your role. These children need caring and competent teachers.

# Appendix A

## Child Protection and out-of-home care

The information following has been adapted from *The home-based care handbook* November 2003, Child Protection and Juvenile Services, Department of Human Services, Victoria.

## Victoria's Child Protection system

The aim of Victoria's system, governed by the *Children Youth and Families Act 2005* (the Act) is to protect children and young people from significant harm resulting from abuse and neglect. The Act gives child protection workers the authority to investigate allegations of child abuse and neglect and, when necessary, to apply to the Children's Court to remove children and young people from the care of their parents.

The Act builds on the foundations of the *Child Wellbeing and Safety Act 2005* which provides an overarching framework for promoting positive outcomes for all children, emphasising that:

- all children should be given an opportunity to reach their full potential and participate in society
- whilst parents are the primary nurturers of the child, society as a whole shares responsibility for children's wellbeing and safety
- planning and delivery of services should focus on sustaining and improving children's outcomes, including their safety, health, development, learning and wellbeing.

The Act operates according to a number of key principles, some of which include:

- The best interests of the child must always be paramount.
- Intervention with families should be the least intrusive option available when ensuring the safety of the child.
- Wherever possible for children should be cared for by their family.
- Supports should be offered to families to enable them to keep caring for their children.
- If a child is not living with their family, a primary goal is to reunite them, if this is in the best interests of the child.
- Wherever possible, children and their families should participate fully in making decisions that affect them.

When the Children's Court decides that a child is not safe living with their parents, the court will make an order that places the child in out-of-home care.

## Victoria's Child Protection system

'Out-of-home care' is the term used in Victoria when a child is placed in care away from their parents. At

any one time, approximately 4000 Victorian children live in out-of-home care. The vast majority are placed there following child protection intervention and in accordance with an order granted by the Children's Court. However a small number of children are placed in out-of-home care on a voluntary basis, with no court order requiring them to live away from their parents.

There are two types of voluntary placements:

- those arranged for children by child protection staff, but without a court order
- those that families or young people arrange directly with community service organisations (CSOs) as a solution to a difficulty they may be experiencing.

Out-of-home care includes two main types of care: residential and home-based.

**Residential care** is provided by paid staff employed by a CSO. Residential care properties usually house three or four people, generally adolescents.

**Home-based care** is provided by people in their own homes. A number of CSOs across the state are funded by the Department of Human Services to deliver home-based care. There are three main types of home-based care:

- *Foster care* is provided by volunteer caregivers in their own homes. Foster caregivers are usually not known to the child before the placement. This type of care can be short term—perhaps just overnight—or long term, sometimes extending for years.
- *Kinship care* involves children living with family or people they know, such as an aunt, grandparent or friend of the family. Kinship care can be short or long term.
- *Permanent care* is the term used when a child is placed with permanent caregivers, because their parents are unable to care for them on a long term basis.

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

# Appendix B

## Partnering Agreement

The Department of Education and the Department of Human Services Partnering Agreement *School Attendance and Engagement of Children and Young People in Out of Home Care* was developed in 2003. It reflects the joint commitment and responsibilities of both Departments to supporting children in out-of-home care to improve their educational experiences and outcomes at school. This includes ensuring a clear understanding of respective roles and responsibilities, a coordinated response to students' educational and social needs and the development of targeted strategies to support these children and young people to ensure engagement and achievement in school.

A key requirement of the Partnering Agreement is that all children and young people in out-of-home care must have a Student Support Group established and an Individual Education Plan developed for them. While it is the responsibility of the School Principal to ensure that this occurs it is vitally important that all relevant people in the child's life work collaboratively to provide appropriate support to the child. The Student Support Group should therefore include the child and their parent as appropriate, the carer, Department of Human Services worker or agency case manager and relevant teaching and support staff.

# Useful resources

## Victorian Government

### Health channel

[www.betterhealth.vic.gov.au](http://www.betterhealth.vic.gov.au)

### Child Protection and Family Services

[www.office-for-children.vic.gov.au](http://www.office-for-children.vic.gov.au)

### every child every chance and Looking After Children

Note especially the *Child development and trauma guide* May 2006

[www.dhs.vic.gov.au/everychildeverychance](http://www.dhs.vic.gov.au/everychildeverychance)

### Child and Adolescent Mental Health Services

[www.health.vic.gov.au/mentalhealth/services/child/index](http://www.health.vic.gov.au/mentalhealth/services/child/index)

### Department of Education student support services

[www.sofweb.vic.edu.au/wellbeing/index.htm](http://www.sofweb.vic.edu.au/wellbeing/index.htm)

### Victorian Aboriginal Child Care Agency (VACCA)

[www.vacca.org.au](http://www.vacca.org.au)

*Working with Aboriginal Children and Families: A Guide for Child Protection and Child and Family Welfare Workers*, published by VACCA September 2006.

## Federal Government

### MindMatters – A mental health promotion initiative for secondary schools

[www.curriculum.edu.au/mindmatters](http://www.curriculum.edu.au/mindmatters)

## Trauma

### Child Trauma Academy

[www.childtraumaacademy.com](http://www.childtraumaacademy.com)

### International Society for Traumatic Stress Studies

[www.istss.org](http://www.istss.org)

### Traumatology

[www.fsu.edu](http://www.fsu.edu)

### Traumatic Stress Institute/Center for Adult & Adolescent Psychotherapy

[www.tsicaap.com](http://www.tsicaap.com)

## Telephone Services

### Parentline 13 22 89

### Maternal and Child Health line 13 22 29

(up to 6 years of age)

### Nurse on Call 1300 60 60 24

24 hour health advice and information from a registered nurse

# Glossary

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

# References

- Allen, Jon, G. (2003) Mentalizing. *Bulletin of the Menninger Clinic*, 67(2) Spring.
- Archer, Caroline & Burnell (2003), Alan (eds) *Trauma, Attachment and Family Permanence: Fear Can Stop You Loving*, Jessica Kingsley Publishers, London.
- Beaulieu D (2003) *Eye Movement Integration Therapy: The Comprehensive Clinical Guide*, Crown House Publishing, Carmarthen.
- Becker-Weidman, A. & Shell, D. (2005) *Creating Capacity for Attachment*, Wood 'N' Barns, Oklahoma, U.S.A.
- Cairns, Kate & Stanway, Chris (2004) Learning the Child: Helping Looked After Children to Learn, a good practice guide for social workers, carers and teachers, *BAAF Adoption & Fostering*, The Russell Press (YU) Nottingham, UK.
- Cassidy & Mohr, (2001) Unsolvable Fear, Trauma, and Psychopathology: Theory, Research, and Clinical Considerations Related to Disorganized Attachment Across the Life Span, *Clinical Psychology: Science and Practice*, 8 (3), Fall.
- Fonagy, Peter (1999) *Transgenerational Consistencies of Attachment: A New Theory* (web version: [www.dspp.com/papers/fonagy2](http://www.dspp.com/papers/fonagy2))
- Garbarino, James (1999) *Lost Boys: Why our Sons Turn Violent and How We Can Save Them*. Anchor Books, New York.
- Golding, K., H. Dent, et al., Eds. (2006). *Thinking psychologically about children who are looked after and adopted. Holding it all together: creating thinking networks*, John Wiley and Sons England.
- Herman, Judith, L. & van der Kolk, Bessel, A. (1987) Traumatic Antecedents of Borderline Personality Disorder. *Psychological Trauma*, American Psychiatry Press Inc. Washington.
- Herman Judith, L., Perry, J. Christopher and van der Kolk, Bessel, A. (1989) *Childhood Trauma in Borderline Personality Disorder* American Journal of Psychiatry.
- Herman, Judith (1992/1997) *Trauma and Recovery: The Aftermath of Violence – From Domestic Abuse to Political Terror* Basic Books, New York.
- Hughes, Daniel A. (1997) *Facilitating Developmental Attachment: The Road to Emotional Recovery and Behavioural Change in Foster and Adopted Children*, Rowman & Littlefield Publishers, Inc. Lanham.
- Matsakis, Aphrodite (1996) *I Can't Get Over It: A Handbook for Trauma Survivors*, 2nd ed, New Harbinger Publications Inc, Oakland.
- Perry, B. (2006) *Applying principles of neurodevelopment to clinical work with maltreated and traumatized children*, The Guilford Press New York.
- Schore, Allan N. (2003a) *Affect Dysregulation and Disorders of the Self*, W.W. Norton and Co. New York.
- Schore, Allan N. (2003b) *Affect Dysregulation and the Repair of the Self*, W.W. Norton and Co. New York.
- Siegel, Daniel J. & Solomon, Marion, F. *Healing Trauma: Attachment, Mind, Body, and Brain*, W.W. Norton & Company, New York.
- Stern, Daniel (1985) *The Interpersonal World of the Infant*. Basic Books, New York.
- Take Two Practice Framework (2007), available through Berrystreet Victoria.
- van der Kolk, Bessel, A. (1996a) *Trauma and Memory*, in van der Kolk, Bessel A., McFarlane, Andrew & Weisaeth, Laars (Eds) *Traumatic Stress: the effects of overwhelming Experience on Mind, Body and Society*. The Guilford Press, New York.
- van der Kolk, Bessel A., McFarlane, Andrew & Weisaeth, Laars (eds) (1996b), *Traumatic Stress: the effects of overwhelming Experience on Mind, Body and Society*, The Guilford Press, New York.
- van der Kolk, Bessel, A. (2005) *Developmental Trauma Disorder*, *Psychiatric Annals*, May.

