Pathways and Planning:

Working through trauma: Level 3 Trauma Recovery Model

Where children have experienced a period of stability and have been provided with the opportunity to develop positive attachments with trusted adults, they may start to recover from the trauma they have experienced and be more attuned to their own feelings. Children who have reached this developmental stage may start to reflect on their previous lives and the trauma they have experienced. This is a necessary but difficult part of recovery and can be associated with extremely challenging behaviour and/or rejection of staff (as indicated by the Trauma Recovery Model (TRM). It's extremely important that practitioners carefully assess any presenting behaviours to distinguish between behaviours that may indicate unmet need and behaviours that are a result of the recovery process (need being met). Often this developmental phase can be recognised by a period of desistance where previous behaviours are less frequent or severe followed by a period where the child's behaviour is once again challenging.

The timeline exercise[1] completed for Sam indicated that he had experienced neglect during his early years (evidenced by a period on the child protection register). Research indicates that neglect can cause severe psychological damage due to its consistent nature and associated feelings of unpredictability/lack of safety, which can heighten anxiety and aggression in adolescence and later life. At the age of four, Same was removed from his parent's care following a serious incident, an undoubtedly further traumatic incident on a child whose capacity to deal with difficult events would already have been reduced.

Between the age of four and fifteen years, Sam was in a long-term foster placement where he had a stable base and the healthy attachments relationships of his carers. The timelining exercise indicated that the challenging behaviours which resulted in Sam's referral to the YOT had only presented during the last 12 months. Unfortunately, this had led to the breakdown of his foster placement (his carers felt they could not meet his needs) and his behaviours escalating further.

Consideration of the stage (age) the behaviours presented, in the context of the trauma Sam had experienced and the periods of desistance allowed the YOT to hypothesise that the stability and positive attachments he formed during his

[1] This examines the child's history and circumstances often from birth to the current time to help to contextualise and understand what has happened to them, what they have experienced and how it may have contributed to their behaviour.

longer-term foster placement meant he reached the stage where he started to process the trauma. This developmental stage can be associated with extremely challenging behaviour and rejection of staff/carers which may help to explain why his placement broke down. A loss/change of placement during this developmental phase (working through trauma) would undoubtedly be experienced as a further traumatic event at a stage when he required intensive support and stability and interventions aimed at helping him process past trauma. The challenging behaviours resulted from his needs having been met (Level 3 TRM) rather than challenging behaviour that results from unmet need (Level 1 TRM).

Multi agency planning

It's important that youth justice practitioners anticipate this stage and the associated behaviours with other practitioners involved in the child's care, so that any difficult or challenging behaviours can be recognised as part of the recovery process. Learning from the South Wales ECM trial (2017) was that when faced with these types of behaviours, practitioners would assume they were doing something wrong. Practitioners/carers were better able to 'stay with the plan' where they understood in advance that such behaviours were a part of the recovery process. In the above example Sam's foster carers believed they could not meet Sam's needs/keep him safe. It is possible that his behaviours arose from the fact they met his needs very well and his outcomes may have been improved if he were able to remain in the same placement and the carers had been provided with support to manage this challenging time.

Where the challenging behaviour is assessed to be a result of the child processing trauma, the child will require continued consistency, predictability, reliability and intensive support from workers with whom they already have an established relationship. It is important to avoid unnecessary changes in the care plan at this stage e.g. changing the child's living arrangements or YOT case manager. When presented with challenging behaviour it is recommended that the focus of professionals shifts from the behaviour and consequence to the stress and dysregulation the child may be feeling. Through this process, they may be assisted to self-regulate their emotions. Children assessed at Level 3 of the TRM will benefit from interventions that assist them work through this trauma.

Counselling/Specialist therapeutic Interventions

Vaswani (2014) interviewed 33 young men in a young offenders institute and indicated that up to 91% of them had experienced bereavement, with an average of 6 bereavements each and traumatic bereavements (suicide and murder being common). Likewise, children referred to YOTs have often experienced repeated rejection and loss, in addition to bereavement. Sometimes the impact can be forgotten/ignored perhaps because these children don't have the skills to articulate their feelings like a friend or colleague might. The research indicates that children who experience loss are being escalated within the criminal justice system. Thus, we need to consider whether our response is sensitive to the child's experience and whether the type of response is going to be effective in reducing offending in the context of bereavement. For example, is a child who has experienced repeated traumatic loss going to be assisted to come to terms with this loss and change behaviours that may

be associated with unresolved pain and grief via a consequence, enforcement procedures or a detention and training order? These types of intervention will seek to address the presenting symptom (offending) but the underlying cause remains unaddressed. These consequences may of course be necessary, but it is suggested that the wider context to the presenting behaviours is considered very carefully at relevant multi agency forums/compliance/engagement panels and shared with police/courts/educational professionals and other decision-making bodies accordingly. Children referred to YOTs have often experienced repeated rejection and loss. Validating their experiences surrounding loss may be an important intervention at this stage (as indicated by the TRM Level 3 interventions (Skuse and Matthew, 2015) that will perhaps be more effective in reducing re-offending.

A child who has experienced loss could be referred to a local bereavement counselling service. However, the child may prefer to complete bereavement work with a practitioner with whom they have already established a relationship. The practitioner could find out key information such as the name of bereaved, the date of death/how/why they died and offer to help the child honour the anniversary of the loss or other key dates. Children can heal through simple conversations.

For example:

> *Dylan's had experienced the bereavement of his grandmother with whom he had lived with as a younger child, when his parents were unable to care for him. There was a history of emotional abuse from his mother and stepfather who decided that Dylan was not allowed to attend his grandmother's funeral as there was no room for him in the funeral car. His YOT worker recognised the importance of Dylan attending the funeral and advocated this to the family who agreed he could travel with his aunt. On the day in question the family sent a text to his worker to say that his aunt could no longer take Dylan to the funeral. The YOT worker made the impromptu decision to take Dylan to the funeral themself. Upon arrival Dylan saw that the rest of the family were dressed formally. He was wearing a very worn tracksuit, this re-enforced his narrative that he did not belong/he was not worthy, and he refused to go in. The YOT worker was unable to influence the day's events and was aware this experience would be a further rejection/trauma on a childhood already marked by neglect and emotional abuse. The plan to support him attend the funeral had not worked out as intended. Dylan was a child who was very difficult to engage and would not consent to any referrals to more specialist services, e.g. CAMHS or counselling. Following the funeral the YOT practitioner would deliberately make time to speak to Dylan about his grandmother, asking her name, birthday about their relationship and the time he had lived with her and some months later they bought flowers and visited his grandmothers grave. Multi agency planning also ensured that these key dates were recorded and shared with other professionals as they may help to explain changes in his behaviour and were key dates that professionals could help him mark in years to come.*

Conversations that heal

The challenging/clinginess or rejection that presents during this stage of recovery (TRM Level 3) can be a difficult and overwhelming for the practitioner as well as the child. Sometimes the overwhelming feelings stem from the practitioner's belief that

they need to try and solve the problem or make things better for the child which can seem like an impossible task. Research shows that just listening brings down stress levels (Dr Sunderland, 2015). The practitioner does need to be a therapist but to provide an intervention that reflects the type of support they would more naturally offer to friends, family members and colleagues who confide in them- validating the emotions rather than outlining consequences or providing solutions.

Children who have experienced trauma will have been exposed to harsh and repeated forms of verbal abuse from the very people who should have been their biggest supporters. Unfortunately, where the traumatic experiences in early childhood manifest as anti-social or offending behavior, negative messages can be further perpetuated (unintentionally), e.g. “Your behaviour is problematic”, “You pose a high risk to the community.” or “You failed to engage with the support offered.” With reference to Dylan (above) these types of messages from Referral Order panels/compliance panels and the criminal courts possibly reinforced what his mother and stepfather had repeatedly told him during his childhood, i.e. he was the problem. Such messages may have been perpetuated further by messages from child protection conferences and core groups where he was described as, “beyond parental control”, where his mental health was repeatedly questioned. When his YOT worker would speak to him about the reasons he was in care he would repeat the narrative he had learned that he was naughty/crazy. The truth, of course, was much more complex, his mother had her own experience of trauma, was the victim of domestic violence from Dylan’s stepfather who still lived at the family home and his father was dependent upon heroin. His parents were unable to offer the stability and attachment that he required. It is possible Dylan needed a mental health assessment but also his behaviour could have been a very normal response to very difficult and traumatic circumstances.

It is important to highlight that the child will already be thinking about the traumatic experience even if they are not talking about it. Often when bad things happen children will think it is their fault, their inner thoughts may be more horrific than the reality of the situation. The child needs to know that the trusted adult can hear the information and doesn’t confirm their skewed perception that they are mad/bad/naughty and that what happened is their fault.

Practice example,

> *When Sonny was three his mother left him in a bath with his baby brother and his brother drowned. There was a history of safeguarding concerns that had preceded this incident. Sonny was immediately removed from his mother’s care and placed in a foster home. Whilst in foster care he alleged he was raped by his foster brother. The allegation was not substantiated but Sonny was removed from the placement because of the allegation. The perpetrator (following further allegations) later admitted the offence on Sonny. However, as several years had passed and Sonny had different workers and several different placements, it was not known whether the matter was revisited with him.*
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> *Once Sonny had established a good relationship with his YOT workers he began sharing information that he had not done before. He would talk about his new self-old self frequently in conversation, e.g. “Do you remember when I used to get into trouble all the time?” and “Do you remember when I first met you*

and I had taken drugs?", indicating he was now at a higher level of the TRM (Level 3). He did not discuss all of the painful events at this stage but referenced having been placed in care because he was naughty and that his mother was angry with him and this is why she does not visit him, indicating that his interpretation of events was his fault; perhaps even more painful that the truth.

The worker was able to respond at various times and stages with phrases such as,

- *Children sometimes think that when bad things happen it is their fault.*
- *Children's brains are not fully grown that's why adults are always in charge.*
- *You must be very angry you are in care and that your mother hasn't visited, that must be very difficult to cope with.*
- *Children under 10 can't get into trouble as younger children always need to be supervised by adults, so only the adult can get into trouble.*
- *Sometimes the police don't have enough evidence to take people to court, but this doesn't mean they didn't commit the offence, or they don't believe the victim, it just means they didn't have the evidence.*

Just having conversations about the events were likely to be extremely valuable for Sonny but here the worker was also indirectly able to modify the traumatic memories and helped him shift blame away from himself. Multi agency discussion were had about revisiting the allegation Sonny had made in a more direct and formal manner.

Empathy

The objective in terms of empathy at this stage is for the practitioner to accept/tolerate the feelings the child is having regarding the traumatic experience as explained above, but it is also of note that practitioners should not try to persuade the child out of the feelings they are having or try and persuade them to consider the feelings of others. The child will only learn to do this through experience – through them having their own experience of being a victim validated by a trusted adult.

Practice example:

Gina had developed a very good relationship with her YOT worker (over a period of 12 months) and in sessions had started to tell them how awful her life was; her mother had died, her father had moved abroad and not maintained contact; she had lost her placement and now her grandfather, her one remaining family contact had stopped speaking to her following an argument. The worker sought consultation from the Enhanced Case Management (ECM) psychologist as they wanted to be able to reassure Gina and help her to make amends with her grandfather, a task that would be difficult to achieve (given the grandfathers own substance misuse issues).

The psychologist advised the worker to demonstrate to Gina that they understood how difficult the experience was for her by affirmation,

understanding and recognising the feelings Gina was having, using language and a tone that conveyed empathy; but not to try and solve the problem, as this was outside of their control and may not have the intended consequences.

Research shows that when trusted adults respond to children with empathy and help them to understand their feelings outcomes are improved.

When a child's distress is met with empathy, it develops the child's ability to empathise which may also prove conducive in 'reducing offending or harm to the community'.

The practitioner might say "I know you are so annoyed that your grandfather didn't come and see you, I can see how frustrated you are".

This is completely different to saying, "Don't worry I am sure he will call you soon".

Disclosures and recalling traumatic events

A child who feels safe and has developed good attachments may be more likely to make a disclosure.

Research demonstrates that experiences of trauma, whether a single event (e.g. a sexual assault) or a sustained stressful experience that might involve multiple trauma types (e.g. neglect, domestic abuse) are also vulnerable to memory distortion. Traumatic memories are more likely to be recorded as brief schemas of our sensory experience rather than a rational progression of events, as the emotional side of our brain is more likely to be activated than the rational side of our brain during these experiences. These findings help to explain why many children experience memory loss or repress important details of the events they experience (Bessel Van De Kolk, 2020). Children may recall feelings or themes but not necessarily details relating to locations, perpetrators, their age or specific dates. Often incidents reported or disclosed to professionals may contain misinformation. This does not mean the events/abuse did not take place. In these circumstances it is recommended that professionals/parents/carers travel alongside the child's reality as opposed to correcting the misinformation; whether the misinformation is intentional or not it will be serving a purpose. The child may also be testing your reactions before making other disclosures.

Responding to misinformation

Children who have experienced trauma and are recovering from trauma may sometimes give misinformation (consciously or unconsciously). This type of behaviour is communicating a need and is a clue to what is happening in the child's inner world.

Possible reasons of the behaviour;

- Stretching the truth is a normative stage of child development, which may have been delayed by developmental trauma.

- Abuse is often characterised by secrecy and deception. Children may have witnessed stretching the truth as the norm, e.g. "don't tell your teacher/social worker that…". Children may also feel that the truth results in unwanted

consequences e.g. they previously disclosed abuse and social workers/police who attended the home and they were removed or perceived they were not believed by professionals/carers.

- Children have learned that adults cannot be trusted or are unsafe, therefore lying seeks to keep others at distance socially and emotionally, e.g. “If they don’t know the real me, they can’t hurt me”.

- Children may be testing if they are being listened to or what action you will take if they make a disclosure.

- The fantasy world may be safer than their reality (protective disassociation). (Triesman, K, 2019)

As above, it is recommended that professionals/parents carers travel alongside the child’s reality as opposed to correcting the misinformation until the child feels safe enough to abandon the need for multiple realities

Make explicit links between trauma and impacts upon the body/behaviour

Interventions at this stage can also seek to make the link between trauma and behaviour explicit for the child so that they can grasp for themselves the relevance to their own experience. Some examples of these types of interventions are included in the practice example below. It can also be useful to try and help children think about what they are feeling in their bodies. For example, supporting the child to make links between their feelings and their bodily sensations. This can be done via verbal statements “I notice you are clenching your fists and breathing fast”, or “sometimes when I am angry my heart beats really fast”. Body mapping exercises can also be completed.

Physical or reparative activities that help to remove children from the demands of everyday life, that help to raise and lower emotions in a safe and nurturing environment can also be of value e.g. yoga, football, card games, board games, gardening, painting.

Practice example:

Gina was referred to ECM. Gina lived with her mother until she died when Gina was 14 years old. It is known that her mother engaged in sex work and substance misuse and Gina experienced neglect throughout this time. She also alleged having been abused by a family member and raped by a friend of her mother at the age of nine and thirteen.

In sessions Gina would often recall events/stories that had allegedly happened throughout her week. On one occasion she told her case manager that she has been in the local park where she witnessed a mother getting drunk whilst caring for her three-year-old daughter. She stated that the mother got increasingly intoxicated and her young daughter was getting very badly burnt in the hot sun. Gina said she was so concerned that she called the police who subsequently attended the park to intervene. Although the story was presented

in a very plausible manner by the child, it subsequently transpired this event did not take place. The ECM psychologist was able to advise professionals that these stories may be indirect disclosures that were intended to test professional reactions, or Gina could be testing the case managers view /perception of the situation. These stories were also indicative of her perhaps beginning to process her past trauma (TRM Level 3). The workers reaction would undoubtedly inform any future disclosures Gina would or would not make. If the YOT case manager were to highlight the incorrect information/seek to hold the her accountable for the misinformation or outline the consequences of telling lies, Gina would possibly experience feelings of shame and this may have prevented her from making any future disclosures.

Whilst it remains unknown whether Gina acted consciously or unconsciously, the story communicated an unmet need for her. When careful consideration was given to stories told by Gina, workers were able to identify the underlying themes, relating to mothers abusing their children. Enlightened with this, the worker could purposefully show empathy for the children in Gina's stories. For example, when discussing the event above the practitioner could highlight;

- *The child was dependent upon her mother to keep her safe*
- *Using Playfulness, Acceptance, Curiosity and Empathy strategies (Dan Hughes 2021) strategies to be curious if this child was subject to other abuse and about how this may impact on the child now and in the future and*
- *How a three-year-old may feel when the police arrived/scared/confused/at fault even though the event was not within their control*
- *How difficult it must be for a three-year-old if /when her mother was intoxicated*

When Gina was completing the reparative element of her YOT intervention, the reparation worker would explain how important it is to pay attention to the vegetables daily, giving them water and shelter from the frost and asked Gina to consider what would happen if they forgot to water the vegetables or didn't attend to them for weeks on end. The reparative worker would emphasise that the vegetables were dependent on them i.e., trying to make explicit the link between adverse conditions and outcomes. Eventually, via this approach, repeated with several different workers with whom Gina had a positive relationships (her case manager, substance misuse worker, social worker and reparation worker), she felt more comfortable discussing her past experiences in a more direct manner as she was confident practitioners would have empathy for her situation, would not blame her and understood how this had impacted on her.

Targets associated with progression/recovery

The child's behaviour may still be challenging and they maybe rejecting or clingy of staff, but practitioners may also notice the child seeks support from practitioners/staff during times of crisis (Skuse and Matthew, 2015). They may now be able to respond

to feeling based questions perhaps answering using feelings-based words. Their language may reflect the start of a development of a new self-versus old self e.g. “Do you remember when I used to…?”. The child will start to process trauma (talk about the past/make connections between past and current behaviour). Disclosures could be made or the child may start to test out practitioner’s reactions should they make a disclosure. They may be recalling past traumatic events (maybe incorrectly) or giving misinformation (intentionally or unintentionally) or telling stories about peers/people they know. They may speak as if you know what happened even though they have not disclosed what happened. There may be increased periods of desistance or periods where the child is calmer or examples of times where the child coped with an event without reverting to previous survival strategies.

Many children referred to YOTs may come to the end of their interventions/orders before they attain the higher levels of the Trauma Recovery Model. This needs to be provided for in the exit strategy.

NOTE: Practice examples have been anonymised and the nature of the significant events have been amended to protect the identity of the children.

References

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