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EDITORIAL

Dag Nordanger[1]

This special issue of "Today's children are tomorrow's parents" is dedicated to the topic of "Childen and trauma". Most likely, if such an issue was produced 15 years ago, its focus would have been quite different. Probably, articles would have focused more on dramatic events visible to the public, such as accidents, disasters and sudden loss. Moreover, it would have been inappropriate at the time not to focus particularly on the Post traumatic stress disorder diagnosis – its origins, symptoms, and its treatment. Since then we have learned, that although these are severe sources of stress for a child, the most devastating traumatic events happen in rooms hidden to the public. We have learned that those experiences which threaten the health and development of a child the most are the *complex traumas* – the persistent traumas which undermine the child's secure base and the relationship to primary caregivers. Examples of such traumas are child maltreatment or abuse, or getting the platform of ones life torn apart because of war and flight. We have also learned that when the traumas are complex, the health consequences are complex as well, and can not be limited to a certain existing diagnostic category such as PTSD.

The recognition of the relational aspects of trauma has made perspectives of developmental psychology central to the field, not the least because of the major advances which have taken place within developmental neurobiology. And since a complex trauma perspective implies that trauma is not just about the dramatic *presence* of certain stressors, but as much about the dramatic *absence* of protective factors, resilience research has become central to the field.

Consequently, support for these children cannot be reduced to a particular therapy, but must be broad, multidisciplinary and resource oriented. Also, it has to be phase oriented, starting from rebuilding the basic platform of safety, stability and primary care, moving towards more specialised symptom focused treatments. The content of this special issue reflects the sketched development in the field, and circle around *4 domains* of knowledge on which any professional working with complexly traumatised children should be educated:

I. *Firstly*, we have to understand the mechanisms involved in complex trauma, what is harmful to a child, and how risk and protective factors interact in both a healthy development and during maladaptive development. Most papers of the special issue address these topics, but the two first ones cover them more exclusively and in depth.
- Mannes, Nordanger and Braarud's paper; *Evolving trends in the field of trauma; Developmental and neurobiological contributions to the understanding of complex trauma,* ad-

[1] Dr. Psychol./Specialist in clinical child and adolescent psychology/Senior researcher, Centre for Child and Adolescent Mental Health, Western Norway, Resource centre on violence and traumatic stress (RVTS), Western Norway, Bergen, Norway, Email: dag.nordanger@uni.no;

dresses the above mentioned development in the field of trauma. It describes what complex trauma is, how it can be understood, and outlines some practical and clinical implications.
- Măirean and Turliuc's paper; *Research Review: Risk and resilience in children. The role of social support*, is a comprehensive overview of our current knowledge base concerning what we need to strengthen and what we need to avoid in order to promote a child's healthy development.

II: *Secondly*, we have to explore the possibility that a child is maltreated and learn to detect the signals. Today, many of these children are living under traumatising conditions for years without anyone interfering, and when their situation is eventually disclosed their problems have become severe. This might in some cases be an issue of training, but, without doubt, as professionals we also have to challenge obstacles in ourselves to be able to "see". There are two papers of this thematic issue which is of great value in this regard:
- Lundén's paper; *To identify preschoolers at risk for maltreatment*, focuses in the importance of identifying children living in adverse circumstances early, and presents a study investigating well-baby nurses and preschool teachers responsiveness to signs of child maltreatment.
- Ugland Albaek and Albaek's paper; *The Missing Link of Assessment: Exploring contributing factors for "non-assessment" of psychological trauma in children and adolescents by professionals*, takes us through a research based exploration of reasons – in our systems and in ourselves – for why assessment of psychological trauma in the children and adolescents is only to a limited extent administered in key institutions.

III: *Thirdly*, we have to support and strengthen the child's caregivers, whether it is the biological-, foster- or adoption parents, to understand and become sensitive to the child's needs. From research we know that a safe, holding and supportive close relationship is a necessity for healthy development, and may provide the corrective experience maltreated children need. Without it, most other attempts to help will fail. Three of the papers contribute with valuable knowledge concerning this domain in particular:
- Muntean's paper; *Trauma of abandoned children and Adoption as promoter of healing process*, present some of her own research into this important issue. The study investigates important factors contribution to successful adoption in terms of the quality of attachment between the child and the new parents.
- Lehmann and Nordanger's paper; *Reflective foster care for maltreated children, informed by advances in the field of Developmental Psychopathology*, focuses on challenges and principles of reflective care for foster children, outlined from developmental psychology, neurobiology and trauma psychology.
- Christie and Doehlie's paper; *Enhancing quality interaction between caregivers and children at risk: The International Child Development Programme (ICDP)*, presents the internationally recognised ICDP programme, and link its principles to core elements in trauma understanding and resilience based interventions dealing with traumatized children.

IV. *Fourthly*, even when the basic protective systems in their lives have been re-established, many complexly traumatised children will need treatment for trauma related symptoms and functional problems. Therapy for these children have to take into account the broad span and the developmental aspects of their symptom profiles, and be phase oriented in the sense that the most basic problems are addressed first. The three last papers of the special issue address treatment, and are all informed by and true to the leading literature in the field:
- Kolflaath Larsen and van der Weele's paper; *Helping families from war to peace: Trauma-*

stabilizing principles for helpers, parents and children, translates modern trauma theory into ten practical principles for working with refugee families traumatised by war.

- Braein and Christie's paper; *Therapy with unaccompanied refugees and asylum-seeking minors* demonstrates how a modern trauma understanding in combination with perspectives of cultural psychology can be applied in treatment of these groups. The principles are illustrated with two case descriptions.
- Heine Steinkopf's paper; *Treatment of complex trauma in children; a multi-family approach*, shows us how a development based and neurobiologically informed understanding can be translated into a group treatment for complexly traumatised children.

I hope all papers will be read with interest, as they, one by one but even more in summary, will give us a basis for acting professionally in ways that can make a difference for a child who has got an unfortunate start of live.

Yours sincerely
Dag Nordanger
Editor of the special issue

EVOLVING TRENDS IN THE FIELD OF TRAUMA; DEVELOPMENTAL AND NEUROBIOLOGICAL CONTRIBUTIONS TO THE UNDERSTANDING OF COMPLEX TRAUMA

Heidi Lee Mannes[1]   **Dag Nordanger**[2]   **Hanne C. Braarud**[3]

Abstract

In recent years, one has experienced a focal shift in the field of trauma from solely considering isolated traumatic events as the cause of psychological symptoms to including other forms of traumatisation emerging from repeated or chronic trauma, referred to as complex trauma. Research suggests that complex trauma gives a more severe symptomatology than single trauma, and is more common than previously believed. Developmental psychology has made important contributions to the conceptualisation of complex trauma. Early exposure to complex trauma causes more serious damage than when such exposure occurs later in life, suggesting a developmental sensitive period for this type of traumatisation. Neurobiology has also informed the field of trauma through stressing the importance of taking into account how the brain is formed, organized, and changed. As new knowledge about trauma has evolved, the field has to re-think how it understand, assess and treat complex trauma.

Keywords: Complex trauma, children, development, neurobiology

Rezumat

În anii din urmă s-a putut vedea o schimbare majoră în domeniul traumei; de la preocuparea față de evenimentele traumatice singulare cauzatoare de simptome psihologice, spre includerea altor forme de traumatizare, legate de trauma cronică, repetată, cunoscută ca traumă complexă. Cercetările arată că trauma complexă conduce la o simpromatologie mult mai severă comparativ cu trauma simplă și este mult mai comună decât se credea înainte. Psihologia developmentală a avut importante contribuții pentru conceptualizarea traumei complexe. Expunerea timpurie la trauma complexă conduce la pierderi mult mai importante decât în cazul în care expunerea se petrece mai târziu în cursul vieții, ceea ce sugerează o perioadă

[1] Psychologist/Assistant researcher, Centre for Child and Adolescent Mental Health, Western Norway,Bergen, Norway, Email: heidi.mannes@uni.no;

[2] Dr. Psychol./Specialist in clinical child and adolescent psychology/Senior researcher, Centre for Child and Adolescent Mental Health, Western Norway, Resource centre on violence and traumatic stress (RVTS), Western Norway, Bergen, Norway,Email: dag.nordanger@uni.no;

[3] Dr. Psychol./Senior researcher, Centre for Child and Adolescent Mental Health, Western Norway, Bergen, Norway, Email: hanne.braarud@uni.no.

developmentală sensibilă pentru acest tip de traumatizare. Neurobiologia a adus de asemenea importante informaţii în domeniul traumei, accentuând importanţa considerării modului în care are loc structurarea creierului, organizarea şi schimbările. Pe măsură ce noile cunoştinţe privind trauma au evoluat, a apărut nevoia de a re-gândi înţelesurile traumei, evaluarea şi tratamentul traumei complexe.

Cuvinte cheie: Traumă complexă, copii, dezvoltare, neurobiologie

Introduction

The aim of this article is to give an introduction to some of the evolving trends in the field of trauma, illuminating the phenomenon referred to as complex trauma. Since it was introduced in 1980, the Post Traumatic Stress Disorder (PTSD) diagnosis has been dominating research and the development of measures and interventions in the trauma field. PTSD is categorised as an anxiety diagnosis based on a single unexpected incidence that represents a threat to survival, giving symptoms of intrusion of traumatic memories, avoidance of reminders of the traumatic event, emotional numbing and hyperarousal (DSM IV-TR) (American Psychiatric Association, 2000). More recently, the focus of trauma psychology has been increasingly directed towards implications of repeated or chronic traumatic stressors, typically referred to as "Complex Trauma" (John Briere, Kaltman, & Green, 2008). Today, it has become common to distinguish between Type I trauma; an unexpected single-incident traumatic event, and Type II trauma/complex trauma; usually occurring repeatedly, cumulative and combined, and involving fundamental betrayal of trust in a primary relationship (Stien & Kendall, 2004). Examples of potentially complexly traumatising adversities are exposure to domestic violence, sexual abuse, serious neglect or exposure combined adversities of war. Reasons for the focal shift in trauma psychology include population surveys showing that complex traumatic exposures are more widespread than previously believed, and compared to single traumatic events, represents a greater threat to public health (J. D. Ford & Courtois, 2009).

The prevalence of childhood complex trauma

For this purpose, we will use the term "complex trauma" as descriptive of exposure to repeated and/or chronic traumatic adversities such as living with domestic violence and sexual abuse, and the term "complex traumatisation" as descriptive of the destructive mechanisms put into play by such traumas. In a Norwegian context, we know from recent a national survey that 11 percent of Norwegian adolescents have experienced severe sexual assault, while 8 percent have been exposed to severe physical violence from a parent (Mossige & Stefansen, 2007). North American research groups and networks, such as National Child Traumatic Stress Network (NCTSN) alongside the San Diego group running the Adverse Childhood Experience (ACE) study, have been particularly central in developing the concept of complex trauma and raising awareness of its prevalence. Their extensive surveys finds prevalence of up to 50 percent of sexual/physical abuse, domestic violence or neglect in risk- (Spinazzola, 2003) as well as in non-risk populations (Felitti et al., 1998).

Impacts of childhood complex trauma

We know today that such adverse experiences, in addition to being life threatening, physiologically violating and terrifying, compromise personal development and basic trust, and thereby survival of the self (Cloitre et al., 2009; J. D. Ford & Courtois, 2009). Research indicates that complex trauma not only is associated with a higher risk for the development of PTSD than Type I trauma, but it also may compromise or alter a persons psychobiological and socio-emotional development when it occurs in critical de-

velopmental periods, and typically involves harm from responsible adults (J. D. Ford & Courtois, 2009). Therefore, complex trauma does not only manifest itself through PTSD or anxiety.

Research shows that, among complexly traumatised children, diagnosis such as depression, ADHD, conduct disorder and attachment disorders may be equally or more common than PTSD (Ackerman, Newton, McPherson, Jones, & Dykman, 1998). More seriously, these are children typically recognised in mental health services as impulsive and antisocial clients (Curtois, 2006), and are later on overrepresented in drug addiction services (Felitti, et al., 1998) and in criminal registries (Teplin, Abram, McClelland, Dulcan, & Mericle, 2002).

As impacts of complex trauma seem to encompass a spectrum of diagnoses and functional problems, a research field has evolved, investigating the extent to which the associated symptoms follow a certain pattern or profile. Recent surveys and reviews seem to suggest that such a pattern exists among complexly traumatised children, and that it involves three domains of *regulation* problems (for an overview of data sources, confer B. van der Kolk & Pynoos, 2009):

1. *Affect and self regulation;* Including fast shifts between intense affective states; problems of calming down; persistent dysphoria; hypersensitivity for affective stimuli; delayed motor development; sleeping-, eating- and digestion problems; hypersensitivity for sounds and tactile stimuli, as well as poorly developed language for emotions and bodily states.

2. *Regulation of attention and behaviour;* Including a narrow and threat oriented focus of attention; misinterpretations of social cues and contexts; social insecurity and distrust in people's intentions; impulsivity; impaired abilities of risk- and consequence analysis, as well as inadequate self soothing strategies.

3. *Socio-emotional functioning*; Including shame and sense of worthlessness, attachment problems; separation anxiety; preoccupation with being cared for; constant fear of rejection, as well as physicalised or sexualised ways of seeking contact with others.

Development and neurobiology
The symptoms presented above may differ substantially and appear contradictory, but they are clarified by present research in developmental psychology and neurobiology. In recent years, these disciplines have made significant progress in areas which help us understand the mechanics involved in traumatisation (Teicher et al., 2003; B. A. van der Kolk, 2005). Below, we would like to draw into attention a few areas of established knowledge we find particularly relevant.

The hierarchical organisation of the brain
The development of the brain happens in a set order (Szalavitz & Perry, 2010), starting from lower sub cortical parts and proceeding through more complex and higher functional parts, namely the cortex (B. D. Perry, Pollard, Blakley, Baker, & Vigilante, 1995). The successive nature of brain development insinuates sensitive phases for stimulating its various structures. This sequential principle also reflects the hierarchic organisation of the brain: All input first enters the lower regulatory areas (brainstem and diencephalon). These areas deal with fundamental activities the concerning survivor, and are characterised by automatic nature. As information moves through neural networks, and is mediated by complex cortical structures, skills such as language and abstract thinking are made possible. At this level of processing information is in reach of cognitive control. Information interacts both within and across these structures, relating both to the internal and the external environment. As input is processed it is matched against stored memories. A normal early interaction promotes communication between these areas. When there is a potential threat to survival or integrity, as in the case of trauma, this threat is com-

municated to lower or sub cortical areas of the brain, where the amygdala and other parts of the limbic systems plays a crucial role in this regard. An alarm response is set off, giving a near reflexive mobilisation of potential for action (including the release of cortisol), while the information of the perceived threat is sent in a slightly slower neural curve to higher cortical areas of the brain where the stimuli can be evaluated, contextualised and made accessible for cognitive control (B. D. Perry, Pollard, Blakley, Baker, & Vigilante, 1995).

Brain plasticity
Plasticity covers in general the mechanism of all learning and adaptations. This is reflected in changes of connectivity between existing neurons, the expansion of existing neurons, and the growth of new neurons (Cozolino, 2009), or, in other words, how individual experiences integrate into brain structures (Smith, 2010). Further, plasticity is explained by two mechanisms of the experienced based synapse connections (Greenough & Black, 1992). The first, experience- expectant processes refer to critical periods, or open windows during a specific period, were certain experiences results in irreversible changes (Knudsen, 2004). During this period, genetically coded synapses are sensitive to minimal stimulation, while stress and overwhelming experiences may lead to elimination of existing synapses (Siegel, 2001). One example of an experienced- expectant process is the development of the visual function (Knudsen, 2004). The second mechanism, experienced-dependent processes refers to the uniquely individual influence of internal and external (environmental) experiences on brain development and maturation (Sheridan & Nelson, 2009). This mechanism is a life long process, but the first years of life are considered as sensitive because of rapid development of neural system and brain organisation. The term "The use dependent brain", introduced by Perry and his co-workers, refers to these mechanisms (B. D. Perry, et al., 1995). Stimulation or lack of such will modify the neural networks of the brain depending on its use.

First, there is a genetically based overproduction of neurons in the fetal period and synapses during the first 3 years in infancy (Siegel, 2001). Then there is a process of pruning in which unused connections are removed while synapses and paths that has been strengthened by repeated experiences are preserved and further developed (Cicchetti & Tucker, 1994). Schatz (1992) describes the same process by saying that "Cells that fire together wire together" (p. 64).

In a practical sense this means that experiences that appear to impact neural development during the first year of life is mainly mediated by the caregiver- child relationship (Sheridan & Nelson, 2009). An infant who repeatedly experiences that his or her need for comfort or good communication are met will subsequently experience the caregivers' particular touch, sense the particular intonation in her voice and particular words that she others during such temporal- emotional experiences. The infant's behaviour are dominated by sub-cortical activity, but experiences such as the caregivers stimulating responses to the child's primitive social behaviour and the caregivers sensitive tactile and vestibular stimulation, give a jump start to the socio-emotional development and attachment processes, and to the organisation of motor networks (Cozolino, 2009). As the child grows and extends his or her spheres of exploration, other experiences outside the intimate relationship may directly affect the child (Sheridan & Nelson, 2009); also explained by the plasticity of the brain.

Connections and networks may be changeable, and underdevelopment of neural structures or oversensitised neural circuits may be reversible. According to Perry (2006) neural systems can be changed, but some systems are easier to change than others. Modifications of the regulatory system are much less likely than modification of cortically mediated functions.

The role of early relationship and affect regulation

Already from conception, the child is embedded in relationships with others who provide nutrition for both physical and psychological growth (Sameroff, 2004). During infancy, the caregiver provides the infant with physiological, behavioural and emotional regulation. The concept of good- enough parenting captures how parents sensitively attend to the infants signal of distress, fear, hunger and displeasure, and then help the small child back into a regulated state (Cozolino, 2009). Caregivers help the infant to calm down and fall to sleep, they sooth when the infant is crying, and the infant can not survive without the caregivers regulatory behaviour. However, even if the infant is 100 % dependent of the parents care, the infant is born with social skills to interact with an other social being (Trevarthen, 2001). Thus, good- enough parenting also involves the caregivers' ability to take part in emotionally attuned interaction with the infant. These reciprocal affective exchanges give the opportunity to share the relational moment and "match" one own biological rhythm with the caregiver (Feldman, 2007). However, it is only short periods during parent-infant interaction that is really reciprocal regulating. In fact, early social interaction shifts between being mutually regulating and de-synchronised. The shifts between mutually regulation, dysregulation and re-establishment of regulation with help from caregiver are developmentally important stress experiences, because it stimulate the infant to develop strategies to handle relational challenges (Tronick, 1989). In a longer perspective the caregiver's resonance with the infant's internal state and the labelling of the infants feelings, enhance the integration of networks dedicated for language and emotions, but also the development of self- regulation (Cozolino, 2009).

Attachment, the emotional bond between the infant and caregiver, develops from birth (Bowlby, 1969). The infant's relational experiences with primary caregiver develop into certain expectations about the caregiver's availability in various situations (Smith & Ulvund, 2004). An infant with relational experiences of an available, sensitive and responsive caregiver develops secure attachment (Siegel, 1999). And secure relational experiences help the small child to construe the caregiving environment as a secure base to explore from, and make predicable association about the past, present and future (Fries, Ziegler, Kurian, Jacoris, & Pollak, 2005). The development of attachment is closely related to reciprocal emotional interaction during infancy, and to the development of self- regulation. Early social relational experiences servs as the fundamental learning about the safety or dangerousness of the world (Cozolino, 2009).

Relevance for the understanding of complex trauma

The research areas addressed above are general sketches of cornerstones in our current knowledge of normal child development. As complex trauma in most cases involves harm caused by caregivers (B. A. van der Kolk, 2005), the same issues have become central in our understanding of a traumatising course of development as well. In some sense, complex trauma may be conceptualised as a dramatic disruption of the same processes a normal and healthy child-caregiver interaction normally promote.

First, bearing in mind that the brain is "use dependent", and that the development of secure attachment and self-regulation are supported by attuned activation level during parent-child interaction, both overstimulation and understimulation during the first years can lead to underdevelopment of certain neurological connections or strengthening of neurological networks that put the child in an alarmed state (Hart, 2006). Exposure to a traumatic event for young children is a complex issue because of the child's limited capacity to judge and understand the threat, and its need to rely on their its caregive

(Schechter & Willheim, 2009). However, when a child experience domestic violence, the violence may be traumatic in its nature, but additionally harmful is the lack of a secure base to seek comfort to during and after the violent episode (Lieberman & Van Horn, 2005). Repeated episodes of domestic violence leave the child in an anxious state, left alone to handle the regulation of the distress because of an absent caregiver (Robinson et al., 2009). Such frequent exposures may lead to compromised self- regulatory abilities (Shipman, Schneider, & Sims, 2005), leaving the child with shifting and ambivalent feelings and behaviour (Cloitre, et al., 2009; Terr, 1991). A fearful brain involves both the fast automatic processes with amygdala as a core function/system and later in development the slower hippocampal-cortical network. These systems reflects both top- down and left- right circuits, which may be dissociated under prolonged stress (Cozolino, 2009).

Moreover, complex traumatised children are kept in lasting preparedness (Eide-Midtsand, 2010). Neurobiologically this implies over-stimulation of the brains "alarm system" (amygdala and parts of the limbic system) (Stien & Kendall, 2004), disturbance of the regulation of stress-hormones, and sensitisation of neural-networks that identify danger and mobilise to self-defence. Simultaneously the connection between these basic brain structures and cortical areas involving language and reasoning are underdeveloped (J. Ford, 2009). For a child exposed to chronic and repeated forms of traumatic stress, this means that the alarm response is set off more and more easily, while the ability to understand the threatening signal in its broader context and gain cognitive control over the affective response, is becoming equally suppressed. A way to see it is that the child's brain has become "threat-oriented" and designed for survival, rather than for explorative learning (Ibid.). As a result, a child who has been living in a threatening home environment may react with aggression or another survival response to an event which another child would perceive as neutral, without being able to understand or explain why.

Practical and clinical implications

Implication for assessment
The patterns of symptoms shown in accordance with complex traumatisation exceed existing trauma diagnosis such as PTSD. Improving the assessment of complex traumatisation has to involve sensitivity for its span of symptoms and openness to other diagnosis than PTSD as indicators of trauma. Based on the argumentation in this article, the patterns of symptoms clustered around issues of regulation are of crucial importance in understanding complex traumatisation. Among the available briefer trauma instrument's Briere's Trauma Symptom Checklist for Children (TSCC) (J. Briere, 1996) captures some of the developmental and neurobiological challenges discussed in this article. For a more comprehensive assessment, the Child Behaviour Checklist (CBCL) (Achenbach, 1996) may also be useful if the notions presented are taken into account. Still, we are short of an accurate assessment-tool for complex traumatisation, and improvements in this regard have to be done in order to formulate early interventions based on an accurate understanding of the matter. Without a matching problem formulation and assessment-tools adjusted interventions for complex traumatisation is far at reach.

The evolving trauma perspectives discussed in this article have contributed to international efforts of renewal of measures and diagnostic frameworks (B. A. van der Kolk, 2009). An extensive initiative to systemise the common denominators for the problems seen in children exposed to offending childhood experiences have been put forward by the Complex Task Force of the NCTSN. The group has proposed a new diagnosis, "Developmental Trauma Disorder", which captures among other things the regulation problems described above, to be included in the next Diagnostic and Statistical Manual of Mental

Disorders (DSM).

The prevalence of complex trauma and the developmental impact of complex traumatic experiences address a larger focus in protecting children from such adversity. Lundén (this issue) points to the key role of well-baby nurses and preschool teachers in identifying child maltreatment in children from 0-5 year. This is also well documented by Olds and colleagues, who has evidenced the preventive role of their Nurse Home Visiting Program during pregnancy (Olds, 2006), both in terms of reducing physical abuse and family stress and in terms of long term prevention of addiction problems, psychological problems and juvenile delinquency (Donelan-McCall, Eckenrode, & Olds, 2009; Eckenrode et al., 2010).

Knowledge from neurobiological research informs us that all childhood experiences, favourable or not favourable, interact with the processes of neurological development (B. D. Perry, 2002). This really underlines the need for better identification of those children who suffer from abuse, maltreatment and neglect, but it should also guide the way clinicians and professionals' form intervention programmes and treatment. So, besides offering individual treatment, it is equally or even more important to intervene in the child's caregiving system (see also Muntean, this issue, and Lehmann and Nordanger, this issue).

Caregiver's (biological, foster or adoption) need to learn to understand the child's problems in light of the child's traumatic experiences and its impact on child development. Bruce Perry (2001) suggest several ways that caregivers can provide parenting which also increase positive bonding; Even if the child is above infancy, it should be held, rocked and cuddled as replacement experiences for what was missed during infancy. Such stimulation enhances the deeper neurological structures for emotional regulation (B. Perry, 2009). This emphasises also the importance of meet-ing these children in correspondence with their emotional age. Further, caregivers who can understand and "read" seemingly odd or distorted behaviour as being the strategies the child developed to in order to adjust to its prior caregiving environment, will also be better equipped to support the child with new, more appropriate strategies. Developing new appropriate strategies can also involve that caregivers' model and teach appropriate behaviour in their own way of being while explaining to the child what they are doing. Also, it is important to time to time just to be together; Play and quiet interactions set a stage in wich caregivers are better able to reach into the child and explore and teach about feelings (B. Perry, 2001). Perry also underline that caregiver should have realistic expectation, and be aware that the progress is typically slow.

Many children who suffer from complex traumatisation are in need of individual treatment. Even if trauma-focused cognitive behaviour treatment (TF-CBT) is recommended as an evidence based treatment for posttraumatic stress (NICE, 2005), clinicians should be aware that children who have suffered from trauma and maltreatment in a prolonged period may neuro-developmentally be too immature to benefit from intervention that rely on neocortical skills (B. Perry, 2009). Stien and Kendall (2004) put forward three essential phases of trauma therapy, based on Judith Herman's work on adult survivors from childhood abuse. First of all, before beginning therapy, the child must be safe from abusive or otherwise perpetrating adults. Phase 1 focuses on stabilization and psycho- education, phase 2 focuses on symptom reduction and memory work, while phase 3 focuses on developmental skills. There is fluidity between the phases, and the therapist should do assessment throughout the therapy. By doing this, the therapist incorporates new information, corrects hypothesis, and evaluates the effectiveness of his own intervention. Stien and Kendall (2004) underline that the therapist should try to understand the effect of trauma

on the child's overall personality, and understand the child's strategies for emotional regulation, how he/she finds comfort, its patterns of arousal, its somatic complains, and more. Based on the individual assessment, the clinician should also consider how long and how frequent every treatment session should be (B. Perry, 2009). Some children may need to see a clinician more frequently than one session each week, with shorter sessions.

Concluding remarks

Since trauma psychology as a discipline to a large extent has evolved around the PTSD diagnose as a core, the focal shift described in this article toward complex trauma and complex symptomatology, implies challenges to both professional and researchers. We have become sharper when it comes to early detection of children at risk, and we have to rethink the ways we measure trauma symptoms and the ways we treat them. Our current knowledge tells clearly that there is no quick fix for these traumas – no short term intervention which alone can cure the pain. The healing process will take the long term efforts of caring adults in cooperation with specialists. Our assessment tools and treatment models have not yet caught up with what research has identified as the main symptoms and problems to target, but there are contributors to a substantial progress in concerning this issue, amongst them the US Complex Trauma Taskforce working to revise the diagnostic system. At the same time, the evolving trends in the field have brought earlier co-existing disciplines on to the same scene, and it is through the joint efforts of trauma psychology, developmental psychology and neurobiology we have moved forward. This multidisciplinary cooperation should also be reflected in the support system around a complexly traumatised child, where we now realise that the trauma therapy specialist only plays one of the many roles needed. It is only through the joint care carried out by caregivers, teachers, child welfare workers, psychologist and others these children can be helped.

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RESEARCH REVIEW: RISK AND RESILIENCE IN CHILDREN. THE ROLE OF SOCIAL SUPPORT

Cornelia Măirean[1]   **Maria Nicoleta Turliuc[2]**

Abstract

The concept of resilience was developed to describe resistance to psychosocial risk experiences. This paper examines the concept of resilience in the context of victimized children and it presents key studies in the literature that address the interplay between risk and protective processes. Traumatic events experienced in early developmental stages can have lasting effects on the individual; in this context, building resilience is important because children's living conditions are rapidly changing worldwide. Factors that may help children to develop the ability to construct a positive life in spite of difficult circumstances are discussed. These include personality traits, coping strategies, and external factors such as school and availability of supportive relationships. Much research on resilience among children had found a positive relationship between social support and resistance to a variety of risk factors. In this article, we argue the pivotal role that social support (especially from family and school) plays in building the capacity for resilience. The implications of resilience research on understanding the process of positive adaptation within the context of adversity are discussed.

Keywords: Resilience, children, social support

Rezumat

Conceptul de rezilienţă a fost dezvoltat pentru a descrie rezistenţa la experienţele cu risc psihosocial. Acest articol examinează conceptul de rezilienţă în cazul copiilor victimizaţi şi prezintă câteva studii cheie din literatura de specialitate care abordează atât factorii de risc cât şi pe cei protectivi. Evenimentele traumatice trăite în stadiile timpurii de dezvoltare pot avea efecte de durată asupra individului; în acest context, a construi rezilienţa copilului este foarte important deoarece condiţiile de viaţă ale copiilor se schimbă rapid peste tot în lume. Sunt discutaţi factori care pot ajuta copiii să-şi dezvolte abilitatea de a-şi construi o viaţă pozitivă în ciuda circumstanţelor dificile. Aceştia includ trăsături de personalitate, strategii de coping precum şi factori externi cum ar fi şcoala şi relaţiile sociale suportive şi disponibile. Numeroase cercetări în rezilienţa copiilor au dezvăluit o relaţie pozitivă între sprijinul social şi rezistenţa la o varietate largă de factori de risc. În acest articol aducem argumente pentru rolul de pivot al sprijinului social (mai ales al celui venit din partea familiei şi a şcolii) în construirea capacităţii de rezilienţă a copilului. Se discută şi rolul cercetării în rezilienţă în înţelegerea

[1] MA, PhD student, Alexandru Ioan Cuza University, Faculty of Psychology, Romania, Email: amariei.cornelia@yahoo.com;
[2] PhD/Professor, Alexandru Ioan Cuza University, Department of Medical Psychology, Romania, Email: turliuc@uaic.ro.

procesului adaptării pozitive în contextul unor adversități.

Cuvinte cheie: Reziliență, copii, sprijin social

Introduction

The purpose of this article is to review research on children resilience, first looking at historical development on the concept of resilience itself, then examining factors that promote children resilience. We focused on presenting the pivotal role that social support (especially from family and school) plays in building and maintain the capacity for resilience.

Resiliency theory is a theoretical perspective that has been developed within developmental psychopathology and ecosystems perspective. In 1979, Kobasa introduced the concept of ''hardiness'', which has been defined as a stable personality resource that consists of three psychological attitudes: commitment, challenge, and control. Commitment is the ability to make positive reinterpretation of critical situations; control refers to the belief that individuals can influence the course of his live, and challenge refers to a belief that fulfilment in life results from the wisdom gained from difficult experiences (Maddi & Khoshaba, 1994).

The concept of resilience was developed to "describe relative resistance to psychosocial risk experiences" (Rutter, 1999b, p. 119). Richardson (2002) defined resilience as the process of coping with adversity that contributes to the development and enrichment of protective factors. According to Vanistendael (1995), resilience consists of two components: resistance against destruction (as a person's capacity to protect his or her integrity under stress) and the ability to construct a positive life in spite of adversity. Traditionally, resilience has been conceptualized as an individual trait (Block & Block, 1980) that helps a child achieve desirable emotional and social functioning despite exposure to negative life events (Rutter, 1985). More recently, the term ''resilience'' has been used in the context of acute trauma, such as combat, accidents, assault, or natural disasters. In this context, resilient individuals are those who experience a trauma but do not develop *post-traumatic stress disorder* (PTSD). A study showed that about 50–60% of Americans are exposed to significant traumatic events over the course of their lifetime, and only 8–20% of those exposed develop PTSD (Kessler, Sonnega, & Bromet, 1995). This findings support the idea that individuals have the ability to sustain their abilities under threat and the capacity to recover from traumatic life events. In this context, we can talk about a process of resilience.

Vulnerability factors and protective factors are core constructs of resiliency theory. Risk factors have been conceptualized as conditions of adversity and factors that reduce resistance to stressors. Protective mechanisms may operate in several ways, according to Rutter (1987): by reducing risk impact, by reducing negative reactions to risk factors, by promoting resiliency traits (i.e., the opposite of vulnerability factors), and by setting up new opportunities for success. Protective and risk mechanisms can vary according to the type of adversity, type of resilient outcome, and life stage under analysis; protective factors in one context may be vulnerability in another (Rutter, 1999).

The term "resilience" has also become known through Werner's work on healthy growth of adolescents and adults despite unfavourable developmental conditions. Werner discovered that, at least during sensitive periods of their development, children had to be supported by an empathic and caring adult (Werner, 1990). Werner and Smith's longitudinal study of 698 infants, many of Hawaiian and Asian descent, provided a major empirical basis for the beginning of resiliency development (Werner & Smith, 1992). Resilience has been associat-

ed consistently with positive outcomes even in those experiencing significant adversity (Masten & Coatsworth, 1998). Based on theoretical definitions of resilience, two conditions are required to identify this process: exposure to adversity and positive developmental outcome (Masten & Coatsworth, 1998). Most of the early research on resilience focused on children at risk. Researchers followed these children over many years and measured their emotional disposition, mental health, social, economic, and occupational status. They identified variables that seemed to promote health and wellbeing (Werner & Smith, 1982). A good illustration of longitudinal research is Rutter's work with mental disorders and with institutionalized Romanian children (Rutter et al., 1990).

Previous studies looked at external situations and examined their effects on individuals. As examples, researchers were concerned about the effects of environmental conditions (such as dangerous neighbourhoods, poverty, single parenthood, parental illness, etc.) on child development. Resilience researchers also focused not only on the environment in which a child lives, but looked at internal processes of the child, at his personality traits.

Research on resilience among children, adolescents, and young adults has found a positive relationship between social support, income, social capital, spirituality, personal/family traits, and resistance to a variety of risk factors, such as psychiatric disorders and school failure (Masten & Coatsworth, 1998; Richardson, 2002). From all these research, several conclusions can be drawn: (a) multiple risks and protective factors may be involved during the lifespan, (b) children may be resilient in some situations but not in others, and (c) factors that are protective in one context may not be so in another context (Lynch, 2003; O'Donnell, Schwab-Stone, & Muyeed, 2002).

Resilience factors for children

We will review some of the factors associated with children resilience. Research has highlighted the protective potential of a range of child characteristics, such as high intelligence, easy temperament, self-mastery, planning skills, internal locus of control, good coping skills, and an easy going temperament (Rutter, 1985, 1987; Masten & Powell, 2003). Garmezy, Masten, and Tellegen (1984) studied children with behavioural disturbance, as well as children of mentally ill parents, for more than 10 years. They stated that three types of factors in children at risk promote resilience: (1) temperamental or dispositional factors of the individual, (2) family ties and cohesion, and (3) external support systems (Garmezy, Masten, & Tellegen, 1984). The first category, temperamental factors, includes characteristics such as intelligence, sociability, self-efficacy, locus of control, self-esteem etc. The *results* of *previous* studies that analyzed these *factors* were *inconsistent.* For example, a number of studies have found that intelligence is associated with resilience (Garmezy et al., 1984), whereas other studies have indicated that in times of stress, intelligence can be related to vulnerability; the explanation for this latter finding is that intelligent children may have a higher sensitivity to certain types of stress (Luther, 1991). Another factor from the first category is sociability (Garmezy et al., 1984). Luther (1991) examined several aspects of sociability in adolescents and found that the most significant protective effect resulted from social expressiveness or verbal fluency of communication. Two factors that also fall under this descriptive category are an internal locus of control and the self-esteem (Luther, 1991; Werner & Smith, 1982). Internal locus of control is a belief that may influence a person to make more active attempts to overcome difficult situations (Luther, 1991). Self esteem refers to a sense of self-worth. For example, Zimrin (1986), who followed abused children over 14 years and at follow-up, found that subjects who scored higher on the positive measures of functioning at follow-up had higher self-esteem as children. Rutter (1987) considers that self-esteem is enhanced by

close relationships with others, such as parents or other family members. Luther (1991) studied inner-city adolescents under stress, and assessed later academic and interpersonal functioning. She found that a belief in an internal locus of control was protective against stressful life events. This finding has been replicated in other studies (Werner and Smith, 1982; Zimrin, 1986). The second and third types of factors listed by Garmezy et al. (1994) involve ties to family and other social support systems, such as school or church. Characteristics of these factors include a feeling of warmth and closeness in the family or other social structure, along with the presence of a caring adult, including a neighbour, parents of peer, or a teacher.

Masten (2001) followed 205 children and families for several years. She's work revealed that young adults that demonstrated resilience had shown the following characteristics in childhood: good intellectual and attention skills, agreeable personality, achievement motivation and conscientiousness, lower stress reactivity, parenting quality, positive self-concept. These characteristics are manifestations of interaction between biology and the environment.

Ungar and Brown (2008) also identifies a number of factors that promote youths' resilience. These factors include the following: material resources, supportive relationships, development of personal identity, experiences of power and control, adherence to cultural traditions, experiences of social integrity, and experiences of a sense of cohesion with others. Cortes and Buchanan (2007) conducted a narrative analysis of child soldiers from Colombia after experiencing armed combat. They consider that six themes of resources are central for facilitating the ability of these children to overcome the trauma of war: (a) a sense of agency, (b) social intelligence, empathy, and affect regulation, (c) a sense of future, hope and growth, (d) shared experience and community connection, (e) a connection to spirituality, (f) and morality.

In addition to the individual attributes described, a number of aspects of the environment were also important in promoting and sustaining resilience. These aspects include a supportive adult, social networks, and mentors within the community. The interaction between individual characteristics and environmental characteristics provide an important support for developing future strengths-based interventions (Cauce, Stewart, Rodriguez, Cochran, & Ginzler, 2003).

Social support
Many studies indicated that social support, a good relationship with parents and peer are all associated with wellbeing in children and adolescents (Kliewer, Murrelle, Mejia, Torres, & Angold, 2001) and with fewer symptoms of posttraumatic stress disorder in children exposed to violence (Salami, 2010). Kuterovac-Jagodic (2003) found that poor social support was a main predictor of posttraumatic stress symptoms for younger children, particularly those symptoms that persisted months and years after the exposure to trauma. An important study (Henshaw & Howarth, 1941) of children during the British evacuations of World War II concluded that, for children, exposure to air raids caused less emotional strain than evacuation and the subsequent family separation. The ability of the caregiver to help the child make meaning of negative events is critical in the child's process of adjustment. Particularly for children, the process of interpreting the negative experiences is characterized by a dynamic interaction whereby the child looks to the reaction of immediate caregivers as a means of interpreting the threat (Ainsworth, Blehar, Waters, & Wall, 1978). For helping children in need is very important to have an empathetic attitude towards the child, to recognize his emotions and to help children talk about their feelings (Pretis & Dimova, 2008).

Social support is usually defined in terms of its source, structure and function. Sherbourne & Stewart (1991) have outlined three

main dimensions of social support: instrumental support (assistance to carry out necessary tasks), informational support (guidance for an individual to carry out activities successfully), and emotional support (caring and emotional comfort provided by others). Researchers have noted the importance of distinguishing between support received from different sources, such as family, peer and significant others (Llabre & Hadi, 1997). The role of social support for children exposed to adversity may differ according to sources of support and according to child's gender. Boys and girls may have different responses to social support received from significant others. For example, to have a positive relationship with a family member may be more indispensable for girls, while a positive family climate may be more important for boys than for girls (Vanderbilt-Adriance & Shaw, 2008). Llabre and Hadi (1997) studied 151 girls and boys exposed to trauma during the Gulf War crisis and observed interactions between social support and gender. They found that, overall, girls reported higher social support compared to boys and social support moderated the impact of trauma exposure on distress in girls, but not in boys. Sources of social support and dimensions of the child's environment (parental warmth, presence of non-parental caretakers, informal sources of emotional support, peer relationships, rules in the household, shared values, access to services) are external protective factors that promote resilience (Cove, Eiseman, & Popkin, 2005). Parents, families, schools, communities, and nonfamily adults are essential elements for building resilience in children and adolescents (Brooks, 2006).

We will further discuss the importance of family and school in children's development. Previous research has outlined the role of these variables in children's life. From example, O'Donnell, Schwab-Stone, and Muyeed (2002) found that both parents and school support were significantly positively associated with resilience in children who had been exposed to community violence.

Family support
Family plays a huge role in the child's life, during the developmental stages. Family dynamics include leadership, decision-making, communication, flexibility, cohesion and support system. Thus family is the best resource available for children whenever there is a problem. This is the reason way one of the most well studied protective factors for children exposed to stress and trauma is effective parenting (Howell, Graham-Bermann, Czyz, & Lilly, 2010).

Initially, resilience was viewed as a personal trait that allowed individuals who are at risk or threat of loss to adjust and continue to have a normal live despite adversity (Masten & Coatsworth, 1998). More recently, Drummond and Marcellus (2003) describe resilience as the outcome of the relationships or interactions between individual, families and communities. The protective effect of family relationships was supported and by previously research (Bifulco, Brown, & Harris, 1987). The presence of one warm supportive parent can help buffer the adverse effects of poverty, divorce, family conflict, and child abuse (Luther & Zigler, 1991). Risk factors, as childhood disability, did not necessarily predict long-term negative outcomes if family and community support are strong. Conversely, a strong sense of self-esteem and self-efficacy which are known protective factors did not necessarily protect children from risk. Moreover, although some internal factors are associated with resilience or non-resilience, these relationships were mediated by environmental influences (Johnson & Howard, 2007). Leon, Ragsdale, Miller, and Spacarelli (2008) also studied parental practices and they conclude that there is a positive association between positive changes in trauma symptom checklist scores and positive parenting practices.

A person who is identified as resilient at one point in time is not resilient forever (Masten & Powell, 2003). The family plays an important role in building children resilience and in the prevention of risky behaviour (Veselska

et al., 2008). The extended family unit is also important and includes parents, brothers/ sisters and grandparents. Siblings can have an essential protective role in children's adjustment over time, by pleasing the social needs of children and providing an additional source of support (Bowes, Maughan, Caspi, Moffitt, and Arseneault, 2010). Building resilience is important because enables children to master current and future challenges. Growing numbers of children are exposed to serious threats to their physical and emotional wellbeing that are inherent in many contemporary societies. Parents play a fundamental role in building the capacity for resilience, by providing a supportive family environment. The model of family functioning described by Olson, Russell, and Sprenkle (1989) identify three characteristics of healthy families, which are: cohesion (which facilitates togetherness), adaptability (balances flexibility and stability) and open, consistent communication. Research studies demonstrate that healthy families solve problems with cooperation, creative brainstorming, and openness to others (Reiss, 1980). In addition, having the ability to reach out to others for support appears to be a characteristic of resilience, both in individuals and in families. In terms of family dynamics, resilient families are less reactive; they employ creative brainstorming when difficulty arises and they express openness to others. For the family, many of the protective factors are clearly associated with the consistency and quality of care and support the individual experiences during infancy, childhood and adolescence.

Early ideas about building resilience through proper parenting are evident in the authoritative education style concept. There is a large body of literature on the relationships between parenting and child well being. Maccoby and Martin (1983) based on their research on preschoolers, identified four parenting styles. The researchers found that parents of mature preschoolers differed from others by using a set of authoritative child-rearing practices. They were controlling and demanding, had high expectations for mature behaviour, and firmly reinforced them by using commands and punishment. At the same time, they were warm and encouraging, listened patiently and sensitively to their youngsters' points of view, and encouraged children's input in family decision making. Baumrind (1966) has emphasized that the rational and reasonable use of firm control makes authoritative child rearing effective in producing positive consequences for children's development. Children have a tendency to internalize such fair parental control strategies. Nurturing, non-permissive parents who are secure in the standards that they hold for their youngsters provide children with models of caring and concern for others. Adolescents with a role model (family or teacher) were more likely to engage in positive health behaviours, in comparison with those without a role model (Yancey, Grant, Kurosky, Kravitz-Wirtz, & Mistry , 2011). Lamborn et al. (1991) found that authoritative parenting practices are associated with the highest levels of competence and the lowest levels of problem behaviour, while authoritarian, permissive, and careless parenting styles were all associated with higher rates of problem behaviour. Warm family relationships and positive home environments were associated with both emotional and behavioural resilience (Bowes et al., 2010). Zakeri, Bahram, and Maryam (2010) also investigated the relationship between the parenting styles and resilience. The results of their study showed that there was a positive and significant association between acceptance-involvement parenting style and resilience. More specifically, warmth, supporting, and child-centred parenting style were associated with the development of resilience. Better parenting practices and better maternal mental health are significant predictors of children's resilience (Howell et al., 2010).

Graham-Bermanna, Grubera, Howell, and Girzb (2009) conducted a study to explore factors that differentiate children with poor adjustment from those with resilience. They found that effective parenting behaviours,

such as using appropriate discipline and setting limits may protect children by providing positive role models. Children who do not share problems with parents and who have feelings of being overly controlled by parents had higher levels of delinquency (Mukhopadhyay, 2010).

Attention to attachment relationships is critical in understanding how children cope in the face of adversity. The separation of a parent and child during a disaster can be very stressful to the child (Peek & Stough, 2010). A mother who is better able to maintain a positive parent–child attachment, may be better able to support her children in mastering developmental tasks (Howell et al., 2010). Some authors have argued that the psychological effects of violence on children may be more dependent on the availability of close, reliable attachment figures to provide support during and following difficult events (Garbarino, Kostelny, & Dubrow, 1991). An attachment figure could be the mother, but in many cases could be another significant person, such as a grandmother or a sister. Less resilient children often lacked strong attachments and social bonds. While the primary caretaker is an important factor in buffering stress and trauma for children, other family members can also protect a child from negative consequences of adversity. In her study of children at risk, Werner (1990) found that secure attachments in infants were related to the presence of a supportive family member, but not exclusively the primary caretaker. The extended family can encourage coping behaviour, and can provide positive models of identification.

Although family is an important source of support for children, it is also and a source of vulnerability. Family risk factors for children include a single-parent household, the family's poverty, illness of parents, parent's psychiatric disorder, foster placement, death of parents or grandparents, physical, emotional, or sexual abuse, parental divorce, remarriage of parents, etc. Some of these factors (such as

divorce) could have implications for children even in their adulthood (Das, 2010). Nevertheless, in many cases, risk factors have an important role in building resilience, because without difficult, stressful situations, there is no chance to develop and manifest resilience. Although the idea of identifying risk factors to poor children development has gained widespread acceptance, we consider that the presence of a risk factor is not a guarantee that a negative consequence, such as lack of discipline, school failure or others behaviour problems, will inevitably occur. With all these risks in their lives, most children who grow up in families with many challenges do overcome the difficulties and manifest resilience. Feldman, Stiffman, & Jong (1987) stated that the social relationships among family members are by far the best predictors of behavioural outcomes in children. But family is not the only source of social support. School increase in importance in children's life, as time goes by. A large longitudinal study of resilience in urban children in the United States found that parent support was a strong predictor of resilience (self-reliance, lower substance abuse, better school adjustment, and less depression) but became less important over time, while school support became more important as children became older (O'Donnell et al., 2002).

School support
An important source of external protection can be school. School-related factors (positive school environment, positive school attitude, good relationships with teachers and peer, after school activities) become relevant for school-aged children (Eriksson, Cater, Andershed, & Andershed, 2010). Children in disadvantaged families are more likely to demonstrate resilient characteristics if they had good relationships with peer and if they attend schools that have good academic record and caring teachers. In some cases, school environment can compensate a dysfunctional family environment. In the absence of supportive conditions in the home environment, the school is considered the next resource that should be

available for children in need (Mampane & Bouwer, 2011). There are studies that have noted the importance of school integration as a protective factor for children (Panter-Brick, Goodman, Tol, & Eggerman, 2011). Brackenreed (2010) agrees that schools should offer opportunities for children to establish good relationships with adults and should ensure that they do not make the situation worse by using faulty practices.

Like family environment, school can be a source of support or a source of stress. School risk factors may involve inappropriate curriculum, weak and inconsistent adult leadership, lack of clarity in rules and policies. All these risk factors may contribute to the strengthening of others abilities.

Teachers play an important role by supporting caring relationships, ensuring that school is a positive experience, and promoting the self-esteem of children and young people. The experience that children have at school helps them to overcome difficulties and to build their self-esteem. Supportive relationships with teachers are important predictors of the psychological wellbeing of traumatized children (Vernberg, Silverman, La Greca, & Prinstein, 1996). Teachers can facilitate discussions about the personal experiences, taking into account the developmental level of their students. They have the difficult task of understanding their students emotionally and of providing them support by listening them, validating their feelings, and by demonstrating empathy and respect (Macksoud, 1993). Teachers' high expectations can structure and guide behaviour, and can also challenge students beyond what they believe they can do. In discussing ecological approaches to interventions for children affected by war, Elbedour, Bensel, and Bastien (1993) emphasized the importance of schools in ameliorating trauma effects. In crises, educational activities have been considered as an important source of social supports to children. Success in school enhances self-esteem, improves coping abilities (Kos & Derviskadic-

Jovanovic, 1998), and provides a lower level of isolation and withdrawal (Vernberg et al., 1996). Gilligan (2002) emphasizes the importance of encouraging resilience and positive qualities such as self esteem in young people who have been abused. He points out ways this can be achieved, in particular through the child's relationship with a teacher. Bickart and Wolin (1997) present a model of how a teacher can practice resilience in the primary school classroom. This model includes the fact that children (a) are involved in assessing their own work and in setting goals for themselves, (b) have many opportunities to work collaboratively, (c) participate in meetings to solve classroom problems, (d) children have opportunities to make choices, (e) feel connected in a classroom structured as a community and (f) play an active role in setting rules for classroom life. Hanewald (2011) consider that teachers and school leaders have an important role in identifying and optimizing the most successful intervention strategies and programs for children. Other studies have also shown the important role that teachers can play in resilient children's lives (Werner & Smith, 1992; Daniel, Vincent, Farrall, Arney, & Lewig, 2009). A number of researchers have pointed to the fact that positive peer relationships may contribute to resilience (Davis, Martin, Kosky, & O'Hanlon, 2000). Positive peer role models are significant protective factors for children. One study showed that providing youth with role models was especially helpful to youth in foster care (Yancey, 1998). In a study of African American children exposed to community violence, family support was found to be important only in reducing anxiety, teacher support was linked only to social competence in the classroom, while peer support had an effect on both anxiety and classroom social competence (Hill & Madhere, 1996). Waaktaar, Christie, Borge, and Torgersen (2004) reported that young people with stressful background experiences demonstrated resilience when they had positive peer relations, self-efficacy, creativity, and coherence.

Conclusion

In this article, we focused on children's weakness and resilience in the wake of psychological trauma. Resilience refers to doing well, despite difficulties. The research points out that the behaviour associated with the term is not simply part of someone's personality, it is not something some people are born with and others are not born with. The term refers to an ability to rise above adversity and come out the better for it. A history of prior exposure to trauma, such as child abuse, is generally associated with the development of more severe PTSD symptoms after a new trauma (Fullerton, Adams, Zhao, & Johnston, 2004). The impact of the stress depends on when the individual experiences it. Resilience research, studies of normal development and psychopathology, all highlight the importance of early childhood for establishing positive relationships and healthy development. Similar to the findings in the adult resiliency research, multiple studies of childhood trauma have found that perceived social support and family cohesion are associated with greater resilience (Koenen, Goodwin, Struening, Hellman, & Guardino, 2003). During the early childhood years, it is important for children to have adequate nutrition and opportunities for learning, and community support for families, to facilitate positive development of cognitive, emotional, and social skills. Young children with healthy attachment relationships and good internal adaptive resources are very likely to succeed in life. Children typically manifest resilience in the face of adversity, as long as their fundamental protective skills and relationships continue to operate and develop. The greatest threats to young children occur when key protective systems and network support are harmed or disrupted. In early childhood, it is particularly important that children have the protections afforded by attachment bonds with competent and loving caregivers. The way children respond to stress may either promote growth and a sense of efficacy or cause behavioural, social, academic, or psychosomatic problems. Resilience research identifies external factors and internal characteristics of those children that develop the capacity to succeed under stressful conditions and recover after they have experienced loss. Social support is an external factor and comes from friends, neighbours, and teachers, who encourage self-esteem and promote competence. Children need coherent experiences and the help of significant others to meet new demands and to cope with new difficulties. Although negative events can disrupt significant social relationships, some social networks are able to maintain children's belief that they are secure and cared for. Resilience will be enhanced if children are able to build and maintain relationships that are pleasurable and rewarding. Children may be resilient to some kinds of environmental risk experiences but not to others. Resilience can also change over time, according to the child's developmental stage and subsequent experiences. Resilience can be enhanced by encouraging positive environments within families, schools and communities, in order to neutralize risks in children's lives. Of these three environments, the family is the most immediate care-giving environment and has the greatest impact on the development of resilience in children (Brooks, 2006). However, school, peer and neighbourhoods also have an important impact on children. As necessitated by an ecological approach, future research on protective factors impacting the wellbeing of children must explore contextual factors across the family, community and societal levels (Chatty & Lewando Hunt, 2001). More studies regarding gender differences in protective factors are also needed (Eriksson et al., 2010). The purpose of the article was to show that, by understanding the role of support from family, peer and school in children's live, people can gain knowledge and can help other children to continue more meaningful lives despite a significant loss. In addition, that knowledge may inform and inspire the adults to choose appropriate education practices for children. The way risk and protective factors interact to produce positive or negative outcomes at different stages of a child's development is

complex and not always clearly understood. In conclusion, our brief review of the children's resilience literature indicates that an important role for children exposed to adversity has the family and school. A caring family or at least one caring adult makes a significant difference in a child development. Our presentation suggests a need for high-quality school activities and supportive teachers that can help and protect children from the hazards of their environment. High-quality programs provide children important opportunities to develop confidence and social skills. A final contribution of this paper has been to facilitate a better understanding of child development, by summarizing risk and especially protective factors in children's life. Children and youth who demonstrate resilience need one or more adults who love and believe in them and remain connected to them in order to provide consistent emotional support. Grandparents, uncles, aunts, friends and teachers have to encourage resilience in children's lives.

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TO IDENTIFY PRESCHOOLERS AT RISK FOR MALTREATMENT

Karin Lundén[1]

Abstract

Swedish well baby nurses and preschool teachers meet almost all children between 0 and 6 years of age. Their ability to identify children at risk for maltreatment is important and they therefore play a considerable role in early detection and prevention of trauma in children. This study is part of a research project conducted in three socio-economically different areas in the city of Göteborg. The aim was to study what signs of maltreatment did well baby nurses and preschool teachers identify in children under their responsibility. The group under study consisted of 12 well baby nurses and 274 preschool teachers. The well baby nurses were responsible for 3 995 and preschool teachers for 1 516 children between 0 and 6 years of age. The results showed that well baby nurses and preschool teachers identified and observed signs of maltreatment in a considerable number of children under their responsibility. There were great differences, however, both between and within the two groups under study. Well baby nurses and preschool teachers in the same area most often did not identify or observe signs in the same children. The signs most frequently observed were signs of physical neglect followed by signs of emotional unavailability in parent-child relation and emotional neglect. Signs of physical abuse were rarely observed.

Keywords: Child maltreatment, prevalence, identification

Rezumat

Asistentele medicale din clinicile de bunăstare a bebeluşilor şi educatoarele pentru preşcolari întâlnesc aproape toţi copiii cu vârste cuprinse între 0 şi 6 ani. Abilitatea lor de a identifica copiii la risc de maltratare este foarte importantă şi joacă un rol esenţial în depistarea şi prevenirea precoce a traumei la copii. Acest studiu reprezintă o parte a unui proiect de cercetare realizat în trei arii ale Goteborg-ului, diferite din punct de vedere socio-economic. Grupul aflat în studiu este alcătuit din 12 asistente medicale de la clinicile de bunăstare a bebeluşului şi 274 educatori de copii preşcolari. Asistentele medicale erau răspunzătoare pentru 3995 de copii iar educatorii pentru 1516 copii cu vârste între 0 şi 6 ani. Rezultatele arată că asistentele medicale şi educatoarele reuşesc să identifice semne de maltratare la un număr considerabil de copii aflaţi în responsabilitatea lor. S-au înregistrat însă mari diferenţe atât între cele două grupe, cât şi în interiorul celor două grupe de studiu. Cel mai adesea asistentele şi educatorii dintr-o anumită arie nu identifică şi nu observă semne de maltratare la aceeaşi copii. Semnele cele mai frecvent identificate se refereau la neglijare fizică urmate de semne de indisponibilitate emoţională în relaţia părinte-copil şi neglijare emoţională. Semne de abuz fizic au fost foarte

[1] PhD, University of Göteborg, Department of Social Work, Göteborg, Sweeden, Email: Karin.Lunden@socwork.gu.se

rar depistate.

Cuvinte cheie: Maltratarea copilului, prevalență, identificare

Introduction
Children do develop in relation to their caregiving environment where parents play an important role. Today there is a considerable knowledge about parent's supportive tasks and other factors that have to be present in order to promote a healthy development in children (Lundén, 2010). Studies where children and their families have been followed over a longer period of time have shown that children, who have been abused and/or neglected, are at great risk for developmental difficulties (Sroufe, Egeland, Carlsson & Collins, 2005). Parent's emotional unavailability in the parent – child relation i.e. psychological maltreatment appeared to have more serious and more profound consequences for children's development than other forms of abuse and neglect. To identify children at risk before an eventual deviant development has progressed too far is an important task for professionals working with children and families (Dunst & Trivette, 1997).

In order to improve early identification of children at risk for maltreatment some central research questions are especially interesting. Questions such as what signs can be considered signs of child abuse and neglect and how prevalent are they? Studies of different design have tried to answer the questions.

<u>Studies where adults and young people were asked about experiences in childhood</u>
Bifulco and Moran (1998) interviewed about 800 women in four studies. Among other things they were asked about their experiences of abuse and neglect in childhood. Psychological abuse was according to Bifulco and Moran that parents exploited their children's dependency. Psychological abuse could include everything from occasional humiliation to regular degradation over time. The authors considered it important to make a difference between the character of

the abuse and it's impact on children. The fact that a child's development is at risk is more important than the actual harm. Result showed that psychological abuse was not so frequently prevalent. A possible explanation was according to the authors not only that psychological abuse is difficult to define but also that psychological abuse often occurred together with other forms of maltreatment and therefore will be misleadingly registered. Based on the work of Bifulco and Moran (1998) a national study was conducted in England by the National Society for the Prevention of Cruelty to Children (NSPPC). The aim was to study young people's (18 – 24 years of age) general childhood experiences but also about child abuse and neglect (Cawson, Wattam, Broker& Kelly, 2000). To interview young people about circumstances in childhood turned out to have some limitations. It was not possible for participants to remember incidences of emotional neglect such as protection and supervision early in life. In the study memory problem affected what kind of instances of maltreatment participants possibly could decide upon.

<u>Studies directed towards professionals working with children</u>
In USA several national studies have been conducted where professionals have been asked about prevalence of child abuse and neglect. The latest, the Fourth National Incidence Study of Child Abuse and Neglect – NIS 4 – studied, among other groups, personnel in national health, child national health and child day care. There were several aims in the study. One was to investigate how many children according to professionals were exposed to physical and psychological abuse, physical neglect and/or emotional neglect. Professionals were first educated in criteria for different forms of maltreatment and thereafter asked how many children they considered maltreated and from what kind of maltreatment

they suffered (US. Department of Health and Human Services, 2010). The study concerned children between 0 and 18 years of age and differentiated between if children suffered physical or psychological harm (harm standard) or if they were at increased risk for such harm (endangered standard). Result showed that on the endangered standard level 4% of children were exposed to some form of child abuse and/or neglect. There was an equal gender distribution with some exceptions. More girls than boys were for example victims of sexual abuse while more boys than girls were identified as emotionally neglected. Result showed also that child maltreatment were more common in families with low income than in families with high income. Especially concerning physical and emotional abuse and physical neglect. Maltreatment was more often found in older children than in younger children.

Scandinavian studies directed towards well baby nurses and preschool teachers
Christensen (1999) conducted a Danish study where about 1000 nurses (responsible for children aged 0 to 3 years) were asked how many children they considered at risk for maltreatment and if so what kind of maltreatment they suffered. A questionnaire was used where participants decided if they had observed different signs of physical and emotional maltreatment or not. The signs were concrete and easy for the nurses to observe in their daily work. Christensen differentiated between active and passive physical maltreatment and active and passive emotional maltreatment. She found that in total 1% of all children between 0 and 3 years of age showed at least one sign of active physical maltreatment, 6% of passive physical maltreatment, 5% of active emotional maltreatment and 6% of passive emotional maltreatment. There were fewer younger than older children identified.

In Sweden the prevalence of maltreatment according to professionals was investigated in two earlier studies. One study was direct-ed towards well baby nurses and another towards preschool teachers (Lagergren, 2001; Sundell, 1997). In both studies questionnaires were sent to participants by mail. The participants had to decide according to a criteria list if children were at risk or not. Lagerberg asked well baby nurses all over Sweden how many children they believed at risk for maltreatment and what kind of maltreatment they were suffering. Result showed that 2% of the children between 0 and 6 years of age were at risk for maltreatment. Physical neglect was most prevalent. There were some gender and age differences. Sexual abuse was for example more common among girls and physical abuse among boys. Older children were more exposed than younger children. Sundell (1997) investigated the prevalence of children at risk for maltreatment according to preschool teachers in three socio-economically different areas in Stockholm. Result showed that 3% of the children were considered victims of child abuse and neglect. Physical neglect was most commonly observed in children while physical abuse was rarely observed.

Well baby nurses and preschool teachers as key personnel in the identification process
Swedish well baby nurses and preschool teachers meet almost all children between 0 and 6 years of age. Especially preschool teachers see children almost everyday and they have possibility to observe children in different situations. Together with well baby nurses they have excellent opportunities to identify children at risk for maltreatment. These two groups of professionals can be considered key personnel in the identification process. Therefore it is valuable to know how many children well baby nurses and preschool teachers believe are at risk for maltreatment and which signs of maltreatment they observe among their children under responsibility. In an earlier study in a larger research project were well baby nurses and preschool teachers asked how many children they from a given definition of child maltreatment considered at risk for child abuse and neglect (Lundén, 2004). Result showed that between 7% and

10% of the children well baby nurses and preschool teachers were responsible for respectively were exposed to maltreatment. It became obvious that participants in the same area or in the same day care entity did not identify the same children as children at risk. A reason for this could be that participants reacted differently on signs of maltreatment. In order to enhance the possibility for children and families to get support and help there was a need to further investigate which signs of maltreatment professionals reacted to. The present study is part of the research project mentioned. The aim of the study was to study: (1) which signs of maltreatment did well baby nurses and preschool teachers observe in children under their responsibility, (2) if personnel in socio-economically different areas differ with regard observed signs of maltreatment and (3) if observed signs depend on age and/or gender.

Method

Participants and procedure
All personnel in well baby clinics and preschools in three socio-economically different areas in Göteborg, the second biggest city in Sweden were involved in the study. In total there were 13 well baby clinics in the areas. One well baby clinic was vacant and therefor excluded. In the remaining 12 clinics there were 12 well baby nurses on duty who all participated in the study. In all there were 33 preschools in the areas. Preschool teachers in twenty-eight of the preschools were included in the study. In all 274 preschool teachers participated. Ninety percentages of all children between 0 and 6 years of age were registered in the 12 well baby clinics (n=3995). The participating preschool teachers were all together responsible for 1 516 children between 1 and 6 years of age. All children registered in preschools were also, with exception for the vacant clinic, patients in the well baby clinics. Working with vulnerable children and their families provoke strong feelings (Lundén, 2010). Therefore methods were used that relied on personal contact. A questionnaire,

developed earlier in the research project was used. The questionnaire consisted of background questions, questions about how many children the participants currently believed at risk for maltreatment according to a given definition (earlier described in Lundén, 2004). The part of the questionnaire used in this study consisted of a number of signs of maltreatment listed below[2]. Participant decided in relation to every sign if they have observed the sign in any child under their responsibility. An individual formula for each child was created in order to sum up all signs observed. All participants filled in the questionnaires individually in the presence of research personnel.

Signs of maltreatment
*Signs of emotional unavailability in the parent-child relation ***

- Child is often rejected at the emotional level by parents
- Only to a small extent are parents able to interpret or react on the emotions and signals of the child
- Child is actively ignored by parents
- Child is threatened with loss of parent´s love or loss of important relations
- Parent threatens to leave child or walk away from it
- Child is not spoken to or talked about in an insulting way
- Parents react in a hostile way to the child's needs
- Parents repeatedly rejects the child or do not answer their contact attempts
- Only to a small extent are parents able to "meet" their child on the level where the child is

Signs of emotional neglect
- Parents keep the child at home because they "need to have the child with them"
- Child is restricted from being together with other children and/or adults
- Different and coincidental adults take

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[2] The questionnaire is a refined version of an instrument earlier used in Denmark (Christensen, 1999).

care of the child

- Child has witnessed physical violence against parent/s or other instances of domestic violence
- Child has often been taken care of by drunk or otherwise intoxicated adults
- Family's daily life is characterized by unpredictability*

Signs of physical neglect

- Child cries for a very long period of time
- Child's diapers are not changed when necessary
- Child appears untidy, smelly or dirty
- Child is not dressed appropriately according to season and weather
- Child is extraordinary tired or atonic
- Child does not gain weight without organic reasons
- Child seems not to be properly been taken care of
- Repeatedly, child has not been picked up from day care
- Child is malnourished or get to much food
- Child is neglected in terms of necessary medical treatment when ill or with regard to routine medical check ups

Signs of physical abuse

- Broken arms, legs, ribs etc.
- "unexplainable bruises
- "unexplainable" burns
- Marks from human bites
- Marks after physical punishment
- Strong blushing and skin irritations
- Scratches or abrasions around mouth, genitals

* Some careful examples were given in order to show the direction of the sign.

Results

In all participants observed signs of maltreatment in 386 children. In 280 children who were earlier identified as at risk for maltreatment at least one sign of maltreatment was observed. In addition preschool teachers observed signs in another 106 children who were not earlier identified. These children were not included

when comparisons were made between well baby nurses and preschool teachers.

In relation to all children in the three areas (n=3995) signs of emotional unavailability in parent-child relation (16%) was most frequent observed followed by signs of physical neglect (9%) and signs of emotional neglect (6%), Signs of physical abuse were rarely observed (0.6%). Most of the children showed signs in more than one category. In order to elucidate which, and how many, signs of maltreatment well baby nurses and preschool teachers observed, signs were categorized as signs of

EmUn	emotional unavailability only
EmNe	emotional neglect alone or in combination with signs of emotional unavailability
PhyNe	physical neglect alone or in combination with signs of emotional unavailability and/or emotional neglect
PhyAb	physical abuse alone or in combination with signs of emotional unavailability, emotional neglect and/or physical neglect

Data were analysed using Chi 2 and Kruskal-Wallis. Because of the amount of significance try outs the significance level of .01 was mostly selected. This study is part of a larger research project "Children at risk for maltreatment" where the following research questions were investigated; how many children did well baby nurses and preschool teachers identify as children at risk for maltreatment, how was the content of the mandatory reporting legislation interpreted by the participants and which expressions were used, what signs did the participants responded to and how did they handle their knowledge and finally what structural factors within child care enhanced or diminished the likelihood for participants to identify children as being at risk of maltreatment and to what extent their interpretation of the mandatory reporting legislation affect the level of reporting. The Ethical Committee of University of Göteborg has evaluated and approved

of the research project (Lundén, 2004). Well baby nurses were in all responsible for 3996 children. Included in these children were also 1516 children looked after by the preschool teachers. As can be seen in table 1 well baby nurses and/or preschool teachers had observed signs of maltreatment in 386 children (9.7%). The participants believed that another 110 children were at risk for maltreatment. In these children, however, no signs were observed. In addition preschool teachers observed signs of maltreatment in 106 children who they did not identify as children at risk.

Table 1. Amount of identified children with observed signs of maltreatment

Observed signs	Identified at risk - yes	Identified at risk - no	
Yes	280 (7%)	106 (2.7%)	386 (9.7%)
No	110 (2.8%)	3 499 (87.6%)	3 609 (90.3%)
	390 (9.8%)	3 605 (90.2%)	3 995

The result for the children who had observed signs of maltreatment (N=386) was then inspected for type of maltreatment (see page 4-5). Where there any differences in observed signs of maltreatment between socio-economically different areas? According to table 2 participants observed signs of maltreatment in considerably more children in areas with low or average socio-economical status than in areas with high status (see table 2). The distribution of signs along the categories was however similar. As can be seen in table 2 signs of physical neglect etc. were most common in all areas followed in two of the areas by signs of emotional unavailability. In the high SES status area signs of emotional unavailability were as commonly observed as signs of physical neglect etc. Signs of physical abuse etc. were rarely observed in all areas. There were some differences between the areas in individual signs though. One of the sign on physical neglect "Child is neglected in terms of necessary medical treatment when ill or with regard to routine medical check ups" was more often observed in the low SES status area compared to the other areas (Chi 2 = 15.68; p< 0.001). Not all signs of physical

neglect were more common in the low SES area. There were other signs that were less common. For instance "Child appears untidy, smelly or dirty" (Chi 2 = 10.33; p <0.01) and "Child appears untidy, smelly or dirty" (Chi 2 = 11.46; p< 0.003) were more frequent in the other areas than in the low SES area. One sign of emotional unavailability "Only to a small extent are parents able to "meet" their child on the level where the child is" (Chi 2 = 8.03; p< 0.002) was more frequently found in the average SES area than in the others.

Table 2 Distribution of children with observed signs in SES different areas

Observed Signs	Low SES area N=1112 Frequency. %	Average SES area N=700 Frequency. (%)	High SES area N=2183 Frequency. (%)
EmUn	45 (4%)	25 (4%)	34 (2%)
EmNe	29 (3%)	23 (3%)	19 (1%)
PhyNe	92 (8%)	44 (6%)	51 (2%)
PhyAb	11 (1%)	7 (1%)	6 (0.03%)
Total	177 (16%)	99 (14%)	110 (5%)

EmUn = Emotional unavailability; EmNe = Emotional neglect + ev. emotional unavailability; PhyVNe= Physical neglet + ev. emotional neglect and/or emotional unavailability; PhyAb = Physical abuse + ev. physical neglect and/or emotional neglect and/or emotional unavailability

Were there differences in boys and girls and in certain ages? Overall the same signs of maltreatment were observed in both boys and girls. There were some differences though. Concerning forms of maltreatment signs of emotional neglect etc. were more often observed in boys than in girls (Chi 2 = 8.48; p< 0.01). One of the individual signs of physical neglect etc. "Child is not dressed appropriately according to season and weather" (Chi 2 = 6.13; p< 0.01) was more frequently observed in girls than in boys. Physical neglect etc. and emotional unavailability were common in children of all ages. In emotional neglect etc. and physical abuse etc. some differences were found (Chi 2 = 34.14; p< 0.001). Signs of emotional neglect were for example more often observed in 5 to 6 years old children than in younger children. Signs of physical abuse etc. were

more frequently observed in 3 to 4 years old than in younger children or in the older ones. Which signs of maltreatment did the participants observe? As can be seen in table 3 well baby nurses observed signs of maltreatment in fewer children (4.6%) than did preschool teachers (8%). Well baby nurses and preschool teachers in the same area observed signs of maltreatment in just 29 children. Preschool teachers observed signs in more children than did well baby nurses. In order to get a more correct picture the children where preschool teachers observed signs but not identified as children at risk for maltreatment were excluded in the comparisons. We found significant differences in all sign categories except emotional unavailability.

Table 3. Distribution of identified children where well baby nurses (WBN) and preschool teachers (PST) observed signs in different categories.

Observed Signs		WBN N=3995 Frequency. (%)	PST N=1516 Frequency. (%)	Chi 2
EmUn		49 (1%)	24 (2%)	NS
EmNe		24 (0.6%)	27 (2%)	16.70***
PhyNe		98 (2.5%)	62 (4%)	10.44**
PhyAb		12 (0.3%)	13 (1%)	7.55**
	Total	183 (4.6%)	126 (8%)	28.90***

EmUn = Emotional unavailability; EmNe = Emotional neglect + ev. emotional unavailability; PhyVNe= Physical neglet + ev. emotional neglect and/or emotional unavailability; PhyAb = Physical abuse + ev. physical neglect and/or emotional neglect and/or emotional unavailability
Children, where both well baby nurses and preschool teachers observed signs have been included as well in well baby nurses' as in preschool teachers' part.
**= p<0.01 ***=p< 0.001

Preschool teachers observed most of the signs more often than did well baby nurses. One of the individual signs of physical neglect (see table 4) "Child is neglected in terms of necessary medical treatment when ill or with regard to routine medical check ups" and another sign of emotional unavailability "Child is not spoken to or talked about in an insulting way" were observed equally often by both groups. The amount of signs observed in children in the maltreatment categories varied respectively between 1 and 16 signs. In all participants observed an average of 3.23 signs in children

under their responsibility. Children who were identified by more than one preschool teacher showed in average more than twice as many signs as those identified by well nurses or just one preschool teacher (Kruskal-Wallis = 65.44; p< 0.0001). Children identified by both well baby nurses and preschool teachers showed in average 6.9 signs.

Table 4. Most common signs observed by well baby nurses and preschool teachers in children

Observed signs	Rank	WBN N= 3995 frequency(%)	PST N=1516 frequency(%)	Chi2
Only to a small extent are parents able to interpret or react on the emotions and signals of the child	1	79 (2%)	75 (5%)	35.68***
Child is often rejected at the emotional level by parents	2	66 (2%)	55 (4%)	19.98***
Only to a small extent are parents able to "meet" their child on the level where the child is	3	49 (1%)	44 (3%)	18.60***
Family's daily life is characterized by unpredictability	4	43 (1%)	45 (3%)	25.04***
Child appears untidy, smelly or dirty	5	24 (.06%)	35 (2%)	30.27***
Parents repeatedly rejects the child or do not answer their contact attempts	6.5	30 (.07%)	44 (3%)	38.40***
Child is neglected in terms of necessary medical treatment when ill or with regard to routine medical check ups	6.5	59 (1%)	21 (1%)	NS
Child is extremely tired or atonic	8	14 (.03%)	35 (2%)	47.82***
Child is not dressed appropriately according to season or weather	9.5	14 (.03%)	31 (2%)	38.96***
Child is not spoken to or talked to in an insulting way	9.5	17 (.04%)	26 (2%)	NS

Children, where both well baby nurses and preschool teachers observed signs have been included as well in well baby nurses' as in preschool teachers' part.
**= p<0.01 ***=p< 0.001

Discussion

The present study shows that well baby nurses and preschool teachers observed signs of maltreatment in every tenth of their children under responsibility. Preschool teachers observed signs in more children than did well baby nurses. Signs of physical neglect were most frequently observed followed by signs

of emotional unavailability in parent-child relation only. Signs of physical abuse were rarely observed. Similar to other studies most children suffered from more than one form of maltreatment (Bifulco & Moran, 1998; Cawson, Wattam, Brooker & Kelly, 2000; Christensen, 1999; Sundell, 1997; U.S. Department of Health and Human Services, 2010). In comparison with other forms of maltreatment, physical neglect seems to occur more frequently not only in this study but also in other studies (Lagerberg, 2001; Sundell, 1997; U.S. Department of Health and Human Services, 2010). Physical neglect is considered to be a most serious threat to children's health and development (Erickson & Egeland, 2002). Another form of maltreatment that has shown an important impact on children's development is emotional unavailability in parent-child relation i.e. psychological maltreatment (Sroufe, Egeland, Carlsson & Collins, 2005). Emotional unavailability can occur by itself but it is most often included in every other form of maltreatment (Brassard, Binggeli & Davidsson, 2002). Psychological maltreatment have been considered most important but difficult to isolate and measure. In our study we have been able to show that it is possible to isolate emotional unavailability and also to measure it. We have also shown that this form of maltreatment is very common. In comparison with other Scandinavian studies the present study in general identified more children at risk than did for example nurses in a Danish study (Christensen, 1996, 1999). The reason for this can be that the Danish study only included nurses responsible for children between 0 and 3 years of age. Another explanation can be that in our study both well baby nurses and preschool teachers were included and preschool teachers identified more children than did well baby nurses. A further explanation can be due to method reasons. As have been mentioned earlier the field of child abuse and neglect provoke strong feelings in professionals (Killén, 1996; Lundén, 2010). It is reasonable to believe this happened to our participants as well. In our study the participants filled in the question-

naire in presence of research personnel. It is reasonable to think that it was easier for the participants to give their questionnaire directly to a human being instead of sending it by post, which was done in other studies. The importance of conduct interviews "face-to-face" has specially been pointed out in other studies when you want to measure prevalence of abuse and neglect. By doing so more children were identified as children at risk (Pilkington & Kraemer, 1995).

The questionnaire used in this study has been used earlier in a Danish study. Therefore we wanted to compare signs observed most commonly in the two studies. We found that the most commonly observed signs of maltreatment in our study also were most common in the Danish study (Christensen, 1996, 1999). To compare our results with other Swedish studies turned out to be more complicated because of methodological reasons. In these studies signs of maltreatment were used where the relation to child abuse and neglect is not so obvious (Lagerberg, 2001; Sundell, 1997). Hopefully the use of research based signs of maltreatment will give us a more realistic picture of how many children are at risk for maltreatment according to professionals who meet almost all children between 0 and 6 years of age.

Preschool teachers and well baby nurses were to a large extent responsible for the same children. Despite this fact results from an earlier study in the research project showed that well baby nurses and preschool teachers did not identify the same children, according to a definition, as children at risk for maltreatment (Lundén, 2004). A thinkable explanation was said to be differences in signs observed. In our study there were no such differences in the distribution of signs observed. There were other differences though.

In all but one category or group of signs did preschool teachers observe more children than did well baby nurses. One of the reasons for this can be that preschool teachers'

way of working facilitate for them to observe signs of maltreatment. They see their children and families almost every day, which is not possible for the well baby nurses to do. Participants observed signs of emotional unavailability in parent-child relation equally often though. A possible explanation for this can be that both well baby nurses and preschool teachers consider the interaction between children and their parents as important and that they therefore are more observant. To be able to recognize a child's vulnerability is a question of connecting what you observe with the existing knowledge of child maltreatment. Result showed that preschool teachers observed signs in a considerable amount of children who they did not identify according to a given definition as children at risk for maltreatment. The same distribution of signs observed was seen in identified children and in children who were not earlier identified as children at risk. Despite the fact that children showed the same signs did preschool teacher not associate what they observed with child abuse and child neglect. In order for children and families to get access to societal help and support professionals has to be able to identify vulnerability and risk for maltreatment in children. There are reasons to believe that more children had been identified as children at risk if participants have had more knowledge about what is considered maltreatment and how serious a threat to children's development it can be.

Well baby nurses are responsible for considerably more children than preschool teachers. However they do not meet their children and families so often. As well baby nurses are responsible for between 300 to 400 children each it was more difficult for them to remember signs in children who they did not identify as children at risk. They did however have a clear picture of identified children. Neither well baby nurses nor preschool teachers have good guidelines to guide them in their work with children at risk. The questionnaire offered the participants a kind of structure as it contained signs of maltreatment based on

research.

Preschool teachers work in teams. Despite the fact that they discuss children frequently all the preschool teachers involved in a child did not observe the same signs shown by the child. It seems as if the ability to observe signs of maltreatment vary between participants. An explanation can be lack of good methods and instruments available for observations. Another explanation can be varying knowledge about the children. A third explanation can be most individual reasons for not recognize vulnerability. Participants observed signs of maltreatment in more children in low SES status area than in high SES status area. This result is consistent with earlier research where a correlation between different forms of maltreatment and socio-economically vulnerable areas is found (NIS-4, U.S. Department of Health and Human Services, 2010). The difference in our study was not as large as expected. The distribution of sign categories however did not differ between the areas. Result showed that signs of physical neglect etc. were as frequent in low SES status area as in the other areas. An explanation can be found in the way studies were conducted. It is not unusual that groups under study consist of families in socio-economically vulnerable areas or families who already are known to Child Protection Services. There is a risk then that physical neglect that takes place in families with good material standard will be overlooked (Christensen, 1999). The correlation between the character of the area and child abuse and neglect cannot be taken for granted. Many economically vulnerable families can physically and psychologically provide for their children. In order to recognize all children at risk focus has to be on development and risk for maltreatment and not only on socio-economical factors (Crittenden, 1999). Some of the individual signs of maltreatment differed however between SES areas. Especially the area with low SES status stood out compared with other areas. "Child is neglected in terms of necessary medical treatment

when ill or with regard to routine medical check ups" occurred more frequent in the low SES status area while other signs of physical neglect such as "appears untidy, smelly and dirty", "is not dressed appropriately according to season and weather", is extraordinary tired or atonic" were less frequent here than in other areas. Swedish well baby nurses are very well aware of families who do not attend to medical check ups or asking for medical help when needed. It is reasonable to believe that families in low SES status areas are exposed to more stress factors than in other areas. One of the consequences can be that they do not have energy enough to visit well baby clinics at time agreed on. Surprisingly result showed that even preschool teachers were observant concerning this sign. It is not so obvious that pedagogical personnel should recognize this sign as often as well baby nurses. By doing so we receive information about how well preschool teachers do know their children under responsibility. Over all most of the other signs of physical neglect mentioned were more frequently observed by preschool teachers than by well baby nurses. The fact that these signs of physical neglect were less often observed in low SES status area is surprising. One explanation can of course be that they de facto were less frequent in children. Another explanation can be that signs of physical neglect are so frequent in the area that participants no longer react on them. The consequences for children and their families can be serious. Two factors supposed to differ between different forms of maltreatment are gender and age (Wolfe, 1999). In conformity with NIS 4 (US. Department of Health and Human Services, 2010) participants in our study observed signs of emotional neglect in more boys than girls. The sign "family's daily life is characterized by unpredictability" was for instance more commonly observed in boys than in girls. A possible explanation for this can be that boys more often than girls have behaviour problems, which can result in lack of supervision. Especially if parents have problems in their parenting ability. The result also showed that signs of physical neglect

were more often observed in girls than in boys, which was not in conformity with other studies (Cawson, Wattam, Brooker & Kelly, 2000; Lagerberg, 2001; Sundell, 1997). Both physical neglect and emotional unavailability in parent-child relation were commonly found in children of different ages between 0 and 6 years. Similar to earlier research emotional neglect was more often found in older children and physical neglect in younger. One explanation could be that it can be easier to recognize physical neglect in young children while emotional neglect can develop silently for many years before it will be more obvious for professionals around the child. Children's physical and emotional development is a process that is affected by many factors (Cicchetti & Valentino, 2006; Sameroff & Fiese, 2000). A possibly deviant development starts long before it becomes obvious to the surrounding world. To prevent difficulties and future suffering it therefore is most important that professionals recognize the child's vulnerability early on and that they do understand what they observe in relation to what we know are serious threats towards children's health and development. There were some limitations of the study. The questionnaire used in the study consisted of signs of maltreatment also used in earlier research (Christensen, 1999). As said earlier participant decided in relation to every sign if they have observed the sign in any child under their responsibility. Preschool teachers filled in the questionnaire in one of their ordinary staff meetings with research personnel present. This procedure was not possible for well baby nurses. They are responsible for several hundred children each and cannot remember their children like preschool teachers could. However they remembered well children already worried about. Therefore we do not know if they like preschool teachers would have observed signs in more children if the procedure has been different. Another question is if the signs really are signs of maltreatment. Most of the signs of physical and psychological abuse and neglect have been used in similar studies and are in

literature considered signs of maltreatment. The fact that every group of signs consists of a number of signs that are relatively close to each other will increase the probability of signs of maltreatment. Besides in most children several signs in different groups of maltreatment were observed. It is possible that signs of physical abuse such as "Strong blushing and skin irritations" or "Scratches or abrasions around mouth, genitals" actually are not signs of physical abuse but rather physical neglect. However this does not alter the total picture of maltreatment. Signs of sexual abuse are not included in the instrument used. Signs of sexual abuse are overall most difficult for well baby nurses and preschool teachers to observe in children. The result in the present study show that well baby nurses and especially preschool teachers observed signs of maltreatment in a large number of children under their responsibility. We do not know how they administered their knowledge. Future research must focus on factors that enhance or make more difficult the likeliness for children and families to get help.

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THE MISSING LINK OF ASSESSMENT: EXPLORING CONTRIBUTING FACTORS FOR "NON-ASSESSMENT" OF PSYCHOLOGICAL TRAUMA IN CHILDREN AND ADOLESCENTS BY PROFESSIONALS

Ane Ugland Albaek[1]

Mogens Albaek[2]

Abstract

Numerous children and adolescents with complex trauma are not offered effective treatment. An important reason for this is presumably underassessment or failure to uncover and identify the psychological trauma of the children. Systematic assessment of psychological trauma in the children and adolescents is only to a limited extent administered to the clients of key institutions for servicing children in need, like child welfare services, mental health services, and pediatric health services. This is in spite of the fact that assessment instruments exist and are available. Research reviewed in this article can be interpreted as directing a suspicion towards "non-assessment" being linked to the professionals' personal characteristics and affiliations. The article presents contributing factors to explain how personal vulnerability can contribute to obstacles of assessment. The article employs implementation theory and research to illuminate the issue of how to ensure actual changes in the assessment related practice of professionals and overcome these obstacles. We propose that theoretical instruction in assessment procedures needs to be supplemented by coaching, practical training in administering assessment tools, and guidance in deliberate practice. In conclusion, the article reviews areas of specific interest for the personal improvement of practitioners working in the emotionally challenging context of children and adolescents exposed to psychological trauma.

Keywords: Childhood trauma, assessment, personal vulnerability

Rezumat

Mulţi copii şi adolescenţi suferind de traumă complexă nu beneficiază de o terapie eficientă. Un important motiv pentru această situaţie ar putea fi subevaluarea sau incapacitatea de a descoperi şi identifica trauma psihologică la copii.O evaluare sistematică a traumei psihologice

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[1] Assistant professor, Ansgar College, Department of Psychology, Kristiansand, Norway, Email: ane@vitavitalis.no;
[2] Clinical psychologist/Chief Research and Strategy Administrator, Resource centre on violence and traumatic stress (RVTS), Southern Norway, Hospital of Southern Norway Kristiansand, Norway, Email: mogens.albak@bufetat.no.

la copii şi adolescenţi se practică, pe o scară limitată, doar pentru beneficiarii serviciilor pentru copii în dificultate, cum ar fi serviciile de bunăstare a copilului, serviciile de sănătate mentală şi serviciile de sănătate pediatrică. Acest lucru se petrece în ciuda faptului că există şi sunt disponibile instrumente de evaluare. Demersul care se realizează în acest articol poate fi interpretat ca o suspiciune direcţionată către absenţa evaluării şi conectarea practicii de 'ne-evaluare' cu caracteristicile personale ale profesioniştilor şi afilierile lor profesionale. Articolul prezintă anumiţi factori care pot contribui la construirea unei explicaţii cu privire la modul în care propria vulnerabilitate poate constitui obstacole în evaluare. Articolul utilizează teoria şi cercetarea implementării pentru a face lumină asupra modului în care pot fi asigurate schimbările necesare în practicile curente de evaluare ale profesioniştilor şi depăşirea acestor obstacole. Propunerea noastră este ca instruirea teoretică în procedurile de evaluare să fie suplimentate de antrenament, formare practică în administrarea instrumentelor de evaluare şi ghidarea unei practici controlate. În concluzie, articolul revede ariile de interes special care necesită a fi ameliorate, personal de către practicienii care lucrează într-un context provocator emoţional, acela al copiilor şi adolescenţilor care au fost expuşi la trauma psihologică.

Cuvinte cheie: Trauma copilăriei, evaluare, vulnerabilitate personală

Introduction

The purpose of this article is to provide an analysis of potential contributing factors in the failure to administer assessment of psychological trauma in children, in institutions with mandate to help exposed children, including child welfare services, mental health services, and pediatric services. Ultimately, the goal of this article is to aid managers of institutions who administer helping services to children and adolescents select appropriate focal areas for training and education of their practitioners. Selecting the right focal areas for the education of practitioners may increase the efficiency of assessment of psychological trauma in children and youth.

Norwegian and international studies show that many children experience traumatic events including abuse, violence, traumatic loss, and emotional neglect. The American Psychological Association (APA) Presidential Task Force on Posttraumatic Stress Disorder and Trauma in Children estimate trauma prevalence to involve almost half of the child population in the USA (La Greca et al., 2009). Other studies reveal similar findings (Van der Kolk & Pynoos, 2009; Felitti et al., 1998). Moreover, studies reveal that many of these children live under critically traumatizing conditions for longer periods of time without the opportunity or resources to heal between events, and that these complexly traumatized children are particularly vulnerable to the development of ongoing stress and/or developmental problems that warrant clinical attention. It is well documented that complex trauma can cause extensive functional- and developmental disorders (Van der Kolk & Pynoos, 2009). Terr (1990) concludes that complex trauma normally does not heal without intervention. To the contrary, it keeps intruding further under the child's defenses and coping strategies. Treatment of complex trauma in children with documented clinical effect exists both as individual treatment (Pynoos & Nader, 1993; Malchiodi, 2003; Web, 1999; Doyle & Stoop, 1999), group treatment (Nisivoccia & Lynn, 1999; Pelcovitz, 1999; Malekoff, 2004) and as family treatment (Groves, 2002; Deblinger et al., 1990). Taking these facts into account, it appears paradoxical that few trauma exposed children with symptoms that warrant clinical attention, receive services (La Greca, 2009), and moreover, even fewer receive treatments that can be effective. Suspicion has been raised as to whether the major contributing factor towards this may be that the assessment of these children, administered by different institutions, rarely includes an assessment tool directed towards discovering the traumatic exposure of

the children (Cameron et al, 2006; Softestad, 2005). Evidence, as well as clinical experience, shows that systematic assessment does not occur routinely in neither mental health care (Frueh et al., 2002; Guterman et al., 2002), pediatric health care (Blount, 2007; Cohen et al., 2006; Holmbeck et al, 2007) nor in child welfare services (Webb et al, 2006).

While it is recognized that a state of the art tool for the assessment of complex trauma in children is missing (Nordanger et al.,in press), institutions like mental health care services, pediatric services and child welfare services do have access to multiple assessment tools that could alleviate the problem. Validated tools available for assessment of potential psychological trauma in children include Trauma Symptom Checklist for Children (TSCC, Elliot & Briere, 1994), Child Behaviour Check List (CBCL, Aschenbach, 1991), children`s Revised Impact of Event Scale (IES-R, Weiss & Marmar, 1996) and Trauma Symptom Checklist for Young Children (TSCYC, Briere, 2005). The question then arises; why do not these institutions assess psychological trauma in children? As of today this question remains unanswered, but research suggest that a contributing factor for this non-assessment may reside in the practitioners` private values and attitudes. Hesse (2002) provides findings suggesting that practitioners may be reluctant to question children about traumatic experiences in order to prevent their own vicarious traumatization, that can be caused by hearing about the traumatic experiences of children. The same phenomenon is reported by Jonkowski (2003) and Pynoos et al (1996). Vicarious traumatization can be defined as the changes that occur in the professionals' enduring ways of experiencing themselves, others, and the world as a result of empathic engagement with clients' trauma experiences (Camerlengo, 2002).

The human factor: How can characteristics of the practitioners affect the execution of assessment of psychological trauma in children?
In the following we present examples from theory and research that can illuminate the issue of how the hypothesis that practitioners' private values and attitudes obstruct assessment and disclosure of psychological trauma, can be documented.

Adverse childhood experiences among professionals
Perhaps an investigation into the demographics of the professionals working with children and youth potentially exposed to trauma, may offer answers to what makes them reluctant to subject themselves to the traumatic stories of children. Research has been undertaken on why people choose a career in a helping profession. Norcross and Farber (2005) explore the issue of why people choose a career as psychotherapists. The most frequent and conscious reason reported by psychotherapists is obviously rooted in a desire to help others. However, they suggest that the decision needs to be understood as a result of multiple, intertwined motives that are partly unconscious and affected by chance encounters. Elliot and Guy (1993) found that female psychotherapists reported higher rates of physical abuse, sexual molestation, alcohol and psychiatric problems of parents, death of a family member, and greater family dysfunction in their families of origin than did other professionals. A large study (n = 751) in North Carolina investigated the level of distress and impairment among social workers measured by the extent of drug use, depression, and burnout symptoms(Siebert, 2001). Estimated lifetime rates among the social workers were 60% for depression, 75 % for burnout, and 52% reported some kind of professional impairment as a result of their distress. The same study examined variables associated with distress and impairment, and found multiple answers; among them the factors of trauma history, personal characteristics and caregiver role identity.

In a Canadian study (Maunder et al., 2010), 176 health care workers reported on experiences of violence, abuse and neglect. Results indicated a prevalence of 68% of the workers who had one or more of these adverse experiences, and 33% of those had adverse experiences before the age of 13. The participants who had experienced childhood violence, abuse, and neglect were significantly more likely to respond to adverse events in adulthood with feelings of anxiety or fear, discouragement or hopelessness, and with feelings of being overwhelmed or helpless. These results are consistent with other research on adverse childhood experiences' correlation with adverse outcomes in adulthood, like the Adverse Childhood Experiences (ACE) study. The ACE study found graded relationships between the number of adverse childhood experiences and many adverse outcomes later in life, for instance adult depression and suicide attempts (Chapman, et al., 2004; Dube, et al., 2001)

This leads us to the understanding that a personal history of violence, abuse, and neglect is common in professionals working with children potentially exposed to trauma. Utilizing this knowledge to understand the issue at hand, why professionals in child welfare services, pediatric healthcare and mental healthcare avoid screening children for psychological trauma, a logical insight into the causal relationship would be that the practitioners' private trauma history leads to an increased vulnerability to vicarious traumatization and therefore an increase in avoidance mechanisms of potentially traumatizing situations. Given that the implied cause here is previous adverse experiences, in particular childhood incidences, one would expect these avoidance mechanisms to be, at least partially, subconscious.

Coping mechanisms of professionals
Coping can be defined as; "constantly changing cognitive and behavioral efforts to manage specific external and/or internal demands that are appraised as taxing or exceeding the resources of a person" (Folkman & Lazarus, 1984). It can also refer to " …anything people do to adjust to the challenges and demands of stress… any adjustments made to reduce the negative impact of stress" (Red Cross). A distinction is usually made between emotion focused coping, and problem focused coping (Folkman & Lazarus, 1984; Compas & Epping, 1993). Emotion focused coping can be defined as coping efforts that are directed toward regulating emotional states: Denial/avoidance, distraction or minimization, wishful thinking, self-control of feelings, seeking meaning, self-blame, expressing/sharing feelings (Ibid). Problem focused coping may be defined as efforts to act on the source of stress to change the person, the environment, or the relationship between the two: Planned problem solving or confrontation (ibid). Problem-focused coping relates to coping efforts directed outward as a means to change the environment.

Studies show that professionals relying heavily on emotion focused coping strategies, like avoidance, are more susceptible to vicarious traumatization (Camerlengo, 2002). In a study comparing coping strategies used to overcome psychological distress between psychologists and laypersons, Norcross et al. (1986) found that psychologists exhibited a larger and more varied repertoire of coping strategies. Another study by Elliot and Guy (1993) revealed that although psychotherapists reported higher rates of physical abuse, sexual molestation, other adverse experiences including family dysfunction in their families of origin, as adults, psychotherapists experienced less anxiety, depression, dissociation, sleep disturbance, and impairment in interpersonal relationships than did women in other professions. Psychotherapists have high frequency of seeking treatment for their psychological distress (78% in the study of Elliot & Guy, 1993), which may increase their multitude of coping strategies and their ability for problem focused coping.

Practitioners' difficulties in believing in children's stories

Ronen (2002) alerts us to the difficulties practitioners display in believing in the children and their stories of traumatic incidences. Children normally do not talk about traumatic events with adults, and when they choose to do so, their reports may be distorted, due to numerous factors. Some of them are cognitive limitations regarding understanding what they have been subjected to (Lieberman & Van Horn, 2004), coping mechanisms involving diminished awareness (Nader, 2004), and they may have a short attention span or language deficiencies (Ronen, 2002). Sexual abuse, severe physical and psychological maltreatment of children (Softestad, 2005; 2008) is closely linked to powerful taboos for most people. Professional helpers of children are predominantly no different from most people, and thus bring their private taboos into their professional practice (Softestad, 2008).

Working with children exposed to psychological trauma is emotionally challenging for professionals and may elicit different mechanisms protecting professionals from children's pain. A closer look at these survival mechanisms can perhaps illuminate the question of why practitioners do not investigate children's potential exposure to violence and abuse, and why we are equipped with this highly effective ability to overlook the sufferings of children. Over-identification with the parents involves projective identification with the parents of potentially traumatized children where the workers project their own feelings and qualities onto the parents and tend to overlook or minimize suspicion of abuse or neglect of the children (Killen, 1996, Softestad, 2008). The mechanism of withdrawal involves avoidance of situations for potential discovery of abuse and neglect, like administering assessment tools for psychological trauma. Problem displacement is another survival mechanism used to shift attention to other more manageable parts of the situation, for instance addressing the child's challenges in the school situation with pedagogical measures, instead of investigating the underlying cause of those challenges. Choosing normative arguments over knowledge based arguments involves focusing on some normative value like "blood is thicker than water" and letting those values validate course of action. Finally, lack of theoretical and practical knowledge regarding psychological trauma leaves professionals susceptible to vicarious traumatization, causing reduced effectiveness of the institutions mandated to help children (Strozier & Evans, 1998; Siebert, 2001).

Shame and the affect-script psychology of practitioners

Kelly (2010) claims that conscious awareness happens solely through affect. Furthermore, he compares the human affect system to a lens separating our consciousness from the world around us, trough which everything has to pass for us to gain conscious knowledge of the phenomena. The human affect system thereby becomes paramount to how people handle their drives, their cognition and their pain. The affects constitute the primary motivational system for people's actions according to Tomkins (ref in Nathanson, 1992). The affect of shame is a highly painful mechanism that operates to end affects of interest or enjoyment (Nathanson, 1992). Furthermore, it is closely linked to experienced loss of control and feelings of helplessness, as well as separation anxiety. A logical assumption would follow that listening to stories of psychological trauma from children induces the affect of shame in practitioners, as well as in people in general. Shame can, according to Kelly, feel like disappointment (i.e. feeling trapped and unable to do what one wants to do); rejection (i.e. the interest in the other person is blocked), loneliness (i.e. the interest in the other person being interested in me is blocked), embarrassment (i.e. my interest in the other person seeing me as perfect and loving me is blocked) and mortification (i.e. what happened is so awful that my interest in living is blocked). Only a very limited amount of people seem to have the affect of shame fully integrated to the extent that they are able to stay in a

situation producing the affect of shame on a distressing level without resorting to defense mechanisms. Subconscious mechanisms of self-preservation may obstruct practitioners` efforts to investigate potential traumatic experiences in children they encounter. Only enhanced self-awareness will contribute to overcoming this obstacle (Kelly, 2011).

Belief in human nature as fundamentally good

The difficulty of facing the reality of violence and abuse may be explained by peoples' unwillingness to deal with the innate evil of such acts (Lieberman et al., 2004). Prevalent thoughts in postmodern society embrace perceptions of reality that excludes evil from everyday existence and replaces conceptions of evil with the notion that evil exists solely in peoples' chosen interpretations (La Cour, 2003). Evil is understood as a misinterpretation that can be extinguished by reinterpreting events. When people are confronted with actions causing harm to others, they process the encounter by means of explaining the actions without involving the concept of evil. Scientific, and especially psychological, explanations for human cruelty are frequently utilized to grasp perpetrators' rationale. Child molesters are understood in reference to their misguided sexual arousal pattern, military torturers are understood as ill-advised in their effort towards the greater good, and terrorists are understood as brainwashed by religious beliefs combined with rage over unjust treatment. Functionally, these explanations for evil acts give people the opportunity to keep their belief that the cores of humans are good, because evil acts are explicable in terms of external circumstances. The explanations for actions represent the mechanisms for actions, but are mistaken for motivations and results of actions. When confronted with vivid descriptions of childhood abuse and violence, the belief in a world we all wish for where people are genuinely good and all evidence to the contrary can be explained as misunderstandings or pathology, is critically challenged. The practitioners' apparent avoidance

of testimonial evidence from children with trauma exposure can be viewed as an avoidance of threats to a world view where inexplicable evil does not exist. Perhaps a collective refusal to incorporate evil into our views of the world causes shortcomings in our work with psychological trauma. In the words of William James; .." evil is an essential part of our existence and the key to the interpretation of our lives" (James, 1987).

Discussion – overcoming the obstacles of the human factor

If we presume that reality is in accordance with the research and theory suggested above, and practitioners' private values and attitudes do obstruct assessment and disclosure of psychological trauma, the leaders of these services face the challenge of how to intervene towards this obstruction. Attention should thus be directed towards factors that can contribute to increase the qualifications of the practitioners, as well as organizational support measures that can facilitate this improvement of staff qualifications. In the following, we will review possible obstacles to execution of assessment procedures for psychological trauma in various organizational factors to be found in the child welfare services, the mental health services, and the pediatric services.

The child welfare of the western world has historically had three interrelated goals (Maluccio, 2008):

1. Protecting children and youth from actual or potential harm, especially child maltreatment
2. Preserving the family unit, including birth family and/or relatives
3. Promoting child well-being and the healthy development of children

These goals have evolved in response to the needs of young people coming to the attention of the child welfare system. Many, or most, of these children are traumatized (ibid). Promoting well-being and positive development requires that the children are protected from

further violations. Initiation of child protection warrants an identification of protection needs. Thorough exploration of the child's life history, situation, and needs, is therefore the core of child protection services' field of practice.

Mental health care and pediatric health care share with child welfare services the super ordinate goals of promoting child well-being and promoting positive development in children and youth. Both mental health care and pediatric health care have a practice that necessitate thorough investigation into, and understanding of, factors linked to dissatisfaction and pathology in children and adolescents, with a focus on both somatic and psychological factors.

Most countries have ratified the United Nations Convention on the Rights of the Child and made it super ordinate to National legislation. This implies that health workers, including mental health and pediatric professionals, have specifically defined responsibilities towards the investigation and reporting of suspicion of child neglect, violence, abuse etc. to child welfare authorities. Professionals in pediatric and mental health care usually have education and training levels sufficient to administer assessment routines, including assessment of psychological trauma, when cases of developmental disorders are presented (La Greca et al.,2009). This is however in contrast to child welfare practitioners, as pointed out by Cameron et al (2006): *"child welfare practitioners may be unlikely to assess for trauma in their practice, due to issues related to their agencies, their educations and training, and their clients"*. With regards to the diagnostics of traumatic sequelaes and symptoms, one may agree with Cameron (2006) that further education or training of child welfare professionals is needed to ensure sufficient levels of confidence in examination. However, child welfare practitioners seem to be in an advantageous position for discovering children at risk for developing complex trauma caused by factors like exposure to violence, neglect, and lack of stimulation. The advantage of the child protection practitioners is that they have a judicial mandate and obligation to investigate and intervene whenever there is suspicion of exposure of children to harmful circumstances. Mental health services and pediatric services, however, have no mandate to approach children that are not enrolled to receive their services.

Despite obvious differences between the institutions of mental health, pediatric health, and child welfare services in field of practice, methods, and formal qualification requirements, they – at least to some extent – qualify as a community of practice. Wenger (1998) defines a community of practice as a web of common engagement, partially overlapping practice, and overlapping repertoire, like language and concepts. The academic language of all three institutions include descriptions like reactive attachment disorder, developmental disorder, conduct disorder, and motor/perceptual developmental disorders, paralleled with a somewhat commonly held understanding of developmental disorders as possible sequelae from psychological maltreatment (Suess & Sroufe, 2005). Thus, information suggests that in all services one can find an already existing definition of trauma assessment; both explicitly in the defined areas of responsibility of the services, and implicitly in the expected level of formal education and competence of the professionals. However, these facts do not appear to result in assessment actions. A provisional conclusion may be that the mere presence of explicit definitions of trauma assessment does not independently increase the likelihood for factual execution of assessment tasks, if the resistance towards this is found in the human factor. Suspicion can therefore point partly towards a support for the suggestion that "non- assessment" is connected to the practitioners' private values and attitudes, and partly that development of, and education in, tools and screening procedures alone is equally unlikely to increase the prevalence of actual trauma assessment.

Bridging the taboos

The elements discussed in this article suggest a conclusion that theoretical instruction of practitioners in the administration of assessment tools for assessing psychological trauma in children is probably insufficient to ensure implementation of the tools in their day to day practice. A meta-analysis of studies on the effects of training and coaching on implementation of skills conducted by Joyce and Showers (2002) showed that theoretical teaching and discussion alone made only 10% of the participants able to document acquirement of new knowledge, although less than 5% actually incorporated that new knowledge into change of practice. Theoretical teaching, discussion, supplemented by clinical demonstration resulted in almost 30% of the participants being able to document knowledge attainment after the course, but the number of participants applying the acquired knowledge to change practice remained unchanged (less than 5%). Further extension of the course involved practical training with feedback during training, which amplified the percentage of participants documenting increased knowledge to 60%; still the amount of participants who actually implemented the knowledge to change their practice remained at less than 5%. Only when theoretical teaching, discussion, demonstration, and practical training with feedback was supplemented by coaching and training over time, the study could document definite changes in performed practice. As many as 95% of the participants now documented a change in practice according to the course goals (Joyce & Showers, 2002).

Ericsson (2006; Ericsson et al, 2007) provides extensive research on how to improve performance and concludes that all outstanding performance is the product of deliberate practice and coaching. Deliberate practice is defined as considerable, specific, and sustained efforts to do something you cannot do well, or at all, beforehand. This is in contrast to what most workers consider practice to be, namely practicing and perfecting what you already know how to do; staying in your comfort zone. Deliberate practice involves two kinds of learning: improving the skills that you already have and extending the reach and range of your skills. The crucial step towards improvement, however, is attentiveness to feedback. For practitioners working in helping professions the formula for improved performance is determining a baseline for effectiveness, engaging in deliberate practice, and getting feedback on their practice (Duncan & Miller, 2008). Ensuring and actively seeking feedback, especially negative feedback with areas of improvement, from others, is paramount to implementing changes in practice. For acceleration of the learning process, expert coaches or mentors should be employed, as they can make the learning material more accessible and give constructive and relevant feedback (Ericsson et al., 2007). This insight from implementation research and performance research suggests that theoretical education should be extended to include systematic deliberate practice and coaching. There is ample reason to assume this is pivotal within a field of practice so embedded with taboos as the area of psychological trauma. The ability to encounter psychological trauma and people with trauma constructively seems to be linked to the personal skills of tolerance for stress, tolerance for destructive behavior, and patience (Nijenhuis, 2011). For implementation to be effective, basic theoretical education should therefore probably be supported by training in affect regulation, training for increased tolerance of discomfort, realistic insight into own history, and increased ability for deliberate, reflective practice. Perhaps, like Camerlengo (2002) suggests, bridging the taboos that seem to obstruct the disclosure and assessment of trauma is contingent on the professionals receiving education, training and coaching in a number of specific interacting skills. The methods that can be recommended include trauma-specific (and assessment-specific) deliberate practice and regular clinical supervision, problem-focused/task-oriented coping skills training, stress-management work shops, and other

occasions to develop positive methods of professional self-care in order to reduce the negative impact of vicarious traumatization.

The amount of research on implementation of basic practice changing (pre-methodic) knowledge and skills have been modest compared to the amount of studies and articles exploring the causality, consequences of, and interventions towards psychological trauma. It is our hope that this imbalance will be restored in the years to come. We look forward to following future research and development in the practice field of assessment of psychological trauma in children and adolescents.

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TRAUMA OF ABANDONED CHILDREN AND ADOPTION AS PROMOTER OF A HEALING PROCESS

Ana Muntean[1]

Abstract

During the second half of the last century the importance of the family milieu for child development was well documented. Promoted through the attachment theory, this idea changed the practices of child protection services all over the world. Because the adoption brings a permanent family to the abandoned child and has the potential to heal the initial trauma related to the abandonment, the adoption was valued as the best solution. In this article we shall apply attachment theory concepts to the analysis of post adoption parent-child relationships. In our research we have evaluated 39 adopted children, now aged 11-16 years, and their adoptive families. The research is done within a project funded by the Ministry of Education in Romania, for the period 2009-2011. The aim of the assessment is to highlight the important factors which can be depicted within the successful adoption. We consider the success of an adoption through the quality of child's attachment. The assessment of adopted children and adoptive parents is based on the attachment theory. At this stage of data interpretation we present some relevant factors of successful adoptions in Romania.

Key words: Psychological trauma, abandonment, adoption, healing process, attachment

Rezumat

Importanţa familiei ca mediu de dezvoltare a copilului a fost cercetată şi bine documentată în cea de a doua parte a secolului trecut. Ideea aceasta a fost promovată odată cu răspândirea teoriei ataşamentului şi a condus la schimbarea practicilor din serviciile de protecţie a copilului din întreaga lume. Deoarece adopţia aduce o familie permanentă copilului abandonat şi are potenţialul de a vindeca trauma iniţială provocată de abandon, adopţia a fost valorizată ca cea mai bună soluţie. În acest articol vom aplica teoria ataşamentului pentru a analiza relaţiile părinte-copil post adopţie. În cadrul cercetării noastre au fost evaluaţi 39 de copii adoptaţi şi familiile lor adoptive. Copiii sunt cu vârste cuprinse între 11-16 ani. Cercetarea s-a realizat în cadrul unui proiect finanţat de către Ministerul Educaţiei din România, în perioada 2009-2011. Scopul cercetării este de a evidenţia factorii cheie ce pot fi depistaţi în adopţiile reuşite. Aprecierea succesului adopţiei se face prin prisma teoriei ataşamentului, din perspectiva calităţii ataşamentului copilului. Evaluarea copiilor şi a părinţilor se face în cadrul teoriei ataşamentului. În acest stadiu al cercetării, prezentăm câţiva factori importanţi în realizarea unor adopţii de succes în România.

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[1] Professor, PhD., West University of Timisoara, School of Sociology and Psychology, Email: anamuntean25@yahoo.com.

Foreword

The first criterion[2] (criterion A1) on PTSD defines the traumatic event connected with the feeling that the life of a person participating at the event or the life of a significant person is at risk. The traumatic event is disruptive and unexpected and challenges the potential of a person to survive and thrive.

Being totally dependent on the parent, the abandonment is the most traumatic event in the child's life. The abandonment induces a great crisis, a fracture into the child's life. This fracture can jeopardize the child's development. We do not have any idea regarding the abuse or neglect to which the child could be exposed prior to abandonment. What is happening to the child after the abandonment is crucial for the child's life. Despite the aversive conditions and expected damaged brought by abandonment, the child's resiliency will play an important role in drawing the differences among abandoned children. The child's resiliency can bring unexpected evolution within abandoned child's life: "… the child, who was orphaned at a young age, grew up in a children's home, became a juvenile delinquent and then settled into stable employment and is now a respected member of the community." (Killian, 2004, p. 33). The resilience is a composed factor 'that empower some children to do well in life, even though they have experienced what seem like insurmountable difficulties.' (Killian, 2004, p.33). Focusing on the resiliency of the abandoned child the professionals as well as the child protection system can feel more optimistic. But the child resiliency does not decrease the responsibility of professionals and social protection system to create and to maintain a healthy and favorable environment for abandoned children. The Resilience is not a given and stable characteristic but a function of a multitude of interactive factors inside and outside the child.

[2] Diagnostic and Statistical Manual of Mental Disorders, Forth Edition, Published by American Psychiatric Association (1994), Text revision (2000)

Within the Romanian system and legislation, there are two possibilities for abandoned children to overcome the situation and to leave the social protection system for a stable situation: either to be reintegrated within the biological family or to be adopted by an adoptive family. It is obvious that adoption is a more reasonable solution and more adequate for the child once abandoned by his/her biological family.

The topic explored

Our focus is to explore the link between the initial trauma faced by adopted children and the success of an adoption, as a healing process of the abandoned child. "Children who have been separated by their biological parents frequently deal with emotional trauma regardless of whether they were abused or not…' and the adoptive 'caregiver can alleviates the trauma by providing a sense of family support." (Sung Hong, Algood, Chiu, Ai-Ping Lee, 2011). We consider successful adoption according to the security of the child in relation to his or her adoptive parents. Attachment theory is the framework of our research, understanding and evaluation.

The moment of the child's abandonment will be the moment 0 in our evaluation. The child's life before the abandonment has also a strong impact on what is happening after adoption. We do not have information for that first period in the child's life. We can assume that the abandonment at a later age increases the child's chances for a healthy development at the beginning of his/her life. The child's age at abandonment will influence the child's chances for adoption. Due to the conditions of our research we do not take in account the time before moment 0 in the adopted children's life. We consider the adoption as the moment 1. What is happening to the child between the moments 0 and 1, is again, very important for the success of the adoption. The literature stresses the influence of the child's

age at adoption, arguing that if the adoption is done at younger ages, then it has better chance to be successful (Chisholm, 1998). On the other hand, the adoptive parents in Romania usually require young children. According to the current legislation in Romania, following the entire legal procedure, the abandoned child cannot be adopted earlier than a minimum of 6 months after the abandonment.

The framework: FISAN research project
The exploration of the connection between the trauma of the adopted children, before the adoption, and the success of an adoption is done here based on the research developed within FISAN[3] project. A sample of 39 adopted children designated by the National Agency of Child Protection, aged 11-16 years old, adopted by Romanian families during 1997-2000, at young ages (0-4 years), were evaluated with a complex set of assessment tools for children and parents. The adoptive families participating in the research live in the Western counties of Romania.

Children answered the CBCL (Child Behavior Checklist) and SSP (School Success Profile) self-reports, and the semi-structured interview, FFI (Friends and Family Interview). The parents were asked to participate at the Parent Development Interview (PDI) and to answer CBCL questionnaires for parents. Our paper is focused on the results of FFI application. The statistical analysis of the data is just at its first stage.

The Friends and Family interview (FFI), from which we are using here the data, is based on a semi structured interview, developed by Howard Steele (2003). Its purpose is the evaluation of the quality of youth's attachment.

The evaluated items are:
- Coherence
- Reflective functioning or mentalization
- The ability to show an understanding

of diverse feelings being present in significant relationships
- Evidence of Safe Haven/Secure Base Availability (in relationship to mother, father, others)
- Evidence of self esteem
- Peer relations
- Anxieties and defense
- Differentiation of parental representations
- Attachment classification rating
- Notes (Remarks during the evaluation process)
- non-verbal codes (fear/distress, and frustration/anger)

Each dimension has 4 evaluation categories:
1 = absent/no evidence
2 = mild evidence
3 = moderate evidence
4 = marked evidence

Attachment is presented from two, respectively four dimensions: autonomous secure attachment and insecure attachment with the following forms: avoidant dismissing attachment, ambivalent (preoccupied) attachment and disorganized/disoriented attachment. FFI is not just an evaluation instrument, but it also has a developmental component by creating a moment of reflection for the child which may give the chance for a mental organization and coherence of the attachment situation within his family (Steele, 2005).

Research data
The sample's demographic description can be visualized bellow (Table 1).

The average age of adopted children is: 28,8 months when the adoption takes the child from institutions, about the same age, 29,4 months, when the child is in a foster care before the adoption and about 16 months when the child is taken into an adoptive family from the hospital.

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[3] 'Factori ce influenteaza succesul adoptiei nationale' (FISAN) is a research project funded by CNCSIS, a structure which belongs to the Ministry of Education in Romania.

Table 1 The sample of adopted children

Nr. crt	The age of the child at the assessment/ years	gender	The age of the child at the adoption (months)/ moment 1	where did the child live Between the moment 0 and the moment 1 (prior to adoption)		
				hospital	in foster care	institutions for orphans
1	11 years	M	1 month		x	
2	11 years	F	36 months			x
3	11 years	M	48 months			x
4	11 years	F	1 month	x		
5	11 years	F	10 months	x		
6	11 years	M	1 month	x		
7	11 years	M	7 months			x
8	12 years	M	24 months		x	
9	12 years	F	24 months		x	
10	12 years	F	24 months		x	
11	12 years	M	36 months		x	
12	12 years	F	9 months	x		
13	12 years	F	5 months	x		
14	12 years	M	2 months	x		
15	12 years	F	48 months		x	
16	12 years	M	11 months			x
17	12 years	F	48 months			x
18	12 years	F	30 months			x
19	13 years	M	16 months			x
20	13 years	F	4 months	x		
21	13 years	F	3 months	x		
22	13 years	F	48 months		x	
23	13 years	F	42 months	x		
24	13 years	F	24 months			x
25	13 years	F	1 month	x		
26	14 years	M	3 months	x		
27	14 years	F	32 months		x	
28	14 years	M	42 months			x
29	14 years	F	14 months			x
30	14 years	F	15 months			x
31	15 years	F	11 months	x		
32	15 years	M	36 months			x
33	15 years	M	42 months	x		
34	15 years	F	2 months	x		
35	16 years	M	48 months	x		
36	16 years	F	36 months	x		
37	16 years	F	36 months	x		
38	16 years	F	30 months	x		
39	16 years	M	48 months			x
Total				46%	21%	33%

Figure 1: The child's age at adoption and the percentage of adopted children
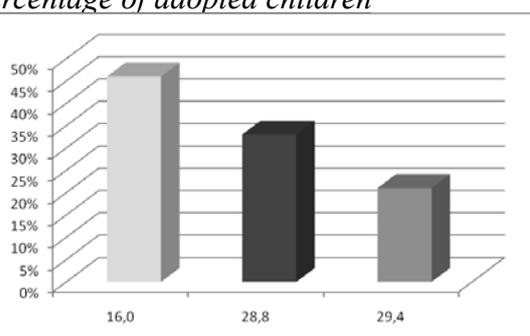
(First to the left column - children adopted from hospital;
Second column - children adopted from institutions;
Third column - adopted from foster care)

Table 2: Ages of children at evaluation

Ages of children at evaluation/ in years/	the number of children	percentages
11 years old	7	18%
12 years old	11	28%
13 years old	7	18%
14 years old	5	13%
15 years old	4	10%
16 years old	5	13 %
total	39	100%

In 2010 and the beginning of 2011, when the 39 adopted children in our sample were assessed, the ages of children varied between 11-16 years old. This aspect is significant at least for two reasons:

1.   Adolescence is a difficult period for all children, especially from the point of view of identity formation;

2.   The type and quality of services provided by the Romanian social protection system to abandoned children, including the children in our sample, between abandonment (moment 0) and adoption (moment 1) can be easily found taking in account the current age of the adopted children. The current adolescents had the moment 0 of their life during the years 1994-2000. The child protection system in Romania started the reorganization of services provided to the children separated from their biological parents mostly in 1997. This reorganization promoted the new concept of the family as the basic environment requested for healthy child development. Consequently, foster families were developed for abandoned children and lots of efforts were done for de-institutionalization.   Only 21% of children were adopted from foster families because foster families were not so common service during the period when the children in our sample were abandoned.

The adoption, in the children's life is placed during 1997-2003. Because the turning point within the child's social protection system in Romania was in 1997, with a new law set-up and with the promotion of new services especially the family foster care, we understand why most of children were adopted from hospitals and less from foster families (see figure 1). There is another important aspect for adopted children: those adopted from the hospitals were at a younger age at the moment of adoption and did not change the residential places until the adoption. The literature stresses the danger, for the child's development, of often changing the living places in a short period of time (Chisholm,1998). Adopted from the hospital, the children spent their life before adoption in only one place. The conditions in the hospital did not favor the development of good attachment relations, as medical staff and other adults were moving around without having specific responsibilities for children. Those adopted from institutions are different. Usually they are older in age and very often, especially when they were abandoned immediately after the delivery, they came in institutions from hospitals where they spent some time at the beginning of their life. The situation of children adopted from foster families is different: they came in foster families from institutions or from hospitals. Coming from institutions, they could have experienced at least 2 living places: hospital and institution. Coming from hospital, they knew prior to adoption the hospital as life environment. The period of social protection system to which we refer had few foster families. Additionally, foster parents were not very well selected, trained and supported.

We can assume that the adopted children evaluated within our project had the traumatic moment 0 followed by other possible traumatic events such as changing the living places and the adults in charge with taking care of them. "..No child enters adoption without having experienced a traumatic event."(Johnson, 2002, p.49)

The adoption of abandoned children and the healing process

Among the 39 adopted children, we found 20 children securely attached or moving toward secure attachment and 19 children exhibiting insecure attachment during the evaluation. This means that half of children found in our research succeeded to heal the initial trauma of their life. The situation concerning the attachment quality within the sample of adopted children is showed bellow:

Table 3. Securely attached Children found at evaluation

Ages of children at evaluation			Number of children assessed with secure attachment	
11 years old	7	18%	5	25%
12 years old	11	28%	7	35%
13 years old	7	18%	2	10%
14 years old	5	13%	3	15%
15 years old	4	10%	1	5%
16 years old	5	13 %	2	10%
total	39	100%	20	100%

A large group of children (35%) who displayed good quality of attachment during the evaluation were 12 years old at that moment. But this situation is not very relevant as most of evaluated children (28%) were 12 years old during the evaluation moment.

According to the moment 1, when children were adopted, the situation of securely attached children is shown bellow.

Table 4. securely attached children found at evaluation and their ages at adoption (moment 1)

Ages of children at adoption (moment 1)	The entire sample		Number of children directed toward secure attachment	
	Number of children			
1-5 months	10	22%	4	20%
7-11 months	5	15%	3	15%
14-16 months	3	9%	3	20%
24-36 moths	12	32%	5	25%
42-48 moths	9	22%	4	20%
Total	39	100%	20	100%

Surprisingly enough children adopted when they were 2-3 years old (25%) seem to have the best chances. This is contrary to the existing literature according to which the young age of the child at adoption is making the difference regarding the success of adoption (Chisholm, 1998; van IJzendoorn, 2005).

Limits of the given data

Due to the fact that the research team could contact and evaluate only the adoptive families found available by the child's protection system we cannot state anything about the general situation in domestic adoption in Romania. FISAN project is looking for successful adoption and we can assume that the county's child protection service and professionals who first met the families did a first selection of the adoptive families prior to the meeting of families with the research team. In other words, the sample of adopted children here is not representative for adopted child in domestic adoption in Romania. However we can assume that the sample here is probably doing better comparing to the general situation in domestic adoption in our country. Even if the domestic adoption developed during the last 14 years all over Romania, there were some counties which simply refused to put in touch the research team with the adoptive families. Several natural and artificial selections of adoptive families are displayed until the research team meet the adoptive family: first is the consign of FISAN Project, looking for successful adoption and for children at a certain age (11-16 years old), adopted at an age before 4 years old; secondly, is the readi-

ness of county council structures in child protection to cooperate; third, is the openness of adoptive family to participate within the research and their ability to disclose to the child the adoption, prior to the research moment. Following all these restrictions we can assume that our data require more cultural context to be taken in account for interpretation and this should be done very carefully.

Conclusions

The adoption process is an important and challenging social situation, which brings to the adopted child a new affiliation, new social network, new experiences and educational standards. This comes in his/her life after the trauma of losing his biological affiliation and social and emotional support. Each moment the complex individual factors face external and internal environmental aspects which generate proactive and retroactive global reactions (Stroufe, et all, 2005). The more than 50% of adopted children found in our FISAN research project to be securely attached represent the children who despite the aversive conditions faced at the beginning of their life could overcome and heal their trauma within the new families brought to them by adoptions. The lower percentage of securely attached adopted children (50%) compared to international data available (about 75% among adopted children and about 62% among biological children[4]) is alarming when we take in account the multiple selections through which the adoptive families passed prior to participate to the evaluation. However taking in account the cultural context in Romania, in which adoption is not a traditional approach for abandoned children, we consider the quality of attachment of children in our sample as being fairly good. In our project we are committed to further research that will highlight cultural differences, vulnerabilities and strengths of Romanian adoptive families.

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[4] *van IJzendoorn , 2005*

REFLECTIVE FOSTER CARE FOR MALTREATED CHILDREN, INFORMED BY ADVANCES IN THE FIELD OF DEVELOPMENTAL PSYCHOPATHOLOGY

Stine Lehmann[1]   **Dag Nordanger**[2]

Abstract

For children placed out of home because of maltreatment, foster families become central agents in releasing their developmental potential. Foster parents and child welfare workers are often dealing with children suffering from symptoms of maladjustment, impairing their relational and general functioning. This article presents a framework for understanding the psychosocial development for children exposed to maltreatment, based on current research and theory in the field of developmental psychopathology. Against this background, some central challenges and implications for reflective foster care are outlined.

Keywords: Foster children, maltreatment, reflective care, developmental psychopathology

Rezumat

Pentru copiii plasați înafara familiei proprii datorită maltratării, familia foster devine agentul central pentru sprijinirea potențialului de dezvoltare de care dispun. Părinții foster ca și lucrătorii din sistemul de bunăstare a copilului au de-a face adeseori cu copii prezentând simptome de dezadaptare care pun în dificultate atât relațiile cât și funcționarea lor generală. Acest articol prezintă un cadru de înțelegere a dezvoltării psiho-sociale a copiilor expuși la maltratare, inspirat de cercetarea și teoria recentă în domeniul psihopatologiei dezvoltării. Pe acest fundal vor fi subliniate unele provocări și implicații ale foster care-ului reflectiv.

Cuvinte cheie: Copii în plasament (foster), maltratare, îngrijire reflectivă, psihopatologia dezvoltării

[1] PhD candidate/Specialist in clinical child and adolescent psychology, Regional Office for Children, Youth and Family Affairs, region south, Toensberg, Norway, University of Bergen, Department of Psychology, Bergen, Norway, Email: stine.lehmann@psykp.uib.no;
[2] Dr. Psychol./Senior researcher/Specialist in clinical child and adolescent psychology, Centre for Child and Adolescent Mental Health, Western Norway, Resource centre on violence and traumatic stress (RVTS), Western Norway, Bergen, Norway, Email: dag.nordanger@uni.no.

Introduction

<u>Background</u>
The number of children living in alternative care has been steadily increasing over the last few decades. In USA, the number of children in the foster care system increased by 60 percent from the early 1980s to the mid 1990s (Leslie et al., 2000). In Australia, from 1996 to 2004 the number of children in alternative care increased by 56 percent (Carbone, Sawyer, Searle, & Robinson, 2007). In Norway, which is a country of nearly 4,9 million inhabitants, approximately 8000 children were living in foster families in 2008 (Statistisk Sentralbyrå, 2009). Cases within the child welfare system concluding with out-of-home placements, often reveal that the child suffers from a combination of several mental health and psychosocial problems (Egelund & Lausten, 2009; Leslie, Hurlburt, Landsverk, Barth, & Slymen, 2004; Tarren-Sweeney & Hazell, 2006).

Many foster children have been removed from their biological parents and placed in a foster home because of maltreatment. Very often, this implies that their attachment bonds have been disrupted and they have experienced severe threat and insecurity. As we will return to below, such strain typically produce problems in the child's ability to regulate affect, attention and social bonds. This again are associated with emotional suffering and symptom manifestations across a wide diagnostic spectrum (B. van der Kolk, Pynoos, R. S. , 2009). The strategy chosen by the child to cope with insecurity and relational stress colours the clinical presentation of mental health and functional problems (Goodyer, 1997), and thereby the way new caregivers are challenged. In addition, psychosocial problems may relate to, and get triggered by, hormonal changes during puberty, cognitive growth and other stressful life events (Mathiesen, 2009).

Foster homes are commonly used as a placement-form for maltreated children internationally. Therefore, foster parents are key agents in society's effort to support children at high risk of developing a wide array of mental health problems because of traumatic experiences. A shared understanding between caregivers and professionals about the ways in which early stress puts the child at risk for maladjustment, will add greatly to the possibilities for moderating outcomes along the child's developmental pathways.

<u>Maltreatment, neglect and abuse</u>
Maltreatment is a common reason for foster placement. The concept of maltreatment may be sorted into four main subcategories: Physical abuse, sexual abuse, neglect and emotional maltreatment (Cicchetti & Toth, 2005). However, as it has been indentified by research as a considerable risk factor for later problems, some literature recommend refining emotional maltreatment into the subcategories of *emotional abuse* and *emotional neglect* (Egeland, 2009). These share the features of being more subtle and harder to detect than physical maltreatment (Egeland, 2009). In this article, for most purposes, maltreatment is used as a common term for all four categories.

<u>Theories addressing child development and -adjustment</u>
A number of research- and theory based models contribute to our understanding of normal development as well as to our understanding of factors leading to impaired functioning. Among these are transactional and ecological models which emphasise that developmental outcomes are neither a function of the individual alone nor the environmental context alone. So, development of the child is seen as a product of the continuous dynamic interactions of the child, and the experiences provided by his or her family and social context (Belsky, 1993; Cicchetti & Toth, 2009; Sameroff, 2009).

Informed by such models, the field of *developmental psychopathology* represents a useful framework for research and for the development of clinical and practical approaches.

This framework seeks to "elucidate the interplay among the biological, psychological and social-contextual aspects of normal and abnormal development across the life-course" (Cicchetti & Toth, 2009). Central principles state that development takes place over time, which the child and its environment mutually influence, each other, and that development occurs in interaction between biology and environment. Research within the field of developmental psychopathology aims at explaining the development of individual patterns of psychosocial adjustment and maladjustment (Sroufe & Rutter, 1984). Attachment theory (Bowlby, 1969), as well as perspectives evolving from recent research and theory building around the "complex trauma" concept (van der Kolk, 2005), are therefore also influential within this frame (confer below).

The aim of this article is to highlight some central aspects of these theories on human development, and suggest how they may provide useful "lenses" for foster parents and professionals working with maltreated foster children.

Focal points of Developmental Psychopathology

Development across the life-span
The child's need for developmental support changes with new and altered developmental tasks, and new challenges will spur new ways to relate to new close persons. This implies that a foster parent needs to understand the child's present competence and its next milestones in order to provide optimal support. This is what Vygotsky (1978) refers to as being "in the zone of proximal development". Being in this zone, takes flexibility from the caregiver. The caregiver has to be able to alter expectations as well as ways of providing practical and emotional support in correspondence with the way the child develops. A common metaphor used to describe this process is that the caregiver must "build scaffolding" around the child (Bateson, 2005), like when a house is being built. This scaffolding must continuously be adjusted to the present stage of the building process.

Development through interaction and attachment; implications for self regulation
Child development cannot be understood separate from the concept of attachment. Attachment is the emotional bond between the infant and the caregiver which develops from the very beginning of their relation (Bowlby, 1969). Today we know that infants are motivated for dialogue and social interaction as such, but attachment behaviour is also a basic strategy and necessity for survival. An infant can not survive without the care from another person – its worst threat is to be abandoned by its primary caregiver (Crittenden, 2008). From birth, infants know how to attach and stay close to their caregivers, in order to get physical and emotional protection. Using for example tears and smiles as inviting signals, the bond is strengthened, and thereafter further strategies are developed, dependent on the response from the caregiver. The child learns quickly to distinguish between what leads to safety, and what leads to danger, and this strategies chosen will be adjusted to these perceptions. When the person who should provide safety at the same time is associated with danger and threat, as in the case of maltreatment, the child is stuck in fear without any solution. Frequent episodes of such relational adversity will affect the child's relational behaviour profoundly.

In infancy and early childhood, the perhaps most central developmental task for the child is to develop self-regulation skills. This is supported by other-regulation from primary caregivers. The ability of self-regulation is needed to purposively regulate body, affect, and mental processes throughout life (Ford, 2009). In a healthy child-caregiver interaction, the caregiver helps the child to restore comfort when there is discomfort or frustration, and is also sensitive to the child's own self-regulating behaviour. In this way, the child gradually internalises these skills

and becomes able to self-regulate (Calkins, 2002).

When the caregiver is absent or not sensitive enough to assist the child's self-regulation, as in the case of neglect, and/or acts in a way which puts the child in a state of alarm or preparedness against threat, as in the case of violence or abuse, the child's self-regulation abilities will be affected. As the knowledge of such mechanisms has evolved, self-regulation problems have become central in the trauma field as well, articulated in the conceptualisation and understanding of impacts of complex childhood trauma (van der Kolk, 2005).

<u>The interaction of neurobiology and environment</u>

It is a well established fact that neurobiological development and experience are mutually influencing each other (Cicchetti & Tucker, 1994; De Bellis, 2005). Several aspects of maltreatment, such as absence, rejection, unpredictability, being physically hurt or witnessing violence, and a feeling of being alone, puts the child both in a state of being deprived of important stimuli and at the same time in a state of severe stress. Such negative influences will inevitable affect the child's neurobiological development. This may be reflected in the development of the self, in emotional, mental and social functioning, as well as in symptoms of mental disorders (Cicchetti & Toth, 2005).

In recent years, neurobiological research has made significant progress on areas which help us understand the mechanism underlying developmental deficits caused by maltreatment. Particularly helpful, to our opinion, is the area of research captured by the concept of "The use-dependent brain" launched by Bruce Perry and his co-workers (B. D. Perry, Pollard, R. A., Blakley, T. L., Baker, W. L., Vigilante, D. , 1995). Research has shown that neurons and neural systems are designed to develop and change in a "use-dependent" way. This implies that our neural network develops in accordance with the

way it is stimulated. After a rapid growth in early infancy, through the process of pruning (Cicchetti & Tucker, 1994) unused connections are sorted out while synapses which are repeatedly activated are maintained (see also Mannes, Nordanger and Braarud, this issue). In practical terms, this means that when a child's spoken to regularly, the neural networks involved will be stimulated and developed. The same networks in an infant not spoken to will be underdeveloped. So the more repeatedly a certain neural connection is activated, the more firmly established it will be (B. D. Perry, 2006). Schatz (1992) refers to the same phenomenon in his famous quote "Cells that fire together wire together" (p. 64).

Brought into the scope of this article, this knowledge tells us that a maltreated child's neural system in many cases will reflect patterns of both underdeveloped neural networks and over-sensitised and over-reactive networks. In particular, many of the problems these children express may be understood as a consequence of being kept in a state of prolonged alarm or preparedness. In neurobiological terms this implies overstimulation of the brains "alarm system" (the amygdala and parts of the limbic system), dysregulation of stress- hormones, and sensitisation of neural-networks that identify danger and mobilize to self-defence. At the same time, the connection between these basic brain structures and cortical areas involving language and the ability to contextualise experiences will be underdeveloped (Ford 2009). A way to see it is that the child's brain has become "threat-oriented" and designed for survival, rather than for explorative learning (Ford, 2009). As a result, a child who has been living in a threatening home-environment may react with aggression or another survival responses to an event which another child maybe would perceive as neutral.

However, it is important to note that the description of a use-dependent brain as also involves *plasticity* (see also Mannes, Nordan-

ger and Braarud in this issue). Harm or delay do not necessarily need to cause permanent impairments of functioning (Cicchetti & Curtis, 2006). Factors such as the child's maturity and age, the severity and durability of maltreatment or neglect, will all influence the level of harm. Maltreatment in early age tend to be more harmful than strain and traumas in more mature age, with repeated and prolonged exposure to violence and traumas in interaction with caregivers increases the risk of mental health problems (Dube et al., 2001; Gillespie & Nemeroff, 2007) .

Clinical presentations of impacts of maltreatment

Over the last few years, there has been growing interest in the possible relationship between different maltreatment profiles and associated profiles of mental health problems. In a longitudinal study, McWay and colleagues explored the relationship between problem behaviours and type of maltreatment, including changes over time (McWey, Cui, & Pazdera, 2010). Children placed in foster homes because of sexual abuse and neglect was found to have higher initial levels of externalizing behaviour problems than a control group of children who had experienced other forms of maltreatment. Furthermore, children placed in foster care as a result of neglect, physical abuse and sexual abuse, showed a faster decrease in externalizing problem behaviour than the control group. Concerning internalizing problems, adolescents in foster care with a history of sexual abuse both had significantly higher initial levels of internalizing behaviour problems than control group children (Ibid.). In another study among adolescent leaving foster care, only physical abuse was associated with externalizing and internalizing behaviours when the effects of other types of abuse were controlled for (McMillen et al., 2005).

In another branch of research, looking more generally into diagnoses among children exposed to adverse experiences, one can see that maltreatment affect broadly. Putnam and

co-workers (2008) found that adults with an history of four or more kinds of relational traumas during their childhood *in average* qualified for more than six DSM diagnosis. The most common diagnoses among children exposed to complex trauma are found to be anxiety, depression, ADHD, conduct disorder, attachment disorders and PTSD (Ackerman, Newton, McPherson, Jones, & Dykman, 1998). In one study, around fifty percent of children exposed to physical and sexual abuse was found to fit the criteria for conduct disorder (Lyttle & Brodie, 2007).

These findings suggest a complex relationship between risk factors and outcome, where social and individual variables interact in creating developmental pathways for children exposed to maltreatment and abuse. Most likely, if there is a pattern in maltreated children's clinical presentation of symptoms, it must be looked after across existing diagnostic categories. Of particular interest in this regard is the extensive initiative of the *Complex Trauma Taskforce* of the US National Child Traumatic Stress Network (NCTSN) around the diagnosis "Developmental Trauma Disorder", which is proposed to be included in the next Diagnostic and Statistical Manual of Mental Disorders (DSM). The working group has gone systematically through cases in child maltreatment in national surveys and registries in the US, and looked for the common denominators in symptomatology. They find three areas of regulatory dysfunction to be salient; Affect regulation, attention and behavioural regulation, and socio-emotional regulation. In the light of advances in developmental psychopathology addressed above, these findings make sense theoretically, and the three domains of regulatory problems are suggested to form the structure of the new diagnosis (B. A. van der Kolk, 2009).

Understanding and helping foster children through reflective care

Risk and protective factors
In the field of developmental psychopathol-

ogy, it is well recognized that a child growing up meets with unique combinations of risk factors for and protective factors against a skewed development (Belsky, 1993). Risk factors may be related to the child itself, e.g. a difficult temperament; to care persons, e.g. mental illness in parents; or to an environment; e.g. practices of corporal punishment. A protective factor may shield against a risk factor; a calm and sensitive mother may protect a child from the effect of an inborn difficult temperament, and a child with secure relations, social competence and an easy temperament may to some extent be protected against adverse experiences. However, as Egeland (2009) points out, risk factors have to be up-weighted by protective factors; "…maladaptation following maltreatment is likely to be related to maladaptation in subsequent developmental periods unless there is a change in the balance of risk and protective factors in the child proximal environment"(Egeland, 2009, pp. 23-24).

Lately, researchers have started to look into the specificity of risk and protective factors, investigating for example which are the factors that protect more against certain kinds of stressors. This is an intricate interplay, and many aspects are yet to be resolved. We have, however, acquired a good overview of general factors predicting adjustment, in the child as well as in its environment, and also of general factors predicting deviation. Ann Masten, a much cited scholar in the resilience field, concludes that the general factors protecting children best against risk are: (a) relationships with competent and caring adults, (b) cognitive and self-regulatory skills, and (c) a positive image of self and motivation to be effective in the environment (Masten, 2001). As we can see, these factors combine with the focal points of developmental psychopathology described above.

Against this background, a foster home has the potential of providing the maltreated child with the protective system it needs for a healthy development from that point on –

for up-weighing the risk factors. It has the potential of being a stabilizing environment, defined as "freedom from crises, or significant emotional , behavioural or relational upheavals" (Ford, 2009, p. 50). The relation to foster parents is important for new learning, because the day-to-day situations in real life may lead the child to new insights and serve as a corrective to previous experience, gradually changing the child's understanding of herself and surrounding persons. At the same time we know that providing a maltreated child with the care and love it needs is not a straightforward issue, as the child may bring into the new relationship wounds and strategies which may set the stage for destructive interaction. Therefore, below, we draw into attention some areas which require a reflective attitude in order to provide these children the best of support, derived from the knowledge base of developmental psychopathology.

Transference to foster care
Transferring a child to a foster home because of maltreatment is the most serious form of intervention taken by child welfare services. The child is removed from what has been evaluated as a harmful care environment, and placed in a safe environment. Attempts to improve the care given by biological parents have been abandoned, because the risk factors are considered to be of a too numerous and/or serious kind, and most likely of a lasting nature. However, coming to a safe place may not automatically be accompanied by a *feeling* of safety by the child. The maltreated child's brain is often wired for survival in danger, and the way in which it sees the word and interpret new information is still affected by a "threat-orientated brain" (confer above). This means that learned expectations based on former experiences, in combination with the child's developmental stage, will influence what the child perceives as stressful and threatening. For foster parents and involved professionals, understanding these processes is of crucial importance to be able to constructively meet the child.

Children growing up with overwhelming, frightening or frightened parents may quickly learn "survival" strategies which imply avoiding stimuli or reactions that reminds them of danger. Insecure attachment relationships are shown to be overrepresented among maltreated children (Crittenden, 1988). Strategies brought along from such relationships may contribute to reproducing and even amplifying an insecure attachment pattern in the new relationship. A typical strategy may be to act independent and avoid seeking comfort and support from adults. One the one hand, a foster child seeming independent and autonomous may be truly strong and rich in resources, with a high degree of self-efficacy. On the other hand, the same behaviour maybe an expression of overregulation of fear and the feeling of vulnerability. This may be the case if the child has already experienced that approaching an adult for consolation or support, triggers insecurity, anger or lack of response in the caregiver. In this way, children who have experienced that adults cannot give them care and support, may later miss important experiences which can make them change their interpersonal strategies.

Other children may have experienced their parents' engagement as unpredictable, for example because of drug abuse or mental health problems. In such cases, the child may fear absence or neglect, and will underregulate their feelings, and develop strategies to be in close contact to keep the adult's attention. Such a situation may lead to uncritical relations to other persons; the child may often be perceived as dissatisfied and bothersome. Such children may later on be prone to engage in risky behaviour, for example because of confusion of sex and emotional intimacy, or because of distrust in spoken words as expressions of genuine feelings. Hence, the child may believe that nobody really cares (Crittenden, 2008).

It should be noted that children removed from a threatening context typically will have difficulties in communicating former adverse experiences directly and verbally. This may partly be because connections between affective states and verbal expressions have not been adequately developed. And because the brain is under ongoing development and maturing, the strategies developed in cooperation with the caregiver, becomes a part of the child's knowledge about herself and about her relations to the world. This knowledge will influence the way in which the child manages to adapt to and add meaning to new information (Cicchetti & Toth, 2005).

The importance of individual assessment
When the child welfare service removes a child from its biological parents, the child's need for care on the one hand, and its need for treatment on the other hand, must be balanced and coordinated. The action taken should be based on a careful assessment of the individual child's functioning and needs, as theories of healthy and of unhealthy development can only predict the probable outcome at group level.

There is a tendency among professionals working with maltreated children to discriminate between types of maltreatment, when considering the level of mental health service the child needs. Professionals and caregivers may perceive certain forms of abuse to be more harmful by nature, and children with a dramatic history of maltreatment may be more likely to be referred to mental health services, independent of their actual clinical need (Bellamy, Gopalan, & Traube, 2010). The field of developmental psychopathology, with its emphasis on the interplay between biological, psychological and socio-contextual aspects of child's development (Cicchetti & Toth, 2009), underlines the importance of careful assessment of each individual child on several arenas of functioning. Relying solely on information of exposure to risk factors in the child's care-environment, one risk missing children exposed to more subtle forms of maltreatment.

For the maltreated child, a developmental scheme is necessary for tracing the roots, aetiology and nature of maladjustment, in order to guide the choice of treatment approach (Cicchetti & Toth, 2005). Assessment tools has been developed especially for assessing exposure to the different maltreatment sub-types, such as the Maltreatment Classification System (Barnett, 1993). The assessment should lead to a comprehensive picture of factors entailing risk, and factors giving protection for this particular child up to the time of the assessment.

In addition, assessment should include emotional, attentional and behavioural problems, functioning in interaction with peers, and areas of resource. For this purpose, general measures such as the Child Behaviour Checklist (CBCL) (Crijnen, 1999) and Strength and Difficulties Questionnaire (SDQ) (Goodman, Ford, Corbin, & Meltzer, 2004) can be of value. And, as follows logically from above, the child's level of functioning with regard to stress responses and affect regulation abilities should be particularly considered and assessed. For this purpose, Briere's Trauma Symptom Checklist for Children (TSCC) would be a choice of recommendation (Briere and Spinazzola, 2009).

When knowing the initial base-line, treatment can be monitored and results evaluated. For foster parents it is of crucial importance to be informed concerning the child's background and present condition in order to be able to adjust to the child's "zone of proximal development" and to "build scaffolding" around the child (confer above).

Adjusting to where the child *is*
The origin of a child's functioning is often unclear: A symptom may be a result of stressful experiences, but may also stem from normal variation of personality, disposition and age dependent development. A given underlying problem may lead to different symptoms for different developmental stages. Therefore it is important to know the child's mental age

to understand her or him. Because of earlier under-stimulation or overwhelmingly frightening experiences, the child may appear older or younger when it comes to language, emotions and other behaviour. There is not always consistency of maturity at the different developmental areas. As already mentioned, the child may have developed strategies to handle experiences she or he has been too immature to cope with. In order to reduce the feeling of insecurity, the child may either have "overstretched" or regressed. This explains why some children seem confusing and are hard to "read". Therefore, one must be careful in taking initiatives of interventions purporting to change the child's strategies, without at the same time reducing the danger that the child needs to protect him or herself against (Crittenden, 2008).

Furthermore; children exposed to maltreatment or neglect may show a general developmental delay, but sometimes delays are more exclusive to areas such as emotion, cognition or motor functioning. In such cases there is no concurrency between the child's development and expected competence based on age. There might also be marked differences between the child's language competence and its emotional maturity. Such differences demand high sensitivity from the foster parents.

This does not mean that we shall put aside ambitions and aims on behalf of the foster child. On the contrary, a literary overview (Egelund, 2009) concluded that the foster child's adult environment shows a tendency to underestimate the importance of education. As a result the child may lack incentives in a highly important arena.

The most important factors in a long-term perspective are first to have sufficient knowledge of the child's present competence, second to agree on realistic short-time aims and decide what the child will need to reach them, and finally to monitor the development continually.

Peers and school as an arena for mastery and development

What a maltreated child has learned about her or himself from former relations may be inappropriate and inhibiting in interactions with others, such as peers and friends in school. As a result, children moved to foster homes are often in need of assistance in learning to interact with the new social environment, in order to dare trying out a wider range of behavioural alternatives towards care persons as well as persons outside the new home.

We know that independently of background and presupposition, school constitutes one of the child's most central arenas. The feeling of peer acceptance is an important factor with regard to the mental health of children and young people. We know that children who fail to cope in school, who lack friends and do not participate in social arenas, run a greater risk of developing mental difficulties (Vinnerlung, 2010). Therefore, efforts to optimise the child's daily school experience are of outmost importance. In some cases a child will need help just to attend school. Others need individual help to improve school results.

It is also important to help the children to take part in spare time activities outside the school arena. Many foster children lack such experience, and will need much help and engagement both to get started and continue their activities. A good starting-point may be time-limited, semi-structured activities with peers. Hopefully, such activities will give the children positive experience, and contribute to the corrective experience of the child's sense of her self and others.

Triggers and affect-regulation

As addressed above, children exposed to or witnessing domestic violence has greater problems with affect-regulation when confronted with subsequent conflict situations than non-maltreated children (Maughan & Cicchetti, 2002). Also, seemingly neutral stimuli may for the child serve as triggers of survival based coping strategies. To the adult the child's response may seem exaggerated, or weird, for example by a total lack of emotional display. When the child's reaction seems out of proportion and hard to understand the adult may become bewildered when it comes to how to interact with the child.

In such cases, professionals supporting foster families should be careful to remind each other and the foster parents that the behaviour reflects learned strategies of the child, which have been functional and have been perceived as necessary in its former relationship. Reflective care should be guided by our knowledge of what are the primary task for a caregiver even in interaction with a newborn; to support the child's self-regulation. An element of this is to regulate the child's affect with your own affect, by for example controlling ones one temper, staying calm, using a toned-down voice, and not behaving intrusive when the child is very angry or over-activated. In interaction with a maltreated child, behaving in such a way requires a reflective attitude, since the natural response to aggressive behaviour and hurtful comments directed towards us may be self defence or aggression. Responding aggressively to the child's aggression will escalate the already over-activated response of the child, and will not serve its need for training of self-regulatory skills.

It is also important to embrace the learning potential of difficult situations. During the daily interaction the adult has a possibility to see how the child reacts when feeling safe, and, on the other hand, how it reacts in stressed situations. It is important to focus on the information which can be drawn from the child's experience. As an observer you may ask yourself; "How old do you think the child is now? Is this episode similar to earlier ones? What happened just before this reaction?" This questioning, reflective and accepting attitude may over time give substantial insight into the child's world and personality. Over time, some of the children internalise the same reflection as a response to acceptance and flexibility from the adults. This will open

up for a gradual development where the older child may be able to reflect open, and finally put words on earlier non-verbal reactions

Flexibility and co-operation

Foster children are a heterogeneous group with diverse levels of experienced stress and vulnerability. Research on occurrence of mental problems in foster children, and on the impacts of trauma and disrupted attachment, indicate that many foster children need assistance from multiple services. Both the foster children and their foster parents are in need of extensive support.

A foster child often relates to several adults: Foster parents, case worker in child-welfare, biological family, teacher and various mental and somatic health services. The parties involved must meet considerable demands, and should comprise a *support group* around the child. To be able to support the child's further development, it is imperative that the adults agree on how to understand the child, and share information making it possible for each one to play her/his particular role. Many foster children have found themselves inside of a "parallel world" which needed to be kept apart and hidden for people at the outside. The child typically has assumed responsibility for avoiding somebody close to them to "break down". These children must re-learn the resilience of adults and the fact that sharing of experiences is not dangerous.

However, the foster child must feel no doubt concerning to whom they should address their needs for support, comfort and close sharing. Foster children will often regard their foster parents as their closest ones. To fulfil their roles as mother- and father figures, foster parents need to be closely informed about all changes the child goes through. Therefore, professionals should have an open and including attitude; Can the foster parents be present in the therapeutic room? Can they be present when the child welfare worker talks with the child? In any case, the child must be absolutely sure who its closest ones – its "main adults", are.

Summary and concluding remarks

Development takes place in interaction between children, caregivers and their environment. The child is in focus, together with the adults so close that they can hold hands. Some of the children placed in foster homes bring with them experiences which have harmed their abilities to regulate themselves and relate to others. Overwhelming experience may have left neurobiological traces. Such harm is not always immediately visible. The main objective is that the child shall be met with an unconditioned acceptance and with reflective care from the first moment. To be able to interpret and constructively meet the needs of a child with a traumatic history, foster parents have straight from the beginning a need for support and security. So around the foster family, a flexible network of competent helpers should be organized.

Goals for the further development of the child must be adjusted to the individual child's starting point – where the child *is*. In the supporting network of family and professionals around the child, there must be agreement about the child's needs, consensus on short-term goals, and a clear division of responsibility. For this, an individual assessment of every single child, its life history and present functioning is imperative. An individual assessment will make a better platform for planning interventions, making more precise goals and for evaluating the effects of our measures.

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ENHANCING QUALITY INTERACTION BETWEEN CAREGIVERS AND CHILDREN AT RISK: THE INTERNATIONAL CHILD DEVELOPMENT PROGRAMME (ICDP)

Helen Johnsen Christie[1]   **Elsa Doehlie[2]**

Abstract

Manmade disasters such as war, abuse, violence or physical punishment causing traumas in children, are all violations of children's rights. The International Child Development Programme (ICDP) is a universal psychosocial programme considered to be a helpful tool in implementing children's rights, protecting children from being violated and promoting psychosocial care for children at risk. The ICDP approach is based on the idea that the best way to help vulnerable children is by helping their caregivers. The article presents central elements in this programme and link them to core elements in trauma understanding and resilience based interventions dealing with traumatized children. We will then describe clinical vignettes from practicing the ICDP in two different contexts with children and their caregivers in South Africa and in a care center for asylum-seeking minors in Norway and discuss some of the aspects of the implementation of the programme.

Keywords: ICDP, children's rights, trauma, intervention, resilience

Rezumat

Dezastrele provocate de om, cum ar fi războiul, abuzul, violenţa sau pedepsele fizice cauzând trauma copiilor sunt în fapt, toate, violări ale drepturilor copiilor. Programul Internaţional de Dezvoltare a Copilului (ICDP) este un program psihosocial universal, considerat a fi un instrument util în implementarea drepturilor copiilor, în protecţia copiilor împotriva expunerii la violenţă, şi în promovarea unor îngrijiri psihosociale pentru copiii la risc. Abordarea ICDP se bazează pe idea că cel mai bun mod de a ajuta copiii vulnerabili este acela de a-i ajuta pe cei care-i îngrijesc. Articolul prezintă elementele centrale ale programului şi face legătura între aceste elemente şi aspectele centrale ale intervenţiilor bazate pe înţelegerea traumei şi a rezilientei,în intervenţiile practicate cu copiii traumatizaţi. Vom prezenta apoi vignete clinice privind aplicarea ICDP în două contexte diferite, cu copii şi îngrijitorii lor, în Africa de Sud,

[1] Psychologist/Researcher/Special advisor, Centre for Child and Adolescent Mental Health, Eastern and Southern Norway, Oslo, Norway, Email: helen.christie@r-bup.no;

[2] Social scientist/Associate Professor, Diakonhjemmet University College, Institute for Social Work and Family Therapy, Oslo, Norway, Email: doehlie@diakonhjemmet.no.

precum şi în centrul de îngrijire a minorilor căutători de azil din Norvegia şi vom discuta unele aspecte din implementarea programului.

Cuvinte cheie: ICDP, drepturile copiilor, traumă, intervenţie, rezilienţă

Children's rights

When families are uprooted by social change, migration, poverty, catastrophes, or war, the caring system often breaks down and has to be reactivated through skilled help and support. Children who lose their parents or have been numbed by severe deprivation and emotional shock are especially vulnerable when the caring systems break down.

To meet these challenges many countries including South Africa and Norway have ratified the UN convention on the Right of the Child (UNCRC). This consists of 54 articles. UNICEF has chosen to promote the convention divided into three categories, commonly referred to as the "3 Ps":

1. The right to provision of basic needs
2. The right to protection from harmful acts and practices
3. The right to participation in decision affecting their lives

The 2009 annual report from the Children's Rights Center in South Africa (CRC-SA 2009) states: *"On paper, South Africa is deeply committed to children's rights, as evidenced by our ratification of the United Nations Convention on the Rights of the Child and five other child related conventions. The South African Constitution addresses these obligations and many of the points raised in the general comments. Despite these firmly documented aspirations, children's rights realization, protection and promotion too often remain elusive in reality. This is evidenced at a very broad level by the fact that as a country we are moving in the reverse direction in meeting our Millennium Developmental Goal commitments. Of equal concern is the public hostility to the idea of children having rights. The misunderstanding and myths about children's rights are a major challenge to right realization, Children's rights are not just ma-terial provisions or services, but are realized in relationships between people: between children and between adults and children in their attitudes and daily life practices."*

This quotation emphasizes two major issues: First; the attitudes towards children, their values and their rights, and second; the daily life practices between adults and children.

The rights to provision, protection and participation must be mediated through sensitive caregivers giving the child a voice, listening to her physical, psychological and existential needs and protecting her from danger and harmful practices.

The ICDP

The ICDP programme has sensitive, empathic care through the interaction between the child and its caregivers as its main focus. By developing meaningful dialogues with children and promoting children's active participation and initiative, the ICDP contributes in promoting children's rights (www.icdp.info).

The ICDP was developed by an international team led by Child Psychology Professor Karsten Hundeide, University of Oslo, Norway. Hundeide started to develop the programme in 1985 and the ICDP organization was founded in 1992. The ICDP has been adopted as a mental health programme by WHO, and close cooperation has been established with UNICEF, particularly in Latin America. The ICDP has conducted training in more than 20 countries.

The ICDP is an international competence building and training programme for psychosocial and educational care of children at risk, and it focuses on both the cognitive, social and emotional development of the child. The ICDP is community-based, cultural sensi-

tive and prophylactic, addressing established groups of children and their caregivers. The programme is influenced by social anthropology, popular traditions theories, attachment theories and recent theories on child development. The ICDP builds competence and confidence in members of an existing child caring system and transfers the training to the local resource persons. Sustainability is achieved by inserting the ICDP as a permanent component inside a network working with children. The programme is particularly relevant to caregivers of children 0-6 years, but it is applicable even with older children and teenagers and elderlies. The following contexts are recommended (ICDP leaflet, 2010):

- *Families and children. To prevent neglect or abuse of children and promote dialogue through group meetings and home visits*
- *Vulnerable children and orphans. To develop minimal standards for human care within a child-care setting related to war, migration, catastrophes, abuse and trauma or abandoned street children*
- *As an integral part of any primary health care programme sensitizing caregivers about their important role for the future development of their child*
- *In preschool- and school programmes, improving the interaction between staff and the children and the children's parents.*
- *Children in institutions. To sensitize staff and improve their quality of care*

Dialogues and guidelines on positive interaction

The content of the programme is formulated in 3 dialogues and 8 guidelines to promote good interaction (Hundeide, 2007).

The *emotionally expressive dialogue* addresses the emotional development and creates the basis of safety and trust:

1. *Show your child love and care*
2. *Follow your child's lead*
3. *Intimate dialogue.*
4. *Give recognition and praise*

The *meaning creating and expansive dialogue* addresses the cognitive development and creates the child's understanding of the world:

5. *Joint focus of attention*
6. *Give meaning*
7. *Expand, give explanation*

The *regulative dialogue* addresses the moral and behavioral development and helps the child learn planning and self-control:

8a. *Step by step planning*
8b. *Scaffolding*
8c. *Positive limit setting*
8d. *Situational limitation*

A positive conception of the child and empathic identification

Unless a child has an adult loving and caring for her, teaching her daily life skills and the ability to meet demanding challenges, her cognitive, social and emotional development will be impaired. In order to develop a positive interaction with the child it is necessary for the caregiver to have a positive conception of the child. The child has to be perceived as a person with potential for development, a person the caregiver cares about and with whom the caregiver can identify empathically with. There is a close relation between the way the child is perceived by her caregivers and the type of care the child is given (Klein, 1992; Smith and Ulvund, 1999). Consequently, the method of redefinition to change negative perception of the child is a central tool in the ICDP. Caregivers who participate in ICDP are taken through a process of self-reflection and encouraged to develop a positive conception of their children, as well as a deeper understanding and confidence about their own roles as caregivers.

Generally speaking, our conceptions of children are embedded in our culture and traditions, but with a wide range of variations reflecting individual life experiences, social and cultural backgrounds and positions. When working within a multicultural society or a culture different from one's own it is impor-

tant to show tolerance for variation. Caregiving practices must be carefully evaluated in their cultural context before being considered a deviation.

The caregiver's capacity for empathic identification is the basis for sensitive caregiving, sensitive interaction and sensitive pedagogy (Hundeide, 2010). Empathy facilitates communication and in order to communicate effectively the caregiver needs to be able to understand the child's affective and cognitive states. In this way the ICDP is inspired by recent caregiving ethics from the philosopher Levinas known for the expression "*face speaks to me and thereby invites me to a relation*" and that it is: seeing the other's face that commits us (Levinas, 2004). The Zulu concept of "Ubuntu", "*I am because you are*", is also an example of how popular traditions have influenced the programme.

The ICDP is based on recent research on child development, particularly on early communication and the infant's competence and contribution to the interaction with the caregiver. The infant is born as a social individual with strong dispositions towards initiating interaction with others. Contrary to earlier perception of infants as passive, the infant is currently defined as competent of interaction (Stern, 1985; Trevathern, 1992; Bråten, 2004). This means that that the child is an active participant in creating the care she receives.

The emotional dialogue
The affective attuning of the caregiver constitutes the basis for the emotionally expressive dialogue. The emotional dialogue emphasizes that showing the child love and care meets the child's needs for a safe and comforting relationship. The emotional dialogue presupposes that the caregiver adjusts to the child's condition and states, and sees and follows the child initiative, expresses positive feelings and acknowledges the child.

Daniel Stern (ibid) constitutes an essential contribution to the understanding of emotional interaction between the infant and the caregiver, specifically through the concepts of imitation and nonverbal communication. Shared emotional conditions are necessary for the child to feel that she is cared for and understood. When the ICDP is referred to as a "*sensitization programme*" this involves training in seeing and interpreting facial expressions, gestures and body language or voice quality.

Donald Winnicot focuses on caregiver-infant interaction as well. The concept of "*the good enough mother*" alludes to the notion that the mother and the child are intuitively and biologically predisposed for interaction and gives evidence to the importance of the emotional dialogue. The concept of "*the potential space*" also draws attention to the importance of play for the emotional and cognitive development of the children (Winnicot, 1971).

ICDP is also leaning upon attachment theory (Bowlby, 1988). The child will search for protection and comfort when she gets scared (Smith, 2002). The child is dependent upon a caregiver who is able to read the signals correctly, and that her signals will subsequently trigger the caregiver's disposition to comfort and support the child emotionally as well as intellectually.

Pedagogic guidance - the meaning creating dialogue
During the last decades infant research has led to extensive exploration of guided interaction between caregivers and children and about how the child is gradually led into cultural community through communicative contact with her caregivers. The caregiver has a responsibility not only to acknowledge the child emotionally but to assume a pedagogic guiding role. The child needs an assistance in her exploration and guidance that promotes her understanding about the world she lives in. The child also needs to master the skills required to adapt to other people and meet the expectations and challenges in life. This type of interaction at an early age seems to fa-

cilitate and support the child's social, linguistic, cognitive and moral development (Rogoff, 2003; Hoffmann, 2000; Schaffer, 1996; Klein, 1992). In addition to safety and secure attachment, guidance for cognitive and intellectual development for children constitutes a vital part of care. If this fails, it may have serious consequences for the child's future development (Hundeide, 2001).

ICDP (Hundeide, 2010) is also influenced by the works of the Russian psychologist Lev Vygotsky and his ideas on learning and development. In order to develop new competences and acquire new knowledge about the world around her, the child needs an adult 'coach' who can challenge her into exploring the unknown. Vygotsky termed this 'The zone of proximal development (ZPD)', an innovative metaphor capable of describing not the actual, but the potential of human cognitive development (Vygotsky, 1978), considered to be the basis for the ICDP meaning creative and expansive dialogue

The regulative dialogue

To support the child in her development, mastery of skills and self-control are necessary. ICDP has as its aim to help the children develop moral understanding and responsibility. This means helping the child to plan carefully step by step and offering only the help that the child needs. Hundeide refers to David Woods stressing that*:" the child should only get the help she needs, because if the child gets too much help she does not develop the independent understanding and control considered important for the child's development of independence and autonomy"* (Hundeide, 2007 p. 62). Graded support and instructional scaffolding provide sufficient support to promote learning when children are exposed to new skills and concepts. Just as scaffolds are removed when a building is finished, it is important to remove support when the child is ready to master the task at hand herself.

The regulating dialogue is about developing control and responsibility. Sense of safety

and trust, contrary to punishment, is a necessary prerequisite for the development of inner control and reflection. Hundeide (2007) refers to Martin Hoffman's concept *"induction",* meaning that control and behavior management is established through explanations and negotiations. This is different from programs directed towards conduct disorder based upon the idea of behavioral corrections through conditioning.

Sensitization and empowerment versus instruction

The ICDP approach to sensitization is to increase the caregivers' sensitivity enabling them to use their own empathic capacity and practical experience to interpret, respond and adjust to the child's expressed feelings. A sensitization programme is the opposite of instruction and ready-made, manual-based programmes containing detailed instructions how caregivers should act and respond to the child in different situations. The ICDP empowers and supports caregiver's self-confidence in caring. The programme is culture sensitive to local practices as long as they are in accordance with its core concepts. The ICDP facilitator needs to establish a close relationship with the caregivers in training, utilizing participatory and empowering methods. Practical application of the ICDP guidelines must be followed up in detail by the facilitators.

The ICDP programme has four levels:
1. Sensitized caregivers
2. Certified facilitators (running groups for caregivers)
3. Certified trainers (training, supervising and certifying facilitators)
4. Super-trainers (training, supervising and certifying trainers)

Trauma and resilience
Having presented central elements in the ICDP we will now present core elements in trauma understanding and resilience based intervention. Further on we will see how these main intervention principles correspond to

the ICDP programme.

The ICDP was developed for children in marginalized care situations, but does not have a specific trauma focus. In our experience, however, the programme has relevance to profylactic work with traumatized children.

Trauma and consequences
Trauma theory has emphasized the experience of singular traumas and the reactions summarized in the PTSD syndrome: the re-experiencing of the trauma, the avoidance pattern, and the state of hyperarousal.

Experienced trauma often fails to be integrated in the memory and continues to be a fragmented part of the consciousness (Van der Kolk, 2005). The episode feels unreal and as is it not happening to me (de-realization, de-personification) (Shapiro, 2009; Nijenhuis, 2006; Diseth et all 2005). Recent contributions in the literature have also looked at how multiple traumas can have serious developmental consequences (Mannes, Nordanger and Braarud, this journal). Complex trauma and developmental trauma consequences will have impact upon the self-perception (self-blame, low self-worth) and the lack of ability to regulate affects (depression, hypersensitivity, difficulties in calming down). The concept "*out of the window of tolerance*" was developed by Nijenhuis (ibid) to describe the hyper- and hypoarousal (dysregulation) a traumatized person often experiences when trauma is triggered. Developmental trauma consequences also include cognitive impairment (attention difficulties, confusion and misinterpretation). Relational problems, difficulties in trusting other people, being able to identify and feel belongingness to others might also be impaired. (See also Braein and Christie, and Mannes, Nordanger and Braarud, this journal; Shapiro, 2009; Van der Kolk, 2005; Herman, 1992).

Resilience - protective and moderating factors
However, exposure to traumatic events does not necessarily lead to traumatic symptoms. A trauma always activates the person's attachment pattern. According to Robert Pynoos a secure attachment to a caregiver represents a "protective shield". The caregiver representing this "shield" gives the child a feeling of protection and connectedness, regulating the child's emotions and helps to create meaning to the trauma experience (Pynoos, 1995; Christie, 1994a). An immediate reassurance of protection and care can, if present, be a tremendous moderating factor. A prolonged period before care and protection is available necessitates a rebuilding of the child's trust in the protective shield, otherwise the state of hyper-arousal will continue.

Resilience literature identifies protective or moderating factors on the individual level, the family level, and the societal/cultural level. Some of the most important non-genetic factors are: feeling of self-worth, autonomy, internal locus of control, good coping skills, sense of coherence (the world seems comprehensible, manageable and meaningful), creativity (symbolization), good child/parent interaction, clear family structures, (rules and rituals), common values between parents and children, having at least one significant other during childhood, and feeling of belongingness (Rutter, 2006; Masten, 2006; Waaktaar et al., 2004a; Waaktaar et al., 2004b; Waaktaar et al., 2000).

A comparison of the central trauma symptoms and the most important resilience factors indicates that they are interrelated:

Table 1. Interrelation between trauma symptoms and resilience factors

TRAUMA SYMPTOMS	RESILIENCE FACTORS
• Loss of sense of reality 　o Dissociation 　o Sensory and memory fragmentation	• Coherent personal narrative 　o Integrated memory 　o Ability to make plans for the future
• Lack of control 　o Deep feeling of helplessness 　o Impaired self-agency	• Internal locus of control 　o Coping skills 　o Manageability
• Emotionally overwhelmed, dysregulation of affects 　o Hyper-arousal 　o Hypo-arousal 　o Impaired symbolization capacity	• Adequate affect regulation 　o Symbolizational capacity 　o Creativity
• Breakdown of cognitive categories 　o Confusion 　o Lack of meaning	• Sense of coherence 　o Comprehensibility 　o Sense of meaning
• Impaired attachment and relational capacity 　o Loneliness 　o Withdrawal 　o Discontinued relations 　o Constant and permanent readiness for rejections	• Close attachment 　o Continued relationships 　o Sense of belonging
• Loss of self worth	• Sense of self worth

An intervention model based on trauma and resilience understanding

When faced with the challenges of helping traumatized children, one must bear in mind both their wounds and the protective or moderating factors (resilience) that can serve as resources in their process to heal. We will here propose an intervention model (table 2) that tries to address the most common trauma symptoms and the central resilience factors. We then try to point out which elements and principles an intervention must consist of to get the intended effect.

Table 2. Intervention model based on resilience factors

Mental domains	Characteristics of traumatic events	Trauma symptoms	Resilience-based principles of intervention	Effects of intervention
• Sense of reality	• External event • Threat to physical or psychological integrity	• Dissociation, feeling of altered reality, and/or sensory fragmentation	• Witnessing and acknowledging fragmented personal experiences	• Re-creation of a sense of reality • Reconnection of the fragmented experiences into a personal narrative
• Sense of self-agency, control, and autonomy	• Sudden, unexpected, uncontrolled	• Helplessness, victimization, lack of control	• Focus on coping skills, proactive capacity, and influence	• Re-installment of autonomy and internal locus of control
• Affective system	• Intense pain and fear	• Emotionally overwhelmed and dysregulated	• Sharing, containing, and training stabilization and emotional regulation	• Expanded affect-tolerance • Reinstalled regulation capacity
• Cognition	• Appear as chaotic and meaningless	• Breakdown of the ability to think and reason, • Confusion • Misinterpretation of guilt	• Providing explanations, and addressing sense of meaning	• Enhanced capacity to reflect, and to include the traumatic experiences into a coherent and meaningful narrative • Correct attribution of responsibility
• Attachment	• Activates attachment systems, and challenges the sustainability of the protective shield	• Impaired attachment and relational capacity, loneliness, withdrawal, and discontinued relations	• Offering a stable and trustworthy relationship	• Capacity for close attachment, sense of belonging and continuous relationships
• Self worth	• Attacks human dignity and self respect	• Humiliation, shame, and guilt	• Showing respect, giving praise and positive feed-back	• Enhanced sense of self respect

(developed from Christie,1994b)

Linking the ICDP principles to the intervention model

The ICDP as a prophylactic and children's rights promoting programme can reach far more children than the group diagnosed as traumatized (PTSD) in the purely clinical sense (Hundeide, 2001).

The basis for the ICDP principles, *empathic identification* with the child, is a precondition for being a witness and to really understand how the child has experienced a traumatic event. The three dialogues also seem interrelated to the principles of the intervention model (table 2). The *emotional dialogue* addresses the significance of being a witness and hereby helps the child to reconnect and re-create the sense of reality. The dialogue also implies following the child's lead (guideline 2), listening carefully to the expressed emotions, helping the child regulate her feelings through the intimate dialogue (guideline 3) and through giving the child comfort and praise (guideline 4). However, showing the child love and protection, thus establishing a protective shield, is by far the most fundamental principle (guideline 1).

The meaning creating dialogue addresses cognitive processes. The child needs mediating assistance in several areas. First of all children need to understand what has happened during the traumatic event, whether there has been a political conflict, war, a natural catastrophe, an accident, or relational violence and abuse. The child will often need the help of an adult to make the outer world comprehensible.

Of equal importance is addressing the child's inner world. Sometimes trauma reactions like nightmares and mood swings can be as frightening as the memory of the event itself. That is why many intervention programmes address the need for psycho-education. The meaning creating dialogue can be used to help the child understand and accept her own reactions as natural and common reactions to unnatural and uncommon events and give her a vocabulary and an awareness for own

emotions and thoughts (guideline 6). The expansion guideline (7) in the meaning creating dialogue can also be utilized to have an interaction with the child about existential meaning, a topic we sometimes underestimate children's need for.

We also know that children often attribute guilt to themselves. In order to grasp the child's own ideas the caregiver has to explore and share the child's associations and questions (guideline 5 – joint attention). If not dealt with, the misinterpretation of responsibility might result in shame and sense of worthlessness .

The regulating dialogue, emphasising scaffolding and step by step planning (guideline 8), can assist the child in developing good coping strategies and self-control. Living in circumstances with violence, abuse and neglect can be experienced as living in chaos. After experiencing traumas, it is of the utmost importance to address the child's understanding of values, of principles of responsibility for own actions and consequences for herself and others. The regulating dialogue addresses what values to agree upon and share in the family. Finally, the step by step planning assists the child in influencing and planning the future and enhancing the child's internal locus of control.

Clinical vignettes

Example 1 from South Africa

The ICDP was implemented by a team from Regional Centre for Child and Adolescent Mental Health (RBUP) in a township in South Africa. Participants were caregivers working in daycare centres , in training to become facilitators (www.icdp.info/ RBUP- Gamalakhe) In one group of caregivers the facilitator noticed that one of the participants seemed emotionally very affected by a discussion on sexual abuse. During the break the facilitator asked the participating mother whether it would be ok for her to share her personal experience during the rest of the group

meeting. The mother then told the group that her daughter had been violently raped and that they had reported the crime to the police without any action from the police. The daughter got pregnant from the rape and gave birth to a baby girl. The mother of the infant died and the little girl was now living with her grandmother (the participant in the ICDP group). The facilitator practiced empathic listening and showed comfort and support during the process (emotional dialogue). However, when following the mothers associations and lead, the most stressful part of the story showed not to be the burden of the past, but the worries for the future. According to the beliefs in her culture, the grandmother was convinced that a child conceived in rape would herself be exposed to rape and possibly die. The facilitator focused upon the meaning creating dialogue, explored the ideas and helped the grandmother to re-define her conception of the child, not as a victim to a predestined fate, but as a child in her care, a child now in a safe and caring environment. The cultural ideas of predestination were shared with other participant. Focus and attention was paid to exploring, explaining and expanding the understanding of the consequences of rape, the effects rape has on the victim, the family and the generations to come.

Example 2 from South Africa (same context)
In a group training to become facilitators one of the members presented a problem in her own family. She was a single mother of three children, and in addition she also had the child of her dead sister in her care. According to the rules in her congregation, she was strongly advised not to talk about death to the children. However, the little girl had now started to ask why there was no picture of her as an infant in their home. The siblings had also hinted something about her not being a real sister. There was a general discussion in the group on how to talk with children about death, what kind of questions they have, and what they need to know. During the next meeting the mother reported how she had sat

down with the girl, initiating a dialogue that opened up for questions and explanations. She had given the girl a picture of the biological mother and together they had visited her grave. This gave an opening to a stronger bond and attachment between the caregiver and the child.

Example 3 from Norway
In Norway unaccompanied asylum seekers under the age of 15 years are the responsibility of the Child Protection Service and are placed in caring institutions. We conducted the ICDP with a group of professionals working at such a center. In spite of the experience the children carry from their homeland, the strain following their flight to Norway and the uncertainty about the future, many of these children show a resilient capacity in adapting to an entirely new environment. The caregivers were eager to strengthen these resilience factors in the children, but sometimes they were confronted with behavior they found difficult to understand. The professionals gave many examples of hoarding behavior among the children. Sometimes it was craving for food and hiding it and sometimes it appeared even more irrational, hoarding the Easter decoration or hiding all the plants from the sitting room under their bed. This behavior was often perceived by the staff as greediness, impoliteness, selfishness and being ungrateful. The staff was interested in how the ICDP could help them to understand the children better and to get a positive conception of them. Ideas were exchanged on how hunger and lack of material necessities had been their daily experience, creating a desperate craving. Helping the staff to get a new understanding of the behavior and a more positive view of the children motivated them to find better ways of dealing with hoarding behavior. This behavior had also caused conflicts among the children. Rejection and marginalizing was therefore important to prevent.
Through step by step planning with the children involved, they learned a way of controlling their impulse to hoard. The children further developed new coping skills to express

themselves.

Summing up

Evaluation of the ICDP programme has so far been limited. An extensive evaluation of the programme is conducted by Looraine Sherr, University of London in cooperation with Department of Psychology, University of Oslo. Preliminary results show promising effects. Final results will published in 2012.

However we have tried to describe and discuss how the ICDP principles can be applied in working with traumatized children and that the principles can be useful in addressing of the main trauma reactions, and reactivate central resilience factors.

The main components in the ICDP correspond to the core principles in the Convention on the Rights of the Child by addressing values in upbringing and the positive perception of children.

The ICDP sensitizes caregivers to children's psychological needs, consequently serving their right to provision, giving them a shield against harmful experiences (providing protection) and listening to how the children want to influence their own lives (confer the three P's). By strengthening the caregivers' sensitivity and improving the quality of interaction with the children, the ICDP can be seen as a programme promoting children's rights.

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HELPING FAMILIES FROM WAR TO PEACE: TRAUMA - STABILIZING PRINCIPLES FOR HELPERS, PARENTS AND CHILDREN

Cecilie Kolflaath Larsen[1]   **Judith van der Weele**[2]

Abstract

It is in the context of relationships healing after trauma takes place. What are the implications of modern trauma theory for teachers, therapists, community health workers, youth workers and parents to support the healing processes after horrors of war? This article is intended as a translation of modern trauma theory into 10 practical principles for people working with war traumatized refugee families. Complex trauma exposure can be caused by war, and children exposed to complex trauma often experience lifelong problems. Research tells us that refugees have psychological trauma symptoms 3 years after arrival to a safe country. The 10 principles for effective trauma stabilizing are developed after a 2 year project with Chechnian refugees in Norway. They are a derived through qualitative information, our clinical understanding combined with trauma theory. The trauma theory in this project has mainly been: Phase oriented treatment, in particular the phase of stabilization, the Polyvagal theory, to describe the universal functioning of the human nervous system in danger and the concept of bottom up processing in neuropsychology.

Keywords: Complex trauma, family treatment, war, Chechnia, Stabilization

Rezumat

În contextul relaţiilor are loc vindecarea după traumă. Ce implicaţii are teoria modernă a traumei pentru profesori, terapeuţi, lucrătorii comunitari în domeniul sănătăţii, lucrătorii cu tinerii şi părinţii implicaţi în sprijinirea proceselor de vindecare în urma ororilor războiului? Acest articol intenţionează o transpunere a teoriei moderne a traumei în 10 principii practice pentru lucrătorii cu familiile refugiate traumatizate de război. Expunerea la trauma complexă poate fi provocată de război iar copiii care au fost expuşi la traume complexe dezvoltă adeseori probleme ce le afectează întreaga viaţă. Cercetătorii arată că refugiaţii prezintă simptome de traumă complexă chiar şi la 3 ani de la sosirea într-o ţară care le dă securitate. Cele 10 principii pentru stabilizarea eficientă a traumei sunt dezvoltate în urma unui proiect de 2 ani cu refugiaţii ceceni aflaţi în Norvegia. Ele sunt derivate în baza unei informaţii calitative, a comprehensiunii noastre clinice, combinate cu teoria traumei. Teoria traumei în acest proiect s-a referit mai

[1] Psychologist, Alternative To Violence, Asker, Norway, Email: cecilie.kolflaath.larsen@atv-stiftelsen.no;
[2] Psychologist/Specialist in clinical psychology, Private practice, Oslo, Norway, Email: judith@vanderweele.no

ales la: terapia orientată fazal, în particular faza de stabilizare, teoria polivagală, descriind funcţionarea universală a sistemului nervos uman, în situaţii de pericol şi conceptul proceselor considerate de jos în sus din neuropsihologie.

Cuvinte cheie: Traumă complexă, terapie familială, război, Cecenia, stabilizare

Introduction

Refugees
The Norwegian Refugee Council defines a refugee as: "any person who has left his/her country based on well- founded fear to be prosecuted due to race, religion, nationality, political viewpoint or belonging to a certain social group" (Lindstad and Skretteberg, 2011, pp 33). UNHCR states that in 2010 there were 43, 7 million refugees. 27, 5 millions of these crossed the border of their country and applied asylum elsewhere. This is the highest number since the beginning of this millennium. 358 840 refugees fled to the western world, and 10 064 of these refugees came to Norway (Lindstad and Skretteberg, 2011).

The traumatic effect of war on families
Figley and Nash (2007, cover) write that "left unchecked, the psychological effects of combat exposure can be devastating to combatants, their families and communities". They further write that "war is likely the toughest challenge a person can face, especially for the teenagers and young adults…" (pp 17). They list up different physical stressors of war as sleep deprivation, memories of noises and blasts, fumes and smells: "Combatants in the field must learn to function on no more than 4 hours sleep at a time- sometimes considerably less." (pp 19). They go on listing up cognitive stressors as helplessness and the horror of carnage; "The greater the identification with the damaged person, the greater the threat to one's own sense of insecurity and vulnerability (pp 27)."

Many war refugees have faced the stressors described by Figley and Nash, especially those who have been in active battle. Lie (2003) found, in her study of 462 refugees, in Norway that 3 years after arriving to Norway the trauma symptoms were still high. The symptoms were worsened by unemployment, worries about family in their home country, lack of support and lack of family in Norway. Research done by the Norwegian Statistics Bureau shows greater psychological difficulties among immigrants in general compared to ethnic Norwegians. Refugees were included in the immigrant population in this study. Immigrants reported as much as three times as often nervousness, inner turmoil and feeling worried. They were four times more likely to experience fear and anxiety, hopelessness, depression (Blom, S. 2010).

Edward Tick says *(2005, pp 2): "War veterans and their families have helped me learn that the traumatic aftermath of war and violence creates wounds so deep they have to be addressed with extraordinary attention, extraordinary resources as well as extraordinary methods. Conventional methods are not adequate for describe these wounds".* War traumas are collective traumas; it is a traumatic experience that affects the entire family as opposed to one family member, the entire society as well as the culture. War affects existence: the meaning, the hope, the pride and the feeling of safety for a group of human beings, both children and adults. War affects parent's ability to be a safe haven for their children, as well as children's ability to trust that they are safe with their parents. "Under most conditions parents are able to help their distressed children restore a sense of safety and control…When trauma occurs in the presence of a supportive, if helpless, caregiver, the child's response is likely to mimic that of the parent – the more disorganized the parent, the more disorganized the child" (Van der Kolk, 2005, pp 403).

War and the body

War oftentimes includes life threat. Life threat activates the deeper and more primitive parts of the brain. The limbic system is more involved in defense than the higher levels of executive functioning (Porges, 2001). The limbic alarm system shuts down the frontal lobes and activates fight, flight or freeze action systems in the body. Rigid thinking, emotional reactiveness and instinctive defensive reactions replace reflective thought and behavior adapted to the present (Porges, 2006; Blindheim, 2011).

Howard Bath (2011) quotes recent research showing that our brain develops by experience. He further refers to research showing that children, living in the suburbs of New York, not having experienced 11th of September themselves, still had a hyperactive amygdala six years after this traumatic event! Children growing up in danger lose the ability to distinguish between the sense of safety and sense of danger. The core of trauma, for both children and adults, is loss of the ability to regulate the intensity and duration of affects (Bath, 2011). Body oriented therapies have been receiving increasing attention in the field of trauma (Shapiro, 2010). A deeper understanding of the chronically overactivated body after trauma has called for more direct work with the dysregulated neurobiology of the traumatized person (van der Kolk, 1996). Levine states that "most animals are programmed to reorient and calm down after trauma, humans with our big complex brains need conscious awareness to bring on our orienting response and the physical, emotional and mental homeostasis in which we function best" (Levine in Shapiro, 2010, pp103). According to Perry (2009) we cannot remove bad (body) memories, but we can give them less space in our mind by creating new positive (body) memories. The most effective strategies according to Perry's neurosequential model are those that are "bottom up processing" interventions. Bottom up processing can be defined as interventions first and foremost anchored in body work more than in cognitive reflection (For example: massage, rhythmic activities, grounding exercises, playful games, body and eye contact).

Complex traumas

The majority of the trauma- research done, has focused on PTSD in a single trauma perspective. This article is about complex war traumas in a family perspective. "The traumatic stress field has adopted the term "complex trauma" to describe the experience of multiple, chronic and prolonged, developmentally adverse traumatic events, most often of an interpersonal nature (eg. sexual or physical abuse, war, community violence) and with early life onset" (Van der Kolk, 2005, pp 402) "Typically, complex trauma exposure results when a child is abused or neglected, but it can also be caused by other kinds of events such as witnessing domestic violence, ethnic cleansing, or war" (Cook et al., 2007, pp 4).
On the symptom level one may say that after trauma defensive reactions become part of the personal make up of a person. Avoidance behavior and intrusions are layered in implicit neural networks. Memory and identity can be fragmented. Affect regulation is disturbed (Herman, 1992; van der Kolk, 1996a). The complexity involves having to adapt over time to dangerous circumstances. Life after war will leave its victims adapting to life in peace as if still at war. People who have suffered complex traumas will in some moments lack the sense of personal ownership to painful memories and reactions, while at other times they are overwhelmed by traumatic memories. "Complex trauma exposure results in a loss of core capacities for self regulation and interpersonal relatedness. Children exposed to complex trauma often experience lifelong problems that place them at risk for additional trauma exposure and cumulative impairment (eg, psychiatric and addictive disorders; chronic medical illness, legal, vocational and family problems). These problems may extend from childhood through adolescence and into adulthood (Cook et al., 2007).

Focus on phases

Most treatments in the trauma field have been developed in a single trauma perspective, but recently new perspectives and understandings when it comes to the treatment of complex traumas. One of the most central understandings among these is the focus on phases from the theory of structural dissociation (van der Hart, Nijenhuis and Steele, 2006). The three intervention phases they describe are stabilization, integration and rehabilitation. This is similar to the perspective of Herman (1992) who defines the stages of recovery as working on safety, remembrance and mourning, reconnection and commonality.

Supporting avoidance of trauma memory

The term "phases" in trauma work has been an eye opener for many of the refugee health care workers. Traditionally trauma work has been understood solely as integration work. Crisis intervention work and debriefing theories have been an important source of inspiration for workers in the field of complex trauma. This infers that mainly by talking about the traumatic experience, one will heal. When helpers see children and parents struggle, the main task becomes referral to psychiatric services. The perspective has been that talking about what has happened to the person will be the basic ingredient for healing. While this often will be effective with a simple PTSD, victims of complex trauma need a stronger focus on regulation of symptoms, on safety and on resource building. Support of avoidance of trauma memory is a relevant intervention in the first phase of treatment. The belief in "working through" trauma in an emotional abreactive way (Nordanger, 2008) is also a western concept of healing. Many refugees will meet therapists and community workers working within this western paradigm. Stabilization theory is congruent with many other cultural paradigms that believe that not talking (too) much about the past is important. Focusing on the present and on the future may be considered to be more stabilizing. Phase oriented trauma theory defines what needs to be in place before more direct trauma work is to be done. (van der Hart, Nijenhuis and Steele, 2006).

Surfing or deep sea diving?

The goal of talking with a child or parents about his/her past should first and foremost be to bring symptom relief. Strong focus on trauma and detailed history taking is discouraged in the first phase, as this activates the traumatized memories. Oftentimes detailed trauma history is a part of intake procedures. Simply said; put headlines on the traumatic experiences but go in depth on assessing the resources! Working on the surface of trauma experience is different from working through trauma memories (van der Hart, Nijenhuis and Steele, 2006). Helpers often are confused in these two types of trauma conversations. Clarity to the difference between stabilizing symptoms and working through trauma history helps the professional network define their role in a more effective way.

The structured split between daily functioning and traumaoriented functioning:

The theory of a structured split between the part of the person stuck in trauma memory and the part of the person focused on daily life is an important perspective. The term "apparently normal personality" has been used to describe how a superficial type of functioning suddenly can turn into an extremely traumatized functioning (van der Hart, Nijenhuis and Steele, 2006). When a child or parent is in the traumatized part of consciousness they will feel that the past is more real than the present. The past is communicated in present tense. The person will be more impulsive and have less capacity to reflect on difficulties, plan for mastery and regulate themselves emotionally. Moving back and forth between these states will be experienced as involuntary. A deep understanding of the dialectic nature of trauma is necessary when working with war refugee families. The fluctuations are normal and need to be planned for.

The structural theory of dissociation says explicitly that healing will come most quickly

when one builds interventions on "daily life functions". The more chronic the trauma the more structured and predictable state shifts, between daily life functioning and traumabased functioning. The phobia between the part of the person holding the past horrors and the part of the person focused on daily life is a central dialectic theme in working with traumatized people (Herman, 1992). The part of the person motivated for school and work needs support from helpers. To do this one needs to identify if a person is in a trauma state or if the person is in the present. When traumastates (like flashbacks, trancestates, freeze and anger responses) are activated; always help the person find their way back to the present (van der Weele and With, 2011; van der Hart, Nijenhuis and Steele, 2006). Structural dissociation theory states that integration increases when one develops relationship to ones dissociated parts. Interventions are tailored to build on the part of the person phobic to their past experience. The "here and now" focused drives are slowly oriented to recognize the feelings, needs and the narrative of the traumatic part. Avoidance is addressed in ways that does not overwhelm.

Chechnian families in war to Chechnian families in peace

In 2009 Alternative to Violence received financial support from the Norwegian Extra-Foundation for Health and Rehabilitation[3]. The goal of the two year project was to develop and improve services to the Chechnian community in Bærum. At that time Bærum had 10% of the Chechnian refugees in Norway, about 600 persons. Chechnian children and parents struggle with massive war traumas after centuries of successive wars (Borchgrevinck, 2007).

The municipal of Bærum was struggling with service delivery to this population. There were reports of domestic violence and difficulties in the relationship between Child Protection Services and Chechnian families. Schools re-

ported aggressive teenage boys and socially isolated girls. The community helpers reported repeated failure in cooperation. Our experience through the project was that though the struggling families were relatively few, they influenced the perception helpers had of the whole Chechnian Community.

As mentioned above our training programs have been based on phase oriented treatment, in particular the phase of stabilization (Herman, 1992; van der Hart, Nijenhuis and Steele, 2006). We have also drawn on the Polyvagal theory (Porges, 2001) in describing the universal functioning of the human nervous system (fight, flight, freeze and submission). Furthermore we have used the concept of bottom up processing in neuropsychology described by Bruce D. Perry (2009). All examples in this article are taken from taken from the project. We have developed 10 principles through linking the above mentioned trauma theory with the qualitative information received from the traumatized refugees themselves as well as the Community Workers. The intercultural aspect of the project is beyond the scope of this article[4].

Ten principles for working with war traumatized families

Our experience is that many helpers are well trained in understanding trauma, but the implications for service delivery to children and their families is not well developed according to central trauma informed principles (Bath, 2008). *Understanding* symptoms of trauma and the aftermath of war that families have been subjected to; will be only a small part of the concrete services parents and children need.

This article will describe 10 principles of trauma informed care based on trauma theory and the clinical application to this particular population. The ten principles of trauma informed care in this article are the following: *1) The appropriate level of trauma history*

knowledge 2) Form an authentic relationship and build trust 3) Normalize and psychoeducate 4) Work through body 5) Focus on when to support and when to challenge 6) Never let correction sabotage for connection 7) Be a lighthouse 8) Focus on the fundament of resources 9) Make structure 10) Focus on rituals.

1. The appropriate level of trauma history knowledge

Understanding trauma symptoms in context will lead to creative solutions of daily life problems. Teachers and school nurses often disagree about who is responsible for talking with the child about the past. In some cases the past is considered irrelevant and strategies are mainly focused on behavior. In our opinion every adult meeting a traumatized child will benefit from knowing some personal history. What you need to know depends on your role; a therapist obviously needs to know more than a teacher. Knowing enables the adult to enhance a relationship to the child, and to discover potential triggers. An *outline* of a child's history will naturally include both traumatic experiences, cultural background and resources.

Achmed[5], 17 years old, lost both his best friends when he was 7 on the way to school as they played with a landmine. Witnessing his friends' death will unavoidably be linked to school, as well as his learning abilities. A teacher not knowing this may interpret his coming late in the morning as laziness, his struggling to concentrate as ADHD, and his trance like state in class as lacking motivation. A teacher knowing Achmed`s trauma background can help to make plans around walking to and from school, can give room for grieving, and can better accept his challenging behavior.

Symptoms of maladjustment, emotional pain and behavioral problems are the starting point for assessing the child's historical context, "Have you been reminded of something in

the past, since you were so upset in class?" In Achmed's case the teacher can develop effective trauma interventions based solely on the outline of the story about his friends' death. As addressed above we call this surfing for knowledge as opposed to deep sea diving. To be a good "trauma surfer" we advise refraining from asking about emotional experience in trauma conversations. Furthermore we recommend focusing on the time line and narrative rather than emotional reflection on the experience (van der Weele, 2006). Can he describe what is going on in his body and mind while walking to school? What does he think will help him stay to in the present while walking to school? Is there something his teacher can do with him when he arrives? Light a candle for his dead friends? Grounding exercises? A joke? A hug?

2. Form an authentic relationship and build trust.

War traumatized families often time have lost trust in humanity, the system and justice. They expect dangers and sense hidden motives; they expect the worst in any relationship. To form an authentic relationship is therefore quite essential. Yalom (2004) says that both in life and in treatment, meaningfulness is a side effect of engagement and obligation. In our opinion an authentic relationship means to be ready for reciprocity; you teach the family about life in peace, they teach you life in war. Honesty, curiosity and humbleness are important ingredients of an authentic relationship. When a family is in crisis they need home visits, help with letters to government authorities. There needs to be someone that is their connecting link between school, kindergarten, social services, doctors, lawyers, municipal offices and government offices. In order to work effectively and authentic with complex traumas we need to leave the office and our personal and organizational comfort zone.

We as helpers need to invest in building a secure relationship, first and foremost with the parents who in turn form secure bonds with

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[5] All the clinical examples in this article are created based on different stories derived from the project.

their children. War refugee parents may be chaotic due to their own unresolved traumas. In order to avoid the development of disorganized attachment in their children parents need help from the outside to structure the chaos and build their own ability to be stable attachment figures. Howard Bath (2011) goes as far as stating that "attachment and trauma are two parts of the elephant". Further he says that the very core of our attachment system is safety, as safety equals survival. Thereby the treatment of traumatized children must start with creating an atmosphere of safety. Children bond with adults that make them feel safe, and a secure bond as well as a feeling of safety is the way towards healing. Therefore the relationship itself is what is most therapeutic for traumatized.

A refugee health nurse wanted to swim with a Chechnian mother to build trust, to help her out of isolation at home, and to support the development of new safe body experiences. The refugee administration disagreed with her use of time. They wanted someone else to do this. In this case she deemed it necessary to invest time in the context of safe activities to build the relationship. The mother's struggle with domestic violence and with her experiences with rape could not be addressed outside of the context of a strong relationship.
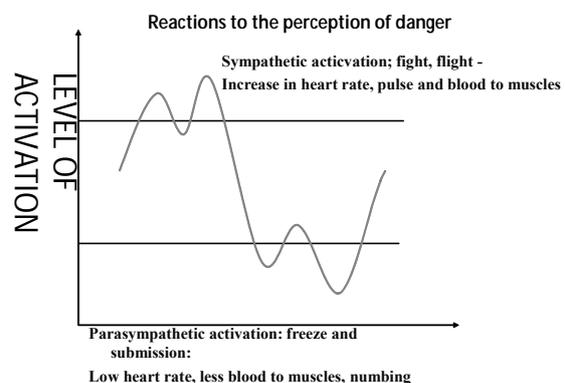
3. Normalize and psychoeducate

In working with traumatized families the importance of telling that their symptoms are *"normal reactions to abnormal experiences"* is central. This may terminate the feeling of being crazy, and will stabilize many trauma symptoms.

One of the most potent psychoeducative strategies has been teaching families and helpers how to hinder both over- and under- activation which is so common in traumatized individuals. The window of tolerance as described by Ogden and Minton (2000) explains both reactions of aggression, anxiety, impulsivity as well as depression, spacing out and freeze

reactions. The concept of window is used to describe a person's own ability to take control over symptoms. First one recognizes triggers and reactions to those triggers. Then one learns regulations skills. These skills consist of different types of grounding, distraction and emotion regulation techniques (van der Weele and With, 2011; van der Hart, Nijenhuis and Steele, 2006). Being in the present is the same as being within the window of tolerance. Being in your trauma memories is the same as being outside, in survival mode. (See figure below)

Salavaat, a father of 3, had an aggressive outburst at home. He was a war veteran and his entire family was war traumatized. His therapist invited his oldest son Mouslim, 11, who had suffered this anger outburst, for a joint session with his father. She showed him "the window of tolerance", to explain how his father was out of his window of tolerance the day he exploded. Mouslim started laughing and said "both Dad and I are above that window almost all the time, right Dad? Mouslim's father told in his next session that Mouslim had commented on him escalating into anger. Knowing about the "window" empowered Mouslim both to understand himself and his dad, to feel a relationship between them and to understand the bridge between present aggression/ activation and past traumas. Last, but not least, it gave him and his father a tool in situations where he suffered under his father's trauma violence; "The window of tolerance" empowered him.

Reactions to the perception of danger

Sympathetic acticvation; fight, flight - Increase in heart rate, pulse and blood to muscles

LEVEL OF ACTIVATION

Parasympathetic activation: freeze and submission: Low heart rate, less blood to muscles, numbing

Stress reduction is a potent strategy for reducing a wide range of trauma symptoms. Triggers create stress, and stress in general makes people vulnerable for their trauma memories; it drains a person for the energy necessary to live in here and now rather than in past traumas. Stress is also a trigger in itself. Activation of adrenaline can be a generalized trigger for former defense responses. Finding a level of activation that keeps the traumatized inside the window of tolerance is challenging task, but when found gives control and is stress reducing. Kickboxing may make a person aggressive and stressed, while swimming calms the body.

In times of economic recession many stress reducing activities are considered a luxury by municipal administration. Is it really necessary for the municipality to invest in skis and seasonal cards? Or to buy bicycles? Families from war do not longer know what peaceful days and relaxing activities are. Left to themselves they struggle finding and motivating themselves for these family activities. To be in *here and now* is an important task to relieve stress. Children from war need to learn what children in peace know instinctively. In lobbying for war refugee health care it is important to define stress reduction strategies as a central trauma intervention. In our experience finding finances in health care budgets for stress reduction strategies as the above mentioned has been a recurring battle.

An important task for the traumatized is to learn what his/her triggers are. Are they loud talking? Teasing from the other pupils? Is nighttime in general a trigger? Is the sound of airplanes a trigger? Triggers are stimuli that bring the traumatized out of the window of tolerance. Triggers can be internal body states or thoughts and feelings. They can be external like seasonal, related to time of day or related to people and places. Triggering stimuli are easily generalized. A central mechanism is the person's felt need to avoid anything what will awaken painful memories. Many times what triggers a person will not be available

for his/hers explicit memory. The experience is encoded in implicit memory.

As war infiltrates all aspects of life, many war refugees find it difficult to identify their triggers. Regular day to day experience feels like a trigger in itself. Focusing on stabilizing factors that keep them in the present can be done without identifying each and every trigger. Learning what stabilizes is equally important as finding triggers; is it drinking water from a magical glass after nightmares? Looking at drawings of super- men and -women with all kinds of magical powers hanging over the bed? Is it sitting in the library in the school breaks, reading and talking with the librarian? Or is it playing football?

We have had many discussions with teachers about whether or not triggerwork should be a part of their job description. Some find triggerwork difficult to combine with the pressure to follow the curriculum. In our opinion trigger work needs to be done where the student is triggered. During conversations one must stop when the traumatized client is not mentally present. If the child needs to walk or play as you talk instead of sitting in your office then that is what you need to do. Use a flip over in every conversation, both to facilitate language and to regulate closeness/distance. When you see the traumatized "space out", change subject and comment: *Where are you now*? *You seem distant! Notice how you breathe! Do you want a glass of water*? Those are simple sentences awakening cortex and bringing all of a person back to here and now (Porges, 2001). To educate about triggers, discover triggers and teach regulation skills are a natural part of the work for all of those working with traumatized families (see also van der Weele and With, 2011).

4. Work through body
Isa, Said and Sedat saw their mother being kidnapped one year ago, upon arrival to Norway. Masked and uniformed men came into their home 2 o'clock at night, pulled mum out of bed and kidnapped her. The mother cancelled her session the day before the one year

anniversary of this trauma. The psychologist came home to the family as she felt that this day was so important that she could not just let the mother slip away. The mother and all 3 kids were at home. This morning the children had woken up crying, in turmoil and none of them wanted to go to school. None of them, not even the mother, knew why they felt so upset, so frightened and so "lost" this day. The psychologist had a bridging conversation; connecting past traumas to present bodily and emotional symptoms. She advised them to have a family party at the exact time of the trauma. The children baked a cake together for the party. This helped them create new pathways for old memories. Psychoeducation about symptoms of distress helped the children bridge the past with the present. But this is only the first step as concrete new bodily experience strengthens the reality of safety in the present.

Creating an environment that is playful, creative and has an emotional lightness demands body focused interventions as this will affect the body's alarm system. Teachers may find it difficult to explain the meaning of fun and play in the curriculum. Staff may want to be creative, do follow up while walking in the woods for example, but find that administration and leadership do not see the value of "out of office" work. Positive body experiences are not luxury but a necessity and in many cases a turning point for the traumatized. For children in school taking breaks during class to be on the swing, extra time at the ping pong table or rhythmic activities will help them calm the body. Noticing your breathing is an intervention we use with all clients, and teach all of the helpers. Regulation of body states just through awareness of breathing will in many cases be more helpful than the use of advanced and difficult breathing techniques. In the workplace we advise that traumatized people have work that will include activity and variation of duties. Static jobs will easily increase access to trauma memory. Stabilizing jobs will be those that include regular physical movement and vari-

ation in tasks.

"Active is better than passive". To stay in the present and focus on movement and variation is trauma stabilizing. Jobs or schooling situations with long lapses of monotonous work will easily open the door for traumatic memory. A part time job combined with sick benefits is better than being on a total sick leave. Coming to class but not participating as usual is more stabilizing than staying home. A job as a chauffeur delivering goods may be preferred to sitting in a ticket office.

5. Focus on when to support and when to challenge

This is a central question for many health care workers. When is it time to demand less avoidance and more active building of daily life? Conflicts often arise in health care teams on the issue whether one should support or challenge the client to start working, to go to school and so on. Should the traumatized child be able to go to school alone or be picked up by a taxi? Should the traumatized parent be able to work full time or part time? The balance between supporting and challenging the traumatized child and parent is a difficult balance. Helpers will easily end in both extremes of this continuum. Some will be overly understanding for the need for isolation and the need for external support in daily functioning, while others will feel that the time is ripe for demands. The conflict between these perspectives are often magnified by the fact that people that are heavily traumatized can look quite capable of regular daily life functioning.

Understanding of the fluctuating functioning after war trauma is challenging for helpers. Many of our programs are not organized to buffer the variation in war refugee functioning. Programs are often organized as being "in the program or out of the program". Trauma symptoms will be reduced with a more realistic assessment of a person's functioning. The following points can be helpful when trying to find the balance between supporting avoidant

strategies and challenging these strategies:

a) The more sleeping difficulties, the lower the amount of challenge. Sleep disturbances make you susceptible for stress. All the 32 clients we have seen in our project; mothers, fathers and children sleep in average only 3 hours per night! This includes children down to the age of 3 and it includes refugees that fled as long as 8 years ago!

b) Impulsive behavior is a sign of the need of less stress and more supportive regulation.

c) When the quality of relationship to you as a health care worker is low, challenge must be low.

e) When the person is in danger, either psychologically or physically, fewer demands can be made on managing daily life. Bombing of your home town in for example Chechnya will mean that classroom demands needs to be adjusted to more support than demand.

f) Living with (domestic) violence will also lead to the need to regulate goals of learning and increase focus on safety issues.

When the refugee has a good relationship to you, does not suffer from impulsive behavior, is in safety and has regained some sleep the focus needs to be on challenging avoidance and focusing on life style changes and future goals.

We use the metaphor "the inner wall" to describe the window of tolerance, trigger management and the balance between support and challenge. "The inner wall" (van der Weele, 2006) explains the fluctuating mental strength a person has to stand down memories that overwhelm. When "the inner wall" is thick, the person can choose to open a door to work on some memories. When "the inner wall" is thin, memories easily involuntarily disturb daily life. The wall is strong when one is in safety, has fun in life, sleeps well and has small realistic goals. The wall weakens when in danger, when stressed and by overwhelming daily duties. We usually say; "each time you do something good for yourself and for your family, your wall gets stronger. Each time your wall gets stronger, you gain more

control over you traumatic memories".

In the project we have arranged dance nights, concerts, separate evenings for women, men, boys and girls with food and nice talks, weekends away together for fathers and sons as well as a Saturday school for the children to learn activities such as drawing and dancing. All these activities take the families out of isolation and focus on past trauma memories, and in to stabilizing group activities that "build their inner wall" based on new pleasant memories. The weekends away for fathers and sons, combined with film making[6] built powerful identity resources, especially for the teenage boys.

6. Never let correction sabotage for connection

The above quote is by Howard Bath (2011) from his work with foster parents in Australia. Many treatment programs and schooling programs have a strong emphasis on behavioral interventions. The problem for traumatized children is that these interventions may suppress their undesirable reactions, but it does not help them *regulate* their defensive responses of fight, flight or freeze. Coregulation is the term used by Bath (2011) as opposed to coercive regulation. When you don't focus on the underlying trauma causing the undesirable behavior you will intervene primarily on a behavioral level by stopping "bad" behavior. Trauma informed interventions will first help the child calm down and will focus on the child's needs. This is opposed to the behavioral strategies that will tend to ignore the child's needs.

When a child feels that he/she is in danger, even when in safety, the most important thing to do is to enhance the feeling of safety. This is done by heeding the principle of emergency exits. When in a classroom, where is the door? Does the child need to see the door to be safe?

One child we worked with was very restless in class. To help her concentrate the teach-

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[6] Directed and edited by Jon Nichols.

ers had her desk facing the wall, with the door behind her. This naturally increased her stress level rather than decreased the stress.
"You may leave/take a break when you need" has been part of all our interventions. This rule supports personal control for increasing ones' own personal sense of safety, and will therefore increase the ability to stay in the group and in individual sessions. In the psychological sense emergency exits mean refraining from direct consequences to undesirable behavior. If the child is angry, has destroyed something, forgotten things or has other behavioral difficulties, preferred interventions are those that first regulate the child back into a sense of safety. When the child has stabilized within the window of tolerance one can talk about the issues involved.

Regulation can involve being allowed to calm down in a safe environment, grounding exercises and emotional support. Immediate consequences when you experience yourself in danger will escalate fear, anger and submissive responses. When outside the window of tolerance the child will not be intellectually present but function impulsively through activated trauma responses. Teachers involved in our training programs had many examples of reacting to undesirable behavior without the context of trauma, and how the approaches of immediate consequences were fruitless. The concept of "not being online" for learning was helpful for teachers in developing strategies to handle trauma related, undesirable classroom behavior, or as Horsman (2000) so aptly put it; *being "too scared to learn".*
Giving choices to children can be a type of psychological emergency exit. It may therefore increase the feeling of safety and control. Other potential emergency exits in school might be; teacher tolerance of the child's unstable functioning due to trauma symptoms. If the child feels welcome on fragile days it will be easier to come to school. We recommend flexible learning situations. When feeling vulnerable on days filled with trauma memories the child might need small groups or one to one learning arenas. Permission to

come in later at days the child feels especially stressed, permission to leave the classroom at moments you need to catch your breath etc. Difficult days can be days for repetition of curriculum, vital and stable days can be used to learn new things (Horsman, 2000).

7. Be a lighthouse
Teaching children and parents to talk to their traumatized part in a regulating way is a general skill taught to helpers. Regulating statements in the stabilization phase will often need to come from helpers first before the traumatized person can start using them. *"Talk to yourself, like you talk to a child that is scared. Be like a good mom to the part of you that is stuck in the bad memory. You can say things like "you are in Norway now, it is safer here". "Yes, what happened is really terrible, look around, look and listen! You are in a Norwegian classroom".*

This strategy can be understood as externalizing within narrative therapy (Epston, 1993). The traumatized person learns to talk to his/hers traumatized self. In modeling these self regulation skills helpers can speak directly to trauma when child or parent are emotionally very upset. Regulating statements need to be culture-, gender- and age- appropriate. To be a lighthouse means that helpers can aid integration by focusing on supportive statements that are central to the traumatic experience. Helpers can speak to guilt directly saying; *"You did what you could in the circumstances".* Or by saying: *"You were young"* to the young person who collaborated with the enemy. One possibility is to combine the comforting statement with putting your hand over your heart. This is a common greeting in the Middle East to show respect to the person you meet. For the client it works well as a bridge to connecting to their traumatized part. They hold their hand to the heart and say to their traumapart; eg. " You are safe(r) now". We instruct them to then take a deep breath and repeat the comforting statement.

Oftentimes helpers feel trapped in the reality of ongoing trauma. They may get overwhelmed together with the traumatized family as opposed to being able to be their lighthouse. An important principle in working with children is; don't believe reality even when it's real![7] Helpers need to avoid being trapped by focusing solely on the worst case scenario. None of us know anything about our future; something might happen that turns our life upside down tomorrow. Children need to feel safe; they need for feel that their parents will do anything in their power to protect them.

With all adults around them in a crisis, the children were emotionally abandoned; there were no attachment figures that could be a lighthouse of hope, or that could help them find their resources to deal with a traumatizing past and a difficult present. Important sentences to say to trauma self for these 3 children were: *"It's difficult now, but things will change".*

8. Focus on the fundament of resources

Helpers naturally will often define refugees first and foremost by their traumatic experiences. Resource building includes broadening the refugee identity, creating meaning, hope and reactivating former personal and family resources.

One of the consequences of war is *the loss of meaning.* Without meaning neither children nor adults can feel they have a life with purpose; to feel meaning lies in the belief of a future and a purpose of your life. Meaning making is therefore one possible resource.
A girl, 11 years old, regained her feeling of purpose after engaging in her country's politics. This, together with EMDR treatment on her main traumatic experience, gave her back her childhood vitality; her ability to engage in relationships, sports and play. She explains that politics is of huge importance to her, it builds her cultural identity.

Another possible resource is *self respect.* One road to self respect is to understand that one's defense systems during traumatic events saved one's life and sanity but in the aftermath may become one's problem. Deep understanding of the human defense system when in danger is healing.

Mouslim's father, Salavaat describes the difference between fathers in peace and fathers in war. He told that he had never joined any of his kids to any football match.

For fathers in war, one of the first things one must to do is to distance oneself from one's children. Loving them and missing them desperately, one cannot focus on serving one's country. Not only does one have to break the bond for one's own mental health and for the service of one's country, it must also be broken for the child's sake. If the child has his/her main attachment to the mother, the chance for the child losing a central attachment figure during war is less.

His boys, had often asked him to come to their football matches, but he had refused not understanding why. Then, one day, after one year of therapy, he came in to the office telling he had joined his youngest son to a football mach. He told he had seen the joy in his son's eyes and he could see how much it meant for the son to finally have his dad there. But for him this closeness felt terrible. He felt panic, fear and desperation! He felt worse than any other time after the war.

Victor Frankl (1969) wrote about how parents in concentration camps start "killing" their emotions, and specifically their longing for their loved ones at home. It is parallel to the process happening to parents in active war duty. To redo this process and reawaken love and emotional bonding is not only difficult work, but existentially it involves realizing one's importance for one's child, one's responsibility, and the potential loss for one's child if one dies. It involves close authentic relationships; it involves understanding the

importance of you as a *person,* as opposed to an object used for the purpose of war (Buber, 1923).

Psychologically it therefore means reinventing the perception of *you* totally. A former warrior, a present father, a former tool for killing and protecting, but now a Self of massive importance for your children's feelings as well as for their emotional development. To open for love hurts, as a Chechnian soldier said:

"War makes the heart shrink and dry inn, to refill it with blood and make it alive again is very, very difficult!

Understanding the difference between fathers in war and fathers in peace functioned as a resource for this father, enabling him to connect authentically rather than instrumentally to his children.

As fathers loose bonding skills in relation to children, children may find their creative resources and abilities to use imagination lacking after the traumas of war.

Isa, Said and Sedat were struggling to sleep and had nightmares after having experienced their mother was kidnapped at 2 o'clock at night. Therapeutic interventions involved drawing supermen -drawings to hang above their beds. The therapist assisted them in drawing themselves with every tool possible to drive away the nightmares. Their ability to imagine alternative endings to nightmares was damaged. The therapist had to help them visualize possible solutions. Their creative resources were numbed by their fear. The therapist modeled creative drawing. Slowly their creativity reawakened and they started drawing creative resources.

Filling the role of being a good and responsible caretaker is central to the identity of parents. Building on this resource is a trauma intervention. In general the political arena has not had an adequate focus on how to help traumatized parents in their role of parenting. In our work with parents, we focused on their resources as caretakers: teaching them to stabilize their children, and encouraging the importance of their traditions and cultural heritage. Many refugees find that their parenting skills are looked down upon by the ethnic majority. They may use physical discipline and find that this is not condoned. They may regulate their children's social life according to customs in their tradition to a larger extent than for example ethnic Norwegians. Parent groups and parent programs focusing on non judgmental dialogue and resource building help parents in exile[8]. ICDP programs were found to be helpful for parents in this project.

Being told again and again that physical discipline is not tolerated, without being informed about the alternatives, degrades parental resources (van der Weele, Ansar and Castro, 2011). Follow up traumatized children may demand resources of the parents that are not acknowledged by the community. Our training strategy has been creating awareness in the municipality to the special challenges in parenting after war.

Simple resource work for teachers and others who work with refugees is just talking about former interests, work and nice stories of former life in peace. To talk about good recipes, nature and cultural traditions awakens resources. When one talks about peaceful and positive memories it will resonate in the body. This helps the person regain a larger basis for their identity than the trauma that may fill them. When helpers know of resources, they can use these to help the person when activated in trauma memory back to the present. Children can draw their resources, write poems, stories, letters and make art work to enhance the strength of their available resources.

9. Make structure
Strategies that traumatized people need are based on the fact that the higher regions of the

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[8] IDCP: International Child Development Program

brain often are "off line". Deficits in executive functioning are central aspects to people struggling with trauma. Memory problems like forgetting appointments, lack of concentration and feeling disoriented in time need to be addressed in treatment. Attention deficits disorders and organizing difficulties that one sees with children within the autism spectrum and ADHD spectrum are similar to those of traumatized children. Teachers we supervised could relate to the need to use those pedagogical strategies developed for Autism and ADHD. In working with attention deficits you can give the child extra time to do the required work and use shorter sessions with time control. Short term goals motivate as well as structured use of one task at a time. Other important interventions are clear and simple instructions, both written and oral instructions as well as repetitions of instructions. (McConnell and Ryser, 2000). In working with traumatized adults reminders of appointments by cell phone texting, written information, and a general respect for memory problems will be just as important as for traumatized children. Traumatized children and parents often time feel burdened by their inner chaos, and therefore welcome this structured intervention style.

10. Focus on rituals
This article promotes refraining from a strong direct focus on trauma in the early phase of healing. One of the challenges becomes how to do this without supporting unhealthy denial. The theory of stabilization can become an excuse to not work with potent painful memories. Giving pain space will decrease the involuntary focus on the traumatic memories. Creating rituals that hold the general experience of pain will be an important part of community's stabilizing work.

While continually supporting not talking so much about trauma in daily life, this is not be confused with denial. Quite the opposite is the case. Finding arenas where the trauma memories can be held with good symbols and rituals are important. Schools can cre-

ate rituals to remember those who have died. The Chechnian community has the tradition of the "Thursday gift". Here one shares food and money with those who have lost their near family members. Focusing on certain historical days, lighting candles or having a corner in the classroom for painful memories may all be ways of framing painful reality. Children with dramatic stories need to have communities and schools who remember that their stories exist. Are there memorials, statues, art work that can be a reminder of the inhabitants' lives?

Summary and concluding remarks
Trauma treatment encompasses much more than individual therapy. Modern trauma theories can structure good trauma intervention programs. This article describes how phase oriented treatment, structural theory of dissociation and neurodevelopmental perspectives can broaden the base of the work done by the municipality and refugee health care system. Helpers need good theory and research to defend effective trauma intervention programs. The most effective strategies may initially cost money, redefine job descriptions of refugee workers and will demand both bureaucratic flexibility and the cooperation among a broad group of health care providers and community workers. Complex trauma describes the condition many war refugees struggle with when in safety. Based on theory, research and experience we have defined 10 important principles in creating trauma informed care.

Creating an environment for life in peace involves connecting symptoms as flashbacks and difficulties in concentration to the historical life narrative. This will provide information necessary to tailor the type of support needed for symptom management. To stabilize daily life, war refugees need to develop authentic relationships and build trust with their helpers. Furthermore normalizing reactions and educating about symptoms will support healing. A central principle is developing interventions that focus on working through the body. Bottom up processing

is more effective in regulating alarmstates than top down processing. When should the help focus on support and when to challenge? Monitoring stress levels, sleep, safety, impulsivity and the quality of relationship with the helper will give some answer to that challenging question. Respecting the overall importance of high quality relationship will implicate restraint in using behavioral strategies to control undesirable behavior. One must focus first and foremost on strategies that regulate the war refugees' state of alarm and help them reconnect to the safe present. Helpers need to inspire the families with strong messages of hope and nurture the traumatized when the past feels stronger than the present. The refugees themselves can learn to calm inner traumaparts by regulating statements and actions. Focus on the fundament of personal resources must be stronger than the focus on traumatic experiences.

Trauma also affects executive functions. Structure in daily life is created by regularity, repetition, and reminders of different sorts that will support the traumatized persons' temporary lack of organizing capabilities. Rituals integrated in the school and local community will help families hold the pain in a stabilizing way. Working with war refugee families with a holistic focus will increase their capacity to heal and integrate in society. As a Chechnian father adequately concluded:
I imagine a brick wall with life in peace on one side and life in war on the other.
Since I came to Norway, 5 years ago, I have peeked over the wall, to "life in peace" in an attempt to understand this life. It is very, very different from "life in war".
When I understand sufficiently to participate in this life, I will climb the wall and jump over! But still I have more to learn..."

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THERAPY WITH UNACCOMPANIED REFUGEES AND ASYLUM-SEEKING MINORS

Mari Kjølseth Bræin[1]   **Helen Johnsen Christie[2]**

Abstract

In this article we would like to convey the usefulness of understanding trauma, trauma treatment and cultural psychology when working with unaccompanied asylum-seeking minors. To demonstrate how this can be done in practice, we describe the courses of treatment for two unaccompanied asylum-seeking minors. Trauma had affected them differently and their treatments had to be modified accordingly. The treatment demonstrates how we can utilize evidence-based methods in combination with cultural sensitivity and own creativity.

Keywords: Unaccompanied minors, trauma, therapy, cultural sensitivity

Rezumat

În acest articol vom discuta importanţa înţelegerii traumei, a terapiei traumei precum şi a psihologiei culturale în lucrul cu minorii neînsoţiţi care cer azil. Pentru a demonstra modul în care se realizează în practică acest lucru, vom descrie întregul parcurs al tratamentului a doi minori neînsoţiţi, reclamanţi de azil. Trauma suferită i-a afectat în mod diferit pe cei doi, iar tratamentul lor a fost modificat în acord cu aceste diferenţe. Tratamentul demonstrează modul în care putem folosi metodele bazate pe dovezi, în combinaţie cu o sensibilitate faţă de aspectele culturale, precum şi propria creativitate.

Cuvinte cheie: Minori neînsoţiţi,   traumă, terapie, sensibilitate culturală

[1] Psychologist, Asker Child and Adolescent Mental Health Clinic, Asker, Norway, Email: mari.braein@gmail.com;
[2] Psychologist/Researcher/Special advisor, Centre for Child and Adolescent Mental Health, Eastern and Southern Norway, Oslo, Norway, Email: helen.christie@r-bup.no.

Introduction

The majority of unaccompanied minor refugees have shouldered great burdens as a result of war, escape and loss. Dittman and Jensen (2010) reviewed the literature about this group of children and found that little is written and most articles are careful to infer conclusions based on research. However, results do indicate that unaccompanied young refugees are a highly vulnerable group and experience a large number of psychological problems when compared to other youth. Unaccompanied minors have a high occurrence of post-traumatic stress disorder (PTSD) (Oppedal et al., 2009). Many unaccompanied minors carry extensive histories of trauma as a result of war, poverty, neglect and abuse, that do not lend themselves to satisfactory description through use of the PTSD diagnosis. The concept of complex PTSD (Herman, 1992) or Developmental Trauma Disorder, DTD (van der Kolk, 2005; Pynoos 1995; see also Mannes, Nordanger and Braarud, this journal) describe the personality change that occurs as a result of significant and repeated traumatic events. Repeated stress weakens a person's ability to feel safe, to regulate his/her own feelings and closeness to or distance from other people. Bruce Perry is one of the leading theorists in the field of trauma and has extensive experience working with severely traumatized children. He found that several of his patients who had been subjected to threats over time had chronically high pulse rates and an elevated level of noradrenaline and adrenaline which persisted even months after the children were in safe locations (Perry, 2006). If this heightened state of alertness persists over time, the results coul be in chronic changes in the brain, especially if the traumas occur early in life (van der Kolk et al, 1996; Perry, 2001). Several studies indicate that good parental support moderates/reduces the risk of mental problems after traumatic experiences (Cohen et al, 1996; Scheeringa et el., 2006, here in Dittman & Jensen, 2010). It is precisely this lack of close relatives and their possibly moderating role that makes unaccompanied refugees particularly vulner-able. Arranging for them to form lasting and close relationships with new adults will give these children the necessary conditions to function as well as possible. Unaccompanied minors who live in foster care have lower levels of depression than those living in institutions (Oppedal ibid). It is therefore paradoxical that many have to move several times during the first year. In many countries only a few are offered foster care among them Norway. Unaccompanied young refugees are seldom referred for mental health treatment despite presenting with severe mental health problems and there has not yet been conducted any study to evaluate psychological interventions (Dittman & Jensen, ibid).

Working with these children we also meet cultural challenges. Although, symptoms of PTSD can be seen across cultures, there is variation among coping strategies and types of symptoms seen in different cultural contexts (Nordanger, 2006). We need to be aware that our diagnosis system is not necessarily the best indicator of what these children need help with. Meeting these children in our clinical practice today, we need to use the best available knowledge in trauma and combine it with cultural sensitivity and our own creativity.

Yousef and Barak

We will now introduce two boys who were both referred to an outpatient clinic as a result of serious trauma. However, the types of trauma were different and so were their reactions to it. When we first met these boys we had little information about the traumas they had been exposed to. However, each of them had serious symptoms that prevented them from functioning in daily life. At first they would appear to be much alike; two boys of the same age, from the same part of the world unable to relate to the past, with little belief in the future, and with significant difficulties here and now.

Yousef had been exposed to serious trauma throughout all his life, both in close relation-

ships, as a result of the horrors of war and a dangerous escape to Norway. Working outdoors, he was one day attacked and abused by members of the Taliban. He woke up bruised, and has suffered from reduced hearing and headaches ever since. During his childhood he had experienced extensive violence from his stepfather. When Yousef was asked if he had some good memories from living in Afghanistan, he replied that he can remember speaking to a chicken and that he dreamed of being able to go to school. Based on knowledge about long-term trauma, Yousef would be at risk of developing both relational and emotional problems. Throughout his life he had to deal with danger and probably had an overactive stress response system. Yousef was diagnosed with PTSD, but given his extensive problems and lengthy history of trauma, the DTD concept would likely be more appropriate. He fulfilled the criteria for a PTSD diagnosis, but he communicated that the unclear situation in the present was what caused him most stress. He tried to "forget the past," and wanted to start a new life in Norway. From a cultural perspective we could assume that the lack of security here and now was most *relevant* for the boy to get help with in the beginning. Yousef calmed down significantly when his asylum application was approved.

Another boy, *Barak*, also came to Norway from the Middle East in the same year. He had grown up surrounded by war as well. He came to Norway at the age of 15 after having lost his entire family in a bomb explosion; mother, father, two brothers and one sister. When he came home after work he found the bodies of his family members spread out over the area. He had an acute stress reaction and stayed in bed for several weeks in his aunt and uncle's house. His aunt found him a burden living there, so his uncle contacted a smuggler to get him to Norway. Barak was exposed to the worst catastrophe imaginable; losing all the people he loved. This trauma totally changed his life and he was sent away to manage on his own without any kind of support around him. We can easily understand that he lost his faith in life and that the only wish he had

when arriving Norway was to die. He met the criteria for PTSD, but also had symptoms of complicated grief disorder (Dyregrov, 2006) and depression. Before this event he had lived a relatively harmonious life together with his family, despite worries related to war and economy. He had a close relationship with his parents and was especially close to his sister, three years older than him. She died in the hospital two days after the bomb attack. Due to the war, the family spent a lot of time together in their house. They dreamed of a life in freedom and often had political discussions. Barak went to school and had many good friends. He was interested in art, music and literature. His only knowledge of Norway was from reading Jostein Gaarder's book "Sofie's World" at the age of 14. Barak experienced that he always had the support and the love he needed at home. However, a brutal war caused him to be all alone in the world with no one to lean on.

Both Yousef and Barak had experienced extensive traumas that had made them unable to function. However, they had been exposed to different types of trauma that impacted them differently. While Barak had been exposed to one massive trauma that totally changed his life, Yousef had been exposed to relational trauma ever since he was little. Barak had experienced good care, attachment and love since he was little, while Yousef had to manage largely on his own as a shepherd. Yousef struggled in a number of areas as a result of traumas and neglect, while Barak's development seemed blocked by an overwhelming trauma. They were both weary and exhausted when arrived in Norway, and they needed secure and caring adults around them as well as clarity in relation to residence permits. Neither of them had gone to a psychologist before and both came from a culture where there is a widespread belief that psychological treatment is for "crazy people." Neither of them wanted to talk about what they had experienced and could not relate to past, present and future. Yousef expressed that he just wanted to forget all the pain, Barak's only wish was

to die. Working with children who have experienced so much pain, you easily feel powerless as a helper. The stories and pain the children carry, can also seem overwhelming for those trying to help them. Good knowledge of trauma treatments that have proven effective is therefore useful. We will now describe some common principles in treatment models and give examples of the most documented manuals and then demonstrate how these were used in relation to Barak and Yousef.

Common factors in different treatment models

There is no preliminary research on effective therapy with unaccompanied minor asylum-seekers (Dittman ibid). We therefore have to use knowledge about traumatized children in general, and at the same time employ knowledge from cultural psychology. There are a number of therapeutic methods that have been developed to treat PTSD. Dyregrov (2004) concluded that effective treatment methods for PTSD consist of more than just conversation and support. Methods rooted in behavioral and cognitive strategies, with a focus directly on traumatic memories, have proven to be most effective.

In her book *The Trauma Treatment Handbook: Protocols Across the Spectrum,* Robin Shapiro provides an overview of the most familiar models of therapy. She identifies what she calls "five threads" which implicitly or explicitly appear in the various models (Shapiro, 2009):

1.   Presence: In trauma therapy it is important to help the patient getting into the here-and-now experience of body, affect and thought . The patient must be helped to stay within the range of tolerance and not be over-activated (emotions becoming too strong) or under-activated (as in avoidance behavior).
2.   Dual attention: In good trauma therapy the client's attention has to be in two places at the same time: they must hold the trauma in mind (exposure) while maintaining focus in current time. In an EMDR approach (Shapiro, 2001), the second focus is in a bilat-

eral stimulation, in more bodily-oriented approaches, attention is paid to what is happening in the body here and now while the trauma memory is activated at the same time.
3.   Emotional activation while in a relationship: Emotional discharge or venting are not sought after in trauma therapy, instead the goal for the person is to experience and recognize the memories and feelings at the same time as s/he is present in a meaningful relationship; the functions of this relationship is to witness, to contain and therefore contribute to the integration of the memory as a part of a person`s story.
4.   Relationship with self and others: Trauma therapy is not only about processing the memories of trauma, it is also about increasing the capacity and tolerance of being in a relationship.
5.   Making meaning of the traumatic events: In models of trauma therapy an important focus is on working with the aspect of meaning. Working with meaning in relation to traumatic events can trigger anger, grief and eventually relief.

A short description of the most well known models for treatment, applied in the cases below

Nijenhuis et al. (2006) have developed a phase-oriented treatment model for people who have been exposed to complex trauma. Based on this model, treatment should be both constructing and processing. Events of a traumatic character can be difficult to integrate as experience because they are overwhelming. Avoidance or phobia of traumatic memories is often an unconscious reaction against taking into account the overwhelming consequences these events had in one's own life (Nijenhuis et al. ibid). The phase-oriented treatment model has an objective of increasing the client's capacity to integrate the trauma-related experiences that he or she has not been able to relate to. However, the model assumes that the patient first needs help to build an experience of security, mental strength and being in the present, called a phase of stabilization, before he or she can begin to digest

and integrate the painful experiences. The phase-oriented treatment model is divided into three main phases of treatment: *stabilization and symptom reduction, processing of traumatic memories,* and *personality integration and rehabilitation.* Throughout the therapeutic process there is a focus on strengthening the client's level of daily functioning, training the client to handle emotions, and adjusting the work in accordance with the client's tolerance limits (window of tolerance). Everything occurs within the framework of a safe relationship between therapist and client. Within a model like this, treatment can be carried out with the help of various tools taken from methods such as TF-CBT, narrative exposure therapy, and others.

Trauma-focused cognitive behavior therapy (TF-CBT) is one of the most well-documented trauma treatment methods for children (Cohen et al., 2006). TF-CBT consists of different modules. Module 1 is psycho-education: a pedagogic part where the patient learns about what happens in the body and the brain when we are exposed to overwhelming events, and what the common reactions are. Moreover, the patient is taught the justification for the various treatment techniques that will be used. Children can be afraid of going crazy, and instruction about common reactions to uncommon events is in itself a way to calm the child down. The next module is: Relaxation and training in affect regulation. Here one learns breathing techniques, grounding, and, for example, guided daydreaming (including travel to a "safe place). This is followed by a module where the person works on recognizing and managing reminders of the trauma ("triggers"). There are many stimuli in daily life that can be reminders of traumatic experiences; sounds, scents, angry voices, sudden movements etc. These can trigger unexpected and incomprehensible reactions. Learning to predict what triggers the traumatic memories, and how to control and predict when they will arise, gives patients a greater sense of control and management. This is taken further through a module with training in cognitive

mastery which means seeing the connection between thoughts, feelings and behavior, and identifying thoughts that are not helpful. The final module is writing down a trauma narrative so that traumatic events can be placed in the context of time and space. Trauma often results in a breakdown in the sense of time. Flashbacks and nightmares (symptoms of reliving the trauma) make a person feel that it is happening again and again, and the memory that should help put the experiences into a historical context, is impaired. TF-CBT is currently being tested on unaccompanied minors under the direction of the National Competence Center for Violence and Traumatic Stress (NCCVTS) in Norway.

One approach that is similar to TF-CBT is narrative exposure therapy (NET), which is also currently being tested on refugees in Norway. NET builds on two main elements: exposure and development of a trauma narrative. The justification for exposure and confrontation with memories of trauma is built upon a rationale of habituation; in other words, if we are exposed to fright-inducing stimuli enough times, eventually we will be able to relate to these with less activation/hyperarousal. The rationale behind the development of a trauma narrative comes from traditions within testimonial therapy developed by specialists connected with the aid organization Victims Voice in partnership with the University of Konstanz. Both good and frightening memories are placed on a timeline of the person's life and the frightening memories (hot spots) are explored and eventually made more detailed. With children (kidNET) a rope is used to portray the timeline, and flowers (good memories) or stones (frightening memories) are placed along this timeline. Many of the refugees come from cultures with strong story-telling traditions and this emphasis on putting the story in context appears to be quite promising (Milde et al., in press).

The models and the common principles we have described, provide good guidelines for treatment, but each treatment plan must be

tailored in accordance with the child's cultural background and characteristics. We will now look more closely at the meaning of cultural sensitivity, followed by a description of important protective factors for the child and the environment.

Cultural sensitivity

When working with unaccompanied minors, special demands are placed on the therapist's cultural sensitivity. By cultural sensitivity we consider the therapist to be exploratory, respectful and curious about the client's ways of thinking and cultural background with a goal of activating the child's own abilities. The National Child Stress Network (paper II) concluded that in order for treatment to be effective for refugee children, it must be culturally relevant, in addition to being holistic and trauma-focused.

A central part of trauma treatment is processing difficult experiences. Unaccompanied minors who come from a culture with a discourse of avoidance will often refuse to bring unpleasant topics to the table. They may have an expectation that it is possible to forget difficult things if they don't think or talk about them. Openness in a therapeutic relationship may seem threatening. Nonetheless, it is important to keep in mind that the child is facing a new cultural influence in Norway. Most children will quickly catch up the idea that talking about difficult things is okay in Norway. This can invite to new understanding and coping strategies that might be useful for the child in the current cultural context.

Knowledge about the current political situation in the child's homeland and about cultural values is useful for the therapist (Ager, 2002). Furthermore, the therapist should know something about the characteristic ways of relating to emotions and how these are expressed (Hundeide, 2003). It is also important for the therapist to be able to clearly convey their own ways of thinking and understanding so that the child understands what the treatment is about. This can serve as the basis

for a "cultural negotiation" about the purpose of treatment (Nordanger, ibid). For many unaccompanied minors, going to therapy is so strange and threatening that a great amount of clarity is needed about the purpose. Building alliance is especially important when working with these children since many of them have been exposed to betrayal of trust. Alliance building may be time-consuming, but it is a crucial part of the treatment. It is not reasonable to begin working on trauma history until after understanding has been reached about what will happen in therapy (Sveaass et al. 2006). It is important to accept the patient's desire to not talk about "the pain" in the beginning, but rather concentrate on helping the child to function better in daily life, for example, by sleeping better at night. If the child experience that therapy is working, his/her confidence will increase and the child may eventually take a chance on sharing more of what is painful.

Coping and protection

Activating the child's competences is largely about identifying and establishing protective factors both in the child and in the surrounding environment. It is important for caregivers to be aware of research on protective factors concerning modifying trauma injuries, both to add to effective coping strategies and to build protective and stabilizing environmental factors. Psychosocial work based on resilience thinking can be especially appropriate (for example Ager's model of interventions in the form of phases, 1997). Close cooperation between the therapist and caregivers is essential. Structuring daily activities in a way that makes life predictable and safe will help promote the child's sense of security.

Crucial protective factors are the child's previous attachment experiences and relational capacity. Secure attachment protects and modifies the effect of traumatic experiences. Traumatic experience releases the child's attachment pattern. Having already insecure or disorganized attachment (children who lack a strategy for seeking closeness when they are

in danger and who, for example, constantly swing between clinginess and rejection - like one sees after long-term neglect and repeated relational traumas), will increase the danger of serious delayed injuries after experiences of trauma. All unaccompanied minors have lost the people closest to them during flight, but some have also suffered great losses earlier in life. If the child is given the opportunity to receive good care and to form new lasting relationships in the new country, this will provide important protection. The ability to play, symbolize and be creative is also valuable. We can express feelings through symbols and process oppositional experiences. We know from studies of the play of traumatized children that when the ability to play breaks down, the play becomes repetitive, rigid and poor, and often ends in disaster or a sudden stop in play. In some cases the ability to play imaginatively completely disappears. Resuscitating this ability becomes an important part of the treatment. (Christie 1995). When we find both the ability to make contact and the ability to symbolize intact, we have a more optimistic starting point than when much of the treatment has to be about building these from zero. Physical activity is also a way of dealing with stress and can be relaxing. The experience of physical strength can promote mental strength.

Strong intellectual abilities provide protection because they increase the chance of success in a new society that demands greater academic skills, cultural adaptation and understanding of social codes. Cognitive capacity is also connected with the ability to create coherence, meaning and hope in life. When war has been chaotic and incomprehensible it is often impossible to experience meaning. If the child has been surrounded by adults who explain a war of liberation against suppression, the traumatic memories can be connected with a greater purpose. Life in a refugee camp can give an experience of emptiness, that life has no value and that a person does not have the ability to influence his/her own situation (Goodman, 2004). For many, com-

ing to a new country can ignite hopes and dreams for the future, but for others, a sense of hopelessness can remain.

When working with unaccompanied minors who have been referred for depression and symptoms of PTSD, reviving hope for the future is crucial for the effectiveness of treatment. Searching for meaning in one's own life can be a difficult process, but if the child succeeds in doing so, this can make possible a new and more positive understanding of him/ herself (Brom et al. 2008). Religious faith can help children find meaning by attributing the events to God's will, which can be a source of strength and hope. It may also be useful to find out if the patient has a relation to heroes from his/her own culture or religion that can be the basis for a conversation about coping. There may also be people from the child's family or local community who have fared well in spite of serious problems. It is important to find dreams the child is having or has had, such as becoming a soccer player, an artist or a doctor. Exploration of dreams can provide access to hope, initiative and engagement. In the beginning this may entail dreams that seem unrealistic, and after a while it will be important to set goals that are more attainable. During therapy, even utopian dreams can be important for re-igniting the spark of life that was in the process of burning out (Kagan, 2008).

Flexibility and creativity
Art and expressive therapy are used a lot in therapy with refugees, but rarely evaluated. Creative methods of working with traumatized refugee children who are shy, are highly resistant or who don't have the language abilities to verbalize traumatic memories, have been useful because these types of methods help children to express traumatic experiences in a way that is less threatening than through conversation (Rousseau et al., 2003). Art and expressive therapy can provide the client with a form of structure, experience of control and a way to express identity and emotions. Play and the use of symbols can

also be very important healing mechanisms; at the same time, we see that with serious trauma it is precisely the symbolic "what-if-game" that lapses and the play becomes less symbolic, more rigid and repetitive (Christie ibid). However, for some traumatized children, creative techniques can be too ambiguous and unstructured and therefore cause anxiety (Hocoy, 2002). In TF-CBT art can be used as a tool in a structured way that can process the child's cognition and affect. The therapist should attempt to find ways of communicating that stimulate engagement in the child. We will now describe the therapy with Barak and Yousef which can illustrate trauma treatment.

"When the dream is to be able to go to school": Yousef's story
All of his life, Yousef had been exposed to serious traumas, both in close relationships and as a result of the war. Throughout his life he had been exposed to danger and probably had an overactive stress response system that contributed to his difficulties with planning, concentrating, regulating emotions and relating to others. In Norway, he experienced that he was still in danger, he seemed nervous and alert. His dream of being able to go to school was being fulfilled, but he struggled to concentrate and to learn the alphabet, something which caused considerable frustration. Sometimes he injured himself by kicking or punching the wall. Other times he destroyed things in the institution.

The emphasis of the work with Yousef involved stabilization. Based on his long-term history of trauma, it was important to think that the work would be about capacity building. Shaping a clear and predictable daily life was crucial. We investigated his cognitive abilities with the assistance of a non-verbal test (Leiter-R) which indicated that he had serious learning disabilities. Extra resources were put in place at school, and he received tutoring.

Yousef was somewhat resistant to starting treatment. He was afraid of "being crazy" and hesitated to talk about difficult things, especially from the past. Treatment began with a description of what treatment is, and what we could work on. He seemed unsure whether he could trust me, and whether talking with me could be of any help. We spent a lot of time building the alliance and on agreeing on what we could work on. He received information about common problems children with his background can have, such as sleeping problems, difficulty concentrating, intrusive memories and mood variations. It was important to reassure that he would always be the one to decide what we would work on, and that he would never be pressured to discuss anything about himself that he did not want to share. We agreed to start by working on his sleeping problems and angry outbursts. I used psycho-education about what constitutes good sleeping habits and gave him advices about what he could do to feel safe before going to bed in the evening. He revealed that he was plagued by serious intrusive memories, which he did not wish to share the content of, but which we could talk about in a general way.

The goal of the stabilization phase is to bring the child back to the here and now. Lack of time perspective causes a person to have a sense of an on-going threat. When traumas are recalled, the person cannot manage to access other relevant information that could correct the experience. This can lead to the intrusive memories giving an experience of constant danger (Axelsen, et al. 2007). It is important to help the child understand that what happened will not happen again, and to help the child regain contact with the here and now by for example, using breathing exercises. Information about how he or she can stop intrusive memories by for instance reminding him/herself that "I am safe" or "that is over now," can be a help. I also used mindfulness exercises which are from a kind of meditation based on bringing out presentness by increasing attention on one's inner and outer surroundings (Greenland, 2010).

We worked further on the angry outbursts that he experienced as troublesome. I recommended that when he was angry, he could roll some paper up tightly and throw it in the trash. This was one of the pieces of advice he cited as being most useful when we concluded therapy one year later. He also received a bike that he used actively when he was frustrated and angry. He could go for long trips, and together we could imagine the boy as a shepherd in his homeland.

After a while he began to share feelings of worry about his mother. He was given help to write letters to her which were sent by the Red Cross. He was not able to call her, but we carried out a role play in which we pretended he was talking to his mother on the phone. In this role-play he reported that he was doing well, but that he missed her and was worried about her. He told her that he was going to school just like he had dreamed of, and that he slept in a bed at night. I also encouraged him to express what he would not dare to say in reality. He said that she never managed to protect him against violence from his stepfather and that all of the painful things that happened still bothered him. He said further that he was afraid his mother would be killed and that he felt guilty about leaving her.

In one session we worked on one recurring dream that bothered him. It was about him having to travel back to his violent stepfather. This dream was made concrete by making a picture in the sand with the help of figures. He made a drawing of how he experienced the dream, and, with the help of figures, he presented the travel back to his violent stepfather. Afterwards he was told to change the plot and to give it a different ending. The new story was about him getting residence in Norway, and he introduced protective figures that took care of him. The session ended with a fantasy trip to the future where we imagined that we were meeting ten years from now. I asked him to imagine what he would be like in ten years and what advice he would give to himself in the present situation. He then ad-

vised himself to look forward, be positive and to find strength in God. After this he stopped having that painful dream about having to travel home. This technique made it possible to find own solution strategies that were anchored in own culture.

As he experienced that therapy was helpful, he became more open and could verbalize traumatic experiences. He was more secure in daily life and functioned better at school. But he was still plagued by memories of the escape in which many of his companions died. The first task given to him was to draw the trip and use different symbols that could symbolize protective and dangerous things he experienced during travel. He drew children who chased after horses and lay dead by the side of the road, a truck full of oranges and children sleeping in train stations. This became a very emotionally demanding session and the boy began to nose bleed. We may have stretched the level of tolerance in relation to a phase-oriented model. However, he received good care from the translator who helped him stop the bleeding in a caring way. In the next session we worked on symbolizing what he needed for the trip but did not get. We used symbols of what he should have had and put them in front of him in a line that represented the trip. He found things that could symbolize what he needed: clothes, food, supervision, warmth, love and money. After this sequence he reported having fewer intrusive images from the trip. Yousef developed well at school, but he still struggled with learning disabilities. He functioned relatively well socially, but had problems trusting others. Therapy ended when the boy was settled in a new city. We recommended foster care, but it was impossible to find a family for him.

The work with Yousef was largely stabilizing, but also to some degree processing of traumatic events. We based our work on a phase-oriented model and utilized symbols and forms of expression that we believe gave him meaning in accordance with his cultural background. The escape to Norway brought

new burdens, but also the possibility to receive the care and security he had not had before. Making a trauma narrative of the trip had a calming effect. He made his dream of going to school come true and got special assistance at school which resulted in academic improvements. However, it is important not to have too high expectations about what the boy will manage as far as education is concerned. Arranging for him to be able to use his resources and coping strategies related to physical work can be of value when making plans for the future.

From war to art: Barak's story
Barak did not fulfill any dreams by coming to Norway, rather he encountered the greatest nightmare of his life: being all alone in a strange world. Just a few months before he had experienced the worst catastrophe imaginable; loosing everyone he loved. This trauma changed his life completely, and he was sent out in the world to manage on his own, without any kind of support. It is easy to understand that he lost his faith in life and that the only thing he wanted to do when he came to Norway was to die.

In conversation with the therapist he cried and expressed an experience of meaninglessness and indifference. He said little, but we agreed that he should try to confirm or invalidate my attempts to verbalize how he felt. He was haunted by intrusive pictures from the day he found his family and felt alone and abandoned. The main focus during this period was looking after his security and on finding a suitable base of care for him. We worked in close cooperation with the institution where he were monitored closely day and night. We wanted to avoid an acute inpatient admission that we assumed would alienate the boy who had, despite everything, some social relationships at the institution.

Similar to Yousef, he was told that his reactions to an extreme situation were quite normal. I utilized some stabilization exercises and taught him breathing techniques, but these

seemed to have little effect during the acute period. I hunted for good memories that he could use when he was having a tough time ("safe place"), but all of his good memories were connected with loss and therefore had a tendency to reinforce the pain. Working to create a break with the traumas of the past like I had done with Yousef did not work because the boy was still in a crisis situation. The most important intervention was to be with him, trying to put his pain, sorrow and feeling of meaninglessness into words.

At the same time, I tried to find out what he was curious about in life. It was his creative abilities that became the source of hope and construction of meaning. He told me that he used to draw, but that it was difficult for him to complete drawings now. I asked him to draw a tree. Afterward, I instructed him to imagine that he "was the tree" in a physical exercise. I explored resources and hope through physical exercises and the drawing. After this, he began to bring drawings to our sessions. I explored feelings, meaning, strength and hope that he expressed through art.

In one session I explored a portrait of a man who was working in the store across the street where he often sat polishing shoes. Barak was having a hard time during this session and seemed indifferent. I used the technique "role-reversal" (for a description of this method, see for example Røine, 1992 or Bræin, 2004) that means making a person imagine to switch roles with another for a short period of time. Barak was asked to imagine that an empty chair represented the man in the store. He was then asked to sit in the chair. I interviewed him as he played the role of the man, about his posture, appearance, age and what life was like in this town. It became clear that this man was someone Barak trusted as a local "hero," who had a very tough time of his own. I asked him what he thought of Barak and if he had any advice for the boy who was now alone in Norway. Throughout this role-reversal I got information about the boy and where he came from,

information I probably would not have got through a regular conversation. In his role as the "wise man "he gave himself advice about continuing to live for the sake of his family. After a while it became meaningful for him to live on in a free country as the only one left from a family in which everyone yearned for freedom. He drew a picture of a path going into a forest and said that he would go this way into the future. He was focused on the idea that the painful experiences would strengthen him on the way.

The stabilization phase was about helping the boy to share and to put the pain into words. At the same time, I was hunting for resources that could be used to strengthen the boy's curiosity about life. Good cooperation between different agencies and engaged helpers made it possible to shape a daily routine for the boy that he experienced as safe and meaningful enough for him to be able to continue living. After some therapy sessions we began to talk about the loss of his family and the images that haunted him. We processed the trauma images from the day he lost his family, both what happened before, during and after he found his family members killed.. In connection with this we talked about the possibility of him having internal dialogues with his family members as a way of keeping them with him further in life.

As we explored his pain, meaning and hope, he also got to know the country he had escaped to. After his asylum application was approved, he moved in with a foster family with whom he could form a lasting relationship and who would see his strengths. One year after attempting suicide, he no longer fulfilled the criteria for any psychiatric diagnosis; not even PTSD. He is thriving in Norway, even though he often has tough days. He experiences that the pain is a part of his life that gives him meaning. Almost every day he has internal dialogues with his dead family members. When he is having a difficult time he readily asks his family members for advice, and he experiences that they answer.

This gives him a great amount of internal support. He feels hope and experiences that his life is meaningful. Through his ability to create meaning, he integrates the past, present and future. This shapes unity and coherence. Near the end of treatment, we made a timeline (a narrative) of his life with stones and flowers that symbolized good and painful events (KIDnet). He stood on the timeline of his life, a long rope which was covered with large and small flowers and stones. He dared to look both forward and backward. He could feel close to the past and experienced that his loved ones were inside of him here and now. At the same time, he experienced support and care from the new family in Norway. He dared to look forward and to believe in his dream of becoming an artist.

The work with Barak was largely about searching for meaning in the new life situation he found himself in. Being the only survivor who could live in freedom provided meaning and hope. Moreover, he developed coping strategies in which he could use family members as internal objects that gave him support in spite of the fact that they were dead. It seemed like this was more important than processing the traumatic moments. In addition, the boy was one of the lucky ones who were able to live in foster care. This meant that a stable environment was maintained for him and that he could continue on his developmental tasks.

Comparing the stories
Examining the similarities and differences in these two courses of therapy, we see two boys of the same age who have both left societies undergoing serious conflicts. The trauma burdens are however, very different. Barak had lived a safe life until the big catastrophe and developed secure attachment to his parents, while Yousef has been abused throughout his life and had extensive problems in accordance with complex traumatization. Barak was in an acute traumatic sorrow, but demonstrated over the course of therapy that he was a boy with great intellectual capacity, strong

symbolic ability, good affective regulation and creativity.

Both boys benefitted from stabilizing interventions, both in relation to their own coping strategies and efforts in the environment. However, Barak was the lucky one who was placed in a foster home and had the opportunity to shape new and lasting relationships, while Yousef was placed in an institution where he related to many adults. Unstable care and constant new relationships are very unfortunate for a boy like Yousef, who needed to form genuine and lasting relationships with adults who could give him the security he had never had before. While the work with Barak was mostly about reviving capacities that had been blocked, most of the work with Yousef was about building capacities he had not developed earlier due to neglect and lack of stimulation. We assume that living in a loving and caring foster home would have given Yousef better conditions for building capacity than staying in an institution with a large turnover of adults. Creative techniques were used with both of them, something we believe enforced engagement and provided the opportunity to express feelings in different ways. Both courses of therapy were about finding meaning, integrity and connection in life. The work was also about processing traumatic experiences, and understanding the events in a new way that provided meaning and hope for the boys in the here and now.

The boys used different coping strategies and have different resources within themselves and their environments. Barak has a large coping repertoire while Yousef derives great joy from physical activity. He can use this to deal with stress, but he is more easily confused and has weaker intellectual capacities. In Barak's case, the acute traumatic sorrow was so urgent that in the beginning he did not respond to stabilization techniques. Instead, he needed a close relationship; a therapist who was present and shared and helped put his feelings into words. Yousef needed help to sort out his present situation, to understand the Norwegian culture and way of life, and

to cope with daily functioning - not least in school. While Yousef is illiterate, and not used to reflection, it became apparent that Barak came from a home where there were many discussions and reflections about values like freedom and democracy. This is something he regained in therapy, and it gives him direction and meaning for the future.

Conclusion

Therapy with unaccompanied minors puts great demands on the therapist's sensitivity and cultural competence. The therapist is confronted with cultural, practical and language-related challenges which may seem overwhelming. The objective is to reawaken the child's abilities by being curious and exploratory. Finding the child's resources and capacities is crucial. At the same time, goal-oriented trauma methodology is also needed; one that is both constructive and processing. Many of these children have survived traumas almost too extreme to imagine. Rewriting stories about helplessness to "heroes from real life" can give the child an experience of mastery and motivation to reach future goals. The therapist should be flexible and have access to various methods which can be used based on how the child prefers to express him/herself. We must tolerate a lack of explanation and knowledge of the child's past concerning both protective factors and risk factors. The children often face an unclear situation in Norway and do not know how long they will be allowed to stay. Starting a course of therapy knowing that there is a risk of it being interrupted by the child moving or being expelled from the country may seem counter-productive because the child is risking yet another interrupted relationship. Nonetheless, we do not believe that treatment should be delayed until the environment appears stable. This would result in many not receiving the assistance they need. An important task in moving forward is to develop and evaluate methods that can ensure that these children receive effective treatment. Until then, we have to live with a lack of knowledge, and utilize evidence-based methods in

combination with our own creativity, flexibility and sensitivity.

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TREATMENT OF COMPLEX TRAUMA IN CHILDREN; A MULTI-FAMILY APPROACH

Heine Steinkopf[1]

Abstract

This article describes a group approach with a multifamiliy design as a possible comprehensive model for giving treatment and support to complexly traumatised children, targeting both the basic brain-functioning on an individual level as well as the social system surrounding the child. Brain functions that are known to be affected by severe traumatisation are described, along with a rationale for targeting these basic functions in order to achieve healing for the child. The article further discusses the need for identifying what therapeutic elements are sufficient for obtaining a healthy development, and raises the question whether treatment needs to be carried out by specialized services.

Keywords: Complex trauma, children, treatment, family

Rezumat

Acest articol descrie o abordare de grup cu un design multifamilial ca un posibil model comprehensiv de terapie şi sprijin, pentru copiii cu traumă complexă, ţintind atât funcţionarea primară a sistemului nervos individual cât şi sistemul social înconjurător al copilului. Sunt descrise funcţiile creierului afectate de traumatizarea complexă, împreună cu raţiunile care stau la baza ţintirii acestor funcţii bazale cu scopul de a realiza vindecarea copilului. În continuare, articolul pune în discuţie nevoia identificării elementelor terapeutice suficiente pentru a asigura o dezvoltare sănătoasă şi formulează câteva întrebări cu privire la obligativitatea ca terapia să fie administrată prin servicii specializate.

Cuvinte cheie: Traumă complexă, copii, tratament, familie

Introduction

Since the introduction of the diagnosis Post Traumatic Stress Disorder (PTSD) in 1980, this diagnosis has dominated both research and clinical practice in the field of trauma psychology. Treatment programs have to a large degree been centred on exposure, in vivo or in vitro to the traumatic incidents, in order to desensitize the body's defensive reactions stemming from the traumatic experience (Foa, Keane & Friedman, 2000). A number of treatment programs have proven effective to deal with PTSD originating from single event traumas (Foa et al., 2000).

More recently, the impact of repeated or chronic traumatisation, often referred to as "complex trauma" (Briere, Kaltman & Green, 2008), has received considerable interest from both researchers and clinicians, along with studies showing that such traumatic exposure is relatively frequent (Ford & Cortois, 2009). Bessel van der Kolk has defined complex trauma as "the experience of multiple, chronic, and prolonged, developmentally adverse traumatic events, most often of an interpersonal nature (e.g., sexual or physical abuse, war, community violence) and early life onset" (2005, p. 402).

It has been demonstrated that many traumatised children do not meet the criteria for PTSD, originally formulated with adults in mind (van der Kolk, 2001), and, while treatment programs for PTSD or single event trauma have received considerable interest in terms of research, treatment practices for complex trauma have yet to be fully established. Models derived from the PTSD-research only are not likely to be sufficient to deal with the diverse sequelae of chronic traumatisation (van der Kolk, 2001). There is also a lack of a unifying conceptualization of the trauma impacts on child development and mental health, and there is in fact no diagnosis, neither in the DSM nor in the ICD-system, which is adequate (Nordanger, 2011).

Extensive research has demonstrated how complex traumatisation disturbs the normal development of the brain, and how both basic and more advanced parts of the brain are affected (Perry, 1999; Siegel, 1999). The knowledge of the damaging effects of complex traumatisation underlines the importance of identifying effective models for protection and treatment of these children, as early as possible in their life, in order to minimize the damages, both for the individual and for the society.

Children exposed to domestic and/or family violence

Children who have been exposed to domestic violence are typically a risk group for developing complex trauma. These children have to cope with an environment marked by their parents' distrust, anger, bitterness, blame and fear of violence. They are often traumatised over the course of many years, with severe effects on many aspects of their development. Issues of safety, dealing with conflicting presentations of what is true or untrue, since parents often present very different stories of what happens, and unpredictability are often dominant themes, along with concerns of the safety of their parents, with frequent efforts to make parents stop fighting (Roseby, Johston, Gentner & Moore, 2005).

Work with these children is difficult, since it involves many processes that often must go parallel to treatment. First, there is the disclosure of violence. This is often hard, since domestic and family violence still is confounded in the mist of taboo in most western societies (Leira, 1990). For different reasons, children are not always believed when they try to tell their secret, as we tend to give larger credibility to adults than to children (Heltne & Steinsvåg, 2011). Along with this, the parent accused of being abusive is rarely ready to admit his/her wrongdoings, and will present a different story, e.g. the child has a vivid imagination, has misunderstood, or the oth-

er parent has an agenda of miscrediting the abuser, in cases of parents not living together and with conflicts of custody.

Second is the question of ensuring safety for victims. In a number of cases, the abuser threatens the other parent, and the child. In some cases the perpetrator is still living in the family. Often a close cooperation both with Child Protection Service and the police is needed, and even in those cases it is hard to be sure of the security situation. A complicating factor is that the nonabusive parent may be psychologically unstable, and may, in fact, herself act abusively towards the children (Christensen & Kock-Nielsen, 1992).

Target areas for treatment of complex trauma

In complex traumatisation basic brain systems have been affected; the attachment system, the emotional system, the system for storing of memories, the arousal system, and the system for detecting and reacting to danger. In addition, the prefrontal executive area of the brain that integrates and "understands" the environment as well as its own functioning is affected. Thus, it is reasonable to suggest that models for intervention should aim at addressing these basic processes of the brain (Siegel, 1999).

Attachment is a system in the brain that organizes important processes, like motivation, emotion and memory, in relation to significant caregiving persons. The infant takes advantage of the mature brain of the caregivers with special respect to the regulation of emotions, and providing the child with a sense of a "secure base". The relationship with early attachment figures helps the child to form "internal working models" of attachment which become the base for later interactions with others (Siegel, 1999). There is significant evidence to the notion that disturbances of the attachment process are precursors to later psychopathology (Stroufe, Duggal, Weinfield & Carlson, 2000). Thus; working with attachment issues like trust, closeness to caring

adults, and internal models for relationships with others would seem of importance.

Emotions are a crucial part of the self-regulation process and the creation of meaning. The system is closely connected to the arousal system, and the "danger detecting "system, and takes part in the appraisal of environmental stimuli in order to protect the organism from harm (Siegel, 1999). It is therefore important that children learn to recognize the impulses coming from the emotional system in order to react properly to information, impulses and challenges in the social and biological surroundings. The brains of traumatised children tend to operate to avoid emotional impulses that are interpreted as hostile or threatening, thus maintaining a dysfunctional way of interacting with the environment (Silberg, 2004), In addition, as pointed out by Schore (2003), the most prominent consequence of early relational trauma is the loss of the ability to regulate the intensity of affects, which underlines the need for healing practices to target the emotional system.

The memory system of the brain is highly sophisticated and complex. It seems that the episodic memory (that is memory for specific events) is located mainly in the limbic system and the orbitofrontal region of the brain. The appraisal of external stimuli is affected by episodic memory, often without the interference of the higher-level processing of the semantic memory in the frontal cortex (Siegel, 1999). Thus, stimuli may evoke nodes of memories with traumatic content, and eliciting an arousal response from the "alarm system" that is not appropriate to deal with the actual challenges in the environment. Bringing episodic memory to a higher-level processing, and thus enabling a memory storage that is more in concert with the actual demands from environment, and that does not constantly provoke hypervigiliance, is an aim for therapeutic interventions (Perry, 1999)

The brain has its own inbuilt danger detecting system which reacts with innate biological

responses facing threat. The basic reactions to perceived threat would be a freeze, or fight/flight response (Siegel, 1999). As stated by Bruce Perry (2006); "traumatised children reset their normal level of arousal. Even when no external threat exists, they are in a constant state of alarm" (p 32). These children are often seen to be constantly scanning their environment for potential sources of danger. This constant activation of "deep brain" arousal leads to an impaired "higher brain" capacity to provide emotional regulation (Bath, 2008). Thus, these children need help to be able to regulate the "deep-brain" fight/flight or freeze arousal. According to van der Kolk (in Sykes Wylie, 2004), integration in lower brain structures could to some degree be achieved by a "bottom-up" process, involving different types of sensory experiences, use of rhythm, playful activities, dancing, and even yoga (Kaiser, Gillette & Spinazzola, 2010; Emerson, Sharma, Chaudry & Turner, 2009).

Mentalisation has been described as the process of being able to understand others from the inside, and yourself from the outside (Allen, Fonagy & Bateman, 2008). In order to be able to selfregulate emotions and arousal there is a need for well-functioning pathways from the deeper parts of the brain to the reflective and cognitive processing part of the brain in the prefrontal cortex (Siegel, 1999). The executive parts of the brain need to understand and to reflect upon the information coming from deeper brain structures, as discussed above. Recent research has demonstrated that consciously labelling troublesome emotions has a direct calming effect on those emotions (Lieberman, Eisenberger, Crockett, Tom, Pfeifer & Way, 2007), as one example of self-regulation skills that can be acquired through guided verbalisation (Bath, 2010).

All therapeutic work with children should include the system immediately surrounding the children; their parents, foster parents, staff at residential care, sometimes also teachers and other significant persons. A system, family or network approach in one way or another is important in order to be able to deal with the totality of children's life situations, and to ensure that possible changes within the child is reinforced and acknowledged by the surroundings.

The Kristiansand multifamily treatment group

The Kristiansand Multifamily Treatment Group (KMTG) has been designed for children who have witnessed or been exposed to violence in the family. The group started out in 2005 as a collaboration project between Sørlandet Hospital, Kristiansand, and Vest Agder Family Services. The KMTG has been greatly inspired by the work of the Marborough Familiy Services in London, where the concept of multi-family therapy (MFT) has been applied on a variety of areas. MFT is anchored both in the theory and practice of systemic and psychodynamic therapy. The main difference from single family therapy is that this setting enables families to go beyond their own perspectives, and make use of the resources of other families, as well as it gives an opportunity to be helpful to others, thus increasing their own feeling of self-worth (Asen & Scholz, 2010). The MFT approach emphasises the principle of "therapist-decentralisation", encouraging the families to be therapeutic to each other, building on the resources and strengths of the families. The group format facilitates a framework for active participation, with role play and playing games, as well as mutual support and constructive criticism from the other families. The experience of not being alone in the world may lead to a greater openness and less reluctance to explore possible changes that need to be undertaken (Asen & Scholz, 2010). For a full account of the Marlborough Multi-family approach, see Asen & Scholz (2010) or Asen, Dawson and McHugh (2001).

In the KMTG, families where violence has occurred are recruited into the group. Violence could be both physical and psychological by nature, and directed either directly towards

the child, or child being witness to spousal abuse or mutual fighting, verbally or physically between the parents. Cases of violence from older children towards mothers have also been admitted. The main perpetrator is not admitted into the group, because of the risk of allowing abuse to continue within the group. Families are interviewed individually before entering the group, to determine their motivation, the degree of exposure to violence and other traumatic experiences, and their ability to commit to the group process. The group starts out with two gatherings of the participating parents (with one exception; mothers). They are invited to take active responsibility in the group process, and to bring in their ideas and appraisals to help the other group members. They are asked to formulate their objectives with participating in the group; when the group is ended, what goals have they achieved, both for themselves, and for their children? The group process takes normally up to 15 sessions, each lasting approximately 2 hours. One should note that the group process is often combined with individual sessions, since not all issues can be handled within the group format.

Targeting basic processes of the brain

Attachment

Attachment issues are targeted through playing games and activities where mother and children participate together. The children see their mothers from a different angle than they are used to, mothers being playful, innovative and resourceful. The parents are encouraged and supported to be gentle, but firm leaders for their children. Through sessions with one-way screen, the children listen to their mothers expressing their love and affection for their children, as well as accounts of how they have struggled to be good caretakers in difficult times. Likewise, the mothers listen to the children discussing different topics from behind the one-way screen. Examples of relevant topics could be their concern for their mothers, children expressing fear, hostility, anger etc both towards the perpetrator

but also towards the mother. The mothers get to know the internal world of their children in a different way, allowing them to develop a more nuanced view of their children's' behaviours and motivations.

Regulation of emotions

Work with regulation of emotions is done through an explicit emphasis on affect regulation and affect recognition throughout the group process. Early in each group session all are asked to give an account of what emotions they have experienced since the previous session, Sometimes children are asked what emotions they think the mothers have had, and vice versa. Emotions are roleplayed and videotaped, with guessing games like "which emotion is displayed now, and how strong is it"? Parents are encouraged to help modulating the children's emotions by actively confirm their actual display of emotions, and to label the emotional expression in general. Emotions are visualized through use of drawings, colours, body postures, metaphors and music.

Memory

It is an aim for the group to help both children and mothers to develop a consistent and coherent story of themselves. In order to achieve this, it is important to be aware of our autobiographical tendency; we are constantly working on our self-narrative in the way we talk, think and interact with others. Often, our self-narratives are constructed on the basis of negative life events, like experiencing abuse, neglect and rejection (White, 2006). In order to try to create a different, and more positive self-narrative, it would be useful to put negative incidents and experiences into words, and try to see them in a context of competence and resourcefulness. In this process, episodic memory is brought into the semantic memory, and subjected to an evaluative process in the prefrontal cortex. For example; "Susan" (10) starts to tell us about how she witnessed her mother being raped by her ex-partner. While giving this story, she seems highly distressed and emotionally disturbed. The other group

members are seen to empathize with her giving attentive body postures and comforting words. We ask "Susan", not what see *saw*, but what her *actions* were. "Susan" recalls that she tried to interfere, she shouted to the rapist, but got knocked out of the way. "What did you do then", we ask. "Susan" tells that she ran out of the house and alarmed a neighbour. The neighbour called the police. The group credits "Susan's" actions, praising how she acted sensibly, and how she ultimately achieved a rescue for her mother.

When children give accounts like this, we are aiming at constructing a self-narrative that is not based on the traumatic content of the experience, but on the actions that were carried out by the child during the event, emphasizing a self-narrative of competence, creativity, action- orientation and smartness (White, 2006).

Regulation of arousal
As stated by Bruce Perry (2006), traumatised children (and adults as well) have a tendency to be in a constant state of alarm. One could say that their threat detection systems are over-active, as if their brains have become permanently re-tuned to the possibility of harm (Bath, 2008). It would be useful for these children to over-learn, or desensitize their alarm responses, to some degree be able to regulate their arousal in a better way. In the group, this issue is targeted by means of various motor-activities; e.g. dancing, using games with rhythmic clapping combined with equally rhythmic verbal messages or focusing on breathing while listening to music. This follows the idea that the strengthening of neural pathways in one area of the brain may lead to an integration of the functions located in that area, and that the rehearsal of certain calming actions, including motor activities, breathing, practicing conscious awareness of own body-reactions, etc, serve to reduce the hypervigiliance of the nervous system of traumatised people.

Mentalising
We try to enhance the mentalising process by using roleplays that are videotaped, and immediately subjected to discussion and reflection while watching the tapes. We focus on facial expressions and body postures on the tape, we stop the tape and encourage reflection on "what is he thinking now", "what emotion is expressed", "what does he think of what she is saying", "and how does he express it", and the like.

Through one-way mirror, children listen to parent's accounts of their love and affection for the children, and likewise, parents listen to the children discussing various topics. After listening, both children and parents are asked to reflect upon their own reactions, thoughts and feelings while listening, all aiming at enhancing their mentalising capacity, and increasing their awareness of their own internal life, as well as trying to understand and reflect upon what's going on in other peoples minds.

The multi-family framework
The effect of the multifamily format can be illustrated by the examples below:
"Morten" (9) lives alone with his mother. His grandfather has been violent to him, as well as to his mother and his grandmother. His mother has struggled to put the past behind, and has moved away from her place of origin. She admits that she occasionally looses control of her own reactions, and unwittingly hits her son. She has worked hard to find better ways of disciplining her child, also with specific interventions by the Child Protection Service. As an extra burden, the mother has got a chronic illness that might turn fatal without proper treatment. "Morten" struggles both with the fear of losing his mother, with the memories of abuse from the grandparent, and the current relationship with his mother who, in stressing situations, may turn abusive towords him. His symptoms appear with problems of concentration, and he gets into fights with other kids at school. When frustrated he seems to loose control, and attacks his mother

violently. Mother and child feel isolated, and they have virtually no social network except for the professionals.

When admitted into the group, his behaviour was disorganized, acting aggressively towards his mother, and with poor social interaction skills. Interestingly, the other children in the group tolerated his behaviour, and gave him feedback on how his acting out was understandable, considering his background. The other mothers gave verbal support to his mother, understanding her feeling of shame in the face of her son's undesirable behaviour. Both mother and child seemed to relax, being tolerated and understood by the group. After few group sessions, "Morten's" behaviour changed, he was more attentive, was easily corrected by his mother, and started to interact constructively with the other group members.

"Ida" (8) was referred to the multifamily group by Child Protection Service. Her mother had for many years suffered from depression, anxiety and periods with psychosis and needed admittance to psychiatric ward. Not until it was disclosed that she was severely abused by her husband, and was helped to leave him, did she start to improve her life. "Ida" had witnessed some extreme situations, her mother being raped, molested, and nearly killed before her eyes. "Ida" herself was extremely anxious, clinging to her mother, and had problems relating to peers.

In the group, "Ida" was always close to her mother. She seemed to be constantly scanning her mother's moods, trying to regulate her state of emotions. This was commented on by some of the other parents. One of the other mothers advised "Ida" that her mother was a grown-up, and that she did not need "Ida" to look after her. This was paralleled with work aiming at identifying and giving names to different emotions, and trying to figure out how these emotions expressed themselves. "Ida" was able to see and express that her need for looking after her mother mirrored her own fear of being left alone, her fear of being rejected. Little by little, "Ida" seemed to relax her preoccupation with looking after her mother, and was seen to interact with the other children in a more age-appropriate way.

These two examples emphasize the strength of a multifamily format, in that the group members take responsibility for the change-process, giving feedback that become more powerful than they would have been coming from professionals.

Preliminary evaluation of this group-based multi-family approach show some promising results, even though the data are not ready for statistical examination. Pre/post evaluation with the ASEBA (Achenbach & Rescorla, 2001) show that areas like concentration-problems and school related difficulties have a tendency to decrease, along with an improvement of the relationship between child and parent; mothers report a better understanding of their children, and less problem-related behaviour on the behalf of the children

Oral feedback from the mothers include the following: "I now understand my child better", "the relationship between me and may child has greatly improved", "My child shows more concentration and endurance with school work" " I don't feel like correcting and disciplining my child as much as I did, after watching how (other group member) treated her child" "I feel much stronger. I don't have to put up with him any longer (ex-husband)".

Discussion
The basic elements of the Kristiansand multi-family group have similarities, and have been inspired by well-known models; the Trauma Focused Cognitive Behavioural model (TF-CBT) (Cohen & Mannarino, 1996), the "Real life heroes" (Kagan, 2007), the model of Joy Silberg (Silberg, 2004) and "A safe place to grow" (Roseby, Johnston, Gentner & Moore, 2005). Among these, TF-CBT and the Real Life Heroes are listed as evidence-supported

and promising practice by the website of the National Child Traumatic Stress Network (National Child Traumatic Stress Network, 2011).

In addition, the Kristiansand group has taken advantage of the experience of the London Marlborough clinic and their work with multifamily groups. The efficacy of the multifamily approach on different problem areas, like eating disorders, mood disorders, schizophrenia and alcohol dependence have been demonstrated by a number of studies (See Asen & Scholz, 2010 for a review). The Marlborough clinic has also done some impressive work with multiproblem families, where problem areas include domestic violence (Asen, Dawson & McHugh, 2001).

The advantages of a multifamily format are obvious; a possibility for participants to take advantage of the experience of others in similar situations, both children and adults see that they are not alone in the world, they have the opportunity to make social contacts that last beyond the group.

Still, there are some disadvantages that need to be taken into consideration; the approach demands resources in terms of time and personnel from the professional services. There is a need for strong top-down support within the services in order to ensure a sustainability of the practice. Some issues need to be dealt with individually, so often the group work needs to be supplemented by individual sessions, both with children and mothers. This further underlines the need for resources, which may represent a problem for some under-budgeted services.

In addition to this; is a model that aims at targeting all aspects of the needs of the traumatised child too ambitious? Is it necessary in order to set healing processes within the child in motion? Could parts of the basic processes of the brain be singled out as more important than others, subjected to a rigorous and targeted intervention, and releasing the brains own

capacity for healing? Does healing of complex trauma necessarily need interventions from highly specialized services? According to population surveys, complex trauma is relatively frequent, and is it cost-effective to run them all through a comprehensive treatment program administered by highly specialized experts?

Howard Bath (2008) argues that healing of the traumatised child could be done basically by a trauma-informed environment, focusing mainly on the three pillars of trauma healing; safety, good-quality relations, and teaching skills to self-regulate emotions and arousal. This could at least apply for situations were children's environments are controlled to the extent that the treatment practices involved can be administered reliably by adults in their immediate surroundings, like in foster homes and residential care. Vernon Kelly (2009) of the Tomkins institute advice us to focus specifically on emotions, to maximize positive affect, minimize negative affect, and overall; minimize affect inhibition. Other researchers and clinicians who advocate more targeted approaches could be cited.

A central problem of identifying areas of interest for treatment is the problem of experimental control. Randomized controlled trials (RCT's), are generally accepted as the "golden-standard" of research, but require a standardisation and manualisation of treatment programs that is very hard to obtain. Some would also argue that such manualisation of treatment could interfere with the quality of treatment, especially since years of research on the efficacy of treatment indicate that the most potent factor for therapeutic change is indeed the qualities of the therapeutic relationship (Asay & Lambert, 1999). Consequently, a broader range of research methods should be considered as equally "golden" as the RCT standard.

Even though modern research has verified a number of specific areas in the brain that are negatively affected by complex traumatisa-

tion, and that a variety of treatment models seem promising, further research and the gaining of clinical experience is needed to identify a "treatment of choice" for complexly traumatised children.

Summary/Conclusion

The Kristiansand Multifamily treatment group would seem to be a promising model for dealing with complex trauma in children. It targets brain functions known to be affected by trauma, and is supposedly empowered by the multifamily format.

However, it's efficiency has yet to be verified by research, as well as whether all it's containing elements are in fact needed to ensure a healthy development for the children.

A recommendation for further studies could be to aim at identifying what elements of treatment are the most important, and, equally significant, what are the most relevant contexts for healing.

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TODAY'S CHILDREN ARE TOMORROW'S PARENTS

INSTRUCTIONS FOR AUTHORS

Short description of the journal

The *Journal Today's Children are Tomorrow's Parents* (TCTP) started in Romania, in 1999. The journal is an useful resource of information for professionals working in the childhood area. Each issue of the Journal is based on a specific topic concerning the prevention of any kind of violence against the child. After more than 10 years of appearance, TCTP journal, arrived at 27th issue, included in the international database EBSCO, is bringing into the author's attention few recommendations.

Types of contributions:

Papers will be considered providing that they have not previously been published or admitted simultaneously elsewhere for publication.

Original, Theoretical, and Empirical Contributions: The paper should conform the APA (Publication Manual of the American Psychological Association) standards, with a legible abstracts of 100 to 280 words). Furthermore the paper should include a clear introductory statement of purpose; historical review when desirable; description of method and scope of observations; full presentation of results; brief comment/discussion on the significance of the findings and any correlation with others in the literature; section on speculation and relevance or implications; summary in brief which may include discussion. Section of references is required.

Brief Communications: Shorter articles of 5 to 7 pages (abstracts and/or references optional).

Articles on Clinical Practice: Authors should provide an account of previous clinical theory in an organized and up-to-date manner distinct from the clinical case material. Further, the clinical case material should occupy no more than a third of the paper. The first third should include only relevant background theory, while the final third should aim to discuss the descriptive presentation of the clinical case material against the background of existing theories and/or modifications needed to accommodate the clinical material.

Invited Reviews: Plans for proposed reviews and invited in draft outline in the first instance. The editors will commission reviews on specific topics. Reviews submitted without invitation or prior approval will be returned.

Submission Requirements:
All submissions should include an abstract, and ordinarily be 15 to 20 pages in length, though occasionally longer papers are considered. In order to facilitate blind peer review, authors are encouraged to prepare a cover sheet that includes identifying details not included in the manuscript which will be sent out for review, less the cover sheet.

E-mail submission to the Editor is preferred; please send an electronic copy of your manuscript to: anamuntean25@yahoo.com. All correspondence, including notification of the Editor-in-Chief's decision and requests for revision takes place by e-mail.

Manuscripts may be submitted in Romanian, French, or English and the author will be informed about the languages of the publication. The Romanian Authors will be asked for providing the translation into the language of publication.

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The editors reserve the right to refuse any manuscript submitted, whether by invitation or otherwise, and to make suggestions and modifications before publication. Submitted papers must be in final form when submitted; manuscripts will be returned for reworking or retyping that do not conform to required style and format.

Abstract: A structured abstract (objective, method, results, conclusions, practical implications) should not exceed 360 words in length covering the main factual points is required. Use complete sentences, and spell out acronyms at first mention.

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Examples of citations in Reference section:

Journal articles:

Egeland, B. (2009). Taking stock: Childhood emotional and developmental psychopathology. *Child Abuse and Neglect. Vol. 33, Nr 1,* pp. 22-27

Authored books:

Sroufe, L. A., Egeland, B., Carlsson, E A.

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Edited books:

George, C. & Solomon, J. (2008). Attachment and caregiving behavioral system. In J. Cassidy & P.R. Shaver (Eds.), *Handbook of attachment: Theory, research, and clinical applications.Second edition.* New York: Guilford Press.

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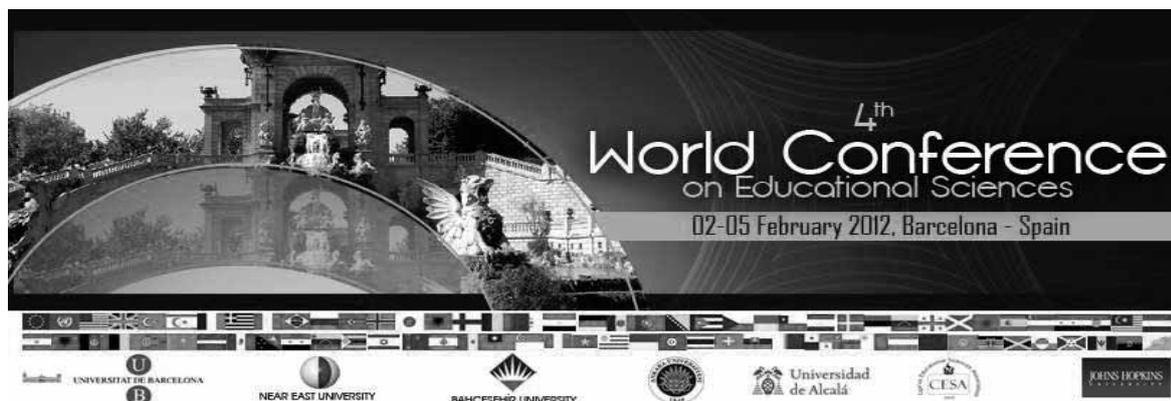
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