Child Safety Commissioner

promoting the safety and wellbeing of children

From isolation to connection

A guide to understanding and working with traumatised children and young people

Acknowledgments

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Foreword

Working with children and young people who have been affected by trauma can be difficult and at times challenging. It can also provide a window of opportunity that can help you to make invaluable changes in a child's life.

From isolation to connection: a guide to understanding and working with traumatised children and young people has been written to help professionals, carers and others understand the needs of children who have been affected by trauma through abuse and neglect.

This guide is part of a series of publications produced by the Office of the Child Safety Commissioner which helps people in contact with children to better understand the effects of trauma and to be better equipped to deal with situations that they encounter. The guide therefore includes a section on strategies for dealing with particular issues; and effective ways of working with young people, taking into account the impact of the negative experiences they have had in their lives.

The guide has been designed to enable you to easily navigate sections within the booklet that will be most useful to you in various situations.

I hope that this guide can be a useful tool for you in your connection with young people who have been affected by abuse and neglect.

Bernie Geary OAM
Child Safety Commissioner

How to use this resource

From isolation to connection is for people working with, caring for, or in contact with children and young people whose lives have been hurt by abuse, neglect or other trauma. It may also be used with young people themselves to help them understand their experiences and reactions.

As a resource it may help you to:

- understand traumatised children and young people better
- collect ideas about how to work with children and young people
- work with families, carers and professionals.

The book can be used in many ways—it is not necessary to start at the beginning and read straight through. Some readers may go directly to the section ***A framework for connection*** (page 5) for ideas on how to help. Others may start by reading the young people's case studies (pages 24 to 33), which illustrate the ***Theory and case studies: trauma, attachment and child development*** section beginning on page 21. For information on the issues that have affected traumatised young people, see ***The impact of abuse, neglect and other trauma*** (page 35).

Some readers may find it helpful to use the ***Glossary of terms*** on page 3 for unfamiliar terms or for terms such as 'shame' which have a particular meaning in the context of trauma, abuse and neglect.

Contents

Focusing on relationships and connection plants us firmly in the social world and reduces the tendency to isolate, individualise and pathologise traumatised children and their families.

Introduction

In this booklet you will find a framework for helping traumatised children and young people to move from isolation (caused by experiences of trauma and disrupted relationships) to greater connection with family, friends and community. In the context of healing, greater connection is a result of improved physical, mental, emotional and spiritual wellbeing, and enhanced relationships skills.

While the main focus for this booklet is on adolescents, it is also relevant for those who work with or care for younger children: professionals who work in the wider child protection system (including residential care workers), Child Protection workers, clinicians, case managers, police, Youth Justice workers, magistrates and others. It may be particularly helpful for those working in therapeutic foster care and therapeutic residential care.

Causes of trauma

The resource will be useful for an understanding of children and young people whose lives have been compromised by trauma. Such trauma may have been caused by war, the experience of being a refugee or asylum seeker, other trauma, or by the (unfortunately) more common experience of growing up neglected or abused. Because the latter is the most common cause of childhood trauma in Australia, this booklet focuses on that experience.

Understanding—the challenge

Many young people do well in spite of adverse and traumatic experiences while growing up. However, far too many of those who end up in our child protection and care, justice and mental health systems have survived by adapting to those adverse conditions. The ways they have done this may have helped them to survive—but these are ways that also lead to trouble.

It can be very difficult to understand why some young people behave in ways that undermine their own health and freedom, and compromise the health and freedom of others. It can be especially hard to understand why young people who have complex histories and complex difficulties seem not to learn from experience, and particularly do not seem to learn from punishment. One of the main aims of this work is to show how trauma and disrupted attachment can delay development and lead to so many difficulties.

Doing the best they can

Many children who have experienced trauma find it very hard to understand social rules. It is easy to label them as bad—so this work attempts to explain why it is better to see them as hurt and injured, and doing the best they can to survive. These young people are isolated by their experiences, their pain and difficulties—and by the strategies they have developed as ways to survive, as they struggle to connect with others and participate in society in ways that are mature and responsible.

It is not the intention of this booklet to excuse dangerous, criminal or hurtful behaviour, as it is vital that we assist all young people to take responsibility for their actions. However, for the group of young people under discussion, we cannot just ask them to do this. We need other ways of assisting, supporting and socialising them so that we can move them from isolation

(imposed by not having the skills to manage relationships, rules and boundaries) to the connection and empowerment brought by those skills.

If we want to help these children and young people move from their isolation, we need to begin with a deep understanding of them and we need to have compassion for their suffering. From our understanding we can reach out to connect with them: as we begin to see them in new ways, they can also begin to see themselves in a more positive light.

Glossary of terms

Affect Affect is different from emotion in that our affects are our primary or core emotions. Most affects exist on a continuum of intensity and comprise: **interest**—(to)—**excitement**; **surprise**—(to)—**startle**; **anger**—(to)—**rage**; **fear**—(to)—**terror**; **distress**—(to)—**anguish**; **enjoyment**—(to)—**joy**; **shame**—(to)—**humiliation**. There are two other affects, **disgust** and **dissmell**, related to evolutionary mechanisms for the detection of spoiled or poisonous food, and the communication of this to others through facial expression (developed pre-language). All of the affects and their facial expressions are found in all humans and our higher primate cousins. *Emotions* include a more complex and comprehensive list, such as guilt, regret, envy, sadness, and so on, and emotions may belong to the family of one or more affects, for example contempt is a combination of anger and disgust. (For more on affect theory see Nathanson, 1992.)

Affective arousal Affective arousal means the arousal of emotions and reactions based on one of the affects. For example, in 'distress—(to)—anguish' a person would experience emotions at the anguish end of the continuum; they would be extremely upset, crying or wailing.

Affect regulation The ability to manage and regulate our own feelings, emotions and reactions (e.g. calm ourselves down when stressed, or respond appropriately to events and experiences).

Attachment The state and quality of an individual's emotional ties to another: develops when one person derives security and comfort from another.

Attachment network For Indigenous children—or others who come from cultures where childcare is shared among mothers, aunts, sisters and grandmothers, and whose cultural experience may be that of having multiple caregivers—it is essentially these carers who provide their 'secure base'. Such a perspective of attachment is in contrast to Westernised models of attachment that promote dyadic attachment principles of 'a primary carer' as the secure base. Essentially this means a change in thinking from a dyadic perspective of attachment to an attachment network approach.

Attachment behaviour Any type of behaviour that causes a person to gain or retain proximity to a preferred individual and that results in an increased sense of safety and security. It is initiated by a perceived separation or a perceived threat of separation from the 'attachment figure'.

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

Coherent narrative When children are helped to put memories, ideas and feelings into words and then use these to develop a story about their histories and themselves.

Dissociation Form of withdrawal, in which the child cuts off from contact with others and the world, becoming numb, unfeeling or unaware. It is a form of mental 'freezing' or 'absence' as an avoidance of overwhelming fear.

Empathy The ability to imagine and share what another is experiencing, while still maintaining an awareness of self and the difference between another's experience and one's own.

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

Internal working model (IWM) Develops from repeated experiences of relationship with the primary caregiver. IWM influences how the child sees him or herself and how they will respond to future relationships. Abused and neglected children have often developed a negative internal working model. They see themselves as unlovable; expect new carers to reject them; see others and the world as unsafe; and feel that relationships cannot be relied upon to keep them safe.

Mentalise To understand and read others from facial expression, tone of voice or body language. The ability to think about our own mind and the minds of others. This leads to the ability to understand why things happen and why people behave as they do.

PACE Therapeutic parenting principles developed by Daniel Hughes (1997) to facilitate secure attachment. Dimensions are: *Playfulness*, *Acceptance*, *Curiosity*, and *Empathy.*

Reflection The ability to stop and think about our experiences, physical feelings, reactions, emotions and thoughts. Reflection helps us to respond to stress thoughtfully, rather than just react.

Resilience A key quality that helps children to rebound from adverse events or experiences. Nurture, protection and attunement gives children a secure base—this secure base is the foundation for resilience.

Shame An affect which induces a complex emotional state where a person experiences overwhelming negative feelings about the self. The family of emotions belonging to shame includes guilt, remorse and regret.

Healthy shame Healthy shame is felt when a person does something wrong, accepts that they have hurt another and experiences shame. This shame leads the person to repair the damage, apologise and make good. This cycle is a part of socialisation.

Trauma Occurs when a person's inner resources are overwhelmed by a perceived or actual external threat. The response may be one of fight, flight or freeze. With adequate internal and external resources, a one-off experience of trauma can heal quickly. Chronic, ongoing exposure to trauma in childhood leads to delayed and distorted child development.

Vicarious trauma Workers who listen to and support children and families who have been victims of trauma (abuse, neglect, family violence, etc.) are at risk of developing a type of secondary trauma or 'vicarious trauma' in which the worker becomes in a sense 'traumatised' from carrying the emotional pain, and the burden of witnessing their clients' stories.

A framework for connection

What is the best way to approach working with traumatised children and young people? The *Spiral of Healing*, below, is one framework to help in understanding, assessing, supporting and assisting young people who continue to suffer—and make others suffer—the long-term impact of trauma. It is also helpful for their families and communities. (Note that because of the limited scope of this booklet this is an introduction to the framework, and not a guide to clinical intervention.)

The challenges of working with traumatised children and young people

Not all young people whose lives have been harmed by trauma are having difficulties. Some are not part of child protection, mental health or justice systems: they may have struggled through on their own, against the odds, doing the best they can. They may have been fortunate enough to find stability and positive influences in their lives—with grandparents, carers, relatives, neighbours, teachers or therapists, who have offered them relationships within which to grow and flourish. There are other traumatised young people who don't come to anyone's attention, either because they slip below the radar, or because they have internalised their pain and don't cause any trouble. These young people need recognition, support and assistance as much as those who are obviously having difficulties.

The *Spiral of Healing* framework (see illustration, page 8) takes into account the impact of abuse, neglect and other trauma. As mentioned in the *Introduction*, it can be very difficult to both understand and deal with young people who struggle to respond to limits and boundaries, have poor affect regulation, do not have much empathy for themselves or others, seem not to understand right and wrong, and have few skills in understanding and responding to the thoughts, feelings and actions of others. These young people find relationships difficult; they struggle to trust adults or authority figures; and have little desire to please the adult world.

There are many challenges when working with and caring for traumatised children and young people. The quality of the relationships we have with them is pivotal to helping them move from isolation to connection. Children need unconditional care: a sense that those involved in their lives will not give up on them, and still respect and value them even when they demonstrate the worst of their pain.

The extremity of their behaviour, the wildness of their rage, the force of the fury we see on the outside is only a dim echo of the fear, sadness, pain, loneliness and loss they feel on the inside.

> Thirteen-year-old Jodie, who has a long history of neglect and sexual abuse, is a young person in extreme pain. Her rejecting attitude to her foster parents and her violence to their three-year-old daughter resulted in her being removed from that placement and she has spent the last few months drifting between youth shelters and the streets. She has been prostituting for money and using drugs and alcohol to numb her pain. How can we help her?

The *Spiral of Healing*: what you can do

There are three phases (or streams) in this framework: *Safety*, *Telling the story* and *Connection and empowerment*, plus a

fourth stream, *Building relationships*, which surrounds and supports the whole spiral. They are based on the work of Judith Herman (1992), and informed by the Sanctuary model (Rivard et al., 2004), and the White Paper from the National Child Traumatic Stress Network (Cook et al., 2003). Herman first conceptualised the phases of recovery as: Safety, Remembrance and Mourning and Reconnection. The phases have been redeveloped in the Australian context, with a particular focus on the *Telling the story* stream, which reflects the contribution of Aboriginal and Torres Strait Islander storytelling traditions as a framework for regulation and healing. The Spiral of Healing streams also incorporate a spiritual dimension, by drawing on spirituality, hope, ritual, ceremony and other cultural practices as healing activities.

The phases that make up this framework can be seen as a spiral, which can move children and young people from the loneliness and isolation of trauma through a process of healing and recovery, into a stronger connection with family, friends and community. The framework begins with isolation—because that is often the most profound and disturbing aspect of the pain a traumatised child lives with—and ends with connection, because this is a true marker of recovery: if a young person has gained the internal strength and skills necessary to manage healthy, loving and satisfying relationships. Focusing on relationships and connection (rather than the more medical model of symptom resolution) plants us firmly in the social world and reduces the tendency to isolate, individualise and pathologise traumatised children and their families. The framework also recognises that recovery from childhood trauma will leave scars, and that there may be times of pain and struggle ahead; however, a person who can rely on others, enjoy the love and company of friends and family and take an active and positive part in community life, will deal with those ups and downs with forbearance and humour.

In this framework, healing and recovery occur in a recursive way as the streams move backwards and forwards, and fold back upon themselves. Safety and trust are gained and lost again, insights achieved, stories told, and new skills developed. Gains are sometimes lost as new challenges undermine the young person's tentative trust in adults and the world, only to be made again as recovery continues. To an extent, the phases follow one after the other—particularly as safety must come before any other interventions. Unless a young person is fundamentally safe, and feels safe and can rely on others, it is not helpful (and may even be dangerous) to move towards therapeutic interventions. Safety has to be created in conjunction with the child protection and legal systems.

The spiral: building relationships, safety, telling the story, and connection and empowerment

Below you will find an overview of the three phases or streams, and the supporting structure of *Building relationships*. Although as mentioned above the phases overlap, each is presented separately, with relationship-based practices to begin the movement of the young person from isolation to connection. (More information about developing these practices is presented further on in this section.)

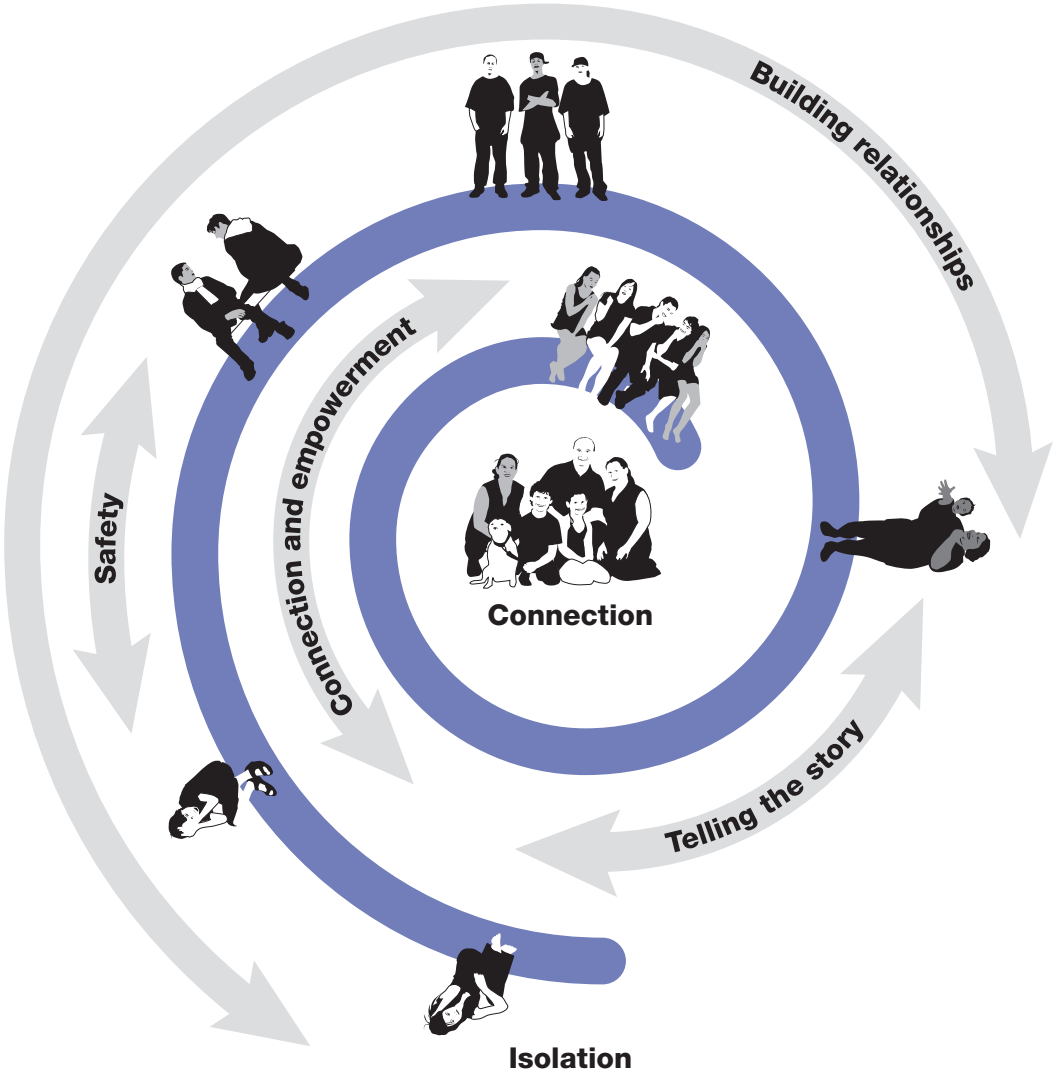


Figure 1 Spiral of healing

Building relationships

This stream of the spiral is fundamental to any recovery process for a child or young person and runs all the way through the spiral.

This stream of the spiral involves:

- helping children and young people to
  - develop safe relationships they can trust
  - build stronger relationships (by being there through tough times; accepting the young person; and being willing to help)
  - maintain existing healthy connections that are safe (for example with school, peers and community members)
  - engage in healthy relationships with a range of other people. For children, this might mean promoting friendships or joining a sports team
- teaching children and young people relationship and social skills, including how to recognise their own and others' emotions
- focusing on affect regulation.

What you might see
As young person feels safer, their difficulties with relationships may appear, as they let their guard down and the real work begins.
Young person may be very resistant to genuine connection, as it challenges their view of themselves and others.

Young person avoids intimacy, because they do not want to face the possibility of rejection.
Young person does not trust that adults will keep them safe.
Young person has problematic relationships with parents and other family members.
Young person has relationships that are marked by conflict, or are short-lived.

What you can do
Use PACE (see below, page 13) to maintain an attitude of empathy.
Build a relationship through structure, nurture and boundaries.
Understand the young person's trauma, and why they are behaving as they are, so you can work with their underlying issues as well as their behaviour.
Use clear boundaries and logical consequences.
Stay calm and well-regulated: lend them your regulation.
Understand your own traumas so that you can stay connected.
Co-regulate with the young person so that they feel supported and understood, and they can begin to rely on adults.
Don't take their behaviour personally.
Use discipline without shaming, and understand their shame when they have been disciplined.
Celebrate skills and achievements, no matter how small.
Engage with family members: the young person will often have relationships with family and these links need to be understood, worked with and strengthened.

Safety

The *Safety* stream of the spiral involves:

- ensuring that abuse, neglect or other trauma has stopped, so that the young person can be guaranteed fundamental safety
- ensuring that children and young people feel physically and emotionally safe
- keeping safe and calm ourselves, as workers, parents or carers
- making sure our organisations are safe places for workers
- creating safety within communities (that is, communities free from violence and harm)
- creating safety within the young person's environment (a safe place)
- creating safe families by addressing family and sexual violence, drug and alcohol abuse, mental illness
- maintaining connection to culture (which often brings a sense of safety)
- using massage (from a qualified masseur), rhythm, dance, music, as well as culturally appropriate ritual and ceremony to regulate physiological and emotional arousal.

What you might see
Young person is feeling unsafe, (and is not able to rely on adults to ensure safety): may display fear masked by angry or dismissing behaviour.
Young person is acting unsafely: perhaps with aggression to others, self harm, running away or engaging in risky behaviours.
Young person has dysregulated affect, and is finding it difficult to manage intense emotions: they may appear 'wired' or hyperactive; or they may be flat, depressive or numb.
Young person is testing everyone to see if they are committed.
Young person is too highly aroused to learn from others or from their own mistakes, as they may be existing in survival mode and not able to take in new information.

What you can do
Make sure any abuse or other trauma has stopped.
Begin to build a relationship, by being honest and reliable, and doing what you say you will do.
Understand trauma.
Help them feel safe through nurture, structure and support.
Use clear boundaries and logical consequences.
Stay calm and well-regulated—even as you set limits on aggression—to avoid power battles.
Understand your own traumas, so you can reflect on your own feelings and reactions.
Co-regulate with the young person: use your own calm to soothe and help them calm.
Don't take their behaviour personally.
Use discipline without shaming.
Use the PACE relationship practices (Playfulness, Acceptance, Curiosity and Empathy: see below, page 13).
Engage with family members—even when young people cannot live at home their families are important to them.

Telling the story

The *Telling the story* stream of the spiral is necessary to allow a young person to make sense of their experiences of trauma and disruption. This leads to the development of a 'coherent narrative', where the whole of person's life makes sense to them. This narrative relieves much of the burden of shame associated with trauma, as children and young people often carry an underlying belief that what has happened was their fault (they were naughty and so were physically punished, they were flirtatious and so were sexually exploited, or they were not worthwhile and so were neglected).

Their coherent narrative can also help a young person reduce tensions and conflicts with family members, as the young person comes to terms with their own experiences of trauma, and understands why their parent was abusive or not protective.

Through this process the young person begins to develop an identity based on strength and positive capacities.

This phase includes:

- developing the young person's capacity to describe thoughts and feelings (through direct teaching and by example)
- helping them to develop richer language, particularly the language for emotion and experience
- reading aloud and telling stories, to develop the young person's familiarity with story and story structure

The process would then continue, through:

- creating opportunities to explore grief and loss relating to separation from family, culture and community
- exploring family or transgenerational trauma
- remembering cultural and historical trauma
- sharing stories within safe and trusting relationships
- enabling trauma to be talked about, rather than hidden, or said in secret, or being a source of shame
- sharing stories of responsibility, compassion and change
- sharing stories of strength, resistance and recovery—to bring a sense of hope.

What you might see
Young person is responding to a safe environment.
Relationships are building, and the young person begins to approach trusted adults for help and support.
Young person is better able to take in information and learn.
Young person is beginning to make sense of their own story.
Opening up may make them more vulnerable and may bring a return of unsafe behaviours.

What you can do
Expect both progress and regression.
Use PACE.
Help them talk.
Help them with their grief.
Help them tell the stories of their day, their interests, their activities, their hopes and desires.
Help them make sense of their experiences—it wasn't their fault.
Develop stories with them.
Read to them.
Challenge them to think.
Insist on respectful behaviour.
Help them develop empathy.
Celebrate skills and achievements, no matter how small.
Engage with family members, or seek assistance for them: they may need to tell their own stories.

Connection and empowerment

This stream of the spiral involves:

- children and young people reconnecting with family, the wider community and society in safe and healthy ways
- children and young people discovering and exploring their own special talents and skills
- individuals, families and communities developing a sense of hope for the future.

What you might see:
– more settled behaviour, with the young person making good decisions about their life
– greater capacity for self-regulation
– more empathy for themselves and others
– more capacity for positive peer relationships
– safe connection with family members
– enjoyment of talents and skills
– connection to community and culture
– young person speaking up for themselves in positive ways.

What you can do
Help them make healthy choices.
Help them learn empathy.
Help them connect with their talents, interests and skills.
Help them connect with positive peers.
Help them connect with family, community and culture.
Help them make sense of their family.
Help them speak up and advocate for themselves.
Build hope.
Inspire them!

How can I connect with the young person? Playfulness, acceptance, curiosity and empathy

There are many ways to connect with children and young people who have experienced abuse, neglect and other traumas. These young people need positive relationships to help begin a process of recovery. The following are some suggestions for encouraging relationship-based interventions.

Underlying pain

The main purpose of relationship-based practice is to connect to the hurt underneath the raging and rejecting behaviour. Workers will manage their own feelings and reactions to the behaviour of young people with greater tolerance once they begin to see the pain that lies beneath it; and young people will begin to feel safe, understood and able to move forward when they begin to make sense of their experiences, through the empathy and compassion of others.

Playfulness, Acceptance, Curiosity and Empathy (PACE)

The PACE model was developed by Daniel Hughes (1997) and remains an excellent template for a relationship-based approach that can be used by foster carers, parents, residential care workers, teachers, youth workers and others. Many frameworks give great ideas for understanding and planning for traumatised young people. PACE gives a set of practical skills, and an attitude.

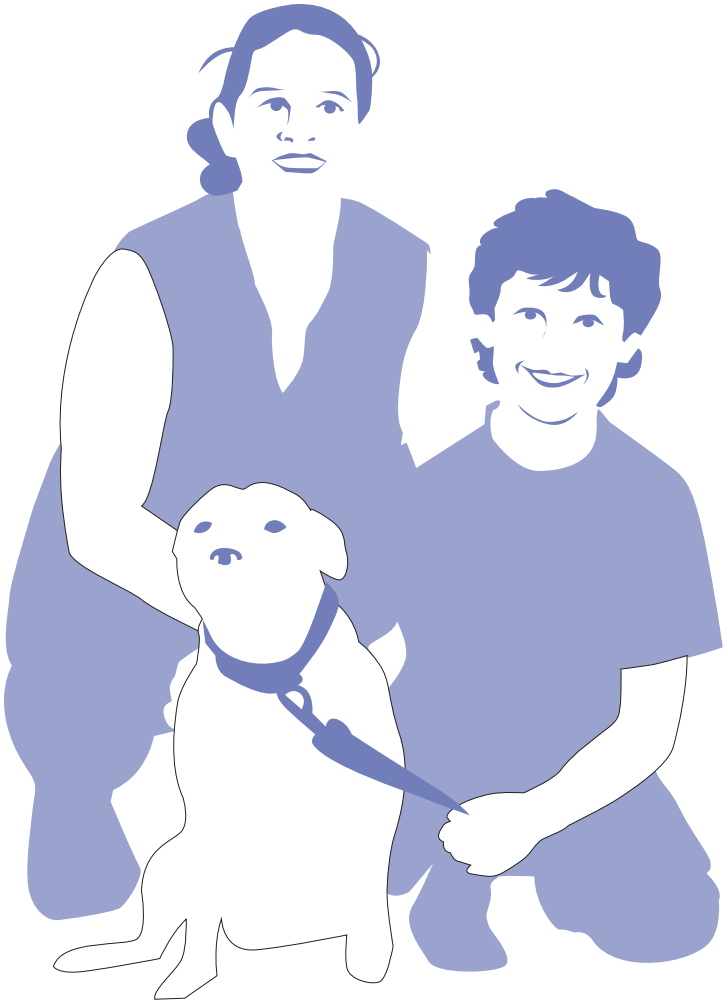
The use of PACE is not aimed at 'changing' the young person; rather it is used to help them feel connected. Through PACE the young person feels understood, and this in turn builds the trust that is necessary for the development of security.

Playfulness

Children and young people need to feel that they are fun to be with: joy brings connection. Playfulness is about having fun with young people and assisting them to join in fun family or community times. Playfulness is also used to defuse tension—giving the young person a response they did not expect, to keep things lively. Life is often all too serious for a young person living with the complexities outlined in this booklet: anything we can do to brighten up their life can be helpful.

Of course, making light of painful feelings, or acting silly based on our own anxiety will bring shame to the young person, not joy. Adults need to be well-regulated in their playfulness, so as to remain joyful and not become overly silly, or participate in jokes at the expense of other staff or young people. Humour and warmth are to be encouraged, but not overreactions or 'revving up' of young people. Adults need to know when to stop and how to regulate themselves, and help young people to regulate.

'I know you don't like doing chores, so let's put on your favourite music and we will do them together.'



Acceptance

When a traumatised young person experiences the understanding and warmth a caring adult can offer them, this challenges the internal working model that has built up through years of neglect and abuse. This negative working model tells them they are unworthy of love and may be to blame for all that has happened.

Acceptance says to the young person, *I don't like what you are doing right now but I understand why you have to do it. I am here to help you do things differently, so you get on better with others and don't get into so much trouble.*

Acceptance avoids angry power battles, and at the same time behavioural limits can be set, and consequences enacted, without any shaming of the young person for their behavioural choice. (Shame may follow, allowing an opportunity for interactive repair.) This process allows an adult to stay calm, which helps the young person regulate themselves.

The use of acceptance often reduces defensiveness and opposition. Adults need to be well-regulated themselves to use acceptance, as they need to be objective about the young person's behaviours and choices, rather than becoming irritated or enraged—even when that behaviour seems personally offensive, aggressive or rejecting. The adult accepts the behaviour because they understand it as coming from the pain the young person is suffering, and because they have a fundamental acceptance of the young person and are able to separate the behaviour from that person.

> 'I know it is hard for you to manage your anger and you will have to contribute to fixing the door you broke, but right now come and sit with me till you calm down and I will help you to manage your anger.'

Curiosity

It can be useful to wonder with a young person about the meaning behind their behaviour and why they do the things they do. Curiosity sometimes means making best guesses about what is going on. The young person and the adult are figuring it out together. Curiosity allows a young person to feel heard and understood. Adults may use 'over-talking', talking to another staff member or parent, wondering aloud at what the young person might be thinking or feeling, why they might be reacting like this, and what might be going on underneath the behaviour. Adults need to be well-regulated to take a reflective, curious stance: not getting upset, frightened, angry or overwhelmed by the young person's behaviour, or by their distressed or distressing affect.

> 'I wonder if you ran away yesterday because you were scared and worried about your mum visiting today?'

> 'I think perhaps you acted like that to push me away because you thought I was going to kick you out like your last foster family did—does that seem right to you?'

Empathy

With empathy we 'feel with' another person; we feel compassion for their struggles or suffering. Empathy eventually allows the young person to acknowledge deeper feelings of fear, sadness, hurt and anger, without fearing judgment. Empathy can be used to soften a young person's defences.

'I'm so sorry that happened to you, it makes me feel really sad you had to go through that.'

'That must have been really hard, good on you for keeping on trying.'

Empathy can also relieve shame, and is often more useful than praise, which can exacerbate shame. Adults need to be well-regulated to be able to convey empathy, which arises naturally from compassion. In this context empathy is a tool that is used to connect with a young person to convey a number of things, such as:

'I care for you even though I am disciplining you.'

'I can see and understand the pain you are in, even if you can't talk about it yet.'

'I know you are in pain and that affects your behaviour.'

For more on this approach to caring for traumatised children and young people see Hughes (1997) and Becker-Weidman & Shell (2005).

Staying calm and regulated

Adults working with traumatised children and young people will inevitably struggle at times to remain calm, centred and well-regulated, and yet this is the key to working with these young people. In particular, carers and residential care workers will need lots of support and empathy for their own struggles to be able to be effective. Good supervision and time put aside to reflect on reactions and responses to young people will put an emphasis on self-reflection, so that workers and carers can establish habits of asking themselves essential questions such as:

'Why did I react like that?'

'Why did that behaviour make me angry?'

'I spent all afternoon helping him, and then he turned on me, why did I feel so rejected?'

'What are the triggers for me?'

'I lost it that time, what can I do differently next time?'

When caring for or working with young people, we need to know ourselves well, to know our own triggers and thresholds, and to know how and when to ask for help. No-one should be made to feel shame for asking for help and/or needing time to become calm and re-regulate. (See also page 16, Taking care of the care-takers.)

Provide tools: techniques and activities

Everyone working with young people needs a box of easy-to-use 'tools', techniques and activities to give to them. Put together your own toolbox by thinking through the things you do that really work, and looking around to see what others do.

Hints for emergency grounding and soothing

To start with, here are two useful suggestions to provide to the young person:

- 'Make a list of the most portable soothing items and ideas and keep the things you need with you—for example a hanky with lavender, a stress ball to squeeze or a lucky charm.'

(This can be done as an exercise with groups of young people, using creative techniques to create a bag of soothing remedies.)

- 'Write your five most effective or useful grounding ideas in abbreviated form (e.g. *Eye contact with a friend*) on an index card and keep this with you. Think of it as emotional first aid!' (Again, this can be done one on one or with a group.)

Both exercises enhance young people's capacity to take care of themselves, and to develop self-awareness and self-soothing. They have been adapted from the Sanctuary model (Rivard et al., 2004).

Taking care of the care-takers

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

The three Rs: Reflection, Regulation, Relaxation

The following are three effective strategies to reduce stress and increase self-awareness.

Reflection

Take time to reflect on the young person you are working with or caring for, and your relationship with them.

- Reflect on their behaviour.
  - What were they doing, and why might they have been doing it?
  - Think about the information you now have about abuse and neglect to make sense of their behaviour.
- Try to understand the behaviour.
  - What is their behaviour telling me?
  - What hurt or need are they expressing because they cannot put what they really want into words?
  - Think about the specific history of this young person. How does their behaviour link to past experience?
- Try to understand yourself.
  - What are my thoughts and feelings about this young person?
  - How can I stay regulated when I am with them?
  - What were my responses to the young person's behaviour?
  - Where is our relationship at?
  - Is the young person able to connect with me and listen, to take strength from the containment and structure I am offering?
  - What assistance do I need to do this work?
  - Who can I talk to about how I feel?

Learn as much as you can about caring for and working with children with trauma and attachment difficulties. Read, surf the internet, talk to others, share your knowledge and experiences, learn from others. There is a list of useful resources and websites at the end of this booklet.

Regulation

It is important to acknowledge and regulate the feelings that arise in you as you are working with or caring for a young person with experiences of trauma and attachment disruption.

Caring for these children can often trigger our own unresolved issues from the past.

- Manage your own emotions and responses by:
  - predicting that the young person might make you angry or upset on purpose, in order to recreate familiar relationship patterns
  - knowing that strong emotions are contagious
  - knowing what your own trigger points are and what upsets you the most
  - taking time to calm yourself when you do get angry or hurt
  - calling for assistance, not trying to do it all alone
  - having clear plans and practices/strategies worked out in advance
  - debriefing after challenging incidents so that you are resolved about what happened and have left the emotions behind.
- Find out as much as you can about affect regulation. Working on regulating your own emotions and reactions will be of enormous benefit to the young people you work with or care for.

Relaxation

Develop the self-awareness to know when you need time out:

- Find the best ways to relax and unwind when the going gets tough.
- Try not to use alcohol and other drugs as a way of unwinding or relaxing.
- Make time for yourself and your family.

- Ensure that you make time for yourself and the things you are interested in (e.g. hobbies, time with friends).

A sense of humour and a realistic approach are valuable attributes:

- Humour can help us keep perspective and not take things personally.
- Be realistic and patient with yourself. Traumatised young people with disrupted attachments often require time to change.

Remember that the true heroes in this work are those who look after themselves, know themselves well and ask for help when they need it!

Support for front-line staff

Organisations need to provide safety, stability and support for staff working with traumatised children and young people, and all levels of management (not just direct care staff) should have a good understanding of the impact of abuse, neglect and other traumas in young people's lives.

Organisations and services should:

- work from practice frameworks that are based on theory and research
- use well-documented and resourced structures for supervision
- have enough staff to manage crises
- provide appropriate training to do the job
- provide access to debriefing
- encourage reflective practice.

Collaborative working practices

The network of workers and carers surrounding traumatised children and young people must have forums to meet in, where there is a sharing of information and a sense of sharing the work. There should be processes for reflection and for managing together the inevitable anxieties that arise. We all need to be open enough to bring along our experiences and worries, so as to share the work of helping children and young people and families who are struggling.

Sometimes the strong emotions stirred up by working with children and families can cause disagreements in how to work with them, or how to advocate for them. These splits in working teams can be very destructive, and ultimately bad for children and young people.

The care team approach

A useful approach when working with complex families and systems is to work as part of a care team. This is essentially a coordinated group of people who meet on a regular basis to think, plan and together provide support for the young person and their family. The care team provides an opportunity for key people to come together on a regular basis to reflect, share their thinking and understanding and coordinate each person's role in supporting the young person and family. These meetings can also make sure that what is planned is actually carried out.

The main difference between a care team and other meetings or forums (such as case conferences, professionals' meetings or stakeholder meetings) is the development of the care team as a working group which promotes an attitude of collaboration

and information-sharing. It is vital that those who are working closely with the young person meet in this way to share the work, so that recommendations and plans can be individualised and implemented by those who know the young person and family. Children and young people and, where appropriate, family members, should be invited to these meetings, and given an opportunity to contribute or at least to be informed of agendas, decisions and plans.

In a care team, the focus on the changing needs of the young person allows for a consistent approach. In practice this means that the young person experiences consistency in their interactions with everyone in the system.

Many decisions can be made by the team, as it has shared information about the young person—although of course some decisions have to be made by a statutory body, such as Child Protection or Youth Justice.

The care team approach:

- ensures adequate assessment of the young person has been conducted and all information shared
- allows for the group to think together about the young person, and to process some of the difficult emotions and anxieties aroused when working with them
- supports the young person's learning, development and growth, as well as their healing from trauma and disrupted attachment
- promotes proactive rather than reactive responses to the young person
- provides an opportunity to identify positive changes in the young person's life, no matter how small
- ensures effective coordination and information-sharing so that intervention strategies will be implemented.

Workers and carers have an important role in the care team, as they have contact with the young person on a day-to-day basis and are in a position to notice both difficulties and changes as they occur.

As mentioned, children and young people may also be involved in care team meetings and should be invited regularly even if they don't want to attend. This helps them to know when the team is meeting and what will be discussed, so that they can have input if they want to.

The next section *Theory and case studies: trauma, attachment and child development* will assist with developing an understanding of some of the theories that are used in the child abuse and neglect field, with case studies providing examples.

Theory and case studies: trauma, attachment and child development

The previous section outlined some of the behaviours shown by children and young people who have experienced trauma from abuse and neglect. We now go on to examine how trauma and attachment disruption affect a child's development. This section introduces the theory behind these processes, illustrated by case studies.

Keep in mind that each child will respond differently to their experience; and few children will display the most severe or complete range of difficulties resulting from trauma. Neglect and the various forms of abuse and other trauma will have different effects; and traumas at varying ages and developmental stages will have different impacts. Try to understand each child as they stand before you, in the light of what happened to them.

Complex layers of experience

Children who have been abused and neglected will often have had many different experiences of adversity. Their infancy may have been insecure with harsh or neglectful parenting. They may not have had an attuned, loving attachment relationship in which they were reflected in their parent's gaze as lovable and delightful. The neglect may have even been severe enough to limit brain growth, or result in learning and regulation difficulties.

Resulting from this experience, the child may have built an internal working model of unworthiness. They may not have learnt to adequately regulate their emotions and reactions, or to develop self-control. When it came time to learn about the limits and boundaries of appropriate behaviour they may have been overly shamed or under-socialised, leading to profound shame about themselves, but little shame about their actions. They may also not have developed much capacity to 'read' others, and so they misunderstand social cues and social relationships. All this may have affected their capacity to empathise with others.

The impact of abuse and neglect

Unfortunately, it seems that often this kind of neglect is complicated by traumatic experiences of abuse, such as witnessing domestic violence, being subjected to physical and emotional abuse, being surrounded by community violence, or being exploited by sexual abuse. Figure 2 highlights the specific problems associated with neglect and abuse respectively, and the impact on the child.

Understanding the complex interplay of abuse, neglect and other trauma can assist us in seeing beyond the disturbed behaviours of such young people and empathising with the lonely, frightened and humiliated child within.

Attachment and early security

Resilience in children is built through the support of attachment figures or a network of attachment figures.

Attachment

Attachment is the system that all human infants use to keep protective carers close and caring (Bowlby, 1988). Attachment behaviours—essentially behaviours which promote closeness—can be readily identified by the infant's attempts to engage carers: crying, smiling, cooing, babbling, etc. Infants take a very active role in keeping the caregiver close, through these

attachment behaviours. They do this not only for protection, but also to prevent caregiver negligence or abandonment.

Through their experience of the attachment system infants develop internal working models of relationships, which guide their expectations of future interactions. The development of internal working models is influenced by infant temperament, attunement between carers and infant, the carer's sensitivity to the infant and the carer's own internal working models (Bowlby, 1988; Ainsworth, 1969).

An example of this is a young child who runs onto the road when his mother is not looking, being narrowly missed by a car. A well-regulated parent will grab the frightened, screaming child and comfort him, while managing her own fear and distress. Later on when both are calm she will talk to the child about always staying close when they are near a road, and the dangers of cars. A less well-regulated parent might grab the child, yelling and crying with her own fear and distress, smack him and shout 'Never go on the road!'. Both parents have been frightened, but one acts to comfort the child while the other acts on her own raw emotions. If we don't get attuned and loving early care ourselves, we tend to act on our emotions, not being able to think or put a child's needs first. The child in the first example will learn about the dangers of cars, and about staying close, while the child in the second example will learn that fear is overwhelming.

Attachment theory has tended to focus on the parent or person primarily responsible for providing care. *Attachment networks* are common in collectivist cultures with strong extended families, such as Aboriginal and Torres Strait Islander

Figure 2: The impact of abuse and neglect

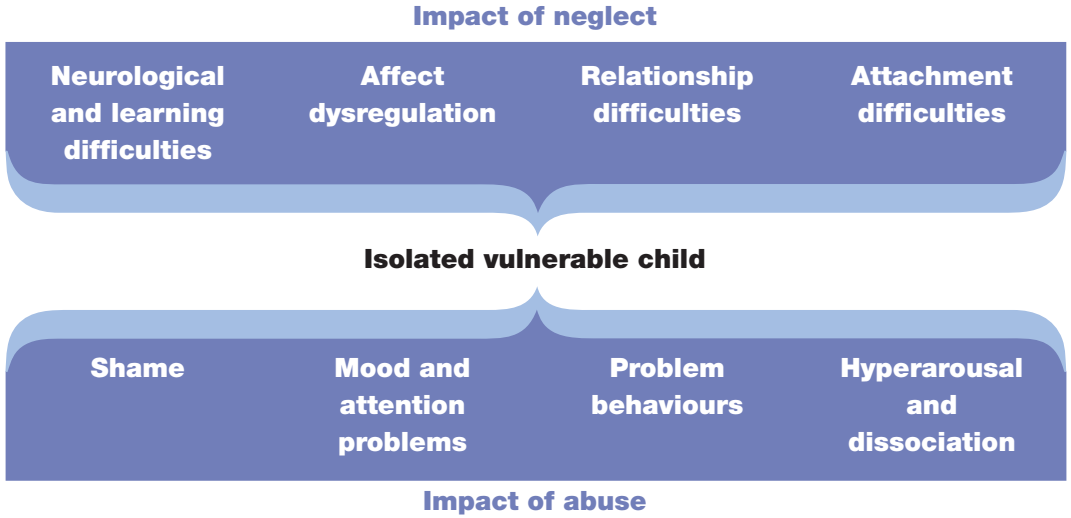
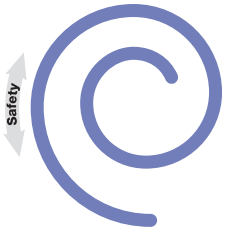


Figure 3: The internal working model

	Positive internal working model	Negative internal working model
View of self	I am lovable	I am unlovable
	I am worthy	I am unworthy
View of the world and relationships	Others are responsive	Others are unavailable
	Others are loving	Others are neglectful
	Others are interested in me	Others are rejecting
	Others are available to me	Others are unresponsive
	The world is relatively safe	The world is unsafe



Case study one: Robbie

Robbie was born premature and drug-addicted, as his 17-year-old mother had been using heroin during her pregnancy. He was tiny and had to stay in hospital for two months. When he went home to his mother, she stayed clean for a while but found him hard to manage and difficult to soothe. He cried and cried and she felt miserable and useless to him. Eventually she started using again and he was often left hungry and dirty. Robbie was removed from her care several times in his first three years, but was returned when she stopped using drugs. Finally Robbie was placed in care when he was four, and did not return.

At four he had many problems, which were exacerbated by frequent moves, as foster carers could not cope with his behaviours, or his placement had to change for other reasons. Carers often said they liked him at first and that he could be quite charming—but then he would push them away once the relationship started getting closer. He was described as finding it difficult to manage relationships, as he did not have many skills in managing his own emotions or reactions, or in dealing with conflicts or solving problems. Robbie also had learning problems and his language was poorly developed. He had frequent aggressive outbursts and other children at kindergarten were often afraid of him. He rocked himself to sleep at night and did not respond to affection from foster parents.

When he was nine his mother—who was no longer an addict—married and had two children, which made Robbie all the more angry and hurt. She would have liked to care for him but also found his behaviour too difficult and worried about the safety of her younger children.

When he was eleven Robbie was placed with carers from a therapeutic fostercare program, and a comprehensive care plan was built to support him. Interventions of massage, music, dance and rhythm were implemented, to help him to regulate himself, along with a therapeutic parenting plan (including PACE) to assist attachment between him and his new caregivers. This included training and intensive support for them and weekly therapy sessions involving both Robbie and his caregivers. Robbie had some home tutoring and he spent the rest of the day with his caregivers. Work was also done with Robbie's mother and her partner, to use their contact in a more productive way. They were also trained in therapeutic parenting practices, even though Robbie will probably never live with them. They were introduced to Robbie's carers, who have offered some support when he visits his family, and the two families now spend some time together. This link has proved very beneficial as it mends part of Robbie's painfully separated world.

Now, at 13, Robbie has settled markedly. He has formed a tentative attachment relationship with his carers and allows them to comfort and discipline him. He can still be aggressive and needs some limits to excitement and stress, and he has ongoing problems with learning and with social and peer relationships. He is happiest at home with his male carer, helping him with carpentry and other projects. He attends school but is still not up to his grade level and will soon go to a supported secondary school. He can spend time in the classroom now and is keen to learn to cook.

and traditional African cultures. They describe situations where more than one person is responsible for connecting with and caring for children, and as such provide a different way of thinking about attachment.

Secure attachment develops resilience, so that a capacity to tolerate stress is built up. Resilience is developed in childhood through exposure to stress, with immediate access to comfort and nurture; in this way a child absorbs a sense of their own self-worth—because their caregiver had them in mind and came to help when there was threat and fear. Many traumatised children are less resilient because they have not had access to such comfort.

Attachment and stress

By soothing the infant when this is appropriate, the caregiver not only protects them from the effects of stressful situations, but also enables the child to develop the biological framework for dealing with future stress. In this process caregivers play a critical role. The caregivers help the child to know their own feelings by giving words to their experience (*oh, you look tired, what a beautiful smile, you look so happy, you're really upset now*); helping the child to regulate their physical body and to know physical boundaries by holding them, touching, playing with and comforting them. Without these early experiences children can grow up not recognising or understanding their emotional and physical states and consequently not able to make good decisions and judgments, not able to manage strong emotions, and lacking trust in the world (van der Kolk, McFarlane & Welsaeth,1996).

Attachment and regulation of emotions and reactions (affect regulation)

One of the most important aspects of the attachment system is that it forms the framework within which we learn to regulate our physiological and emotional reactions. The presence of attuned caregivers—who are able to regulate their own reactions and levels of emotion or affect arousal—leads directly to the infant beginning to regulate their own arousal levels.

In fact with new knowledge from 'brain science', or neurobiology, some attachment theorists suggest that '… attachment theory stresses the primacy of affect and is fundamentally a regulation theory' (Schore & Schore, 2008, p.10).

Case study two: Jodie

Jodie was an easy, settled baby, and had a good beginning in life. Unfortunately her father was killed in an accident when she was two, and her mother then married a man who turned out to be very violent. He frequently beat Jodie's mum and once took Jodie away with him and refused to give her back. The police eventually found him and he held Jodie hostage for two days before shooting himself in front of her. She was only five.

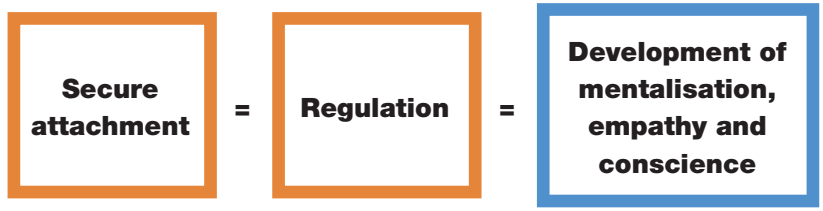
Both her mother and Jodie were deeply traumatised by these events and Jodie's mother developed post traumatic stress disorder (PTSD) and became very depressed. Jodie had some treatment at the time, but because her mother was so affected it was hard for her to fully recover.

Jodie was placed in care at the age of nine when her mother became ill with cancer. She was a quiet, withdrawn child and started self-harming at twelve, causing a great deal of damage to her arms and leg by carving into them. Jodie spent several years moving between residential care and psychiatric hospitals, hardly attending school and missing out on many normal adolescent activities.

When she was 14 she was admitted to a therapeutic residential program set up specifically for young women, where she benefited from a sense of containment and safety, the warmth and support of staff and the group program. The clinician there made contact with Jodie's mother, who was dying. Jodie had been kept away from her mother by well-meaning workers who thought her illness would be too upsetting, and that Jodie would upset her mother. However, Jodie managed well—with support—and she and her mother had several months of very positive contact before her mother died. During this time Jodie also had contact with her mother's extended family, and one of her cousins took an interest in her, and helped her through the grief that followed her mother's death.

Jodie seemed to grow in maturity through these experiences, while all the time drawing on the relationships in the residential unit. She still sometimes harms herself, but has become much better at letting others know when she is distressed. She hopes to go and live with her mother's cousin at some time in the future, although she doesn't feel ready yet.

Figure 4: Secure attachment



Neglected infants who do not have access to enough care, attunement, security and regulation may grow into childhood without the basic framework to regulate their emotions and reactions, read the emotions and reactions of others (mentalisation), feel empathy for others, feel shame when misbehaving (conscience) and manage shame about themselves. Even when well established, this basic framework can be undermined by the trauma of abuse or later neglect.

Attachment and adolescence

By adolescence a specific attachment organisation or style has become an intrinsic part of a person's makeup, rather than the multiple patterns with different caregivers seen in earlier childhood. This style or pattern can still change—influenced negatively by trauma, loss or extreme stress, or enhanced by the security of healing relationships. Usually the pattern established by adolescence will predict attachment patterns with future partners and children, unless greater security of attachment is gained through supportive adult relationships or therapy.

Attachment, socialisation and shame

Attachment relationships with caregivers also form the framework for socialisation: the means by which a cultural group creates the boundaries for acceptable and unacceptable behaviour. Combined with other aspects of early development and attachment such as security and trust, the socialisation process begins in infancy. It then leads to the development of conscience; of being able to manage and regulate affects and emotions; of the ability to empathise with others; and of the capacity to understand the thoughts, emotions and actions of others.

Healthy shame

One aspect of socialisation is healthy shame. If we are reasonably well socialised we feel shame when we do the wrong thing, particularly when we do something that hurts another, intentionally or unintentionally. This is healthy shame. Shame should motivate us to repair the hurt we have caused and to avoid similar actions in the future—because we know right from wrong (conscience); we understand the impact of our action on the thoughts and feelings of others (mentalisation); and because we feel their pain (empathy).

Socialisation is vital to the survival of the individual within the group, and of the group itself.

The shame/socialisation cycle and the impact of abuse and neglect

As outlined above, infants who receive sufficient care, attunement, security and regulation have a framework for regulating their emotions. In their second year of life children begin to experience discipline: their caregiver will provide boundaries and limits to inappropriate behaviour. This creates a shame response, through the caregiver's anger or disapproval; and in a secure attachment relationship this shame is resolved through interactive repair (Schore, 1996; Hughes, 1997). Interactive repair involves a well-regulated caregiver who notices the child's distress, overcomes their anger or fear at the child's behaviour and helps the child return to a calm emotional state, through either 'business as usual', distraction or providing comfort.

Neglect

Neglected infants are unlikely to have secure enough attachment relationships, as they have not received the necessary attention, caregiving, affection, regulation, play and soothing. Therefore the first part of the socialisation cycle is already compromised. In the second year of life, when there is a need for discipline and boundaries, caregivers are less likely to impose

Case study three: Rosa

Rosa, whose mother has a mild intellectual disability, suffered some neglect in infancy, as her mum struggled to look after her needs. Fortunately her grandmother was very involved, and this helped when she was a baby. However, her grandmother was elderly and became ill.

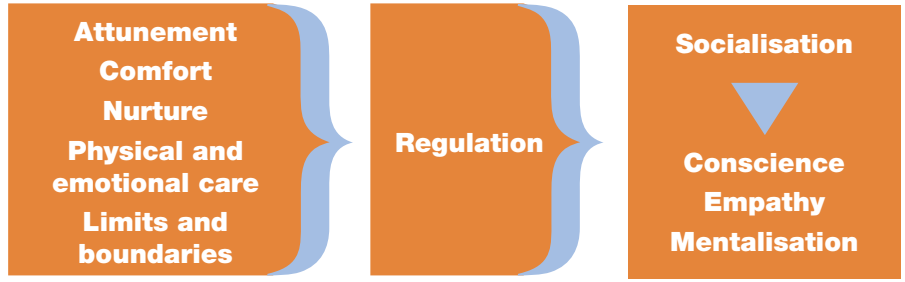
When Rosa was a toddler her mother found it very hard to discipline her and would scream at her whenever she did anything wrong, or looked like she might be in danger. Her mum found it really hard to stay calm when angry or frightened. When she screamed at Rosa she would never pick her up and comfort her afterwards, as she thought this would spoil her and she needed to learn to do what her mother told her.

As a child Rosa was a very timid girl who would freeze whenever she was in any kind of trouble, and she rarely spoke. She found it difficult to look anyone in the eye and had no friends except a younger cousin. Rosa often stayed home from school as her mother liked the company and they would watch TV all day.

By Year 7, at 12, she was way behind her grade level and was thought to be intellectually disabled herself. Although in previous years there had been several notifications, Rosa's mother would always comply with Child Protection orders and with support would sort out whatever the problem was. Unfortunately when the support stopped things would return to the same state.

During Year 7 there was another notification, based on Rosa's absences from school, her poor academic achievement, her very poor hygiene and her mother's refusal to allow an educational assessment, and this time more effort was made to help Rosa. The Child Protection case manager worked with Rosa's mother and linked them into a local Fostercare agency, where a 'grandmother' was found. This was an older woman with a large extended family and lots of energy. She spent a lot of time with Rosa, talking, helping her with grooming and hygiene, introducing her to music and art. Rosa's mother was jealous at first, but found that she was included in many activities and family celebrations. Rosa had an educational assessment which indicated that she was actually of average intelligence and the school put a plan in place to help her catch up with her peers. Rosa started to enjoy reading and listening to music, and found some friends who liked to do the same things. Still very quiet and shy, Rosa is making progress.

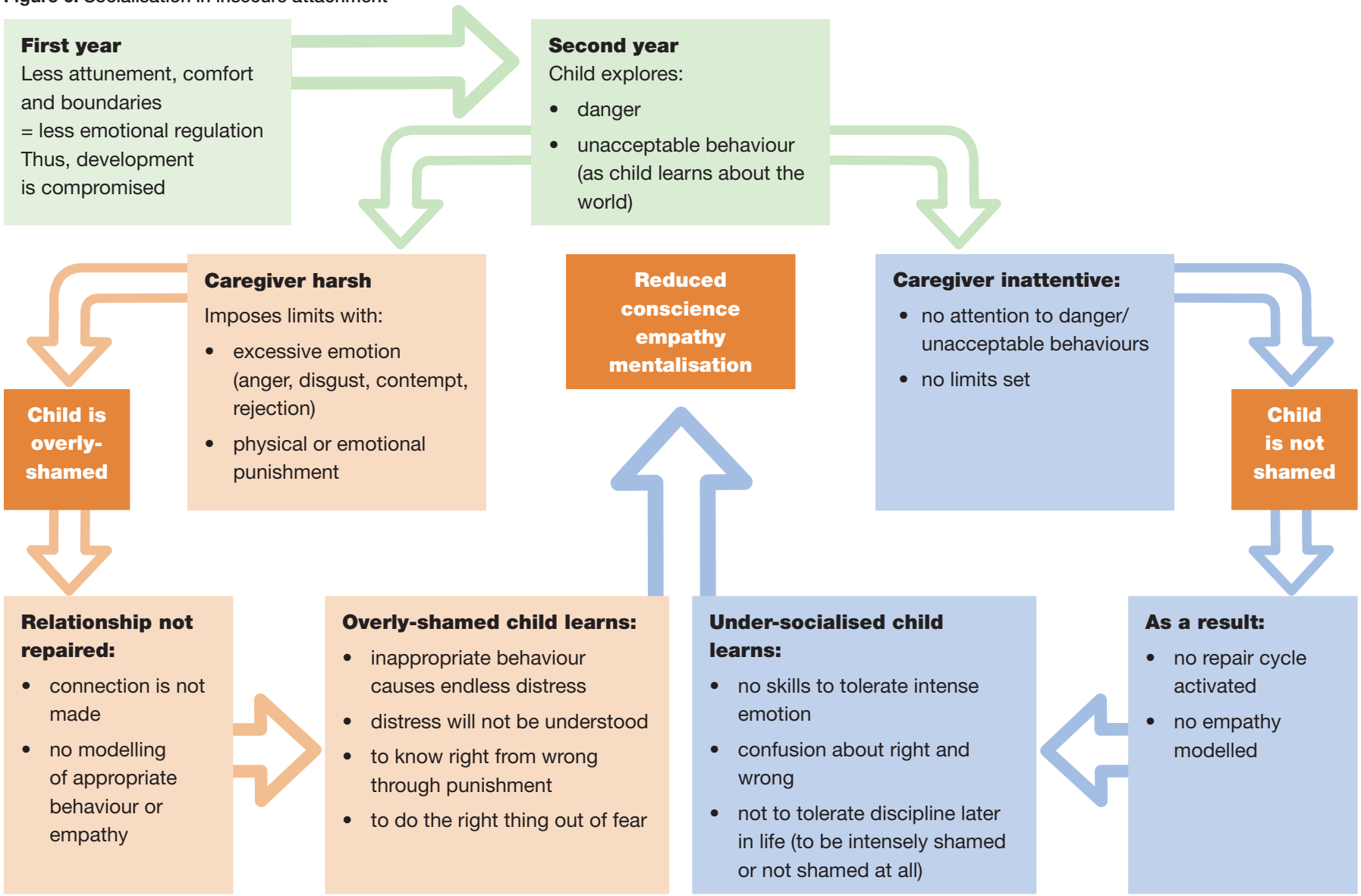
Figure 5: Socialisation in secure attachment



appropriate limits that elicit a shame response which falls within the normal range: there is either too much anger, disgust, contempt or rejection (the overly-shamed child) or not enough disapproval or anger (the under-socialised child).

When a child feels shame because their caregiver is angry or disapproving, the attuned caregiver will repair the relationship with warmth and nurturing, showing the child that it is their *action* that is the problem and they are still loved. With less

Figure 6: Socialisation in insecure attachment



Case study four: Jared

Jared, an Aboriginal boy from central Victoria, had an early life full of chaos. His family moved house a lot due to poverty and his parents often fought about money or other things. His dad was sometimes violent and his mum would get hurt. His dad would try to find work, but had little education or skills and could not hold a job for long. His father, an Aboriginal man, came from a family who had suffered a lot of disruption and trauma over many generations—both his mother and his grandmother had been removed from their families, with the resulting trauma and disruption to child-rearing skills.

Jared's mother was not Aboriginal, and had grown up in a large migrant family with a father who was alcoholic and often violent. Jared had a large extended family on both sides, and his aunts and uncles often took him and his sisters for months at a time while the parents tried to get things together. Although loving and well-meaning Jared's parents were often stressed, tired and too worried to pay much attention to what the children were doing—and often did not pull them up when they were naughty. When Jared was three he ran out on the road when no-one was watching him and was hit by a car, which left him with a permanent limp.

Jared had trouble understanding when he was in trouble at school or in the neighborhood, and would become enraged when someone tried to discipline him, as it aroused deep shame which he did not have the resources to deal with. By early adolescence he had been in trouble with the police on many occasions and was facing charges for stealing cars.

When Jared was 15 there was a notification to Child Protection about his younger sisters, who had complained at school that there was no food in the house and the parents had gone away and left Jared in charge. Jared had hit them several times to try to get them to do their homework and to cook, and so Child Protection became involved. The children were put into the care of an aunt while things were sorted out, which included provision of help for the family around finances, job training for Jared's dad, domestic violence counselling for both parents, and a move to better housing. The local Aboriginal agency was involved with the plan and some of the counselling, and also arranged a mentor for Jared who was able to connect him with cultural activities and other young Aboriginal people. This man slowly introduced Jared to aspects of his culture (including law) which helped Jared understand more about right and wrong, and helped him to manage his emotions and reactions in a more mature way.

Jared did not want to continue at school and found an apprenticeship. He has settled into being a likable and hard-working young man. Jared's father also became interested in his own history and culture, and joined in with the group of local men who were exploring aspects of culture they had been cut off from. Jared's father also began to see an Aboriginal grief and loss counsellor to try to resolve some of his longstanding problems.

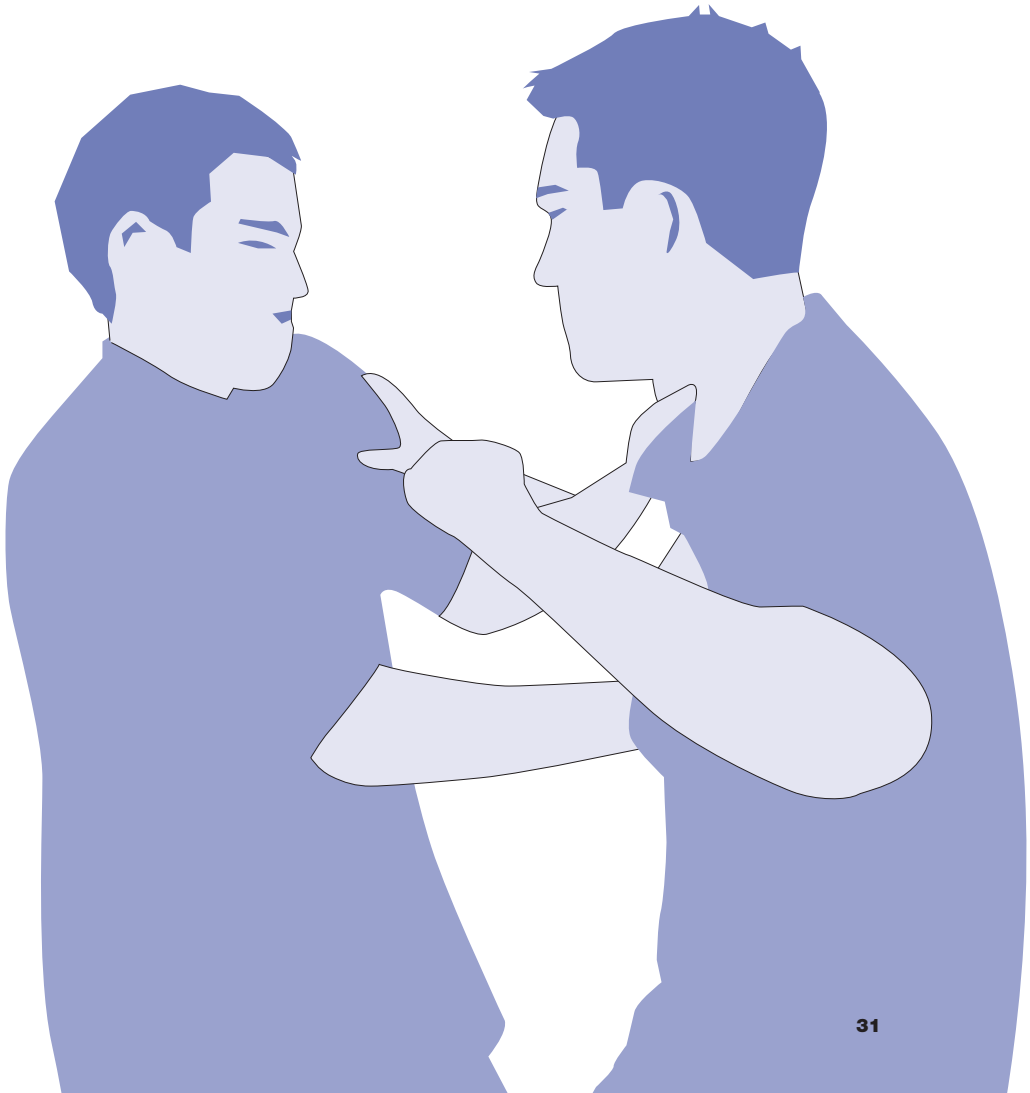
regulated and attuned caregivers, the repair may be inadequate, as the caregiver who struggles to form a secure attachment relationship with the child may struggle to be patient and sensitive enough to regulate the child's shame and re-attune in a timely and warm manner (Schore, 1996; Hughes, 1997).

Abuse creates fear

Abuse, on the other hand, creates fear. The fear response creates many negative changes in the child's developing neurological, emotional, cognitive and relational systems. Trauma has a negative effect on a person's affect regulation. Adults or children who have been traumatised (by abuse or other events) often show a reduced capacity to modulate or regulate their emotional or affective arousal (Perry & Szalavitz, 2006; van der Kolk, 2005). Therefore the developing child who is traumatised may struggle to regulate all emotional experiences, including shame—even if early attachment and the shame/socialisation cycle has been adequate.

Abuse creates shame

At the same time as the fear response to trauma is impacting on the child, the abuse that is suffered also creates shame. Children who have been abused and neglected often have intense shame responses to feelings of failure or insult and to the experience of being disciplined. It is as if all the humiliation of the abuse is triggered any time they perceive themselves as failing or wrong, leaving them feeling intrinsically bad and worthless. Being overwhelmed by shame increases affect dysregulation and often leads to aggressive outbursts. Many traumatised children try very hard to control their environments so as not to feel paralysing shame (Hughes, 1997). This shame is a shame about the self; it is rarely shame about actions and it is not the healthy shame that socialises the growing child.



Trauma theory

Integrated with an understanding of attachment, affect regulation and socialisation, we also need to understand the impact of trauma. In one definition of trauma it is said to involve something happening that is so terrible it overwhelms our ability to cope:

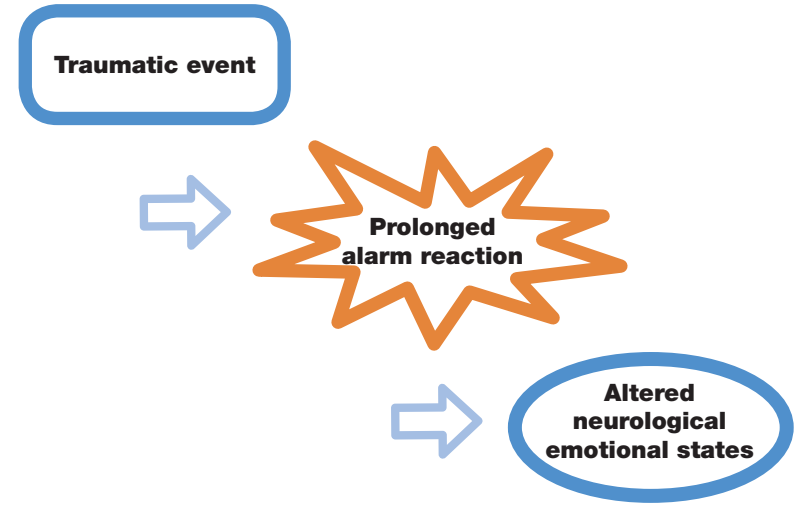
> At the moment of trauma, the victim is (made) helpless by overwhelming force … Traumatic events overwhelm the ordinary systems of care that give people a sense of control, connection, and meaning (Herman 1992, p.33).

Trauma occurs when an event is so frightening it causes a prolonged alarm reaction (van der Kolk, McFarlane, and Welsaeth, 1996) where the body is primed and pumped with chemicals and enzymes such as adrenaline, and does not calm down for a long time. In any person, this creates an altered neurological state. The severity of this state depends on a number of factors, including previous experiences of trauma and the availability of support. Children are more vulnerable to trauma than adults (van der Kolk, McFarlane, and Welsaeth, 1996).

Flight, fight or freeze

When exposed to trauma the brain responds by releasing the stress hormones that make it possible to prepare to fight, run or freeze (the fight, flight or freeze response). When we are confronted with a dangerous or potentially dangerous situation, our brain goes on alert and makes the body ready to respond. It does this by increasing the adrenaline in our system so we can be faster and stronger. When the threat is no longer there, our brain releases other chemicals such as cortisol to reduce the adrenaline in our bodies. This helps us to relax and to quiet down. We no longer need to fight or run so our body adjusts accordingly. This is a normal, healthy reaction in humans and animals.

Figure 7: Trauma affects the brain (adapted from Perry, 2006)



The brain's response to fear

These responses come from deep within the brain, in its most primitive parts. At the same time, stress hormones released during and after a frightening event reduce the functioning of the more complex, thinking parts of the brain that are required to make sense of what is happening. When a child is exposed to significant fear-inducing trauma while they are developing, their brain will store information about the traumatic event, so that it can alert the child to future danger; this is very protective and adaptive, but leaves the child with an altered baseline of

Case study five: Sharni

Sharni's mother became psychotic after giving birth, which led to a diagnosis of schizophrenia a few years later. Her mum was OK some of the time, and her medication kept her mostly stable, although she did have a few breakdowns when Sharni was small. During these times when her mum was in hospital Sharni went to stay with her aunt and uncle. These visits lasting a few months occurred every two or three years, and during these times her older cousin sexually abused her. This started when she was two and continued until she was nine. She did tell her mother, but unfortunately the information got caught up in her mother's illness at the time and the authorities thought that the abuse had not happened, but was one of her mother's delusions.

Sharni told a teacher when she was eleven that it had really happened, and there was a better response. Eventually the cousin was charged, and she had to testify against him. Although she had been doing well at school and had many friends, after the court case she seemed to go downhill. She changed her friendship group and at 12 started having sex with an older boy. At 13 she ran away from home and was living on the streets and prostituting herself. She was placed in residential care, but would frequently abscond. She became pregnant at 15 but was too unstable to keep her baby, who went into permanent care.

Sharni continues to run away and spends most of her time living on the streets, giving sex for food, alcohol and cigarettes. Sharni has not responded to any of the plans put in place for her yet, but there is a group of workers in a street kids program who keep an eye out for her, and let her know she can come to them for help and support when she needs to.

responding to stress, so that they are rarely in a calm or neutral state. They will be in a constant state of physiological arousal, which is often referred to as hyperarousal (Perry, 2006).

Dissociation

In some situations where fighting or running is not possible, our brain may help us to freeze. In these situations, our breathing may slow down and chemicals such as endorphins are released that help us to be very still or even to go numb and therefore feel less pain. This state often leads to dissociation. Hyperarousal and dissociation are both manifestations of affect dysregulation.

It is not uncommon for a younger child to adapt to abuse—particularly sexual abuse—through dissociation, because they are powerless to act. However, at adolescence this response can change, leading to acting out, aggression, running away and risk-taking or self-harming behaviours. The dissociation is often still there (with numbing of feelings and physical sensations, difficulty in reflective thinking, and avoidance of meaningful relationships), but with an overlay of destructive and self-destructive behaviours.

Neglect and deprivation

Neglect is best understood through the lenses of trauma, attachment theories and child development. Each time a young child is left cold, hungry, dirty or unattended this experience triggers a fear response, which turns to terror if it goes on for long. This fear or terror will have the same effect as abuse on the brain and body of the child. The terror is also compounded by the lack of stimulation usually seen in neglect, which slows brain growth and social development. It is further compounded by the lack of an attuned attachment relationship, where the child is not getting the opportunity to understand themselves and others within a loving relationship, or experience the healthy shame/socialisation cycle highlighted above.

Neglected children are therefore compromised in many ways. Perry (2005) describes other developmental and neurobiological consequences of neglect. He points out that the brain and body are based on a 'use it or lose it' principle for most of their functions. For example, if a child does not hear language and is not communicated with, then he or she will eventually lose the capacity to learn anything but rudimentary language.

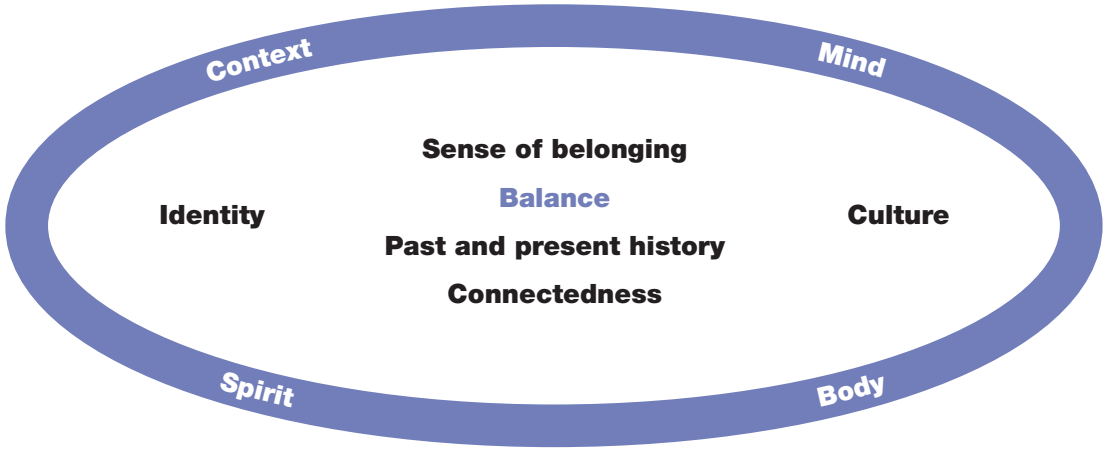
The next section provides a detailed explanation of a range of specific difficulties seen in or experienced by traumatised children and young people, their families and communities.

The impact of abuse, neglect and other trauma

The previous section outlined the theoretical basis for understanding child development, trauma and attachment disruption; below you will find a detailed account of difficulties in the lives of young people caused by abuse and neglect. For ease of understanding, these difficulties have been grouped according to four aspects of human life, as illustrated below in the Relational World View (Cross, 2002; Hill, 2006). The Relational World View is relational and holistic, in that it includes context, mind, body, spirit and relationships.

The four aspects or quadrants are seen as embedded within relationships, in the relational web that surrounds, supports and nourishes all people. The strength of the relational web determines much of our capacity to withstand stress and to support and nurture others.

Figure 8: The Relational World View*



Adapted from *Coade, Downey & McClung (2008) *Yarning up on Trauma*

It is important to remember that abuse, neglect and other trauma have different impacts on different children—and that while we have to take seriously the negative impacts of trauma, we cannot underestimate the strength of human resilience. When working with traumatised children and young people it is also important to make a clear and comprehensive assessment of their situation that includes their strengths and their difficulties, that details their history of trauma and attachment disruption, and takes their current living situation into account.

All of the impacts listed here have to be seen as being on a continuum of severity, and it is very rare for one young person to display all of them.

This section is intended as a guide to understanding the many ways that abuse, neglect and other trauma can impact on child development.

Taking this relational view of human potential, we can see that the impact of experiences of trauma can be matched to mind, body, spirit, context and relationships.

Context

Many of the issues facing children, young people and families exist in their life contexts. Issues of poverty, poor housing, lack of access to education and work, as well as community violence and broader issues of intergenerational trauma have an impact on young lives. Context is also a source of strength, as supportive family and community contexts will provide safety, nurture and challenge for young people.

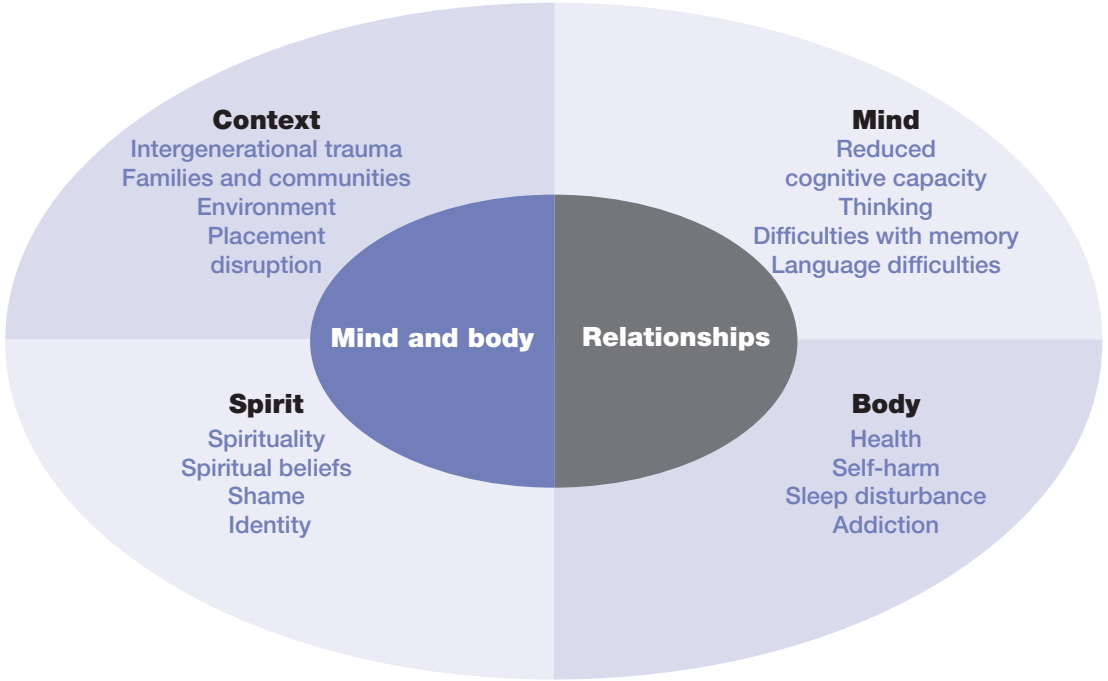
Intergenerational impact

Traumas reverberate down the generations. They show up as problems of substance abuse, mental illness, family violence, child abuse and neglect, often accompanied by poverty, isolation and physical illness. Problems are often found together, and often they make each other worse: for example, alcohol abuse increases the likelihood and severity of spouse abuse, and that abuse decreases a woman's capacity to care for her children and keep them safe. In other examples, victims of sexual abuse in one generation may abuse the children in the next generation. For Aboriginal and Torres Strait Islander families, members of the Stolen Generations can experience ongoing pain, dislocation, grief and the loss of traditional knowledge, language, connection to land and spirituality, as well as loss of knowledge about good parenting.

Families and communities

Trauma impacts on individuals, but also on whole families and communities. Trauma experienced by one person will usually have a ripple effect and other family members, extended family, friends, colleagues and even acquaintances can suffer from the impact of that trauma. Trauma happening to one child or family member can remind others of their own traumas and serve to intensify their suffering. (Of course, trauma to one individual can also pull families together, to support the hurt member.) Abuse and neglect of children and young people can have far-reaching impacts on family members and others: these range from shock, horror, grief and anger to blame.

Figure 9: The impact of trauma



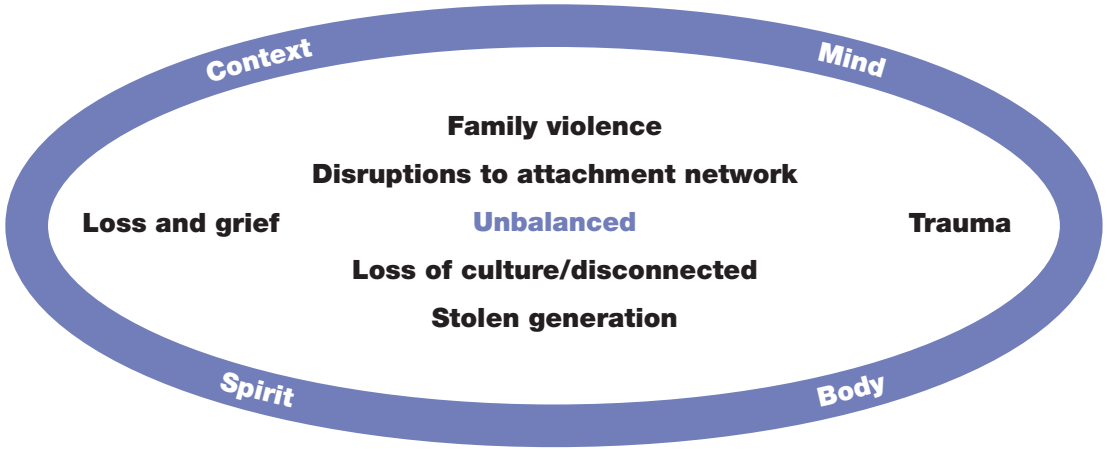
Environment

Children and young people who are living in environments of neglect or abuse are affected in the ways described in this booklet. However, there are other environmental forces which impact on children's development. Poverty, poor housing, lack of access to clean water or nutritious food have terrible impacts on children, as do social forces such as discrimination and racism.

Placement disruption

Children and young people who are removed from home—who are separated from their parents due to abuse and/or neglect—have to undergo a massive internal reorganisation. They have to adjust to a new living situation with new parents or carers, new siblings and often a new school. Aboriginal and Torres Strait Islander children who are moved from their communities can also lose connection to land, to extended family, to traditional cultural practices and a sense of belonging. This is a total dislocation—and coupled with the ongoing effects of the actual abuse or neglect is a 'double whammy'. Unfortunately, in our out-of-home care system many children and young people move frequently from placement to placement, sometimes because of problems caused by the child's own difficult behaviours.

Figure 10: Development under adversity: Weak relational web



Adapted from *Coade, Downey & McClung (2008) *Yarning up on Trauma*

Mind

The human brain is organised in a hierarchical way, with all incoming sensory information first entering the lower, or more primitive parts of the brain (the brain stem), where no conscious thought exists. The brain uses the incoming information over time to build patterns and associations, to build inside the mind a picture of the world, in order to explain and to interact with the world outside.

If patterns and associations built up in childhood are primarily associated with threat, that person's brain will have built inside them a picture of a threatening world and they will respond to the world outside as if there was constant threat. This person will respond to neutral triggers as if they were threats, and the part of the brain doing the responding will be the lower part of the brain, not the higher 'thinking' part—the cortex (Perry, 2005). (Refer to *Trauma theory* in the previous section for more information about this response.)

Reduced cognitive capacity

Some children and young people with severe early neglect and/or severe traumatic experiences have cognitive delays. For optimum brain growth children need the security of early attuned relationships, free from extremes of stress and trauma. While it may be difficult to determine the cause of delays in many children and young people—as some have a parent with an intellectual disability—when extreme neglect is suffered in early infancy this has the potential to limit intellectual growth.

Some children are not necessarily delayed in terms of brain growth, but often appear to have cognitive and academic

delays due to hyperarousal or dissociation. Hyperarousal, the state of being 'hyped up' or 'wired', usually leads to attention problems—and these then lead to academic and cognitive difficulties, as the young person finds it hard to concentrate on learning. Dissociation—being 'spaced out'—can lead to gaps in learning, due to inattention and problems with concentration.

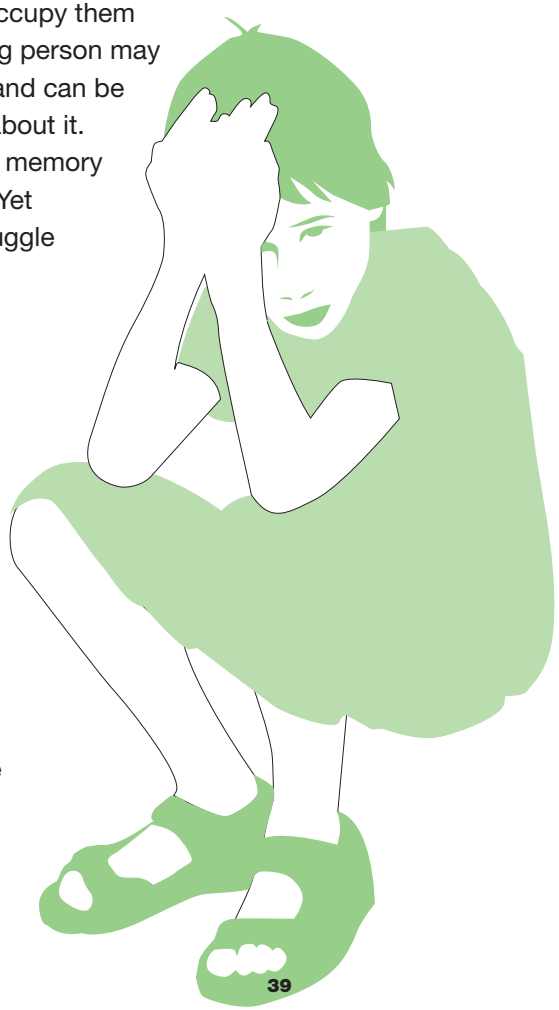
Thinking

One of the most difficult issues for those who interact with traumatised children and young people comes from the problems these young people have in thinking. Their minds often seem very disorganised: they forget things, leave their clothes where they fall, leave their toys and other mess for others to clean up after them; they don't seem to pay attention; and they can seem thoughtless and uncaring due to that thoughtlessness. However, it is by refusing to think about their caregiver's thoughts that some victims of childhood abuse and neglect cope: they then can avoid having to think about their caregiver's wish to harm them (Fonagy, 2000). They close down any thoughts that come into their minds about that harm because thinking takes them down corridors of pain. It is better if they close the door rather than go down those corridors. Eventually they have closed so many doors in their minds that they can hardly think about anything.

To cope with relationships we all need to be able to think about what other people might be thinking. We all 'read' people. We read their faces and gestures and we make quick, often accurate, assumptions about what they might be thinking. We do this all the time, checking out our assumptions with questions, looks and gestures. Young people who have closed doors in their minds find it very difficult to read social cues and can easily misunderstand the thoughts and intentions of others.

Difficulties with memory

Some traumatised children and young people may be overwhelmed by memories of abuse, which preoccupy them and reduce their capacity to concentrate. A young person may experience frequent flashbacks of sexual abuse and can be very distressed by these, even if they rarely talk about it. Other young people have different problems with memory and find it hard to remember day-to-day events. Yet others may have a good general memory but struggle with working memory: they find it hard to hold on to information while they are thinking about that information. Learning in maths is often very poor because of this. At times problems with affect dysregulation also interfere with memory, as the young person cannot pay attention while in a hyperaroused or dissociative state and at those times is not able to take in information.



Language difficulties

Trauma and attachment disruption reduce the capacity to listen and retain information, to understand complex concepts and to express ideas and thoughts. This can hold back language development. Early relationships need to be rich in language—including the language

of emotions and relationship—for a young person to fully understand language and to express themselves adequately.

Several language areas in the brain are affected by trauma and by deprivation. Problems show up as difficulties in finding words for experience and translating emotions into words. Some young people have trouble with receptive language (understanding what others mean) and need information broken up into small, manageable pieces before they can complete a task. Others have trouble with expressive language (making themselves understood), and need help organising their thoughts into speech.

Mind and body

As outlined in the *Theory* section, children who are abused and neglected experience significant fear responses while they are still developing, leaving their brains with an altered baseline of responding to stress. Unable to regulate their affect, they experience physiological effects such as hyperarousal and dissociation.

Affect dysregulation

To be able to achieve self-control and to experience an emotional life of normal highs and lows, to be able to find joy in human interactions as well as in quiet reflection, we need to be able to regulate our affective[1] arousal. This is a task that begins at birth: in a secure attachment relationship our caregivers regulate our arousal for us through attuned care. Over time, children develop internal regulation of their own affect, a process which continues through adolescence.

Affect regulation in adolescence

The massive reorganisation that occurs with the onset of puberty often means physical, cognitive and emotional upheaval for young people. In families where there is ongoing secure attachment the process of co-regulation continues, where caregivers help young people by staying calm (mostly is good enough!) and regulated themselves, while offering support, comfort, limits and boundaries—thus transferring their regulated state. For children and young people who do not have a secure, well-regulated caregiver with whom they have an attachment relationship, the turmoil of adolescence can be overwhelming, leaving a young person in a consistently dysregulated state. This process is very evident to anyone accustomed to working with young adolescents—who may have seemed settled and happy in late childhood, but to whom the arrival of puberty can mean 'going off the rails'.

Hyperarousal and dissociation

As mentioned, affect dysregulation usually appears as either hyperarousal or dissociation. Young people who are hyperaroused usually look 'wired', or 'revved up', whereas young people in a dissociative state appear 'spaced out' or 'not present'. They can also switch between these two states.

Hyperarousal often goes hand in hand with hypervigilance. Hypervigilant young people will often perceive neutral stimuli as threatening, and although physiologically prepared for danger,

1 see Glossary

they are in practice very poor at assessing real danger, and often put themselves in situations of risk. Attention and concentration are both severely reduced by hypervigilance, as the young person is constantly on the alert for danger.

Affect dysregulation may also lead to dissociation. Dissociative young people often do not know how they feel; they may seem distant, numb, vague and unreachable; and they may become oppositional in response to a demand for attention, contact, and closeness.

Sexualised behaviour

Traumatic sexualisation is a predictable outcome of some forms of childhood trauma, and can result from sexual abuse, exposure to adult sexual activity and pornography and family violence (absorbing attitudes of abuse to women and children). Traumatic sexualisation can lead to:

- sexual preoccupation, with frequent masturbation, sometimes in inappropriate settings
- sexual aggression, which may include rape
- inappropriate sexually aggressive play, where aggressive sexual thoughts and feelings are displayed in the child's play (with objects, toys or animals), but not necessarily aggressive acts to others
- promiscuous sexual activity, with flirtatious behaviour, inappropriate boundaries or active seeking out of sexual interactions. This can lead to the child or young person being sexually exploited by others, and engaging in prostitution.

The severity of problem sexual behaviours is directly related to the severity of abuse: for example, the frequency, number of perpetrators, the use of force. Of course, not all sexually abused children exhibit sexualised behaviours, and some may have difficulties in other areas of development and behaviour.

Body

Abuse, neglect and other trauma impact on a person's health, and can also lead to self-harm, sleep disturbance, and substance use and misuse.

Health

Many studies have shown that there is a direct relationship between adverse childhood experiences and a range of adult diseases and ill health. These health difficulties are not related to any injuries suffered as a result of abuse or neglect. The health problems of those who have been abused and neglected in childhood include ischemic heart disease, cancer, chronic lung disease, skeletal fractures and liver disease (Bloom, 1999). Some of this ill health arises from poor lifestyle choices due to low self-esteem, while other problems may be related to a more complex interplay of mind and body.

During adolescence—when young people begin to have greater choice about their lives and activities—many who have had disrupted, abusive or neglectful childhoods will begin to make unhealthy lifestyle choices, such as the use of drugs and alcohol; poor sleep habits; poor hygiene and attention to health and dental care; poor sexual health; and poor nutrition. Many of these may be habits learnt in chaotic families or copied from parents or other family members. Care must be paid to the health and lifestyle choices of young people to assist them develop healthy habits of self-care.

Self-harm

Self-harm can be difficult to understand, but is very common in traumatised and highly stressed young people. Self-harm usually appears during adolescence, although some younger children also hurt themselves deliberately. The causes can be different for different young people. Some self-harm because they become 'addicted' to the endorphin release that accompanies traumatic stress, and they will cause trauma to themselves to obtain that endorphin release. Others have developed a profound self-hatred and act that hatred out on their bodies. Some suffer from deep depression and their self-harm is closely associated with a wish to end their pain; when this despair is severe it can become suicidality. Still others self-harm to overcome the numb and alienated feelings that come from dissociation—in this case the self-inflicted pain is an attempt to feel something rather than feel nothing. Another group of young people who have been abused may internalise the aggression of the abuser, and they then become the victims of their own aggression (Cairns and Stanway, 2004).

Sleep disturbance

Sleep disturbance is common in traumatised children and young people. Some young people who have missed out on a secure early relationship will never have learnt to put themselves to sleep, never having been given the comfort and support to do so as infants. Some who have been subjected to abuse or surrounded by frightening, violent events will not want to sleep due to fear of what might happen in the night. Others who have been removed from home will be distressed due to this dislocation and will have trouble sleeping in unfamiliar surroundings. Yet others will have developed internal patterns of hyperarousal, anxiety and fear that interfere with their sleeping patterns. These young people may be woken in the night by nightmares, and will lie awake, fearful and anxious for hours. A smaller number may use sleep as a dissociative mechanism, oversleeping to avoid the world, or falling asleep as a response to a trauma trigger in the environment. Whatever the cause, young people who are not rested may struggle with relationships, with learning or just with getting through the day.

Substance use and misuse

For any person there are many pathways to a problematic use of substances or other harmful activities that may become addictive—and many who have problems with addictions did not have traumatic or neglected childhoods. Genetics, social forces, advertising, peer pressure and personality all contribute.

As adolescents are the group most likely to experiment with activities or substances that may be harmful or addictive, we need an accurate assessment of each young person to

determine the seriousness of such behaviour. One young person's experimentation with tobacco, alcohol or recreational drugs may be short-lived and relatively harmless, while another's may be more likely to result in serious harm or addiction problems and consequent mental and physical health issues.

Once we understand the impact of trauma it is not difficult to see how this might be involved in the development of problematic substance use. Firstly, affect dysregulation can easily lead to the use of excitement-generating activities and substances, as young people try to maintain some balance and equilibrium in their unbalanced emotional world. Calming down from a hyperaroused state, or revving up from a dissociative state may help a young person feel more in control of their emotions, or may bring a desired 'out of control' state. Young people who are experiencing painful thoughts, memories and emotions are easily led to the use of addictive activities and substances to numb themselves against that pain. Likewise, young people experiencing intense levels of shame are vulnerable to similar activities to distract them from this intolerable burden.

Spirit

Spirit can be thought of in many ways, and is seen differently in different cultural contexts. It can refer to spiritual or religious beliefs, or can be thought of as life energy, or spiritedness. Trauma can interfere with this sense of life energy or spiritedness.

The dispossession and genocide imposed upon Indigenous people in Australia—and the consequent intergenerational trauma—can disrupt the capacity to connect with the spiritual world. This depletion of spirit reduces energy and vitality. Likewise the disruption and trauma caused by war and the refugee experience can diminish people's access to sustaining spiritual and cultural practices, particularly where those practices have been used as the basis for persecution, discrimination and dislocation.

Spirituality and spiritual beliefs

For children and young people entering the care and protection system it is difficult to remain connected to family traditions, cultural expressions and religious affiliations. It may also be that abuse, neglect and other trauma interfere with spiritual beliefs—in destroying hope and the belief that there is any protection offered by religious or spiritual ideals. These issues are rarely discussed with young people.

Shame

While shame itself is addressed elsewhere in this booklet (see page 31), it is important to recognise the debilitating effect of shame on the spirit. Intense shame about the self saps energy and contributes to overall ill health and lack of equilibrium.

Identity

Adolescence is a time of identity formation, when healthy young people are flexible in their approach to experimentation and making choices. Even more than adults, young people are prone to comparing themselves with others. For a young person who has suffered some trauma or disruption, who may not be doing

well at school or with friendships, who may not live at home, who has a parent in jail or with a mental illness or addiction—when looking around at peers who are seemingly doing better and living 'normal' lives, it is incredibly difficult to compare themselves favourably.

Such comparisons create further shame and the young person may become fixed in a shame-based identity.

This is made even more difficult for Indigenous young people in our care and protection systems, whose sense of a positive racial identity is compromised by racism and the common dislocation from family, community, culture, land and language.

Relationships

Abuse, neglect and other traumas have a huge effect on a young person's ability to form and maintain relationships. This may also be true for family members, whose social, historical and environmental situation may not be favourable to the development and maintenance of healthy, caring relationships.

Misunderstanding others

The interruption to development caused by early neglect—as well as the impact of subsequent trauma—leads to an adolescence in which a young person may not have the resources that underpin relationship skills. They often have a reduced capacity to mentalise: that is, to understand and read others from facial expression, tone of voice or body language. Children and young people who are affected in this way tend to misinterpret the signals and intentions of others and may make the wrong assumptions about what others mean. At the same time, a young person who is 'wired for danger', who is constantly in a 'fight, flight or freeze' mode, will be searching their environment (including other people) for signs of threat. They will often misinterpret the neutral or even friendly intentions of others as dangerous to them, and respond with all of their survival mechanisms (such as aggression, rejection, cynicism).

Conflict, hostility and rejection

The above difficulties are exacerbated by feelings of intense shame about the self, which can manifest in an internal working model of unworthiness (I am not worthy of love) which is then played out in relationship dynamics of hostility, rejection, dependence and conflict. When these relationship dynamics are at play, a young person who has difficulty regulating their emotional arousal and reactivity will often experience their own emotions as overwhelming—but will also experience the emotions of others as overwhelming, as they have no buffer to protect them. They may then experience an escalation of their own emotional arousal in response to that of others. This kind

of intense emotional reaction is likely to increase the feelings of unworthiness and shame, as these young people may also know that others have much better relationship capacities than they do. Adolescents invariably compare themselves to others.

Reduced empathy

These complex difficulties may also include problems empathising with others, which is a capacity that seems to develop alongside affect regulation and mentalisation. Without a capacity to empathise it is difficult for young people to understand cause and effect in relationships, to acknowledge their own responsibility for their actions, or to take care of and respect others. The high levels of shame felt about the self can also make it difficult to feel necessary shame about actions that might hurt others, and so shame can interfere with empathy as well. Unfortunately these young people may also have reduced empathy for themselves, which is likely to increase their shame about self, making issues of shame and empathy a vicious cycle.

Controlling behaviours

When the young person was experiencing terrible and frightening abuse, they invariably had no control over what was happening to them. Later, as a response to that earlier lack of control they may try to control their environment and the adults within those environments. This often leads to debilitating power struggles. Some of these young people will try to control others in order to reduce their own feelings of being out of control; to try to keep others from connecting with them; and to minimise feelings of shame. They may find connection with adults very threatening and will display aggressive and oppositional behaviours to push others away, trying to control them through making them angry or disgusted.

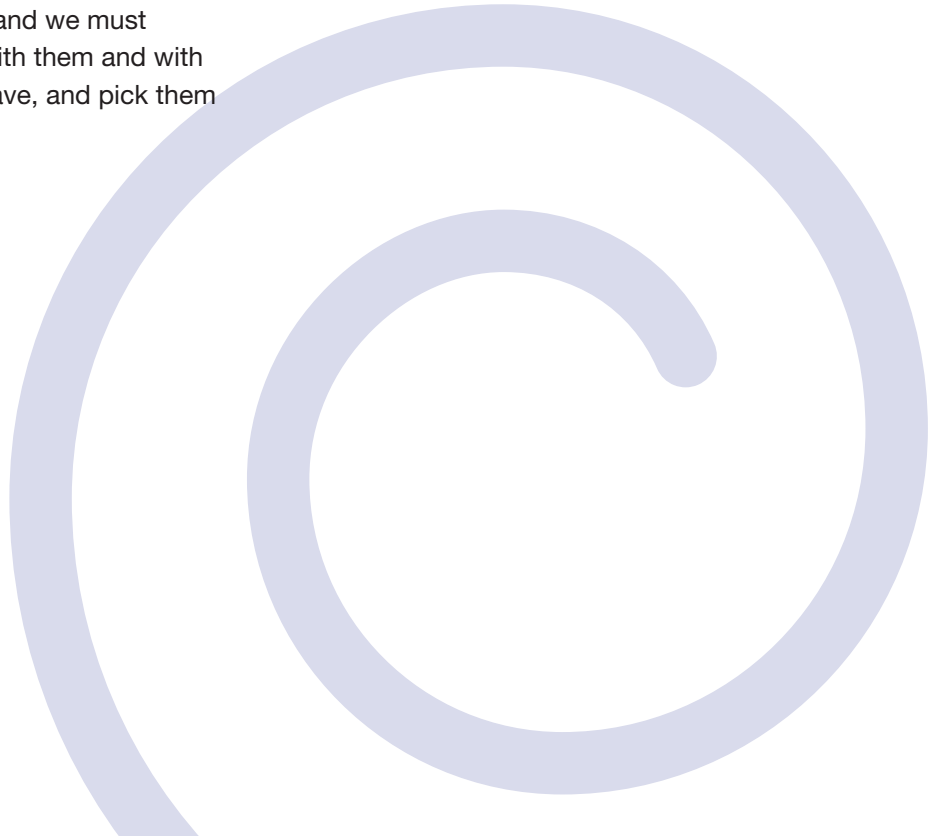
Poor peer relationships

Children who struggle with relationship skills (such as attunement, and the reading of another's body language and facial expression) find it difficult to engage in mutually satisfying play with other children, because they often don't understand the usual rules of relationships such as turn taking and sharing. They find friendship difficult, and other children often react negatively to their aggression, silliness or bossy, controlling behaviour. Lack of the natural progression of skill building that should happen during childhood, coupled with all the difficulties described above, may leave young people with few friends, or only friends with similar problems to their own. (Some of these friendships can be very positive—if young people can gain strength from understanding that others may have had the same issues as they do—however, some may have few friends, or only friends to get into trouble with.) Friendship is very important to children and young people and a young person who struggles to make and keep friends will often suffer very low self-esteem. Being able to maintain friendships is a sign of resilience.

Conclusion

Adolescence is a time of particular vulnerability, as young people have much greater mobility and access to the resources of the adult world than children.

Many children and young people who have been traumatised—particularly when that trauma has begun with neglect in early childhood—may continue to struggle throughout their lives. Too many young people are abandoned by the people and the systems that are supposed to care for them; and there are not always happy endings for these young people, who tend to have higher rates of mental illness and involvement in criminality than other young people. However, many will come through the complexities of their adolescence to become caring and productive members of our communities; and we must remain patient, maintain strong relationships with them and with each other, celebrate the successes they do have, and pick them up each time they fall.



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