



THE TRAUMA OF PARENTING TRAUMATISED CHILDREN

“My son brought home his school report card, threw it at me, offered an expletive about f...ing teachers before he ran upstairs, slammed the door and started throwing things around his room. I know the report contains comments about his disrupting the class and bullying other kids and that I will have to talk to him about this. I understand that school is difficult for him because I know that the changes he has to manage each day remind him of the four foster homes he lived in before he came home to me. Although his attitude is one of anger and unconcern I know he will be ashamed of his report and feel it confirms what a failure he is; I don't want to increase his feelings of failure. My heart is thumping. I realise I'm listening for signs of anger as I prepare dinner and try to work out how and when it would be best to talk to him in a way that will minimise the possibility that he will get angry and punch me. I dread going into school tomorrow knowing that other parents have complained about my son bullying their children. I long for my husband to come home but he's working late, as he often is these days. Then I remember the day I got a bad report when I was a child. I worried about how and when I should share it with my parents to reduce their upset and annoyance and listened hard to my mum preparing dinner to 'suss' whether she was in a 'good' or 'bad' mood. I was embarrassed by my report but knew I could do better. I wonder how life has got so crazy and feel a failure as a parent, as a person and as a wife.”

Introduction:

It is an accepted truth that children deserve to be parented in safe, secure and healthy environments. It's also widely accepted that not all children experience safe care and that there are occasions when the state has to intervene to protect children from abuse and neglect by removing them from their family of origin and placing them with substitute carers, be that foster carers, adopters or other birth family members. Alongside recognising the damage done to children as a result of early abuse and neglect is the



recognition that working with and parenting these children can be challenging. What is, perhaps, less well recognised is the depth and breadth of these challenges or the long-term impact on both the children and the families in which they live; there continues to be a belief that children will recover from neglect and/or abuse once they are placed in loving, secure and safe families. The aim of this article is to challenge this belief by exploring the impact of abandonment abuse and neglect, not only on children but, centrally, on the foster carers, adopters and kinship carers who parent children where it has been deemed that a return home to birth parents is not in their interests. (*For purposes of simplicity we will refer to these carers as 'parenting figures'.*)

In doing this we aim to provide parenting figures with support and understanding as well as reducing the feelings of isolation that is often integral to parenting 'looked after' children. We also aim to help professionals develop a deeper understanding of the pressures that caring for abandoned abused and neglected children can have on families. We believe that this will go some way towards helping parents and professionals join together in mutual understanding and support in the vital work they do in caring for some of the most vulnerable and needy children in our society today.

In this article we consider the definitions of trauma: primary, secondary, vicarious and trans-generational that are involved in parenting 'looked after' children; definitions that are exemplified in the above quote. We explore what trauma means for children who are, or have been in the care system, and who have suffered the trauma of neglect, abuse and/or abandonment at the hands of the people who should have cared and protected them; i.e. their birth parents. We focus on the impact on the parenting figures who are caring for these children and offer suggestions to support parents and children as they move beyond the traumas of the past along the path towards healthy and secure attachments.

What Is Trauma?

Trauma is defined in the Oxford English Dictionary as an 'emotional shock following a stressful event' and as a 'distressing or emotionally disturbing experience'. It 'results from events outside normal human experience which overwhelm usual coping mechanisms'. It is associated with terror and helplessness and often involves a feeling that the individual or someone important to them is at serious risk. A traumatic incident is therefore one that threatens an individual's sense of safety and security. If the traumatic incident is either

extreme in terms of severity or duration, or repeated, an individual's sense of safety and security is likely to be further compromised; feelings of fear can become endemic to the way we view ourselves and the environment in which we live. It is the endemic and repeated nature of trauma that impacts abandoned, abused and neglected children and those living with them and it is this endemic nature that can turn what might appear like fairly minor stressors, at least on the surface, into traumatic ones. How apparently minor stressors become traumatic ones is significant in considering trauma in the lives of 'looked after' children and their parenting figures.

How Does Trauma Apply To 'Looked After' Children?

Whether 'Looked After' children were accommodated at birth or subsequently they share one thing in common; they have experienced separation from their birth parents an experience that is likely to have engendered feelings of abandonment. Many will also have suffered abuse and/or neglect; some will have experienced multiple transitions within the care system. All of these can be recognised as 'distressing or emotionally disturbing experiences' that are 'associated with terror and helplessness' and 'a feeling that the individual or someone important to them is at serious risk'. Sadly the corollary that the emotional experience 'results from events outside normal human experience' may not be true for an abused or neglected child or for their parenting figures. Instead abuse and neglect may be experienced by children on a daily basis and become endemic to the way they view themselves and the world around them. It is the way they find a 'usual coping mechanism' to manage ongoing abuse and neglect that continues to impact them as they move to new families and which, in turn impacts on family life.

Babies can be born traumatised. Foetal exposure to drugs, alcohol and/or domestic abuse means that the foetus is at risk for developing in a toxic environment that can profoundly impact their psychological and physiological well-being. (Scottish Government 2013) After birth, even if placed in the safety of foster care, these babies' first experiences of life are likely to continue the trauma of their pre-birth experiences. Babies born drug dependent may need post-natal hospital care where they experience 'multiple caregivers' and therefore multiple abandonments; they may be more fractious and difficult to settle meaning that they cannot find comfort by being soothed and also meaning that they are unlikely to feel the sense of calm that promotes feelings of safety and security (Potts 2005). The result is that they are likely to experience a threat to their physical and/or

psychological integrity which, in turn, engenders feelings of fear, horror and/or helplessness. Essentially these babies have greater care needs than the 'average' baby and less ability to benefit from safe, loving care.

Birth parents who, perhaps due to having experienced unsafe care themselves as children, can struggle to provide adequate care for their baby. This means that a baby who needs better than average nurture and care, may, in remaining with a birth mother who is struggling, receive less than average nurture and care. This is likely to compound the traumatised baby's pre-birth difficulties meaning that threats to their physical and/or psychological integrity are more intense.

Research has highlighted the intersubjective nature of the way in which babies develop their sense of themselves, their environment and their carers (Stern 1998, Siegel 2012). The meaning babies give to experiences is 'state dependent'; i.e. dependent on the nature of their relationship with their primary carers and the sense that these carers input to their baby. A mother struggling to parent her child as a result of having a childhood history of abuse and neglect, being reliant on drugs and/or alcohol, being subject to domestic violence and/or through post-natal depression may wish to provide a loving and stable environment for her baby but instead finds herself struggling to meet her baby's needs in a sensitive, timely and loving way. Instead of conveying a message that her care is safe and that the world is a safe place, an angry, scared or dismissive mother might convey a message that the world is a scary place, that her parenting cannot be trusted and/or that her baby is creating stress and pressure. Babies living in this environment may develop an additional belief that they do not 'deserve' to have their needs met. Essentially the mother is downloading her view that the world is an unsafe, dangerous and scary place onto her baby at a time when the baby is just beginning to develop an understanding of the world and their place within it (Sunderland 2006).

The neuro-biology of trauma demonstrates that the impact of abuse, neglect and/or abandonment is most profound during a baby's earliest months and years; and by the frequency and intensity of these experiences. This is significant for babies who are subject to abuse and neglect at time when they are totally dependent on their parents for survival. Babies have no means to protect themselves, they have no escape route; early trauma experienced from survival figures is therefore likely to feel more extreme; i.e. to engender

even greater fear and terror than it would in older children or adults. Furthermore babies live 'in the moment' meaning that relatively minor traumas can feel overwhelming to them. This, along with the frequency of incidents, can mean that babies can experience abuse and neglect as life threatening and lifelong; i.e. as trauma (Lanius, Vermetten, Pain 2010).

Abused and/or neglected children who have been exposed to on-going trauma, over a prolonged period of time, and during a time when they had few opportunities to experience safety and security carry brain and body responses consistent with their traumatic experiences. A growing body of scientific research supports this by identifying the way in which the neuro-biological impact of early abuse impacts children in their brains and in their bodies meaning that traumatised children can develop different neurological patterns to their non-traumatised counterparts (Shonkoff & Levitt 2010).

Exposure to stress chemicals such as adrenaline and cortisol can also have a long-lasting impact on traumatised children's ways of understanding themselves and the world around them. Furthermore the intersubjective nature of the way in which babies and children make sense of the world means that traumatised children develop 'mirror neuron patterning' that colours their understanding of the intentions of the adults who are caring for them; in effect they may interpret the positive intentions of safe and loving parenting figures as potentially abusive and threatening (Iacoboni et al 2005).

Furthermore the nature of abuse and neglect means that traumatised children are likely to have experienced repeated trauma. It is this accumulative impact of traumatic incidents that is a key factor in understanding the traumatisation of both children and their parenting figures.

Traumatised children often have difficulty making and maintaining healthy attachments and in trusting adults especially those in a caring role; they are likely to struggle to feel a sense of self-worth. Feeling helpless and hopeless, they may display anger, withdrawal, extreme controlling behaviours and a seeming refusal to accept the parameters of 'ordinary' family life. Some children respond by becoming the 'good child' acting out their distress by extreme compliance or by passive /aggressive responses. The beliefs that underlie these controlling, oppositional and withdrawn behaviours, embedded as they are within the neuro-biological structure of the traumatised child's brain and body, means that the emotional, psychological and behavioural impact on the body and brain of early trauma

is both profound and long-lasting; it may have become their 'usual coping mechanism' to manage stress. Trauma experienced in the womb and/or in a baby's early months and years can therefore continue to impact through later childhood, into adolescence and adulthood. For example, fewer than 1% of all children in England are in care but looked after children make up 30% of boys and 44% of girls in custody. (Ministry of Justice 2012).

What Is The Impact Of Parenting Traumatized Children?

By definition looked after children who have been traumatized by neglect, abuse and/or abandonment have not received 'good enough' parenting prior to being accommodated; they are therefore likely to have parenting needs different from their non-traumatized peers. This, together with the emotional and behavioural difficulties they present makes the task of caring for them a very challenging one. These challenges are likely to stretch the resources of even the most stable and caring families. Indeed, as David Conrad in his article on secondary trauma in foster care points out, *"the expectation that we can be immersed in suffering and loss daily and not be touched by it is as unrealistic as expecting to be able to walk through water without getting wet."* (Rachel Remen, *Kitchen Table Wisdom*) (Conrad 2004) Conrad emphasised that foster carers who parent traumatized children, and listen to their stories, are likely to feel their hurt. He adds that the empathy that allows them to do this is often the most important tool parenting figures have to help the children in their care; however the more empathic parenting figures are, the greater their risk for internalising the trauma of their children. This is compounded by several other factors. Parenting is essentially a 24/7 'job' meaning that parental figures caring for traumatized children may have insufficient recovery time to help them process their children's disclosures and acting out behaviours. This is important because trauma reactions are only reduced when we can process and integrate the experience and interpret its meaning. Archer and Gordon in their book, *Reparenting the Child Who Hurts* (Archer and Gordon 2013) emphasise that carers need to recognise that children's behaviour is the 'language' they use to convey their sense of themselves and their world. They also emphasise that it takes time and patience to be able to see beyond the behaviour to the underlying meaning. Carers who lack recovery time are likely to struggle to have the physical and psychological space to manage this. This is exemplified in the quote at the beginning of this article where the mother is working hard to empathise with her son while, at the same time, trying to prepare dinner and worrying about her own and her son's physical safety.

It is difficult to achieve adulthood without experiencing some personal trauma and loss. Children's traumas can reactivate carers' personal trauma experiences; even trauma experiences that were felt to be resolved may be triggered in caring for a traumatised child. For Conrad, this adds to the likelihood that parenting figures will develop signs of 'secondary trauma'.

While Conrad's contentions are undoubtedly true the authors of this article feel that the impact of living with traumatised children is far more complex than this; that parenting figures are often not only at risk from secondary trauma but also from primary and vicarious trauma symptoms. In order to explore this we need to consider the nature of traumatic incidents and the definition of these three concepts.

Rethinking Trauma In Parenting Traumatised Children:

As stated above, a traumatic incident is defined as an 'emotional shock following a stressful event' and 'results from events outside normal human experience which overwhelm usual coping mechanisms'. Traumatic incidents, and traumatisation, can be subdivided into primary trauma, secondary trauma, vicarious trauma and trans-generational trauma. People susceptible to primary trauma are usually present when the traumatic incident occurs; secondary trauma is possible when people witness or hear about the aftermath of a traumatic incident; vicarious trauma is a concern for people who hear about traumatic incidents; and trans-generational trauma is a term sometimes used to describe the traumatic symptomatology displayed by the descendants of trauma survivors.

Trans-generational or intergenerational trauma is important when we consider the histories of looked after children. Birth parents may have developed a trauma model of parenting as a result of being subject to abuse themselves as babies and children (Ney 1988). This trauma model of parenting means that, despite efforts to parent their children in a safe and caring way, parents may not have the 'Internal Working Model' (Bowlby 1969) of parenting that helps them respond to their children in safe and non-abusive way. There are further implications. The wider family network may not have been a protective factor for abused and neglected children. Since most abuse happens within families and that the grandparents of 'looked after' children may have been implicated in their parents' abuse experiences as children, we have to be open to the possibility that care by wider family

members may have replicated a child's experiences in their immediate family. This is likely to have reinforced the message that the world is not a safe place and that children cannot depend on adults to have their needs met. For example, over 90% of children who were subject to sexual abuse were abused by someone they know (NSPCC statistics 2013).

Bessel van der Kolk defines people who are traumatised from those who once had something unpleasant happen to them, in terms of a difficulty for the former with past/present differentiation (Herman, 1992; van der Kolk, 1989 & 1996). For the traumatised individual some aspect of the trauma is experienced as a here and now reality. This is important when considering the impact of living with a traumatised child.

Traumatised children bring their neuro-biological brain patterns with them into any new family. This, alongside the impact of mirror neuron firing means that, in a very real sense, traumatised children can interpret benign actions of parenting figures as potentially abusive ones. For example, a parent may respond, appropriately, to a child's request for sweets just before dinner with a refusal. The parent is doing this with good intentions; i.e. to encourage healthy and nutritious eating. Children who have suffered early neglect may interpret their parents actions as demonstrating a lack of meeting basic needs and be flooded with a feeling of hunger that replicates early experiences of being a baby lying in a cot and wondering if mummy is ever going to come and feed them; i.e. even when they are being offered safe and loving care traumatised children can continue to experience trauma as an ongoing here and now reality for many years; as primary trauma. Thus, as exemplified in the son's reaction to receiving his school report, minor reminders of early trauma can catapult children into a major trauma reaction in day to day interactions in safe and caring families.

The Impact Of Primary Trauma For Parenting Figures:

The impact of living with a traumatised child is profound. Parenting figures regularly talk about having to manage lying, stealing, aggression and oppositional behaviour in their children, behaviours that, if they happened outside of family life and as a single incident, would be recognised as potentially traumatising. Parenting figures may be managing such behaviours on a daily and sometimes hourly basis. Day-to-day interactions may have the potential to develop into a traumatic event as can be seen from our quote.

The potentially traumatising effect of being lied to by one's boss, having your purse stolen,

or being subject to assault or road rage is recognisable and would be viewed as a primary trauma experience. Since these events as single experiences are recognised as potentially traumatic, parenting figures who experience such incidents on a regular basis and in the place (their family home) where they should feel safest and most secure are experiencing primary trauma as an ongoing, here and now reality.

We might expect the victim of primary trauma to be angry and would understand such a reaction; we might advise a change of job to ensure that the victim is not exposed to the perpetrator. These 'restitutive solutions' may not be available in families. Placement breakdown is the only way of ensuring a 'job' change but this is not something that is readily available to parenting figures who usually want, and are expected, to continue to parent the children in their care. An angry response is also not seen as an appropriate way to manage an angry, acting out child; parenting figures are expected to show empathy and understanding whatever the provocation. Indeed, had the mother in our quote responded to her son with anger the likely outcome would have been increased anger from the child and increased likelihood that this would escalate into violence.

Furthermore parenting figures may have to manage a child whose behaviour fluctuates between extreme control and extreme compliance; or a child who presents one personae to one carer and a different one to another carer or professional. These fluctuations which replicate the chaos often experienced by children who lived with drug or alcohol abusing parents can lead to parenting figures experiencing family life as one dominated by uncertainty and confusion. It may also lead to parenting figures feeling isolated and alone; a feeling that was experienced by the mother in our quote, a feeling which, in turn, reflected her son's early primary trauma history of having nobody to turn to and no means of escape. The child's primary trauma experiences are therefore replicated in parental experiences of primary trauma; having nobody to turn to and no means of escape are significant factors that change an 'unpleasant experience' into a traumatic one.

While the traumas suffered by parenting figures occur during adulthood; i.e. when their neuro-biological patterns are laid down, the impact of living with trauma in adulthood should not be under-estimated. Our bodies respond to a potentially traumatic event with an increase in the production of the cortisol that allows us to quickly react to danger and to ensure safety. However, exposure to trauma on a regular basis can mean that levels of cortisol production can become unhealthy (Stannard 2013). Exposure to regular trauma in

adults, as in children, can also lead to changes in mirror neuron firing and to a trauma reaction being triggered by relatively minor stressors. The mother in our quote was responding to the possibility of her son's aggression in a way that replicated her body's response to previous aggressive outbursts; i.e. with an increase in heart rate and probably with an increase in cortisol production that would have had an impact whether or not her son, on this occasion, became aggressive.

The combination of these factors alongside having to manage children's difficult behaviour and to continuing to provide care whatever the behavioural challenges means that, in a very real sense, parenting figures are likely to experience trauma as a here and now and continuing reality; i.e. as primary trauma.

The Impact Of Secondary Trauma:

Secondary trauma is most likely to occur when people witness the aftermath of a traumatic incident. According to Dr Charles Figley, author of *Compassion Fatigue, Coping with Secondary Traumatic Stress Disorder*, (Figley 1995) secondary traumatic stress is 'the natural consequent behaviours resulting from knowledge about a traumatizing event experienced by a significant other. It is the stress resulting from helping or wanting to help a traumatised or suffering person'. This confirms David Conrad's view that people who work with, listen to and try and help traumatised children are at risk for internalising their children's trauma, leading to secondary trauma. There are a number of reasons for this.

1. Parenting is often seen as a core aspect of the way we, and others, define us. Parenting figures who use their own experiences as children, the perception of other parents and how these beliefs are replicated in societal views of good parenting to determine what constitutes a 'good parent' may feel a sense of failure as when parenting a traumatised child. For example, parents who feel that 'good' parents should ensure that their children complete homework tasks, or have children who are polite and respectful to other people, especially adults are likely to have their perception of themselves challenged by an oppositional child who refuses to complete homework or who is rude and truculent. If parents' deep feelings of failure is replicated in societal responses; for example by teachers putting pressure on carers to ensure that children hand their homework on time, or other parents who blame carers whose children disrupt class and playground activities these feelings can be intensified especially if the child presents as cooperative with and polite to others. In this situation parenting figures may begin to

question their efficacy as parents, feelings that may (unwittingly) be intensified by statements from others that question the parent's interpretation of their child's difficulties. It's very hard to maintain a feeling of efficacy as a parent if one's child and other people convey messages that they are not managing well.

2. Parenting figures undertake extensive training and assessment in the process of becoming parents. Inevitably this process conveys a feeling of success or failure which may be re-awakened when parenting figures struggle to parent the children in their care. Feelings of failure may well lead to a shame reaction ('I'm a bad parent') which makes it even harder for carers to feel good about themselves, acknowledge difficulties or seek support.
3. Parenting figures need to recognise that a traumatised child's behaviour might reflect their early experiences and the beliefs these engendered rather than the here and now (Archer & Gordon 2013). The often relentless and inexplicable nature of a child's behavioural challenges can make this difficult to do. Being in 'fire-fighting mode', with little or no time to reflect on the deeper meaning behind children's difficulties, makes it hard to remember that children's behaviour makes sense in light of their history. Lack of information about the child's traumatic experiences and training on the impact of early trauma on a child's neuro-biological development is likely to make remembering even harder.
4. Caring for a child who challenges parental authority is exhausting and can turn parenting from a joyful and fulfilling task to one that is permeated with anger and frustration. Anger and frustration, while a natural consequence of living with a child who challenges one's core sense of being, can lead to a parenting stance that reflects a 'them' and 'us' style instead of a reciprocal relationship. In this situation parents are more likely to see their children's behaviour as a personal attack than an expression of the child's traumatic re-enactment of their inner world, thus reducing the reciprocal relationship that is the key to helping children repair and the key to parenting figures being able to help them. In turn this can lead to foster carers experiencing 'blocked care'. (Hughes & Baylin 2012)

5. In addition, lack of understanding from friends and professionals who convey messages that 'all children do that' minimises parents' concerns and increase feelings of isolation. It can also add to feelings of lack of self-worth; if they can't successfully parent a child who is like other children they must be really terrible parents.
6. The pervasive nature of children's difficulties can lead parents to feel that there is no way out of their situation. Giving up (disruption) might be a possibility, but in reality this means relinquishing the parenting role rather than finding a way to improve it. In this environment hopelessness and helplessness is likely to prevail. This adds to the intensity of parents' secondary trauma experience.

Secondary trauma may also be experienced by siblings. A 'too good child' who is living with an angry, acting out sibling may have started to attach to new parenting figures but live in fear that their placement might disrupt as a result of their sibling's behaviour. This fear might preclude the 'too good child' from being able to show 'all of themselves' to their parenting figures and reduce their capacity for attachment. The child might feel that the pain of disruption will be lessened if they keep their feelings in check.

While not the subject of this article, the same factors may be true for professionals; the residential staff, social workers, therapists, teachers who are supporting traumatised children and their carers. We can all be impacted by trauma and it is those professionals who are at the forefront of caring and/or who have the greatest capacity for empathy that are most likely to suffer a secondary trauma reaction.

The Implications Of Vicarious Trauma:

Vicarious trauma arises in people who hear about traumatic incidents. It may arise in families where one parent experiences the bulk of the child's traumatic re-enactment. Often this role is filled by the mother figure in the family. This may be partly because mothers are more likely to be stay at home parents and therefore bear the brunt of the parenting. However, equally important is the nature of parent/child relationships. Children are born to mothers not fathers and their first intimate relationship (pre-birth) is therefore with their mother. After birth this symbiotic relationship continues; in their first few months babies look more towards their mother than anyone else (Fahlberg 2008). Father figures become increasingly important as babies develop an interest in their wider world as they grow and develop into toddlerhood. Traumatized children may therefore have intrinsic

feelings that mothers should have protected them from harm and abandonment regardless of the perpetrator of their traumatic experiences. Children may therefore need to resolve their relationship with new mother figures before being able to focus on their relationship with new father figures. Fathers watching difficulties emerging in the mother/child relationship and seeing their previously loving and caring wife/partner becoming increasingly angry and frustrated are at risk of developing vicarious trauma. This is likely to place increased stress on families.

Ways of managing vicarious trauma can include denial or withdrawal. Denial may be more pertinent when a child acts out their distress in challenging behaviours when fathers are not present; acting out a 'good child' role when, typically, fathers return from work. Withdrawal may be seen in fathers spending increasing periods of time at work, as is the situation in our quote. While both are understandable the result is likely to be a deterioration in family harmony.

Birth children living with a traumatised sibling may suffer vicarious trauma. Birth children who were part of the adoption assessment by supporting their parents' plans may feel guilt about the stress and pressure they see in their parents. They may feel anger at their sibling's behaviour but feel guilt about this because they know what a difficult time their sibling had pre-placement. They may feel they can't express their feelings because they don't want to put additional pressure on parents.

Vicarious trauma may be particularly relevant for professionals working with traumatised children and their families. It is impossible to hear about trauma without it having an impact and the impact is most likely to be felt by professionals who are empathetic and caring and who have had life experiences which reflect the experiences of the families they are supporting. In these circumstances it might be tempting to blame parenting figures for difficulties in the parent/child relationship rather than focus on the complex nature of the child's traumatic re-enactment of early experiences. This may be intensified for workers who were involved in the removal of children from birth families and/or placement in the new family. Feelings of guilt about potential placement breakdown might be displaced onto blaming of parental figures.

Residential staff are also prone to suffering vicarious trauma especially if they truly recognise the level of trauma suffered by the children they are caring for; i.e. if they recognise not only what children experienced but also what it did to them. 'Burn out' may

be a potent sign of vicarious trauma.

What About Trans-generational Trauma?

The Trans-generational nature of children's traumas can often be seen when we consider the history of birth parents. In our experience very few parents set out to traumatise their children. However very often the parents of traumatised children were themselves traumatised as children and have carried patterns of parenting learned as babies and children into their role as parents; having no role model to provide positive parenting they repeat the patterns they learned as children. (NSPCC research briefing, June 2014)

What Can Make A Difference?

The impact of trauma is profound, long-lasting and pervasive. However brain neuroplasticity (Schoore 1994; Seigel 2010) means that change is possible for both children and their carers.

Addressing safety issues is vital in reducing stress in families. For this reason working on primary trauma issues is the fundamental first step in the process of helping both parenting figures and the children they are caring for. For example, work with the mother in our quote needs to begin by helping her feel safer in her own home by addressing her son's aggression. Although aggression needs to be understood as a defence against fear, children also need to hear a clear message that aggression is unacceptable. A family poster that offers this message along with strategies to develop different ways of expressing their feelings by, for example, encouraging them to discharge increased adrenaline levels by running, jumping, trampolining etc. might help. Forward planning and support to help parents manage difficult behaviour in their children may help to increase safety for both children and parents. Safety for the mother in our quote, and therefore for her son, may have increased if the school had talked to the mother in advance of the report card being sent home, perhaps arranging a meeting where the child and parents were supported to share the report and think about a way forward.

What also helps is making sure that support and attention is offered to the 'victim' of any aggression. Parents may, understandably, be so busy trying to manage aggression from their 'acting out' child that their 'acting in' 'too good' child is in danger of being overlooked.

Parenting figures who embrace developmental reparenting (Archer & Gordon 2013) can help their children begin to trust, feel safe and develop the healthy attachments that can lead to changes in their neuro-biological brain patterns and a reduce adrenaline and cortisol production. Demonstrating empathy for the underlying reasons for children's difficulties, offering opportunities to change unhealthy ways of interacting, and being clear about parental intentions before dealing with situations that might be misconstrued, helps children to feel understood and supported. This can, eventually, lead to a reduction in primary trauma re-enactment for both parent and child. However, in order to do this parental figures need to feel supported and understood themselves. They need to have their feelings and experiences validated and be offered support rather than criticism. While living with aggression and controlling behaviour is potentially traumatising, reducing parents' feelings of isolation will help to protect them from its impact.

Parents also need support and opportunities for relaxation and space from the parenting task. Friends who might struggle to understand a traumatised child can still help by offering opportunities for non-parenting activities; meeting for a coffee can give parents an opportunity to feel they have worth outside of their role as parents. This can give parents the emotional space to be able to reflect on their children's behavioural language. Recognising that a child's behaviour is a reflection of their past traumas and not a reflection of them as parents is likely to increase parents' feelings of self-worth and therefore reduce the emotional impact of the behaviour.

Secondary trauma arises from listening to and internalising children's disclosures and expressions of distress, be these verbal or non-verbal as was the case in the child in our quote. It arises when parental figures are able to put themselves in their children's shoes and understand not only what happened to them but also what it did to them. This is a very powerful healing tool for children. It helps them feel that they are accepted 'warts and all' and can lead to increased feelings of self-worth. Parents also need to find someone with whom they can share their experiences and feelings. Like their children they need praise for the good job they are doing and support to recognise that all parents make mistakes.

Vicarious trauma can be reduced when parents are encouraged to listen to and share their feelings with each other and when they find time for themselves as individuals and as a couple. If finding a child minder is difficult, supporting parents to spend time together after

the children are in bed might be possible.

One parent could be encouraged to support the siblings of an angry, aggressive child to ensure that siblings have attention and the space to be able to share their feelings. This can help both parent and child feel a sense of belonging and increased understanding. In order to do this it might be necessary to challenge the myth that we need to treat children equally; instead we need to treat them uniquely and in a way that reflects each child's needs, skills and talents.

ADAPT (Scotland):

ADAPT (Scotland) supports foster and adoptive parents and the traumatised children in their care to find ways of managing life in happier and healthier ways. ADAPT, founded by Christine Gordon and Karen Wallace, helps parents and children increase their understanding of the reasons why they struggle alongside offering strategies that create the safe base where change is possible. In recognising that parenting and working with traumatised children is extremely challenging; our approach helps to make the challenge a little more manageable. ADAPT's work is based on the developmental reparenting principles exposed by Dan Hughes and Kim Golding (Golding and Hughes 2012) and by Caroline Archer and Christine Gordon in their previously quoted book, *Reparenting the Child Who Hurts*.

Developmental reparenting is a concept associated with parenting practise that developed within the adoption and fostering communities from attachment theory and research. It provides a way for parents or parenting figures, through support from a trained parent mentor to understand the needs of traumatised children who have been through the care system. It aims to find ways to help children repair the trauma of the abuse and neglect which led to them being accommodated. Developmental reparenting considers all aspects of children's functioning and how trauma affects children physically, emotionally and intellectually.

Parent mentoring is based on the values of developmental reparenting and our approach is based on the principles of PLACE. Parents need to communicate and interact with their children by being, *Playful, Loving, Accepting, Curious and Empathic*. Parent mentors at ADAPT support parenting figures in becoming trauma sensitive parents by helping them to

develop an attitude of PLACE when understanding and responding to their children. We support parents to understand their children in the context of their early years and the neurobiological impact of trauma in their child's brain, body, behaviour and cognition. This is reinforced by a plan of intervention that is bespoke to them as a family by providing strategies and practical suggestions to support recovery. The programme helps parents to link the theory and research and to put this in to practice to help them regain their parenting confidence.

Our programme helps to make and sustain the changes that are intrinsic to helping children heal. It is tailored for each family around a set of core elements; understanding children's difficulties, a relevant and flexible parenting plan, strategies for new ways of parenting, supports to put strategies into action, confidence in therapeutic parenting, reducing conflict and stress, putting parents in loving control, therapeutic work to help children trust that parents can meet their needs, a framework that allows children to feel safe enough to change and manage their lives in healthier ways and a safe environment for parents to look at difficulties and explore new approaches.

ADAPT works alongside other professionals to ensure that there is wider community understanding of the needs of traumatised children. It promotes the development of a coherent plan for helping children and families and the support to put plans in to action.

It is our view that professionals need to be aware of the impact of parenting looked after children, who have suffered the trauma of neglect and abuse in their early years. This is crucial if they are to provide trauma sensitive support. What we often find are parents whose confidence in their parenting capacity has been eroded; they often blame themselves for the difficulties within the family. This may be exacerbated by professionals who criticise and judge them, based on their own lack of understanding. We have become increasingly aware that there is a need to for training in order for services to provide trauma sensitive support. We also need a systematic approach where therapeutic interventions are seen as integral to a child's recovery rather than an expensive alternative.

It has been our experience that when professionals are supported in considering other reasons as to why parents may present as aloof, uncaring, uncooperative (secondary trauma/blocked care responses) this often helps them in seeing it from another perspective and to empathise rather than to judge.

Summary:

This article has looked at trauma and its impact on children and the parental figures who are caring for them. It highlights the various aspects of trauma; primary, secondary and vicarious trauma; the pervasive and long-lasting nature of trauma; and its impact on family life. The article stresses that both children and foster carers can suffer from all aspects of trauma.

Abused and neglected children have clearly had primary trauma experiences that they are likely to re-enact in new homes. The resulting challenging behaviours can lead to new carers experiencing primary trauma in the environment in which they should feel safest; this can be experienced with a level of pervasiveness and intensity that can be overwhelming. This needs to be recognised to reduce the feelings of isolation and lack of understanding that can perpetuate primary trauma experiences for both adults and children.

Empathy is seen as an essential element in being a caring and successful parenting figure; it is this skill that allows carers to stand in their children's shoes, understand the nature of their difficulties and help them begin the repair process. However the very ability to engage in this way is what places carers at risk for developing secondary trauma. It is vital that professionals working with and supporting parenting figures recognise this and interpret carers' actions in light of the stresses of caring for traumatised children. Empathetic support is more likely to help carers continue to care for the damaged children in their care, than criticism and blame.

The impact of secondary trauma for birth children or siblings of an aggressive, acting out child should not be underestimated. Birth children may witness behaviours that leave them distressed and they may feel they cannot share this distress with parents who are themselves under considerable stress. A 'compliant' sibling may see their more overtly acting out sibling as a threat to a placement in which they have started to feel a sense of security and attachment. Such children may feel that they cannot act out their own distress for fear that this will tip their carers 'over the edge'.

Vicarious trauma may be experienced by wider family members and by partners who are

less involved in the caring role. Worrying about what is happening at home when they are at work and fear of being overwhelmed can lead partners to withdraw and thus lead to an increase in family stress.

Parents and siblings of parenting figures can struggle to understand why a child might continue to act out their inner distress especially if the child has been living in the family home for a protracted period. This can lead to wider family members being angry with either the child or their family member or both. Anger with a child can increase that child's trauma reaction; their belief that they are 'bad' and unworthy of being understood and supported can increase. It can lead to unhelpful advice being offered; for example statements that 'all children do that' or exhorting that the carer is less/more strict, less/more loving etc. This does not help carers to feel understood and reduces their capacity to seek support from the family that may have offered support, pre-placement. This, in turn, can lead to increased feelings of isolation and increased secondary trauma reaction.

An African proverb suggests that it takes a community to raise a child. While traumatised children need to develop a secure attachment to their primary carers this needs to be within a context of societal (community) understanding of the impact of trauma on children and the people who have the compassion and empathy to care for them and attempt to help them repair. In this sense we, as the wider community, have a shared responsibility to offer a listening ear and support for those whose lives have been and continue to be touched by trauma.

Christine Gordon and Karen Wallace

ADAPT (Scotland)

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