

TRAUMA AND RELATIONAL CARE: INTEGRATING AN AWARENESS OF TRAUMA INTO THE CHARACTERISTICS OF RELATIONAL CHILD AND YOUTH CARE

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Abstract: Healing—the restorative process of becoming healthy and whole—is a central element in recovery from trauma. The integration of trauma-informed care into relational practice supports this healing process. The characteristics of relational child and youth care have been defined (Garfat & Fulcher, 2012) and organized into a framework (Freeman & Garfat, 2014). The impact of trauma and an example of relational trauma in early childhood are explained, and select characteristics are identified and described in the context of trauma-informed practice.

Key words: relational care, children and youth, trauma

Healing is the restorative process of becoming healthy and whole, and is a central element in recovery from exposure to childhood trauma. It is a natural outcome of quality relational child and youth care. When a human life begins to be restored, individuals regain their own dignity, value, and original glory. This process is facilitated through relationships. A relational approach to recovery from trauma acknowledges that “relationships between caregivers [sic] and young people are the primary means through which opportunities for healing, development, and flourishing are provided” (Smith, Fulcher, & Doran, 2013, p. 42). Relational practice must be responsive to the impact of trauma in order to best support the healing process for young people and their families.

Moving Beyond Labels

Too many systems and people are preoccupied with labeling and diagnosing the problems we experience in life. There are numerous categories related to trauma, including complex trauma, developmental trauma, posttraumatic stress, and a range of trauma related disorders. There has also been, over the past decade, an emphasis on becoming trauma-informed in our systems of care. While knowledge and skill in connecting with and supporting young people affected by trauma are critical in our work, the emphasis on trauma-informed practice often seems more connected to marketing a model or system than it is to personalized, relational care.

The awareness people have of the world is largely filtered through how they have learned to see and interpret their experiences and the experiences of others. Consider how this impacts the way in which one understands a young person’s experience of trauma:

If their doctors focus on their mood swings, they will be identified as bipolar and prescribed lithium or valproate. If the professionals are most impressed with their despair, they will be told they are suffering from major depression and given antidepressants. If the doctors focus on their restlessness and lack of attention, they may be categorized as ADHD and treated with Ritalin or other stimulants. And if [one] happens to take a trauma history, and the [young person] actually volunteers the relevant information, he or she might receive the diagnosis of PTSD. None of these diagnoses will be completely off the mark, and none of them will begin to meaningfully describe who these [young people] are and what they suffer from (van der Kolk, 2014).

The task of child and youth care practitioners extends beyond labeling young people and involves engaging them in a meaningful way. This requires both an understanding of trauma as well as an understanding of the core characteristics of relational care.

The Impact of Trauma

Traumatic experiences can occur early in life, be complex (e.g., multiple events, occurring over time, interpersonal), and they are known to have adverse impact over a lifespan (Anda et al, 2006). Trauma can be the result of abuse, neglect, or witnessing violence in the home as well as related to loss, poverty, and other life experiences.

Childhood trauma can impact the whole young person, especially the way an individual thinks, feels, and interprets the world. This can become problematic when a young person is exposed to “danger that is unpredictable and uncontrollable because the child’s body must allocate resources that are normally dedicated to growth and development instead to survival” (Cook, Blaustein, Spinazzola, & van der Kolk, 2003, p. 8).

The impact of trauma has both immediate and long term outcomes. This can result in young people having a “distrust of other people, inhibition of curiosity, distrust of their own senses, and the tendency to find everything unreal” (Bowlby, 2008, p. 103). According to the National Collaborative on Adversity and Resilience, such adversity in childhood:

[It] changes the way children learn, play, and grow, [and] biomedical research has shown how early trauma can last a lifetime: It leaves tracks in the brain, floods the body with stress hormones, hikes the risk of engaging in unhealthy behaviors and boosts our vulnerability to heart disease, depression, diabetes and other physical and mental health problems. [Yet] emerging neuroscience has also affirmed some good news . . . If the human brain can be hurt, it can also be healed (2013, p. 6).

When a young person is preoccupied with survival, there is less attention and energy available for normal developmental tasks. The real problem of trauma is the resulting isolation and self-blame that occurs. Relational child and youth care is less concerned with treating the trauma and more concerned with restoring the young person to community and their sense of value. If relationships can be hurt, they can also be healed.

So a key question for the child and youth care practitioner becomes: How can I best support this healing and restorative process for the youth I serve? The following case example highlights this impact during important developmental stages and is followed by a discussion on the characteristics of relational care that support restoration and healing from such traumatic life experiences.

Kids in Cages: A Case Example

Along with her older sister, a young child entered the child welfare system as a result of significant neglect and abuse. Being adopted from the foster care system seemed to offer hope, yet what was to come was more damaging than the experiences of the past. She would soon find herself locked in a cage in her adoptive home in a failed attempt at controlling her behavior.

The school-age girl and her sister were placed in a home with two other children who had also been removed from abusive conditions. Their adoptive mother operated a day care center and had another dozen or so children attending each day. While the children in day care played in the house and outside on the lawn, the four adopted children were kept in the basement, with the two girls locked in cages nearly around the clock.

One of the workers in the day care center explained that she never saw the foster care mother “read to the youngest, never cuddled with her, [and] never kissed her” (Welsh, 2007a). Yet, as vital as reading and physical touch is to child development, this was only the surface of her maltreatment.

In their cages they were fed a diet primarily of peanut butter sandwiches and were given a bucket for toileting. The youngest had “only two sets of clothes, which frequently reeked of urine [and her] boots didn’t even fit, being too big” (Welsh, 2007a). Her only experience outside of the basement was when “she was taken outside in the yard to receive an outdoor shower . . . while dressed in her clothes, and was not given a fresh set of clothes to replace her wet ones afterwards” (Welsh, 2007a).

The two girls’ older adoptive sister was given preferential treatment. She was, for example, allowed to roam the house and could eat what and when she wanted. Investigators found further abuses: photographs and paintings of her in sexually provocative poses and discovered she was medicated to suppress the onset of puberty.

The social workers who investigated their living conditions described it as cruel and torturous (Welsh, 2007b). Along with the two younger girls being locked in-

side cages, receiving insufficient nutrition, and subjected to the cold and the smell of urine and feces, they were sometimes punished with cold showers in the early morning and having to write apologetic letters describing their own faults and blame. The letters, if not deemed long enough, would result in having even what little privileges they had taken from them.

During the resulting criminal trial, the adoptive mother explained that the girls had tried to manipulate her, and she was forced to lock them up because they had “a syndrome common to some foster children who experience serious difficulties forming emotional bonds [and] because the kids have such deep emotional problems” (Welsh, 2007a). Even though the children received funds from the state through the adoption support system (and at a higher rate than typical payments due to their past emotional trauma), none of the funds were used for counseling, clothes, or other basic needs. In the end, the mother pleaded guilty and received a ten year suspended sentence, serving one year in county jail and the remainder of the sentence on probation.

The girls rescued from this situation of neglect and abuse displayed violent and perplexing behaviors. The approach the parent—and the system—had adopted to caring for them was completely lacking of an understanding of trauma and any concept of engaging them through a caring, relational approach.

After the youngest’s removal from the adoptive home, she was placed in a local emergency shelter for abused and neglected children. It was both confusing and comforting for her as she met the adults and other young people in her new environment. During one of her first meetings with her therapist at the shelter, she entered the room crawling from the washroom to the office on the carpeted floor. Her therapist had offered a chair but her only outward acknowledgement was to make motions and sounds like a cat. Her behavior was both confusing and challenging as she seemed to deflect any attempt at connecting with her care providers.

The traumatic experience this girl lived through taught her that it is not safe to trust or depend on others. She, and others from similar experiences, find little perception of safety and tend to develop a negative sense of their own worth. These circumstances make it difficult for such traumatized children to relate with others in the everyday world as they grow and develop. Because of their disrupted experience of the joy of childhood, they are “missing elements of their lives that are vital to optimal development, and these elements often start with broken relationships” (Baker & White-McMahon, 2011, p. 14). It is understandable that traumatized children might work hard to avoid making close connections with others. They may think it is the only way to avoid danger.

Eight months after the girl was removed from her adoptive home and crawled into her therapist’s office, she was observed entering a classroom, talking and laughing with peers. She smiled and waved as she entered the room, seemingly on the journey to restoration. She began to experience at least some joy and hope in her daily life. What happened in eight months that promoted such change? The

next section explores some key characteristics of relational care that contributed to her restoration.

Healing in the Everyday: Anchor Characteristics of Relational Care

What should everyday life events begin to look like for this young girl? For this young girl, mealtimes were challenging because she wanted to eat off of the floor. Bathing was unusual and awkward because she had become accustomed to being hosed off in the yard. The typical routines of waking and sleeping and rhythms of daily life had to be reestablished.

How can a child and youth care practitioner use these moments in daily living as opportunities for nurturing growth and development, especially in ways that support relationally reparative experiences? Treatment and behavioral approaches may be helpful, and at times necessary, but the deepest needs for such an individual is relational care that repairs or restores traumatized children. According to Baker and White-McManhon, "Repair [does not mean] a problem that must be completely solved . . . Rather, repair simply means to bring the youth to a [stable and healthy] state that allows for more adaptive functioning and the opportunity to achieve his or her greatest potential" (2011, p. 93). These reparative experiences occur in everyday life, in moments and situations where the child care practitioner in the role of a caring adult is best positioned to be of influence and support.

The following characteristics of relational child and youth care (see Figure 1) have been defined (Garfat & Fulcher, 2012) and organized into a framework (Freeman & Garfat, 2014). The characteristics and framework are straightforward, yet profound enough to ground practitioners in an approach for the length of their career. The focus of this article is the application of the anchor characteristics—love, meaning making, and connection and engagement—and their relevance in facilitating the process of healing from relational trauma.

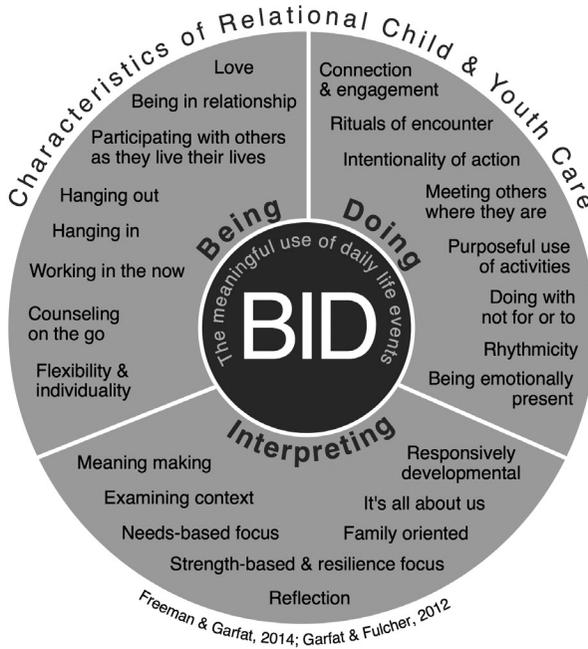


Figure 1: Characteristics of relational child and youth care

Love As a Way of Being

Love is the first characteristic related to our way of being with others (Freeman & Garfat, 2013). Work with young people affected by trauma must come primarily from a place of love. It has a role in both internal motivation and external experience with young people. According to Smith, Fulcher, and Doran, “Love and affection are essential but are often lacking in the lives of children in care, and . . . this has a significant impact on their emotional well-being and, for some, a lasting impact on their future prospects” (2013, p. 43). Love gives traumatized children the experience of someone they can feel safe with, someone who makes them feel special.

Loving young persons struggling with the impact of trauma is not easy or simplistic. The barriers and conflicting feelings in both young persons and practitioners stem from the children’s background:

Repeated experiences of rejection, betrayal, and abuse [which have led to] feeling they are bad, worthless, or not worthy of being loved. This combined with poor developmental competencies and subsequent feelings of ineptitude lead to self-blame and guilt. Negative self—and other—attributions and expectations further exacerbate the...tendency towards hy-

pervigilance and [disrupted] information processing. Responses to both neutral and traumatic stimuli tend to be confused and disorganized, leading to further self-perceptions of helplessness (Gregorowski & Seedat, 2013, p. 107).

When a young person is scared and struggling with the impact of trauma, love may be the last thing they are able to embrace while at the same time be their greatest need.

Various constructs summarizing human needs have included love. Maslow (1943) labeled it "love and belonging" and placed it in his hierarchy between safety and esteem needs. Glasser (1999) called it by the same name and included it directly after survival needs in his more linear and overlapping categories. Brendtro, Brokenleg, and Van Bockern (2001) integrated it in their more circular model, especially in the concepts of belonging and generosity. As an identified basic need in the human experience, love must have a place in the care of young people.

Some practice settings seem to operate with the idea that love is beyond the scope of relational care. This may come from a place of fear of attachment on the part of the adults or sometimes from a fear of accusation of abuse or poor boundaries. Practitioners must remember that "most young children need a lot more physical affection and admiration than they get, even in a normal family [and while they] must be protected from unwelcomed attention [it can not be] at the cost of denying them one of their deepest needs" (Keith-Lucas, 1993, pp. 1–2).

Keith-Lucas described in a classic article on children and love that one young girl, with similar experiences to the one described above, asked him if he really liked being kind to her: "I could see Emma being told as part of her therapy that the staff loved her but doubting if they really meant it. Words often don't mean much to a child, when actions and body language do" (Keith-Lucas, 1993, p. 3). It is important, that when "one really does love a child, not merely apply love as a [technique or bandage]" (Keith-Lucas, 1993, p. 3).

Love underlies quality care. Child and youth care workers cannot be in this work, at least in a lasting and meaningful way, without a sense of love for others. Love is what keeps one patient and kind. So there is a sense that when practitioners begin to lose their patience or find themselves with unkind thoughts and words, it is love to which they may need to return. Love is what keeps them seeing the potential in others and expecting the best from them. It is what keeps them hanging in with young persons when things get difficult (Garfat & Fulcher, 2012). Love is also what drives them to celebrate the accomplishments of others regardless of who gets the credit.

Making Meaning From Our Experiences

The second characteristic is related to a way of interpreting experiences within in the relational exchange. This is meaning making, which has been defined as “the process young persons go through in making sense of their experiences” (Garfat & Fulcher, 2012, p. 18). Its aim is to guide us in increasing the sense of safety and self-awareness the young persons (and practitioners) have in their experiences.

Experiences of trauma—especially those which occur in early childhood—impact the way persons make meaning out of their other experiences, shaping their worldview and how they understand and interact with others around them. They may come to believe that the world is unsafe. They may internalize feelings and thoughts that they are unimportant or of no value in the world.

Similarly, the adults in young persons’ lives are constantly interpreting, even if unconsciously, and looking to make sense out of a children’s actions. Without an awareness of trauma and focus on supporting their growth, this interpretation may result in actions that hinder rather than help young persons. Work with young people can become “overly focused on behavior management or even controlling children’s behavior . . . [while] effective workers interpret [such] behavior and respond sensitively, rather than immediately trying to impose external controls” (Anglin, 2014, p. 54).

The context behind a behavior might range from grief, fear, anxiety, despair, or hopelessness. It is the challenge and responsibility of practitioners to recognize and respond to the need behind the behavior. They must interpret and reinterpret what they see and help the young persons begin to interpret and reinterpret their experience. How they explain and understand what young persons have or are currently experiencing in the moment directly impacts the validity and effectiveness of their response.

It is important that [practitioners] adopt the language of collaboration and do not see themselves as agents of control. A trauma-informed mindset assumes that [all behavior] is a result of unmet needs . . . [and that if a young person is] not doing well, there is a reason related to how well they are able to think about and process their immediate circumstances (American Association of Children’s Residential Centers, 2014, p. 101).

Interpretation is central to all experience. It occurs whether people are aware of it or not, and pausing to reflect and reinterpret is the first step toward improving the quality of care for young people.

Connection and Engagement as an End, Not a Means

The third characteristic is related to the ways in which child and youth care workers take action in their care: connection and engagement (Freeman & Garfat, 2013). They can be with others and interpret the meaning of their relational exchange, but if there is no action, there is no caring taking place.

Individuals who have few positive relational interactions—a child without a healthy family [or] clan—during or after trauma have a much more difficult time decreasing the trauma-induced activation of the stress response systems . . . [yet it is] healthy relational interactions with safe and familiar individuals [which] buffer and heal trauma-related problems (Ludy-Dobson & Perry, 2010).

The most important thing young persons affected by trauma need is to connect with another. The aim of this action or way of doing is to support young persons in their process of restoration.

Meaningful connection and engagement are difficult to achieve, if at all, in rigidly prescribed roles that emphasize physical and emotional distancing from young persons. It is only when practitioners involve their “personal selves into caring relationships in a professional context that . . . [they] can enter into such relationships with appropriate authenticity and spontaneity” (Smith, Fulcher, & Doran, 2013, p. 44). Yet one difficulty is that traumatized children may be focused on survival and a response to stress that includes fighting or fleeing from such authentic connection. It is a natural way to prepare themselves to minimize injury.

The experience of developmental trauma means that the child is likely to have experienced disrupted relationships, involving experiences from loss and betrayal to actual physical harm. The resulting negative expectations of the intentions and actions of others make it likely that even positive interactions will be experienced as potentially ineffectual or harmful (Gregorowski & Seedat, 2013, p. 113).

With such expectations present, ways of connecting must be creative, involving, for example, using fun and humor. What may seem like play or simply hanging out to other children may be the most effective way to connect and engage with young persons who have experienced traumatic relationships in their past. Young people affected by traumatic experiences need “environments that immerse them in positive, repetitive rehearsals of healthy interactions and activities” (Gaskill & Perry, 2013, p. 186). Regulation begins with introducing safety and rhythm into daily life.

Systems with practitioners who are reactive to the symptoms of trauma unintentionally isolate young persons. Coercive practices such as point systems, se-

clusion, suspension, and removal of activities must be minimized if they are to best support young people recovering from trauma. These outdated coercive practices “by their nature reenact the experience of the child having to work external systems to gain even an illusion of control over [their] life, and are most difficult for the most seriously traumatized children” (American Association of Children’s Residential Centers, 2014, pp. 102–104).

Connection and engagement are vital to relational care in themselves and not simply as a means toward surface goals such as school attendance, behavioral change, or reduction of self-harm. Although these things may improve the life of young persons, they can not overshadow the power of human connection and engagement in and of itself.

Implications for Organizational Culture

Since in some countries a large number of young people in care live in group settings, it is important to consider the implications of trauma sensitivity on organizational culture. Family settings are systems as well, so the same implications apply for the home environment.

Organizational leaders are responsible to shape a culture which supports trauma-sensitive practice. Policies and procedures play a role and so do the ongoing professional development and support of practitioners. Supervisors need to evaluate and hire practitioners who have natural talents and are willing to develop their skills to maximize effectiveness. Training and professional development should include knowledge and skills related to how to perform the following:

- connect with young people and families in a way that is sensitive to the impact of trauma
- build relationships that are collaborative rather than controlling
- reduce stress in the environment (especially by minimizing coercive and controlling interactions)
- promote a welcoming and hospitable environment
- engage young people in fun and meaningful activities that promote self-awareness, development, and self-regulation

See Figure 2 for suggested reflection and discussion questions to stimulate learning and application in home or group settings.

1. Think of a young person you have worked with who was impacted by significant trauma. What did you learn from the experience? What did the young person learn from the experience?

2. Consider experiences that may have been traumatic for you in your own experience as a young person. How did they impact the ways in which you viewed yourself or the world around you as you grew up?

3. What do you think of the concept of love in relational care? What place does it have in your daily practice?

4. Think of the numerous ways in which you interpret the actions and meaning of behavior during the course of a day. In what ways might you adjust or increase awareness of the ways you find meaning in those exchanges?

5. Connection and engagement were explained as an end rather than a means to an end. In what ways do you connect with young people with a predetermined goal in mind? How might you adjust to make your connection and engagement with them even more meaningful?

6. As a supervisor or manager, what programmatic changes might you make to move your program toward a more trauma sensitive-environment?

Figure 2: Questions for individual reflection or group discussion

Conclusion

Young people affected by trauma have valuable things to teach us, and they contribute to the world. Their healing—the restorative process of becoming healthy and whole—needs to be a focus in the various forms of support provided for them. It is up to child and youth care practitioners to support them and give voice to their experience. The characteristics of relational care, love, meaning making, and connection and engagement are central elements in supporting their restoration and recovery from exposure to childhood trauma. It is relational practice, when in-

formed and sensitive to impact of trauma, which best supports the healing process for young people—and it is such practice that restores the depth of human dignity and respect our world needs.

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