NSW GOVERNMENT | Family & Community Services

Module 4
Neglect Psychological and Emotional Harm

Essential Readings

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The contents of these readings are summaries of resources and literature. All references are located at the end of each article.

EARLY CHILDHOOD DEVELOPMENT

Human development is shaped by the dynamic and continuous interaction between biology and experience.

Culture influences every aspect of human development and is reflected in child-rearing beliefs and practices designed to promote healthy adaptation.

The mastery of self regulation is a cornerstone of early childhood development.

Children are active participants in their own development, reflecting the intrinsic human drive to explore and master one's environment.

Human relationships are the building blocks of healthy development.

The broad range of individual differences among young children often make it difficult to distinguish normal variations and maturational delays from transient disorders and persistent impairments.

The development of children unfolds along individual pathways whose trajectories are characterised by continuities and discontinuities, as well as by a series of significant transitions (i.e. developmental milestones/tasks).

Human development is shaped by the ongoing interplay among sources of vulnerability and sources of resilience.

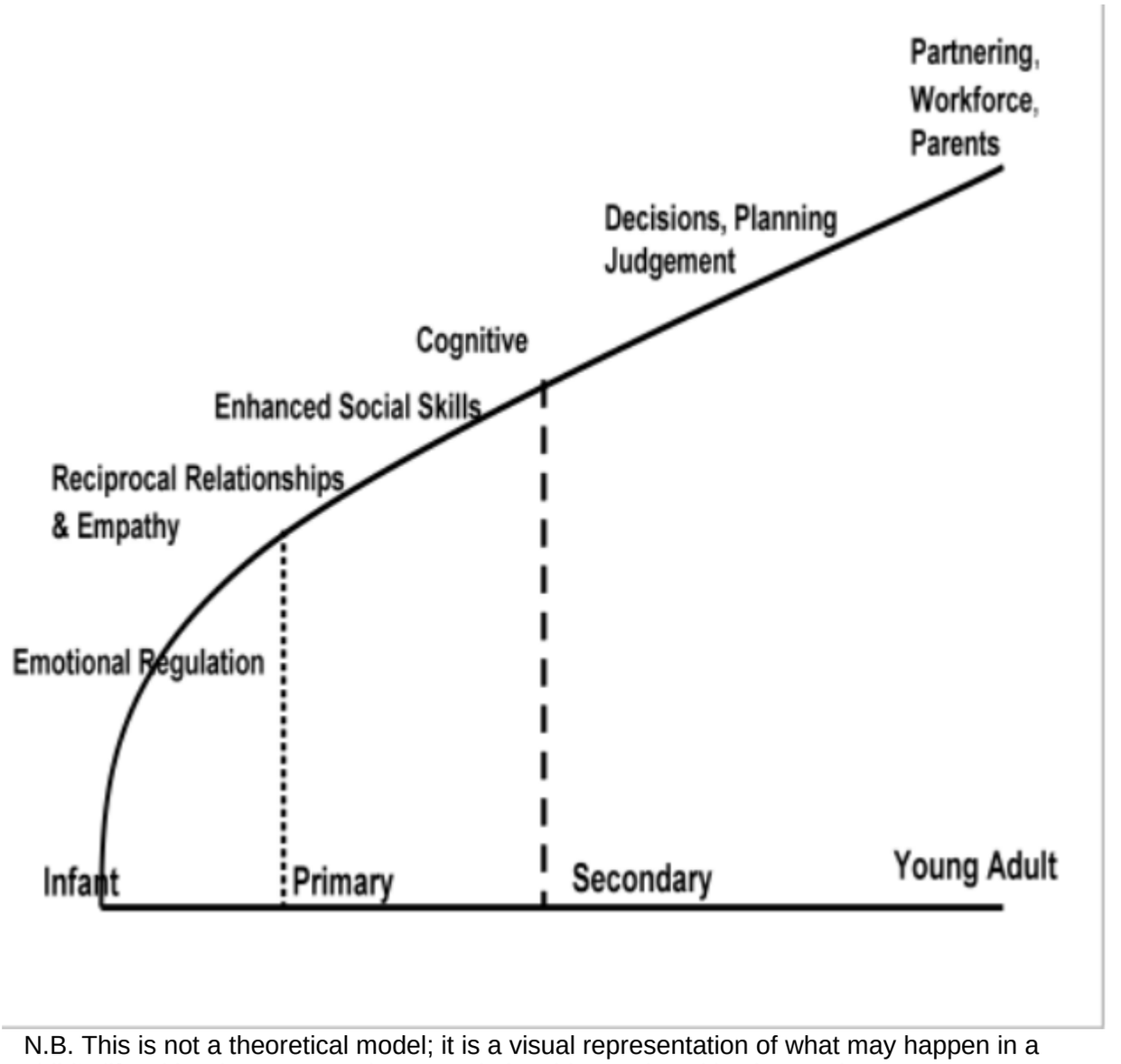
The timing of early experiences can matter, but more often than not, the developing child remains vulnerable to risks and open to protective influences throughout the early years of life and into childhood.

The course of development can be altered in early childhood by effective interventions that change the balance between risk and protection, thereby shifting the odds in favour of more adaptive outcomes.

Reference:

Shonkoff, JP & Phillips, DA (eds.) (2001) From neurons to neighbourhoods: The science of early childhood development, 2nd edition, National Academy Press, Washington, DC.

SOCIAL AND EMOTIONAL DEVELOPMENT



N.B. This is not a theoretical model; it is a visual representation of what may happen in a child's life with adequate attachment, relationships and positive interaction.

THE IMPORTANCE OF ATTACHMENT

Attachment is defined as an affectionate bond between two individuals that serves to join them emotionally. In the field of child psychology, the term refers to the relationship between a child and a caregiver that begins at birth and endures throughout a life span.

The most important relationship in a child's life is the attachment to his or her primary caregiver. This is due to the fact that early attachments determine the biological and emotional 'template' for all future relationships. Healthy attachment to the primary caregiver (most often the mother) built by repetitive bonding experiences during infancy provides safety and security and helps with the learning of emotional regulation. This in turn promotes a solid foundation for future healthy relationships. In contrast, problems with bonding and attachment can lead to a fragile biological and emotional foundation for future relationships.

What determines successful attachment?

Attachment theory, which originated with the seminal work of John Bowlby (1969), suggests that the earliest bonds formed between children and their caregivers have a tremendous impact on a child's later development. The quality of attachment between a child and their caregivers influence every aspect of a child's life; the child's social functioning, well-being and competency and the development of self-reliance. Research suggests that it does not matter who the primary attachment figure is in the child's life. Infants can form affective bonds with mothers, fathers, grandparents or longer-term foster parents. However to form an attachment, a child needs to experience an enduring and continuous relationship with a caregiver (Office of the Senior Practitioner, June 2014).

Attachment theory focuses on the importance of secure and positive relationships, as a child's sense of self is developed through his/her interactions with others. A child who experiences responsive, nurturing and consistent care-giving is more likely to develop secure attachments and have a positive image of themselves and of the world around them. Secure attachment is crucial to the development of trust and positive interpersonal relationships, and influences the physical, intellectual and psychological development of infants and children. An empathic interaction between a child and their caregiver, as a result of a relationship based on attunement, is the basis of Secure Attachment (Siegel, 2012).

When a parent/caregiver is consistent and predictable in their responses to a child, it creates an internal model of security for the child. The child will view their attachment figure (parent/caregiver) as a secure base from which they can go out and explore the world, reach their potential, have meaningful relationships with others, and regulate their emotions. They are able to develop equilibrium of energy flow between mind, relationships and brain for a 'healthy' development and growth into adulthood.

Interpersonal neurobiology asserts that attunement between a child and their parent/caregiver allows for bonding to occur and most importantly creates internal security for a child. Attunement is defined as the ability to hear, see, sense, interpret and respond to another's verbal and nonverbal cues, in a way that communicates to the other person that they are truly heard and understood. Psychobiological research in attachment, has found that attunement between a mother and child exists in a continual subtle interactive exchange of looks, eye contact, vocalisation, body language and speech (Siegel, 2012).

Attachment theory includes four patterns of attachment: Secure, Insecure – anxious/ambivalent, Insecure – anxious/avoidant and Disorganised attachment.
In brief, the four patterns of attachment are (Lamont, 2010);

Secure attachment – Children experience their caregiver as a safe base from which to explore the world, and seek comfort from their parent when frightened or distressed. The internal working model of securely attached infants is one of attunement; they expect their needs will be met and their emotions will be regulated by their caregiver. They freely explore their environment in the presence of their caregiver, display distress when separated or left with strangers, but are comforted and happy when reunited with their parent.

Insecure attachment

Anxious/ambivalent – Children experience their caregiver as inconsistent in their responsiveness, and develop an inability to depend on them when they need comfort or care. Ambivalent infants tend to be wary of strangers and explore little, even when their parent is present. Although they may display extreme anxiety and distress when separated from their parent, they tend to resist comfort or display ambivalence upon their return. The internal working model of these infants is based upon uncertainty and has resulted from a caregiver being un- attuned to the child's emotional needs. Although a parent may be physically present, the child is uncertain that they can provide comfort.

Anxious/avoidant – Children experience their caregiver as consistently unresponsive to their needs, emotionally unavailable, imperceptive and at times rejecting. Infants appear to ignore or avoid their caregiver, displaying little reaction if their caregiver leaves or returns, and may show no preference between a parent and a complete stranger when seeking attention. The internal working model of avoidant infants is beginning to develop emotional independence, as they learn that their attempts at communication and comfort seeking are dismissed or rejected by their caregiver.

Disorganised attachment – Children may experience their caregiver as a simultaneous source of comfort and danger, resulting in an inconsistent and unorganised pattern of attachment. Often due to environments characterised by abuse or neglect; caregivers with psychological illness and/ or substance abuse, the parent-child relationship is not functional and thus the attunement and responsiveness to a child's needs is not successfully developed.

The internal working model of disorganised infants is one of contradiction. They may be clingy and explore little, or exhibit a confusing mix of behaviours including extreme displays of fear, freezing, disorientation or repetitive stereotypical movements.

Attachment Theory – in practice	
1. It provides a model for all other relationships.	Out of this early connection, children form an understanding of self and others. For instance: a child who is loved, cared for, and listened to may believe that he or she is lovable and worthy and that others are generally trustworthy and will be available if needed a child who is consistently rejected and ignored may believe that he or she is unimportant or unlovable and that others are uninterested, unavailable, and likely to reject any attempts to gain support a child who is frequently hurt or excessively punished may believe that he or she is bad and that others are unsafe and potentially dangerous a child whose parents are inconsistently available (e.g., due to substance use or mental health issues) may believe that adults are not able to handle things and are unpredictable in their responses. These children often feel overly responsible for the well-being of others, and may be controlling or clingy in their interactions.
2. It provides the earliest training ground for coping with and expressing emotions.	when children are born, they do not have the skills to deal with emotions on their own. They rely on parents to comfort them and help them manage distress. When children consistently receive nurturance from their parents, they learn that feelings are not permanent, that distress can be tolerated, and that it will eventually subside. When support is first provided externally, over time, children will internalise these same coping skills. Eventually, children are able to independently regulate their emotional experience children who receive inconsistent, neglectful, or rejecting care giving have little support in managing the challenging experiences of early childhood. When they feel distress, they must rely on primitive and frequently ineffective or insufficient coping skills. As a result, two primary consequences emerge: first, the child is unable to develop more advanced coping skills. While other children get better and better at dealing with emotions over time, these children continue to act and look like much younger children in the face of distress second, children may become frightened by or guarded against emotional experience in general, as all feelings may be perceived as potentially threatening and overwhelming.
3. It provides a safe environment for healthy development.	every developmental stage has key tasks that children work to accomplish. The attachment system provides the safety that gives children confidence in approaching these tasks. Success in relationships, school, identity, and, ultimately, independent functioning all stem in part from the support that the attachment system initially provides when children do not have the safety net of a secure attachment system, the energy that other children are able to invest in accomplishments instead must be invested in self-protection and survival.

Reference:

This paper was created by Learning & Development and draws from NSW Department of Human Services, Family and Community Services, Caseworker Development Course, Child Protection Dynamics, Trainer's Manual, January 2009, V1R6.

Bowlby, J., 1969, *Attachment. Attachment and Loss: Vol 1. Loss*, Basic Books, New York.

Blaustein M.E. & Kinniburgh K.M., 2010, *Treating Traumatic Stress in Children and Adolescents: How to Foster Resilience through Attachment, Self-Regulation, and Competency,* Guildford Press, New York.

Fahlberg, V., 2004, 'Attachment and separation', *British Agencies for Adoption & Fostering*, 1979 Originally published: Lansing: Michigan Dept. of Social Services, p 60. Cited in National Scientific Council on the Developing Child, 'Young Children Develop in an Environment of Relationships'. Working Paper No. 1, viewed 12 June 2009. **http://www.developingchild.net**

Lamont, A. (2010) The effects of child abuse on children and adolescents NCPC Resource Sheet retrieved from **http://www.aifs.gov.au/nch/pubs/sheets/rs17/rs17.html**

NSW Department of FACS, Office of the Senior Practitioner (2014) Attachment in Practice **http://docsonline.dcs.gov.au/internal-services/research--evaluation-and-data/research-to-practice/past-seminars/attachment_in_practice.html**

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Perry, B., 2001, 'Bonding and Attachment in Maltreated Children: Consequences of Emotional Neglect in Childhood'; The Child Trauma Academy: **http://aia.berkeley.edu/strengthening_connections/handouts/perry/Bonding%20and%20Attachment.pdf**

Siegel, D. (2012) Pocket Guide to Interpersonal Neurobiology, an integrative handbook of the mind, W.W. Norton & Company. New York

ATTACHMENT AND CULTU RE

The way a child is nurtured and how they develop into adulthood, is determined by culture, family and community. Keller (2012) argued that attachment theory may only be the norm in Western, middle-class families, for the following reasons:

- The theory centres on the mother-infant bond, and views the mother figure as the primary carer of the infant; however this notion does not encompass those cultures and families in socioeconomic situations that may have limited resources and means, and who distribute care giving responsibilities across a network of relatives such as aunts, uncles, grandparents and siblings. There are also other alternative forms of childcare for working parents that play a significant role in the developing infant, such as early childhood centres, afterschool care, nanny's etc.

- The attachment theory's emphasis on the importance of attachment bond between mother and child on creating a safe base implies that any deviation from this is less than an ideal childhood. In fact there have been studies on cross-cultural attachment that suggest that by dismissing other forms of child nurturing, we are undervaluing those avenues that equally meet the attachment needs of a developing infant.

- The idea of secure attachment, suggest that the child is sensitively attuned to their mother and seeks comfort and safety from the mother. However a study in Northern Germany found that childrearing is the opposite and involved a greater push towards children's independence.

FACS, Research to Practice Notes on Attachment and Culture (Office of the Senior Practitioner, June 2014), also outlines the need to apply what we know about attachment in a culturally appropriate way:

- In Attachment theory, secure attachment relies on the caregiver being sensitive to the child's needs; however how attunement is expressed by the parent/caregiver, differs in different cultures. For example an Aboriginal caregiver will wait for a smile after feeding before burping the baby. In contrast, western mothers will often wait until the child cries or communicates distress before responding.

- Social competency is defined differently in various cultures. In Western cultures, a child displaying autonomy, resilience and efficacy is a show of competence; whereas in Aboriginal communities' competency is demonstrated by early group dependency and cohesion, spiritual connectedness and traditional links to land and community.

In addition, the following behaviours and actions should not be automatically considered as a sign of insecure attachment:

- Young children in Aboriginal communities are encouraged to feed themselves, and they are discouraged to express negative emotions as it is considered disrespectful.

- Children under two years of age in Aboriginal communities may be discouraged from exploration, and older children are expected to be self-reliant and to look after their siblings.

- In many Aboriginal communities, caregiving is often shared by multiple women who will provide enduring mothering and supporting role until adulthood. Children may reach out to any of these mothering figures (not just their mother), to build a sense of security.

Reference:

Keller, H. (2013) 'Attachment and Culture', *Journal of Cross-Cultural Psychology*, 44, 2: pp. 175-194.

NSW Department of FACS, Office of the Senior Practitioner (2014) Attachment in Practice **http://docsonline.dcs.gov.au/internal-services/research--evaluation-and-data/research-to-practice/past-seminars/attachment_in_practice.html**

TYPES OF NEGLECT

Neglect refers to the failure by a parent or caregiver to provide a child (where they are in a position to do so), with the conditions that are culturally accepted as being essential for their physical and emotional development and wellbeing. Neglectful behaviours are an act of omission, or by willful choice, and can be divided into different types of neglect (Child Neglect, cobar.org, 2014, & Horwath, 2013):

Physical neglect is characterised by the caregiver's failure to provide basic physical necessities, such as safe, clean and adequate clothing, housing, food and health care. This form of neglect can be difficult to assess due to differing values and ideas about standards of care. Physical neglect is generally the most common type of neglect, and it is also the most likely to receive trivial responses in casework practice. For example providing a skip bin to clean up rubbish in a house, rather than identifying and providi ng support and a sustainable solution to the underlying cause.

Emotional (or psychological) neglect is characterised by a lack of caregiver's warmth, nurturance, encouragement and support. Many researchers have differentiated this type of neglect from emo tional abuse based on the parent/caregiver's intent. It is argued that emotional neglect occurs as an act of omission or inability to provide adequate and appropriate responses to the child's emotional needs. In contrast, the parent/caregiver is emotionally abusive, by deliberately choosing to be unresponsive to the child's emotional needs.

Educational neglect is characterised by a caregiver's failure to provide appropriate educational opportunities for the child by either failing to enroll him/her into a school or providing appropriate educational alternatives such as home schooling or special educational support and training that is needed.

Medical neglect is characterised by a caregiver minimising or denying a child's health needs, and failing to seek appropriate medical treatment or the administration of necessary medication. This includes a parent/caregiver's refusal to provide medical care for an emergency situation or for a child's ongoing illness or disability that may be treatable, which results in the child's frequent hospitalisation or significant deterioration. In non-emergency situation, medical neglect can lead to overall poor health and compounded medical problems.

Nutritional neglect is characterised as the inadequate nutritional provision for a child that impacts on his/her normal growth and development. This is generally termed as 'failure to thrive', which involves the child not achieving their physical and developmental milestones. In recent years, childhood obesity has been acknowledged as a form of nutritional neglect, due to the long-term impact on the child's health and wellbeing.

Supervision/Guidance; this is categorised in three different forms of neglect:

inadequate supervision
exposure to hazards
lack of appropriate guidance

Environmental neglect is characterised by the caregiver's failure to ensure environmental safety, opportunities and resources (Price-Robertson & Bromfield, 2009).

Age Specific Indicators of Child Neglect

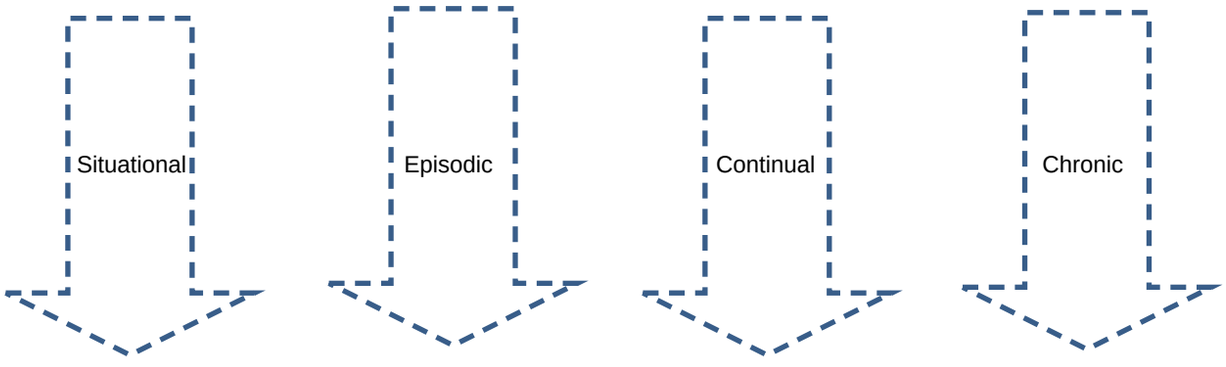
Physical	Development	Behavior
Key Features in Infants (0-2)		
failure to thrive, weight, height and head circumference small recurrent and persistent minor infections frequent attendance at G.P, casualty departments. hospital admissions with recurrent accidents/ illnesses late presentation with physical symptoms (impetigo, nappy rash).	late attainment of general developmental milestones.	attachment disorders anxious, avoidance, difficult to console.
Key Features in Pre-School Children (2-5)		
failure to thrive, weight and height affected unkempt and dirty/poor hygiene repeated accidents at home.	language delay, attention span limited socio-emotional immaturity.	overactive, aggressive and impulsive indiscriminate friendliness seeks physical contact from strangers.
Key Features in School Children (5-16)		
short stature, variable weight gain poor hygiene, poor general health unkempt appearance underweight or obese delayed puberty.	mild to moderate learning difficulties low self-esteem poor coping skills socio-emotional immaturity poor attention.	disordered or few relationships self stimulating or self injurious behaviour or both soiling, wetting conduct disorders, aggressive, destructive, withdrawn poor/erratic attendance at school runaways, delinquent behaviour.

Reference:
Child Neglect (2014) Colorado Bar Association, retrieved from http://www.cobar.org/index.cfm/ID/0/subID/5303/Child-Neglect

Horwath, J. (2013) The Complex Issue of Child Neglect, Discussion Paper, Hartlepool Safeguarding Children Board

NSW Department of FACS (2014) 'Responding to Chronic Neglect', Facilitator Guide, V2.

CONTINUUM OF NEGLECT



response to unusual life stressors/events
carer may regress to established level of competence
distraction from child's needs.

response to periods/episodes of stress or challenge
between episodes strengths and protective factors evident
patterns of adaptation evident in many children.

inability to manage self and complex issues
poor coping often result of poor childhood experiences
few alternative templates for coping or functioning.

often personality based
primary immaturity – preoccupied with own needs
chaotic lifestyle/relations
unresponsive to intervention – potential for change
poor/very low child's needs rendered invisible.

GOOD ~~**PROGNOSIS**~~ **POOR** →

Situational neglect can be identified as neglect that occurs because of a specific situation or crisis e.g. bereavement , and as such this will tend to only last up to a period of time, depending on the situation.

Episodic neglect can be identified where an episode of neglect will generally recur at specific times in a person's life cycle e.g. binge drinking.

Continual neglect can be identified as an ongoing distraction from the child's needs through persistent life difficulties e.g. untreated mental illness.

Chronic neglect can be identified as where the caregivers are facing an enormity of complex problems, with multiple disadvantages and often with long term involvement with child protection and family support services e.g. chronic hazardous use of alcohol and other drugs.

References:
This paper was adapted from Killen (1982 & 1991) and created by NSW Department of Human Services, Family and Community Services, Caseworker Development Course, Child Protection Dynamics, Trainer's Manual, January 2009, V1R6.

Child Neglect (2014) Colorado Bar Association, retrieved from
http://www.cobar.org/index.cfm/ID/0/subID/5303/Child-Neglect

Horwath, J. (2013) The Complex Issue of Child Neglect, Discussion Paper, Hartlepool Safeguarding Children Board.

NSW Department of FACS, Centre for Parenting and Research (2005) Neglect Key Issues, Research to Practice Notes
http://docsonline.dcs.gov.au/docsintwr/_assets/main/document/rfba/neglect_key_issues.pdf

NSW Department of FACS (2014) 'Responding to Chronic Neglect', Facilitator Guide, V2

Price-Robertson, R. & Bromfield, L. (2009) *What is child abuse?* NCPC Resource Sheet, retrieved from
http://www.aifs.gov.au/nch/pubs/sheets/rs6/rs6.html

Watson, J. (2005) Child Neglect: Literature Review. NSW Department of FACS

SUMMARY OF FACS NEGLECT POLICY

The Causes of Child Neglect

A number of factors have been associated with neglect. They can be categorised as parental, child and environmental factors.

Parental Factors: Substance misuse, dysfunctional parent – child relationship, lack of affection, lack of attention and stimulation, mental health difficulties, low maternal self -esteem, domestic violence, age of parent/carer (risk generally increased for younger, teenage mothers), negative childhood experiences, history of parenting (previous abuse/neglect), dangerous/damaging expectations upon the child, inappropriate supervision, failure to seek appropriate medical attention, lack of social support.

Child Factors: Age of the child (the younger the child , the higher the risk), children with disabilities and children with learning difficulties.

Environmental Factors: Poverty, homelessness, financial stressors, unemployment.

FACS Neglect Policy – key messages

Message:	Implications:
1. Children need predictable, reliable and responsive care:	All children are born wired for feelings, with a genetic predisposition to form strong attachments with their primary carers. All children are born ready to learn. For healthy development the physical, social, intellectual and emotional needs of the child must be met. Children's early experiences are critical in determining how they develop. Nurturing relationships are essential. Young brains need stimulation to trigger activity and help them grow and develop. Parents and carers need to: o be actively involved in the care of their child o connect with and be sensitive to their child o express warmth and affection with their child o try to see the world through their child's eyes o be aware of their impact on their child, and change their behaviour if needed o adapt their parenting style according to the demands of different situations
2. Neglect seriously harms children:	Neglect can cause serious and life-long harm. The consequences are particularly serious when neglect occurs during a child's early years. A single incident of neglect can be fatal. Chronic neglect involves repeated omissions of care. This results in cumulative harm for the child. Neglected children suffer harm to their physical, cognitive, emotional, psychological, and social

	development. If children are ignored or not responded to in their early relationships, or if their early relationships are disrupted, their ability to form healthy relationships can be a life-long problem. Children who have been neglected are prone to internalising problems. This can result in low self-esteem, depression, social withdrawal, apathy, passivity, and helplessness. Neglected children are often delayed in their cognitive and language development and have poor communication skills. They can also be delayed in their physical growth and development.
3. We misunderstand neglect if we look only at the current incident	Neglect can be a single incident. But neglect that comes to the attention of Family and Community Services is usually repeated, and is often chronic. Each incident, if viewed separately, can seem unimportant or even trivial. But repeated incidents result in cumulative harm for the child. Understanding neglect means that we are aware of the possibility of a pattern of neglect when we are investigating an incident of abuse. Understanding neglect means that allocation decisions take account of: o the history and pattern of risk and harm. o the cumulative harm impacts of neglect.
4. Neglect rarely exists on its own	Neglect often coexists with other risk issues such as problem alcohol or other drug use, domestic violence, and mental illness. Parents may be preoccupied with using, obtaining or paying for alcohol or drugs. This can impair their ability to see, prioritise, and meet their child's needs. Intoxicated or drug-affected adults cannot accurately see risk for their child. Their judgement is impaired. Babies and infants are at increased risk of serious physical harm if they share a bed with an intoxicated adult. There is a strong relationship between maternal depression and neglect. Living with mental illness can absorb a parent's attention and take their focus away from the child. This is particularly true where mental illness is undiagnosed or unmanaged. Domestic violence often co-exists with neglect. Witnessing domestic violence has a serious impact on children. Any chronic conflict between adults can mean their attention is focussed on each other rather than on their

	child.
5. Past behaviour is our best clue about a parent's capacity to care for their child	Realistic assessment of parents' capacity to provide that care is a critical part of neglect casework. Many parents who neglect their children are themselves experiencing significant problems and difficulties. These parents often do not intend to neglect. For some caseworkers it can feel unfair to conclude that parenting is inadequate where parents are struggling and their neglect is unintentional. Our empathy with parents in these situations can lead us to overestimate their capacity to manage their own issues while also providing the care their children need. Our task is to realistically assess whether, with supports, the parent is both willing and able to provide predictable, reliable and responsive care over the long-term. A parent's past behaviour is a key factor in determining parental capacity. Without strong and compelling evidence to the contrary, past behaviour is the best predictor of future behaviour. Children need predictable, reliable and responsive care.
6. We need to understand Aboriginal perspectives to understand neglect in Aboriginal families.	When working with Aboriginal families, we need to understand the impact of the Stolen Generations and the legacy of past welfare policies and practices. While we need to understand the consequences of generational social and economic disadvantage, we also need to understand the resilience and strengths of Aboriginal families, kinship networks, and communities. Cultural awareness and consultation with Aboriginal caseworkers is our best means of understanding and responding in a culturally sensitive way. Consultation with Aboriginal Caseworkers should occur early in the assessment process and at each significant decision-making point in all cases. Consultation will enhance engagement and support meaningful participation of Aboriginal families.
7. Understanding Neglect Means Focussing On The Experience Of The Child	Neglect may result in children feeling hungry, in pain, afraid, anxious, unloved and worthless. Neglect shapes what the child is experiencing and learning about her or himself, about other people and about the world around them. We need to remain aware of the possible serious impacts of neglect on the child as she or he grows up. Our focus can shift from the child to the parents without us noticing – we need to remain alert to this possibility. Losing our focus on the child is a particular risk when the parents themselves are experiencing significant

	problems and difficulties. It is never helpful to allow parents to lose sight of the fact that we are there for the child. Transparent casework practice means being clear with parents that our assistance with their problems and needs is given to improve the experience of their child.

References:
NSW Department of FACS (2006) Policy on Child Neglect
http://docsonline.dcs.gov.au/docsintwr/_assets/main/business_help/documents/policies/neglect_policy.pdf

NSW Department of FACS, Centre for Parenting and Research (2005) Neglect Key Issues, Research to Practice Notes
http://docsonline.dcs.gov.au/docsintwr/_assets/main/document/rfba/neglect_key_issues.pdf

CHILDREN AND YOUNG PERSONS (CARE AND PROTECTION) ACT 1998 - SECT 23

The Act considers children and young persons to be at risk of significant harm, under the following grounds:

23 Child or young person at risk of significant harm

(1) For the purposes of this Part and Part 3, a child or young person is "at risk of significant harm" if current concerns exist for the safety, welfare or well-being of the child or young person because of the presence, to a significant extent, of any one or more of the following circumstances:

(a) the child's or young person's **basic physical or psychological needs are not being met or are at risk of not being met**,

(b) the parents or other caregivers **have not arranged and are unable or unwilling to arrange for the child or young person to receive necessary medical care,**

(b1) in the case of a child or young person who is required to attend school in accordance with the *Education Act 1990* -the parents or other caregivers **have not arranged and are unable or unwilling to arrange for the child or young person to receive an education in accordance with that Act,**

(c) the child or young person has been, or is at risk of being, physically or sexually abused or ill-treated,

(d) the child or young person is living in a household where there have been incidents of domestic violence and, as a consequence, the child or young person is at risk of serious physical or psychological harm,

(e) a parent or other caregiver has behaved in such a way towards the child or young person that the child or young person has suffered or is at risk of suffering serious psychological harm,

(f) the child was the subject of a pre-natal report under section 25 and the birth mother of the child did not engage successfully with support services to eliminate, or minimise to the lowest level reasonably practical, the risk factors that gave rise to the report.

Note : Physical or sexual abuse may include an assault and can exist despite the fact that consent has been given.

(2) Any such circumstances may relate to a single act or omission or to a series of acts or omissions.

Note : See also sections 154 (2) (a) and 156A (3) for other circumstances in which a child or young person is taken to be at risk of significant harm.

References:
NSW Children and Young Persons (Care and Protection) Act, 1998
http://www.legislation.nsw.gov.au/xref/inforce/?xref=Type%3Dact%20AND%20Year%3D1998%20AND%20no%3D157&nohits=y

MANAGING NEGLECT AND CASE PLANNING

Neglect is, in general, more likely to be overlooked than any other type of child maltreatment and abuse. This is because neglect is often accompanied by some other forms of abuse that tend to be the focus of intervention. Neglect issues are therefore trivialised. However research has shown that the effects of neglect can be potentially fatal, cause great distress to children, and lead to a wide variety of negative impacts during childhood and later in adulthood depending on the type, severity and frequency of the neglect. This can include; medical and mental health issues, poor educational attainment, difficulties in forming and maintaining relationships, and substance abuse etc. (Daniel et al, 2011 cited by Hartlepool Safeguarding Children Board, September 2013).

It is therefore crucial that we recognise the types of neglect and their impact on children, as well as identifying the underlying causes of the neglect to provide the most appropriate intervention. The following suggestions are some of the most effective strategies to help families manage neglect issues, and should be considered in your case planning:

- interventions must be prioritised to meet a family's immediate needs, such as homelessness or inadequate housing, unemployment and poverty
- i nterventions must be concrete and specific to a family's needs, for example; providing food, nappies, fixing a broken washing machine, setting up cab vouchers to attend appointments, setting up childcare, connecting parents to parenting educational courses etc
- more intensive support should be given when there is a child under 12 months old in the family, or if the child has a disability
- services and interventions should be offered in view of providing long-term solutions and support.

Interventions to improve outcomes for neglected children and young people might include:

1. High quality childcare

Given the lack of stimulation and nurturing in neglectful families, the most effective way of improving outcomes for these children may be to target them directly in the form of high quality child care and education.

2. Home visiting programs

Although the evidence that home visiting reduces the rate of child abuse and neglect is still not conclusive, home visiting can act as an early detection mechanism prior to cases entering the statutory child protection system.

3. Co-located multi-component programs

Greatest gains are made when programs offer co-located services for both parents and children.

For example, where services such as high quality child care and pre-school are co-located and there are strong links to health care services (e.g. baby immunisation) and parent education and support, developmental outcomes for children are improved.

Reference:
This paper was created by Learning & Development and draws on material from the NSW Department of Human Services, Family and Community Services Caseworker Development Course, Child Protection Dynamics, Trainer's Manual, January 2009, V1R6.

Horwath, J (2013) The Complex Issue of Child Neglect, Discussion paper, Hartlepool Safeguarding Children Board.

Watson, J. (2005) Child Neglect: Literature Review. NSW Department of FACS

EMOTIONAL ABUSE IN CHILDREN AND ADOLESCENTS

Emotional maltreatment is also referred to as 'emotional abuse'; 'psychological maltreatment' or 'psychological abuse'. It relates to a parent or caregiver's inappropriate verbal or symbolic acts towards a child or young person and/or a pattern of failing repeatedly over time to provide a child or young person with adequate non-physical nurture and emotional availability. This can include acts of commission or omission. Such acts are highly likely to damage a child's self esteem and social competence (Price-Robertson & Bromfield 2009).

The following five categories all fall within the overall definition of emotional abuse and neglect (Glaser, 1993):

Emotional unavailability, unresponsiveness, and neglect:
Includes parental insensitivity. The primary carer(s) are usually preoccupied with their own particular difficulties such as mental ill health (including postnatal depression) and substance abuse, or with, for example, overwhelming work commitments. They are unable or unavailable to respond to the child's emotional needs, with no provision of an adequate alternative.

Negative attributions and misattributions to the child:
Hostility towards, denigration and rejection of a child who is perceived as deserving these. Some children grow to believe in and act out the negative attributions placed upon them.

Developmentally inappropriate or inconsistent interactions with the child:

- expectations of the child beyond her or his developmental capabilities
- overprotection and limitation of exploration and learning
- exposure to confusing or traumatic events and interactions

This category contains a number of different interactions including exposure to domestic violence and parental (para) suicide. The parents lack knowledge of age-appropriate care giving and disciplining practices and child development, often because of their own childhood experiences. Their interactions with their children, while harmful, are thoughtless and misguided rather than intending harm.

Failure to recognise or acknowledge the child's individuality and psychological boundary:
Using the child for the fulfilment of the parent's psychological needs.
Inability to distinguish between the child's reality and the adult's beliefs and wishes. Factitious Disorder by Proxy is one variant of this category. Category Four of emotional abuse is also not infrequently found in the context of custody and contact disputes within parents' divorce proceedings.

Failing to promote the child's social adaptation:
Promoting mis-socialisation (including corrupting);
Psychological neglect (failure to provide adequate cognitive stimulation and/or opportunities for experiential learning). This category contains both omission and commission, including isolating children and involving them in criminal activities.

Reference:
Price-Robertson, R. & Bromfield, L. (2009) What is child abuse? NCPC Resource Sheet, retrieved from **http://www.aifs.gov.au/nch/pubs/sheets/rs6/rs6.html**

Glaser, D. (2002) 'Emotional abuse and neglect (psychological maltreatment): a conceptual framework', *Child Abuse & Neglect*, 26, 6-7, pp. 697-714.

PSYCHOLOGICAL AND EMOTIONAL ABUSE: BEHAVIOURAL FORMS

Type of Parental Behaviour	Infant	Toddler
Rejecting	refuses to accept child's primary attachment refuses to return smiles, punishes child for vocalizations abandons baby.	actively excludes child from family activities refuses to allow child to hug caregiver, pushes child away; treats child differently from siblings.
Terrorising	consistently violates the child's ability to handle new situations and uncertainty teases or scares infants by throwing them up in the air, despite the child's obvious distress reacts in unpredictable ways to the infant's cries.	uses extreme measures to threaten or punish the child verbal threats of mysterious harm such as attacks by monsters, leaving the child in the dark, etc. alternating rage with warmth.
Ignoring	fails to respond to the infant's social behaviours which form the basis for attachment mechanical care giving with no affection; failing to make eye contact with the infant.	patterns of apathetic treatment and lack of awareness of the child's needs does not speak with the child at meals, leaves the child alone for long periods of time, or does not respond to requests for help.
Isolating	denies the child social interactions with others refuses to allow relatives and family friends to visit the infant leaves the infant unsupervised for long periods of time.	teaches the child to avoid social contact beyond the caregiver-child interaction punishes child for making social overtures to other children; rewards child for withdrawing from social contacts.
Corrupting	reinforces bizarre habits or creates addictions creates drug dependencies; reinforces sexual behaviours.	gives inappropriate reinforcement for antisocial behaviours. Rewards children for aggressive acts toward animals or other children 'brainwashes' child into racism.

Type of Parental Behaviour	School-Aged Child	Adolescent
Rejecting	consistently communicates to children that they are inferior or bad uses labels such as ‘bad child’ or ‘dummy’, tells children they are responsible for family problems.	refuses to acknowledge the changes in children as they grow up, attacking their self-esteem treating an adolescent like a young child, excessive criticism, and verbal humiliation.
Terrorising	places children in ‘double binds’ or places inconsistent or frightening demands on children. sets up unrealistic expectations and criticizes the child for not meeting them. forces the child to choose between parents or primary caretakers. teases the child or plays cruel games.	threatens to or actually subjects the child to public humiliation threatens to reveal embarrassing facts to the child’s friends forces the child into degrading punishments.
Ignoring	fails to protect the child from threats when caregiver is aware of the child’s need for help. fails to protect the child from assault by other family members shows no interest in the child’s education or life outside the home.	gives up parenting roles and shows no interest in the child says, ‘this child is hopeless; I give up’ and means it refuses to listen to children’s discussion of their lives and activities focuses on other relationships at the exclusion of children.
Isolating	attempts to remove the child from social relationships with peers refuses to allow other children to visit the home; keeps the child from engaging in after-school activities.	over-controls the child’s social interactions, restricting the child’s freedom to an extreme degree refuses to allow and/ or punishes the child for engaging in normal social activities (i.e. dating) accuses child of lying, doing drugs, etc. whenever the child leaves home.
Corrupting	continues to involve the child in illegal or immoral behaviour, encouraging the child to be part of this lifestyle at the expense of healthier behaviours	continues to involve the child in illegal or immoral behaviour, encouraging the child to be part of this lifestyle at the expense of healthier behaviours involves the child in prostitution

	involves the child in prostitution encourages the child to hit or verbally abuse siblings encourages drug use.	encourages the child to hit or verbally abuse siblings encourages drug use.

Reference:
This paper was created by Learning & Development and draws from NSW Department of Human Services, Family and Community Services, Caseworker Development Course, Child Protection Dynamics, Trainer's Manual, January 2009, V1R6.

CUMULATIVE HARM

Cumulative harm refers to the effects of multiple adverse or harmful circumstances and events in a child's life. The unremitting daily impact of these experiences on the child can be profound and exponential, and diminish a child's sense of safety, stability and wellbeing.

Cumulative harm may be caused by an accumulation of a single recurring adverse circumstance or event (such as unrelenting low-level care); or by multiple circumstances or events (such as persistent verbal abuse and denigration, inconsistent or harsh discipline, and/or exposure to family violence).

This means cumulative harm may be a factor in any protective concern causing trauma to the child (such as neglect, physical abuse, emotional abuse, sexual abuse or witnessing family violence). Also, because cumulative harm can be caused by a pattern of harmful events, it is unlikely that a child will be reported to child protection explicitly due to concerns about 'cumulative harm'. This means that as caseworkers, you need to be alert to the possibility of multiple adverse circumstances and events in all reports, and to consider not just the information presented in the current report but the past history of involvement that may be indicative of cumulative harm. The focus of any assessment and intervention must be to answer two questions: 'Is this child safe?' and 'How is this child developing?'

Reference:
Victorian Government, Department of Human Services (2014)
http://www.dhs.vic.gov.au/for-service-providers/children,-youth-and-families/child-protection/specialist-practice-resources-for-child-protection-workers/cumulative-harm-specialist-practice-resource

CHILD DEVELOPMENT AND TRAU MA GUIDE

Child development and trauma

0 – 12 Months

Developmental trends

The following information needs to be understood in the context of the overview statement on child development:

0-2 weeks

anticipates in relationship with caregivers through facial expression, gazing, fussing, crying	is unable to support head unaided hands closed involuntarily in the grasp reflex	startles at sudden loud noises reflexively asks for a break by looking away, arching back, frowning, and crying

By 4 weeks

focuses on a face	follows an object moved in an arc about 15 cm above face until straight ahead	changes vocalisation to communicate hunger, boredom and tiredness

By 6-8 weeks

Participates in and initiates interactions with caregivers through vocalisation, eye contact, fussing, and crying	may start to smile at familiar faces may start to ‘coo’	turns in the direction of a voice

By 3-4 months

increasing initiation of interaction with caregivers begins to regulate emotions and self soothe through attachment to primary carer can lie on tummy with head held up to 90 degrees, looking around can wave a rattle, starts to play with own fingers and toes	may reach for things to try and hold them learns by looking at, holding, and mouthing different objects laughs out loud follows an object in an arc about 15 cm above the face for 180 degrees (from one side to the other) notices strangers	may even be able to: keep head level with body when pulled to sitting say “ah”, “goo” or similar vowel consonant combinations blow a raspberry

By 6 months

says “ah”, “goo” or similar vowel consonant combinations sits without support	makes associations between what is heard, tasted and felt	may even be able to roll both ways and help to feed himself learns and grows by touching and tasting different foods

By 9 months		
strongly participates in, and initiates interactions with, caregivers lets you know when help is wanted and communicates with facial expressions, gestures, sounds or one or two words like “dada” and “mamma” watches reactions to emotions and by seeing you express your feelings, starts to recognise and imitates happy, sad, excited or fearful emotions	unusually high anxiety when separated from parents/carers is likely to be wary of, and anxious with, strangers expresses positive and negative emotions learns to trust that basic needs will be met	works to get to a toy out of reach looks for a dropped object may even be able to bottom shuffle, crawl, stand knows that a hidden object exists waves goodbye, plays peekaboo
Possible indicators of trauma		
increased tension, irritability, reactivity, and inability to relax increased startle response lack of eye contact sleep and eating disruption	loss of eating skills loss of acquired motor skills avoidance of eye contact arching back/inability to be soothed uncharacteristic aggression	avoids touching new surfaces eg. grass, sand and other tactile experiences avoids, or is alarmed by, trauma related reminders, eg sights, sounds, smells, textures, tastes and physical triggers
fight, flight, freeze response uncharacteristic, inconsolable or rageful crying, and neediness increased fussiness, separation fears, and clinginess withdrawal/lack of usual responsiveness limp, displays no interest	unusually high anxiety when separated from primary caregivers heightened indiscriminate attachment behaviour reduced capacity to feel emotions – can appear ‘numb’ ‘frozen watchfulness’	loss of acquired language skills genital pain: including signs of inflammation, bruising, bleeding or diagnosis of sexually transmitted disease
Trauma impact		
neurobiology of brain and central nervous system altered by switched on alarm response behavioural changes	regression in recently acquired developmental gains hyperarousal, hypervigilance and hyperactivity	sleep disruption loss of acquired motor skills lowered stress threshold lowered immune system
fear response to reminders of trauma mood and personality changes loss of, or reduced capacity to attune with caregiver	insecure, anxious, or disorganised attachment behaviour heightened anxiety when separated from primary parent/carer	cognitive delays and memory difficulties loss of acquired communication skills

loss of, or reduced capacity to manage emotional states or self soothe	indiscriminate relating reduced capacity to feel emotions - can appear 'numb'	

Parental/carer support following trauma

Encourage parent(s)/carers to: seek, accept and increase support for themselves, to manage their own shock and emotional responses seek information and advice about the child's developmental progress maintain the child's routines around holding, sleeping and eating seek support (from partner, kin, MCH nurse) to understand, and respond to, infant's cues	avoid unnecessary separations from important caregivers maintain calm atmosphere in child's presence. Provide additional soothing activities avoid exposing child to reminders of trauma expect child's temporary regression; and clinginess - don't panic tolerate clinginess and independence take time out to recharge

Child development and trauma

12 Months – 3 Years

Developmental trends

The following information needs to be understood in the context of the overview statement on child development:

By 12 months

enjoys communicating with family and other familiar people seeks comfort, and reassurance from familiar objects, family, carers, and is able to be soothed by them begins to self soothe when distressed understands a lot more than they can say expresses feelings with gestures, sounds and facial expressions expresses more intense emotions and moods	does not like to be separated from familiar people moves away from things that upset or annoy can walk with assistance holding on to furniture or hands pulls up to standing position gets into a sitting position claps hands (play pat-a-cake) indicates wants in ways other than crying learns and grows in confidence by doing things repeatedly and exploring	picks up objects using thumb and forefinger in opposition (pincer) grasp is sensitive to approval and disapproval May even be able to: understand cause and effect understand that when you leave, you still exist crawl, stand, walk follow a one step instruction – "go get your shoes" respond to music

By 18 months

can use at least two words and learning many more	says "no" a lot is beginning to develop a	may even be able to: let you know what he is thinking and feeling through

drinks from a cup can walk and run	sense of individuality needs structure, routine and limits to manage intense emotions	gestures pretend play and play alongside others
By 2 years		
takes off clothing 'feeds'/'bathes' a doll, 'washes' dishes, likes to 'help' builds a tower of four or more cubes recognises/identifies two items in a picture by pointing	plays alone but needs a familiar adult nearby actively plays and explores in complex ways	may even be: able to string words together eager to control, unable to share unable to stop himself doing something unacceptable even after reminders tantrums
By 2 1/2 years		
uses 50 words or more combines words (by about 25 months)	follows a two-step command without gestures (by 25 months) alternates between clinginess and independence	helps with simple household routines conscience is undeveloped; child thinks "I want it, I will take it"
By 3 years		
washes and dries hands identifies a friend by naming throws a ball overhand speaks and can be usually understood half the time	uses prepositions (by, to, in, on top of) carries on a conversation of two or three sentences helps with simple chores may be toilet trained	conscience is starting to develop; child thinks "I would take it but my parents will be upset with me"
Possible indicators of trauma		
behavioural changes, regression to behaviour of a younger child increased tension, irritability, reactivity, and inability to relax increased startle response sleep and eating disruption	loss of eating skills loss of recently acquired motor skills avoidance of eye contact inability to be soothed uncharacteristic aggression	avoids touching new surfaces eg. grass, sand and other tactile experiences avoids, or is alarmed by, trauma related reminders, eg sights, sounds, smells textures, tastes and physical triggers
fight, flight, freeze uncharacteristic, inconsolable, or rageful crying, and neediness fussiness, separation fears, and clinginess withdrawal/lack of usual responsiveness	unusually anxious when separated from primary caregivers heightened indiscriminate attachment behaviour reduced capacity to feel emotions – can appear 'numb', apathetic or limp	loss of acquired language skills inappropriate sexualised behaviour/touching sexualised play with toys genital pain, inflammation, bruising, bleeding or diagnosis of sexually

loss of self-confidence	‘frozen watchfulness’	transmitted disease
Trauma impact		
neurobiology of brain and central nervous system altered by switched on alarm response behavioural changes	regression in recently acquired developmental gains hyperarousal, hypervigilance and hyperactivity sleep disruption	loss of acquired motor skills lowered stress threshold lowered immune system greater food sensitivities
fear response to reminders of trauma mood and personality changes loss of, or reduced capacity to attune with caregiver loss of, or reduced capacity to manage emotional states or self soothe	insecure, anxious, or disorganised attachment behaviour heightened anxiety when separated from primary parent/carer indiscriminate relating increased resistance to parental direction	memory for trauma may be evident in behaviour, language or play cognitive delays and memory difficulties loss of acquired communication skills
Parental/carer support following trauma		
Encourage parent(s)/carers to: seek, accept and increase support for themselves to manage their own shock and emotional responses seek information and advice about the child’s developmental progress maintain the child’s routines around holding, sleeping and eating avoid unnecessary separations from important caretakers	seek support (from partner, kin, MCH nurse) to understand, and respond to, infant’s cues maintain calm atmosphere in child’s presence. Provide additional soothing activities avoid exposing child to reminders of trauma. expect child’s temporary regression; and clinginess - don’t panic tolerate clinginess and independence take time out to recharge	

Child development and trauma **3 – 5 Years**		
Developmental trends		
The following information needs to be understood in the context of the overview statement on child development:		
Between 3 -4 years		
communicates freely with family members and familiar others seeks comfort, and reassurance from familiar family and carers, and is able to be soothed by them has developing capacity to self soothe when distressed	needs adult help to negotiate conflict is starting to manage emotions is starting to play with other children and share has real friendships with other children	holds crayons with fingers, not fists dresses and undresses without much help communicates well in simple sentences and may understand about 1000 words pronunciation has improved,

understands the cause of feelings and can label them extends the circle of special adults eg. to grandparents, baby-sitter	is becoming more coordinated at running, climbing, and other large-muscle play can walk up steps, throw and catch a large ball using two hands and body use play tools and may be able to ride a tricycle	likes to talk about own interests fine motor skill increases, can mark with crayons, turn pages in a book day time toilet training often attained
Between 4 -5 years		
knows own name and age is becoming more independent from family needs structure, routine and limits to manage intense emotions is asking lots of questions is learning about differences between people takes time making up his mind	is developing confidence in physical feats but can misjudge abilities likes active play and exercise and needs at least 60 minutes of this per day eye-hand coordination is becoming more practised and refined cuts along the line with scissors/can draw people with at least four 'parts' shows a preference for being right-handed or left-handed	converses about topics and understands 2500 to 3000 words loves silly jokes and 'rude' words is curious about body and sexuality and role-plays at being grown-up may show pride in accomplishing tasks conscience is starting to develop, child weighs risks and actions; "I would take it but my parents would find out"
Possible indicators of trauma		
behavioural change increased tension, irritability, reactivity and inability to relax regression to behaviour of younger child uncharacteristic aggression Reduced eye contact	loss of focus, lack of concentration and inattentiveness complains of bodily aches, pains or illness with no explanation loss of recently acquired skills (toileting, eating, self-care) enuresis, encopresis	sleep disturbances, nightmares, night terrors, sleepwalking fearfulness of going to sleep and being alone at night inability to seek comfort or to be comforted
mood and personality changes obvious anxiety and fearfulness withdrawal and quieting specific, trauma-related fears; general fearfulness intense repetitive play often obvious involvement of playmates in trauma related play at school and day care separation anxiety with parents/others	reduced capacity to feel emotions - may appear 'numb', limp, apathetic repeated retelling of traumatic event loss of recently acquired language and vocabulary loss of interest in activities loss of energy and concentration at school	sudden intense masturbation demonstration of adult sexual knowledge through inappropriate sexualised behaviour genital pain, inflammation, bruising, bleeding or diagnosis of sexually transmitted disease sexualised play with toys may verbally describe sexual abuse, pointing to body parts and telling about the 'game' they played

loss of self-esteem and self confidence		sexualised drawing
Trauma impact		
behavioural changes hyperarousal, hypervigilance, hyperactivity loss of toileting and eating skills	regression in recently acquired developmental gains sleep disturbances, night terrors	enuresis and encopresis delayed gross motor and visual-perceptual skills
fear of trauma recurring mood and personality changes loss of, or reduced capacity to attune with caregiver loss of, or reduced capacity to manage emotional states or self soothe increased need for control fear of separation	loss of self-esteem and self confidence confusion about trauma evident in play…magical explanations and unclear understanding of causes of bad events vulnerable to anniversary reactions set off by seasonal reminders, holidays, and other events	memory of intrusive visual images from traumatic event may be demonstrated/ recalled in words and play at the older end of this age range, children are more likely to have lasting, accurate verbal and pictorial memory for central events of trauma speech, cognitive and auditory processing delays
Parental/carer support following trauma		
Encourage parent(s)/carers to: seek, accept and increase support for themselves to manage their own shock and emotional responses remain calm. Listen to and tolerate child's retelling of event respect child's fears; give child time to cope with fears protect child from re-exposure to frightening situations and reminders of trauma, including scary T.V. programs, movies, stories, and physical or locational reminders of trauma	accept and help the child to name strong feelings during brief conversations (the child cannot talk about these feelings or the experience for long) expect and understand child's regression while maintaining basic household rules expect some difficult or uncharacteristic behaviour seek information and advice about child's developmental and educational progress take time out to recharge	

Child development and trauma

5 – 7 Years

Developmental trends		
The following information needs to be understood in the context of the overview statement on child development:		
Physical skills		
active, involved in physical activity, vigorous play may tire easily	variation in levels of coordination and skill many become increasingly proficient in skills, games,	some may be able to ride bicycle may use hands with dexterity and skill to make things, do

	sports	craft and build things
Social-emotional development		
has strong relationships within the family and integral place in family dynamics needs caregiver assistance and structure to regulate extremes of emotion generally anxious to please and to gain adult approval, praise and reassurance	conscience is starting to be influenced by internal control or doing the right thing "I would take it, but if my parents found out, they would be disapproving" not fully capable of estimating own abilities, may become frustrated by failure reassured by predictable routines friendships very important, although they may change regularly	may need help moving into and becoming part of a group some children will maintain strong friendships over the period may experience mood swings able to share, although not all the time perception of, and level of regard for self, fairly well developed
Cognitive and creative characteristics		
emerging literacy and numeracy abilities, gaining skills in reading and writing variable attention and ability to stay on task; attends better if interested good communication skills, remembers, tells and enjoys jokes	may require verbal, written or behavioural cues and reminders to follow directions and obey rules skills in listening and understanding may be more advanced than expression perspective broadens as experiences at school and in the community expand	most valuable learning occurs through play rules more likely to be followed if he/she has contributed to them may have strong creative urges to make things
Possible indicators of trauma		
behavioural change increased tension, irritability, reactivity and inability to relax sleep disturbances, nightmares, night terrors, difficulty falling or staying asleep regression to behaviour of younger child	lack of eye contact 'spacey', distractible, or hyperactive behaviour toileting accidents/enuresis, encopresis or smearing of faeces eating disturbances	bodily aches and pains – no apparent reason accident proneness absconding/truanting from school fire lighting, hurting animals
obvious anxiety, fearfulness and loss of self esteem frightened by own intensity of feelings specific fears efforts to distance from feelings of shame, guilt, humiliation and reduced capacity to feel emotions reduced capacity to feel	vulnerable to anniversary reactions caused by seasonal events, holidays, etc repeated retelling of traumatic event withdrawal, depressed affect 'blanking out' or loss of concentration when under stress at school with lowering of performance	explicit, aggressive, exploitive, sexualised relating/engagement with other children sexualised behaviour towards adults verbally describes experiences of sexual abuse pointing to body parts and telling about the 'game' they played

emotions - may appear 'numb', or apathetic 'frozen watchfulness'		sexualised drawing excessive concern or preoccupation with private parts and adult sexual behaviour verbal or behavioural indications of age-inappropriate knowledge of adult sexual behaviour running away from home
Trauma impact		
changes in behaviour hyperarousal, hypervigilance, hyperactivity regression in recently acquired developmental gains sleep disturbances due to intrusive imagery enuresis and encopresis	trauma driven, acting out risk taking behaviour eating disturbances loss of concentration and memory flight into driven activity or retreat from others to manage inner turmoil	post-traumatic re-enactments of traumatic event that may occur secretly and involve siblings or playmates loss of interest in previously pleasurable activities
fear of trauma recurring mood or personality change loss of, or reduced capacity to attune with caregiver loss of, or reduced capacity to manage emotional states or self soothe increased self-focusing and withdrawal concern about personal responsibility for trauma wish for revenge and action oriented responses to trauma	may experience acute distress encountering any reminder of trauma lowered self-esteem increased anxiety or depression fearful of closeness and love	child is likely to have detailed, long-term and sensory memory for traumatic event. Sometimes the memory is fragmented or repressed factual, accurate memory may be embellished by elements of fear or wish; perception of duration may be distorted intrusion of unwanted visual images and traumatic reactions disrupt concentration and create anxiety often without parent awareness vulnerable to flashbacks of recall and anniversary reactions to reminders of trauma speech and cognitive delays
Parental/carer support following trauma		
Encourage parent(s)/carers to: seek, accept and increase support for themselves to manage their own shock and emotional responses listen to and tolerate child's retelling of event – respect child's fears; give child time to cope		expect some time-limited decrease in child's school performance and help the child to accept this as a temporary result of the trauma protect child from re-exposure to frightening situations and reminders of trauma, including scary television programs, movies, stories, and

with fears increase monitoring and awareness of child's play, which may involve secretive re-enactments of trauma with peers and siblings; set limits on scary or harmful play permit child to try out new ideas to cope with fearfulness at bedtime: extra reading time, radio on, listening to a tape in the middle of the night to undo the residue of fear from a nightmare reassure the older child that feelings of fear or behaviours that feel out of control or babyish eg. night wetting are normal after a frightening experience and that the child will feel more like himself or herself with time encourage child to talk about confusing feelings, worries, daydreams, mental review of traumatic images, and disruptions of concentration by accepting the feelings, listening carefully, and reminding child that these are normal but hard reactions following a very scary event maintain communication with school staff and monitor child's coping with demands at school or in community activities	physical or locational reminders of trauma expect and understand child's regression or some difficult or uncharacteristic behaviour while maintaining basic household rules listen for a child's misunderstanding of a traumatic event, particularly those that involve self-blame and magical thinking gently help child develop a realistic understanding of event. Be mindful of the possibility of anniversary reactions remain aware of your own reactions to the child's trauma. Provide reassurance to child that feelings will diminish over time provide opportunities for child to experience control and make choices in daily activities seek information and advice on child's developmental and educational progress provide the child with frequent high protein snacks/meals during the day take time out to recharge

Child development and trauma

7 – 9 Years

Developmental trends

The following information needs to be understood in the context of the overview statement on child development:

Physical skills

improved coordination, control and agility compared to younger children skilled at large motor movements such as skipping and playing ball games	often practises new physical skills over and over for mastery enjoys team and competitive sports and games	improved stamina and strength

Social-emotional development

strong need to belong to, and be a part of, family and peer relationships is increasingly able to regulate emotions increasingly independent of parents; still needs their comfort and security	conscience and moral values become internalised "I want it, but I don't feel good about doing things like that" increased confidence, more independent and takes greater responsibility	peers seen as important spends more time with them friendships are based on common interests and are likely to be enduring feelings of self worth come increasingly from peers friends often same gender,

begins to see situations from others perspective – empathy able to resolve conflicts verbally and knows when to seek adult help	needs reassurance; understands increased effort leads to improvements humour is component of interactions with others	friendship groups small
Self Concept		
can take some responsibility for self and as a family member increasingly influenced by media and by peers learns to deal with success and failure	may compare self with others and find self wanting, not measuring up can exercise self control and curb desires to engage in undesirable behaviour – has understanding of right and wrong	can manage own daily routines may experience signs of onset of puberty near end of this age range (girls particularly)
Cognitive and creative characteristics		
can contribute to long-term plans engages in long and complex conversations	has increasingly sophisticated literacy and numeracy skills	may be a competent user of computers or play a musical instrument
Possible indicators of trauma		
behavioural change increased tension, irritability, reactivity and inability to relax sleep disturbances, nightmares, night terrors, difficulty falling or staying asleep Regression to behaviour of younger child	lack of eye contact ‘spacey’ or distractible behaviour ‘blanking out’ or lacks concentration when under stress at school with lowering of performance eating disturbances	toileting accidents/enuresis, encopresis or smearing of faeces bodily aches and pains - no apparent reason accident proneness absconding/truanting from school fire lighting, hurting animals
obvious anxiety, fearfulness and loss of self-esteem frightened by own intensity of feelings specific post-traumatic fears efforts to distance from feelings of shame, guilt, humiliation reduced capacity to feel emotions – may appear ‘numb’ vulnerable to anniversary reactions caused by seasonal events, holidays, etc.	repeated retelling of traumatic event withdrawal, depressed affect or black outs in concentration blanking out/loss of ability to concentrate when under learning stress at school with lowering of performance explicit, aggressive, exploitive, sexualised relating/engagement with other children, older children or adults hinting about sexual	verbally describes experiences of sexual abuse and describes the ‘game’ they played excessive concern or preoccupation with private parts and adult sexual behaviour verbal or behavioural indications of age-inappropriate knowledge of adult sexual behaviour sexualised drawing or written ‘stories’ running away from home

	experience	
Trauma impact		
changes in behaviour Hyper-arousal, hyper-vigilance, hyper-activity regression in recently acquired developmental gains sleep disturbances due to intrusive imagery	enuresis and encopresis eating disturbances loss of concentration and memory post-traumatic re-enactments of traumatic event that may occur secretly and involve siblings or playmates	trauma driven, acting out risk taking behaviour flight into driven activity or retreat from others to manage inner turmoil loss of interest in previously pleasurable activities
fear of trauma recurring mood or personality changes loss of, or reduced capacity to attune with caregiver loss of, or reduced capacity to manage emotional states or self soothe increased self-focusing and withdrawal concern about personal responsibility for trauma wish for revenge and action oriented responses to trauma	may experience acute distress encountering any reminder of trauma lowered self-esteem increased anxiety or depression fearful of closeness and love	child is likely to have detailed, long-term and sensory memory for traumatic event. Sometimes the memory is fragmented or repressed factual, accurate memory may be embellished by elements of fear or wish; perception of duration may be distorted intrusion of unwanted visual images and traumatic reactions disrupt concentration and create anxiety often without parent awareness vulnerable to flashbacks of recall and anniversary reactions to reminders of trauma speech and cognitive delays
Parental/carer support following trauma		
Encourage parent(s)/carers to: seek, accept and increase support for themselves to manage their own shock and emotional responses remain calm. Listen to and tolerate child's retelling of event - respect child's fears; give child time to cope with fears increase monitoring and awareness of child's play, which may involve secretive re-enactments of trauma with peers and siblings; set limits on scary or harmful play permit child to try out new ideas to cope with fearfulness at bedtime: extra reading time, radio on, listening to a tape in the middle of the night to undo the residue of fear from a nightmare reassure the older child that feelings of fear or behaviours that feel out of control or babyish eg. night wetting are normal after a	expect some time-limited decrease in child's school performance and help the child to accept this as a temporary result of the trauma protect child from re-exposure to frightening situations and reminders of trauma, including scary television programs, movies, stories, and physical or locational reminders of trauma expect and understand child's regression or some difficult or uncharacteristic behaviour while maintaining basic household rules listen for a child's misunderstanding of a traumatic event, particularly those that involve self-blame and magical thinking gently help child develop a realistic understanding of event. Be mindful of the possibility of anniversary reactions remain aware of your own reactions to the child's trauma. Provide reassurance to child that	

frightening experience and that the child will feel more like himself or herself with time encourage child to talk about confusing feelings, worries, daydreams, mental review of traumatic images, and disruptions of concentration by accepting the feelings, listening carefully, and reminding child that these are normal but hard reactions following a very scary event maintain communication with school staff and monitor child's coping with demands at school or in community activities	feelings will diminish over time provide opportunities for child to experience control and make choices in daily activities seek information and advice on child's developmental and educational progress provide the child with frequent high protein snacks/meals during the day take time out to recharge

Child development and trauma

12 - 18 Years

Developmental trends

The following information needs to be understood in the context of the overview statement on child development:

Physical development

significant physical growth and body changes develops greater expertise/skills in sport	changing health needs for diet, rest, exercise, hygiene and dental care puberty, menstruation sexuality and contraception	increased need for nutritious balanced diet, including adequate calcium, protein and iron

Self Concept

can be pre-occupied with self secondary sex characteristics affect self concept, relationships with others and activities undertaken	dealing with own sexuality and that of peers developing identity based on gender and culture	becoming an adult, including opportunities and challenges

Social-emotional development

empathy for others ability to make decisions (moral) values and a moral system become firmer and affect views and opinions spends time with peers for social and emotional needs beyond parents and family peer assessment influences self concept, behaviour/need to conform	may explore sexuality by engaging in sexual behaviours and intimate relationships develops wider interests seeks greater autonomy personally, in decision making more responsible in tasks at home, school and work experiences emotional turmoil, strong feelings and unpredictable mood	interdependent with parents and family conflict with family more likely through puberty able to negotiate and assert boundaries learning to give and take (reciprocity) focus is on the present - may take significant risks understands appropriate behaviour but may lack self

girls have ‘best friends’, boys have ‘mates’	swings	control/insight
Cognitive and creative characteristics		
interdependent with parents and family conflict with family more likely through puberty	can appreciate others’ perspectives and see a problem or situation from different angles	career choice may be realistic, or at odds with school performance and talents
Possible indicators of trauma		
increased tension, irritability, reactivity and inability to relax accident proneness reduced eye contact sleep disturbances, nightmares	enuresis, encopresis eating disturbances/disorders absconding or truanting and challenging behaviours substance abuse	aggressive/violent behaviour fire lighting, hurting animals suicidal ideation self harming eg. cutting, burning
efforts to distance from feelings of shame and humiliation loss of self-esteem and self confidence acute psychological distress personality changes and changes in quality of important relationships evident	increased self-focusing and withdrawal reduced capacity to feel emotions – may appear ‘numb’ wish for revenge and action oriented responses to trauma partial loss of memory and ability to concentrate	trauma flashbacks acute awareness of parental reactions; wish to protect parents from own distress sexually exploitive or aggressive interactions with younger children sexually promiscuous behaviour or total avoidance of sexual involvement running away from home
Trauma impact		
sleep disturbances, nightmares hyperarousal, hypervigilance, hyperactivity eating disturbances or disorders trauma acting out, risk taking, sexualised, reckless, regressive or violent behaviour	flight into driven activity and involvement with others or retreat from others in order to manage inner turmoil vulnerability to withdrawal and pessimistic world view	vulnerability to depression, anxiety, stress disorders, and suicidal ideation vulnerability to conduct, attachment, eating and behavioural disorders
mood and personality changes and changes in quality of important relationships evident loss of, or reduced capacity to attune with caregiver loss of, or reduced capacity to	flight into adulthood seen as way of escaping impact and memory of trauma (early marriage, pregnancy, dropping out of school, abandoning peer group for older set of	Memory for trauma includes: acute awareness of and distress with intrusive imagery and memories of trauma vulnerability to flash backs, episodes of recall, anniversary reactions and seasonal

manage emotional states or self soothe lowered self-esteem	friends) fear of growing up and need to stay within family orbit	reminders of trauma may experience acute distress encountering any reminder of trauma partial loss of memory and concentration

Parental/carer support following trauma

Encourage parent(s)/carers to:

- seek, accept and increase support for themselves to manage their own shock and emotions
- remain calm. Encourage younger and older adolescents to talk about traumatic event with family members
- provide opportunities for young person to spend time with friends who are supportive and meaningful
- reassure young person that strong feelings - whether of guilt, shame, embarrassment, or wish for revenge - are normal following a trauma
- help young person find activities that offer opportunities to experience mastery, control, and self-esteem
- encourage pleasurable physical activities such as sports and dancing
- monitor young person's coping at home, school, and in peer group
- address acting-out behaviour involving aggression or self destructive behaviour quickly and firmly with limit setting and professional help
- take signs of depression, self harm, accident proneness, recklessness, and persistent personality change seriously by seeking help
- help young person develop a sense of perspective on the impact of the traumatic event and a sense of the importance of time in recovering
- encourage delaying big decisions
- seek information/advice about young person's developmental and educational progress
- provide the young person with frequent high protein snacks/meals during the day
- take time to recharge

Child development and trauma

Some important points about this resource

This resource has been prepared because of the importance of professionals in the Family Services, Child Protection and Placement and Support areas understanding the typical developmental pathways of children and the typical indicators of trauma at differing ages and stages. It is intended to inform good practice and assist with the task of an overall assessment, and of itself is not a developmental or risk assessment framework. Rather, it is a prompt for busy workers to integrate knowledge from child development, child abuse and trauma and importantly to offer practical, age appropriate advice as to the needs of children and their parents and carers when trauma has occurred.

Engaging families, carers, significant people and other professionals who know the child well as a source of information about the child, will result in a more complete picture. It is essential to have accurate information about the values and child rearing practices of the cultural group to which a child belongs, in order to appreciate that child's development.

The following points give an essential perspective for using the information in the child development and trauma resource sheets about specific age groups:

Children, even at birth, are not 'blank slates'; they are born with a certain neurological make -up and temperament. As children get older, these individual differences become greater as they are affected by their experiences and environment. This is particularly the case where the child is born either drug dependent or with foetal alcohol syndrome.

Even very young babies differ in temperament e.g. activity level, amount and intensity of crying, ability to adapt to changes, general mood, etc.

From birth on, children play an active role in their own development and impact on others around them.

Culture, family, home and community play an important role in children's development, as they impact on a child's experiences and opportunit ies. Cultural groups are likely to have particular values, priorities and practices in child rearing that will influence children's development and learning of particular skills and behaviours. The development of children from some cultural backgrounds will vary from traditional developmental norms, which usually reflect an Anglo-Western perspective.

As children get older, it becomes increasingly difficult to list specific developmental milestones, as the achievement of many of these depends very much on the opportunities that the child has to practice them, and also, on the experiences available to the child. A child will not be able to ride a bicycle unless they have access to a bicycle.

Development does not occur in a straight line or evenly. Development progresses in a sequential manner, although it is essential to note that while the path of development is somewhat predictable, there is variation in what is considered normal development. That is to say no two children develop in exactly the same way.

The pace of development is more rapid in the very early years than at any other time in life.

Every area of development impacts on other areas. Developmental delays in one area will impact on the child's ability to consolidate skills and progress through to the next developmental stage.

Most experts now agree that both nature and nurture interact to influence almost every significant aspect of a child's development.

General health affects development and behaviour. Minor illnesses will have short to medium term effects, while chronic health conditions can have long-term effects. Nutritional deficiencies will also have negative impacts on developmental progression.

Specific characteristics and behaviours are indicative only. Many specific developmental characteristics should be seen as 'flags' of a child's behaviour, which may need to be looked at more closely, if a child is not meeting them. Practitioners should refer to the Best interests case practice model and relevant specialist practice resources in undertaking further assessments of child and family.

Some important points about development

The information in this resource provides a brief overview of typically developing children. Except where there are obvious signs, you would need to see a child a number of times to establish that there is something atypical. Keep in mind that if children who are in a new or 'artificial' situation, unwell, stressed, interacting with someone they do not know, or if they need to be fed or changed, then their behaviour will be affected and is not likely to be typical for that child. Premature babies, those with low birth weights or those with a chemical dependency will generally take longer to reach developmental milestones.

The indicators of trauma listed in this resource should not become judgements about the particular child or family made in isolation from others who know the child and family well, or from other sources of information. However, they are a useful alert that a more thorough contextual assessment may be required.

There has been an explosion of knowledge in regard to the detrimental impact of neglect and child abuse trauma on the developing child, and particularly on the neurological development of infants. It is critical to have a good working knowledge of this growing evidence base so that we can be more helpful to families and child focused. For a more thorough exploration of the relevant theoretical, research and evidence base, it is recommended that you read the papers on the Best Interests principles, cumulative harm and stability, which are available on the every child every chance website: **www.dhs.vic.gov.au/everychildeverychance**

The following basic points are useful to keep in mind and to discuss with parents and young people:

Children need stable, sensitive, loving, stimulating relationships and environments in order to reach their potential. They are particularly vulnerable to witnessing and experiencing violence, abuse and neglectful circumstances. Abuse and neglect at the hands of those who are meant to care is particularly distressing and harmful for infants, children and adolescents.

Given that children will still form attachments and relationships with caregivers who are abusive and neglectful; they will accommodate to the parenting style they experience. Obviously they have no choice given their age and vulnerability, and in more chronic and extreme circumstances, they will show a complex trauma response. They can eventually make meaning of their circumstances by believing that the abuse is their fault and that they are inherently bad.

Infants, children and adults will adapt to frightening and overwhelming circumstances by the body's survival response, where the autonomic nervous system will become activated and switch on to the freeze/fight/flight response. Immediately the body is flooded with a biochemical response which includes Adrenalin and Cortisol, and the child feels agitated and hyper-vigilant. Infants may show a 'frozen watchfulness' and children and young people can dissociate and appear to be 'zoned out'.

Prolonged exposure to these circumstances can lead to 'toxic stress' for a child which changes the child's brain development, sensitises the child to further stress, leads to persistent state of hyper vigilance and arousal and effects future learning and concentration. Most importantly, it impairs the child's ability to trust and relate to others. When children are traumatised, they find it very hard to regulate behaviour and soothe or calm themselves. They often attract the description of being hyperactive'.

Babies are particularly attuned to their significant caregivers and will sense their fear and traumatic stress; this is particularly the case where family violence is present. They will become unsettled and therefore more demanding of an already overwhelmed parent. The first task of any service is to support the non-offending parent and to engage the family in safety.

Traumatic memories are stored differently in the brain compared to everyday memories. They are encoded in vivid images and sensations and lack a verbal narrative and context. As they are unprocessed and more primitive, they are likely to flood the child or adult when triggers like smells, sights, sounds or internal or external reminders present at a later stage.

These flashbacks can influence our affective and cognitive functioning i.e. intense feelings, that are often unspeakable; or *cognitive*, i.e. vivid memories or parts of memories, which seem to be actually occurring. Alcohol and drug abuse are the classic destructive attempts to numb out the pain and avoid these distressing and intrusive experiences.

Children are particularly vulnerable to flashbacks at quiet times or at bedtimes and will often avoid both, by acting out at school and bedtimes. They can experience severe sleep disruption, intrusive nightmares which add to their 'disregulated' behaviour, and limits their capacity at school the next day. Adolescents will often stay up all night to avoid the nightmares and sleep in the safety of the daylight. Self harming behaviours release endorphins which can become an habitual response.

Cumulative harm can overwhelm a child and particular attention needs to be given to understanding the complexity of the child's experience. These children require calm, patient, safe and nurturing parenting in order to recover, and may well require a multi-systemic response to engage the required services to assist.

The recovery process for children and young people is enhanced by the belief and support of non-offending family members and significant others. They need to be made safe and given opportunities to integrate and make sense of their experiences.

It is important to acknowledge that parents can have the same post-traumatic responses, dependent upon their own childhoods or histories of adversity. For example, a parent may have experienced parenting that produced cognitive-behavioural patterns of functioning that undermines effective parenting and coping strategies. It is normal for parents to feel overwhelmed and suffer shock, anger, severe grief, sleep disturbances and other trauma related responses. Practitioners therefore need to also engage with parents in addressing their own trauma, in order to help them get to a position where they can help their children.

Case practice needs to be child centred and family sensitive.

Factors which pose risks to healthy child development

The presence of one or more risk factors, alongside a cluster of trauma indicators, may greatly increase the risk to the child's wellbeing and should flag the need for further chi ld and family assessment, using the best interests case practice model. The following risk factors can impact on children and families and the care-giving environment:

Child and family risk factors

family violence, current or past

mental health issue or disorder, current or past (including self-harm and suicide attempts)

alcohol/substance abuse, current or past, addictive behaviours

disability or complex medical needs e.g. intellectual or physical disability, acquired brain injury

newborn, prematurity, low birth weight, chemically dependent, foetal alcohol syndrome, feeding/sleeping/settling difficulties, prolonged and frequent crying

- unsafe sleeping practices for infants e.g. side or tummy sleeping, ill-fitting mattress, cot cluttered with pillows, beddin g, or soft toys which can cover infant's face, co -sleeping with sibling or with parent who is on medication, drugs/alcohol or smokes, using other unsafe sleeping place such as a couch, or exposure to cigarette smoke
- disorganised or insecure attachment relationship (child does not seek comfort or affection from caregivers when in need)
- developmental delay
- history of neglect or abuse, state care, child death or placement of child or siblings
- separations from parents or caregivers
- parent, partner, close relative or sibling with a history of assault, prostitution or sexual offences
- experience of intergenerational abuse/trauma
- compounded or unresolved experiences of loss and grief
- chaotic household/lifestyle/problem gambling
- poverty, financial hardship, unemployment
- social isolation (family, extended family, community and cultural isolation)
- inadequate housing/transience/homelessness
- lack of stimulation and learning opportunities, disengagement from school, truanting
- inattention to developmental health needs/poor diet
- disadvantaged community
- racism
- recent refugee experience.

Parent risk factors

- parent/carer under 20 years or under 20 years at birth of first child
- lack of willingness or ability to prioritise child's needs above own
- rejection or scapegoating of child
- harsh, inconsistent discipline, neglect or abuse
- inadequate supervision of child or emotional enmeshment
- single parenting/multiple partners
- inadequate antenatal care or alcohol/substance abuse during pregnancy
- parents' own history of trauma and upbringing.

Wider factors that influence positive outcomes

- sense of belonging to home, family, community and a strong cultural identity
- pro-social peer group
- positive parental expectations, home learning environment and opportunities at major life transitions
- access to child and adult focused services e.g. health, mental health, maternal and child health, early intervention, disability, drug and alcohol, family support, family preservation,

parenting education, recreational facilities and other child and family support and therapeutic services

accessible and affordable child care and high quality preschool programs

inclusive community neighbourhoods/settings

service system's understanding of neglect and abuse.

References:

Victorian Government, Department of Human Services (2014) Child Development and Trauma Guide: Specialist Practice Resource

http://www.dhs.vic.gov.au/for-service-providers/children,-youth-and-families/child-protection/specialist-practice-resources-for-child-protection-workers/child-development-and-trauma-specialist-practice-resource