GLOBAL CAPACITY BUILDING NETWORK
A Branch of LAMb International

Becoming Trauma Informed

AWARENESS MODULE

Trainer Guide

The Impact of Trauma on the Life of a Child

(MAY 2019)

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Trainer Resources

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PRIOR TO TRAINING

TRAINER NOTE: Have the **AGENDA flipchart** posted on the wall and draw the following other flipcharts listed on **TR #3 (page 62)** & post around the room:

- **WIIFM** with header (what people want to learn – use during introduction activity and at end of the training)
- **FLIPCHART #4 – Visual of Boy**

In addition, you can also create a number of additional reference FLIPCHARTS as listed in **TRAINER RESOURCE #3 – List of Flipcharts by Section of Trainer Guide** to use throughout the training as you will referencing the material many times.

Ensure you make enough copies of the **HANDOUT PACKAGEs** for the participants along with the extra (separate handouts):

- **Visual of Child** – cardstock/paper with visual of boy/girl for introduction activity
- **Evaluation** (for last day of training)

Decide whether to incorporate the SLIDEs from **TRAINER RESOURCE #2** throughout your presentations; NOTE the SLIDE numbering may be off then.

Time Frame

The total training time frame is **3 hours**; and can be done in one block of time or 3 separate blocks of 1 hour each.

Materials Needed

PowerPoint presentation (with videos embedded)
Laptop and LCD projector
Flipchart paper & markers
Handout package for each participant (refer to HANDOUTS electronic file folder)

Visual of boy or girl – separate card stock page

- Note Taking Sheet
- Overview: GCBN Trauma Informed Training Series
- Domains of Impairment in Children Exposed to Complex Trauma

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- Case scenarios: Sarah, Larry & Jonathan & Abbie
- Developmental Checklist & Indicators of Developmental Delays for Children Exposed to Trauma
- Essential Skills for Trauma-Informed Care
- Essential Skills of Trauma-Informed Care & How to Help the Child
- Effects of Caregiving
- Circle of Support
- How Am I Going to Use This in My Work with Children?

System Evaluation form - separate

Overview of Module

This awareness-building workshop is designed to introduce participants to the topic of psychological trauma for children and how to build trauma competent care givers and service providers. It is a brief introduction into the more detailed **Building Trauma Competent Care Providers®** training series offered by the Global Capacity Building Network and LAMb International.

This awareness building workshop is designed to define what we mean by psychological trauma and examine its impact on child development. We will introduce practical strategies and tools within the context of the seven essential skills of trauma informed care that are designed to help participants deal with the emotional and behavioral needs of traumatized children.

These awareness building workshop materials have been provided to you by GCBN/LAMb International through the World Without Orphans website to use free of charge. While we encourage you to adapt the resources to "fit" your work/cultural framework (i.e. changing the the handouts, powerpoint slides or case examples to "fit" with your jurisdiction and adding your own examples), we ask that you maintain the integrity of the materials presented here and reference the GCBN & LAMb International as follows:

As GCBN has a **"no-competition" clause** related to all of our training materials, we ask that you do not receive remuneration for providing this training and that you let us know how you are using said material; particularly if extensive edits are being made. For example, you would not be able to privately contract with other systems to offer this training and receive remuneration for such without the written permission of GCBN; c/o Ruby Johnston at the email address below).

We encourage you to present this awareness module in the format presented here. It has been designed using evidence-based adult learning methodology to specifically support the transfer of learning from the training session to real life. As such, we have combined lecture, large group and small group activities in such a way as to keep the learner focused and engaged throughout the training.

We are excited to help your system build a trauma-informed system of care for children and youth who "come from hard places". Together we CAN achieve our vision ***that every child will grow up in a safe, stable and nurturing permanent family, and know their Heavenly Father.***

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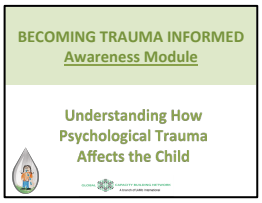
Section 1
Getting Off to a Good Start

Time for this Section: 30 minutes

2 minutes

SLIDE #1 – Becoming Trauma Informed



A. Welcome and Introductions

1. Thank the system/agency for inviting you to deliver this training.
2. Thank participants for attending this session to learn about psychological trauma for children and how to effectively care for children with a trauma history.
3. BRIEFLY introduce yourself to the group share length of time or experience working with children who have a history of trauma.

5 minutes

SLIDE #2 Overview of TI Series

HANDOUT – Overview: Building Trauma Competent…

B. Overview of Training Series & This Module

This 3-hour workshop is designed to introduce participants to the topic of psychological trauma for children and how to build trauma competent care givers, service providers and children's workers

It is a brief introduction into the more detailed **Building Trauma Competent Care Providers®** training series offered by the Global Capacity Building Network of LAMb International.

TRAINER NOTE: Use **TRAINER RESOURCE #1** to provide an overview of the purpose and learning objectives for each of the modules in the *Building Trauma Competent Care Providers Training Series®*.

Use **SLIDE #2** and **HANDOUT – Overview…** and review the overview of the 8 part - *Building Trauma Competent Care Providers Training Series®*

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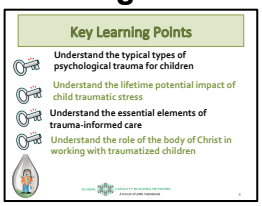
SLIDE #3 – Key Learning Points



This awareness building workshop is designed to define what we mean by psychological trauma and examine its impact on child development and behaviour.

We will introduce key skills needed for trauma informed care that are suggested to help participants deal with the emotional and behavioral needs of traumatized children.

Review **Key Learning Points** for this awareness session on **SLIDE #3:**

1. Understand the typical types of psychological trauma for children
2. Understand the lifetime potential impact of child traumatic stress
3. Understand the essential elements of trauma-informed care
4. Understand the role of the body of Christ in working with traumatized children

HANDOUT – NOTE Taking Sheet page 7

These learning points, along with other power point slides have been included in **HANDOUT –NOTE Taking Sheet (page 7)** for their reference/use throughout the session.

TR #2 on pages 57 – 59 of this Trainer Guide

TRAINER NOTE: OPTIONAL: In order to achieve this learning objective #4, use **TRAINER RESOURCE #2** (on page 57 – 59 of this Trainer Guide) and the **SLIDEs #45 – 51** at the end of the power point presentation file and insert them throughout the training presentation (especially at breaks or after videos/large group discussions/ small group activities[1].

NOTE: The numbering of the power point slides will have to be adjusted by the trainer as they won't match from this point on if you have inserted the new slide.

[1] **TRAINER RESOURCE #2** is adapted from an excerpt from Wellman, Jack (2015).

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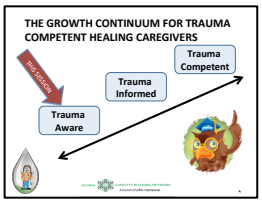
SLIDE #4  	**TRAINER NOTE:** Clarify that this training is only awareness building. The journey to becoming trauma competent in our work with children involves a more intensive learning process as depicted on **SLIDE #4**. This awareness workshop is the first step. Encourage participants to use the **BIBLIOGRAPHY** at the back of the handout package to begin their learning journey. Also encourage them to attend other more in-depth training workshops such as the 8-part training series offered through the Global Capacity Building Network. **TRAINER NOTE**: Provide the information about how to contact the GCBN listed in the footer if asked.
5 minutes **Flipchart #1 Agenda** (listed on page 60 of this manual under **TRAINER RESOURCE #3 – Flipcharts**)	**C. Other Stuff to Get Us Off to a Good Start** 1. Reviewing the ***AGENDA*** for each day (which should be on a flipchart for participants to follow along throughout the training). It is important to make the connection between what people want to learn & what will be covered in the agenda. 2. **Develop Group Guidelines: (keep this moving)** It is recommended that you develop these guidelines WITH the group rather than FOR the group. It is more likely that participants will follow through with guidelines that THEY develop vs. those that YOU impose on the group. The **purpose** of establishing group guidelines is to encourage participation and to create a safe training environment. Reinforce that you want to ensure that the training progresses smoothly and safely for everyone in the group. Since much of the workshop depends upon their participation, you want to encourage learning by asking questions, by challenging each other, by raising problems and issues, and by contributing their own experiences and knowledge.

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Therefore request the group's assistance in coming up with a few group guidelines or "things you need from the trainer and/or the participants to make this a successful learning experience for yourself…"

In developing group guidelines, it is important to include the following:

- Maintain confidentiality
- Demonstrate respect for one another (ask the group to define what respect looks and sounds like; e.g. one person speaking at a time, not letting side conversations detract from others' learning, challenge the idea but not the person, no put downs, etc.)
- Contribute to a safe training environment
- Share your ideas/expertise so that we can learn from one another

- Only share what you are comfortable sharing and letting others hear
- Start/end times & break
- Cell phones on vibrate and no texting please
- Attendance expectations (check with management)

Post Group Guidelines flip chart on the wall so that people can refer to it throughout the training. You may have to provide gentle reminders of these group guidelines if you see/hear anyone deviating from the agreed upon guidelines.

TRAINER NOTE: Trainers should be aware and recognize signs where the participant is upset and may need a few quiet minutes alone with the presenter. Providing a forum for discussion should help all participants clear their heads and help them continue with the training in a good emotional space.

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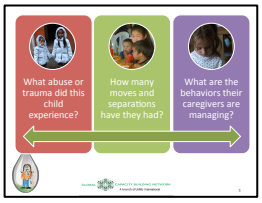
15 minutes

7 minutes

Separate HANDOUT – Visual of Boy/ Girl on cardex or think paper (1 copy/participant)

SLIDE #5



E. Goals & Essentials of Trauma Informed Care

1. SMALL GROUP ACTIVITY

Ask each participant to think about a child they know/live or work with who has experienced trauma of some sort. Ask them to take the visual of the child (**Visual of Boy/Girl – separate HANDOUT**) and answer the three questions from **SLIDE #5**:

1. What abuse or trauma did the child experience?
2. How many moves and separations did the child have in their life up to now?
3. What are the behaviors that their caregivers are having to deal with now?

Give the group about **five minutes** to work independently. (Play quiet music if possible while they answer the questions.)

- After each participant has had time to answer the questions ask the group to work with a partner and share what they know about their child.

- Then ask for two volunteers to share their child with the large group.
- Following this sharing, ask the group to keep the child that in the mind throughout the three hour session.

- Summarize this activity with the following lecture/over view…

2. LECTURE/LGD: Goals of TI Care

8 minutes

TR #4 & FC #3 (see page 60 this manual)

TRAINER NOTE: We suggest you use **TRAINER RESOURCE #4** and place the **CARDSTOCK VISUAL of the BOY** in the middle of the **FLIPCHART #3** on the wall.

Also place **TRAINER RESOURCE #5 – Goals of TI Care** around the visual of the boy **(TRAINER RESOURCE #5)** as you explain the 3 goals. These goals match those of the World Without Orphans.

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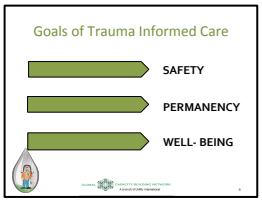
TR #5 posted on wall manual) **SLIDE #6 Goals of TI**



page 7 of NOTE Taking Handout

There are **three goals of trauma informed care (SLIDE #6 & TRAINER RESOURCE #4)** that everyone who touches the life of a child should know.

1. **Safety** – the environment in which the child lives should be safe physically, emotionally, psychologically and spiritually.

2. **Permanency** – every decision made for a child should be made with the lens of permanency (a permanent family/community)…does the child live with his permanent family?

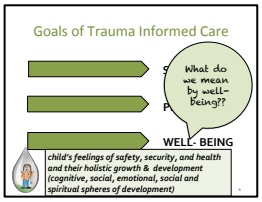
4. **Well-being** – every aspect of a child's life from home to school to community should promote his well-being…

> **TRAINER NOTE:** You can also refer participants to pages 6 – 8 of NCTSN's 2013 *Tool Kit* for how trauma negatively impacts children's ability to achieve these fundamental goals – this toolkit is referenced in their HANDOUT Bibliography.

Large Group Discussion: Ask "What does well-being mean to you?" Accept answers as given.

Ensure you define well-being to include the child's feelings of safety, security, and health and their holistic growth & development (cognitive, social, emotional, social and spiritual spheres of development).

Animate call out circle & box on SLIDE #6:



Segue to Next Section: The next section is designed to promote our understanding of what we mean by trauma; with an emphasis on psychological trauma…

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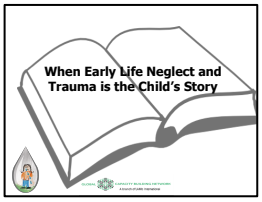
Section 2
When Early Neglect & Trauma is the Child's Story

Time for this Section: 40 minutes (55 with break)

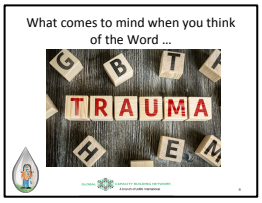
SLIDE #7 – Section 2



18 minutes

2 minutes

SLIDE #8 – Trauma?



2 minutes

Encourage participants to take notes beside the relevant slides on **Note Taking HANDOUT page 7 again**

Purpose of this section is to help participants understand the extent of trauma many children experience and how this can continue to impact their lives beyond childhood.

A. Introducing the Issue: Distinguishing Trauma from Stress

1. Large Group Discussion:

Use **SLIDE #8** and ask the questions: ***What comes to mind when you think of the word trauma***. What specific kinds of trauma have children in care experienced?

2. LECTURE: Defining Trauma

"Defining trauma is not without its controversies. Those who approach it from a clinical perspective tend to view trauma as a combination of a terrible event or series of events that involve real or perceived threats of death or serious injury, or threat to the physical integrity of the person or others, and from which that person experiences overwhelming fear, hopelessness, helplessness, or horror" (Wilson et al., 2013, page 3.

Sometimes when people experience an event so terrible and frightening that it is difficult for most of us to imagine, they suffer from shock. This can happen after a one-time natural catastrophe like a hurricane or a flood or after an experience like seeing a bomb attack or seeing someone shot.

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Sometimes this kind of shock can happen when an unpleasant experience occurs time and time again in a child's life, like being beaten or sexually abused repeatedly. Particular signs of stress can occur after experiencing an event directly, from witnessing an event, or even hearing about such an event in regard to a family member[i].

Some survivors of trauma, however, favor a definition that places greater emphasis on the subjective experience and the level of stress an individual perceives, independent of the actual event or series of events that threaten the individual with death, serious injury, or loss of their physical integrity such as a highly emotional argument with a family member (US Dept of Health & Social Services, Substance Abuse and Mental Health Services Administration, 2012).

Either way, this type of overwhelming stress, especially when it occurs over and over, can create significant long-term impacts, including changes in the physiology of the brains of developing children.

Before we go any further, let's look at trauma through the eyes of a child…

8 minutes

SLIDE #9 – Video

3. **VIDEO: (OPTIONAL Section)** ***Through Our Eyes: Children, Violence & Trauma***. Show this **8-minute** video, which helps participants understand how violence and trauma affect children, including the serious and long-lasting consequences for their physical and mental health; signs that a child may be exposed to violence or trauma; and the staggering cost of child maltreatment to families and communities.

TRAINER NOTE: ***Video is embedded in SLIDE #9 – just click the stat arrow.*** It is also available at: https://www.youtube.com/watch?v=z8vZxDa2KPM

Watch participants as they are viewing this video to see their emotional reactions. You may want to briefly de-brief their reactions/questions concerning the video. Encourage participants to talk to you at break in more detail if needed.

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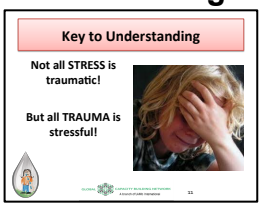
6 minutes

SLIDE #10 – What is Stress?

Encourage participants to take notes beside the relevant slides on **Note Taking HANDOUT page 7 again**

SLIDE #11– Key to Understanding



4. LECTURE/LGD – Distinguishing Stress from Trauma?

a) Use **SLIDE #10** to ask the group to define stress.

b) Then define stress & distinguish it from trauma using the information below:

Just as it is for trauma, it is difficult to define stress. Stress is a somewhat ambiguous term because it is experienced differently by everyone. Stress can come from experiences that are problematic and also from experiences that are quite pleasant – such as a holiday or a birth in the family which can be quite demanding on the families time and energy.

Animate box on SLIDE #10: Stress has been defined as: "a state of mental or emotional strain or tension resulting from adverse or demanding circumstances"[2].

Generally speaking, stress is a sense of being overloaded and a person's concern whether they can cope with the pressures that have presented themselves. While stress puts pressures upon us to respond, to cope, and so on, there is not a sense that it is life threatening.

c) **LGD:** Ask the participants to identify their own experiences related to every day stressful events.

They may suggest things such as "being late for work", "being late for this training", "missing a deadline", "missing an appointment", applying for a new job, preparing a meal for 50 relatives at a holiday, etc. Reinforce that stress is different from trauma…

While **not all stress is traumatic, ALL TRAUMA IS STRESSFUL!! (SLIDE #11)**

Segue to Next Section: The next section will help use distinguish between the different types of trauma that children experience.

[2] *Oxford Living Dictionaries* (2019). Available at: https://en.oxforddictionaries.com/definition/stress

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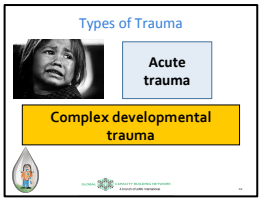
15 minutes

5 minutes

Encourage participants to take notes beside the relevant slides on **Note Taking HANDOUT page 7 again**

Refer to overview of different types of trauma on **page 43 – 45** of this Trainer Guide for your information

SLIDE #12 – Types of Trauma



Animate 1st box

Animate 2nd box

B. Types of Trauma

1. LECTURE:

When early life trauma and neglect is the child's story, that child is set on a trajectory path that leads them to behavioral issues and possible mental health issues well into adulthood – unless that trajectory is interrupted with trauma-informed care by trauma competent healing parents and social workers.

There are six risks factors when looking at trauma:

1. Difficult/traumatic time during pregnancy
2. Difficult birth
3. Separation/hospitalization at birth
4. Acute trauma
5. Abuse
6. Neglect

As we discussed previously, there is a difference between stress and what is called **Acute Trauma.**

Acute traumatic stress is defined as a terrifying event that a person experiences, witnesses or learns about in which grave physical harm occurred or was threatened. The traumatic event causes the person to feel intense fear, terror or a sense of helplessness. Acute traumatic stress is experienced by anyone witnessing a traumatic event or violence.

2. Large Group Discussion (LGD): Ask the group for examples of an acute traumatic event they have heard about or experienced. They may suggest such things as a car accident, hurricane, fire, etc.

Most of the orphaned children we work with will have experienced stress. They also may have experienced acute trauma. Furthermore, most of them will have experienced far more. This is called ***complex developmental trauma***.

As defined by the National Child Traumatic Stress Network, "complex trauma describes both children's exposure to multiple traumatic events—often of an invasive, interpersonal nature—and the wide-ranging, long-term effects of this exposure.

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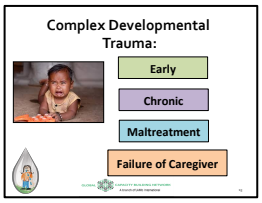
	These events are severe and pervasive, such as abuse or profound neglect. They usually occur early in life and can disrupt many aspects of the child's development and the formation of a sense of self. Since these events often occur with a caregiver, they may interfere with the child's ability to form a secure attachment. Many aspects of a child's healthy physical and mental development rely on this primary source of safety and stability"[3]
10 minutes **SLIDE 16 – Complex Developmental Trauma**  Read articles in ARTICLES #1 to #3 (listed on **page 43** of this Trainer Guide) **Flipchart #4 with visual of boy (TR #5) again** Refer to **TR #6** for Case Vignette	**3. LECTURE/LGD – Complex Developmental Trauma:** There are four elements that comprise **complex developmental trauma**[4]: 1. **Early** - when the trauma is experienced prenatally, in infancy or during the early years of a child's life. 2. The trauma is **chronic** in that a young child is exposed to danger over time that is unpredictable or uncontrollable. 3. This danger is **always a form of maltreatment** – physical, emotional, psychological or sexual abuse or some form of neglect. 4. The trauma is significant for the child because of the **absence of a caregiver** who reliably and responsively protects and nurtures the child from the traumatic experiences. **TRAINER NOTE:** Use the events listed on **TRAINER RESOURCE #6 – Case Vignette** to describe a child's complex trauma beginning with his prenatal experience. OR share a story of a child that you are familiar with – being CAREFUL to ensure confidentiality – not giving the

[3] NCTSN (undated). *Complex Trauma.* Available on their website at: https://www.nctsn.org/what-is-child-trauma/trauma-types/complex-trauma

[4] This material is adapted from http://nctsn.org/trauma-types/complex-trauma

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child's name or where he/she lives now.

When the early caregiving relationship provides the primary context within which children learn about themselves, their emotions and their relationships, a secure attachment happens.

This secure attachment supports a child's development in many essential areas, including his capacity for regulating physical and emotional states, his sense of safety (without which he will be reluctant to explore his environment), his early knowledge of how to exert an influence on the world, and his early capacity for communication.

When the child-caregiver relationship is the source of trauma, the attachment relationship is severely compromised.

Caregiving that is erratic, rejecting, hostile, or abusive leaves a child feeling helpless and abandoned.

In order to cope, the child attempts to exert some control, often by disconnecting from social relationships or by acting coercively towards others.

Children exposed to unpredictable violence or repeated abandonment often learn to cope with threatening events and emotions by blocking out how they process of what is happening around them.

As a result, when they are faced with challenging situations in the future, they cannot formulate a coherent, organized response. These children often have great difficulty regulating their emotions, managing stress, developing concern for others, and using language to solve problems.

Large Group Discussion (LGD): Ask the group for examples of complex trauma that they have heard about or experienced. They may suggest such things as chronic neglect, chronic physical, sexual, emotional abuse, exposure to chronic family violence and so on.

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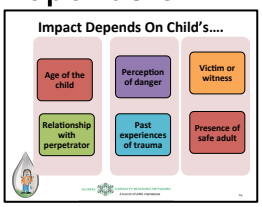
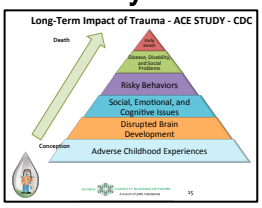
7 minutes

SLIDE #14 – Impact Depends on…



Encourage participants to take notes beside the relevant slides on **Note Taking HANDOUT page 8**

SLIDE 18 – ACEs Pyramid



C. How Trauma Impacts Development

1. LECTURE: Degree of Impact[5]:

The degree of impact to which trauma can have on a child depends on a number of factors:

- Age and developmental stage at time of trauma experience(s)
- Child's perception of danger faced
- Whether child was a victim or witness
- Child' s relationship with perpetrator
- Child's past experiences of trauma
- Presence/availability of a safe adult who can offer help and protection

2. LECTURE/LGD: ACE Childhood Experiences

TRAINER NOTE: It is important to read the overview of the ACEs study on **page 46 – 47** of this Trainer Guide to be familiar with the findings in detail.

In 1998, Dr. Vince Felitti (and others) published his long-term study of childhood trauma, or what is now referred to as Adverse Childhood Experiences (ACEs).

Adults who experienced multiple adverse childhood experiences (ACEs), including child maltreatment, are more likely to:

a) Have disrupted brain development

b) Have significant social, emotional and cognitive issues

c) Develop health risk behaviors such as alcoholism, drug abuse, depression, suicide attempts, smoking, physical inactivity, severe obesity, early initiation of sexual activity, having over 50 sexual intercourse partners, contracting sexually transmitted disease, and intimate partner violence

[5] This material is adapted from *Child Welfare Trauma Training Toolkit* (NCTSN, 2013, page 19 – 20)

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HANDOUT – ACES SURVEY page 29 – 29  	d) The number of adverse childhood experiences showed a graded relationship to the presence of adult diseases including heart disease, cancer, chronic lung disease, skeletal fractures, and liver disease (Felitti et al., 1998). e) More recent analyses of the ACEs data has suggested that ACEs may be an indicator of a chaotic family environment that results in an increased risk of premature death among family members (Brown, et al., 2009). As you can see, complex developmental trauma can have a lasting, lifelong impact on the child. Encourage participants to complete the ACES study at the back of their handout package for their own self-awareness either during the following break or after this session. It is important that participants do this on their own to promote their self-awareness and need to ensure that their own trauma experiences/history doesn't negatively impact their ability to help a child work through their own history. **TRAINER NOTE:** Again, trainers should be aware and recognize signs where the participant is upset and may need a few quiet minutes alone with the presenter (perhaps during the break). Providing a forum for discussion should help all participants clear their heads and help them continue with the training in a good emotional space.
15 minutes	**COFFEE BREAK**

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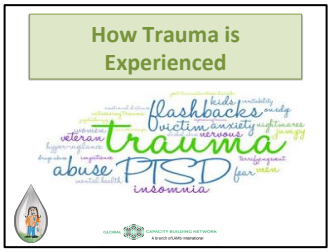
Section 3
How Trauma is Experienced by the Child

Time for This Section: 25 minutes

SLIDE #16



6 minutes

The **purpose of this section** is understand children's different responses to trauma and how experience creates a blue-print for children's behaviour.

A. We Learn By Experience

TRAINER NOTE: This in an interactive experiential role play between the trainer and participants.

SLIDE #17 – We learn by experience

1. Simulated Experience (3 minutes)

Imagine you are walking through a park and you glance down and there is a huge snake **(SLIDE #17)**

How do you react?

SLIDE #18 – Walk #2

Now imagine you are walking through that park a few days later.

How do you think you might feel? **(SLIDE #18)**

SLIDE #19 – Walk #3

And if you see a stick on the path, you will be startled because you think it is a snake again.

And now every time you go on a walk, you will feel that way because the snake changed your perception of the park and even your safety. **(SLIDE #19)**

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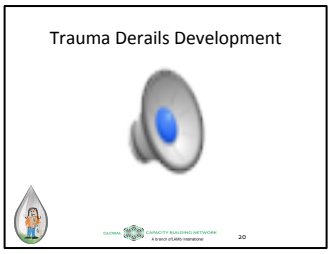
SLIDE #20 – Video

3 minutes



Encourage participants to jot down notes while watching the video on **page 8** of the **HANDOUT package – Note Taking Sheet continued**

You can refer them to the 2 slides at the bottom of this page for a summary of how a person's internal alarm system works related to trauma

Living in this type of trauma state has far-reaching effects on nearly every aspect of the child's development and functioning.

2. Video: Toxic Stress Derails Development

Introduce video on **SLIDE #20**: To fully understand how the brain reacts to danger it helps to take examine what is going on.

Encourage participants to jot down notes and refer to the slides noted on **HANDOUT – Note Taking Sheet again.**

TRAINER NOTE: ***Video is embedded in SLIDE #20 – just click the stat arrow.*** It is also available at: https://www.youtube.com/watch?v=rVwFkcOZHJw

After the video, summarize the following key points:

Learning how to cope with adversity is an important part of healthy development. While moderate, short-lived stress responses in the body can promote growth, toxic stress is the strong, unrelieved activation of the body's stress management system in the absence of protective adult support.

Without caring adults to buffer children, the unrelenting stress caused by extreme poverty, neglect, abuse, or severe maternal depression can weaken the architecture of the developing brain, with long-term consequences for learning, behavior, and both physical and mental health.

Healthy development in the early years provides the building blocks for educational achievement, economic productivity, responsible citizenship, lifelong health, strong communities, and successful parenting of the next generation. And the opposite is true; children who experience complex trauma have distinct disadvantages when it comes to their brain development.

Segue to Next Section: Let's look at the impact of trauma on the child's development.

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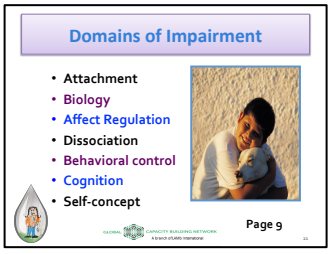
10 minutes

Refer participants to **page 10 in HANDOUT PACKAGE – Domains of Impairment** to follow along with review

SLIDE #21 – Domains of Impairment



B. Domains of Impairment

TRAINER NOTE: Refer participants to **page 10 in the HANDOUT PACKAGE – Domains of Impairment** and highlight the following key points:

(SLIDE #21) Children who experience trauma suffer impairment in many of the following areas[6]:

- ***Attachment.*** Traumatized children feel that the world is uncertain and unpredictable. Their relationships can be characterized by problems with boundaries as well as distrust and suspiciousness. As a result, traumatized children can become socially isolated and have difficulty relating to and empathizing with others.

- ***Biology.*** Traumatized children demonstrate biologically based challenges, including problems with movement and sensation, hypersensitivity to physical contact, and insensitivity to pain. They can have problems with coordination, balance, and body tone, as well as unexplained physical symptoms and increased medical problems (e.g., asthma, skin problems, and autoimmune disorders).

- ***Mood regulation***. Children exposed to trauma can have difficulty regulating their emotions as well as difficulty knowing and describing their feelings and internal states. They may struggle to communicate their wishes and desires to others.

- ***Dissociation***. Some traumatized children experience a feeling of detachment or depersonalization, as if they are "observing" something happening to them that is unreal. They can also demonstrate amnesia-like states[7].

[6] This material is adapted from *Child Welfare Trauma Training Toolkit* (NCTSN, 2008, page 7 – 8) and referenced in Spinazzola, et al. (2005).

[7] **TRAINER NOTE:** Participants might not know the meaning of these two words on the handout: Analgesia – cannot feel pain; Somatization – stress goes to a physical response

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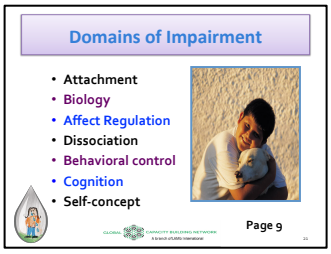
SLIDE #21 – Domains of Impairment again 	• ***Behavioral control.*** Traumatized children can demonstrate poor impulse control, self-destructive behavior, and aggression towards others. Sleep disturbances and eating disorders can also be manifestations of child traumatic stress. • ***Cognition.*** Children exposed to trauma can have problems focusing on and completing tasks in school as well as difficulty planning for and anticipating future events. They sometimes have difficulty understanding their own contribution to what happens to them. Some traumatized children demonstrate learning difficulties and problems with language development. • ***Self-concept.*** Traumatized children can experience a lack of a continuous, predictable sense of self. They can suffer from disturbances of body image, low self-esteem, shame, and guilt. It is important for us to recognize the complexity of a child's lifetime trauma history and to not focus solely on the single event that might have precipitated a report. **2. Individual Reflection:** Trainer asks each participant to spend time looking over the handout (page 7) and identify children with whom they work and know that might be experiencing challenges in each of these seven (7) developmental components.
4 minutes	**B. Trauma Impacts Physical Health**[8] From infancy through adolescence, the body's biology develops. Normal biological function is partly determined by environment. When a child grows up afraid or under constant or extreme stress, the immune system and body's stress response systems may not develop normally.

[8] NCTSN (undated). *Effects of Complex Trauma.* Available at: https://www.nctsn.org/what-is-child-trauma/trauma-types/complex-trauma/effects

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	Later on, when the child or adult is exposed to even ordinary levels of stress, these systems may automatically respond as if the individual is under extreme stress. For example, an individual may experience significant physiological reactivity such as rapid breathing or heart pounding, or may "shut down" entirely when presented with stressful situations. These responses, while adaptive when faced with a significant threat, are out of proportion in the context of normal stress and are often perceived by others as "overreacting" or as unresponsive or detached. Children with complex trauma histories may develop chronic or recurrent physical complaints, such as headaches or stomachaches. Adults with histories of trauma in childhood have been shown to have more chronic physical conditions and problems. They may engage in risky behaviors that compound these conditions (e.g., smoking, substance use, and diet and exercise habits that lead to obesity). Complexly traumatized youth frequently suffer from body dysregulation, meaning they over-respond or under-respond to sensory stimuli. For example, they may be hypersensitive to sounds, smells, touch or light, or they may suffer from anesthesia and analgesia, in which they are unaware of pain, touch, or internal physical sensations. As a result, they may injure themselves without feeling pain, suffer from physical problems without being aware of them, or, the converse – they may complain of chronic pain in various body areas for which no physical cause can be found.

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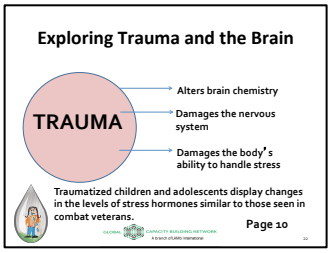
C. Trauma & the Developing Brain

5 minutes

SLIDE #22 – Exploring Trauma and the Brain



Encourage participants to take notes beside the relevant slides on **Note Taking HANDOUT page 11**

1. LECTURE – Trauma & the Developing Brain

SLIDE #21: Complex trauma in a child's environment can impair the development of their brain and nervous system:

- Trauma can have serious consequences for the normal development of children's brains, brain chemistry, and nervous system.
- Trauma-induced alterations in biological stress systems can adversely affect brain development, cognitive and academic skills, and language acquisition.
- These changes may affect the way traumatized children and adolescents respond to future stress in their lives, and may also influence their long-term health.
- Traumatized children and adolescents display changes in the levels of stress hormones similar to those seen in combat veterans.

In early childhood, trauma can affect a child biologically and cognitively and is associated with reduced size of the cortex. The cortex is responsible for many complex functions, including memory, attention, perceptual awareness, thinking, language, and consciousness.

Trauma can also affect "cross talk" between the brain's 2 hemispheres, including the parts governing emotions.

Furthermore, an absence of mental stimulation in neglectful environments may limit the brain from developing to its full potential. **SLIDE #23** shows two brain scans. The one on the left is that of a normal three-year-old child who had the good parenting, nurturing and developed normally.

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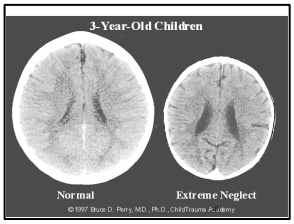
SLIDE 23 – Brain Scan 3 yr. olds  Refer to page 48 of this Trainer Guide for more information on this brain scan. DO NOT lecture on it though	The brain scan on the right is that of a three year old who was completely left on his own in an orphanage in Romania (look at how small it is in comparison to the "healthy" brain on the left. Researchers found that found that early institutionalization; severe physical and emotional neglect changed both the structure and the function of the brain. Any time spent in an institution shrunk the volume of gray matter, or brain cell bodies, in the brain. Brain development is relationship dependent and in institutions, those relationships generally do not happen. **Segue to Next Section:** In general, children who have been exposed to repeated stressful or traumatic events within an environment of abuse and neglect are more vulnerable to experiencing traumatic stress. Let's look at the impact of trauma on attachment in more detail…
15 minutes **2 minutes** Refer to an excellent ARTICLE #4 (in the ARTICLES folder) to enhance your understanding as noted on page 49 of this manual	**D. Trauma Derails Attachment & Relationship Development**[9] The importance of a child's close relationship with a caregiver cannot be overestimated. Through relationships with important attachment figures, children learn to trust others, regulate their emotions, and interact with the world; they develop a sense of the world as safe or unsafe, and come to understand their own value as individuals. When those relationships are unstable or unpredictable, children learn that they cannot rely on others to help them. When primary caregivers exploit and abuse a child, the child learns that he or she is bad and the world is a terrible place.

[9] Source: NCTSN (undated). *Effects of Complex* Trauma (page 1). Available at: https://www.nctsn.org/what-is-child-trauma/trauma-types/complex-trauma/effects

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5 minutes Encourage participants to take notes beside the relevant slides on **Note Taking HANDOUT page 11 again** 	The majority of abused or neglected children have difficulty developing a strong healthy attachment to a caregiver. Children who do not have healthy attachments have been shown to be more vulnerable to stress. They have trouble controlling and expressing emotions, and may react violently or inappropriately to situations. Our ability to develop healthy, supportive relationships with friends and significant others depends on our having first developed those kinds of relationships in our families. A child with a complex trauma history may have problems later in life as an adult with their romantic relationships, in friendships, and with authority figures, such as teachers or police officers. **LECTURE – Attachment & Cycle of Trust**[10] It is important to understand healthy attachment and how it typically occurs. The development of attachment is an ongoing social process. It is not a one-time event. Attachment develops over time as one's needs are met by significant others. The more consistently a child's needs are met over time by trusted others, the deeper the level of attachment. If needs are met inconsistently (neglect), attachment may be weakened. If the caregivers change frequently (child moves from one placement to another), attachment may be interrupted or impaired. Impaired attachment has extremely serious long-term consequences on the individual's ability to sustain relationships, to become independent, and to develop a conscience and self-discipline. One of the proposed theories about how children become attached to their caregivers is a process known as the "Arousal/Relaxation" Cycle," developed by pediatrician, Dr. Vera Fahlberg (*Attachment and*

[10] The information on the Cycle of Trust (Fahlberg, 1979) is typically taught to parents in the Pre-Service Foster Care Training Series. However, what is not generally taught is the neurobiological aspect of attachment breakdown.

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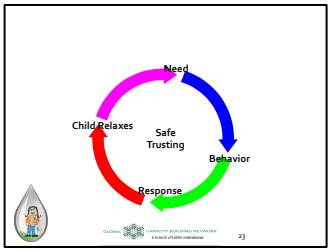
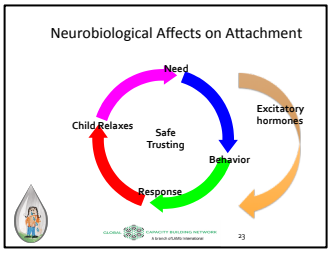
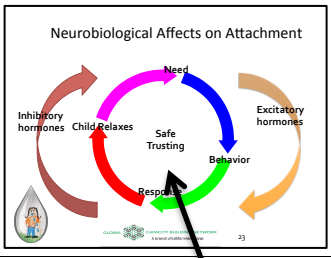
FLIPCHART #4 & SLIDE #24 – Trust Cycle



SLIDE #24 again



with animation



Separation, 1979).
This is also known as the cycle of trust (**SLIDE #24 & FLIPCHART #4).**

Infants and small children have many basic needs: food, clothing, shelter, diaper changes, love, comfort, protection, and stimulation. Children express their **needs (animate)** by certain **behaviours (animate)** such as crying, whining, screaming, clinging, following, and so on.

When a child has a need that leads to arousal….which sets the **excitatory hormones** to work – like cortisol (**animate arrow on SLIDE #24)**

The caregiver determines what need the child is expressing, and **responds (animate)** by taking steps to meet the need. Once the need is met, the child enters a period of **relaxation (animate)** and quiescence until the next need state arises.

Once the parent responds, the **inhibitory hormones**, like serotonin, kick in and the child relaxes and feels safe (**animate arrow on SLIDE #24).**

What happens with our children is that the parents may come inconsistently, not at all or with chaos or violence and the inhibitory hormones never kick in and the child never relaxes. That means that the child lives in the chronic state of fear.

This cycle is repeated many times during each day. Children come to recognize the environment as predictable and consistent, which **increases trust** in the caregiver **(animate)**.

Consequently, the child becomes attached to the primary caregiver. The separation of a child from the primary caregiver interrupts this process and threatens the development of a healthy attachment.

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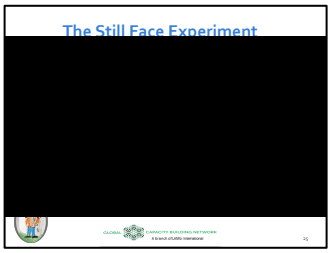
3 minutes **SLIDE #25 – Still Face Experiment**  Information on this video is summarized on page 65 of this Trainer Guide	Let's watch this process in action… **2. VIDEO & LGD – *Still Face Experiment*** Using the "Still Face" Experiment (2007), conducted by Dr. Edward Tronick, a mother denies her baby attention for a short period of time. You can see how the child tries to reconnect with the mother and then quickly becomes upset and disregulated; only to return to a happy state once the mother reconnects physically, verbally and emotionally with her child. **TRAINER NOTE:** The **3-minute** video is embedded in the **SLIDE #25**. Just click the arrow to start the video clip.
5 minutes Encourage participants to jot down notes on **page 10 – More Note Taking** during the video & discussion 	**3. Large Group Discussion:** Guide the group in a discussion about their thoughts and feelings after viewing this video. What would it feel like to be a child who experienced this type of wonderful and absent connection with their mother day after day, or even many times during a single day? What would be happening in her brain as well as emotionally and psychologically? **ANSWER:** In these situations, the child does not receive any chance to return to the good, and may become stuck. This video depicts how prolonged lack of attention can move an infant from good socialization, to periods of bad but repairable socialization. **TRAINER NOTE:** There are some very serious ethical problems with an experiment of this nature. We should NEVER be experimenting with children; and certainly not in the area of creating attachment deficits. **Segue to Next Section:** While the GCBN trauma training series delves into these domain impairments in more detail, we will provide an overview of how trauma impacts a child's development across the developmental domains.

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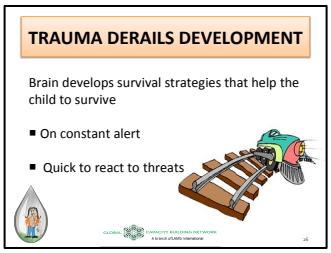
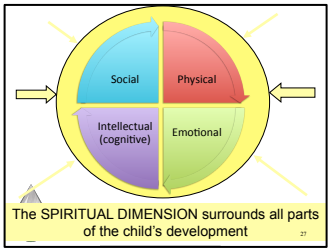
Section 4
Trauma & the Age Related Developmental Impact

Time for This Section: 35 minutes

SLIDE #26 – Trauma Derails Dev'mt



SLIDE #27 – Dev'mtal Domains



Encourage participants to take notes beside the relevant slides on **More Note Taking HANDOUT page 11 again**

A. Trauma Derails Development

1. LECTURE: Trauma Derails Development

(SLIDE #26) As mentioned in a previous section, the brain develops survival strategies (behaviours) that help the child to survive. It results in the child being on constant alert and being quick to react to threats – real or perceived.

(SLIDE #27) In addition, trauma can impact all domains of a child's development: physical, emotional, intellectual (cognitive), social and spiritual (which is illustrated as the circle surrounding the other 4 domains completing their identity wheel).

TRAINER NOTE: Refer to **page 50 – 51** of this Trainer Guide for overview of developmental domains. DO NOT lecture on this information though – it is to enhance your understanding. Module 3 and 4 of the GCBN Trauma Series goes into more details here.

30 minutes

15 minutes

2. Small Group Activity

1. Divide participants into the following three (3) small groups and assign them one of the following developmental scenarios:

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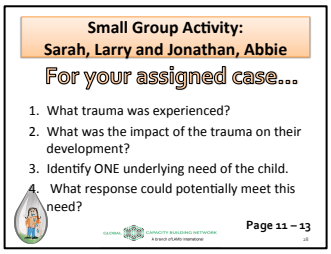
SLIDE #28 – Small Group Activity…

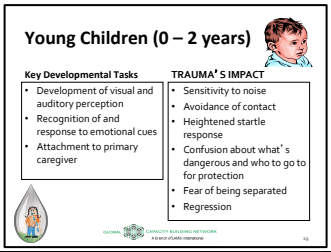


Encourage participants to use **Scenario HANDOUT (page 11 – 13 of Handout package)** to answer the questions

Reporting out:

15 minutes

SLIDE #29 – Infants & Toddlers



- Infants & toddlers (Sarah)
- Preschool children (Larry & Jonathon)
- School-aged children (Abbie)

2. They are to discuss what trauma the child or children experience and what impact that has had on their development by answering the questions on **SLIDE #28** and their handout pages #11 – 13)

   a. What trauma did the child experience?

   b. What is the impact of the trauma on their development

   c. What is the underlying need of the child?

   d. What response could potentially meet this need?

3. Give the small groups up to **15 minutes** to complete the assignment.

Have each small group report their responses, and then the trainer adds the lecture content on the **SLIDEs #29 – 31** respectively after group 1, then group 2 and then group 3.

After each group presents their information, the trainer then displays/reviews any missing points on the corresponding developmental slides (refer to additional content information on the NOTES PAGE of each slide):

a. **Infants & Toddlers – Sarah** (**SLIDE# 29**)[11]

- Become passive, quiet, and easily alarmed
- Become fearful, especially regarding separations and new situations
- Experience confusion about assessing threat and finding protection, especially in cases where a parent or caretaker is the aggressor
- Regress to recent behaviors (e.g., baby talk, bed-

[11] ANSWERS for the impact of trauma on stages of development is referenced from the work of NCTSN (2008, page 17).

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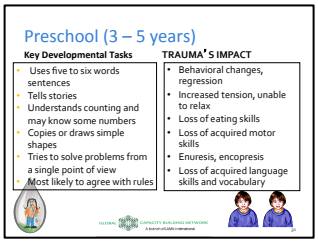
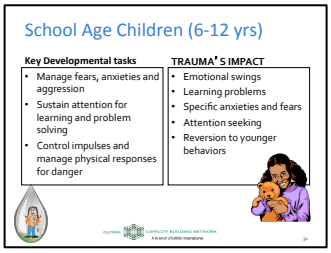
SLIDE #30 – Pre-schoolers



SLIDE #31 – School Age



wetting, crying)
- Experience strong startle reactions, night terrors, or aggressive outbursts

b. **Preschool – Larry and Jonathan (SLIDE #30)**

- Behavioral changes, regression
- Increased tension, unable to relax
- Loss of eating skills
- Loss of acquired motor skills
- Enuresis, encopresis
- Loss of acquired language skills and vocabulary

c. **School Age Children – Abbie** (**SLIDE #31**)

In addition to the points noted on **SLIDE #31:**

- Emotional swings
- Learning problems
- Specific anxieties and fears
- Attention seeking
- Reversion to younger behaviors

The responses of school-age children include their experiencing a wider range of unwanted and intrusive thoughts and images.

School-age children think about frightening moments that occurred during their traumatic experiences. They also go over in their minds what could have stopped the event from happening and what could have made it turn out differently. They can have thoughts of revenge that they cannot resolve.

School-age children respond to very concrete reminders (e.g., someone with the same hairstyle as an abuser, or the monkey bars on a playground where a child got shot), and are likely to develop intense, specific new fears that link back to the original danger.

They can easily have "fears of recurrence" that result in their avoiding even enjoyable activities they would like to do.

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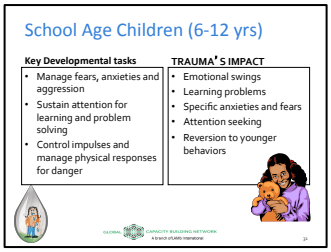
More than any other group, school-age children may shift between shy or withdrawn behavior and unusually aggressive behavior.

Normal sleep patterns can be disturbed, and their lack of restful sleep can interfere with daytime concentration and attention.

SLIDE #32 – Adolescents



TRAINER NOTE: There is no case scenario for adolescents (13+ years). Trainer uses **SLIDE #39** to conclude with the review of how trauma impacts the adolescent's development.

Impact of Trauma:

- Difficulty imagining or planning for the future
- Over or underestimating danger
- Inappropriate aggression
- Reckless and /of self-destructive behaviors

d. ***Adolescents (13+ years)***

Adolescents are particularly challenged by their traumatic stress reactions. They may interpret their reactions as childish or as signs of "going crazy," being weak, or being different from everyone else. They may be embarrassed by bouts of fear and exaggerated physical responses. They may believe that they are unique in their pain and suffering, resulting in a sense of personal isolation.

Adolescents are also very sensitive to the failure of family, school, or community to protect them or to carry out justice. After a traumatic event, they may turn even more to peers to evaluate risks and to support and protect them. Adolescent behavior in response to traumatic reminders can go to either of two extremes: reckless behavior that endangers themselves (such as self-cutting) and others, or extreme avoidant behavior that can derail their adolescent years. Adolescents may attempt to avoid overwhelming emotions and physical responses through the use of alcohol and drugs. Late-night studying, television watching, and partying can mask an underlying sleep disturbance.

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SLIDE #33 – Excellent Resource

Refer participants to the HANDOUT – Developmental Checklist on **pages 14 – 19**

TRAINER NOTE: We will explore the impact of trauma on the adolescent's development in much more detail in *Module 4* of the GCBN trauma training series.

Use **SLIDE #33** and refer to **Excellent Resource – Developmental Checklist** on **pages 14 – 19 of the HANDOUT package** to use when assessing the potential impact of trauma on their child (there are boxes for YES and NO responses) for each of the stages of child development

Segue to Next Section: We will now explore how we can help a child impacted by trauma.

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Section 5
What is a Trauma Competent Healing Caregiver?

Time for This Section: 30 minutes

4 minutes

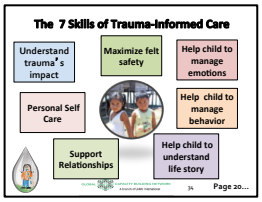
A. Trauma Competent Care Giver Skill Set

LECTURE: Essentials of TI Care (5 minutes)

Because most of the trauma experienced by children occurs in the context of a relationship with an adult, their healing process must also occur within the context of an adult – a trauma competent healing caregiver. This section explores the characteristics of such an adult.

TRAINER NOTE: Place **TRAINER RESOURCE #7 – Essential Skills Placards** around the visual of the boy **(TRAINER RESOURCE #4)** as you explain the skills.

SLIDE #34 Essential Skills of TI Care



TR #7 posted on wall around TR #4/FC#3

Refer participants to **Handout – Essential Skills of TI Care (page – 21) of**

(SLIDE #34) The seven (7) essential skills of trauma informed (TI) care outlined by the National Child Traumatic Stress Network (March 2008a) require that:

1. Caregivers understand the impact trauma has on child's behavior, development, and relationships.
2. Caregivers maximize the child's sense of safety.
3. Caregivers assist children in reducing overwhelming emotion.
4. Caregivers children to understand and modify overwhelming behaviors.
5. Caregivers support and promote positive and stable relationships in the life of the child.
6. Caregivers help the child develop a strength-based

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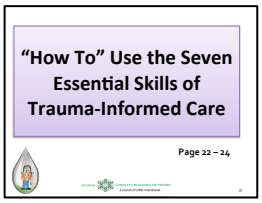
HANDOUT Package

understanding of his/her life story and to make new meaning of their trauma history and current experiences.

7. Caregivers demonstrate the ability to take care of themselves.

While this training module does not afford us the time to explore each of these skill sets in more detail – or to practice these skills – we have included a valuable handout from the *GCBN Module 1 – Becoming Trauma Informed: Impact of Trauma on the Life of a Child* session entitled **Essential Skills of Trauma Informed Care and "How-To" Help the Child** for your reference.

SLIDE #35 – "How To"



Refer participants to **page 22 – 24** of the **HANDOUT package** for this handout

Encourage participants to attend this (or similar) training series to enhance their knowledge and skill application of these essential skills.

Segue to Next Section: Because helping children deal with their trauma history is best conducted through the relationship, we want to focus of how to prepare yourself to be a trauma competency healing caregiver.

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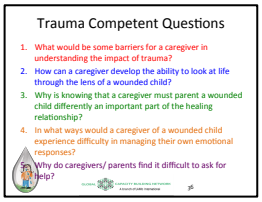
16 minutes

10 minutes

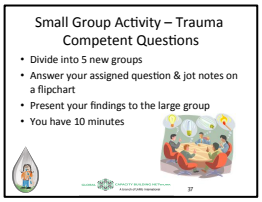
Coloured sticks or stickers to make 5 small groups

TR #8 (one for each group)

SLIDE #36 – Trauma Competent Questions



SLIDE #37 – Small Group Activity



B. Self-Awareness – Asking Trauma Competent Questions

TRAINER NOTE: This activity is designed to ensure the group understands the importance of self-awareness and self-reflection if we are to successful care for traumatized children.

1. **Create 5 new small groups**

TRAINER NOTE: Use colored sticks or stickers (to match the colours on **SLIDE #36** with the **5 Trauma Competent Questions** (listed on **TRAINER RESOURCE #8**).

Have participants pick a stick/sticker randomly and then convene with other participants of the same colour to form their 5 new groups.

Assign each group one of the **5 Trauma Competent Questions (TRAINER RESOURCE #8)**:

1. What would be some barriers for a caregiver in understanding the impact of trauma?
2. How can a caregiver develop the ability to look at life through the lens of a wounded child?
3. Why is knowing that a caregiver must parent a wounded child differently an important part of the healing relationship?
4. In what ways would a caregiver of a wounded child experience difficulty in managing their own emotional responses?
5. Why do caregivers/ parents find it difficult to ask for help?

2. **Review Instructions**

Each group can take up to **10 minutes** to answer their question and be prepared to report out to the large group

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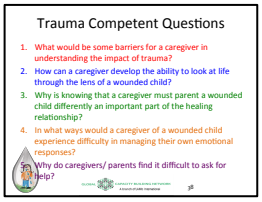
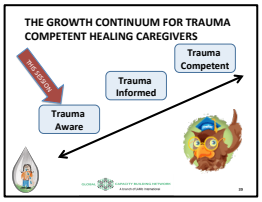
5 minutes **Use SLIDE #38 to guide the reporting out process**  (duplicate of SLIDE #36)	**3. Debrief Small Group Work** Have each group report their work and demonstrate their understanding of the question. This reporting out process should take **up to 5 minutes**. Trainer can add to their work if necessary. **TRAINER NOTE:** Watch your timing here as you need to give 15 minutes for the final wrap up section. **ANSWERS:** Refer to pages 52 – 53 of this Trainer Guide for potential answers to the small group work.
1 minute **SLIDE #39 – The growth continuum again**  	**4. Concluding LECTURE:** A Trauma Competent Healing Caregiver/Parent is someone who has an awareness of their own personal history and its potential impact on their capacity to care for a child with a traumatic past. **(SLIDE#39)** As we discussed at the beginning of this awareness session, we are on a journey of growth. First by becoming aware of the impact of traumatic life experiences on a child, then growing in knowledge and eventually mastering skills as we become more and more competent. A trauma competent healing caregiver understands the seven (7) essential skills and moves from awareness to knowledge to skill application **(SLIDE #39 again – arrow going upward)**.

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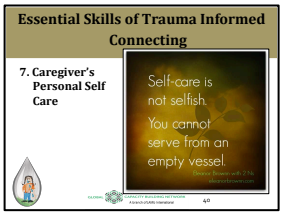
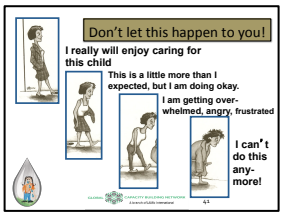
2 minutes

SLIDE #40 – Essential Skill #7



SLIDE 41 – Don't let this happen to you



C. Essential Skills #7. Caregiver's Personal Self-Care

1. LECTURE: Importance of Self Care

SLIDE #40 – *Self care in not selfish. You cannot serve from an empty vessel* (Eleanor Brown)

Begin this section by saying: We don't want this to happen to you (SLIDE #41):

- Going from "I really will enjoy caring for this child"; to
- "This is a little more than I expected, but I am doing okay", to
- "I am getting overwhelmed, angry & frustrated!" to finally
- "I can't do this anymore!!!"

We must pay attention to the warning signs that we are not doing well. Ask the group: ***"What are those warning signs?"***

Possible ANSWERS: (Animate boxes on SLIDE #41)

- Physical exhaustion
- Emotional Exhaustion
- Eating/sleeping problems
- Irritability
- Isolating one's self

3 minutes

2. LECTURE & ACTIVITY: Circle of Support

TRAINER NOTE: You can skip this activity if time is short – just encourage people to complete this self-awareness assessment.

As we will explore Skill Set #7 in more detail in the GCBN *Module 7 – Secondary Traumatic Stress*, it important it is for a worker/caregiver to have a circle of support.

Having one or two people to help us in our role as care provider to a child from hard places is NOT enough to support those who are working with children or youth

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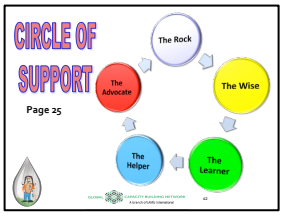
affected by trauma. Rather, workers require a Circle of Support that includes at least five (5) connections needed to combat burnout and secondary traumatic stress.

SLIDE #42 – Circle of Support



As a final self-care activity, we will create our own personal Circle of Support by naming at least one person for each of the areas. You cannot use any person's name more than once.

Encourage participants to use **HANDOUT – Circle of Support (on page 25 of the HANDOUT Package)** and complete their circle of support as we review some ideas of what this person can do for you…

HANDOUT – Effects of Caregiving (page 25 of HANDOUT PACKAGE)

Use **SLIDE #42** to review the five components of the Circle of Support:

Person #1: The Rock – this person is always there for you. They are there in the most difficult of times and will continue to accept and support you unconditionally.

Person #2: The Wise – this person will always tell you the truth even when it is not what you want to hear.

Person #3: The Learner – they will do research for you, learn with you and support you on your journey to learn new and more effective ways of working and managing stress associated with the job.

Person #4: The Helper – this person is there to pitch in – they know when you need a break and are willing to help out. They help you with paper work, answer your calls, take your turn with a particular task and so on.

Person #5: The Advocate – they "have your back" and will always stand up for your and support you. They are your "cheering section."

We need all five of these types of people in our lives – knowing who is there and where we need to develop support is a good first step in our self care efforts.

Conclusion: Encourage participants to work at developing and finding a person for each of the 5 types of helpers in their journey towards being trauma competent.

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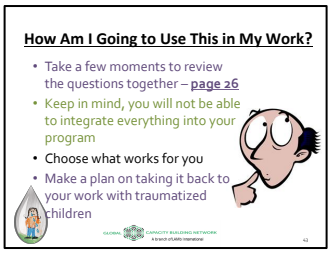
Section 6
Action Planning, TOL, Evaluation & Closing

Time Needed for This Section: up to 10 minutes

Please do NOT short-change the action planning and closure section. It is important that participants have time to reflect on the training, what they learned, and how they plan to bring their learning back to the office/home.

5 minutes

SLIDE #43 – How Am I Going to Use …



HANDOUT – How Am I Going to Use This in My Work? (page 26 of the Handout Package)

Purpose of This Section: To provide closure to the training, to encourage the **transfer of learning (TOL)** process by ensuring participants create their own action plan for how they will bring this training back to their work/home life.

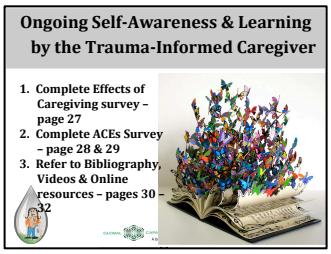
A. Taking It Back

Use **SLIDE #43** to review the instructions for this activity.

1. **Action Plan** – Have each person reflect on the questions on **HANDOUT – How Am I Going to Use This in My Work? (page 26 of the Handout Package)**.

   Have them keep in mind that they may not be able to integrate everything into their program so encourage them to choose what works for them.

SLIDE #44 – TOL



HANDOUT – Caregiving Survey page 27 & ACES SURVEY

2. **Transfer of Learning Opportunities** – On-going Self Awareness and Learning by the Trauma Competent Care Provider. Encourage participants to complete:

   a. **Effects of Caregiving Survey** to identify their level of negative vs. positive perspective related to working with traumatized children

   b. **ACES Survey** to identify their own trauma history and how this might impact their ability to work with traumatized children

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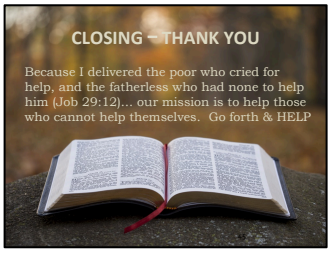
page 28 – 29 HANDOUT – Circle of Support page 25 again 	c. Complete **HANDOUT – Circle of Support** to ensure that they have someone for each of the key 5 support pillars. Once again, encourage participants to take ongoing training and development to fine-turn and enhance their knowledge and skills and work towards being trauma competent.
5 minutes WIIFM Flipchart HANDOUT package Bibliography, Videos & Online resources 	**B. Evaluation & Closing** Refer participants to the **WIIFM Flipchart** and review what they originally identified as their learning objectives. Ask the group whether we effectively met these learning objectives in this training module. 1. Circulating system's evaluation forms to be completed; 2. Informing participants about the helpful resources in their handout package including **books, videos workbooks, articles, and the online resources are valuable resources for further development on pages 30 – 32** of the handout package. 3. After sharing the closing comment below, close the group with a prayer (if it is a faith based group) and encourage participants to continue on their journey to being a trauma competent care giver.
SLIDE #45 – use to close your session 	**Conclusion Comment:** When Job wrote "Because I delivered the poor who cried for help, and the fatherless who had none to help him" (Job 29:12) he was saying that he knew that it was good to help those who cannot help themselves; like the poor and the orphans. God will hold us accountable for everything we do in this life but also includes our neglecting the widows and orphans because if we do neglect them, this only proves that we are not practicing nor living out what James calls pure religions (James 1:27).
	THE END OF TRAINING

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TRAINER ADDENDUM

The **purpose of this ADDENDUM** is to provide additional content information or trainer-specific instructions to help process the various activities built into the trainer manual. New trainers can use this ADDENDUM to build their confidence and competence for delivering the standardized Trauma-Informed (TI) Training series by the Global Capacity Building Network (GCBN) – a branch of LAMb International.

It is important to remember that the TI training manuals have been **designed to support the adult learning and transfer of learning process**. As such, it is recommended that the trainers follow the sequencing laid out in this manual as there is "a method to our madness!". This awareness module has been designed using evidence-based curriculum development techniques. Similarly, it is critically important that each of the training modules in the TI series is delivered in the recommended sequencing (from #1 to #8) as each builds on the next.

While you are "married to the content", you can be "engaged to the process"; meaning that, while you need to stay "true" to the content as provided in the manual and this ADDENDUM, you can choose the method of delivering said activities – e.g. if you want to do a large group discussion vs. a small group activity that may be fine. Furthermore, you are able to contextualize the handouts or case examples to "fit" with your jurisdiction.

If you wish to make any content related changes, you need to FIRST summarize your changes in writing to GCBN (c/o Ruby Johnston at the email address below). Ms. Johnston will review your requested changes and communicate the GCBN position in writing within 30 days of receipt of said request. Until such a change request is granted, we ask that you continue to use the original materials. Thank you.

All of the training materials provided by GCBN – e.g. trainer manuals, handouts, power point presentations, etc. – are only to be used in the performance of providing Trauma-Informed Training Series in your country. Written approval is required to provide this training outside of your agency's jurisdiction. While you are able to include your agency's logo in the header/footer of the materials, we ask that you also include the GCBN logo/information since all of the materials are the **© of GCBN** (as referenced on page 2 of this manual).

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Section 2. When Early Neglect & Trauma is the Child's Story

Section 2A. Introducing the Issues: Distinguishing Trauma from Stress

TRAINER NOTE: Trainers **must** be familiar with and be able to **refer to the key points** related to the theory on trauma as it relates to children including being able to distinguish between stress, acute & chronic trauma, and complex developmental trauma. Read the **ARTICLEs #1 – 3** found in the ARTICLES electronic folder to help enhance your understanding of the topic area. DO NOT add content though.

ARTICLE #1: ***CW360° Trauma-Informed Child Welfare Practice*** (CASCW, Winter 2013).

ARTICLE #2: ***What is Complex Trauma? A Resource Guide for Youth and Those Who Care About Them*** (NCTSN, 2017)

ARTICLE #3: ***Effects of Traumatic Events on Children: An Introduction*** (Perry, 2003).

Section 2B. Types of Traumatic Stress[ii] [12] (on page 14 of the Trainer Guide)

Acute trauma: A single traumatic event that is limited in time is called an acute trauma. An earthquake, dog bite, or motor vehicle accident are all examples of acute traumas. Other examples include:

- School shootings
- Gang-related incidents
- Terrorist attacks
- Natural disasters (e.g., wildfires, floods, hurricanes)
- Serious accidents
- Sudden or violent loss of a loved one
- Physical or sexual assault (e.g., being shot or raped)

Over the course of even a brief acute event, a child may go through a variety of complicated sensations, thoughts, feelings, and physical responses that rapidly shift as the child assesses and reassesses the danger faced and the prospects of safety. As the event unfolds, the child's pounding heart, out-of-control emotions, and other physical reactions are frightening in and of themselves and contribute to his or her sense of being overwhelmed.

[12] **Excerpt from pages 6 – 8 of *Child Welfare Trauma Training Toolkit: Comprehensive Guide*** *(2nd edition)* by the National Child Traumatic Stress Network (NCTSN, March 2008). Used with permission.

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Chronic trauma: When a child has experienced multiple traumatic events, the term chronic trauma is used. Chronic trauma may refer to multiple and varied events—such as a child who is exposed to domestic violence, is involved in a serious car accident, and then becomes a victim of community violence—or longstanding trauma such as physical abuse or war. One prevalent from of chronic trauma is child neglect, defined as the failure to provide for a child's basic physical, medical, educational, and emotional needs. Neglect can have serious and lifelong consequences. Particularly for very young children who are completely dependent on caregivers for sustenance, experiencing neglect can feel acutely threatening. Neglect often occurs in the context of other maltreatment, such as periods of abandonment and abuse, and is frequently associated with other psychosocial stressors and forms of adversity such as extreme poverty and parental substance abuse.

The effects of chronic trauma are often cumulative, as each event serves to remind the child of prior trauma and reinforce its negative impact. A child exposed to a series of traumas may become more overwhelmed by each subsequent event and more convinced that the world is not a safe place. Over time, a child who has felt overwhelmed over and over again may become more sensitive and less able to tolerate ordinary everyday stress.

Complex developmental trauma: Complex trauma is a term used by some experts to describe both exposure to chronic trauma—usually caused by adults entrusted with the child's care, such as parents or caregivers—and the immediate and long-term impact of such exposure on the child (Cook et al., 2005). Children who have experienced complex trauma have endured multiple interpersonal traumatic events (such as physical or sexual abuse, profound neglect, or community violence) from a very young age (typically younger than age 5).

When trauma is associated with the failure of those who should be protecting and nurturing a child, it has profound, multifaceted, and far-reaching effects on nearly every aspect of the child's development and functioning. These children suffer impairment in many of the following areas:

- *Attachment.* Traumatized children feel that the world is uncertain and unpredictable. Their relationships can be characterized by problems with boundaries as well as distrust and suspiciousness. As a result, traumatized children can become socially isolated and have difficulty relating to and empathizing with others.

- *Biology.* Traumatized children demonstrate biologically based challenges, including problems with movement and sensation, hypersensitivity to physical contact, and insensitivity to pain. They can have problems with coordination, balance, and body tone, as well as unexplained physical

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symptoms and increased medical problems (e.g., asthma, skin problems, and autoimmune disorders).

- *Mood regulation.* Children exposed to trauma can have difficulty regulating their emotions as well as difficulty knowing and describing their feelings and internal states. They may struggle to communicate their wishes and desires to others.

- *Dissociation.* Some traumatized children experience a feeling of detachment or depersonalization, as if they are "observing" something happening to them that is unreal. They can also demonstrate amnesia-like states.

- *Behavioral control.* Traumatized children can demonstrate poor impulse control, self-destructive behavior, and aggression towards others. Sleep disturbances and eating disorders can also be manifestations of child traumatic stress.

- *Cognition.* Children exposed to trauma can have problems focusing on and completing tasks in school as well as difficulty planning for and anticipating future events. They sometimes have difficulty understanding their own contribution to what happens to them. Some traumatized children demonstrate learning difficulties and problems with language development.

- *Self-concept.* Traumatized children can experience a lack of a continuous, predictable sense of self. They can suffer from disturbances of body image, low self-esteem, shame, and guilt.

Children involved with the child welfare system are likely to have experienced both acute and chronic trauma, in environments characterized by adversity and deprivation, and often without the mitigating influence of consistent and supportive caregivers. It is important for child welfare workers to recognize the complexity of a child's lifetime trauma history and to not focus solely on the single event that might have precipitated a report. In general, children who have been exposed to repeated stressful events within an environment of abuse and neglect are more vulnerable to experiencing traumatic stress.

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Section 2C(2). How Trauma Impacts Development (Refer to page 17 of Trainer Guide)

Excerpt from the Adverse Childhood Experience Study:[iii]

ABOUT THE STUDY: What everyone should know!

Over 17,000 Kaiser Permanente members voluntarily participated in a study to find out about how stressful or traumatic experiences during childhood affect adult health. After all the identifying information about the patients was removed, the Centers for Disease Control and Prevention processed the information the patients provided in their questionnaires.

Here's What Was Learned:

Many people experience harsh events in their childhood. 63% of the people who participated in the study had experienced at least one category of childhood trauma. Over 20% experienced 3 or more categories of trauma, which is referred to as "***Adverse Childhood Experiences***" (ACEs).

- 11% experienced emotional abuse.
- 28% experienced physical abuse.
- 21% experienced sexual abuse.
- 15% experienced emotional neglect.
- 10% experienced physical neglect.
- 13% witnessed their mothers being treated violently.
- 27% grew up with someone in the household using alcohol and/or drugs.
- 19% grew up with a mentally-ill person in the household.
- 23% lost a parent due to separation or divorce.
- 5% grew up with a household member in jail or prison.

ACEs seem to account for one-half to two-thirds of the serious problems with drug use. They increase the likelihood that girls will have sex before reaching 15 years of age, and that boys or young men will be more likely to impregnate a teenage girl. Adversity in childhood causes mental health disorders such as depression, hallucinations and post-traumatic stress disorders.

The more categories of trauma experienced in childhood, the greater the likelihood of experiencing:

- ❖ alcoholism and alcohol abuse
- ❖ chronic obstructive pulmonary disease (COPD)
- ❖ depression
- ❖ fetal death
- ❖ poor health-related quality of life
- ❖ illicit drug use

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- ischemic heart disease
- liver disease
- risk for intimate partner violence
- multiple sexual partners
- sexually transmitted diseases (STDs)
- smoking
- obesity
- suicide attempts
- unintended pregnancies

For more information about the ACE Study, email carolredding@acestudy.org, visit www.acestudy.org, or the Centers for Disease Control and Prevention at: http://www.cdc.gov/NCCDPHP/ACE/[13]

Section 3C(1). Trauma & the Developing Brain (Refer to page 24 - 25 of Trainer Guide)

TRAINER NOTE: Use the following information to understand and speak to **BRAIN IMAGING (SLIDE #23)**

TRAINER NOTE: The following information is for the TRAINER's benefit only at this point. DO NOT LECTURE fully on this information. This will be part of the lecture in *Module 4. Impact of Trauma on the Life of the Adolescent* by the GCBN.

In order to understand how trauma impacts development, it is important to understand how the brain develops and is impacted when chronic trauma is the child's story.

Brain development starts before a child is born. The brain develops from the brain stem upward, moving on to the midbrain, limbic system and then on the to cortex. The brain is made up of cells called neurons.

When a child experiences different things – the neurons pass information from one neuron to another – creating pathways. These pathways are strengthened by repeated experiences. The more an experience is repeated, the stronger is the pathway. This refers to both positive and negative experiences. The brain is a "use –

[13] Cardiac ischemia may be asymptomatic or may cause chest pain, known as angina pectoris. It occurs when the heart muscle, or myocardium, receives insufficient blood flow. This most frequently results from atherosclerosis, which is the long-term accumulation of cholesterol-rich plaques in the coronary arteries. Ischemic heart disease is the most common cause of death in most Western countries and a major cause of hospital admissions (Wikipedia, 2018).

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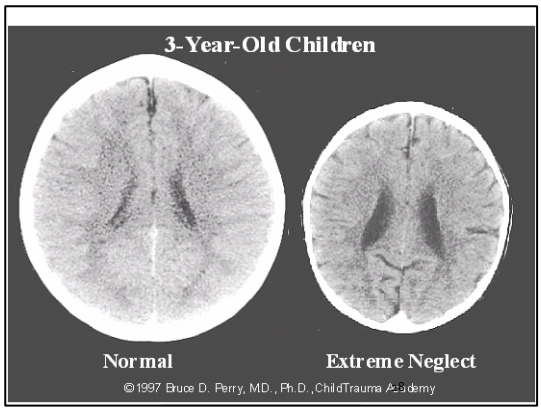
dependent" organ – the neurons that fire together, wire together (OR use it or lose it!)

When a child experiences a traumatic event and there is prolonged alarm reaction, it alters the neural system (Perry, 2003).[iv]

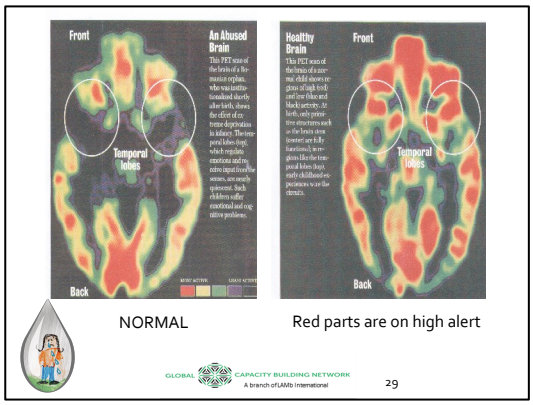


As you can see in the power point (**SLIDE #23**) of the two brains[14] (on the right the brain of a healthy child, on the left, the brain of a child who was from a Romanian orphanage).

The brain on the right is a normal and healthy child. You can see by the ***red, the active sections*** of the brain, from the brain stem to the frontal cortex. The brain stem (or lower part of the brain) is sometimes called the Reptilian Brain. This is where our survival instinct resides. It can be called our "flight, fight or freeze" functioning – our fear brain.

The **Limbic Section** of the brain functions with our emotions, and the front of the brain, or the **Cerebral Cortex** is the decision making part of the brain. For a healthy brain, moving from brain stem to cortex to limbic are all normal functions with healthy pathways.

As noted on the visual at the side, you can see the red active or "alert" part of the brain is the "fear" brain.



Abuse, neglect and/or abandonment, are examples of traumatic events in the life of a child that alter the brain and hinder healthy development of pathways. This child is on alert all the time and ready for "fight, flight or freeze."

Traumatic events in childhood increase the risk of many challenging social (e.g., teen pregnancy, drug abuse, school failure, aggression, anti-social behaviours), neuropsychiatric (e.g., conduct disorders, PTSD, dissociative disorders), and medical problems (e.g., heart disease, asthma) (Perry, 2003) – just as we saw in the

[14] Brain picture taken from ACE study document (Felitti, et al., 1998)

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ACE study.

Section 3D. Trauma Derails Attachment – Relationship Development (Refer to page 25 – 26 of Trainer Guide)

TRAINER NOTE: Refer to **ARTICLE #4 – *Bonding & Attachment in Maltreated Children*** for excellent background information on the process of emotional attachment and how trauma detracts from this critical developmental milestone for children; found in the ARTICLES electronic file folder.

ARTICLE #4: Perry, Bruce D. (2013). "Bonding & Attachment in Maltreated Children: Consequences of Emotional Neglect in Childhood", *The Child Trauma Academy*. Available at: https://childtrauma.org/wp-content/uploads/2013/11/Bonding_13.pdf

Section 4. Trauma & the Age-Related Developmental Impact

Section 4A. Trauma Derails Development (refer to page 29 of the Trainer Guide)

TRAINER NOTE: The following overview of the developmental domains is an excerpt from IHS (2008). *Caseworker Module VII. Impact of Abuse & Neglect on Child Development* (used with permission).

The following information is for the TRAINER's benefit only. DO NOT LECTURE fully on this information.

Overview of the Developmental Domains

Physical development consists of the development of the body structure, including muscles, bones, and organ systems. Physical development usually describes the relationship between the person's ability to perceive the environment and to respond to those perceptions by interacting within the environment. Thus, physical development is generally comprised of *sensory* development, dealing with the organ systems underlying the senses and perception; *motor* development, dealing with the actions of the muscles; and the *nervous system's coordination* of both perception and movement.

Sensory development is part of physical development and includes the development of vision, hearing, taste, touch, and smell, and the coordination and integration of perceptual input from these systems by the central nervous system. Vision has both motor and sensory components. Muscles regulate the physical

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structures of the eye to permit focusing; neurological pathways transmit visual input to the brain. For the first year of life, children's development is most pronounced in the sensory and motor domains. For this reason, Piaget has named this early stage of development *sensorimotor.*
Motor activity depends upon muscle strength and coordination. *Gross motor activities* such as standing, sitting, walking, and running, involve the large muscles of the body. *Fine motor activities*, including speech, vision, and the use of hands and fingers, involve the small muscles of the body. Both large and small muscle activities are controlled and coordinated by the central nervous system.

Cognitive development is sometimes referred to as "intellectual" or "mental" development. Cognitive is the proper term. Cognitive activities include thinking, perception, memory, reasoning, concept development, problem-solving ability, and abstract thinking. *Language*, with its requirements of symbolization and memory, is one of the most important and complicated cognitive activities. **It is important to differentiate between language and speech. Understanding and formulating language is a complex cognitive activity. Speaking, however, is a motor activity. Language and speech are controlled by different parts of the brain.

Social development includes the child's interactions with other people and the child's involvement in social groups. The earliest social task is attachment. The development of relationships with adults and peers, the understanding & acting out social roles, the adoption of group values and norms, the adoption of a moral system, and eventually assuming a productive role in society, are all social tasks.

Emotional development includes the development of personal traits and characteristics, including a personal identity, self-esteem, the ability to enter into reciprocal emotional relationships, and mood and affect (feelings and emotions) that are appropriate for one's age and for the situation.

Sexual development While it is NOT one of the 4 key domains, it is a perfect example of the interconnectedness of the 4 domains. It involves the child's physical development of sexual organs and senses, cognitive development to understand what is happening, as well as the emotional and social development and need for intimacy.

Sexual Development is a lifelong learning process about our sexuality, the genital parts of our body, who we are, our sense of identity as men or women or both, how we see our places in the world, and our intimate relationships with others. As we grow and mature, our needs change, our capabilities change, and our desire for intimacy and closeness changes. Our experiences and the experiences of people close to us shape our expectations and our values about sexuality.

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Spiritual Development[15] is NOT defined in the child welfare literature as it relates to child development. As noted by Wikipedia (2018), spiritual development involves "the development of personality towards a religious or spiritual desired better personality". Tony Evans (2014), author of *Raising Kingdom Kids: Giving Your Child a Living Faith* talks about helping children develop integrity as part of their spiritual development:

"Certainly we help provide the basic building blocks of character as we raise our kids with knowledge of God's love and the principles He cares about. Integrity is vital to the security of a kingdom, it holds equal importance in our children's lives. We create clear boundaries and limits to protect our kids, but integrity is what holds those boundaries in place. This essential virtue gives our children the strength to resist Satan when he tries to rob them of living out God's plan for their lives.

But developing integrity in our kids is a deeper matter than simply teaching them biblical values. It requires a broader, more complete understanding of the reasons for living according to these values. We can determine if they are living with an authentic love and reverence for God's principles and how consistently they adhere to these values. Do their personal walls of protection — their moral standards — seem to only exist when certain people are watching? Help your kids realize that true integrity means living out convictions consistently, so that what they say and what they do — particularly when no one else is around—is the same."

Section 4B. Small Group Activity (refer to pages 29 – 30 of the Trainer Guide)

TIP

TRAINER NOTE: Use the notes on the **SLIDES #29 – 32** as answers to the small group's work. You can also reference the following information from the following article:

ARTICLE #5: (NCTSN, 2008). *Child Welfare Trauma Training Tool Kit:* [16]*Comprehensive Guide*. Los Angeles, CA: Author, pages 17. Available at: http://43ejba1otx5n1btits42mnsv-wpengine.netdna-ssl.com/wp-content/uploads/2012/12/traumatraining.pdf

[15] Written by Katherine Hallick for GCBN (2019); references found on https://www.focusonthefamily.com/parenting/spiritual-growth-for-kids/character-development-integrity/fostering-integrity-in-your-child

[16] Source: GCBN (2019). *Becoming Trauma Informed: Impact of Trauma on the Life of a Child Trainer Manual.* Dayton, OH: LAMb International©.

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Section 5B. <u>Self-Awareness: asking Trauma Informed Questions (Small Group Activity)</u> (refer to page 36 of the Trainer Guide)

TRAINER NOTE: To divide participants into 5 new groups for this final activity, use coloured sticks or stickers (to match the colours on **TRAINER RESOURCE #8 – TI QUESTIONS**). Distribute one of the **TR #8 cards** to each small group. **ANSWERS noted below…**

1. **A Trauma Competent Healing Caregiver (TCHC) is one who understands the life altering impact of trauma**

It means that the adult caring for a child with a history of trauma has been changed at the core of who he would have been. As Dr. Bruce Perry (2003) states, children are wounded in the context of relationships. Children can be healed in the <u>context of healthy, loving, nurturing relationships</u>.

A TCHC understands that children are wounded by relationships in their lives and altered by them. A TCHP also understands that children are healed by safe and trusting relationships and can move from brokenness to wholeness with caregiver/parents who will journey with them.

2. **A Trauma Competent Healing Caregiver (TCHC) is one who can view life from the lens of a wounded child**

It means that I grow in understanding that my wounded child does not see from a clear lens, untarnished by life, but through a broken lens, shattered by the abuse and neglect that has stolen their innocence. Wounded children don't see adults as safe people– but as harmful people. Why would it be any different?

Wounded children don't see adults as trusting people – they don't know what trust feels like. A TCHC is willing to put on the lens of a wounded child and work at seeing life from his/her perspective. They are willing to give the child the time he needs.

3. **A Trauma Competent Healing Caregiver (TCHC) is one who understands he/she needs to Caregiver/Parent differently**

A TCHC is willing to set aside preconceived ideas of how to parent children.

They are willing to say, "even though I have been a successful Caregiver/Parent of our biological children, I understand that I am going to need to learn new ways of thinking about myself and how I nurture and structure the life of a wounded child."

Having an open and flexible perspective means that a caregiver has a teachable mind and heart that are open to learning a whole new way of relating to a child.

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4. **A Trauma Competent Healing Caregiver (TCHC) is one who knows that they must learn to manage their own emotional responses while helping children learn to manage their own emotional responses**

Adults caring for children with a traumatic past know that there will be challenges to them personally and they need to prepare for those challenges by learning to manage their own emotional responses to a child's behavior.

5. **A Trauma Competent Healing Caregiver (TCHC) is someone who asks for help.**

That sounds like a simple thought, but beneath it are many challenges for foster/adoptive caregiver/parent.

Being willing to ask for help means that a caregiver faces the reality that he/she doesn't have all the answers. It says that he/she must open themselves to others, making them vulnerable and open to others.

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TRAINER RESOURCES

TRAINER RESOURCE #1 - Overview of the Trauma Informed Series

Every year, millions of children around the world endure the trauma of abuse, violence, natural disasters, and other adverse elements (NCCEV, 2003). These experiences often result in significant emotional and behavioural challenges that can profoundly affect a child's life and often brings them into contact with child-serving systems.

LAMB International, in partnership with the Institute for Human Services has developed a sequential 8-part, **15-day training series** for adults working and living with children affected by trauma (including parents, foster parents, adoptive parents, residential care workers, day care workers, teachers, child protection workers, psychologists, youth probation workers, etc.).

Each training module is designed to build on the proceeding one and provide evidence-based, practice informed information and practical strategies to empower adults to understand, care for, and work with the traumatized child. It is recommended that each module be taken in the following sequence:

MODULE 1. Becoming Trauma Informed: Impact of Trauma on the Life of a Child (3 days) This module looks at the impact of trauma on the life of a child by addressing the essential skills of trauma informed care, defining types of trauma, and examining the impact of trauma on typical child development. The module also helps the participant understand and navigate the emotional and behavioral needs of traumatized children by introducing practical strategies and tools within the context of the seven essential skills of trauma informed care®. Finally, participants will gain practice knowledge and skills through application exercises designed to enhance their work within a foster home, orphanage or child protection work setting.

Training Objectives:

1. To understand the goals of child welfare services for protecting children from harm and neglect
2. To understand the essential skills of trauma informed care
3. To understand the potential lifetime impact of trauma on typical child development
4. To recognize how on-going stressors in a child's life exacerbate child traumatic stress.
5. To identify coping responses, strengths and protective factors that promote positive adjustment for traumatized children
6. To identify new strategies, techniques and skills to manage children with a traumatic history

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Module 2. Sensory Processing & Integration (1 day & ½ day learning lab)
Traumatic stress overwhelms a child's sense of safety and can lead to a variety of survival strategies for coping; some helpful and some maladaptive. Helping a child develop a tangible sense of 'FELT-safety' is critical for their functioning and healthy physical and emotional growth. This module will provide care-givers with tangible tools to support healthy brain chemistry, recognize a child's sensory "hot spots", and create safe predicable settings to live and grow.

Training Objectives:

1. To understand potential impact Sensory Processing Disorder has on a child with psychological trauma.
2. To understand sensory processing disorder through the lens of a child
3. To recognize how Sensory Processing Challenges impact each of the 8 senses.
4. To identify strategies, techniques and skills to manage children with sensory challenges or Sensory Processing Disorder.

Module 3. Helping the Traumatized Child Learn to Regulate their Emotions (1 day & ½ day learning lab) When working with the traumatized child, it is critical to remember that all behavior has meaning. Therefore, when a child is reacting to traumatic experiences and flash backs, they can present very challenging emotional and behaviors that require adult intervention. These 'acting out behaviors' can result from an emotional need, a physical need, or a sensory processing issue. This module will explore several reasons for the challenging behavior and present trauma informed responses designed to help the child regulate their emotions and resulting behaviors; while teaching care givers to recognize and manage their own responses to the child's behavior.

Training Objectives:

1. To understand how psychological trauma has the potential to impact a child's ability to self-regulate.
2. To identify and use evidence-based strategies and techniques to help children learn to self-regulate.
3. To understand how trauma and loss contributes to a child's emotional challenges.
4. Can create tools and materials to use in any environment to teach children ways to self-regulate.

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Module 4. Impact of Trauma on the Life of an Adolescent (3 days) This module incorporates the most recent research on how trauma impacts brain development and affects an adolescent's behaviour and relationships. We will explore exciting ways in which understanding how the brain functions can improve the lives of adolescents; making their relationships more fulfilling and less lonely and distressing on both sides of the generational divide. This road map for understanding the adolescent mind will help care providers become more empathetic and understanding of teenagers and result in emotional regulation and behavioral adaptation.

Training Objectives:

1. To understand the impact of trauma on adolescents.
2. To understand the behavioral challenges of adolescents with psychological trauma.
3. Can develop strategies and skills to work with challenging behaviors.
4. Can identify the impact that the adolescent's psychological trauma has on the parent and/or worker.

Module 5. Always Ready: Resilience in My Back Pocket (2 days) As they grow and develop, all children are working on the basic resiliency building tasks of attachment, self-control and initiative while relying heavily on the resiliency characteristics of their caregivers; which they begin to internalize. If traumatized children live with parents or caregivers who, themselves are struggling with the impact of trauma, their resiliency development may be compromised. This module will introduce the ARC® framework for building resilience in traumatized children. This evidence-based practice model teaches care providers to intervene in the context of safe, nurturing relationships and provide opportunities for the child to build attachment, learn to self-regulate and feel competent in performing developmentally appropriate day-to-day tasks.

Training Objectives:

1. To understand that resilience building blocks include simple actions, responses and attitudes of those working with traumatized children and youth.
2. To understand resiliency in the context of children affected by childhood trauma
3. To understand the six (6) key strategies designed to help youth find the resilience for their own success; including finding a sense of purpose, encouraging problem solving, promoting self-awareness, helping the youth become a life long learner, teaching how to become resilient to the impact of change and how to keep themselves safe.
4. Can use the six (6) strategies to help youth develop the key characteristics of resiliency.

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Module 6. Creating Nurturing Families/Groups for Traumatized Children/Youth (1 day) Because a child's recovery from trauma, their ongoing development, and resiliency building is dependent on their relationship with their caregiver, it is imperative that agencies provide training and support to the caregivers (whether they are parents, relatives, foster parents and the like). This module will present an assessment framework that explores the caregivers own trauma experiences, how this will impact their care-giving ability, and their external resiliency factors. While trauma histories can have a significant impact on caregiving, it should not be assumed that caregivers who have experienced trauma are "damaged" and incapable of providing care. If a caregiver has experienced trauma and successfully managed its effects, they can be excellent role models and resources for children with complex trauma. When agencies are aware of the caregiver's own trauma histories, they can design training and supports that meet the needs of both the caregivers and the traumatized child.

Training Objectives: TBD

Module 7. Secondary Traumatic Stress: Its Impact on the Caregiver (2 days) For helping professionals working with traumatized children and their families, "the essential act of listening to trauma stories may take an emotional toll that compromises professional functioning and diminishes quality of life" (NCTSNSTC, 2011, page 1). Our awareness of the impact of this indirect trauma exposure - referred to as **secondary traumatic stress** - is a basic element to protecting the health of the worker and ensuring that traumatized children and their families receive the best possible care from those who are committed to helping them. This training module is therefore designed to provide a concise overview of secondary traumatic stress, how it differs from stress and burnout, its potential impact on child-serving professionals and explore options for prevention and interventions for the professional helper.

Training Objectives:

1. To understand the typical causes & indicators of secondary traumatic stress associated with working with traumatized children, and understand how it differs from stress, burnout, compassion fatigue, vicarious trauma and post-secondary stress disorder (PTSD).

2. To understand how the body responds in one (or more) of the five predictable ways when threatened or traumatized and how to use this information to sustain ourselves when working with traumatized children.

3. To conduct a self-assessment of own levels and sources of stress, compassion satisfaction, level of burn-out and secondary traumatic stress as a pre-requisite to identifying personal strategies to prevent and address such.
4. To understand how to apply basic principles of intervention for trauma-informed workers and care providers.

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5. To understand the individual, agency and systemic contributors to work place trauma, and identify strategies to reform agency systems to support worker resiliency.

Module 8. Building a Trauma Informed System of Care (2 days) This module will present the core components of an evidence-based foster/adoptive home program that incorporate trauma informed teachings. The module will identify the key characteristics of a trauma competent caregiver and expand on the teachings from Module 6 to present an assessment framework to alternate care providers including foster and/or adoptive parents. In addition, it will incorporate information from Module 7 to ensure that alternate care providers receive training and support on the impact of secondary traumatic stress and that agency's design programs that incorporate this level of service. Finally, it will present a framework for partnering with other relevant health, social, education and justice systems to build a comprehensive, seamless response team for the traumatized child.

Training Objectives: TBD

National Center for Children Exposed to Violence (NCCEV, 2003). Available at: http:// medicine.yale.edu/childstudycenter/cvtc/about/ Accessed July 30, 2015.

National Child Traumatic Stress Network, Secondary Traumatic Stress Committee. (NCTSNSTC, 2011). *Secondary traumatic stress: A fact sheet for child-serving professionals.* Los Angeles, CA, and Durham, NC: National Center for Child Traumatic Stress.

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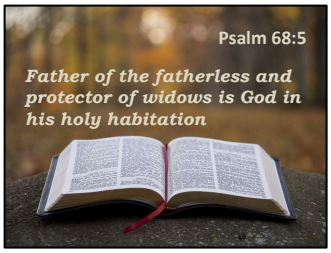
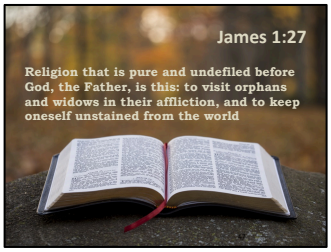
TRAINER RESOURCE #2 – Achieving Learning Objective #4

Understand the role of the body of Christ in working with traumatized children

OPTIONAL: In order to achieve this learning objective, use the **SLIDEs #45 – 51** at the end of the power point presentation file and insert them throughout the training presentation (especially at breaks or after videos/large group discussions/ small group activities.

The following is adapted from an excerpt from Wellman, Jack (2015). "Top 7 Bible Verses About Orphans", from *Christian Crier* (Available at: https://www.patheos.com/blogs/christiancrier/2015/06/26/top-7-bible-verses-about-orphans/)

SLIDE #46 	God is highly concerned about orphans. Here are 7 of the top Bible verses about orphans. **Psalm 68:5 "Father of the fatherless and protector of widows is God in his holy habitation."** What a tender side of God this is Who is a Father to the fatherless (orphans) and protector of the widows. Most of the world seems to ignore the widows and the orphans because they don't seem to matter in this world. Those who teach and preach the health, wealth, and prosperity gospel, which as Paul wrote, is not really a gospel at all (Gal 1:7), must think that they're in such a state because they don't have enough faith. Paul wrote that "the gospel I preached is not of human origin. I did not receive it from any man, nor was I taught it; rather, I received it by revelation from Jesus Christ" (Gal 1:11b-12) and if a church does teach and preach the real gospel, then it will have true religion, and true religion is highly concerned with orphans and widows (James 1:27) as we will read next.
SLIDE #47 	**James 1:27 "Religion that is pure and undefiled before God, the Father, is this: to visit orphans and widows in their affliction, and to keep oneself unstained from the world."** Want a great definition of pure religion? There is no better definition found in the Bible than in James 1:27 and it includes keeping oneself unstained or unspotted from the world but the first order of importance, and perhaps why James puts it first, is that of visiting the orphans and the

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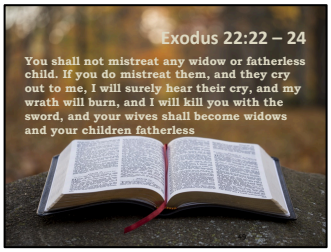
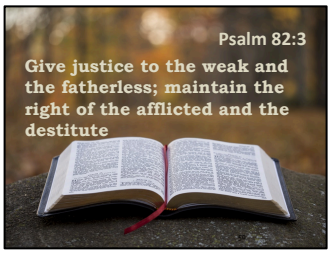
	widows in their affliction. Can you think of a better place than a nursing home or an assisted care living center to minister to (next to an orphanage) because almost every one of the nursing home residents are both orphans (parents deceased) and widows or widowers (with their spouse gone). Of course, those of us with the honour and privilege to work directly with the millions of orphans around the world have a special mission intrusted to us.
SLIDE #48 	**John 14:18 "I will not leave you as orphans; I will come to you."** Just before Jesus left to go to the cross and die for their sins (and ours) and later ascend back up to heaven, the disciples were very anxious about Jesus' speaking that He was going away and to where they could not (yet) come. Jesus' reassurance to them is one for us too that He will not leave us orphans because He promises that He will come again to them and for us. We can share this gospel with the orphans to provide home and peace that He is with them and watching over them.
SLIDE #49 	**Exodus 22:22-24 "You shall not mistreat any widow or fatherless child. If you do mistreat them, and they cry out to me, I will surely hear their cry, and my wrath will burn, and I will kill you with the sword, and your wives shall become widows and your children fatherless."** This verse is crystal clear about God's concern for the widows and orphans. The law is clear. They are not to be mistreated and this mistreatment could be in the form of neglect, abuse, or taking advantage of those who are in a defenseless position. For those who do take advantage of these disenfranchised people, God's wrath is a promise.
SLIDE #50 	**Psalm 82:3 "Give justice to the weak and the fatherless; maintain the right of the afflicted and the destitute."** When the psalmist writes about maintaining the rights of the afflicted and destitute, which consist of the weak and the fatherless (orphans), he is establishing the fact that Israel did have laws that defended the defenseless but in Jesus' day, there was no justice for these people which is why He rebuked those were the experts in the law and they knew better; "Woe to you, scribes and Pharisees, hypocrites, because you devour widows' houses, and for a

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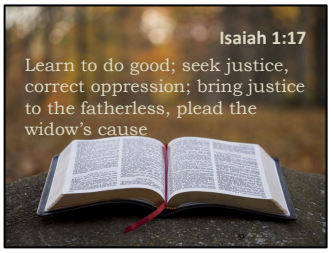
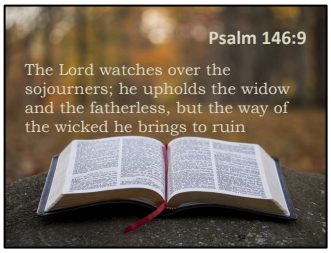
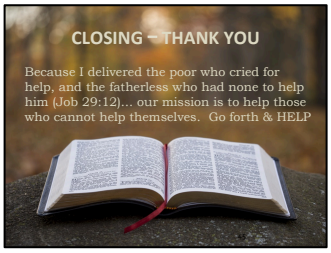
	pretense you make long prayers; therefore you will receive greater condemnation" (Matt 23:14). The word "woe" is Greek for "ouai" and means it is a judgment from God.
SLIDE #51 	**Isaiah 1:17 "Learn to do good; seek justice, correct oppression; bring justice to the fatherless, plead the widow's cause."** Isaiah would have never written that they need to "Learn to do good [and] seek justice" and "correct oppression" if they were already doing it. They needed to learn to do this because apparently they were not providing justice to the orphans nor were they pleading for the cause of the widows. This was all the more reason for Isaiah's scathing chastisement of Judah and part of the reason that they would be sent into captivity.
SLIDE #52 	**Psalm 146:9 "The Lord watches over the sojourners; he upholds the widow and the fatherless, but the way of the wicked he brings to ruin."** We are all sojourners in this world; just passing through so we are no different than strangers today who we are commanded to make feel welcome (Matt 25:31-40). God upholds the widow and the orphans but in due time, He will bring to the wicked His judgment (Rev 20:12-15).
SLIDE #45 – use to close your session 	**Conclusion** When Job wrote "Because I delivered the poor who cried for help, and the fatherless who had none to help him" (Job 29:12) he was saying that he knew that it was good to help those who cannot help themselves; like the poor and the orphans. God will hold us accountable for everything we do in this life but also includes our neglecting the widows and orphans because if we do neglect them, this only proves that we are not practicing nor living out what James calls pure religions (James 1:27).

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TRAINER RESOURCE #3 – FLIPCHARTS by Section of Trainer Guide

SECTION 1D.

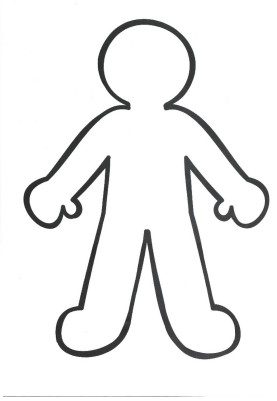
FC #1 – Agenda

1. Getting Off to a Good Start
2. When Early Neglect and Trauma is the Child's Story
3. How Trauma is Experienced
4. Trauma and the Brain
5. Trauma and the Age-Related Developmental Impact
6. Application: A Look At Tommy's Case (optional activity)
7. The Invisible Suitcase
8. What is a Trauma Competent Healing Caregiver?
9. Practice Using the Seven Essential Skills of Trauma Informed Care
10. Action Planning, TOL, Evaluation & Closure

FC #2 – Group Guidelines (Header only) – OPTIONAL

SECTION 1E.

FC #3 – Blank poster with visual of boy (TR #4) in centre

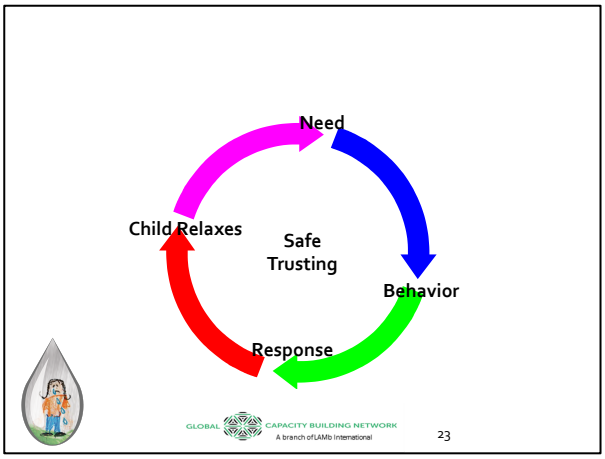


SECTION 2B.

FC #3 AGAIN (to list all the abusive events during discussion)

SECTION 4B

FC #4 – Cycle of Trust



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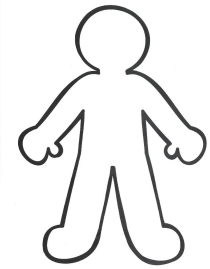
TRAINER RESOURCE #4 – Goals of Trauma Informed Care

Refer to **separate file** in TRAINER GUIDE electronic file folder of this name and print on cardex and laminate (if possible). These are mini-posters posted around the room for future reference throughout the training.

TRAINER RESOURCE #5 – Visual of Boy

Refer to **separate file** in TRAINER GUIDE electronic file folder of this name.

Also print **Separate HANDOUT – Image of Boy/Girl** on cardex or regular paper – one/ participant for the introduction activity (day 1)



TRAINER RESOURCE #6 – Trauma Life Story

Refer to **separate file** in TRAINER GUIDE electronic file folder of this name of a case example of a child experiencing complex developmental trauma. OR insert your own case example here.

TRAINER RESOURCE #7 – Essential Skills of Trauma Informed Care

Refer to **separate file** in TRAINER GUIDE electronic file folder of this name and print on cardstock and laminate (if possible). These are mini-posters posted around the room for future reference throughout the training.

TRAINER RESOURCE #8 – Trauma Informed Small Group Questions

Refer to **separate file** in TRAINER GUIDE electronic file folder of this name. These are mini-posters to distribute to the five (5) small groups for the activity on page 36 of the TRAINER GUIDE.

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VIDEOS:

Through Our Eyes – Children, Violence & Trauma by the Office for Victims of Crime (Feb 27, 2013) about how violence and trauma affect children, including the serious and long-lasting consequences for their physical and mental health; signs that a child may be exposed to violence or trauma; and the staggering cost of child maltreatment to families, communities, and the Nation. Victims lend their voices to this video to provide first-hand accounts of how their exposure to violence as children affected them. Available at: https://www.youtube.com/watch?v=z8vZxDa2KPM

Still Face Experiment by Dr. Edward Tronick (Infant-Parent Mental Health Program). Copyright © 2007 ZERO TO THREE http://www.zerotothree.org Ed Tronick, director of UMass Boston's Infant-Parent Mental Health Program and Distinguished Professor of Psychology, discusses the cognitive abilities of infants to read and react to their social surroundings. The video is an excerpt from Lovett Productions' HELPING BABIES FROM THE BENCH: USING THE SCIENCE OF EARLY CHILDHOOD IN COURT. Using the "Still Face" Experiment, in which a mother denies her baby attention for a short period of time, Tronick describes how prolonged lack of attention can move an infant from good socialization, to periods of bad but repairable socialization. In "ugly" situations the child does not receive any chance to return to the good, and may become stuck.

Toxic Stress Derails Healthy Development by the Centre for the Developing Child at Harvard University (September 2011). This video is part three of a three-part series from the Center and the National Scientific Council on the Developing Child. The series depicts how advances in neuroscience, molecular biology, and genomics now give us a much better understanding of how early experiences are built into our bodies and brains, for better or for worse. Healthy development in the early years provides the building blocks for educational achievement, economic productivity, responsible citizenship, lifelong health, strong communities, and successful parenting of the next generation. Available at: https://www.youtube.com/watch?v=rVwFkcOZHJw

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ONLINE RESOURCES:

Aces too High website has a wealth of resources including links to videos, readings and online trainings. Access at: https://acestoohigh.com/resources/

National Child Traumatic Stress Network (NCTSN, 2011). *Resource Parent Workshop: Participant Handbook (cs-3)*. This is a centralized resource for providers and resource parents who are using or interested in using *Caring for Children Who Have Experienced Trauma: A Workshop for Resource Parents* in their communities. Available at: https://www.nctsn.org/resources/resource-parent-curriculum-rpc-online

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This is another valuable resources full of key information about complex trauma and how to work with children affected by trauma in a practical way.

The Post Institute (undated). *Parenting Attachment Challenged Children: "Hands-On" Home Study Course* by Bryan Post. Includes over 12 hours of video and audio material plus a 5 hour CD-Rom course with illustrated workbook. To purchase, go to: www.postinstitute.com/AttachmentDisorder. Cost $297.00 USD

_____ (undated). *Trauma, Brain & Relationship: Helping Children Heal* by Dr. Bruce Perry, Daniel Siegel, Dr. Marcy Axness, Bryan Post and others. Video DVD available only at: www.postinstitute.com Cost $34.95 USD

This website also has other books, videos and resources free of charge.

ONGOING TRAINER LEARNING/DEVELOPMENT: Stress Trauma & Resilience Research

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REFERENCE NOTES FOR THIS MODULE:

[i] Definition of Trauma is taken from: http://www.aboutourkids.org/families/disorders_treatments/az_disorder_guide/posttraumatic_stress_disorder/definition_trauma

[ii] Source: pages 6 – 8 of NCTSN (2008). **ARTICLE #5** in the ARTICLES electronic file folder

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