Childhood Trauma in Mind: Integrating Trauma-informed Care in ECEC

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Abstract

Early childhood experience of trauma is highly prevalent and has far-reaching consequences. Young children are particularly vulnerable to experiencing trauma and children who enter foster care often have complex trauma related difficulties. In Ireland, many young children enter foster care each year and services to support their recovery are chronically under resourced. Early Childhood Education and Care Professionals are located in a unique position to provide children with crucial supports that may aid children's recovery and healing from trauma. This paper describes the impact of childhood trauma and how this may impact Early Childhood Education and Care (ECEC). Then, it describes trauma-informed care, an approach that may support children's recovery from trauma and how it could be integrated into ECEC practices in the Irish context. The paper concludes that there is a need for trauma-informed care professional development for Early Childhood Professionals to support this. It is also recognising that the current research base to support this intervention is limited and thus, the need for more research is warranted.

Introduction

Childhood trauma has been identified as a major public health problem worldwide (Felitti et al., 2019). In particular, the experience of childhood trauma of occurring in the context of the home has been identified as being extremely common (D'Andrea et al., 2012). The risk factors for early childhood trauma are also well established. These include child poverty, lone parenthood, parental drug or alcohol dependency, domestic violence, and parental mental health difficulties (Gilbert et al., 2012; Moullin et al., 2014). Research indicates that

young children are at particular risk to childhood trauma (Lieberman et al., 2011, Fusco and Fantuzzo 2009). In the USA, children under age 3 were found to have three times more the rate of children aged 16 and 17 (15 to 5 children per 1,000, respectively) to have experienced childhood trauma (Child Trends, 2019). The development of child protection and welfare systems identification and intervention of childhood trauma has led to increased rates of children received into care. Children in care most often have experience of chronic forms of abuse which include neglect, physical abuse, emotional abuse, sexual abuse, and exposure to domestic violence (Pynoos et al., 2011). These experiences of abuse are often not only chronic, but prolonged, repetitive, cumulative, and overwhelming for these children and most importantly, are unrepaired (Spinazzola et al., 2005, , Cook et al. ,2005, Gabowitz et al., 2008, Greeson et al., 2011). The defining feature of this experience is that of occurring with the context of the interpersonal relationship between the child and caregiver, essentially a failure of caregiving attachment and attunement (Miller et al., 2000, Tarren-Sweeney, 2008; McAuley and Davis, 2009; Forbes et al., 2011; Greeson et al., 2011, Kinsey and Schlosser, 2013; Kelly and Salmon, 2014; Hambrick et al., 2016). The link between the experience of adverse childhood experiences (ACEs) trauma and mental health difficulties is well established. However, for children in foster care, they are more likely to be exposed to ACEs than their counterparts. They are up to seven times more likely to experience a parent incarcerated or a household member abuse substances (Turney and Wildeman, 2017). As a result, the prevalence of mental health difficulties is higher (Ford et al., 2007; Leslie et al., 2004).

Children in Care in Ireland

In Ireland, in 2018, about 50 children per 10,000 population aged 0-17 years were in care, equating to 5974 children, not including children in respite arrangements and separated children seeking asylum (Tusla, 2018). 878 of these children were admitted to care in 2018; of these, over a quarter were repeated admissions (26%: 226) and for the remaining children, it was their first time admission (74%: 652) (Tusla, 2018). The majority of all children admitted were placed in foster care (90%: 791); 73% (638) with general foster carers, 19% (153) with relative foster carers, 6% (53) were placed in residential care and 4% (34) in other type placements such as special care. 50% (442) of these children were male and 50% (436) female. In 2018, for all children admitted, the most common age at admission was for children 1 year or less, accounting for 31% (181/878) of children. Pre-school children (aged 2- 4) accounted for 16% (143/878), young

children (aged 5-12) for 35% (310/878), and adolescents (aged 13-18) for 28% (244/878). The primary reasons for children's first time admission to care and primary reason for being in care indicated was neglect (45%, 45 %), followed by child welfare concerns (33%, 41 %). Physical abuse (10%, 6%), emotional (8%, 6%), and sexual abuse (3%, 2%) were also indicated (Tusla, 2018) (Table 1).

Primary Reason	Admission to Foster Care n (%)	Being in Foster Care n (%)
Neglect	296 (45)	2675 (45)
Child Welfare Concerns	216 (33)	2452 (41)
Physical Abuse	67 (10)	328 (6)
Emotional Abuse	55 (8)	346 (6)
Sexual Abuse	18 (3)	173 (2)
Total	652 (99)	5974 (100)

Table 1 Primary Reason for First Admission and Being in Foster Care

Note: From "Annual Review on the Adequacy of Child Care and Family Support Services Available 2018," by Tusla, Child and Family Agency, 2018, p. 37-65. Copyright 2018 by Tusla.

The responsibility for meeting the complex needs of these children falls between the services of the Tusla Child and Family Agency and CAMHS, Child and Adolescent Mental Health Services in Ireland. However, the Independent Child Death Review Group (Shannon and Gibbons, 2012) identified specific failures in the Irish mental health services. These included weaknesses in sharing information between agencies, children's mental health needs not being clearly identified, delay or failure in assessment, and lack of service coordination. It highlighted the need for children in care to have comprehensive assessments. However, it still remains the case that children in care are not screened for mental health difficulties on entry to care which is routine practice in the UK for children over 4 years (Baginsky et al., 2017). Screening and assessment has been consistently highlighted as a prerequisite for children entering foster care to ensure that their needs are accurately assessed at the earliest stage and appropriate intervention put in place (Goemans et al., 2018, Griffin et al., 2011, Greeson et al., 2011).

However, accessing services, such as CAMHS, has become very challenging in practice, reflecting the chronically under resourced status of Irish mental health services for children in care (McNicholas et al., 2011; McElvaney et al., 2013; Lucey and Pol;2013). In Ireland, ECEC often play a critical role in the lives of children who have experienced trauma. Despite the growing body of literature, outside of Ireland, that supports the empirical understanding of early childhood trauma impact and prevalence, a gap exists in realising the potential role ECEC could play in meeting the needs of these children (Loomis, 2018; Bartlett and Smith, 2019). Worryingly, in Ireland, the experiences of childhood trauma is seldom acknowledged in early childhood education (Butler, 2019). Without appropriate professional development for Early Childhood Professionals the complex needs of these children may be misunderstood or not recognised in a ECEC setting. This paper firstly, describes the impact of childhood trauma and how this may impact ECEC. Then, it describes trauma-informed care, an approach that may support children's recovery from trauma and how it could be integrated into ECEC practices in the Irish context.

The Impact of Childhood Trauma

Recent advances in neuroscience and attachment theory have led to a more comprehensive understanding regarding the impact of interpersonal trauma on child development (Teicher et al., 2010; De Bellis, 2010; Fisher et al., 2016; Nemeroff, 2016). The integrated and multidisciplinary conceptualisation of developmental trauma captures the extent of the impact of chronic interpersonal experience of trauma that occurs within the caregiving context (Van der Kolk, 2005; Cook et al., 2005; D'Andrea et al., 2012; Kisiel et al., 2014). This conceptualisation offers professionals a comprehensive understanding of trauma impact. It has been well received by professionals, it builds on professional's expertise, and provides a framework for understanding trauma impact (Lotty, 2019). Depending on the severity and complexity of their exposure to trauma, this can have a pervasive impact across a wide range of a child's functioning in the areas of attachment, biology, affect regulation, cognition, behavioural control, dissociation, and selfconcept (Cook et al., 2003; V D'Andrea et al., 2012; D'Andrea et al., 2012; Van Der Kolk, 2015). Therefore, this conceptualisation accounts for the extent of the impact on a child's development and functioning (D'Andrea et al., 2012; Cook et al., 2005). The symptoms resulting from developmental trauma exposure in early life may incorporate those of post-traumatic stress disorder (PTSD), but symptoms that extend beyond these may also be present (Cook et al., 2003). Children in foster

care were found to be three to five times more likely than children not placed in foster care to experience mental health conditions such as depression, anxiety, behavioural or conduct problems, and Attention Deficit Disorder/Attention Deficit Hyperactivity Disorder (Turney and Wildeman, 2017), and to have higher rates of PTSD (Greeson et al., 2011; Ai et al., 2013). However, the current lack of a single diagnosis that captures these children's symptomology (Van der Kolk and d'Andrea, 2010; Kisiel et al. , 2014) poses a number of difficulties. These include: multiple diagnoses (Van der Kolk and d' Andrea, 2010), not meeting the criteria for PTSD (Pynoos et al., 2008; van der Kolk et al., 2009), or not meeting the criteria for any mental health disorders (Tarren-Sweeney, 2014), despite their significant trauma and attachment related difficulties. Of note here is that the criteria for PTSD are based on constructs that were originally framed from rigid psychopathology states in adulthood (Bremness and Polzin, 2014; Polzin, 2014). PTSD focuses on a single traumatic event not in the context of an attachment relationships. Because of the lack of clear diagnostic criteria, child welfare agencies are typically inclined to focus treatment on the presenting behaviour of the child, and not on the underlying presentations associated with developmental trauma (Cook et al., 2003; Greeson et al., 2011). Applying the concept of developmental trauma into child education and care practices offers an opportunity to increase understanding of the impact of chronic childhood interpersonal trauma, the nature of the challenges these children face, and to develop ways to intervene more effectively (Rittner et al., 2011; DeJong 2010; Greeson et al., 2011; Kisiel et al., 2014). This would involve ECEC services to become trauma-informed, developing a trauma-informed perspective to practice in order to best support children and their families (Pynoos et al. ,2011).

The Impact of Trauma in an Early Childhood Education and Care Settings

Removal of children from the source of maltreatment and trauma experience and the placement with foster carers may suggest that children will adapt to a new, safe environment. However, the impact of trauma, neurological changes developed as survival strategies while living in a threatening environment (Teicher et al., 2010), the process of adapting to an unfamiliar environment, can be challenging and slow for children. While they have been provided with a place of safety, the impact of previous experiences of trauma are on going and can be long-lasting (Cook et al., 2005). Difficulties may increase on coming into care such as externalized behaviours (Lawrence et al., 2006; Vanderfaeillie et al., 2013) that may be frightening, unmanageable, and appear bizarre. Research

indicates that in ECEC settings, including pre-schools, such externalized behaviours are associated with increased stress and emotional exhaustion for pre-school teachers (Friedman-Krauss et al. ,2014; Jeon et al., 2018). This is likely to have an impact on the Early Childhood Professional's capacity to meet these children's needs and promote positive relationships with the children (Whitaker et al., 2015). While these children have needs similar to other children (universal needs), they also have traumagenic needs (Bath et al., 2018) that need to be recognised and met by the Early Childhood Professional. Without specific understanding and knowledge of trauma-impact and intervention, children's presenting emotional and behavioural expression of these needs may be misunderstood; thus, leading to strategies that are inadvertently harmful (compounding trauma impact), or at the very least ineffective.

Supporting Children's Traumagenic Needs

Trauma-informed Care

Trauma-informed Care (TIC) has been influenced by the growing awareness of implications of early childhood trauma and the need to respond in effective ways (Yatchmenoff, 2015; Berliner and Kolko, 2016). This awareness was fuelled by a number of developments, the understanding of traumatic stress through research on the neurobiology of stress (Porges, 2011) and the impact of trauma on brain development (Riem et al., 2015). The Adverse Childhood Study (ACE) (Felitti et al., 1998) found strong associations between the impact of childhood trauma and long lasting consequences for health from an epidemiological perspective (Kelly-Irving and Delpierre, 2019). TIC subsequently emerged as an approach based on the integrative multidisciplinary understanding of the impact of childhood trauma to effectively respond to trauma. TIC as an approach can be described as incorporating four important elements which recognised the importance of;

(1) the widespread impact of trauma and understanding of potential paths for recovery,

(2) the signs and symptoms of trauma in children, families, and staff,

(3) responding by fully integrating knowledge about trauma into policies, procedures, and practices, and

(4) actively avoiding of re-traumatisation of children and the adults who care for them (SAMHSA, 2014).

Initially, TIC focused on the identification and development of trauma-specific evidence-based treatment (EBT) (Black et al., 2012; Fraser et al., 2013; Dorsey et al., 2017). However, attention shifted to the implementation of TIC in child welfare systems, as professionals and researchers were concerned that most children who come into contact with child welfare services often have chronic and complex trauma histories but do not receive mental health treatment (Strand and Sprang, 2018). The movement also recognised that in order to meet the complex needs of these children, a more systemic approach was needed. This has traditionally not been taken in addressing the impact of trauma on children and families (Ko et al., 2008; Beyerlein and Bloch, 2014). This has resulted in a paradigm shift away from a traditionally deficit orientated understanding of trauma that individualises the person's difficulties and minimises the wider contextual influences, towards a more compassionate and contextualised standpoint (Knight, 2015). TIC is concerned with issues of social justice, power relationships, and human rights (Tseris, 2018), placing the response to trauma within a strengths-based framework that considers the person's broader ecological context. This is often captured in the literature as a shifting away from the question 'what is wrong with you?' towards the more empathetic question 'what has happened to you? (American Academy of Pediatrics, 2014). By 2004, the National Childhood Traumatic Stress Network (NCTSN), in the USA, was applying the concepts of TIC to Trauma-informed child welfare systems (TICWS) that led to a definition of a TICWS. TICWS is identified as a system:

In which all parties involved recognise and respond to the varying impact of traumatic stress on children, caregivers and those who have contact with the system. Programs and organizations within the system infuse this knowledge, awareness and skills into their organizational cultures, policies, and practices. They act in collaboration, using the best available science, to facilitate and support resiliency and recovery (Chadwick Trauma-Informed Systems Project 2013: 11).

The definition focuses not only on children, but also their caregivers and the child welfare workforce who seek to support them. It recognises that all of these groups are affected by trauma, including primary traumatic experiences that they may have experienced and the exposure to secondary trauma by caring for or working with children and families that have experienced trauma. The definition goes beyond the development of knowledge and awareness of trauma impact, but emphasises the need for the system to apply that knowledge in daily practices, in the culture of the organisation, and in interagency partnerships such as ECEC. Further to this, six practice guiding principles were developed

by SAMHSA (2014) to underpin the approach: safety, trustworthiness and transparency, peer support, collaboration and mutuality, empowerment and humility, and responsiveness (recognition of cultural, diversity and historical trauma issues). Thus, TIC is strongly aligned to the values of ECEC practice (National Council for Curriculum and Assessment, 2009).

TIC interventions can be carried out by professionals and carers, outside a formal clinical setting, by those working with, and caring for, children in roles such as early childhood education and care settings. These types of interventions have three main components (Bath, 2015) and were first identified by Van der Kolk (2005), and later by Bath (2008). Namely:

1) developing the child's sense of safety

2) promoting healing relationships between the child and caregiver and

3) teaching self-management and coping skills.

These three "pillars "lay the foundations for supporting the child in engaging in a formal therapeutic relationship, if required (Bath, 2008; Bath, 2015). Neuroscientific research provides evidence that children who are exposed to developmental trauma have impairment of their self-regulation capacities (Frewen and Lanius, 2006; Dale et al., 2009;Teicher et al., 2010, Schore, 2015,). This impairment is linked to emotional and behavioural difficulties (Racusin et al., 2005; Brendtro et al., 2009; Siegel, 2015). Thus, enhancing professionals' and caregivers' capacities to support the child to develop self-regulation has become the overarching key component of these interventions (Racusin et al., 2005; Dozier et al., 2006; Gunnar and Fisher, 2006; Schore, 2009; D'Andrea et al., 2012; Van Der Kolk, 2015).The phased approach seeks to ensure the foundations are laid out and then built upon to support the child in his or her recovery.

The first phase:

focuses on building the child's feeling of safety (pillar 1). The target of developing "felt" safety aims to support the child in developing arousal and affect regulation and reduce reactive fear based behaviours (Steele, 2008; Teicher et al., 2010; Nolte et al., 2011; Nemeroff, 2016;Shonkoff 2016). Developmental trauma involves prolonged and repeated exposure to trauma which serves to impair the stress arousal system (Porges, 2011). This results in emotional and behavioural difficulties that stem from pervasive biological and emotional dysregulation. Owing to the plastic nature of the stress arousal system in the brain (Roozendaal et al., 2009), it can be positively influenced by intervention

(Slopen et al., 2014). Addressing the child's dysregulated arousal system is the avenue to addressing attachment and cognitive based difficulties (Cook et al., 2003; Bath, 2008; Courtois and Ford, 2009; Bath, 2015).

The second phase:

is focused on building a trusting relationship between the foster carer and the child (pillar 2). This is built on the ongoing development of supporting the child to experience a feeling of safety (biological, emotional and psychological). The focus is to provide ongoing positive experiences of attunement communication that build affect regulation and secure attachment (Fonagy et al., 2007; Schore and Schore, 2008; Ford and Courtois, 2009; Siegel, 2015) . Here, the focus is on promoting organized attachment behaviour/addressing the child's disrupted attachment system. This relationship provides the scaffolding to support the child's socio-cognitive development.

The third phase:

The focus is on developing positive coping skills in the child (pillar 3), including emotional and cognitive regulation (Bath, 2015). This involves further identifying the child's unmet developmental needs. These unmet needs have stemmed from a lack of basic development skills resulting from interpersonal trauma exposure in the child's early development (Bosquet Enlow et al., 2012). This may include the basic foundations of executive functions (working memory, inhibitory control and cognitive flexibility). This stage focus is on addressing the child's needs by building coping skills, through trusting relationships with the foster carers and others. Over time, the focus is to support the child build a coherent sense of personal identity and competence.

Trauma-informed Care and Early Childhood Education and Care Professionals

Early Childhood Professionals are located in a unique position where they can provide crucial supports for children who have experienced trauma (Loomis, 2018). TIC, essentially a relational regulatory approach aligns well with ECEC guidelines for good practice (National Council for Curriculum and Assessment 2009). Early Childhood Professionals are well placed to provide children with TIC through supporting children's experience of a feeling of safety, develop trusting relationships with them, and supporting children to develop coping skills. In ECEC settings such as pre-schools, professionals may support felt safety through providing children with emotional containment (Douglas, 2007),

routine, predictability, and promoting a sense of control from a trauma-informed perspective. This may involve the recognition of children's trauma triggers and supporting them when they are overwhelmed by emotions and behaviours. ECEC may support children by using de-escalation techniques, desensitising children, and developing children's strategies to cope with trauma triggers. They can also give attention to the ECEC environment, reducing sensory insensitivity and promoting a sense of safety in the classroom/care setting.

Building trusting relationships with children being at the core of ECEC practice is also a fundamental component of providing TIC. The Early Years Professional is already placed to build healthy relationships with children in their care (Gillespie and Hunter, 2011). Thus, the Early Years Professionals could integrate their existing understanding of relational practice into the context of understanding the impact of developmental trauma on the attachment system. In the context of an understanding of attachment trauma, TIC seeks to create positive experiences of intersubjectivity and attunement (Trevarthen, 2001) for children as often as possible in the everyday interactions. The emphasis on the importance of the role of play in ECEC practice (Gonzales-Mena and Widmeyer Eyer, 2009) fits well here as play is viewed as an important vehicle for children's recovery from trauma (Terr, 2011). However, approaching play with children who have experienced trauma requires consideration, given that often these children may have little or no experience of healthy play (Gaskill and Perry, 2014). Children may feel threatened by the close proximity of an adult in a play-based context. Thus, using a trauma lens is likely to support a more thoughtful reflective approach to interacting with children, using approaches such as non-directive child led play. Non-directive child led play may support the child's experience of trust, security, and reduce stress (Solter, 2013), and provide children the opportunity of positive relational experiences that support child development from a trauma-informed perspective.

Developing coping skills also requires a trauma lens for children who have experienced trauma. This involves approaching supporting children to develop coping skills with a developmentally sensitive perspective. Children who have experienced trauma often may be developmentally 'younger' than their chronological age owing to the prolonged and chronic nature of developmentally traumatising experiences. ECEC has a central role in children's development (Davies, 2010). For example, ECEC emphasises emotional and social development, both areas of child development that often has been impacted by early childhood trauma (Burns et al., 2010). Research has indicated that young children who have experienced trauma have difficulties

with the facial recognition of emotions (Pollak et al., 2000). Thus, ECEC could provide meaningful supports to children's social and emotional development who have experienced such gaps in these areas of their development. ECEC also could support children's behaviour regulation, by recognising trauma related behaviour and subsequently responding using trauma-informed care behavioural strategies that support emotional regulation and the child-carer relationship (Siegel and Bryson, 2016).

Language development is also a key area where ECEC support children. This is also very relevant for children who have experienced trauma, as language development is also an area often impacted by early childhood trauma (Bartlett and Smith, 2019). These core coping skills, addressing gaps in children's development, are only developed in the context of trusting relationships and a sense of safety. While the Early Childhood Professional has the opportunity to provide children with TIC in their role, without specific training in TIC, they are unlikely to have the knowledge and understanding of the impact of childhood trauma. Thus, they may have difficulty in recognising trauma related behaviours and, in turn, be unable to respond in effective ways using evidenced-based practices. TIC is underpinned by the core component that professionals do not retraumatise, however, without specific training, professionals are at risk of inadvertently re-traumatising and further compounding children's difficulties (SAMHSA, 2014).

ECEC also have the unique position to support healthy relationships between children and their caregivers (Gillespie and Hunter, 2011) as experts in early childhood education and care. They are also key stakeholders in foster care as they are often important members of the team around the child within the foster care system (Lotty, forthcoming). In a recent doctoral study that developed an effective TIC intervention for foster carers in Ireland (Lotty, Dunn-Galvin and Bantry-White, 2020), one of the key recommendations of the study was to develop trauma-informed care training for key stakeholders in the lives of children in foster care, which include the Early Childhood Professionals. It is likely that by increasing Early Childhood Professionals capacity to recognise trauma related behaviours and provide trauma-informed care, this will also support children's foster families. It is more likely to promote collaborative practices between Early Childhood Professionals and foster carers, aligning with the principles of trauma-informed foster care (Lotty, 2019) and ECEC guidelines for good practice (National Council for Curriculum and Assessment, 2009).

The research base to support TIC in ECEC programmes is limited (Bartlett et al.,

2017; Loomis 2018). However, there are some examples of promising practices in the USA (Bartlett and Smith, 2019). TIC training and mentoring provided to ECEC professionals and evidenced based clinical treatment to children through partnerships with mental health services resulting in improvement in child behaviour (Holmes et al., 2015), academic achievement, socio-emotional competence, and reduced symptoms of child PTSD (Jaycox, 2011). Kanine et al., (2018) recently reported effectiveness of a TIC intervention that increased pre-school teachers' capacity to provide children with TIC in the classroom and increased child socioemotional skills.

Conclusion

Early childhood trauma is prevalent and far-reaching. In Ireland, many young children enter foster care each year who have endured developmentally traumatising experiences. The resources that are needed to address early childhood trauma are overstretched and chronically under resourced in Ireland. Trauma-informed Care is an approach that may support children's amelioration from early childhood trauma that can be provided by the professionals and carers such as Early Years Professionals. The core components of TIC align well with ECEC practices and could be integrated into existing practices. While, the research base to support TIC in ECEC settings is limited and there is an urgent need for more research some promising interventions are emerging. These interventions included the component of ECEC professional development in understanding and application of TIC. To conclude, the ECEC professionals are in a unique position to provide children with TIC and make a contribution to children's recovery and healing from trauma. Thus, developing the capacity for Early Childhood Professionals to have both the knowledge and skills to provide children with trauma-informed care should be an important consideration.

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