International Society for the Study of Trauma and Dissociation

# Child Protection Officials

## Who is this Fact Sheet For?

This sheet is for child protection personnel, legal personnel, and other support staff who are working with young people who have experienced trauma. Trauma and dissociation can impact a child's emotions, behavior, relationships, attention, communication, and learning. As a result, child protection personnel, legal personnel, and other support staff are in a unique position to recognize when trauma responses and symptoms may be interfering with a child's behavior and communication. They also have key roles in referring children and youth to licensed professionals who can recommend specialized assessments and interventions, and work with families and other professionals to support these children.

Leading researchers believe childhood trauma to be the worst public health crisis of our time. Research shows early treatment for trauma and dissociation results in better, longer term mental health outcomes for children and youth (Kisiel et al., 2009; Silberg & Dallam, 2009; Hulette et al., 2008). The information below is intended to assist in understanding and helping children who have experienced trauma and who may be experiencing dissociation. As you read through this fact sheet, do note that self-care for all involved is important and is encouraged.

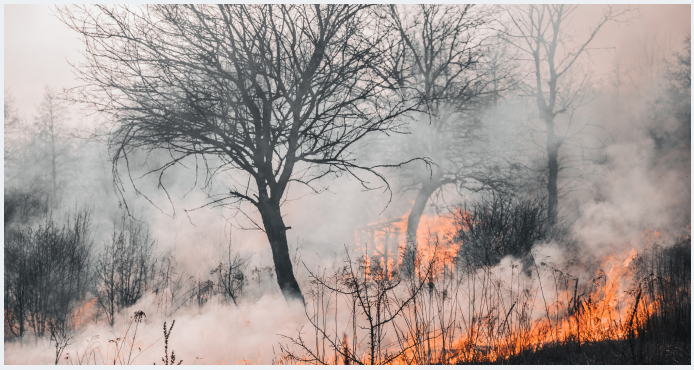
## Could it be Trauma?

### Could It Be Trauma?

*"Individual trauma results from an event, series of events, or set of circumstances experienced by an individual as physically or emotionally harmful or life-threatening with lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being. "-- SAMHSA, 2014, p.7*

Trauma occurs when a child experiences an event that overwhelms them and exceeds their ability to cope, changing how they see and experience themselves, others, and the world around them. It may be an objectively stressful event (e.g., an accident, abuse, severe illness) or a subjectively stressful event (e.g., separation from a caregiver, witnessing violence), which may lead to psychological and biologically-based survival responses that can continue long after the traumatic event has passed. It's important to note that not all

stressful events are experienced as traumatic in and of themselves, meaning that not every young person who experiences an extremely stressful event will be traumatized, but some will be. That said, some types of events are so extreme that they are likely to be traumatizing to most people. A traumatic event may be experienced directly by the individual, witnessed as happening to someone else, or learned about as having happened to a loved one or one's community. In psychological terms, "traumatic events" have traditionally been considered those that harm the psychological integrity of an individual, and may be single occurrences, chronic and repetitive over time, or complex in nature, meaning more than one type of potentially traumatic event has been experienced and/or within important relationships. These may include:



- Physical abuse
- Sexual abuse
- Neglect of physical, emotional, medical, and educational needs
- Incarceration of a loved one
- Emotional abuse (e.g., yelling, screaming, exploitation, and/or critical, demeaning statements being directed toward the child that leads to feeling unloved and/or thinking they are unwanted)
- Witnessing family violence (this includes indirect exposure)
- The intergenerational impacts of historical traumas in communities of people (e.g., genocide, chattel slavery, and colonization
- Being cared for by chronically frightened or frightening caregivers
- Painful, scary, and/or life-threatening medical conditions and procedures
- Pre-Birth trauma, affecting the mother and/or developing infant emotionally, medically, and/or physically
- Unplanned/unwanted pregnancy
- Accidents that lead, or could have led, to serious physical injury or death
- Witnessing or experiencing school and/or community violence
- Substandard living conditions such as poverty, homelessness and/or poor quality housing, food scarcity, poor air and water quality, parental/guardian unemployment
- Bullying
- Oppression, discrimination, and hate crimes related to social and/or cultural identity (e.g., racism, ageism, transphobia and trans-erasure, homophobia and heterosexism, xenophobia, sexism, classism)
- Trafficking (e.g., labor, sex)
- Grief and loss, including violent, repeated and/or extended separations from loved ones (including abduction/kidnapping of the child)
- Parental separation, abandonment, and/or alienation
- Mental illness and/or substance abuse in the home
- Natural disasters, including the climate crisis and COVID-19
- Human-made disasters

## What is Relational or Attachment Trauma?

Secure attachment bonds form in infancy when caregivers can accurately attune to and regulate the infant's internal states of arousal. Healthy attachment to a caregiver is a biological need for children and supports optimal growth and development. Early attachment problems can sabotage the neurodevelopment of the developing child, their ability to learn to regulate and modulate affect, and develop a coherent sense of self. Many factors can impact the attachment relationship between an infant/child/youth and a caregiver including accessibility and responsiveness, the ability and willingness to provide comfort and protection when a child is expressing emotion, unmanaged health issues or mental illness, substance abuse, unresolved child maltreatment and neglect, infant temperament, or illness.

Children are biologically driven to approach their caregiver for care and protection, but also instinctively compelled to flee from frightening experiences and others. When caregivers are the source of distress and fright, children are placed in an irresolvable paradox. This paradox is traumatic for children and may be referred to as attachment wounding. Attachment wounding manifests in emotional dysregulation, oppositional behavior, hyperactivity, tantrums, inattention and difficulty concentrating, and possible dissociative symptoms (see "What is dissociation" below). Poor attachment between caregiver and child contribute to greater vulnerability to re-victimization, or a risk to later experiences of trauma.

## What is Complex Trauma?

Complex trauma describes exposure to multiple types of traumatic events that are repetitive and have wide-ranging and long-term impacts on a person (Herman, 2015). Adverse experiences that might result in complex trauma are usually severe, chronic and ongoing, pervasive, and interpersonal in nature. Complex trauma typically begins early in life (sometimes in infancy) and can disrupt many areas of child development including the ability to form safe, secure attachments with others.

## Red Flags/What to Look for to Spot Trauma in Children

Traumatic stress in children may be expressed through:

**Behaviors**

Significant changes in activity level and increased disruptive behaviors or reduced activity observed as shutting down, zoning out, over-compliance, or flat affect; developmental regressions or delays in meeting social-emotional milestones in areas of communication, regulation, attention, and play; oppositional and/or defiant behaviors; being easily startled; self-destructive and/or self-injurious behaviors; avoiding certain activities, people, places, and things; use of substances, disordered eating, and other unhealthy ways to cope.

**Mood**
Increased irritability; rapid mood swings; passivity; 'spacing out;' flat affect; depression or withdrawal; temper tantrums; overwhelming feelings of sadness, anxiety, worry, anger, fear, hopelessness, physical aggression; shutting down emotion; thoughts of suicide or wanting to die.

**Social**
Clingy, or withdrawn and isolated; difficulties with social and/or physical boundaries; trouble forming and sustaining relationships; anticipating and perceiving rejection and/or abandonment.

**Cognitive**
Difficulties with memory and processing new information; making inferences or appearing to give conflicting statements; difficulties with communication, attention and focus; difficulty remembering tasks, recent or past significant/insignificant events; struggling to meet expectations; more easily distractible; finding it challenging to learn new things; spacing out; expressing a foreshortened sense of their future; having negative thoughts and expectations about themselves, others and the future; not recognizing/remembering people they have previously met or are acquainted with, and low self-esteem and self-confidence.

**Body/Physical**
Unexplained headaches, stomachaches, vague aches, and pains; sensitivity/insensitivity to pain; feeling detached from their body; difficulty recognizing what their body needs (e.g., hunger, temperature); disruptions in sleep cycles, eating patterns, and elimination patterns (medically unexplained struggles with bladder and bowel control, and/or diarrhea/constipation); and events of seizure-like motions, which are non-epileptic in nature.

## What is Dissociation?

Dissociation can be considered a biological and psychological response that may occur during or after traumatic events as a means of coping with the experience(s). Dissociation is a process that occurs when the brain disconnects awareness from experience, feeling, sensation, and/or the self. Children, like adults, may dissociate when they are overwhelmed by fear or pain and cannot escape. When there is no escape from the widespread and repetitive nature of complex trauma, children may continually use dissociation to disconnect from and block out what is happening to them, what they are feeling, what they are thinking, who is causing the harm or pain, and what they are sensing in order to cope and survive. The ability to dissociate is rooted in protection and the innate ability to survive the unimaginable.

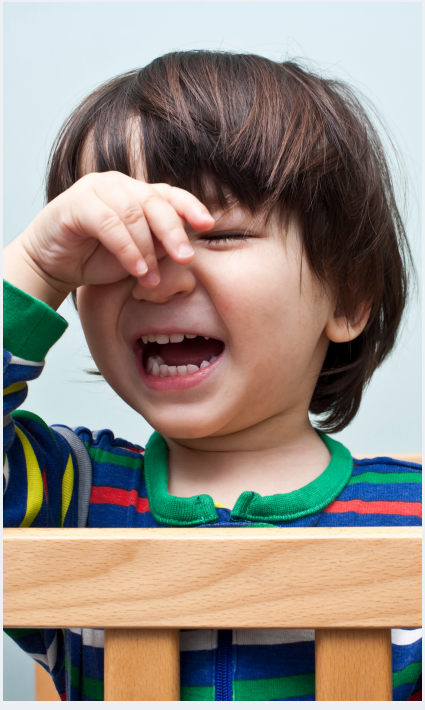
DA child may dissociate during and after any of the traumatic events listed above, or when later reminded of any of the events listed above, even long after the event(s) are over. Reminders are called "triggers" and triggers are unique to the child and their experiences. It is important to remember that if the child receives support and feels safe soon after a frightening or distressing event, any dissociation may be temporary and therefore, not problematic. However, in addition to dissociating during and after a traumatic event, for some people dissociation can become a longer term coping strategy to get through stressful, but not necessarily traumatic, situations in everyday life.

The symptoms below are examples of how dissociation may manifest in children/adolescents:

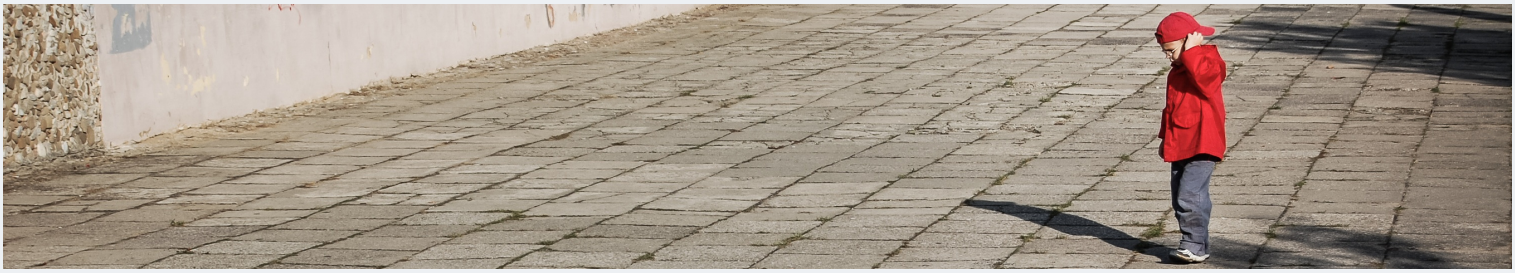
## What Symptoms May I See in a Child or Adolescent?

Dissociation can show up in unique ways for kids and youth, leaving adults confused at what may be happening. These symptoms may occur only a few times a year, or may be much more frequent and occur several times a day. Some of the common symptoms of dissociation that may warrant further investigation may include:

- Sudden and abrupt changes in mood, behavior, feelings, or attitudes that a child may not be able to explain or remember (which may include making and then retracting allegations; inconsistent reports of events; muteness; alternations between submissive behavior and appearing frightened; defending caregivers who are known to have hurt them; difficulty with memory).
- Appearing unaffected (e.g. sleeping through or ignoring chaos in the environment).
- 'Spacing out' or 'zoning out,' and not knowing what is going on around them. Time may pass and they don't know what happened during that time. They may have difficulty remembering information.
- Behaving aggressive or mean at one point, and then becoming passive, loving or caretaking at another time.
- Sudden emotional shifts from one extreme feeling to a completely different or opposite feeling without showing any of the in-between emotions. The reason for this change in emotion may not be clear or make sense to you.
- Seeming calm one moment and then in the next moment becoming explosive, aggressive, frightened, tearful or panicky.
- Expression of emotions that do not fit what is happening, such as laughing during a sad and upsetting situation or becoming sad or angry in a joyful situation.
- Not showing emotions, denying having feelings, or appearing to not be aware of any feelings at all.
- Behaving very grown up one moment and then behaving or talking like a much younger child (even a baby) at another moment.
- Using different names to refer to themselves, or referring to themselves as "we."
- Using different voices or mannerisms at different times.
- Dramatic and sudden changes in facial expression, such as going from smiling to angry without any apparent reason.



- Eyes appear to be in a dead stare when you are talking to them, like they are miles away, or with a glazed look, particularly when aggressive, enraged or scared.
- Wanting to wear their favorite outfit, eat their favorite food, or play with their favorite toy or game, but then later on, or perhaps the next day, they say they hate the clothes, food, toy or game. They may also not be able to explain this change, stating they never liked the outfit or food.
- Finding themselves in a place and not knowing or remembering how they got there. For example, at school they may be sent to the principal's office for misbehaving and not remember leaving the classroom, walking to the office, or why they are even there.
- Thinking and feeling that a completely safe situation is extremely unsafe and presenting as very fearful, or alternatively, interpreting unsafe situations as safe.
- Having no recall of important events, such as birthdays, holidays, family vacations or camping trips.
- Having no memory of having done something even when someone saw them do it. These children are often accused of lying.
- 'Hearing' voices inside their head that tell them to do things (note that children seldom talk about this unless directly asked). You may observe them talking outloud to themselves.
- Reporting that there are people inside them that say mean things and boss them around, or that provide comfort. These are different from the pretend or imaginary friends that young children commonly have and outgrow.
- Thinking badly about themselves, perhaps even wanting to die, and seeing the world as a frightening and threatening place. Then suddenly they may feel good about themselves and the world, and hopeful about the future.
- Flashbacks, or reliving a traumatic event, during which they are unaware of their present surroundings.
- Physical or bodily changes that a doctor may not be able to find a medical problem or cause for, which may be a result of the tension or anxiety fromtrauma that is being 'held' unconsciously in the body.
- Wetting or soiling themselves without feeling it, smelling it, or even knowing it is happening.
- Getting hurt (e.g., getting a cut, breaking a bone, or harming themselves) and not feeling the pain or being aware that they have been hurt. Unexplained physical injuries.
- Feeling their body parts change and get smaller or bigger, or feeling like parts of their body have disappeared or are not real.
- Feeling like they are seeing everything around them through a fog or like a dream, as if the world around them isn't real or feels very far away.
- Complaints of stomach aches, headaches, seizure-like motions, or other physical problems (e.g. difficulty breathing, trouble walking, genital pain) that cannot be physically explained.



## Reaching Out for Help of Further Investigation

When a child/adolescent is showing symptoms of trauma and/or dissociation, start by discussing your concerns with the legal and/or agency's support team, licensed staff, and the child's parent, guardian or guardian ad litem. Case workers, Child Protective Service or legal professionals should refrain from making any assumptions about diagnoses, instead sharing your concerns with other service professionals and mental health professionals who may be working with the child/adolescent. Describe what you see and reach out to licensed staff that can make recommendations around referrals for an assessment by a mental health professional specializing in treating trauma and dissociation. This assessment would evaluate the child/adolescent's symptoms, strengths and challenges, as well as identify the supports that would be most beneficial for the particular child/adolescent.

When a child entrusts you with information about the trauma they've experienced, make sure you continue to listen empathetically without asking leading questions that might trigger the child, as well as reaching out to a mental health professional. Listening in and of itself can already create a great resource for/within the child. See Section 5 for more details.

Be aware that unresolved distressing events, trauma, and dissociation can affect a child/adolescent's ability to articulate, testify, process questioning and information, and recall information. Note that children/adolescents with communication and neurodevelopmental disorders (e.g. intellectual disabilities, autism spectrum disorders) may be especially vulnerable to the additional impact of trauma. Symptoms of unresolved distress, traum,a and dissociation respond well to specialized treatment, particularly with early diagnosis and treatment. See ISSTD AdultFact Sheet V: Getting Treatment for Complex Trauma and Dissociation for information about finding the right mental health professional to refer to.

## Creating Hope- Treatment for Complex Trauma and Dissociation in Kids and Youth

Complex trauma and dissociation may present very differently when it comes to various aspects of a child's life. For example, a child may have separation anxiety issues, low self-worth, sleeping problems, self-harming or self-destructive behaviors, academic and social issues, dissociative symptoms (as mentioned above), or unexplained medical complaints, among other challenges. All of these can make it confusing to search for and provide appropriate help. It is important to realize that due to the growing insights into complex trauma and dissociation, as well as resilience and treatment possibilities, there are effective treatments for trauma and dissociation available. Depending on the child's specific strengths and challenges, treatment may sometimes be lengthy; however, the therapeutic process can help bring about profound change. Caseworkers, mentors, guardians ad litem, and other related personnel have an important role in supporting the child's healing.

## Steps You Can Take in the Assessment and Treatment Process

Healing of complex trauma happens within the context of relationships, and child protection workers and legal personnel can be powerful role models and sources of connection for youth.

- Identify a licensed practitioner that can provide additional support and direction, and work alongside them to minimize retraumatization.
- Work diligently to create emotional and physical safety for the child as quickly as possible. This includes providing choices and options, as trauma often takes away a young person's sense of agency.
- Collaborate with the child's safe caregiving system, as well as the identified licensed mental health and medical professionals involved in the child's care. A collaborative approach ensures consistency and appropriate wrap-around support across all areas of the child's life.
- Learn about how trauma impacts children and affects their availability for contact with the alleged perpetrator in any reunification planning, as well as how important it is for caseworkers, legal teams, and agency staff to support children.
- Learn about dissociation, become more aware of when it is happening, and how to talk with the child at those times.
- Work with the child and agency staff to develop a greater sense of safety at school and other environments, such as home visits or supervised access visits.
- Respect that triggers can elicit a child's dissociative responses and work alongside the child's treatment team to decrease these triggers.
- Work with the child's treatment team to help reorient a child when dissociation starts to happen.
- Maintain a perspective of openness and objectivity, and cultivate a culture of hope about the future within your agencies.

Child protection workers and legal representatives may also benefit from support for themselves as they work towards helping these children/adolescents. Working with traumatized young people may increase risk for burnout and compassion fatigue. Reaching out to informal support networks (e.g., friends, family), colleagues/peers, and/or to your own mental health professionals (e.g., therapist, physician) can help you maintain your own wellbeing within the context of working with a child with unique needs. Although healing can sometimes seem like a long process, children can experience relief and improvements. Children heal best when they have a supportive team around them. Child protection workers and the legal system have key positions within this team alongside caregivers, educators, mental health, and medical professionals involved in the child's care. Healing is achieved through working together.

# References and Helpful Resources

Gurwitch, R. H., Messer, E. P., Masse, J., Olafson, E., Boat, B. W., & Putnam, F. W. (2016). Child–Adult Relationship Enhancement (CARE): An evidence-informed program for children with a history of trauma and other behavioral challenges. Child Abuse & Neglect, 53, 138-145.

Faust, J. (2018). Reunification family therapy: A treatment manual. Hogrefe Publishing.
Herman, J. (1997). Trauma and Recovery: The Aftermath of Violence-From Domestic Abuse to Political Terror. New York: Basic Books.

Hewitt, S. K. (2008). Therapeutically managing reunification after abuse allegations. Journal of child sexual abuse, 17(1), 17-19.

Hulette, A., Freyd, J. , Pears, K., Hyoun, K., Fisher, P., & Becker-Blease, K. (2008). Dissociation and Posttraumatic Symptoms in Maltreated Preschool Children. Journal of Child & Adolescent Trauma, Vol. 1, 93-108.

Kisiel, C., Fehrenbach, T., Small, L., & Lyons, J. S. (2009). Assessment of Complex Trauma Exposure, Responses, and Service Needs Among Children and Adolescents in Child Welfare. Journal of Child Adolescent Trauma, 2(3), 143–160.

Silberg, J. L., & Dallam, S. (2009). Dissociation in children and adolescents: At the crossroads. In P.F. Dell & J.A. O'Neil (Eds.). (2010). Dissociation and the dissociative disorders: DSM-V and beyond. Routledge, 67-105.

Waters, F.S. (2007). Trauma and dissociation training video for child protective services workers, forensic evaluators and prosecutors. ISSTD.

Water, F.S. (2004). Forensic evaluations of children. In A.S. Frankel & P.J. Kinsler's (Eds.) Forensic Forum, ISSD News, Vol. 22 (1).

Yehuda, N. (2016) Communicating Trauma: Clinical presentations and interventions with traumatized children, Routledge, New York.