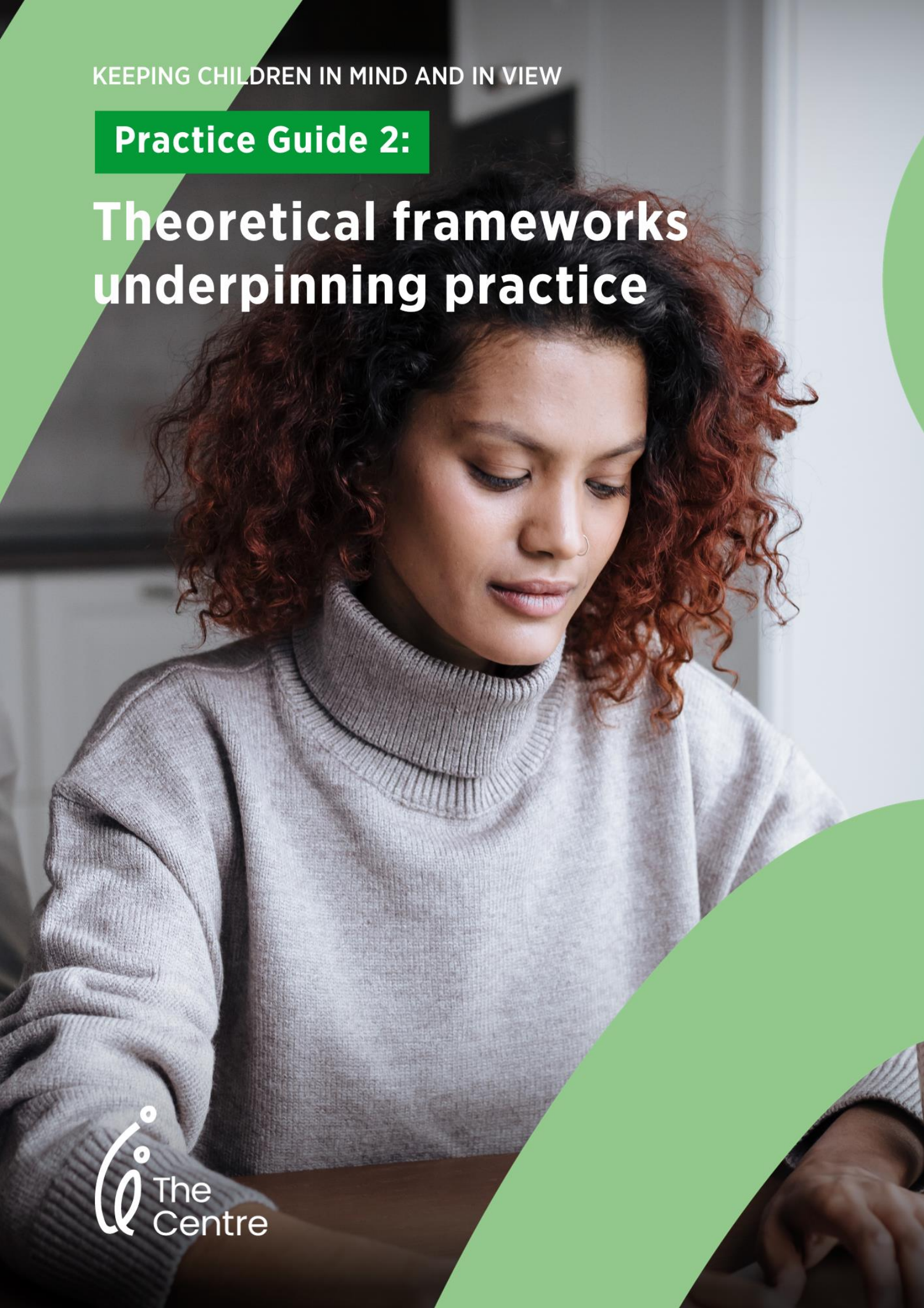
KEEPING CHILDREN IN MIND AND IN VIEW

## Practice Guide 2:

# Theoretical frameworks underpinning practice



The Centre

## Acknowledgement of Country

The Centre acknowledges the past and present traditional custodians of the land on which we work. We pay respect to Elders past and present. We acknowledge that sovereignty was never ceded and that this was and always will be Aboriginal land.

## Contents



## Acronyms

| | |
|---|---|
| BICPM | Best Interest Case Practice Model |
| CALD | culturally and linguistically diverse |
| LGBTIQA+ | lesbian, gay, bisexual, transgender, intersex, queer, asexual |

## Foreword

This guide is one in a series of practice guides written by the Centre for Excellence in Child and Family Welfare to enable practitioners to keep children first and foremost in service system responses. Funding for these guides has been provided by Family Safety Victoria.

The aim of the guides is to support key workforces involved in maintaining child safety and wellbeing to:

- use a child rights lens
- identify and prioritise what is in the child's best interests
- work in ways that promote children's participation in the decision making and processes that affect them
- document what happens to children so that they are kept in mind and in view.

The guides are intended to make sure that children and young people are at the centre of our thinking and our practice. They are not intended to replace leader or manager practice guidance or to replace existing agency protocols; rather, they are aimed at providing practical, simple and accessible information that will increase practitioner understanding of how to work with children and young people and enhance confidence in their ability to do so.

In engaging with children, particular attention needs to be paid to the safety and wellbeing of children who are non-verbal or very young, who have developmental challenges, who have a disability, who are from a non-English speaking background, who are Aboriginal or Torres Strait Islander, who have a parent with a disability or mental ill-health, who identify as LGBTIQA+ or who experience (and/or use) violence in the home.

The guides aim to address confidence and knowledge gaps for practitioners across the sector and promote the importance of effective and meaningful observation, communication and empowerment of children and young people. They are intended to be an easy to understand, practical reference tool for new practitioners, or for practitioners who have not had significant experience in working with children or young people.

## Theoretical frameworks underpinning practice

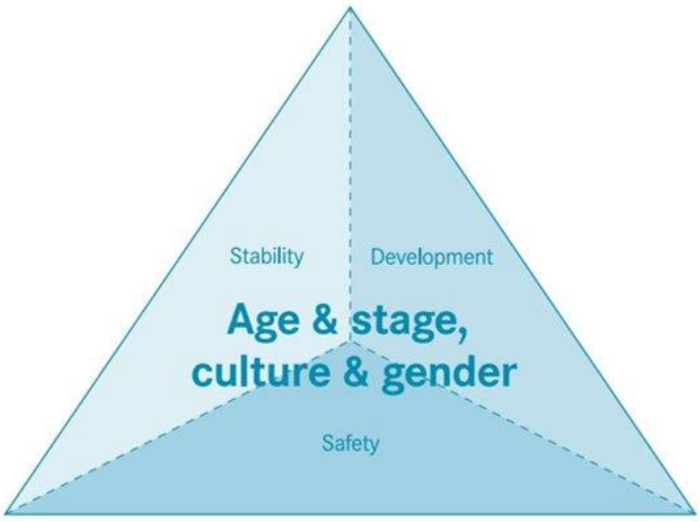
This guide examines some of the key theoretical frameworks and concepts that underpin practice when engaging with children and young people.

### Understanding the Best Interest Case Practice Model

The Best Interest Case Practice Model (BICPM) is the foundation for practice in working with children, (including unborn children) young people and their families, including culturally and linguistically diverse (CALD) and Aboriginal children/families. BICPM focuses on:

- safety
- stability
- development.

Each dimension of the child's experience needs to be viewed through the lens of the age and stage of the child, their culture and their gender. The diagram below shows the key elements of BICPM.




BICPM expects practitioners to consider each aspect of the child's experience, keeping in mind their chronological age, stage of development, gender, culture and social influences when evaluating what a child needs to keep them safe, and to ensure that the child has the best opportunity to achieve their potential.

The framework is enabled through section 10 of the *Child Youth and Families Act 2005* which states that the best interests must always be paramount when making a decision or taking action with regard to a child (young person).[1]

### Understanding trauma and trauma theory

> Trauma is the emotional, psychological and physiological residue left over from heightened stress that accompanies experiences of threat, violence, and life-challenging events.[2]

Trauma is typically defined as an event or events which are outside the ordinary and which are generally

[1] Miller, R. 2012, Best interests case practice model: Summary guide. Victorian Department of Human Services, pp. 2–5.
[2] Thomas, L. 2019, What is trauma? Australian Childhood Foundation, https://professionals.childhood.org.au/prosody/2019/03/what-is-trauma/

distressing and affect a person's ability to respond or cope. Trauma can be an isolated event, involve a series of incidents or be chronic. *Simple trauma* generally refers to discrete events such as accidents, illness or disease and natural or human-made disasters while *complex trauma* typically refers to ongoing threats of violation or violence between a child and another person such as bullying, abuse, neglect or exposure to family violence.[3]

Early childhood trauma is likely to fall into the realm of complex trauma or chronic traumatic stress. Complex trauma occurs with cumulative exposure to traumatic experiences that can involve interpersonal violation and can occur within the child's caregiving system.

There is a growing body of evidence from neurodevelopmental research that shows traumatised children's brains develop differently from those of emotionally healthy children.[4] The brain chemistry is altered (increased cortisol, increased adrenaline, then eventually decreased adrenaline) and the brain structure can be adversely impacted.[5] There is evidence to suggest that chronic early childhood trauma can have a lasting impact on developmental and life outcomes with increased risk for poorer psychological, emotional, sensory and neurological problems.[6] Child maltreatment, including abuse and neglect have also been associated with high rates of death of young people.[7]

A young child's response to trauma is usually very different from that of an adult. If a child is traumatised pre-verbally, they have no language to help them make sense of the situation. If the maltreatment is chronic, then the child comes to believe this is 'normal' and does not consciously see themselves as traumatised. Neurobiological research shows that the 'abnormal' physiological changes caused by trauma become chronic and normalised for children suffering from complex trauma.[8]

## Trauma theory

> Screening for trauma exposure and symptoms is a critical first step for many professionals who are supporting children and families. [9]

Trauma theory provides a theoretical framework for professionals to understand the impact trauma has on individuals. It is based on the following key characteristics.[10]

Disassociation: A child or young person experiencing disassociation may show little understanding of time, where they are, and in severe cases, *who* they are, to self-protect and keep them safe from the experience of trauma.

---

[3] Tobin, M. 2016, Childhood trauma: Developmental pathways and implications for the classroom, *Changing minds: Discussions in Neuroscience, Psychology and Education,* iss. 3, Australian Council for Educational Research.
[4] McLean, S. 2016, The effect of trauma on the brain development of children: Evidence-based principles for supporting the recovery of children in care, CFCA Practice Resource. Australian Institute of Family Studies.
[5] Perry, B. 2003, Effects of trauma events on children: An introduction, The Child Trauma Academy.
[6] Tobin.
[7] Segal, L. Armfield, J. Gnanamanickam, E. Preen, D. Brown, D. Coidge, J. & Nguyen, H. 2021, Child maltreatment and mortality in young adults, *Pediatrics*, vol. 147, iss. 1.
[8] Cross, D., Fani, N., Powers, A. & Bradley, B. 2017, Neurobiological development in the context of childhood trauma, *Clinical Psychology: Science and Practice*, vol. 24, iss. 2, pp. 111–124.
[9] Murray, K., Conradi, L., Forkey, H., Griffin, J., Halladay Goldman, J., Hendricks, A., Malcolm-Brown, J., Manly, J., Noroña, C., Ocampo, A., Tullberg, E., Willeto DeCrane, V. & Wind-Hummingbird, K. 2022, Child neglect and trauma: A fact sheet for providers, National Center for Child Traumatic Stress.
[10] Goodman, R. 2017, Contemporary trauma theory and trauma-informed care in substance use disorders: A conceptual model for integrating coping and resilience, *Advances in Social Work*, vol. 18, iss. 1.

They may present with:

- long periods of silence
- lack of eye movement, or a fixed stare
- lack of variation in tone or volume in their speech
- incongruent or lack of responses to questions asked of them or about them
- responses to questions that are not consistent with the present tense or situation
- repetitive yet aimless movements.

If a professional is concerned that a child or young person is experiencing disassociation, it is critical that they immediately check with other professionals who may be involved with the child, and appropriate family members regarding what therapeutic treatment the child is receiving and follow prescribed recommendations.

Attachment: John Bowlby's attachment theory suggested that children are born with an innate need to form attachments.[11] Such attachments assist in survival by making sure that the child receives care and protection. Children strive to stay close and connected to their caregivers who, in turn, provide a safe haven and a secure base for exploration. Trauma affects a child's ability to develop healthy, interpersonal relationships and to establish trust. Exposure to early relational trauma can play a key role in the development of attachment problems. These can be associated with possible abuse and neglect experienced at early ages and the development of unhealthy relationships.[12]

Re-enactment: The re-experiencing of trauma may present for children and young people through the re-enactment of the original traumatic events. This is commonly seen in children and young people as mimicking. Some younger children may use toys or props to re-enact their experiences. For young people this is observed more in their actions. They may engage in actions that cause them injury or harm, in risk taking behaviours and repeatedly engaging in harmful relationships.

Professionals should take time to listen to children and young people who engage in re-enactment and have the patience and confidence to be able to support the child or young person to be able to reflect on this behaviour. They should also coordinate their response in consultation with other professionals and adults involved in providing the child or young person with support to manage their behaviours.

Impairment in emotional capacities: Emotional numbing and emotional dysregulation are the direct effects of trauma on the brain. Emotional numbing is the mental and emotional process of shutting out feelings and can be a strategy used to protect a person from experiencing any additional pain or trauma. Children and young people who have experienced trauma may present as being flat or distant or may be misrepresented as being disinterested and not willing to engage, or avoidant or resistant to receiving support. Professionals assisting children and young people who may present in this way, may need to persist with attempts to engage with them, and to try and encourage them to participate in planning relating to them.

Some trauma survivors may have difficulty in regulating their emotions such as anger, shame, anxiety and

[11] Bowlby, J. 1988, A secure base: Parent-child attachment and healthy human development, Basic Books.
[12] Erozkan, A. 2016, The link between types of attachment and childhood trauma, *Universal Journal of Educational Research*, vol. 4, iss. 5, pp. 1071–79.

sadness. This is more likely to occur when they have experienced trauma from a young age.[13] Emotional dysregulation in children and young people can, at times, be mis-understood and interpreted as them being irrational, over-reacting, melodramatic and attention seeking, or as unnecessarily abusive or aggressive. Those experiencing emotional dysregulation may engage in substance abuse in an attempt to regain control, as well as in high-risk or compulsive behaviours and eating disorders.

Being aware of this can assist professionals in working with children and young people who are showing signs of dysregulation. It can be helpful to explore safe and creative ways to manage these presentations, including therapeutic supports and engagement in activities that children and young people may find enjoyable or re-directing their attention on positive aspects of their lives.

## Other impacts of trauma on children's behaviour

Physical manifestations: Children and young people may complain of headaches or stomach aches when a professional is engaging with them as it reminds them of their trauma experience, or they are uncomfortable. They may also need to go to the toilet regularly, or in some cases complain of being short of breath or dizzy. It is important not to discount these complaints as being avoidant or evasive.

Hyperarousal: They may experience abnormally heightened states of anxiety when they think about a traumatic event, which can present as difficulty falling asleep, difficulty concentrating, irritability, angry outbursts, being constantly on guard or startled easily.

Children and young people presenting with these symptoms can be perceived as being 'difficult' or non-compliant. Professionals need to be mindful of when to engage with children or young people exhibiting these symptoms. For example, choosing a time of day to ensure the child or young person is able to stay awake and making sure that they feel safe in the environment.

Sleep disturbances: As with hyperarousal, sleep disturbances may be an indicator of trauma which can involve nightmares and restless sleep. Children or young people who experience sleep disturbances might present as yawning, being sleepy or disoriented. Similar to engaging with children and young people who present with hyperarousal, it may be best to avoid meeting with them early in the morning or late in the afternoon.

Cognitive manifestations: The following presentations may be indicators of trauma which are impacting on a child or young person's cognitive functioning. Children and young people may be afraid of going to places, even where they are likely to be safe and supported, as they may have previously experienced trauma in a similar place. It is important to try to establish the reason for the child or young person's distress and attempt to provide them with support and reassurance, whether by relocating to a different place, or simply by listening to what they are telling you they need.

Excessive or inappropriate guilt: This can occur when a child or young person is trying to make sense of their trauma to gain control of the experience and take responsibility, leading to feelings of guilt.[14] This may present for children and young people who are victims of family violence, and who may harbour feelings of guilt and shame, feeling that they had not protected siblings or other family members from the violence and trauma. The child or young person may articulate these feelings to professionals or these may be evident

[13] van der Kolk, B. Roth, S. Pelcovitz, D. & Mandel, F. 1993, Complex PTSD: Results of the PTSD field trials for DSM-IV, American Psychiatric Association.
[14] Center for Substance Abuse Treatment (US), 2014, Trauma-informed care in behavioral health services, Substance Abuse and Mental Health Services Administration (US), Treatment Improvement Protocol (TIP) Series, no. 57.

through the child or young person participating in risk-taking behaviour, or through self-harm.

Consideration should be given to implementing therapeutic supports for the child or young person and providing care to them. If therapeutic supports are already in place, then it is recommended that professionals consult with them to understand how best to support this child or young person.

Trauma bonding: This involves positive feelings for an abuser, making the abused person feel attached to and dependent on their abuser. Indicators of a child or young person developing or having developed trauma bonds may include them making excuses for or covering up for the person who is responsible for the abuse or harm. In covering up the abuse, they may lie to their friends and family by saying that it did not occur. They may also lie about the circumstances surrounding the abuse in an attempt to try to reason or rationalise. Children and young people may believe that they are at fault, which is likely to bring about further feelings of guilt and shame, and may present through risk-taking behaviour, substance use and self-harm.

Intrusive thoughts and memories: These occur when thoughts and memories associated with the traumatic event or events come without warning, triggering strong emotional and behavioural reactions, which may be appear as though the trauma is re-occurring at that time.[15] It is particularly important to understand these effects when engaging or interviewing children and young people. Even when a child is not talking specifically about the experiences of trauma, these thoughts and memories may emerge and professionals need to be able to support the child to feel safe and comfortable.

Self-destructive behaviours: Self-harm for children and young people may present in a variety of different ways, including engaging in, or initiating violent behaviour with others, risk-taking behaviour that may lead to serious injury or harm, placing themselves in environments or situations that may lead to them being injured or attacked by others, or using weapons or implements to bring about pain or cause injury to themselves. Professionals need to work with the child or young person and their informal and formal networks to ensure their immediate safety, mitigate risk and implement or follow any therapeutic recommendations, if deemed necessary.

Children and young people may drink alcohol to excess and use illicit or non-prescribed or prescribed prescription medication, cigarettes, chroming or other chemicals as a way of escaping, or causing harm to themselves, or to provide them with a mis-conceived sense of relief. It is essential for professionals to ensure the immediate safety of the child or young person involved. By working with the child or young person's formal and informal networks, they need to confirm there is a supportive ongoing safety plan in place which involves therapeutic intervention.

## Maslow's Hierarchy of Needs

Abraham Maslow contended that human beings are motivated by a hierarchy of needs, and that some needs are prioritised over others. Once each need is met or fulfilled, then individuals look to the next priority that motivates them. The five needs (starting from most basic to highest needs) conceptualised by Maslow are:

- physiological needs
- safety needs
- belonging needs
- esteem needs

[15]Ibid., ch. 3, Understanding the impact of trauma.

- self-actualisation needs.

Professionals have an important role in making sure children's basic needs are being met, that they are not suffering from neglect, are not at risk of harm, have sources of affection and reassurance, pride in cultural or other identity, and are given opportunities to succeed and to reach their potential. This is particularly important where a child or young person does not have a parent or caregiver able to meet some or all of these needs.


Physiological needs: These relate to food, drink, shelter, warmth, clothing and sleep and are the most crucial for survival.

Safety needs: Children's safety needs, include having a sense of order, predictability and control in their lives. Where parents/caregivers or family members are unable to meet these needs, professionals can make sure children are placed in safe and secure environments. Safety needs include families having a stable and sufficient source of income and the capacity to access medical and material aid, if necessary.

Belonging: A sense of belonging refers to the emotional need for connectedness and establishing and maintaining interpersonal relationships that depend on trust. This sense of belonging can come from parents and primary caregivers, family members, siblings and friends and may vary according to the child's age and stage of development. Children and young people also need access to strong friendships and loving and nurturing relationships, which help them to feel they are valued and cared for, and which provide reassurance of their worth. In some cases, professionals may refer the child to therapeutic supports or counselling to enable the child or young person to strengthen their relationships.

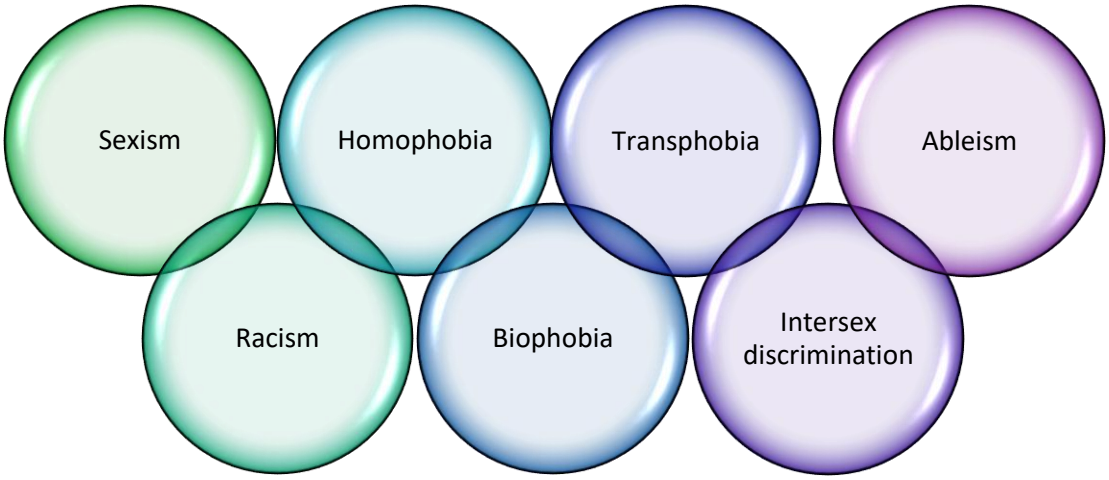
Self-esteem: Self-esteem follows once physiological, safety and belonging needs have been met and involves a sense of self-worth, self-respect, and accomplishment. Maslow indicated that the need for respect is most important for children and adolescents and precedes real self-esteem or dignity. Professionals can support them by reassuring and highlighting the positive attributes of children and young people with low confidence and low self-esteem.

Self-actualisation: Self-actualisation involves the realisation of potential and self-fulfilment. For children it involves them seeking to understand who they are and who they want to be. They may need to be supported by professionals to recognise their potential, have access to opportunities to celebrate achievements, and additional supports to assist families to encourage the young person to continue to seek growth and achieve fulfillment.

## Intersectionality

Intersectionality is a theoretical approach that highlights the interconnected nature of social categorisations and the impact of these multiple and intersecting forms of structural discrimination on individuals. It acknowledges all the complex systems and structures that can create disadvantage such as gender identity, sexual orientation, nationality, Aboriginality, ethnicity, colour, language, religion, class, socioeconomic status, refugee or asylum seeker background, migration or visa status, ability and age.

Attitudes, systems and structures in society and organisations can interact to create inequality and result in exclusion. These include:




When these aspects or characteristics combine:

- there is a greater risk of people experiencing family violence
- people find it harder to get the help they need due to systemic barriers
- there is increased risk of social isolation.

### Practice implications

Children, young people and their families may have experienced multiple, systemic barriers to opportunity, various forms of prejudice and regular encounters with services which have left them feeling judged. Such

experiences can contribute to distrust of authorities, services and professionals and reluctance to engage with services.

It is important to recognise a child or young person and their families' unique experience of intersectionality. Not all children or young people of a particular marginalised group will share the same experience.

Consulting with community leaders, members and groups who have been affected by policies and practices that have led to their oppression and discrimination can show a child or young person with the same intersectional characteristics that they are valued.

Intersectionality should encourage collaboration across the community and across professions. No single professional will have expertise in all facets of a child or young person's life, and the child or young person will benefit from professionals drawing on appropriate specialists and experts to provide the widest possible support for children and young people.

Intersectionality should also encourage professional self-reflection and self-awareness. When engaging with children and their families, professionals need to recognise their own social identity and privilege, such as gender, cultural background, socioeconomic status and access to education. They need to be sensitive to any differences and use inclusive language. It might be that other professionals can better speak to the experiences of the child or young person than they can.

## Systems theory

Systems theory is a conceptual framework based on the principle that the component parts of a system can best be understood in the context of the relationships with each other and with other systems, rather than in isolation. For example, a person's family, friends, school, employment, community and social and physical environments will all influence their functioning and wellbeing.

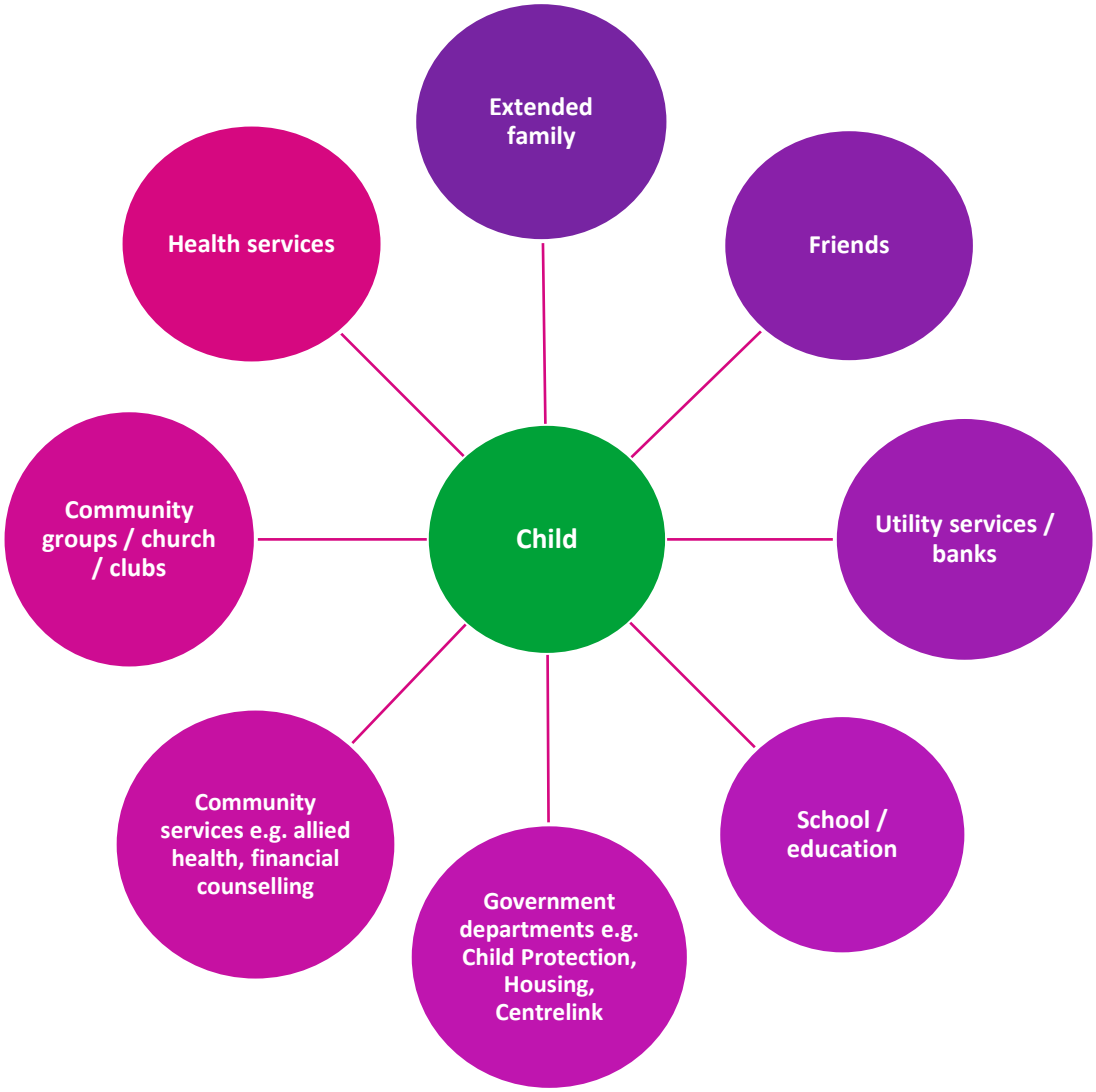
The various systems can be categorised at a micro level (such as family relationships), mezzo level (such as school, work and community connections), or macro level (wider community and society). As the individual interacts with various systems, they both influence and are influenced by their environment.

Applying systems theory to practice enables a more complete picture of the factors affecting a client's life, decisions and actions. It can also be useful in removing blame or stigma from an individual and validating their current challenges.

### Ecomaps

Ecomaps are a valuable way of placing the client or family in their current social context by providing a visual depiction of their connections to their external world. Ecomaps can capture family dynamics, connections to social support systems and to the community, and also detail the quality of these various relationships and connections. An ecomap can effectively highlight gaps where resources or supports may need to be added or strengthened and areas of service duplication. Creating an ecomap collaboratively with a client or family members can also be a valuable tool for building rapport and demonstrating curiosity and interest in their experiences and challenges.

Below is an example of an ecomap. This could also include a key which identifies the quality of relationships, such as whether the connection is strong or weak, or is a source of support (positive impact) or stress or harm (negative or detrimental impact).


Extended family
Health services
Friends
Community groups / church / clubs
Child
Utility services / banks
Community services e.g. allied health, financial counselling
Government departments e.g. Child Protection, Housing, Centrelink
School / education